



NIHR POLICY RESEARCH UNIT IN HEALTH AND SOCIAL  
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**Integrated Care Systems: What can current reforms learn from past  
research on regional co-ordination of health and care in England?**

A literature review

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## **EXECUTIVE SUMMARY**

### **Introduction**

This report is part of the research of the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm) on the developing architecture of system management in the English NHS – including Sustainability and Transformation Partnerships, Integrated Care Systems or their successors – commissioned by the Department of Health and Social Care.

Five years since the publication of the *Five Year Forward View* (NHS, 2014), the integration of health and social care at a ‘system’ level remains a central NHS policy priority in England. The *NHS Long Term Plan* (NHS, 2019a) further set out how organisations are to continue to work together collaboratively across bounded geographic territories with the aim of improving co-ordination of local health and care services to encourage the better use of resources and through managing population health. Without change to legislation, encouraging system-wide collaboration marks a major shift in policy direction away from the primacy of quasi-market competition.

Forty-four non-statutory Sustainability and Transformation Partnerships (STPs) of NHS commissioners and providers, local authorities, and in some cases, voluntary and private sector organisations have been formed across England. Fourteen of the more ‘mature’ partnerships have since been designated Integrated Care Systems (ICSs) to be granted increased autonomy, providing greater freedom over how they manage resources collectively. There are usually three spatial levels of organisation within each STP/ICS: ‘neighbourhoods’ covering a population of roughly 30,000 – 50,000; ‘place’ between 250,000-500,000 people and STP/ICS ‘system’ level between 1 million – 3 million. In addition, seven new regional teams bring together NHS England and NHS Improvement at a regional level, intended to harmonise their operations for system-wide working.

Despite undergoing continuous reinvention, an intermediate tier has existed for most of the history of the English NHS, with statutory authorities (at times, several layers of authorities) responsible variously for long-term strategic planning, allocating resources, acting as market umpires, and overseeing delivery of local health services. The latest reforms mark a return of an intermediate tier, filling a vacuum left behind by the abolition of Strategic Health Authorities (SHAs) in 2013. However, unlike previous health authorities, STPs and ICSs are not statutory bodies, but instead exist as non-statutory voluntary partnerships despite being effectively mandated by NHS England.

This report presents the findings of a review of literature on previous intermediate tiers in the NHS. Drawing on peer-reviewed academic research, historical analysis and commentary from academic and policy sources, it examines their functions and responsibilities, how they operated in practice and their interaction with local government. Putting current reforms in their geographical and historical context, we draw out lessons for the challenges and opportunities STPs and ICSs may encounter in the years ahead.

## **Summary of our findings**

Our review of literature reveals there has not been extensive, systematic research into intermediate tiers of the health service in England over the last seven decades. During this time, regions have continuously been a target for reform. There is no consensus among policy makers or commentators over where functions and responsibilities should be located. Differing views appear to have been shaped by different political strategies and policy trends. Organisational change has accelerated in recent years. Broadly speaking, operating within intractable tensions facing the health service, regions have progressively declined in their influence. Once responsible for the allocation of resources, their reduced role coincides with new forms of performance and financial management. Nevertheless, our review shows that longer-term strategic planning has usually occurred at an intermediate level. Through situating current changes in their historical and geographical context, a series of key themes and their implications for policy can be identified.

## **Implications of the literature for current policy**

### ***System-wide co-ordination and oversight***

There are certain benefits in an intermediate tier planning and overseeing services, as well as mediating centre-local relations. Previous intermediate tiers operated with planning functions across wider geographic areas, as well as having capacity for dispute resolution and managing finances. Ongoing mergers of Clinical Commissioning Groups (CCGs) appear to be a recognition of the benefits of co-ordinating certain functions over larger geographies than that of the existing CCGs, although disputes over where functions and responsibilities are best located will likely prove a recurrent issue. Hierarchy in the NHS remains strong and the ability for STPs and ICSs to provide a counter balance to national bodies appears weak. It is not yet clear what the role and mechanisms available to the new regional teams of NHS England/Improvement will be, but it is likely that they will act as agents of central control. Unless ICSs were to become statutory bodies with clear authority and stronger mechanisms to sustain agreements, given the inevitable conflicts embedded within the existing organisational landscape, current reforms at both 'system' and 'regional' level do not resemble a 'return to health authorities', even if certain functions of SHAs are being recreated.

### ***Between system working and organisational autonomy***

In the absence of changes to the individual regulation of NHS organisations, system-wide collaboration between organisations will remain challenging. Thus, having an intermediate body to facilitate closer working has benefits. Yet in the absence of any primary legislative changes, the current policy will require STPs and ICSs to operate with further 'workarounds' to support closer working in a regulatory landscape established to promote competition. The complexity of governance arrangements required to undertake decisions across the different geographies within (and beyond) STPs/ICSs may well impede local service changes at the pace demanded. Partnerships will likely be tested by individual organisational risks, contentious decisions and response to crises.

### ***Appropriate scale***

There is no 'perfect scale' for integrated commissioning or planning. Establishing where is 'best' also depends on the particular service or function under question. How proposed primary care-led models of care fit together across neighbourhood, place and system levels will demand careful attention. Fine-grained oversight of the delivery of local services such as primary and community care requires detailed local knowledge and strong relationships across a territory with a meaningful identity among those involved, including staff and the public. Yet how this intersects with the commissioning, monitoring and regulation of the wider geographies associated with acute and specialised sectors, and potentially politically contentious decisions remains unclear. It will therefore be particularly important to define carefully the scope, role and responsibilities of 'places'.

### ***Place matters***

Tensions aligning *national* health with *local* government have been in existence since the NHS was created. These will not be resolved by the latest policies. Different attempts have been made over the years to align or integrate health and social care services at the intermediate tier. Coterminality of boundaries may help co-ordinate health and social care, although NHS commissioners, Trusts, and local authorities now operate across different geographies. Caution must be exercised in assuming aligning boundaries and establishing partnership arrangements will necessarily lead to 'integrated care' for patients. Pooled budgets and co-commissioning have been increasingly used in recent years, however the associated political and technical difficulties are unlikely to be overcome under the current arrangements. STPs and ICSs will not operate uniformly across the country. With local government facing major financial pressures, aligning local priorities and decisions will be important, if challenging. Expected 'participation' remains unclear, however the role of Health and Wellbeing Boards may prove significant. How voluntary and private sector organisations are embedded within the new partnerships also remains uncertain. Health and well-being is influenced by more than health services alone, however, concerns policy-making is NHS-centric are by no means unprecedented. Both local and national politics will impact reform, not least given uncertainties over social care as well as questions over accountability and involvement of the public.

### ***Reform takes time***

Top-down reorganisation has been pursued at remarkable pace in recent decades. Policy churn is now a widely recognised phenomenon. Legislation alone does not determine how systems function. However, using 'workarounds' to circumvent existing legislation is problematic given the absence of political scrutiny and reflection. It takes time before the effects of reform become apparent, yet reorganisation now occurs without time to generate sufficient evidence or to learn lessons from previous failures. As debates over the future of the purchaser/provider split continue, policymakers should not expect the current changes to solve the complex challenges facing health and social care in England. Yet nor should urgency to reform provide sufficient justification to move onto the next reorganisation if expected outcomes are not achieved rapidly.

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## 1. INTRODUCTION

The National Health Service (NHS) was created in 1948 as a national, publicly-provided, healthcare system funded through general taxation to provide comprehensive care free at the point of need. Hospitals were nationalised whilst general practitioners became part of the NHS as independent contractors rather than salaried employees. The provision of social care was retained by local government and, unlike the NHS, needs and means-tested. Over the last seven decades, both health and social care has undergone extensive reform across the four countries of the United Kingdom. In England – the primary focus of this review – this has been shaped by policy debates over where decisions are best made and by whom, how much local variation and flexibility should be possible or allowed, how and by whom should services be organised and provided, as well as who is to be held accountable for access to services and quality of care patients receive. At the same time, historical divides embedded at the creation of the NHS between primary and specialist care, health and social care (as well as mental and physical health care) continue to have significance more than 70 years later. With the policy aim in England for Sustainability and Transformation Partnership (STPs) and Integrated Care Systems (ICSs) to overcome these historical structural divides, it once again raises fundamental questions over how health and social care should be organised.

An ‘intermediate tier’ shaped by central policy-making decisions whilst overseeing the organisation of local health services has been a feature for nearly the entire history of the NHS. ‘Regions’ have been a near constant – if constantly changing – feature within the organisation of healthcare. This differs and diverges from moves towards and away from regional government in England over the years. It also presents certain definitional challenges. Regions are spatial formations; intermediate tiers are organisational. Regions may be intermediate to varying degrees but intermediate tiers are not necessarily regional. In this report we provide a theoretical basis for understanding and explaining this conceptual difficulty. However, it is important to provide some initial definitional clarity. For consistency, we define an intermediate tier – statutory or otherwise – as a collective term for all layers of *management or administration* between the centre and the front line of (health) service delivery. Within the specific context of health and social care, we define regions as a *spatial scale*, or level, below national deriving its authority from the centre and overseeing a substantial geographical territory.

For many decades, intermediate bodies, usually statutory authorities, have negotiated two opposing tensions within the organisation of the NHS: should the health service be understood as a series of local health services combined into a national system or a national health service that is locally managed (Butler, 1992; Mohan, 1995; Powell, 1998)? Consequently, the intermediate tier has been under continuous reinvention, especially in recent decades, with their functions and responsibilities shifting as new policy interventions and priorities come and go. Some periods of the organisation of the NHS have involved multiple tiers of oversight, whilst at other times the structure has been relatively lean, with few layers between the ‘local’ front line of service delivery and

'centre'. Joint or collaborative structural arrangements with local government have at different times been more or less aligned, if not integrated, over the course of multiple reorganisations.

The NHS has historically operated with a principally hierarchical bureaucratic structure. Reforms in the early 1990s led to the introduction of an 'internal market' in the NHS that separated 'purchasers' and 'providers' of healthcare services and encouraged providers of health services to operate, take decisions and be regulated as competing business-like organisations. The purchaser/provider split profoundly transformed the role of regions in the organisation of health and care. Administrative hierarchically-organised territorial units with relatively coherent boundaries such as regions, areas, districts, gave way to more organisationally-focused and more geographically porous, if by no means detached, bodies such as Health Authorities and Strategic Health Authorities. Today, the English NHS operates as a 'quasi-market' with a mix of NHS and private providers (and social care is now provided principally by private sector providers). The *Health and Social Care Act 2012* codified and extended quasi market structures and regulation for the NHS. In this top-down re-organisation of 2012, it is significant to note that the statutory intermediate Strategic Health Authorities were abolished, leaving no statutory body between the national level and local purchasing organisations.

Since 2014 and the publication of the *Five Year Forward View* (2014), 'integration' has become the prevailing policy direction for organising health and care, despite the fact that the *Health and Social Care Act 2012* remains in force. Yet, integration and integrated care are malleable terms; integrated services, funding and contracts should *not* be assumed to be the same as integrated care for patients. Broadly speaking, integration is frequently used to describe co-ordinating care to overcome the divides between health and social care, primary and secondary care, and mental and physical health. In pursuing a more integrated service, national policy making now prioritises organisational co-operation through the creation of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), intended to shape how health and care is planned, co-ordinated and delivered across England. By prioritising place-based co-operation over organisational competition, the emergence of ICSs raises questions as to the future of the competition orientated *Health and Social Care Act 2012*, a provider and regulatory landscape focused principally on organisational autonomy, whilst indicating the necessity for a return in some form to strategic regional or sub-regional oversight.

Reasons for the changing roles of intermediate tier in the NHS are historically and geographically complex. Reorganisations are shaped by different policy claims over 'natural geographies' of planning or organising care, where 'best' to locate responsibilities and functions, as well as changing relationships with other parts of health and care systems. The composition of intermediate tiers, their intended functions, where patients travel in order to access care and who these bodies represent has varied over structural reorganisations. Different functions and responsibilities shift from one level to

another as policy agendas and priorities have changed, even if policy narratives surrounding decentralisation or devolution may not necessarily have corresponded the reality (Allen, 2006; Lorne *et al.*, 2019).

To learn from past reorganisations analytically, rather than just descriptively, it is necessary to provide a theoretical basis for understanding the changing dynamics of ‘the region’. As a core concept in academic disciplines such as geography, the making and remaking of regions (at any particular spatial scale) is *integral* to, not just the outcome of, different policy interventions. Processes of *region-making* are contested and multiple. Consequently, as we have already highlighted, discussing ‘regional’ or ‘intermediate’ tiers, it is easy to get confused as to what is under investigation. This presents a problem when referring to specific ‘regional’ or ‘sub-regional’ NHS bodies at different times in its history (a problem also reflected within the literature).

We provide a theoretical framework for the shifting dynamics of regions in the NHS in *Section 3*. For now, we simply state that the difficulty in finding consistency and stability around the composition and functions of regions in the NHS is not accidental. Thus, when adopting a theoretical perspective, we refer to regions in their broadest conceptual sense. However, *Figure 1* provides some consistency of terms when specifically referencing structures in between local and national scales in the NHS to help orientate readers. From an NHS-specific perspective, we use the collective term of the intermediate tier (or tiers), which includes ‘regional’ authorities, as just one of these tiers. Additionally, intermediate tiers may be statutory or non-statutory. Situated within the dynamics of centralisation and decentralisation, intermediate bodies may at times have greater autonomy (decentralist) or may operate merely as administrative layers (de-concentration). This is discussed more extensively in *Section 3*.

In this report, we consider evidence about the purpose and function of previous intermediate tiers in the planning, co-ordination and delivery of care. It is widely-recognised that the serial reinvention of the intermediate tier has featured heavily in the continuous reorganisation of the NHS in what has been described as a ‘triumph of hope over experience’ (Edwards, 2010). Where evidence is available, we consider how previous regional and system-wide planning and organisation of health services functioned, what issues they faced, what tools were available, and how they worked. We also explore how these bodies related to the long-standing challenges of joint working between the NHS and local government to examine collaboration in the planning and co-ordination of health and social care, as well as the role of the voluntary and private sectors.



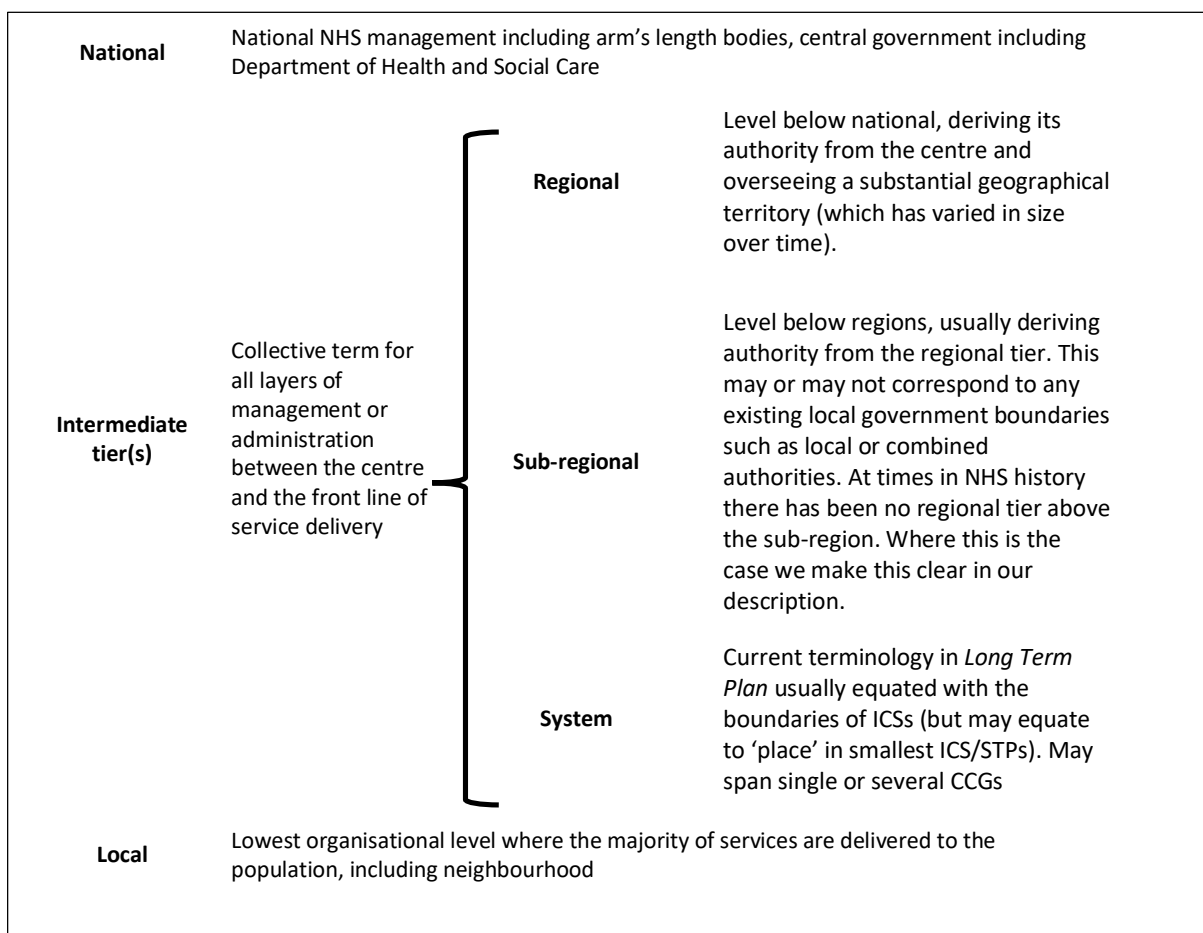


Figure 1 – Summary of NHS terminology

Our review is intended to inform policy makers and NHS colleagues dealing with the ongoing attempts to co-ordinate health care and also align or integrate health with social care. Through putting current reforms in their historical and geographic context, we identify key themes and challenges that those involved in ICSs and STPs may likely face. To achieve this, we address a series of research questions:

- What functions were exercised by previous intermediate tiers of co-ordination in the NHS?
- What organisational form did they take and how were they governed?
- How have health and local authorities previously co-ordinated health and social care?
- What key themes can we observe from past intermediate tiers to inform the ongoing contemporary reforms?
- What challenges and issues might we anticipate Integrated Care Systems will face?

## 2. CURRENT POLICY CONTEXT

### 2.1. Integration and the Five Year Forward View

'Integration' is central to current national NHS policy-making in England. The overarching policy direction was first set out with the publication of the *Five Year Forward View* by NHS England *et al.* (2014) in October 2014. The change in policy direction came less than three years after the passing of the *Health and Social Care Act 2012* intended to further emphasise market competition between both NHS and non-NHS providers of healthcare. The *Five Year Forward View* did not provide a definition of integration, but broadly advocated 'breaking down the barriers' that were said to have existed since the formation of the NHS in 1948: between health and social care, between primary and secondary care, between mental and physical health care and between prevention and treatment.

Several reasons were given to establish why the shift towards integrated care was required. Some of the forces behind a shift towards integration were identified as global trends: changes in the health needs of patients with longer-term conditions, as well as personal preferences; technological changes in treatment and the delivery of services; and the stated implausibility of returning to the same level of increases in healthcare expenditure as those of the first decade of the 21<sup>st</sup> century, as a consequence of austerity measures which had been chosen as the prevailing response to the global financial crisis (NHS, 2014). Three gaps specific to England were also identified: First, the *health and well-being gap*, i.e. if prevention were not taken seriously, health inequalities would widen, healthy life expectancies would stall and new treatment would not be affordable. Second, the *care and quality gap*, i.e. that if care were not redesigned, new technology harnessed and variations in quality and safety remedied, unavoidable variations in outcomes would continue and needs would be unmet. Third, the *funding and efficiency gap*, i.e. that if there were an inability to implement broad and at times controversial health system efficiencies, then the future NHS would experience a mixture of worse services, fewer staff, financial deficits and new treatments would be limited (NHS, 2014, p. 7).

A core objective of the *Five Year Forward View* was to encourage local areas to establish pilots (known as *Vanguards*) which would test new ways of working together across sector boundaries. Crucially, these pilots were intended to establish new 'products and frameworks' which would support the wider roll-out of integrated care organisations comprised of multiple local service delivery organisations holding collaborative contracts to deliver care across sector boundaries (Checkland *et al.*, 2019). In practice, whilst many integrated care initiatives were established, integrated care organisations holding collaborative contracts were not (Checkland *et al.*, 2019). This has some implications for regional/sub-regional oversight in the future, and we will return to this in the discussion.

Additionally, the *Five Year Forward View* set out plans for Clinical Commissioning Groups (CCGs) to take a greater role in primary care commissioning as part of a co-

commissioning initiative. Clinical Commissioning Groups were able to apply to do so at one of three levels – from ‘greater involvement’, through ‘joint commissioning’, to ‘delegated authority’ – with each offering increasing influence over the process, albeit with statutory responsibility residing with NHS England. Co-commissioning was launched in April 2015, but from late 2015 communications from NHS England began encouraging CCGs to move towards full delegated commissioning (NHS England, 2015). This continues to be the aspiration of NHS England on the basis that delegated commissioning is ‘delivering the most benefits for local populations’, and at the time of writing the vast majority of CCGs have taken this up (184 of 191) with only a handful currently operating with joint commissioning (2) or greater involvement (5) approaches (NHS England, no date). Research (McDermott *et al.*, 2018) has emphasised, however, the extent to which current arrangements represent a ‘workaround’ of existing legislation and statutory duties that contains within it an unresolvable tension between conflicts of interest and local knowledge informing commissioning decisions, and contributes to ambiguity over how responsibilities for primary care performance management arrangements should work in practice.

In 2015, the process of creating Sustainability and Transformation Plans (STPs) was initiated (later becoming ‘Partnerships’). NHS England *et al.* (2015, p. 4) issued guidance that stressed moves towards place-based planning processes would involve ‘local leaders coming together as a team, developing a shared vision with the local community, which also involves local government as appropriate; [and] programming a coherent set of activities to make it happen’. 209 CCGs, as well as local authorities and NHS providers, were directed by national NHS bodies to work together to establish the ‘geographic scope of their STP’ constituting their ‘transformation footprint’ for the period between October 2016 and March 2021. Building on initial pilots fostering moves towards integrated care, the vision for STPs was they would bring together NHS and other organisations into integrated, collaborative partnerships. Thus planning guidance entitled *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21* (NHS, 2015, p. 4) was issued to every NHS provider and commissioning body stating that:

We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View ... Planning by individual institutions will increasingly be supplemented with planning by place for local populations ... As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity ... The STP must also cover better integration with local authority services.

Organisations were initially given one month to produce their STPs, on the basis that ‘we don’t have the luxury of waiting until perfect plans are completed’ (NHS, 2015, p. 3). Despite the time pressures imposed, national guidance emphasised STPs were to be local plans, rather than a top-down reorganisation:

‘Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver services, transformation and public health programmes required... In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time’ (NHS, 2015, p. 6).

By March 2016, 44 bounded STPs were created and mapped across England, covering an average population size of 1.2 million (NHS England, 2016). STP leaders were drawn from NHS organisations, with the exception of 4 who were from local authorities. The new STPs had no statutory basis and all existing organisational accountabilities remained. National submission of STP documentation covering the period between October 2016 and March 2021 was required in order to enable their allocation of a portion of the Sustainability and Transformation Fund that in 2016/7 amounted to £2.1 billion (Hammond *et al.*, 2017).

Importantly, no legislative changes were made in connection with the STP process. The existing organisational landscape and regulatory framework orientated towards organisational competition and individual organisational regulation and monitoring continued to exist, despite the shift towards system-wide working. The formative stages of the creation of STPs was also politically problematic given the public were largely excluded from involvement in the rapid production of the plans (Black and Mays, 2016) and several local authorities raised concerns with or disassociated themselves from their constitutive STPs (HSJ, 2017, 2018).

By 2017, when STPs formally became Sustainability and Transformation *Partnerships*, some parts of the country were already enacting further changes. The most high-profile and wide-ranging of these was Greater Manchester. In February 2015, it was announced that a health and social care devolution deal had been agreed between NHS England and the 12 Clinical Commissioning Groups (CCGs) and 10 local authorities in the city-region of Greater Manchester (NHS, 2015). Their new partnership arrangements were, effectively, a front-runner to the 44 STPs. They also became one of the 14 most ‘advanced’ STPs that have subsequently evolved into Integrated Care Systems (ICSs).

ICSs are the principal motivator of this review, for which we now turn to provide definition. For the purposes of clarity, it is useful to state that STPs were the forerunners to ICSs, and there is an expectation from NHS England that all STPs will have evolved into ICSs by 2021. However, many STPs in England have yet to be redesignated ICSs, and we recognise that there is currently a degree of ambiguity between these terms.

## 2.2. Definition and evolution of Integrated Care Systems

Unlike previous reforms, led by the Department of Health, current national policy priorities have been driven by arm's length bodies, principally NHS England (legally, NHS Commissioning Board) working with others such as NHS Improvement, albeit under the badge of 'the NHS'. Formal definition of ICSs (or STPs) has not been set out in legislation, but evolved over time in policy documents published by NHS England. As discussed above, ICSs emerged out of a series of policy documents and announcements since the initial creation of STPs. How they are expected to work in practice is still evolving, although NHS England state that they expect all parts of England to be covered by an ICS by April 2021. Importantly, although the development of ICSs (and STPs) have been effectively mandated by NHS England, they are *not* statutory bodies. Existing organisational accountabilities and forms remain and individual organisations can withdraw from the new partnerships at any time.

The *Next Steps on the NHS Five Year Forward View* (2017) published in March 2017 stated that the more 'advanced' STPs would go further in a move to more fully integrating their services and funding in what were called at the time Accountable Care Systems (ACSs). ACSs were positioned as an evolution of existing STPs – 'or groups of organisations within an STP sub-area' – whereby systems of NHS commissioners and providers, often working together with local authorities, will opt to take collective responsibility for both resources and the population health of their territory (NHS, 2017, p. 36). In doing so, they will be granted greater controls over how they operate their local system.

The *NHS Long Term Plan* (NHS, 2019a) published in January 2019 continued to emphasise the move towards integrated partnerships prioritising collaboration over competition. It states that ICSs (as ACSs had been renamed) 'bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care' (NHS, 2019a, p. 29). ICSs are intended to be 'bottom-up' partnership arrangements, rather than following a single national blueprint and there are currently no extensive, fixed set of requirements to which all ICSs must adhere. The current STPs and ICSs vary considerably in population size and organisational complexity. However, broadly speaking, the new 'system-level' ICS or STP (population size of 1-3 million) sits in a hierarchy with 'place' level (population size of 250, 000 – 500,000, usually local authority areas) and 'neighbourhood' level (population size of 35,000-50,000) beneath it and 'regional' level above through the regional arms of NHS England and NHS Improvement (discussed further below).

Local authorities have a key role in working at 'place' level through ICS structures whereby 'commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation' (NHS, 2019a, p. 10). Recent NHS policy guidance on *Designing integrated care systems (ICSs) in England* sets out the 'place' level as covering a population of roughly 250,000 – 500,000, 'served by a set of

health and care providers in a town or district, connecting primary care networks to broader services including those provided by local councils, community hospitals or voluntary organisations' (NHS, 2019b). The 'place' level was anticipated to be the spatial scale through which Accountable (or Integrated) Care Organisations were to exist, however, they do not currently exist (see figure 2 below).

Level	Function	Priorities
<b>Neighbourhood (c. 30,000 to 50,000 people)</b>	<ul style="list-style-type: none"> <li>• Integrated multi-disciplinary teams</li> <li>• Strengthened primary care through primary care networks – working across practices and health and social care</li> <li>• Proactive role in population health and prevention</li> <li>• Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).</li> </ul>	<ul style="list-style-type: none"> <li>• Integrate primary and community services</li> <li>• Implement integrated care models</li> <li>• Embed and use population health management approaches</li> <li>• Roll out primary care networks with expanded neighbourhood teams</li> <li>• Embed primary care network contract and shared savings scheme</li> <li>• Appoint named accountable clinical director of each network</li> </ul>
<b>Place (c. 250,000 – 500,000 people)</b>	<ul style="list-style-type: none"> <li>• Typically council/borough level</li> <li>• Integration of hospital, council and primary care teams / services</li> <li>• Develop new provider models for 'anticipatory' care</li> <li>• Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance</li> </ul>	<ul style="list-style-type: none"> <li>• Closer working with local government and voluntary sector partners on prevention and health inequalities</li> <li>• Primary care network leadership to form part of provider alliances or other collaborative arrangements</li> <li>• Implement integrated care models</li> <li>• Embed population health management approaches</li> <li>• Deliver Long-Term Plan commitments on care delivery and redesign</li> <li>• Implement Enhanced Health in Care Homes (EHCH) model</li> </ul>
<b>System (c. 1 million to 3 million people)</b>	<ul style="list-style-type: none"> <li>• System strategy and planning</li> <li>• Develop governance and accountability arrangements across system</li> <li>• Implement strategic change</li> <li>• Manage performance and collective financial resources</li> <li>• Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system)</li> <li>• Collaboration between acute providers and the development of group models</li> <li>• Appoint partnership board and independent chair</li> <li>• Develop sufficient clinical and managerial capacity</li> </ul>
<b>NHS England and NHS Improvement (regional)</b>	<ul style="list-style-type: none"> <li>• Agree system objectives</li> <li>• Hold systems to account</li> <li>• Support system development</li> <li>• Improvement and, where required, intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Increased autonomy to systems</li> <li>• Revised oversight and assurance model</li> <li>• Regional directors to agree system-wide objectives with systems</li> <li>• Bespoke development plan for each STP to support achievement of ICS status</li> </ul>
<b>NHS England and NHS Improvement (national)</b>	<ul style="list-style-type: none"> <li>• Continue to provide policy position and national strategy</li> <li>• Develop and deliver practical support to systems, through regional teams</li> <li>• Continue to drive national programmes e.g. Getting It Right First Time (GIRFT)</li> <li>• Provide support to regions as they develop system transformation teams</li> </ul>	

Figure 2 – Reproduction of spatial scales and functions of NHS *Long Term Plan* (NHS, 2019a: 3)

Integrated Care Systems are intended to focus on shared decision-making with providers about the allocation of resources, service design and improving population health, although under existing legislation, any procurement or awarding of contracts must be undertaken by NHS commissioners. Recent guidance published by NHS England (NHS, 2019b, p. 3) sets out the functions of ICSs as follows: to develop system strategy and planning; to develop system-wide governance and accountability arrangements; to lead the implementation of strategic change; to manage performance and collective financial resources; and to identify and spread best practices across the system to reduce unwarranted variation in care and outcomes. The governance of ICSs as set out in the *Long Term Plan* (NHS, 2019a, p. 30) should include:

- ‘a partnership board, drawn from and representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector and other partners;
- a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/governing bodies;
- sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes;
- full engagement with primary care, including through a named accountable Clinical Director of each primary care network;
- a greater emphasis by the Care Quality Commission (CQC) on partnership working and system-wide quality in its regulatory activity, so that providers are held to account for what they are doing to improve quality across their local area;
- all providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives;
- clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, as will Clinical Senates and other clinical advisory bodies. ICSs and Health and Wellbeing Boards will also work closely together’.

The existing CCGs are required to become streamlined and strategic, which ‘typically’ will require moving towards mergers that lead to a single CCG covering each ICS in order to ‘enable a single set of commissioning decisions at system level’ (NHS, 2019a, p. 29), although many of the ‘frontrunner’ ICSs feature more than one CCG (for instance, as one of the biggest ICSs, Greater Manchester continues to have ten CCGs working with the 10

largely coterminous local authorities, despite their new ICS-wide partnerships arrangements (Walshe *et al.*, 2018)).

Seven new regional teams led by regional directors as part of the new NHS Executive Group, were announced in December 2018 (NHS England, 2018b). The new teams are regional arms of an amalgamation of NHS England and NHS Improvement.<sup>3</sup> Their role is currently loosely defined as working to ‘support local systems to provide more joined up and sustainable care for patients’ (NHS England, 2019a: np). The regional teams are ‘responsible for the quality, financial and operational performance of all NHS organisations in their region, drawing on the expertise and support of our corporate teams to improve services for patients and support local transformation’ and they are also tasked with supporting the development and identity formation of the STPs and ICSs (NHS England, 2019a: np). At the time of writing, these roles are still evolving.

In addition, there have been simultaneous policy developments aimed at encouraging groups of organisations merging to become larger integrated care organisations which would be contracted with the NHS through the Integrated Care Provider (ICP) contract (previously known as the Accountable Care Organisation contract) developed by NHS England (NHS England, 2018a). NHS England guidance (NHS, 2019b) suggests ICSs will in general operate over a larger population than any single provider, ICP or otherwise. There has been no indication nationally that this will happen everywhere in England and initial attempts to roll out ICP contracts have been delayed, following judicial reviews and public consultations. At the time of writing, no ICP contract has been agreed. To allay concerns that for profit firms might wish to form ICPs, a recent Commons Health and Social Care Committee (2019) report advised that the ability for an ICP contract to be held by a non-statutory body should be ruled out and NHS England has confirmed that only NHS owned ICPs would currently be approved (HSJ, 2019).

### **2.3. Primary Care Networks**

Important organisational changes are also currently taking place at other spatial scales that will impact system-wide planning, organising and oversight of local services. At a neighbourhood level has been the formation of Primary Care Networks (PCNs). Introduced in the *NHS Long Term Plan* (NHS, 2019a), but building on an aspiration for greater ‘at scale’ working in primary care established in the *Five Year Forward View* (NHS, 2014), PCNs involve groups of GP practices (typically covering patient populations of 30,000-50,000, with approximately 1,300 PCNs in England in total) agreeing to work more closely with each other, as well as attempting to integrate better with community health care services and other local health and care organisations. The intended benefits of PCNs include: providing more accessible and integrated care for patients, reducing

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<sup>3</sup> In the absence of any legislative change, a merger between the NHS Commissioning Board and NHS Improvement (itself an informal amalgamation of Monitor and NHS Trust Development Agency) is not legally possible at present.



pressures on the primary care workforce, providing footprints for integrated community-based teams, and more proactive assessment of the health needs of local populations and the development of tailored interventions to address these. In terms of scale, NHS England state that PCNs must be 'small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system' (NHS England, 2019b). They are expected to be geographically contiguous and reside within CCG and ICS boundaries. Each PCN must employ a Clinical Director to represent the interests of his/her network at the ICS level and communicate information from one to the other.

The decision of whether to join a PCN is voluntary for a GP practice but the incentives to do so are strong and the vast majority decided to do so by the 1<sup>st</sup> July 2019 deadline. This involved each practice signing up to a Network Contract (a Directed Enhanced Service, an extension to the GP contract), which will provide an opportunity to attract £1.8bn of funding to general practice over five years. Some of this funding will relate to the achievement of certain requirements associated with seven service specifications set out in the Network Contract, which will evolve annually. From 2020/21, PCNs will be required to demonstrate achievements relating to five of these (e.g. structured medicines review and optimisation; enhanced care in care homes), with the final two introduced from 2021/22 (cardiovascular disease prevention and diagnosis; and tackling neighbourhood inequalities). To support PCNs to deliver the service specifications, and with an expectation of alleviating some GP workforce pressures, an Additional Roles Reimbursement Scheme (ARRS) has been introduced, which will see Networks receive the majority of funding (staggered by year according to role) to employ clinical pharmacists (2019), social prescribing link workers (2019), physician associates (2020), first contact physiotherapists (2020) and first contact paramedics (2021).

Research into PCNs is currently underway led by other members of the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm). Therefore, whilst links are noted here, their development is analysed in depth elsewhere.

### **3. THEORETICAL OVERVIEW**

Although the ‘region’ is a widely used term in health policy and health systems research, as well as popular vocabulary more broadly, it is seldom conceptualised. The under-theorisation of regions within health and social care systems literatures is closely related to well-recognised issues with decentralisation, risking becoming a ‘empty concept’ due to the lack of conceptual clarity (cf. Peckham, 2016), suffering from ‘terminological obfuscation’ (Greener *et al.*, 2009). How we conceptualise regions has implications for how we can learn from past research into regions in the NHS as well as how we might anticipate likely challenges that current reforms will potentially face. Therefore, before turning to outline our analytical framework for this review, it is important to first situate regions within the relevant wider theoretical literature.

#### **3.1. Conceptualising the region**

What is a region? And why does it matter? Regions can be assumed to hold obvious meaning, as a geographic context or bounded container for a particular policy intervention, for instance, or the location for a set of institutions and the populations that they represent or for which they have responsibility. Regionalisation can be positioned within cyclical trends of localism and centralisation, closely associated to processes of decentralisation and/or devolution evoking the notion of the shifting of powers, resources and responsibilities down from national to sub-national spatial scales or away from ‘the centre’ (De Vries, 2000). And yet, the region can be used variously to refer to local, sub-national or supra-national scales, according to the particular phenomena under investigation. Moreover, in recent decades, the delivery of health and care systems have increasingly involved of a broader range of private and voluntary agencies and organisations such that the ‘regional’ tier of organisation no longer strictly relates to a single public health authority in a neat state hierarchy. Thus, networked, ‘horizontal’ relationships can also become an important dimension within the organisation and provision of public services including in healthcare (Exworthy and Powell, 2004) in the shadow of hierarchy. This raises questions of who is involved in the making of regions and to what effect. Defining ‘regional spaces’, then, is far from straightforward and can vary over time (Jones, 2010). This presents a challenge when looking to the past to anticipate contemporary challenges.

As a central concept to academic disciplines such as geography and political science, how regions (at any particular spatial scale) are conceptualised is highly contested and the subject of extensive debate (Jones, 2010; Cochrane, 2018). We do not elaborate substantively on these debates here. Rather we simply observe that struggles over regional spaces have profound impact on how they are governed and function, spanning a range of inter-connected areas such as uneven economic development, the political and administrative territorial organisation of public services and the forging of particular, often contested, identities. Crucially, for the purposes of our review, the challenge in articulating or agreeing how a region is conceptualised and delineated is not merely a

question of population size or descriptive terminology but *integral* to how regions are made and re-made over time.

Put simply, regions are ‘social constructs that are created in political, economic, cultural and administrative practices and discourses’ (Paasi, 2000, p. 6). They are spatial formations that are produced through a multitude of social processes, rather than existing as a reified backdrop to social action. Accordingly, we may understand a region as:

‘a temporary permanence, something held stable, though not fixed and absolute, at different points in time, for different purposes. There is, then, no single reading of a region. Regions are multiple entities and we should look at the process and practices of region-making historically and spatially’ (Jones, 2010, p. 1).

As the above quote emphasises, analytical attention should be given to processes of *region-making*. If we recognise regions are ‘forged historically through political and policy struggles involving state and nonstate forces’ (Jones, 2010, p. 1), historically-sensitive accounts are crucial for understanding the changing geographies of regions, including for the co-ordination of health and social care. Consequently, for our review it is important to observe:

‘There is no ‘objective’ or purely technical definition of the region or the ‘right’ spatial level at which to conduct particular policies or regulate economic, social and environmental systems. Instead, different conceptualizations of the region have developed across time and in different places, and have competed with each other’ (Keating, 2017, p. 2).

To understand where the latest turn towards integrated care systems comes from, it is important to examine the impact of past waves of administrative reorganisation displaying elements of both change and continuity, materially, institutionally and rhetorically in the NHS and local government (Powell, 2018). In other words, it is necessary ‘to go back’ before we can move ‘forward’ (Thrift, 1994).

The re-making of regions in health and social care occurs across different geographical scales and sites at different points in time within different governance frames. The continuous re-invention of intermediate tiers between local and national in co-ordination of health and social care is produced through *dynamic* spatial processes and practices of ‘institutionalization’ that remake regions unevenly (Paasi, 1986). Rather than a neat temporal layering of a fixed or rigid set of new regional reforms over the previous round of reform, elements of past reforms continue to endure and influence contemporary institutional arrangements, whilst other elements are removed (Coleman *et al.*, 2010). Thus, the shifting of powers across and through sub-national spaces – for which we can include the role of intermediate tiers in the NHS – ‘never entails the creation of a ‘blank slate’ on which totally new scalar arrangements could be established, but occurs through

a conflictual 'layering' process in which emergent rescaling strategies collide with, and only partially rework inherited landscapes of state scalar organization' (Brenner, 2009).

Policy-making processes relating to the spatial re-structuring of health and social care are mediated by different national, regional and local actors and their interactions, variously and unevenly shape processes of change and subsequent outcomes. In this sense, we must be sensitive to how reforms are 'a matter of micro-political struggle, as well as reflecting wider, more 'structural' imperatives' (Peck, 2001, p. 451). Analysis must therefore take into consideration how the construction of particular policy problems get articulated by policy makers, politicians and other actors steering and struggling with the reform of health and social care. As Lindblom (1968, p. 13) denotes, '[p]olicy makers are not faced with a given problem. Instead they have to identify and formulate their problem'. Thus, for our purposes here, this requires paying attention to how the construction of regions are embodied with particular contested meanings and claims that shift over time.

It is helpful to illustrate this point with a brief example. As we discuss in detail in *Sections 4.2 – 4.4* below, *Regional Health Authorities* (RHAs) were a constant organisational feature in the NHS between 1974 until 1994/6. During this time, regional authorities spanned more-or-less similar geographical territories. Yet their roles, functions and workings altered substantively as relationships with local and national organisations changed. Thus, despite enduring several reforms, the changing 'composition' of how the regions were governed was shaped by wider political strategies, changes in personnel, alterations to resource allocation formula, the growing influence of general management, changing medical and care practices, wider social and demographic shifts and changing legislation, most significantly through the introduction of the purchaser/provider split. Therefore, if delimiting *Regional Health Authorities* on a map of England, regions appear more or less static, covering similar geographic territories over several decades, operating at the same spatial scale between local and national levels. However, as we have already established, regions are socially produced, continuously under negotiation, and therefore analytical and empirical focus must be on the terms through which regional spaces are made and re-made. RHAs, following our example here, were radically transformed in how they functioned and interacted with local and national scales throughout this period.

Through appreciating these dynamics, it is not possible to directly compare contemporary integrated care systems 'like-for-like' with previous intermediate tiers in the NHS. As *Section 4* illustrates, the continuous reinvention of regions at different scales within health and social care *roll-forward* out of the real or perceived failures of previous reforms, with certain organisational legacies and relationships enduring, whilst other aspects are variously re-shuffled, recreated or removed. Learning from the past research into intermediate tiers in the organisation of the NHS and its connections with local government requires situating the development of integrated care systems within their geographical and historical context. It is through doing so that we can draw out key themes to help anticipate issues within the current reforms, the focus of *Section 5*. Additionally, due to the central funding of the NHS, regions take a particular

organisational form that leads to certain limits regarding decentralisation. Consequently, despite recent devolution initiatives (discussed more later), we cannot view the NHS as having political devolution, for example. Statutory duties are set centrally and thus powers are likely to be executive rather than supported politically. Power is devolved from the centre yet remains accountable to the centre, and thus can be distinguished from devolved political power. As we elaborate later, this is also the root of the many tensions between local government and the NHS.

### **3.2. Analytical framework**

We now set out our analytical framework situating the current development of integrated care systems within the geographical and historical context of previous reorganisations. To understand the changing construction of intermediate tiers, we must be necessarily selective in our focus, given timescales covered and the extent of issues associated to the co-ordination of health and care. In making this move, we echo Atkinson (2007), who observes that any approach to studying decentralisation within health systems research is necessarily partial, due to the range and complexity of processes involved rendering in-depth analysis in all areas impossible. Our analytical framework for understanding regions in health and social care combine three main elements. These are as follows:

- **Processes of re-scaling between national and sub-national spatial scales** – the interplay of shifting powers, resources and responsibilities across and between spatial scales
- **The changing ‘composition’ of the regional co-ordination of health and care** – the shifting dynamics of regions shaped by bureaucratic hierarchy, markets and partnerships
- **The discursive construction of regions within the formulation of policy problems/solutions** – how regions are talked about and shaped by claims made about what interventions are intended to achieve. Often connected to particular spatial imaginaries such as ‘empowering the front-line’ or ‘natural geographies’ of care.

Firstly, since the 1970s, devolution of powers, resources and responsibilities from national to sub-national scales such as regions and localities has been an overarching global trend (Rodríguez-Pose and Gill, 2003). The concepts of ‘devolution’ and ‘decentralisation’ are contested terms and care is required to outline the specific aspects of re-scaling processes (MacKinnon, 2015). Broadly speaking, devolution/decentralisation refers to the political, economic and social processes through which different functions are shifted between different spatial scales, the interactions between these scales, and how tensions between them are continuously negotiated. As a form of state re-structuring, devolution/decentralisation corresponds with the capacity of particular political or administrative levels to take decisions and the constraints placed upon them through the multi-faceted tensions associated with centralisation-decentralisation.

As noted, the ‘terminological obfuscation’ surrounding decentralisation is so frequent in policy that it can be hard to assess whether the intended aims of the latest reform have or have not been achieved (Greener *et al.*, 2009). Health systems literatures frequently cite Rondinelli’s (1981) typology of decentralisation as a sliding scale from the least to most de-centralised, namely: de-concentration; delegation; devolution; and privatisation and/or the transfer of power to non-state organisations. Bossert’s (1998) theorisation of ‘decision space’ has been used to explore the extent to which local autonomy is available in a range of areas of relevance to health and social care systems, such as finances, service organisation, human resources and rules of governance (Exworthy and Frosini, 2008; Checkland, Dam, *et al.*, 2018). In seeking to address the multi-directional complexities of reorganisations across spatial scales, Peckham *et al.* (2005) developed the Arrow’s Framework, sensitive to the simultaneity of decentralisation and centralisation across different issues/areas. Their work illustrates that the decentralisation of power does not just shift from one scale to another or always in the same direction (i.e. national, to regional, to local). This is helpful for identifying the extent of decentralisation taking place. Whilst rhetoric accompanying many reorganisations suggests an appetite for decentralisation, in practice this has historically been limited in scope (Peckham *et al.*, 2005).

Broadly speaking, rescaling is neither unidirectional nor zero-sum (Cox, 2009). For our purposes here, we emphasise the significance of the *interplay* of power relations across scales, between regions within local and national scales and their different organisations. Regions (at any particular scale) are constituted through their *inter-relations* with other spatial scales (Lorne *et al.*, 2019). In other words, there is a need to make clear what resources, responsibilities and powers sit at what particular spatial scale and with whom, but also to understand the qualitative changing relations as these different spatial scales and their changing organisational bodies, intersect, and sit in tension.

Second, the shifting composition of regional co-ordination between hierarchies, markets and partnerships relates to the changing forms and mechanisms through which public services are organised, regulated and monitored. Where we can observe notable changing levers, mechanisms and approaches in how health services are organised over recent decades, emphasis is placed on the function of ‘regional’ bodies within the sedimented overlaying of modes of co-ordination over time. This is closely associated with the growing complexity of co-ordinating service provision. Although the NHS is conventionally presented as having experienced relatively neatly defined paradigm shifts from bureaucratic hierarchies to more market and then partnership-based modes of co-ordination, such characterisation has been deemed overly simplistic (e.g. Exworthy, Powell and Mohan, 1999). Instead, Exworthy, Powell and Mohan (1999, p. 15) argue that it is more accurate to examine waves of NHS reform in terms of a ‘changing mix between quasi-hierarchies, quasi-markets and quasi-networks’. As we discuss later, hierarchies continue to endure in the English NHS (Osipovic *et al.*, 2019). Therefore, combined with

analytical understanding of the spatial dimensions of the governing of regions (Lorne *et al.*, 2019), our framework pays attention to the shifting composition of the modes of co-ordination and the impacts of historical changes on subsequent reorganisations of regions.

Third, we seek to highlight the positioning of regions in the formulation of policy problems/solutions and the geography of discourse. The increasing rate of structural reorganisation is a well-recognised phenomenon in the literature on the NHS, particularly with regards to the regional or sub-regional bodies (Edwards, 2010). For example, health systems research adopting historical perspectives has observed that: ‘Some solutions such as market-based reform have flowed and ebbed over the years, and the ‘solution’ of structural reorganisation in one year has become the ‘problem’ in a future year’ (Powell, 2018). To supplement our above focus on re-scaling and the changing governance of health systems, it is necessary to explore how policy makers rhetorically position regions within this changing landscape.

Sense-making and meaning-making are integral to the making and implementing of policy. Where policy is *discursively* mediated, conditioned by particular claims, this third aspect pays attention to how the real or perceived failures of previous policy reforms go on to shape subsequent reforms, such that the way in which policy ‘problems’ are identified and constructed shapes how policy ‘solutions’ are subsequently formulated (Sum and Jessop, 2013). Theoretical approaches within cultural political economy exploring regional economic development can support how we understand regions within the organisation of the NHS and how their remaking has been shaped by policy problem and solution formation. To elaborate:

“A pendulum swing effect has been experienced, whereby UK state strategy, in turn linked to how the policy problem is constructed and its solution articulated, has *moved* and oscillated between national, regional, and local patterns of state projects and modes of state interventions. The previous round of state spatial restructuring has been used as the explanation for state intervention failure, with the next round seeking to address this through developing spatial horizons, also failing in turn”.

(Jones, 2019, pp. 29–30, original emphasis).

The discursive aspect of policy-making complements focus on re-scaling and changing governance to provide a fuller account of how previous reorganisations shape subsequent changes. In the current context, we shall discuss how this is helpful in understanding a rhetorical shift away from market competition in the absence of legislative change, and connectedly, the recreation of intermediate tiers of ‘system-wide’ co-ordination.

### 3.3. Challenges with terminology

As we stated in the *Introduction*, defining and analysing ‘regional’ and ‘sub regional’ units of analysis in the NHS is not straightforward. In literature on the (English) NHS, there is a frequent conflation or terminological imprecision in the spatial vocabulary of terms, sometimes equating ‘regional’ or ‘local’ to describe ‘local level priority setters’ of the ‘meso’ level (Smith, Mitton and Davidson, 2014) or ‘periphery’ and ‘field’. Different terms have been adopted to describe the spatial co-ordination of health and care, such as ‘local health economies’ (Exworthy and Frosini, 2008), ‘health geography’ (NHS, 2015), ‘place’ (Hammond *et al.*, 2017), ‘regional place-based’ systems (Checkland, Dam, *et al.*, 2018), ‘geographical footprints’ and ‘local health systems’ (Alderwick and Ham, 2016), as just a few more recent examples.

Likewise, local government has experienced significant changes since the creation of the post-war welfare state (Cochrane, 1993) including contentious boundary reconfigurations, albeit organised around more obviously place-based geographies including district, borough and county councils, combined authorities and regional government (even if their current activities increasingly reach beyond those administrative boundaries). In the most immediate sense for co-ordination between health and social care, these different geographies present technical challenges associated with the differences between local census-based population and the GP registered patient-list. More broadly, it reflects the growing complexities and accelerated churn of reorganisations.

It is important to recognise that different NHS organisations (particularly following the purchaser/provider split), local authorities, private providers, patients and the public more broadly have very different relationships with regions and places. This can include patient and financial flows, electoral boundaries, and multiple identities shaped by spatial, organisational and professional histories and politics (Hammond *et al.*, 2017; Lorne *et al.*, 2019). In the similar way that the accounts in the literature of the ‘centre’ not consistently referring to a single site, whether in the organisation of the NHS (Ham, 1981; Locock and Dopson, 2007) or central government more broadly (Rhodes, 1988), defining what is understood by regions is difficult and varied.

It is therefore no coincidence that it is difficult to find a consistent spatial terminology to pin-down the intermediate levels that sit between the local and national amidst the accelerated churn of NHS and local government re-organisation. For instance, the role of regions within the ‘spatial selectivity’ of state strategies becomes apparent in *Section 4* illustrating how policy interventions are inscribed with particular intentions, targeting different geographic scales or spaces in attempts to implement certain policy agendas (Jones, 1997). Different claims to the ‘natural geographies’ within which health and care should be organised exist at different points in time, alongside different combinations of governing mechanisms and organisational arrangements deemed appropriate to achieve such strategies. Thus, there is no consistent intermediate tier within the NHS over its



seven decades. Rather regions have been the target for successive reforms, shaped by a mixture of enduring and changing relationships with local and national government and other bodies whilst being subject to fluctuating policy agendas. In short, the difficulty in finding a consistent vocabulary to describe the intermediate tier reflects the lack of consistency caused by continual NHS and local government reorganisation.

### **3.4. Methods**

The literature review takes the form of a 'narrative review' that makes explicit the approach to identification and selection of sources (Pope, Mays and Popay, 2007). A key strength of a narrative review approach is that it enables flexibility in search procedures encompassing a large and diverse evidence base (Dixon-woods *et al.*, 2004). Literature is selected according to relevance as opposed to a fixed set of methodological criteria. The narrative review approach was deemed the most appropriate strategy for identifying key thematic issues relevant to integrated care systems based upon previous research into the regional co-ordination of health and social care systems, given the practical challenges faced when undertaking this review.

Key challenges identified following an initial scoping search of the literature and expert advice from academics in the field were that: there has not been consistent empirical peer-reviewed research into the intermediate tier of the NHS over its seven decades; a wide range of sources would be required to generate sufficient insight from past reforms drawing from academic and 'grey' literatures; it would be necessary to be selective in the focus of what areas are deemed relevant to motivate our study given the complexities and breadth of issues associated with the regional organisation of health and care systems; and that there is no consistent search term(s), reflecting the shifting spatial and organisational/administrative arrangements over the seven decades, as outlined in the preceding sub-sections.

We adopted a pragmatic approach in our literature search strategy. First, we searched four databases (PubMed, Google Scholar, Web of Science, NIHR) for published research over the last seven decades of the NHS using a wide range of search terms such as 'decentralisation' and 'regions' combined with 'NHS OR National Health Service' – using access to full texts via two different universities. Subsequent searches for the specific organisation names such as 'Regional Health Authorities' or 'Strategic Health Authorities' were later included to support our review, given that the intermediate tier of organisation in the NHS has rarely featured as the main focus of empirical studies. We did not restrict our search to specific dates. Titles and abstracts of articles were reviewed, extended to rapid scans of articles, where necessary. We focused on qualitative published studies and/or theoretical literature, written in English. Because of the wide range of search terms required this search was extensive but not exhaustive.

Second, through 'snowballing' of references key published articles and textbooks were identified, including ascertaining key authors in the field. The snowballing of references was significant in our search, given the nature of the search required. Additionally, a

hand-search of the London School of Hygiene & Tropical Medicine library of policy documents and pamphlets was undertaken to locate additional policy materials from previous reforms. On several occasions, efforts to gain access to empirical studies of health authorities have proved fruitless as materials were only available within university archives in paper format.

There is relatively limited empirical research explicitly focused on regional and sub-regional tier(s) of the NHS, given that regions are considered as part of wider analysis and accounts of NHS reorganisations. Where available we focus on in-depth peer-reviewed studies, however, in the absence of empirical studies, we often draw on historical accounts of the NHS from well-regarded historians and political scientists as well as NHS policy commentators in key journals such as the BMJ to provide insights into reforms where limited peer-reviewed academic research could be found. Two NHS historians were consulted in locating specific archival materials as well as recommended sources. In total, 153 sources were drawn upon. Details of the search strategy are provided in Appendix 1.

Narrative reviews have their limitations. They are non-systematic in their format, on the basis of selectively identifying literature sources, rather than setting out to document exhaustively all published research evidence in a regimented approach, usually with less weighting given to the assessing the methodological quality of research sources with a fixed set of criteria (Pope, Mays and Popay, 2007). However, narrative reviews are widely recognised to contribute valuable approaches to reviewing literature and in many instances deemed the most appropriate for policy-orientated reviews and enabling synthesis of complex and dynamic processes (Dixon-woods *et al.*, 2004; Pope, Mays and Popay, 2007). As we stated above, our initial scoping review of literature illustrate there has been no extensive, in-depth systematic research that has documented and analysed the functioning of the intermediate tier of the NHS, and its integration (or lack thereof) with social care, over the last seven decades, an issue raised by several key authors exploring this area of research (Dopson, Locock and Stewart, 1999; Checkland, Dam, *et al.*, 2018). We have already argued in this section that we cannot derive directly comparable evidence from one regional reorganisation to the next. Instead, a narrative review enabling a flexible interpretive approach drawing from a wide range of sources materials to support the identification of key thematic issues was deemed most useful for informing understanding of ongoing reorganisation.

Finally, key differences existed between the nations of the United Kingdom and their health systems long before the devolution of the UK NHS in 1999. There is, however, a tendency for historical accounts of the NHS to be England-centric (Hunter, 1982). Given our specific focus on England, the majority of the literature we draw on relates to changes and experiences relating to England. It is beyond the scope and purpose of this research to unpack distinctions between the four countries, although we note the importance of doing this to support comparative studies to encourage learning.

#### **4. PUTTING INTEGRATED CARE SYSTEMS IN THEIR GEOHISTORICAL CONTEXT**

To understand the current formation of Sustainability and Transformation Partnerships and Integrated Care Systems, we now turn to examine the key responsibilities and functions of previous intermediate tiers, how they worked in practice and how this corresponds with joint working between health and local authorities. A table providing a summary of the different tiers concludes the section.

‘Integration’ of health and social care is not a new policy phenomenon, and at various points has been a specific policy ambition for successive governments over the course of the last four decades (Humphries, 2015). Whilst it is not our intention to provide a comprehensive history of all initiatives for health and social care integration in England, it is useful to note calls for the need to ‘unify’ or ‘integrate’ health and social care have been present ever since the formation of the NHS in 1948 as part of the post-war national welfare state (Wistow, 2012). Mohan (2002) provides an excellent account of the impacts of regionalism in the decades running up to the creation of the NHS, however, this era is beyond the scope of our review.

##### **4.1. Regions in the tripartite National Health Service**

The NHS was established in 1948 with a ‘tripartite system’ of nationalised hospitals administered by Regional Hospital Boards (RHBs), primary care delivered by independent contractors rather than salaried government employees, and community and social support services delivered by local government. The initial role of the 14 RHBs – initially Regional Boards – was to administer and allocate funding for hospitals across England and Wales. They were a regional administrative tier that oversaw the Local Hospital Management committees – initially District Committees – in the organisation of the recently nationalised voluntary and municipal hospitals. Initially, regional population for RHBs varied from 1.298 million in Oxford to 4.399 million in Manchester, based upon calculations by the Ministry of Health in 1947 (The National Archives, 1947). According to the *National Health Service Act, 1946*, within the establishment of a comprehensive health service, the RHBs were ‘for the purposes of exercising functions with respect to the administration of Hospitals and specialist services in those areas’ (National Health Service Act, 1946, para. 11). Thus, local authorities continued to hold responsibility for community services including child and maternal welfare, district nursing, vaccination and learning disabilities and non-hospital based mental illnesses; and 138 Executive Councils administered the family practitioner services whereby GPs, dentists, pharmacists and opticians were financed directly by the Ministry of Health (Rivett, 1996).

Four key functions for RHBs can be discerned. These were:

- the planning of nationalised hospital services, medical staffing and hospital capital works;
- running certain services such as blood transfusion, pathological services and mass radiography;

- managing financial allocations to Hospital Management Committees, appointing their Chairs, members;
- administrative responsibilities for providing general support and advice (Rivett, 1996).

Allocation of resources by the regions was summarised by the *Lancet* (1950, p. 403) soon after the formation of RHBs as receiving block grants and subsequently needing 'to manage their own affairs'. Hospital Management Committees focused on the day-to-day running of the hospitals within the catchment of the 'natural hospital district' defined at the time as an 'area able to support a general hospital or combined group of hospitals big enough to employ a full specialist staff for all normal needs' (Webster, 1998b, p. 19). Initial plans were considered for regions to take over local authority-administered health services, such as ambulance services, health visitors and maternity and child welfare, but as a concession to local government, these were retained by 146 Local Health Authorities (Webster, 1998b).

An early report reproduced in *Public Administration* (1949) documents surprise at the number of regions created (14), with the suggestion that twenty or thirty had initially been anticipated. The lower number related to the intention for each RHB to be linked to a university medical school, described in Webster (1998) as the catchment of the 'natural hospital region'. At the same time, the territorial geography of the regions was intended to not be constrained by local authority boundaries and the potential for their control (Mohan, 2002). Despite suggestions that the regional tier would not be overly interfering, the *Public Administration* (Public Administration, 1949) report also raised an opposing concern that the regions risked becoming distant, remote bodies. The report continues that these initial fears were largely misplaced as 'it seems that the boards are carrying out as envisaged their functions as policy-directing, controlling, and co-ordinating authorities, with the role of ensuring the planned distribution of resources and the general guidance of the service' (Public Administration, 1949). Officers of the RHBs were appointed (rather than elected) from local government or from voluntary hospitals, with some medical professionals and university staff, and occasionally nurses and trade unionists (Public Administration, 1949; Klein, 2010) and despite certain national influences in respect of pay and conditions, Klein (2010, p. 33) states that '[t]he values and traditions of localism were thus built into the administrative structure of the NHS from the start'. Whilst under the 'general direction' of the Minister, the regions were to have a key role to support a 'free and flexible degree of decentralisation control' (Foot, 1973; cited in Mohan, 2002). Yet conversely, with the pull from central government seeking to exercise firmer control, chairs of the RHBs complained of the political centre interfering in their concerns through what were seen as overly burdensome circulars and excessive bureaucracy (Klein, 2010).

In respect of the regional administrative function, it was stated in the *Lancet* (1950, p. 403) '[t]he idea that administrative responsibility for the hospital and specialist services

would be vested in the region was never fully realised ... the passing of the Act was not accompanied by any sufficiently drastic overhaul of the machinery at Whitehall to ensure that circulars, or other decisions, did not by-pass or overrule the regional hospital boards. The [regional hospital] boards thus received the insignia of administrative authority without the substance, and a certain amount of friction and confusion has followed'. The *Jones Report* produced for Nye Bevan described the 'fundamental incompatibility between central control and local autonomy' as a consequence of the tension between how money was raised and how it was spent (Jones, 1950; cited in Klein, 2010). Yet Bevan described RHBs and Hospital Management Committees as having 'substantial executive powers' to counter the risks of bureaucratic over-centralisation (Klein, 2010, p. 35). Reflecting on his time in office in the 1960s, the former Secretary of State for Social Services, Richard Crossman (1972; cited in Day and Klein, 1997) stated: 'In much the same way Health Service freedom lies in the fact that the centre is weak and the Regional Hospital Boards are strong, while the GPs in their enclave are separated off safely from attack'. Crossman is frequently quoted in historical accounts as describing regional chairs like 'feudal barons', or 'Persian satraps' in relation to the 'weak Persian emperor' at the centre (e.g. Timmins, 2018).

This presents a mixed picture of the role of regions spanning several decades. The RHBs were embedded within centre-periphery relations that have long characterised a tension within the administrative structure of the NHS – between that of local autonomy and national accountability (discussed further in *Section 5.1.*). Thus, debates over the functioning of an intermediate regional administrative tier and how it interacts with the local level can be understood to be present from the very start of the NHS. Whilst not autonomous, the role of regions in overseeing hospital administration can be understood as the product of interaction or negotiation of centre-local relations 'rather than the imposition of national plans' alone (Klein, 2010, p. 37; our emphasis). Indeed, this interaction is reflected in different accounts of RHBs as experiencing regional autonomy, central control or something in between (Ham, 1981). At different times, in relation to different issues, the 'centre' was more or less successful at directing how the regions operated. For example, the ability for central government to ensure policy was implemented in regions was constrained, particularly with efforts to boost 'Cinderella' services. Yet, the *Hospital Plan 1962* to support an expansion of district hospital construction was connected to long-term public expenditure, which proved significant for mobilising RHBs in moves towards longer-term planning (Mohan, 2002). Given the financial controls implemented by the Treasury in the early years, along with Ministry of Health restrictions on staffing and finance (Ham, 1981), regions became increasingly powerful as funding increased for an expansion in District General Hospitals, with the RHBs shaping priorities of new hospital construction through development plans (Rivett, 1996), even if the actual increase in capital investment was not as much as the RHBs sought (Mohan, 2002). As Ham's study of Leeds RHB concludes, '[t]he capacity of the central [government] department to ensure its policies were implemented was limited'

even as the centre became more interventionist in the 1960s through legal and financial controls.

Conventional wisdom often presents the early decades of the NHS as a hierarchical 'command and control' healthcare system *par excellence*. With the exception of intervention from the Ministry of Health exercising concern about expenditure levels, the centre did not have the levers to *command* as such, but rather this was policy making was through *exhortation* (Klein, 2010). The initial configuration of regions within the NHS may be best understood as operating under a 'quasi-hierarchy', given that hierarchies, strategy and planning in the health service was not firmly established until the introduction of *authorities* as part of a nested hierarchy that were soon to come about through with first NHS reorganisation in 1974 (Exworthy, Powell and Mohan, 1999). Indeed, the role of professional policy networks and the professional autonomy of doctors during the earlier years in the NHS has been raised as significant in shaping decision-making (Exworthy, Powell and Mohan, 1999). On balance, recognising the growing role of state intervention, long-term strategic planning and technical expertise, and later the rise of technologies of public management enabling central bodies to control at a distance, this was a period when regions may arguably be considered their most influential with a relative degree of autonomy to pursue their own strategies, if by no means unconstrained from national powers.

Over time, the costs of running the health service increased, prompting the commissioning of the *Guillebaud Report* (1956). Counter to the prevailing concerns of the Conservative government that the NHS was becoming 'too expensive', the enquiry found that costs were increasing due to inflation and demographic changes, such that in relative terms, costs were actually falling. Whilst the report did not go on to recommend restructuring the NHS, it provided an early foundation for calls for moves towards strengthening oversight and supervision in the NHS. Pressure towards unification of the NHS to address problems embodied in the tripartite system grew throughout the 1960s, with the publication of the *Porritt Report* (Medical Services Review Committee, 1962), whilst the *Ministry of Health and Ministry of Social Security* were consolidated into the *Department of Health and Social Security* in 1968 (Webster, 1998). The importance of bringing together health and local authority services were foregrounded by key reports of the Royal Commission on Local Government and the Committee on the Provision of Personal Social Services, otherwise known as the *Seebohm Report* (Seebohm, 1968), recommending bringing together different social services into single departments within local government (Rivett, 1996). Yet, it would not be for almost a quarter of a century that moves were made towards a structural re-organisation of the NHS as the beginnings of the 'introduction of the concept of managerialism represent[ing] a policy paradigm based on the belief that organisational change would improve service provision' (Elkind, 1998, p. 1717).

#### 4.2. NHS unification and hierarchy of regions, areas and districts

The first major reorganisation of the NHS came about in the 1970s during a time of marked political uncertainty amidst economic crisis. This would be a catalyst, if not sole driving force, for the rupturing of the consensus over the post-war welfare regime in the UK. Political responses involved the implementation of public expenditure controls and a decade of increased industrial action and unrest, alongside growing hostility between the medical profession and the government (Klein, 2010). The NHS had benefitted from increased funding through successive governments following growth in public expenditure on the welfare state in the 1960s to early-to-mid-70s. However, there was growing concern throughout the 1960s that the initial tripartite separation of hospitals, general practitioners and local authority health services would require a new 'organisational fix' (Klein, 2010, p. 66). The *National Health Service Reorganisation Act 1973* planned under the Heath-led Conservative government would survive the general election (which Heath lost) and be implemented by the incoming Labour government, who later sought to strengthen democratic input into the planning process. For both Conservative and Labour governments, the purpose of the reorganisation was, at least in principle, to unify health services, increase cooperation between health and local authorities, and to bring about clarity as to the functions of each tier of the system in order to promote better management of the health service (Webster, 1998). Yet, as Begley and Sheard (2019) denote, the compromises in the lead up to and implementation of the 1974 reorganisation have long been perceived as a failure.

This reorganisation saw the creation of 14 Regional Health Authorities (RHAs), 90 Area Health Authorities (AHAs) and more than 200 District Management Teams (DMTs), the latter not yet established as statutory authorities. Crucially, this was a hierarchical unitary system with each tier directly accountable to that above it, characterised by the maxim of 'maximum delegation downward, maximum accountability upward' (Klein, 2010: 72). There was an obligation for health and local authorities to work together such that in 'exercising their respective functions Health Authorities and local authorities shall co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales' (National Health Service Reorganisation Act 1973, 1973, para. 10(1)). The majority of community health services were transferred across from local authorities to the NHS, although services outside of NHS control included occupational health, environmental health, personal social services and prison and armed force health services (Office of Health Economics, 1977). Overall, the reorganisation supported increased co-ordination *within* the NHS, but reduced co-ordination *between* community and social services (Ottewill and Wall, 1990; cited in Exworthy and Peckham, 1998). Taking place soon after the *Local Government Act 1972*, AHAs became largely coterminous with local government boundaries, with a few exceptions (Webster, 1998). It has been suggested that co-terminosity of local and health authorities may have been as much a chance by-product of reorganisation rather than necessarily a carefully planned outcome (Exworthy and Peckham, 1998), or at least a second best option premised on the hope that 'co-habitation [i.e. co-terminosity] would

lead to co-ordination' given the political inability to fully unify local and health authorities (Klein, 2010, p. 67). Not only did the 1974 reforms fail to resolve the long-recognised problems of the division between health and social care, but arguably *entrenched* them (Wistow, 2012).

*Regional Health Authorities* replaced Regional Hospital Boards, covering slightly modified but broadly similar geographic territories, given that Wales would become managed separately for the first time. The regions were intended to operate principally as a planning *authority*. Regional Health Authorities strengthened the regional tier, with a broader remit having responsibility for the health of their local population, not just for hospitals as previously, with overall planning of clinical services and employment of senior clinical staff (Levitt, Wall and Appleby, 1999). Their purpose was to translate national policy priorities into a framework for each region and they had responsibility for allocating capital and revenue resources to AHAs in order to meet national objectives, as well as providing certain services such as ambulances directly (Office of Health Economics, 1977; Rivett, 1996; Dopson, Locock and Stewart, 1999). Teaching hospitals also became accountable to the RHA, such that for the first time they were required to align with the priorities of the region rather than pursuing their own direction. Regional Health Authorities were therefore largely planning functions focused on longer-term strategy feeding back to the Department of Health and Social Security (DHSS) data on the health needs of their population with the intention that they would support the development of future health priorities and policies, as well as providing a channel for communication both upwards and downwards (Dopson and Stewart, 1998).

Through a hierarchical system of corporate accountability, AHAs were held accountable to the RHA above them, with RHAs having the ability to delegate functions to them. AHAs had to comply with the orders from their superior tier. Whilst RHAs were corporately accountable to the DHSS, they were not regional outposts of the DHSS (contrasting, as we discuss later, with the *Regional Offices* that would subsequently replace them as outposts of the NHS Executive and thus part of the Civil Service). However, their members *were* originally appointed by the Secretary of State. As a result of being employees of their RHA, staff loyalty has been suggested to lie first and foremost with the RHA and improving patient care (Dopson and Stewart, 1998). Significantly, the 1976 reforms under Labour would see greater emphasis on local government whereby a third of each RHA (and also AHAs, more below) was comprised of local authority members (Office of Health Economics, 1977).

*Area Health Authorities* were the principal operational level for services with a statutory responsibility for the running of the health service locally, corresponding to what we may call a 'sub-regional' tier. Their geographic boundaries were coterminous with Local Government following the Local Government Act 1972, with 16 in London, and 74 outside of London (Webster, 1998b, p. 108) and they were the lowest statutory level of authority employing many staff. Monitoring was based on a hierarchy, with AHAs accountable to



RHAs, and RHAs accountable to DHSS (Harrison, 1988). In their composition, AHAs had 15 members (16 in teaching areas, known as AHA(T)s) and these members were appointed by the RHA above them, excluding the paid AHA chair who, like RHAs, was appointed by the Secretary of State. Under the 1976 Labour reforms a third of their membership thus became local authority members and two additional NHS staff members were added. Joint Consultative Committees (JCCs) were set-up to advise on shared concerns between local and health authorities, with money available for joint projects between local and health authorities, albeit with specific rules (Office of Health Economics, 1977, p. 9). The 90 AHAs were also coterminous with the 90 Family Practitioner Committees which administered GP contracts. Whilst the Family Practitioner Committees were intended to be sub-ordinate to AHA, they continued to have direct relationships with DHSS (differing slightly in areas with teaching hospitals) thus never operating as strictly sub-ordinate to AHAs.

At district level, sitting beneath AHAs in the hierarchy, were District Management Teams (DMTs). As the most 'basic unit of management' according to Klein (2010), they were not statutory authorities, but rather administrative teams appointed by AHAs to integrate health services in districts of 250,000-300,000 (Office of Health Economics, 1977: 9). The DMTs were intended as the smallest spatial scale through which health professions would collaborate to plan care effectively according to the needs of the population, described by the Office for Health Economics (1977, p. 6) as 'natural health communities'. They included a district finance officer, nursing officer, community physician and administrator as well as Chair and Vice-Chair of the District Medical Committee representing their local consultants and GPs for each district (Office of Health Economics, 1977). DMTs were managerially accountable to the Area Teams that formed part of AHAs (Harrison, 1988). Community Health Councils (CHCs) were also created at District level 'to represent the interests of the health service of the public in its district', albeit without accountability or responsibility, their broad function was often susceptible to claims directed towards them of being ineffective and irrelevant (Pickard, 1997, p. 276; see also Harrison, 1988). Somewhat ironically, despite their perceived weakness, CHCs were one of the most enduring features of the English NHS, surviving multiple subsequent reorganisations, remaining in existence through to 2002/3, when they were abolished for being a 'political inconvenience' in their frequent oppositional position (Gorsky, 2013, p. 106).

As with the initial organisation of the NHS, peer-reviewed empirical research into RHAs, AHAs and Districts is limited, although NHS historians and grey literature produced at the time provides a basis for understanding how the regions and areas functioned in practice. Broadly speaking, the first major reorganisation in the NHS brought with it several gains with unification of different parts with some co-ordination across health and local authority areas and a population health focus. However, despite the potential for joint working between local and health authorities with the external JCCs, they were described by Office of Health Economics (1977) as ineffective given that there were no

obvious mechanisms to resolve issues concerned with competing economic interests of NHS and local government. In London, there were often disputes over boundaries given the nature of services in the capital. The regions were ultimately in a difficult intermediate position, as, according to Dopson and Stewart (1998), they were criticised for failing to challenge the demands of the centre, but also for being overly bureaucratic and interfering in local management issues, as well as operating with a surplus of priorities and a lack of fairness in how resources were allocated.

The 1974 reorganisation, Klein (2010, p. 76) states, marked the high point of 'paternalistic rationalism' characterised by the 'grey book' central manual setting out how management and administration of the NHS would be structured. It provided a rather rigid organisational structure comprised of multiple layers of decision making, even before reaching those within hospitals and community services. At the time, the BMJ (1975) argued the absence of clear definition of what 'delegation downwards' actually meant in practice produced conflicts between the regions, areas and districts (see also, Rivett, 1998). Decision-making was by 'consensus management' whereby decisions had to be agreed by all in the team rather than an Executive figure. Webster (1998a, p. 110) argued that whilst a laudable aim, in practice this was a 'recipe for paralysis' resulting in lowest-common denominator decisions, although different historical accounts seem to vary with regards to the alleged ineffectiveness making decisions in this way. In a study of the Yorkshire and Northern RHAs at the time, it was observed that the chair of the Yorkshire region instructed local authority members that despite their role in their constituencies 'RHA members were 'not wearing any hats' and that they were expected to play their part in the management of the NHS as individuals, not as representatives of particular localities or interests' (Elcock, 1978, p. 384). Other concerns were raised with regards to the effectiveness and monitoring of the sub-ordinate AHAs, although the study found that a comparison of the two RHAs showed operational processes and collective personas differed between the regions (Elcock, 1978).

Questions were raised as to whether a regional tier was a cumbersome intermediate body complicating the balance between national strategy and policy formulation and local autonomy and decision-making. In Scotland, in way of comparison, a different structure was present at this time, with AHAs directly reported to DHSS, circumventing a regional tier. However, these relations, too, were problematic (Office for Health Economics, 1977, p. 29), suggesting regions were not necessarily the problem *per se*. Prior to the first major reorganisation, planning was described as haphazard and *ad hoc* (Tallis, 1981), having RHAs to incorporate longer term planning into day to day activities had certain beneficial impact by shifting from management in response to crisis to planned management. By the late 1970s, with the planning system fully established, whilst certain regions had sought to set the strategic direction for how care should be developed within their geography, 'it was apparent that most Regions had not been able to give consideration to community services and to the joint planning of services with local authorities' (Tallis, 1981, p. 5). The understanding and information gathering provided by RHAs did provide

important insights into areas of difficulty as set out in their regional strategic plans that would go on to shape government priority documents (Tallis, 1981). However, the role of regions in the collection of local data on behalf of central government may be understood to operate with a centralising effect in ways that regions had not previously. It is also of note that the reorganisation was said to have had limited impact on General Practitioners who consequently took little interest in the changes (Rivett, 1998).

#### **4.3. De-layering, decentralisation and the rise of general management**

On the arrival of the first Thatcher administration in 1979, a key element of reform was to simplify the hierarchical layers of administration that now existed in the NHS. It was a move to cut administrative costs, along with embedding business-like management principles and logics into public services (Greengross, Grant and Collini, 1999). In 1982, the 90 Area Health Authorities were abolished and replaced by 192 *District Health Authorities* (DHAs) as statutory bodies, reshaping District Management Teams, covering what was described in a government circular at the time as ‘the smallest possible geographical area within which it is possible to carry out the integrated planning, provision and development of health services’. This occurred during an era in which the government increasingly encouraged decentralisation policies (Exworthy and Peckham, 1998) emphasising the ‘virtues of localism and small size’ with decisions intended to be taken as close as possible to where services were delivered (Klein, 2010: 98). This was significant, Klein (2010: 99) adds, as it marks the weakening of the authority of experts instead focusing on the assumption that ‘local people know best’, a clear challenge to centralised planning.

Yet the prevailing *local* spatial imaginary championed by the Thatcher government was also inherently political, as well as contradictory, most acutely felt in the transformation of local government over the course of the 1980s (Cochrane, 1993). Amidst hostility between the Thatcher-led government and local and municipal socialist councils, the ‘new right’ under Thatcher increasingly stressed the role of market alternatives, privatisation and value for money principles, in political opposition to local and metropolitan councils pursuing state intervention and collective, rather than individualistic, solutions (Cochrane, 1993). By 1986, the urban Left local authorities were weakened and the metropolitan councils abolished. This transformation is significant in local authorities increasingly becoming restricted towards being ‘enabling’ through adoption of market-orientated approaches to the delivery of local services. Compulsory Competitive Tendering embedded in the *Local Government Act 1988* functioned to transform how local council services were organised. Considerable variation manifested across different local authorities with some very supportive of Compulsory Competitive Tendering whilst others much less so, although, this period underscores efforts to embed market mechanisms and logics within local government.

In the NHS, statutory DHAs were to take over responsibilities from the abolished AHAs, becoming responsible for the planning, development and management of services. They

were to be the smallest scale geography possible to carry out integrated planning, service provision and development of primary care, community services and services relating to district general hospitals. CHCs were, as noted above, retained. Prior to the *Griffiths Review* (1983), DHAs followed consensus-based decision-making. However, in a rejection of the 1976 Labour reforms, there was now to be a reduced proportion of local government members on their boards, whilst worker representation was abandoned with trade unions having reduced influence through now only being able to appoint a single member (Klein, 2010). Districts were hailed as the ‘natural’ and most appropriate geography that would be closest to their communities tailored to their local needs to enable more flexible forms of planning and managing of services for a population between approximately 200,000 and 500,000 people organised around the catchments of district general hospitals (notably, a similar geography to that of ‘place’ within the contemporary *Long Term Plan* (NHS, 2019a), albeit based on a different organising principle); the intermediate RHA covering populations of several million people continued to exist during this time retaining their role in allocating capital and revenue and increased monitoring responsibilities but stepping back from day-to-day operations (Greengross, Grant and Collini, 1999, p. 10; Levitt, Wall and Appleby, 1999). The RHAs also retained their ministerial-appointed chairs. Significantly, in the reforms, coterminosity between area health and local authority boundaries was also lost (Greengross, Grant and Collini, 1999; Klein, 2010).

Long-standing centre-local tensions were not resolved in this move towards de-centralisation, and the problems associated with removing coterminosity between health and local authorities led to further complexities, despite the prevailing policy narrative of simplification (Klein, 2010). Efforts were made to bolster joint planning through strengthening the existing Joint Commissioning Committees (JCCs) of the 1976 reforms by having their own staff and a degree of accountability to the Secretary of State, however, this soon came under criticism (Wistow, 2012). As Griffiths (1988; cited in Wistow, 2012, p. 105) went on to declare, there was a need the end the ‘discredited refuge of imploring collaboration and exhorting action’ whilst the Public Accounts Committee raised concerns that joint planning was ineffective. Additionally, during this period, there was an expansion of research exploring the different structural, financial and professional ‘barriers’ to integration between health and social care. It is of significance to contemporary reforms that Wistow (2012, p. 105) observes how the framing of the policy problem in this way ‘fixed attention on obstacles to integration rather than the root causes of continuing fragmentation in planning and service delivery’.

Major changes took place nationally during this period. The ‘centre’ had up until this point largely remaining unchanged, but the *Griffiths Review* (1983) led to the formation of the NHS Supervisory Board and NHS Management Board orientated towards what we might see as representing the early stages of adopting principles of New Public Management in the health service (Dopson, Locock and Stewart, 1999). The problematic split relationship between the two national boards would also go on to typify the problems associated with

'separating steering from rowing' (Day and Klein, 1997, p. 4) and by the end of the decade, the Secretary of State for Health would take over the Management Board.

The Griffiths Review marked a significant moment both symbolically and practically in the reconstitution of management in the health service (Webster, 1998b), a major turning point in public policy introducing market logics into the operation of the NHS (Gorsky, 2013). Its best known impact was bringing about the end of consensus management and the rise of general management, bringing in managers from outside the NHS and the pursuit of more business-orientated organisation of the health service. During this period, managers were increasingly portrayed as responsible for problems facing the health service, undermining their existing 'diplomat' style role, and with it, a firm attempt to ensure regional Chairs more firmly adhered to the government's priorities (Harrison, 1988). The composition of who sat on regional boards had now become substantively different over the course of the past few decades. Performance indicators were beginning to take on significance in how power was exercised in the health service, with the first set of 70 indicators for England circulated by DHSS in 1983 (Department of Health & Social Security, 1983) to compare aspects that spanned clinical and financial measures as well as workforce and estates between health authorities (Harrison, 1988).

Both RHAs and the Management Board were portrayed as distant bodies according to Dopson (1994, p. 338) 'trapping local management in a strait-jacket of central directives, political interference and inadequate central funding' (see also Dopson, Locock and Stewart, 1999). The *Merrison Royal Commission Report* proposed that RHAs could become mini-corporations, an idea proposed by one of the Chairs of the RHAs (Webster, 1998). Although this was ultimately rejected by government, it was to pre-empt a major NHS reorganisation that would have profound impact on the regional tier of the NHS.

#### **4.4. Purchaser/provider split with regions becoming market umpires**

Following the creation of a separate Department of Health in 1988, the White Paper *Working for Patients* (1989) was published providing the foundation for major structural change throughout the NHS. The identified problem to be solved was that the NHS was deemed bureaucratic and inefficient so that a new market-like paradigm in healthcare organisation was to be introduced (Klein, 2010). Notably, the phrase 'internal market' is absent from *Working for Patients* and competition rarely features, instead the policy rhetoric is principally that of local delegation (Webster, 1998). The passing of *The NHS and Community Care Act 1990* was a significant change in the organisation of the NHS introducing a purchaser/provider split, which the official historian of the NHS, Charles Webster (1998, p. 197) describes as 'the biggest shake-up the health service had ever seen'. The turn of the 1990s undoubtedly represented a significant rupture in the administration of the health service, whilst local government had now heavily transformed from being an integral part of the local welfare state, most symbolically exemplified by disputes over the introduction of the Poll Tax. Specifically in the field of social care, the White Paper *Caring for People* (Department of Health, 1989) emphasised

market competition on the basis, if not reality, of fully-marketised conditions with a clear separation of 'purchasers' and a mixed range of 'providers' (Charlesworth, Clarke and Cochrane, 2006). *Caring for People* (1989: para 3.4.3) sets out the claim:

'Stimulating the development of non-statutory service providers will result in a range of benefits for the consumer ... a wider range of choice of services; services which meet individual needs in a more flexible and innovative way; ... competition between providers, resulting in better value for money and a more cost-effective service.

Much has been written about the introduction of the quasi-market in the NHS from a range of analytical and political perspectives and it is not necessary to rehearse the debates here (Bartlett and Harrison, 1993; Robinson and Le Grand, 1994; Webster, 1998b; Klein, 2010). Most simply, the purchasing of healthcare services was split up between District Health Authorities, some GP Fundholders (GPFHs) with secondary care provided by hospitals and community services that could seek status as more business-orientated 'self-managing' trusts (Bartlett and Harrison, 1993). Family Health Service Authorities (FHSAs) administered, if not negotiated, contract payments with GPs and others. Crucially, this period uncoupled the organisation of services from a defined territorial geography as under health authorities (Exworthy, 1998), and with it, marked a period of major change for the functioning of the regional intermediate tier.

With the purchaser/provider split, DHAs became purchasing bodies for both hospital and community services. The DHAs received funding allocations to pay for residents on a weighted capitation basis, rather than allocating funding for providing services in their hospitals. Money was intended to follow patients who were to be considered more akin to 'customers' (Ham, 1990). The number of DHAs varied over time. In 1991 there were 190 DHAs, although this reduced to 108 by 1994 (Joyce, 2001) and their population catchments varied considerably, from 89,000 to 860,000<sup>4</sup>, and with annual revenue budgets ranging from £13 to £183 million at their creation (Ham, 1991). The renewed DHAs had a number of functions: purchasing healthcare services for their residents; managing local directly managed units that fell within their catchment prior to those units becoming NHS Trusts (which came with increased autonomy and increased operational decision-making responsibilities previously at district level); assessing population health need and holding public health responsibilities (Ham, 1991). Here, DHAs were required to agree priorities, or, in other words, ration services (Levitt, Wall and Appleby, 1999).

Therefore, as purchasers now paying hospitals through a new contracting system, DHAs became bodies with staff who required expertise in areas such as contracting, quality

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<sup>4</sup> The reason for the considerable variation is hard to discern, however, it is likely due to the legacies of the existing Districts.

assurance and public health with the intention that they were to become lean and strategic. Districts no longer had direct control over all secondary care providers now intended to be 'self-governing' units. Perceived power relations between districts and providers altered, even between individual managers, with DHAs no longer acting as a focal point for translating national policy decisions or providing local head office-type services, with Trusts now able to determine their own management structures, acquire and sell their own assets and employ their own staff on terms they set (Ashburner, Ferlie and Fitzgerald, 1996). Whilst relations between DHAs and FHSAs have been characterised as fraught prior to their later amalgamation in 1996 (see Section 4.5.), relationships between health authorities and local authorities has been stated as more significant, even if the differences in national and local funding allocations were always bound to prove challenging (Levitt, Wall and Appleby, 1999). Notably, under Section 28A of the NHS Act 1977, DHAs were unable to transfer money in perpetuity to local authorities and so the various mechanisms used to work around this issue often generated new problems as a consequence (Levitt, Wall and Appleby, 1999).

Following the passing of *Health Authorities Act 1995*, DHAs and FHSAs had their functions merged and transferred to new Health Authorities responsible for purchasing care, and undertaking population health needs assessments. Formed in April 1996, Health Authorities took on primary care contracting roles from the abolished FHSAs and they also had responsibility for:

- joint commissioning strategies to link fundholder purchasing to that of purchasing by the Health Authority; setting budgets for fundholding;
- monitoring providers;
- developing purchasing skills for fundholders (Wainwright and Calnan, 2011)

These changes brought a shift in rhetoric from delegation and incrementalism to that of a return to planning and accountability (Wainwright and Calnan, 2012). Here, Wainwright and Calnan (2011) suggest that this typified the tension between market-orientated decentralisation running up against the centralisation of state hierarchy. The separation of purchasers and providers prevented the integration of primary and secondary care (Rivett, 1996). Indeed, as Rivett (1996) observes, control of the market became a concern; NHS Trusts with their new organisation freedoms were not keen for regional command to simply be replaced by regional market management. And yet, whilst the Conservative Party expressed a pro-market ideology coinciding with the rhetoric of devolution, the pull of a centralising national health service and its oversight was nevertheless reasserting itself.

Thus, the role of the regional tier never sat comfortably with the purchaser/provider split reorganisation (Levitt, Wall and Appleby, 1999). RHAs provided strategic direction and oversight of the local workings of the internal market, continuing to exercise a regulatory function for both purchasers and providers such that 'within the confines of upward

accountability, they had considerable scope for local autonomy and thus provided a distinct and influential level of management between the local and the central' (Moon and Brown, 2000, p. 66). However, the potential for RHAs to intervene sat uneasily with the market-orientated dynamics introduced through the purchaser/provider split (Levitt, Wall and Appleby, 1999), marking their substantive decline. The *Functions and Responsibilities Review* in 1993 motivated the reorganisation of existing Regional Health Authorities operating as the intermediate regional administrative tier in between the Secretary of State for Health and DHAs and FHSAs (Department of Health, 1993) into becoming 8 Regional Offices (Dopson, Locock and Stewart, 1999). Unlike the semi-autonomous RHAs, the reduced number of Regional Offices, covering wider geographic areas, were to become regional outposts of the NHS Executive, part of the Department of Health with the substantively reduced number of staff becoming civil servants (Locock and Dopson, 1999). The two regional bodies ran in parallel for two years from 1994 until 1996 when RHAs were finally abolished following legislation (Locock and Dopson, 2007). It marked the end of the administrative hierarchy initially established by Keith Joseph back in the 1974 (Webster, 1998).

Significantly, this would be first time in the NHS that regional directors would to be directly accountable to the NHS chief executive, as opposed to their respective regional authorities (Ham, 1993), creating a tighter line of performance management (Kewell, Hawkins and Ferlie, 2002) and signalling the decline of the powerful, and still at the time politically appointed, regional chairs. The regional boundary spanning role may have been retained but with resources now allocated directly to health authorities rather than regions as before, this signalled the decline of the regions as discrete entities (Dopson, Locock and Stewart, 1999). As local purchasers were intended to become stronger through increased decentralisation, the necessity for the regional tier was seen to have diminished (Klein, 2010). Moreover, data collection techniques could be seen to no longer require the regions on behalf of central government. Thus, after 48 years with substantive regional bodies playing an essential role in the development of the NHS, the regions were, if not entirely removed, heavily diminished (Rivett, 1996).

The reorganisation took place as a consequence of what Day and Klein (1997, p. 14) describe as 'increasing disillusion with the role of regions. Several had been embroiled in financial scandals of various kinds. And there was a widespread perception that regions were a cumbersome, overstaffed and ineffective mechanism for implementing central government policy'. The Secretary of State for Health at the time, Virginia Bottomley, was cited in the BMJ as declaring the 'unfinished business' of regional reforms suggesting that whilst RHAs having worked well for two decades their hands-on approach was now to be considered outmoded (Warden, 1993). This can be seen in light of the wider policy focus on a decentralised service with self-governing Trusts and the ambition to 'streamline the central management structure of the NHS and consolidate joint working between DHAs and FHSAs' (Department of Health, 1993: foreword). Therefore, what remained of the regions was to again being move towards a more strategic – rather than operational –



role in the purchasing of services (Day and Klein, 1997). However, given the size of the NHS, it was reported that there was some wariness within the Department of Health in abolishing the intermediate tier entirely following the view that the NHS could not be ran from a single headquarters (Warden, 1993).

The function of the new regional offices was to ensure co-ordination – now, significantly, ensuring separation – of purchasers and providers (Dopson, Locock and Stewart, 1999). This required operating with a structure that had identifiable purchaser and provider arms. The regional directors of the revised intermediate tier had dual roles: ‘contributing on national level issues as members of the NHS Executive Board and also taking responsibility for the performance of purchasers and providers in their region’ (NHS Executive, 1994, p. 8). Significantly, with new emphasis on setting performance criteria and evaluating providers, as well as the development of purchasing, it was the first time the regional tier would hold both roles to manage the market regionally, given that the provider management role previously resided nationally with a separate trust outposts of the NHS Executive (Ham, 1993; Dopson, Locock and Stewart, 1999; Levitt, Wall and Appleby, 1999). Regional offices were therefore intended to function as ‘umpires’ of the internal market in their region, along with being mandated with the implementation of national policy as well as creating regional health plans and strategies (Kewell, Hawkins and Ferlie, 2002). Unlike RHAs, the principle allocation of revenue went to the Health Authorities rather than the regional offices, whilst responsibility for GP Fundholder budgets although supposed to lie with the regions, was effectively also undertaken by the health authorities (Dopson, Locock and Stewart, 1999). Ultimately, the new ‘regions’ were less substantive and had far less power (Rivett, 1996).

Changes to regional offices took place amidst changes at ‘higher’ and ‘lower’ tiers, again raising questions over the future role of the regions as a level of organisation. The NHS Executive was growing in its influence at the centre, whilst the DHAs and Family Health Services Authorities were unified into single Health Authorities by 1996 (more below). Several NHS commentaries have reflected on the apparent paradox of the time, for ‘as the purchaser/provider split brought an element of competition, decentralisation and marketisation to the NHS, the centre in practice also increased its grip’ (Timmins, 2018, p. 24), such that ‘[a]lmost 50 years after the NHS was first created, in the second half of the 1990s it became a *national* service’ with lines of accountability unambiguously pulling control towards the centre, despite the policy narrative of decentralisation (Klein, 2010, p. 171). As Locock and Dopson (2007) state, despite rhetoric at the time of ‘single centre working’, there was no one single ‘centre’, which variously meant at the time the wider Department of Health, the NHS Executive or the regional outposts.

The uncertain role of the regional offices became apparent, with questions raised as to whether they were regulators, managers or planning functions, and whether they should be supporting or facilitating Trust mergers (Dopson, Locock and Stewart, 1999). Those working in the regional offices had to negotiate different instances of boundary spanning,

such as balancing control and flexibility, intentions to be light-touch with performance management which entailed having to operate firm control in response to political pledges about waiting times, as well as negotiating the two different cultures of civil service and the NHS (Dopson, Locock and Stewart, 1999). The reforms became emblematic of increasing policy churn: 'With the reduced role for regions, the change of role for DHAs and the merger of FHSAs, we found very few islands of stability left in the NHS. Many respondents also identified problems with change overload, perpetual reorganization and 'change upon change.'" (Ashburner, Ferlie and Fitzgerald, 1996, p. 7). Indeed, Regional Offices would only last for five years, being briefly taken over in 2001 by four regional Directorates of health and social care, that themselves would go on to last for less than two years (Edwards, 2010). Edwards (2010), writing on behalf of NHS Confederation, suggests that the rapid regional churn during this period can be attributed to senior politicians being involved in organisational redesign that ultimately failed to galvanise real commitment and quickly unravelled as a consequence.

#### **4.5. Remaking the intermediate tier amidst markets and partnerships**

Despite running on an election campaign seeking the abolition of the quasi-market in the NHS, this agenda was not pursued by New Labour when elected in 1997. Upon arrival in government, New Labour revised existing Health Authorities presenting to Parliament the 1997 publication of *'The New NHS. Modern. Dependable'*. This came with a shift towards a rhetoric of partnership working typical of the 'Third Way' agenda, as well as a rise in emphasis on greater integration of health and care services. Echoing previous appeals to reducing administrative burdens, the renewed Health Authorities were to have a strategic function that 'will help overcome the fragmentation which characterised the internal market' (The new NHS. Modern. Dependable., 1997, p. 24).

The revised functions of Health Authorities, as set out in *'The New NHS'* were:

- assessing the health needs of their local population;
- producing strategy for their local Health Improvement Programme with other local partners;
- decision-making for range and location of healthcare services;
- determining local targets and standards to meet national priorities;
- supporting the rapid development of Primary Care Groups including allocating their resources and holding them to account (The New NHS. Modern. Dependable, 1997: p.25).

Responsibility for direct commissioning of services was devolved from Health Authorities to new Primary Care Groups (PCGs), badged as building on the claimed successes of GP Fundholders and other local commissioning projects. This was intended to bring together the strategic input from Health Authorities with innovation of PCGs in the name of patient benefit (The New NHS. Modern. Dependable, 1997: p.28). Progressively, PCGs would go

on to reach the status as Primary Care Trusts (PCTs), which were statutory bodies replacing health authorities in 1999. It was suggested in the White Paper that this transition would take up to ten years, but in practice by 2002 all areas had established PCTs.

Although present since the late 1980s, we can witness the rise of ‘partnerships’ and ‘joined-up government’ in public services under the New Labour administration. Health and social care has been positioned as an exemplar in this policy shift in emphasis from competition towards compulsory collaborative-based relations (Heenan and Birrell, 2006 see also, Newman, 2001). This is exemplified by strategic level Health Improvement Plans (HImPs) supported by *1999 Health Act* that enabled the potential for pooled budgets and delegating statutory authority to lead organisations.

In 2001, the Secretary of State Alan Milburn MP stated that the NHS was deemed ‘top heavy’ by PCTs and Trusts, with ‘confused lines of accountability with trusts reporting to the Department of Health’s regional offices and PCTs reporting to health authorities’ (Klein, 2010: 242). Thus Strategic Health Authorities (SHAs) were established in 2002, marking the reinvention of an intermediate tier in the NHS once again. At this point, the 95 Health Authorities had now been replaced by approximately 200 PCTs, and 28 SHAs were created following the passing of *The National Health Service Reform and Health Care Professionals Act 2002*. The SHAs initially covered much smaller territorial geographies than previous regional bodies (although larger geographies than the Health Authorities) at approximately 1.5m population, although they were later reduced to 10 in number. The policy agenda became rhetorically orientated towards developing a patient-centred NHS, empowering front-line workers and encouraging innovation. The 28 strategic health authorities became responsible for performance managing PCTs and Trusts (many of which went on to become ‘semi-autonomous’ with their elevation to Foundation Trust status - the first 10 forming in 2005), and Regional offices were removed, leaving nominal Regional Directors of Health and Social Care, although they were outside of the chain of accountability (Klein, 2010).

Strategic Health Authorities were statutory bodies that, according to the *Delivering the NHS Plan (2002)*, were to be responsible for the day-to-day management of the NHS as local headquarters of the NHS. This involved having overall responsibility to hold the local health service to account, to balance the books financially whilst meeting targets and to build capacity for both acute Trusts and Primary Care Trusts. Their function was to create a strategic framework for local health services and to manage PCTs (who had the responsibility for ensuring local health services were provided) and Trusts through local accountability agreements (*Shifting the Balance of Power within the NHS, 2001*). They were effectively guiding patient choice through taking decisions about the architecture of services (Klein, 2010). SHAs were ‘to step back from service planning and commissioning to lead the strategic development of the local health service and performance manage PCTs and NHS Trusts on the basis of local accountability

agreements' (Shifting the Balance of Power within the NHS, 2001). The function of SHAs was having oversight of the needs of the overall 'health economy' with NHS Trusts and Primary Care Trusts both accountable to the SHA, with SHAs themselves being accountable to the Secretary of State in the Department for Health.

Significantly, SHAs also played a mediatory role such that: "Where conflicts occur between local NHS bodies or problems arise that threaten the delivery of objectives the Strategic Health Authority will intervene and broker solutions as necessary" (Shifting the Balance of Power within the NHS, 2001, p. 17). SHAs were thus required to identify poor performance and could escalate intervention measures for 'underperforming' providers. However, this was not the case for more autonomous Foundation Trusts where neither the SHA nor Secretary of State could intervene as this fell under the remit of the new regulatory body Monitor (Klein, 2010). The initial changes, however, were reorganised once again after only two years. PCTs were what Sir Nigel Crisp (2005, p. 2) described as representing a shift 'from being a provider driven service to a commissioning driven service' leading to far fewer PCTs, that were, like the 1974 reforms, to be largely coterminous with local authority boundaries, and the SHAs shrank in number to 10. Their territories looked rather like the Regional Offices of the Department of Health that were recently abolished (Klein, 2010), indeed, resembling more closely the 8 Government Offices of the Regions that existed between 1994 and 2011.

A study of governance in the NHS which included interviews with SHA staff, reported some variation in the extent to which different SHAs would assert their local influence and identity in relation to national policy priorities, although SHA Chief Executives broadly agreed that national priorities of balancing of the books and meeting targets was one of their central roles (Storey *et al.*, 2010). In their allocation of budgets, SHAs exercised their capacity to shift budgets around the health system where some Trusts were in deficit or surplus, although this ran into tension with pressure for 'failing' Trusts who would be sent 'turnaround teams' to review and produce reports on action to be taken if Trusts were financially unstable, demonstrating the more ambiguous and uncertain powers that SHA Chief Executives could exercise (Storey *et al.*, 2010). This aspect of the benefits of a strategic body that could 'hold the ring' (Checkland, Dam, *et al.*, 2018) for the health system frequently features in commentaries on the present NHS, following their abolition in the *Health and Social Care Act 2012* (discussed below). On the other hand, in light of the *Francis Report* following the inquiry into the failings in care at Mid-Staffordshire NHS Foundation Trust, its authors reflected on the role of the SHA in exercising top-down performance management pressures within the NHS, particularly focusing on financial control totals: 'A theme running through many of the interviews was that although the Francis Report had been very critical of a top-down NHS management style, overly focused on targets and financial compliance at the expense of the quality of care, nothing had really changed in the wider regulatory system, and things had possibly got worse' (Thorlby *et al.*, 2014, p. 23).

#### 4.6. Unmaking the intermediate tier with new layers of complexity

In 2010, a Conservative-led Coalition government was elected in the shadow of the 2007/8 financial crisis. A programme of austerity measures became a central feature of then-Prime Minister David Cameron's political platform framed around 'living within our means' and 'getting the deficient down'. Although the NHS would witness the slowest increase in its funding in its history, it would be local government that would experience the most substantive budget reductions, with the unevenness of cuts particular impacting London boroughs and urban areas with a declining industrial base (Gray and Barford, 2018).

Despite the suggestion that under the Conservatives there would be 'no top-down re-organisation of the NHS', the White Paper *'Equity and Excellence: Liberating the NHS'* was published soon after the 2010 general election (Department of Health, 2010). It provided the basis for what would amount to a major top-down re-organisation of the NHS. A key element of the reforms was to increase local autonomy through the empowerment of clinical professionals leading decision-making at a local level: "The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level." (Department of Health, 2010, para 6.0). Market competition was encouraged and following a 'pause' in the development of *Health and Social Care Bill*, associated with concerns such as changes to 'any willing provider' of healthcare services, as well as questions over who would be in charge of the NHS (in light of a shift from the Secretary of State to have a 'duty to provide' to a 'duty to promote'), the Health and Social Care Bill 2012 received royal assent to become the *Health and Social Care Act* in March 2012.

Regional oversight was abolished under the *Health and Social Care Act 2012*, marking the end of Strategic Health Authorities and Primary Care Trusts. It therefore removed the role of regional tier in the English NHS as well as a break of the organisational hierarchy of the NHS featuring the Department of Health at its apex (Checkland, Dam, *et al.*, 2018). The abolition of the SHAs was justified on the basis that there would be no requirement for intermediate coordination as new locally autonomous health commissioners would be more effective and efficient working within a national accountability framework by 'radically simplifying the architecture of the health and care system' (Department of Health, 2010, para 5.4). The *Act* created NHS England (legally, the NHS Commissioning Board) as an executive non-departmental 'arm's length' public body with the express intention of removing political interference from the NHS. NHS England has operated with growing influence under the leadership of Chief Executive Simon Stevens: 'Although mandated by the Department of Health it has increasingly operated as policy-maker, developing policies in tension with existing legislation, while Ministers have faded from public-facing accounts of service operation' (Hammond *et al.*, 2018). Additionally, 27 Local Area Teams of NHS England were established as part of the *Act* to provide oversight of their geographical areas, but it was clearly stated by then-Chief Executive of NHS in England, Sir David Nicholson, that these would be 'outposts' of NHS England rather than

autonomous decision-making bodies (Pulse, 2011). Within a year, however, these were absorbed into four regional teams that operated with a much reduced budget (Checkland, Dam, *et al.*, 2018). The regional teams were intended to manage GP contracts. This role a regional requirement for how NHS England was to operate. Thus whilst not specifically a devolved regional function as such, it suggests geographical de-concentration of administration and management had a role in the new arrangements.

A number of studies examining the impacts of the 2012 Act have demonstrated the growing complexity of accountability in what was supposed to be a 'bottom up' reform without a centrally-defined blueprint (Checkland *et al.*, 2016; Checkland, Dam, *et al.*, 2018; Hammond *et al.*, 2018). Studies examining the effects of competition regulation reported views of both NHS commissioners and providers concerning an absence of an organisation responsible 'hold the ring' locally as was previously the case for Strategic Health Authorities (Checkland, Dam, *et al.*, 2018). Despite the policy agenda to simplify the system architecture of the NHS, the 2012 Act reforms increased fragmentation and complexity, with subsequent creation of bodies and fora attempting to re-create functions of previous intermediate bodies to maintain system integrity, co-ordinating delivery and manage performance (Checkland, Dam, *et al.*, 2018).

Moreover, research has suggested that the shift away from PCTs being responsible for the bulk of purchasing to a combination of CCGs, local authorities, NHS Commissioning Board and Public Health England creates challenging inter-organisational relationships for initiatives and services operating at different scales and with different geographical territories (Hammond *et al.*, 2017; Checkland *et al.*, 2018). As a result of the 2012 Act, CCGs took on responsibility for commissioning the majority of services for their local populations. One notable area of exception, however, were those services that GPs themselves provided. Concerns about potential conflicts of interest were highlighted as part of the justification for NHS England to commission primary care services nationwide. This separation of commissioning responsibilities proved somewhat problematic in practice. NHS England commissioners often lacked sufficient knowledge about the local landscapes of primary care and related care provision they were commissioning – a problem compounded across the health service by the departure of many long-standing commissioners and managers, as a result of the abolishment of PCTs, with extensive situated knowledge and productive inter-personal relationships – and the division of responsibilities between CCGs and NHS England meant that it was challenging to, for example, effectively shift funding between primary and community care in the interests of patients (McDermott *et al.*, 2018).

#### **4.7. Place-based systems, devolution and the return of regions?**

Just a few years after the top-down reorganisation of the *Health and Social Care Act 2012*, collaborative and place-based integration became the focus of national policy. The evolutionary changes were initiated by NHS England and marked a significant shift in emphasis. The policy direction was first set out in the *Five Year Forward View*, and it is

significant that the word ‘competition’ did not feature once (Hammond *et al.*, 2018, p. 11). Indeed, not only is the decline in competition within the policy narrative significant, but so too is the continued increasing influence of NHS England, shifting from having oversight of the delivery of NHS services towards arranging provision with greater responsibility for shaping how healthcare is organised (Hammond *et al.*, 2018). Section 2 has already set out the recent background to current reforms, including STPs and ICSs, so it is not necessary to repeat all details here. However, reprising certain changes underway is useful in light of the above sub-sections.

The *Long Term Plan* (NHS, 2019b) set out the expected roles and functions of ICSs, once STPs become more ‘mature’ in their collaborative relationships (NHS, 2019b). A clear emphasis is placed on partnership working with a STP/ICS board expected to include NHS commissioners, as well as NHS trusts, an accountable Clinical Director from each primary care network in their ICS, as well as members from local authorities, and possibly the voluntary and private sector, although the role of the private sector in governance arrangements is currently unclear. ICSs are to have a locally-appointed non-executive chair, requiring approval from NHS England and Improvement, alongside involvement of clinical and managerial figures from across the ‘system’ in order to support the implementation of decision-making. Additionally, the *Long Term Plan* (NHS, 2019a, p. 30) emphasises that ‘all providers within an ICS will be required to contribute to ICS goals and performance, backed up by a) potential new licence conditions (subject to consultation) supporting NHS providers to take responsibility, with system partners, for wider objectives in relation to use of NHS resources and population health; and b) longer-term NHS contracts with all providers, that include clear requirements to collaborate in support of system objectives’.

Relationships between CCGs are changing, too. Current NHS Clinical Commissioning Groups are required to become ‘streamlined’ and strategic, which ‘typically’ will require moving towards mergers that lead to a single CCG for each ICS in order to ‘enable a single set of commissioning decisions at system level’ (NHS, 2019b, p. 29), although many of the ‘frontrunner’ ICSs feature more than one CCG (for example, Greater Manchester, one of the ‘frontrunner’ ICSs that has ten CCGs working with their coterminous local authorities, within their new ICS-wide partnerships arrangements (Walshe *et al.*, 2018)). Integrated Care Systems are therefore meant to focus on shared decision-making with providers about the allocation of resources, service design and improving population health, although under existing legislation, any procurement or awarding of contracts must be undertaken by NHS commissioners.

STPs and ICSs (the focus of on-going research by the authors of this report), along with other major changes such as the regional teams and Primary Care Networks are continuing to develop and therefore it is too soon to draw extensive conclusions. The development of the regional teams also remains unclear, and certainly too soon for any research to have been undertaken. As discussed below, how the new nominally ‘regional’

teams interact with and shape STPs and ICSs remains a key focus of attention. However, existing research illustrates the emergence of several key issues, discussed more extensively with reference to previous rounds of reform in section 5. Concerns have been raised regarding system-wide accountability in the absence of a statutory body operating at the STP/ICS level, limiting the decision-making capacity of STPs, given that primary accountabilities remain with existing regulators, boards and the public (Moran, Allen and Mcdermott, 2018, p. 5; Moran et al., under review). Moreover, this research foregrounds challenges between engaging participating organisations, including local authorities, in new arrangements, existing working relationships with organisations in different STP footprints and through the continued influence of existing governance structures and interventions from previous changes. The extent to which STP leaders have the capacity and mechanisms at their disposal to hold partnership organisations to account remains a key area of attention.

Greater Manchester has one of the more 'mature' set of governance arrangements and relationships, and findings from research into health and social care in Greater Manchester (Walshe *et al.*, 2018; Lorne *et al.*, 2019) offer some insight into potential issues and challenges facing integrated care systems across England. The ongoing reorganisation of health and social care in Greater Manchester can be described as 'soft devolution' because, unlike devolution to the four countries of the UK, the Greater Manchester reforms have minimal statutory basis. In what is effectively a 'front runner' integrated care system, the arrangements can be seen as a form of administrative delegation between the Department of Health and Social Care, arm's length national bodies including NHS England and NHS Improvement and the multitude of NHS organisations, primary care representative and local authorities in Greater Manchester (see further Greater Manchester Combined Authority, 2015). Consequently, Walshe et al. (2018: 6) suggest health and social care devolution has 'not been an exercise in allowing local autonomy or control over policy, but over its implementation'. The *Cities and Local Government Devolution Act 2016* made the formal devolution of NHS functions possible to combined authorities such as Greater Manchester. However, more extensive (political) devolution has not yet taken place. Nonetheless, the same study foregrounds the ongoing work required to hold together the relatively fragile organisational arrangements given the divergent accountabilities and regulatory regimes, with the new Partnership Team (with its Chief Officer an NHS England employee) using 'system maturity' to help leverage additional delegated commissioning functions to more closely align with the city-region and its wider public service reform agenda (Lorne *et al.*, 2019). Whilst strategic planning in Greater Manchester was positioned as a composite of the city-region's agenda as much as the national policy direction, in reality there is little that does not fit with the overarching national direction of policy-making focus towards integrated care (Walshe *et al.*, 2018).



#### 4.8. Summary of intermediate tiers over time

Name	Years	Population (approx.)	Form and relations	Key functions / responsibilities
Regional Hospital Boards (14)	1948 – 1974	1.2 – 4.4m	<ul style="list-style-type: none"> <li>Statutory boards responsible to Ministry of Health</li> <li>Comprised of unelected members</li> </ul>	<ul style="list-style-type: none"> <li>Allocate resources to and responsible for oversight of hospitals</li> <li>Oversight of regional policy</li> <li>Provide national policy guidance</li> <li>Ensure quality levels of care</li> </ul>
Hospital Management Committees (388)	Pre-NHS – 1974	Unknown	<ul style="list-style-type: none"> <li>Responsible to Regional Health Boards</li> <li>Teaching hospitals had own Board of Governors, directly responsible to Ministry of Health circumventing regions.</li> </ul>	<ul style="list-style-type: none"> <li>Day-to-day administration of hospital services</li> </ul>
Regional Health Authorities (14), later reduced to (8)	1974 – 1994/6	As of 1991, 2 – 5 million	<ul style="list-style-type: none"> <li>Statutory body responsible to DHSS</li> <li>Chair politically-appointed by Secretary of State, with 18-24 members included local authority members and others</li> <li>1976 reforms led to 1/3 local elected members</li> <li>Decision-making through consensus management</li> </ul> <p><i>Post-Griffiths Review:</i></p> <ul style="list-style-type: none"> <li>Decision-making through general management rather than consensus</li> <li>Chairs continue to be appointed by Secretary of State</li> </ul> <p><i>Post-purchaser / provider split:</i></p> <ul style="list-style-type: none"> <li>By 1994, reduced to 8, running parallel to new regional offices and abolished formally in 1996</li> </ul>	<ul style="list-style-type: none"> <li>Principally planning function focused on longer-term priorities,</li> <li>Responsibility for the local population, no longer just for hospitals</li> <li>Allocate capital and revenue resources to AHAs in order to meet national objectives, including resolving competing AHA claims for resources</li> <li>Translate national policy priorities into a framework for each region by producing regional plans and ensure their implementation</li> <li>Monitor performance of AHAs and annually reviewed their objectives, plans and budgets submitted to them</li> <li>Some direct provision of services such as ambulances and RHAs employed consultants and senior registrars.</li> </ul> <p><i>Post-Griffiths Review:</i></p> <ul style="list-style-type: none"> <li>By 1980s, reduced influence on day-to-day operations instead concentrating on capital and revenue allocation</li> </ul> <p><i>Post-purchaser/provider split:</i></p> <ul style="list-style-type: none"> <li>Post-1991, RHAs provided strategic direction and oversight of the local workings of the internal market</li> <li>Exercise a regulatory function for both purchasers and providers</li> </ul>

Area Health Authorities (90)	1974 - 1982	500,000 – 1,000,000	<ul style="list-style-type: none"> <li>• Lowest-level statutory body directly accountable to RHA, and employ most NHS staff</li> <li>• Chair politically appointed, all other members (15-16) selected by superior RHA</li> </ul>	<ul style="list-style-type: none"> <li>• Full responsibility for operational activities and some planning responsibilities.</li> <li>• To provider staff for Family Practitioner Committees Largely co-terminus with local authorities with Joint Consultative Committees a mechanism to encourage consultative working with local government</li> </ul>
District Health Authorities (192)	1982 – 1996	200,000 – 500,000	<ul style="list-style-type: none"> <li>• District Health Teams existed since 1974, became statutory health authorities in 1982.</li> <li>• Responsible to RHA</li> <li>• Decision-making through consensus management</li> </ul> <p><u>Post-Griffiths Review:</u></p> <ul style="list-style-type: none"> <li>• Reduced local authority membership, worker representation abolished and trade union-selected posts reduced to a single member.</li> </ul> <p><u>Post-purchaser / provider split:</u></p> <ul style="list-style-type: none"> <li>• Local authorities lost the right to appoint members of the DHAs</li> </ul>	<ul style="list-style-type: none"> <li>• Responsible for service planning, development and management in accordance with national and regional strategic guidelines, as well as provision of facilities</li> <li>• To be smallest scale geography to carry out integrated planning, service provision and development of primary care, community services and services relating to district general hospital</li> </ul> <p><u>Post-purchaser / provider split:</u></p> <ul style="list-style-type: none"> <li>• Became purchasing bodies for both hospital and community services for their residents through contracting</li> <li>• Assessing population health need and holding public health responsibilities through annual report of local priorities</li> <li>• Managing local directly managed units that fall within their catchment</li> </ul>
Regional Offices (8), briefly reduced to (4)	1996 – 2002 2002 – 2003	Unknown	<ul style="list-style-type: none"> <li>• Outposts of the NHS Executive, part of the Department of Health with staff becoming civil servants</li> </ul>	<ul style="list-style-type: none"> <li>• To ensure co-ordination and ensuring separation of purchasers and providers as umpires</li> <li>• Responsibility for monitoring the performance of purchasers and providers in their region</li> <li>• Contribute to national level issues as members of the NHS Executive Board</li> <li>• Responsibility for regional allocation of resources removed, now going directly to health authorities</li> </ul>
Health Authorities (100)	1996 – 2002	Unknown	<ul style="list-style-type: none"> <li>• Statutory unitary authorities that combined the functions of District Health Authorities and Family Health Services Authorities (responsible for the management of primary care)</li> </ul>	<ul style="list-style-type: none"> <li>• To identify the strategic priorities for improving local quality through health needs assessment for Health Improvement Programmes and determining their investments accordingly</li> <li>• Supporting and facilitating the development of clinical governance amongst all local</li> </ul>

				<p>NHS organisations, especially creation of Primary Care Groups</p> <ul style="list-style-type: none"> <li>• Allocate resources to Primary Care Groups and hold them to account</li> <li>• Identifying specialist services with insufficient 'critical mass' to undertake on local basis</li> </ul>
Strategic Health Authorities (28) later reduced to (10)	2002 – 2006  2006 – 2012	1.1 – 2.7m  2.5 -7.5m	<ul style="list-style-type: none"> <li>• Statutory authority responsible for day-to-day management of NHS as local headquarters of the NHS</li> </ul>	<ul style="list-style-type: none"> <li>• Overall responsibility for 'system management' to hold the local health service to account, build capacity of acute Trusts and Primary Care Trusts and support the improvement of performance</li> <li>• To create strategic framework for local health services</li> <li>• To manage NHS Trusts and Primary Care Trusts through local accountability agreements.</li> </ul>
Clinical Commissioning Groups (~210 since reduced to 191)	2012 - current	221,000 (median)	<ul style="list-style-type: none"> <li>• Membership bodies with local GP practice members</li> <li>• Elected governing body comprised of GPs, other clinicians and lay members</li> <li>• Independent, and accountable to the Secretary of State for Health and Social Care through NHS England</li> </ul>	<ul style="list-style-type: none"> <li>• Responsible for commissioning healthcare including mental health services, urgent and emergency care, elective hospital services, and community care;</li> <li>• Responsible for approximately 2/3 of the total NHS England budget</li> <li>• Responsible for the health of local population</li> </ul>
Regional Sectors, later Teams (4)	2012 - 2016	7.8 – 15.6m	<ul style="list-style-type: none"> <li>• Regional offices of the NHS Commissioning Board</li> </ul>	<ul style="list-style-type: none"> <li>• Provider oversight function</li> <li>• Degree of responsibility for commissioning national screening programmes</li> <li>• Intended to manage GP contracts</li> </ul>
Local Area Teams (27) reduced to (12) in 2015	2012 – 2015	1.2 m – 3m	<ul style="list-style-type: none"> <li>• Local offices of NHS Commissioning Board / NHS England – later subsumed into the 4 Regional Teams</li> </ul>	<ul style="list-style-type: none"> <li>• Principally a local system oversight function and supports CCG development and assurance</li> <li>• Had no substantive decision-making powers or policy influence</li> <li>• 10 LATs had responsibility for specialised services, and some offender and armed forces commissioning</li> </ul>
Sustainability and Transformation Partnerships / Integrated Care Systems (44/17)	2015 - current	300,000 – 3m (1.2m average)	<ul style="list-style-type: none"> <li>• Non-statutory partnership arrangements with non-elected STP leads (mostly NHS, occasional local authority)</li> <li>• 14 most advanced areas have become Integrated Care Systems (including 'devolved' areas)</li> </ul>	<ul style="list-style-type: none"> <li>• Develop system strategy and planning</li> <li>• Develop system-wide governance and accountability arrangements</li> <li>• Lead the implementation of strategic change</li> <li>• Manage performance and collective financial resources;</li> <li>• Identify and spread best practices across the system to</li> </ul>

			<ul style="list-style-type: none"> <li>• All existing statutory organisations existed as previously</li> <li>• All areas of England to be covered by an ICS by 2021/22 that are 'typically' governed by one ICS-wide merged CCG</li> </ul>	reduce unwarranted variation in care and outcomes
Regional teams of NHS England / Improvement (7)	2018 – current	Unknown	<ul style="list-style-type: none"> <li>• Regional teams of NHS England and Improvement</li> <li>• Closer working between NHS England and Improvement but continue to exist legally as separate entities</li> </ul>	<ul style="list-style-type: none"> <li>• To support local systems to provide more joined up and sustainable care for patients</li> <li>• Responsible for the quality, financial and operational performance of all NHS organisations in their region, drawing on the expertise and support of our corporate teams to improve services for patients and support local transformation</li> <li>• Support the development of the STPs and ICSs including identity formation</li> </ul>

## 5. KEY THEMES FOR INTEGRATED CARE SYSTEMS

This section focuses on key themes we might anticipate in the move towards integrated care systems as part of the ongoing reforms in health and social care across England. We do so through synthesising key themes identifiable through our focus on previous intermediate tiers in co-ordinating local health and care services and informed by our analytical framework motivating this review. It is useful to recognise that the following themes are inter-connected rather than discrete.

### 5.1. Mediating centre-local relations: Autonomy in the shadow of hierarchy

Strategic planning, system co-ordination, quality improvement and performance management have all fallen within the remit of a statutory regional tier over the decades as the NHS has been reorganised (Davies, 2014). To discuss the current reorganisation including the functions and overall 'strength' or 'capacity' of the regional tiers of previous reorganisations, it is necessary to hold particular regional functions separately to help unpack the key issues. Therefore, this section focuses on the role of an intermediate tier in mediating centre-local relations focusing on finances and strategic planning. *Section 5.2* focuses on managing local relationships 'within' the region (referring to all intermediate tiers), focusing on oversight, accountabilities and managing conflicts.

An intermediate tier has functioned as a mediatory, interpreter or buffer-like body, negotiating centre-local tensions ever since healthcare was situated principally within the remit of a nationalised health service rather than within local authorities (Peckham *et al.*, 2005). Attempts to strike a balance between local autonomy and central authority is a well-recognised dynamic within the NHS (Checkland, Dam, *et al.*, 2018), our previous section illustrating the 'ever-swinging pendulum' through waves of reorganisation displaying 'a necessary and continuing tension between a bias to the centre and to the periphery' (Ferlie and Pettigrew, 1996, p. 498). The apparent paradox of 'centralized-decentralization' observable over recent decades has been the source of much analytical disagreement, through the centralising of control over strategy and policy whilst creating decentralised units for service delivery, the introduction of a market in service delivery and performance management regimes (Hoggett, 1996; Peckham *et al.*, 2005). What is important for understanding the emerging ICS/STPs arrangements is that they will not *resolve* centre-local tensions, irrespective of their real or perceived strength or their statutory or non-statutory basis.

Historically, intermediate tiers played an important role in financial allocations. Regional Health Authorities allocated capital and revenue to the Area tier beneath it in the hierarchy. Resources delegated to the semi-autonomous RHAs was to support the meeting of national objectives, as well as playing a key role in resolved competing claims to resources. The creation of regional offices ended this function, with the allocation of resources by-passing the intermediate tier, for which we may draw certain parallel with the limited remit of the new NHS England/Improvement regional teams. Funding was once again allocated to SHAs, along with PCTs receiving funding directly by the

Department of Health during the New Labour years, before their abolition following the Health and Social Care Act 2012. It is significant that there are current examples such as in Greater Manchester whereby aspects of national transformation funding have been routed through the devolved partnership arrangements at the ICS level, albeit in the absence of a statutory body to hold funding, NHS funds are still held by either NHS England or delegated to the local CCGs (Walshe *et al.*, 2018). **Importantly, the latest STPs/ICSs arrangements do not represent a return to a large statutory authority allocating capital and revenue, despite this existing as a significant function within past reforms, if undoubtedly strongly steered by central government. Whilst current reforms suggest that the intermediate tier should develop system planning, it does so without obvious financial levers to achieve this, nor the authority to hold lower tiers to account.**

Broadly speaking, we can observe a declining influence of the regions within the organisation of the NHS, although we would note that there is no neat consensus among commentators due to disagreement over analysing the tensions of centralisation-decentralisation. Arguably, an intermediate tier of the NHS was at its more influential in the lead up to the reorganisations of the 1970s as longer-term planning took hold where regions had notable influence on shaping the expansion of district general hospitals following the *1962 Hospital Plan*. How power is exercised across the NHS has altered immeasurably over recent decades, even prior to the purchaser/provider split, given the influence of the rise of general management, new techniques of performance management and the end of consensus-based decision-making. The paradox of increasing central control over policy-making and strategy coincided with increasing decentralisation of operational control following the 1989 'Working for Patients' reforms (Hughes and Griffiths, 2010, p. 71) characterised in the literature whereby 'greater decentralisation downwards is often balanced against tighter accountability upward' (Ferlie and Pettigrew, 1996: 499). Thus, prior to and following the purchaser/provider split, the ongoing centripetal pull of powers centrally becomes apparent, particularly through performance and financial management, with political expediency often overriding a rhetorical commitment to devolution (Hoggett, 1996). **It is difficult to envisage either STPs/ICSs or the new regional teams being able to substantively counter balance national influences (whether arm's length bodies or Department of Health and Social Care), not least given the growing financial and operational pressures.**

Thus far, we have raised the relative 'weakness' of current STPs and ICSs compared to previous intermediate tiers. However, through recognising that regions are actively and continuously under construction, it should not be assumed that all STPs/ICSs will develop in the same way according to national direction alone. Intermediate tiers have historically played a significant role in balancing national and local planning priorities, yet there can be a tendency within prevailing narratives to document healthcare reforms from what Day and Klein (1997) acknowledge as the 'distorting prism' of London (see also, Mohan,

2002). Not all intermediate tiers operated uniformly across England in the past and different intermediate authorities had operated, at times, in varied ways with different identities and organisational and political power dynamics. Such variation is present in Elcock's (1978) study of the *Northern* and *Yorkshire* RHAs, for instance, whilst Dopson and Stewart (1998, p. 93) observe how in-depth studies of local health services have long 'questioned the assumption underlying the reorganizations of 1974, 1982 and 1983 that policy is made at the centre, transmitted to the periphery and implemented there'. In more recent history, whilst some variation was observed in SHAs, the centripetal forces of central government grew stronger. A degree of relative caution is required therefore in positioning intermediate tiers within the dominant hierarchical organisation of the NHS and the control of national bodies, although certainly more recently, studies suggest that whilst there may have been some difference in the extent to which national policy was tailored to regional priorities, there has been a tendency towards strong central performance management regimes and the direct influence of the Secretary of State and Prime Minister discouraging major local flexibility and difference (e.g. Storey *et al.*, 2010). This dynamic for SHAs was captured in the phrase: 'what the Government of the day wants the health service to deliver, we deliver' (Storey, 2011, p. 638). As we discuss more fully below, the significance of existing histories of working together, and indeed, long-standing local organisational tensions, as well as the influence of local government, may prove relatively influential in diverging to a relative extent from the expected functioning of STPs/ICSs in the eyes of national bodies. Indeed, NHS England and others have suggested they recognise that 'one size does not fit all'. Nonetheless, given recent history, how this is negotiated in practice is likely to sit in sharp tension with the emphasis on national frameworks, maturity indexes and 'must dos'.

**Overall, compared to previous years, non-statutory 'system-level' integrated care systems may be considered much less powerful, without the *authority* over lower tiers as with previous RHAs or SHAs which operated with relatively considerable influence over strategic and financial planning. The current 'system' level partnerships are composed of local member organisations, rather than as discrete entities, situated within a broadly hierarchical structure. Moreover, each constituent organisation retains its existing accountabilities and statutory roles. Ultimately, the capacity for STPs and ICSs to counter overarching national influences (albeit now from NHS England and Improvement rather than necessarily Department of Health as with previous reforms), would appear relatively constrained, given the continued impact of hierarchy in the organisation of the NHS and the minimal formal levers at the 'system' level. STPs/ICSs continue to experience tensions of the past balancing the hierarchical role of the centre and local autonomy and difference, although the reach of national bodies may prove challenging to resist.**

## 5.2. An intermediate body to hold the 'system' together

When it was decided in the early 1990s that the long-standing, albeit heavily reformed, Regional Health Authorities were to be abolished in light of the purchaser/provider split in the NHS, the Secretary of State at the time remarked that the changes were resolving the 'unfinished business' of the regions (Warden, 1993). Yet, as documented in Section 4 above, when intermediate tiers have been removed in recent decades, they have tended to have been reinstated soon after (Storey, 2011). Where the last primary legislative changes to the NHS in England were motivated by a policy agenda seeking to 'radically delayer' the NHS (Department of Health 2010, p5) removing an intermediate tier of organisation, taking a longer perspective on NHS reform, it should not be surprising that the current reorganisation resembles a return to a multi-tiered structure. The vacuum created through the absence of a co-ordinating organisation or authority overseeing strategic planning, competing interests and managing relationships across more-than-local geographies following the abolitions of SHAs is a notable theme in recent research-led literature.

**The current reforms appear to bring back in intermediate tiers at 'regional' and 'system level' just a few years since the *Health and Social Care Act 2012* that in terms of size broadly resemble the structure of that of regions, areas and districts. However, due to the growing complexity, diversity of public, private and voluntary sector agencies and organisations involved in different aspects of the organisation, provision and regulation of healthcare, the latest reforms are only an echo of the hierarchically-structured, nested scalar architecture of accountabilities that characterised the first major structural reorganisation of the NHS in the 1970s. Organisational and operational complexity are not 'disentangled' by the latest reforms but worked around, even if efforts are underway to clarify (if not simplify) what is co-ordinated at different spatial scales.** Recent research into health and social care devolution in Greater Manchester (Lorne et al., 2019: 4) illustrates the 'multi-scalar' organisation of health and social care is 'constructed through the interplay of overlapping, entangled and unstable negotiations of power that hold together rather than exist at a particular spatial scale *a priori*' encouraging 'attention to the ongoing arrangement of different local, regional or national actors and how they interact and intersect'. Crucial to this is that the purchaser/provider split remains in place, despite political and technical questions raised over its future. Consequently, it is most relevant for the remainder of this sub-section to focus on the changing role of an intermediate tier managing local relationships post-1991, whether as regional offices that worked to 'hold the system together' (Dopson, Locock and Stewart, 1999) or Strategic Health Authorities that existed to 'hold the ring' (Checkland, Dam, Hammond, *et al.*, 2018).

Research suggests there was some evidence of positive relationships between health authorities and the regional offices, with the regions supporting local co-ordination and cohesion, helping to share learning, aiding communication and keeping contact with what was happening locally (Dopson, Locock and Stewart. 1999). At the same time, the same



research denotes the fine balance that was required to be struck between intervention and 'light touch' monitoring of performance. Despite the reintroduction of provider monitoring powers for the regional offices, concerns were raised as to whether they had sufficient clout to intervene in the market and whether the regional tier, no longer as a statutory authority, had been undermined as resources were allocated directly to health authorities, bypassing the regions (unlike with RHAs). Additionally, issues existed as to whether the regional offices lacked capacity to counter the influential Trusts, with the suggestion that they could struggle with challenging major service reconfiguration. Parallels between the role of the regional offices and the emergence of regional teams, as regional outposts may be drawn. Indeed, the transitional dynamics as regional offices understood their role shifting from that of market umpires towards relationship managers could prove instructive here (Kewell, Hawkins and Ferlie, 2002). With the return of more substantive statutory bodies, in way of Strategic Health Authorities, the intermediate tier had more ability, or at least, authority, to be able to broker local relationships with a stronger control over capital expenditure as a key lever on offer to the SHA (Storey *et al.*, 2010). Yet, the ability of the SHA to hold together their health economy was also heavily steered by national priorities. Ultimately, it may be considered beneficial, if not necessary, to have a body that oversees the co-ordination of local organisations and the configuration of services from a more-than-local spatial scale in attempts to balance different parts of the 'system'.

**Unlike previous intermediate tiers, and whilst recognising that the current arrangements are evolving, there is a notable absence of mechanisms to achieve and sustain agreements given the inevitable conflicts and disagreements embedded within the existing organisational and legislative landscape. Just as the relations between STP/ICS and the new regional teams remains open-ended, establishing and managing the relationships between 'place' level and how this intersects with the STP/ICS 'system' remains a key area of importance and uncertainty.** The place level is significant in that this may be broadly understood as local authority area, a more enduring geographical territory with more defined (if not uncontested) identities. It is the level with which local authorities are to work together with NHS commissioners, however, the expectation set out by NHS England is to move towards quasi-mergers towards having one CCG across the geography of the STP/ICS. There can be instances of multiple places in existence across and beyond the boundaries of each STP/ICS. It has not unprecedented historically within the NHS, for the geography of intermediate tiers to exceed the scale of local authorities and thus potential control (Mohan, 2002). **However, there is uncertainty over how the different relations between organisations comprising each STP/ICS are expected to 'hold together' given the complex and uneven geographies of organisations and authorities within (and beyond the boundaries of) each STP, with local authorities having their own local priorities and politics** (more in Section 5.6.). **In addition, 'place' level in the evolving system is currently left undefined, with no central direction as to which organisations will collaborate, over which types of service.** As partnership

agreements, we would expect the functioning of STPs and ICSs to rely on building and sustaining relations of mutual accountability between different organisations within and, at times beyond, geographical areas which will require substantive ongoing work and energy. How collaborations operate at 'place' level will have an important role in determining how this plays out in practice.

### **5.3. Negotiating competition and co-operation**

The intermediate tier can shape dynamics of competition and co-operation, irrespective of any changes to their statutory basis according with current legislation. Recent previous studies of SHAs outline how they sought to strike a balance between making competition work, particularly given the push for organisational autonomy intended for the Foundation Trust model, whilst also recognising at least some need for collaboration (Storey et al., 2011). Studies since the *Health and Social Care Act 2012* have found that whilst the norms and further adoption of market principles have become in many cases embedded, the everyday practices of commissioners often tended to favour collaborative working (Osipovič *et al.*, 2016; Sanderson, Allen and Osipovic, 2017). It is not currently clear how STPs/ICSs will manage the dynamics between cooperation and competition within each system.

The treatment of private and voluntary sector providers in STPs/ICSs is ambiguous. The latest Health and Social Care Act 2012 reforms continue to exist, with private health providers able to operate as before, although their status in the governance arrangements is unclear. Despite the lack of emphasis on market competition following the publication of the *Five Year Forward View* in 2014, the market regime of the 2012 Act has not been abolished. In the absence of legislative change, a possibility of increasingly competitive STP/ICS dynamics 'within' each system remains open given that intermediate tiers are not by definition 'anti-competition'. For instance, the regional offices were intended to function as 'market stewards' and although the economic regulator has signalled declining emphasis on competition and increasing permissiveness of more collaborative approaches to commissioning (Osipovic *et al.*, 2019), it is conceivable this could alter under changing political circumstances in central government. Conversely, there is potential for complaints from the private sector given that they do not currently feature prominently in emerging system-wide governance arrangements (Sanderson, Allen and Osipovic, 2016).

**We should expect both the latest ICS/STPs and regional directors to both operate with some ambiguity in their functions, particularly in a period of major change in policy direction (i.e. the turn from competition to coordination through cooperation).** This was the case for regional offices in the years following the creation of the internal market uncertain as to whether they existed to regulate, manage or plan for their regional geographies and local providers (Kewell, Hawkins and Ferlie, 2002). Collaboration between NHS providers can be encouraged at the STP/ICSs level and

broadly speaking, this has been the overarching publicly expressed position of NHS England. However, this cannot be enforced as a consequence of the continued impact of legislation whereby each organisation continues to be regulated as separate organisations.

#### **5.4. The continuous search for the 'best' size and scale**

The last seven decades of reform show there is neither consistency nor consensus over what spatial scale is 'best' to take decisions over the co-ordination of health and social care, nor agreement over how to do it. Through tracing the pendulum swing of re-organisations over previous decades, we can observe the changing role of the regions shaped by a re-shuffling of which particular territorial geographies and spatial scales are deemed 'most appropriate' or 'best' for different functions, roles and responsibilities. The literature demonstrates considerable variation in the size, form and function, as well as differing claims to the 'natural geographies' for organising care over the decades. For instance, we can observe how organisation centred upon district general hospitals in the 1960s shifts through to an emphasis on 'community-based' care in recent decades, dovetailing to some extent with particular notions of localism. Yet, even in recent years, we may distinguish a notable shift in the positioning of STPs as the 'natural' geography for transforming the organisation of care (NHS, 2015, p. 6) towards increasing emphasis on the 'natural geographies' of the neighbourhood within the formative stages of Primary Care Networks as the 'cornerstone' of integrated care (NHS, 2019b). Whilst working across both spatial scales is of course not incompatible, given the evolutionary nature of policy-making involving considerable ambiguity, disagreement over what 'natural geographies' of organisations are best for what decisions may well prove significant, as the preceding sub-sections have already suggested.

Recent literature highlights how commissioners under the *Health and Social Care Act 2012* were allocated responsibilities for different services creating a complex commissioning landscape. Checkland et al. (2018) illustrate that for specialist commissioning, the national level sets priorities and strategy, whilst contracting and the managing of relations between commissioners and providers takes place locally, via the local area teams. Moreover, increasing numbers of CCGs merging in recent years, appears to demonstrate a recognition of the need to commission many activities beyond the geography of the original size of CCGs, towards that of the system-wide or sub-system wide scale of commissioning. However, caution has been expressed in assuming that the (re)turn to system-level commissioning will inevitably lead to improvements in commissioning in itself, or that the existing problems associated with fragmentation will be resolved through this move towards STP/ICS wide commissioning (Checkland, Hammond, et al., 2018). Where joint decision-making requires seeking and maintaining consensus, recent research in 'devolved' Greater Manchester suggests that finding agreement over what scale is best for what particular decisions may prove challenging, particularly where both NHS and local authority members are involved or engaged, even with relatively coterminous local government and CCG geographies (Walshe et al., 2018).

As outlined above, the ability to sustain contentious strategic decisions that impact on a complex organisational and operational landscape should be anticipated to be challenging.

It is well-recognised that integrated care is a malleable concept, interpreted in different ways in theory and in practice (Goodwin and Smith, 2011). **A look to past reorganisations illustrates that there is no ‘perfect scale’ for ‘integrated’ (or unified) commissioning/planning, and establishing ‘where’ is best depends on the particular service or function under question. Indeed, historical perspectives demonstrate the ways in which the ‘where’, ‘how’ and ‘why’ questions over planning or commissioning are shaped by different political strategies, policy trends and enduring organisational legacies impacted by both national reforms and particular local context. Consequently, for STPs and ICSs, given the current integration reforms rely substantively on building and maintaining collaborative relations, we would anticipate finding consensus over where best to take decisions within STPs/ICSs a recurrent challenge that does not easily get resolved, even where there may be broad agreement on the overarching strategic direction of organising care.**

#### **5.5. Challenges with joint working between local government and the NHS**

The above sections have focused principally on the NHS. However, the relationships between the NHS and local government are significant, as well as other partners and agencies involved in the co-ordination of health and social care services. Importantly, most social care is now provided by the private sector. Local government rests on a very different governance framework to that of NHS organisations, with far stronger local ties, connected to different notions of local political democracy and autonomy. Moreover, alongside growing attention towards place and the wider social determinants of health, the role of public, private and voluntary sectors in wider fields of public policy, such as housing, environment and education is, once again, important. Various structures and mechanisms to bring health and local government into closer alignment have been used in efforts to overcome the divides between NHS and local government since 1948. Assumptions persist relating to joint commissioning (or planning) *necessarily* leading to the improvements in quality and efficiency, in part shaped by a problem of conceptual ambiguity, although it is notable that of literature on joint commissioning of health and care, a relatively small proportion is based on in-depth peer-reviewed academic work (Dickinson *et al.*, 2013).

Aligning geographic boundaries between local authority and NHS organisations has long featured as a structural ‘solution’ to closer working between health and social care. As outlined in *Section 4*, coterminosity has ebbed and flowed over the years. Efforts to achieve coterminosity at different spatial scales between health, social care, as well as other areas such as education and housing agencies, inevitably creates a dilemma of finding coterminosity at one scale at the neglect of others (Exworthy and Peckham, 1998). Bringing together NHS and local authority budgets in a satisfactory way that co-ordinates

different funding arrangements has proven a persistent challenge (e.g. Judge and Mays, 1994). Going back to the 1974/6 reforms, we can observe challenges relating to decision-making through consensus management, particularly amidst different organisational structures, budgets and allocation of funding oversight, geographic boundaries and planning cycles (Glendinning and Coleman, 2004). Moreover, overcoming the challenges between different professional identities and ‘cultures’ is well-recognised enduring issue (Glendinning and Coleman, 2004).

Joined-up working through partnerships to counter fragmentation has received considerable attention in recent decades in England. There has been a tendency for emphasis to be placed on facilitating joint commissioning through establishing new structures rather than necessarily providing clear information regarding what and how joint commissioning should be achieved (Dickinson *et al.*, 2013). Reflecting on the tendency for structural ‘solutions’, Glasby *et al.* (2011) state that ‘evidence and experience suggests a series of more important processes, approaches and concepts that might help to promote more effective inter-agency working—including a focus on outcomes, consideration of the depth and breadth of relationship required and the need to work together on different levels’. Moreover, Hudson (2011) reflecting on ten years of joint commissioning, remarks on the paucity of achievements despite a plethora of policy initiatives and widespread promotion of ‘partnerships’ within policy. Indeed, we might be wise to recognise that a turn to ‘place’, along with prevention and moving care closer to home, has a much longer history in health and social care, despite renewed enthusiasm in recent years, featuring as one of the imperatives of joint commissioning (Hudson, 2011). Recent analysis of the Better Care Fund initiative has been suggested to have faced boundary issues where STP footprints do not align with that of CCG and/or local authorities, whilst momentum behind the newer STP plans may have undermined focus on the Better Care Fund (Forder *et al.*, 2018). In line with international evidence, research into the Better Care Fund has demonstrated challenges in agreeing and aligning programme spending as well as issues with risk management and joint financial responsibilities (Harlock *et al.*, 2019). For STPs and ICSs, we would expect many of the existing challenges to continue.

**At present, it is possible to discern two major issues affecting Local Authority/NHS cooperation in the evolving system. Firstly, there is ambiguity about the role of Local Authorities in STPs/ICSs. The NHS Long Term Plan (2019a, p. 30) states that there is ‘a clear expectation’ that Local Authorities will ‘wish to participate’ in STPs/ICSs. This suggests a lack of engagement prior to the publication of the Long Term Plan, and clarity over the nature of Local Authority ‘participation’ remains lacking. Secondly, the obvious level at which joint working between the NHS and Local Authorities will be operationalised is the level currently labelled as ‘place’. This is described as covering a population of 250-500,000 people, but at present it remains entirely undefined, beyond a vague description of the development of ‘provider alliances or other collaborative arrangements’ (NHS, 2019b). This lack of clarity makes it very difficult for Local Authority leaders, who may not be able to clearly identify who it is they should be collaborating with across a particular area.**

The paradoxical term ‘statutory voluntarism’ has been used previously to convey the problems associated to the mandating of partnership and co-operation between health and social care organisations (Paton, 1999, p. 69). In light of the current changes to integrate care, we might now reflect on the further challenges of non-statutory mandatory voluntarism, whereby NHS-centric policy-making struggles to overcome historic divides between organisations and across different geographies, not helped by the lack of clarity associated with both ICSs and the currently designated ‘place’ level of the system. It is perhaps noteworthy that ‘place’ level corresponds to the approximate size of District Health Authorities following the 1982 reorganisation.

### **5.6. Ensuring adequate democratic accountability and public involvement**

Literature on the early stages of STPs reflects the difficult formative stages of their development with the wider public largely excluded from the process, arousing suspicion and political contestation (Black and Mays, 2016; Hammond *et al.*, 2017). Connecting with the preceding sub-section, commentators have noted the substantial institutional barriers to integrating health and social care through the STP process, given that it is local authorities that have experienced far more pronounced financial challenges with substantive cuts to their budgets over the previous decade (Walshe, 2017). However, whilst recent literature illustrates tricky relationships between the wider public and the latest reforms, this is by no means a new phenomenon.

With compromise and complexity embedded in the tensions between *local* government and a *national* health services long featuring in the organisation of health and care services in England, intermediate tiers are bound up within ‘the conflict between those who regard the NHS as a body needing only effective and efficient management and those who believe it must be democratically accountable’ (Elcock, 1978, p. 396). The changing composition of decision-making bodies is of importance to these debates. Since the Griffiths Review of the 1980s, who sits on boards of intermediate tiers has altered, with the erosion of trade union and workforce representation. Decision-making based on consensus – often critiqued for lack of efficiency – was abolished in a move to the principles of general management and executive decisions. Until the abolition of Regional Health Authorities, Chairs were politically appointed by the Secretary of State, although whether this represents democratic accountability may well be rightly contested. Taking a more recent look at local democratic involvement and political debate within health and local government, we may consider the ongoing significance of Health and Wellbeing Boards. Despite varying quite considerably in their structure and representation, Health and Wellbeing Boards are an existing mechanism as ‘system stewards’ that will continue to have relevance (if not necessarily influence) in the latest (re)turn to place-based services and systems (Coleman *et al.*, 2014; Coleman, Dhesi and Peckham, 2016; Local Government Association, 2019). Likewise, as statutory mechanisms, Health Overview and Scrutiny functions of local authorities will also continue to be relevant. Put another way, current reforms may be wise to recognise the existing mechanisms in place that link NHS and local government in the rush to roll-out STPs and ICSs. Following the previous

sub-section, the contradiction between narratives of 'partnership' and top-down directives again raises questions over patient and public involvement in priority-setting within STPs and ICSs (Coultras, Kieslich and Littlejohns, 2019). Recent research cautions that where failure to earn public trust in large-scale change in the NHS may be counter-productive for sustaining collaborative relationships required for binding together STPs, and now ICSs (Coultras, Kieslich and Littlejohns, 2019).

**Moves to bring local government and NHS organisations closely together through the creation of STPs and ICSs brings us back to long-standing tensions shaping the organisation of health and social care in England. With local government and NHS organisations having completely different centre-local governance contexts, it is inevitable that problems will occur in the new partnership arrangements. We began this section by outlining the inherent tension of an intermediate tier situated within centre-local relations within the NHS existing on one hand as a national service which is locally managed, on the other, groupings of local services within national guidelines (Butler, 1992: 125). Integrated care systems are likely to face a challenging relationship with the public - variously, as patients, voters, workers and carers - regarding how they will seek to simultaneously hold NHS organisations and local authorities to account locally, regionally, and nationally.**

## 6. CONCLUSION

The purpose of this literature review has been to examine previous intermediate tiers in the organisation of the NHS in England, to understand what levers and mechanisms were available at 'regional' and/or 'sub-regional' levels in the co-ordination of services and how they functioned in practice. It has also considered the roles and relationships with local government in the integration of health and social care services. There has not been sustained, systematic research into the role of intermediate tiers of the NHS throughout its history, and we should exercise some degree of care when drawing conclusions. Nonetheless, we have drawn on various studies to establish a series of key themes to help inform what issues and opportunities we should anticipate as the new systems architecture of Sustainability and Transformation Partnerships and Integrated Care Systems develop over the next few years.

On balance, the latest turn to intermediate tiers is a comparably 'weak' arrangement, operating as looser collaborative partnerships rather than as intermediate tier statutory authorities. The extent to which an intermediate body has capacity to challenge the influence of national bodies – whether arm's length bodies or the Department of Health and Social Care – has demonstrably declined in recent decades; in the absence of statutory authority, and given the financial strain faced across the NHS and local government, the ability for ICSs and their constituent partnership organisations to pursue and agree their own system-wide agenda diverging from national policy-making (and any associated resources) may be constrained. A distinctly emergent, iterative approach to policy-making has been adopted encouraging local flexibility and place-based approaches to health and well-being. Yet how a top-down reorganisation is negotiated given the suggested unwillingness (or inability) to pursue major primary legislative change will endure as an ongoing challenge, in light of the continued influence of the *Health and Social Care Act 2012*, and the organisational complexity of the current health and social care landscape.

The evidence would suggest certain benefits of an intermediate body seeking to co-ordinate some services over larger geographic areas than that of the existing Clinical Commissioning Groups. The on-going mergers of CCGs would seem to be a recognition of this. Indeed, whilst not all NHS managers may rush to champion the return of Strategic Health Authorities, having some capacity to allocate resources in the interests of the wider local or regional system, rather than solely organisational interests, may well find support. Nonetheless, it is important to recognise that in the absence of legislative changes, organisational decision-making and protectionism will continue in some form. The trend towards increasing the size and geographical coverage of CCGs up to the ICS level through mergers may also bring problems. Our review suggests that there is a continuing role for sub-regional oversight at a geographical scale of approximately 250-500,000 population. This is the level currently referred to as 'place' in the NHS Long Term Plan, and its form, responsibilities and structure is at present left undefined. This is potentially problematic, as it is clear that the fine grained oversight of the delivery of local



services such as primary and community care requires detailed local knowledge and strong relationships across a geographical territory which is intuitively meaningful to those involved, including the public (McDermott *et al.*, 2018). It is therefore important that the scope and role of 'place' in the evolving system is defined.

History would suggest that the impact of the current reforms may to some degree play out in different ways in different places. Existing relationships, organisational legacies, and influential senior leaders will likely impact the extent to which current integrated arrangements will develop and be sustained. Similarly, relationships with local authorities, and local elected officials, may prove important in the functioning of the new integrated care systems. The tensions between the National Health Service and local government will not be resolved by changes in the NHS intermediate tier governance arrangements in spite of current enthusiasm for place-based working. Co-terminosity and co-commissioning have been sought by local government and health authorities throughout the years, and although intuitively attractive, debates exist over the extent to which they have been effective. The strength of partnership working may be tested by contentious decisions, both between organisations within Integrated Care Systems, but also in relation to local citizens and patients. Local and national political dynamics may well continue to shape and constrain the latest reforms, especially the ongoing uncertainties over social care funding.

Despite facing continuous re-invention, a regional or sub-regional tier has been a consistent feature for almost the entire history of the NHS. Their purpose, function and operation has shifted considerably over the years. Given the loss of an intermediate statutory authority providing strategic and financial oversight in recent years, it should be unsurprising we are witnessing a return to at least some elements within contemporary reforms. Whilst the literature illustrates the different ways in which such intermediate tiers have operated in the NHS, as a healthcare system that continues to be influenced by the hierarchy of national bodies, the literature suggests there is benefit in having an intermediate tier to negotiate centre-local relations. However, the latest iteration does not currently have the same powers as past authorities, and the complexity of governance arrangements necessary to compensate for the lack of statutory status of ICSs may make taking decisions and sustaining agreement challenging. The role of the NHS England/Improvement regional teams remains as yet unclear, although we may draw parallels with previous roles of the Regional Offices that operated as outposts of the NHS Executive, rather than the more influential role of the semi-autonomous Regional Health Authorities. Furthermore, we can observe a long history of uneasy relations between health and local authorities. The level currently being referred to as 'place' will be crucial here, and its role and remit needs to be urgently clarified.

Finally, the history of NHS policy-making has long been shaped by compromise and response to crisis. Reorganisation of regions within the NHS has tended to be pursued at ever-growing pace as the solution to the latest problems facing the health service. Once

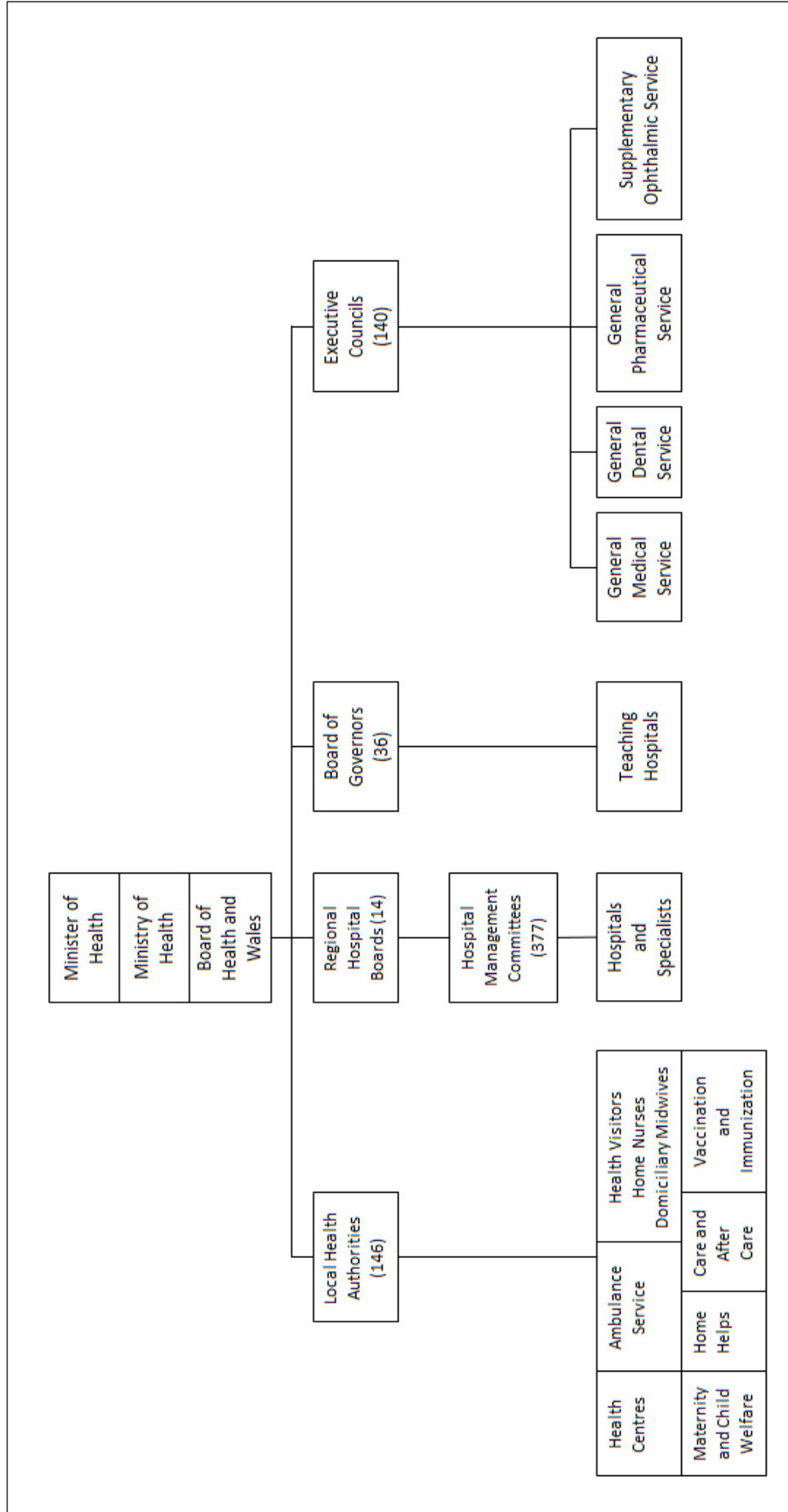
again, there is an urgency to reforms currently taking place, without legislative change and subsequent conventional routines of scrutiny, reflection and political debate. Policy-makers would be wise to not expect structural reorganisation to offer the 'solution' that resolves the remarkably complex challenges facing the co-ordination of health, and long-standing challenges with social care. Yet nor does this provide sufficient justification to move onto the next structural reorganisation if expected outcomes are not achieved rapidly.

## 7. APPENDIX

### SEARCH STRATEGY

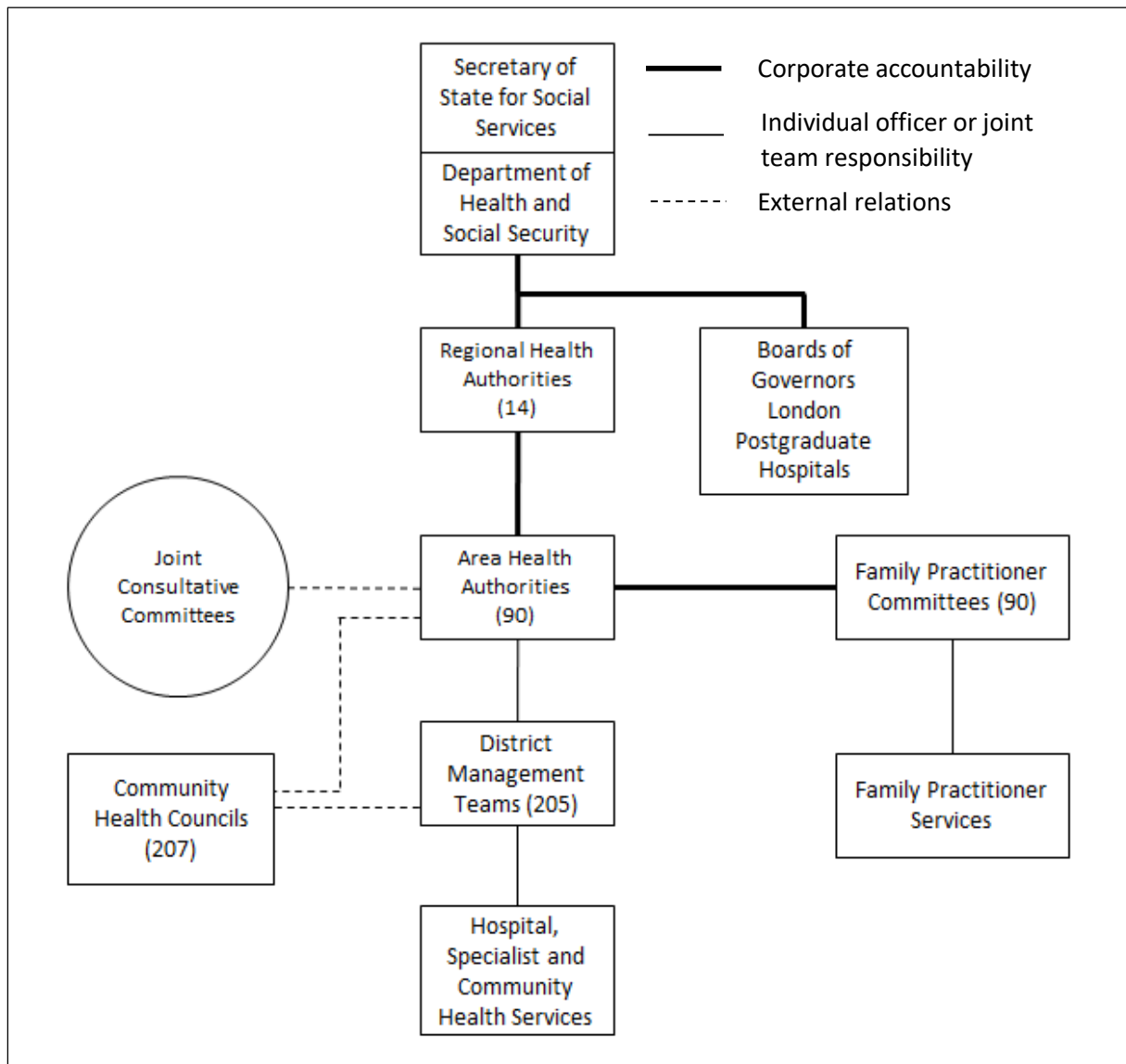
DATABASE	SEARCH TERMS
<i>Academics sources</i>	
Pubmed	'region' OR 'regional' OR 'regional governance' OR 'regional administration'
Google Scholar	'decentralisation' OR 'decentralization' 'localism' OR
Web of Science	'devolution' OR 'meso' OR 'intermediate' OR 'sustainability and transformation plans' OR 'sustainability and transformation partnerships' OR 'integrated care systems' OR 'regional health authorities' OR 'regional hospital boards' OR 'regional offices' OR 'strategic health authorities' OR 'district health authorities' OR 'area health authorities' OR 'health authorities' AND 'NHS' OR 'National Health Service'
<i>Grey sources</i>	
NIHR	As above
<b>Inclusion criteria</b>	
Language	English
Published	Any year

## The National Health Service in England and Wales - 1948



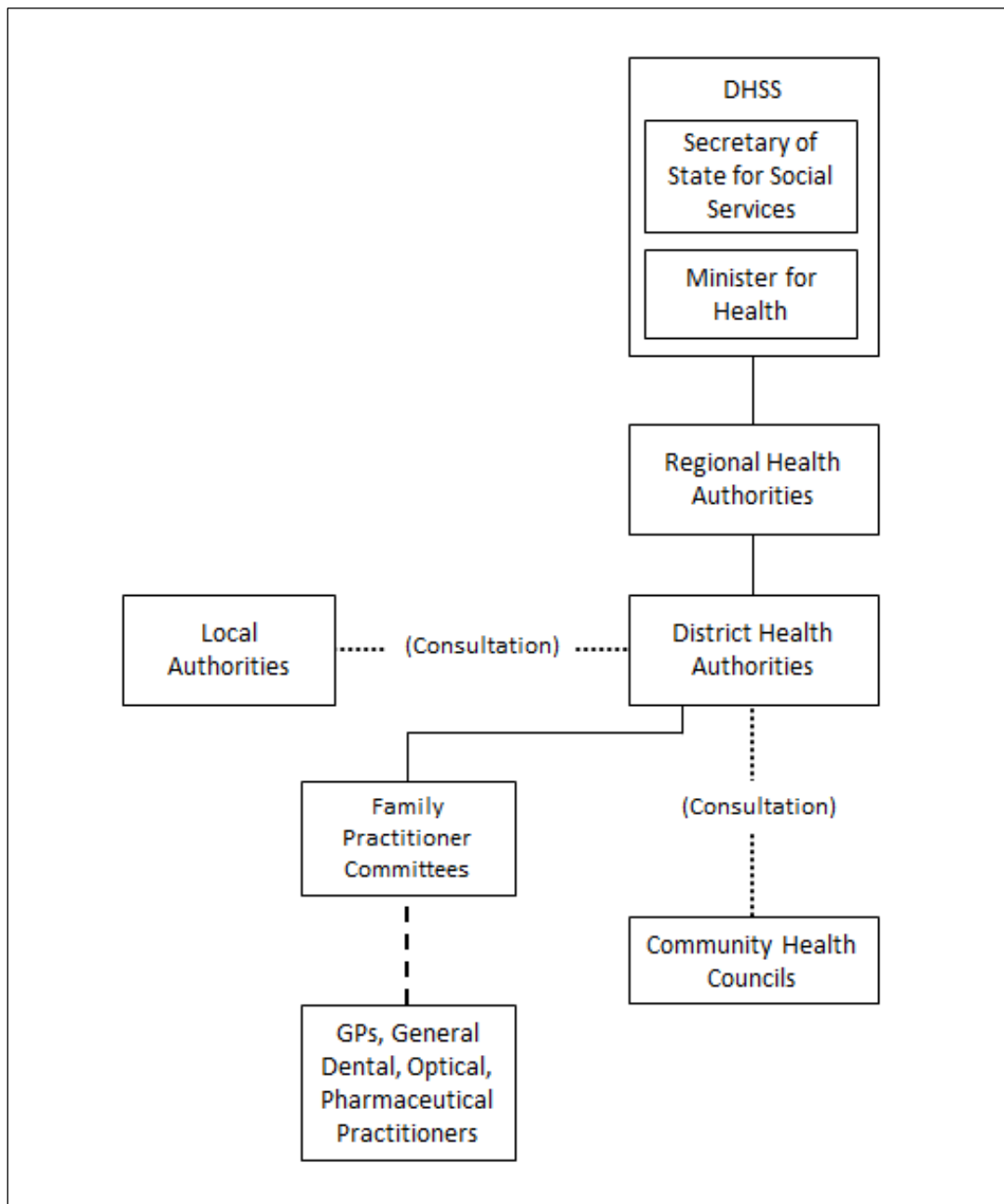
Reproduction of Webster (1998: 21)

## The National Health Service in England, 1974



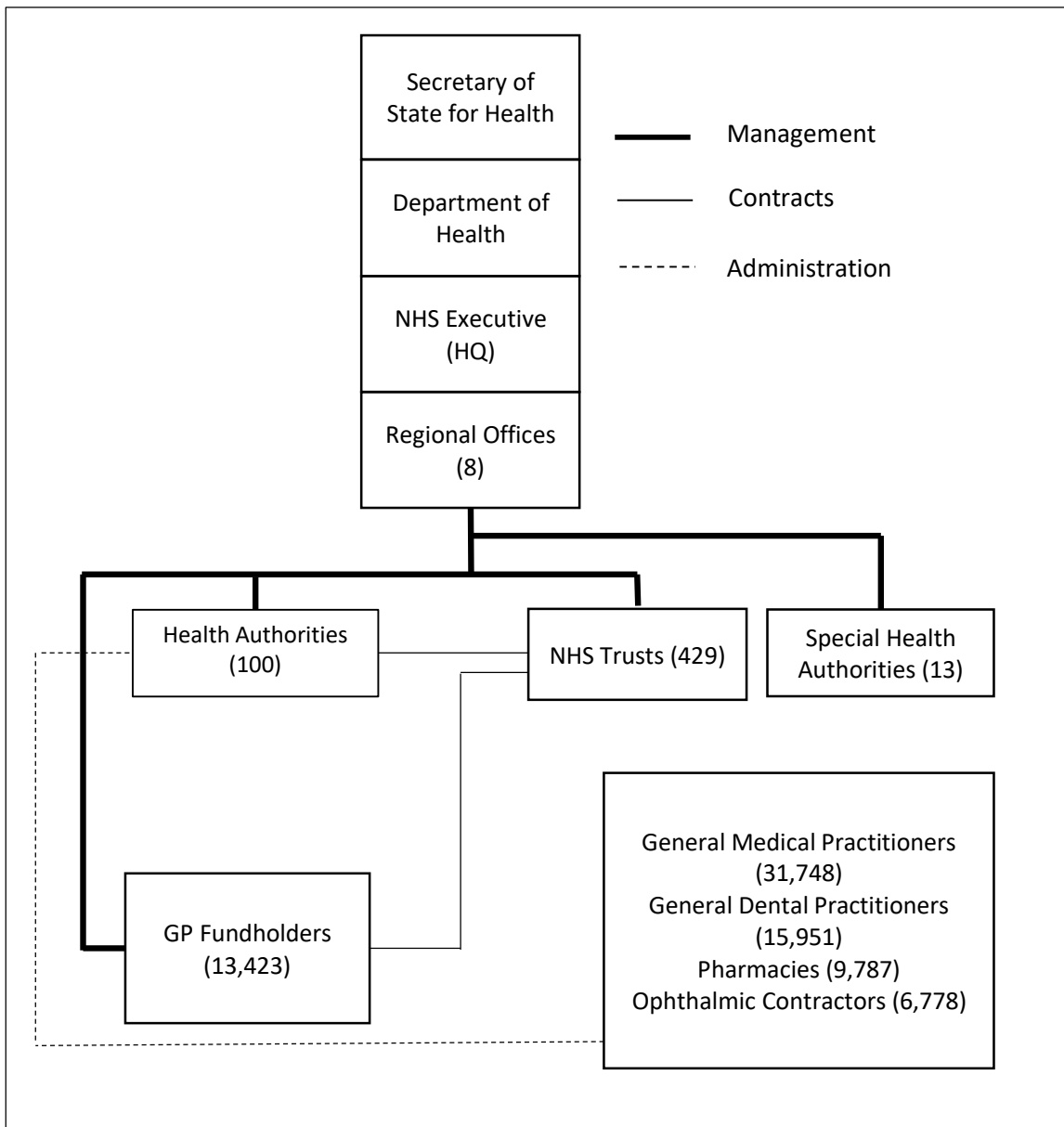
Reproduction of Webster (1998: 108)

## The National Health Service in England, 1982



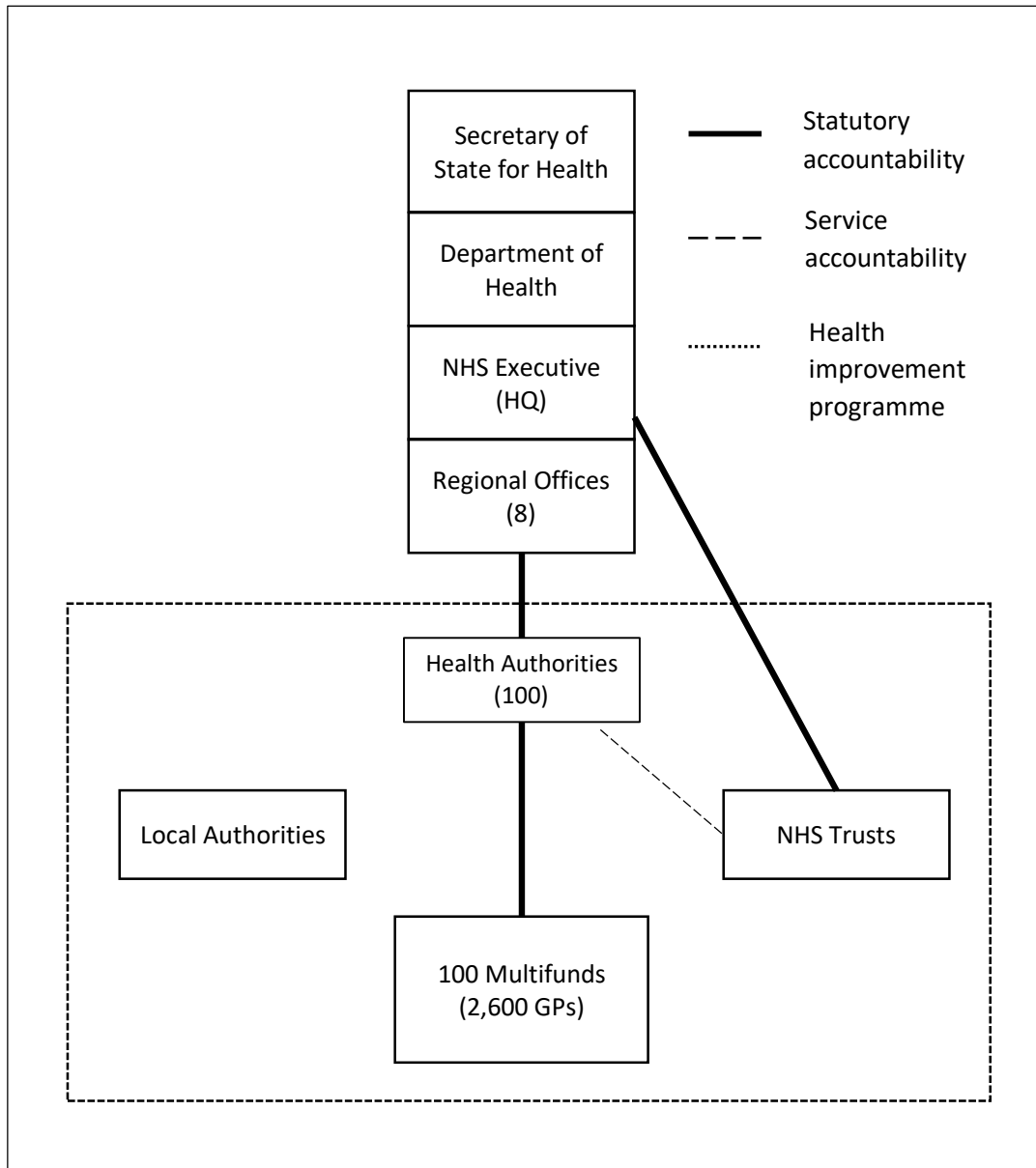
Modification of Harrison (1988: 23)

## The National Health Service in England, 1997a



Reproduction of Department of Health (1997), Departmental Report, Cm. 3612, annex E, The Stationary

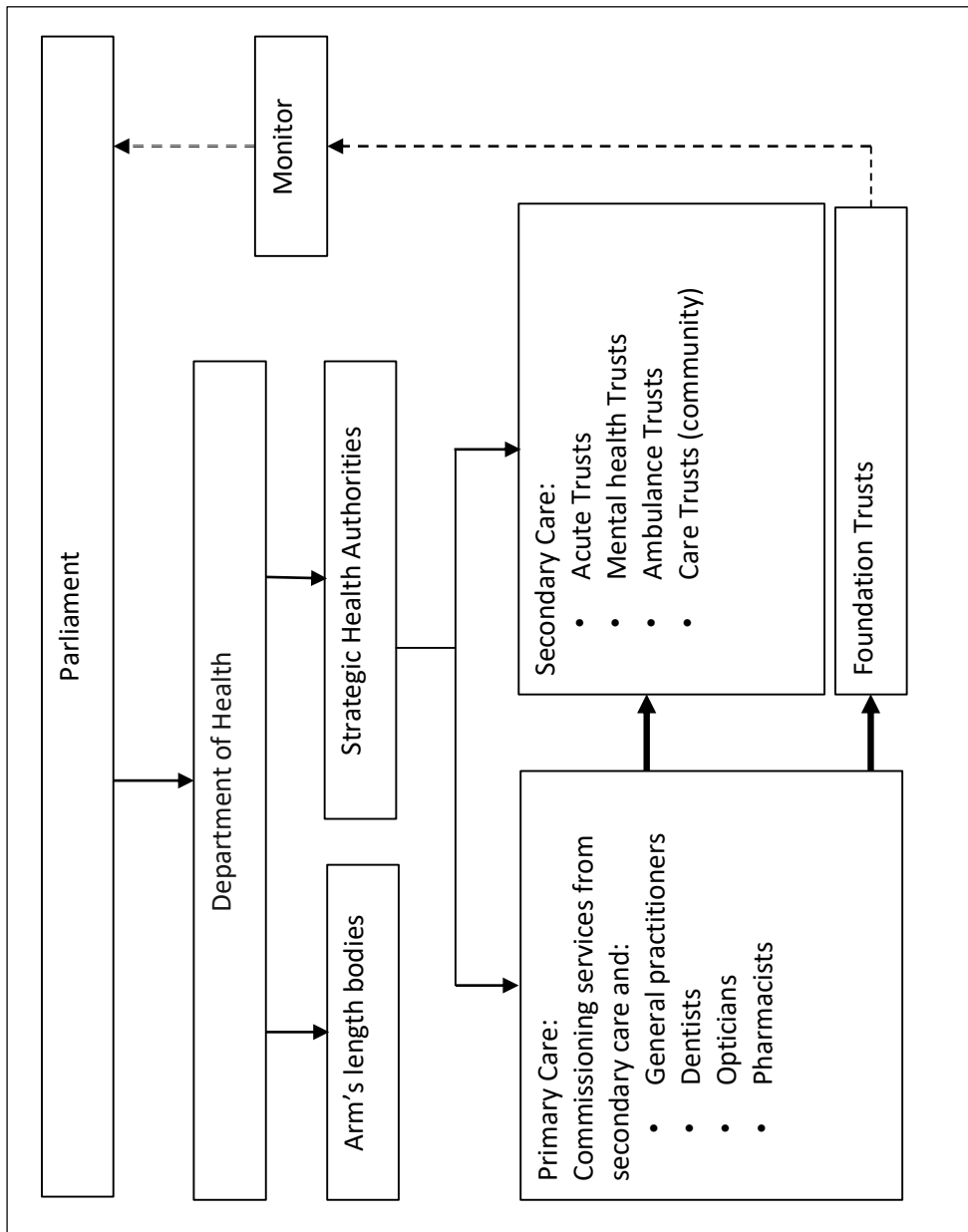
## The National Health Service, 1997b



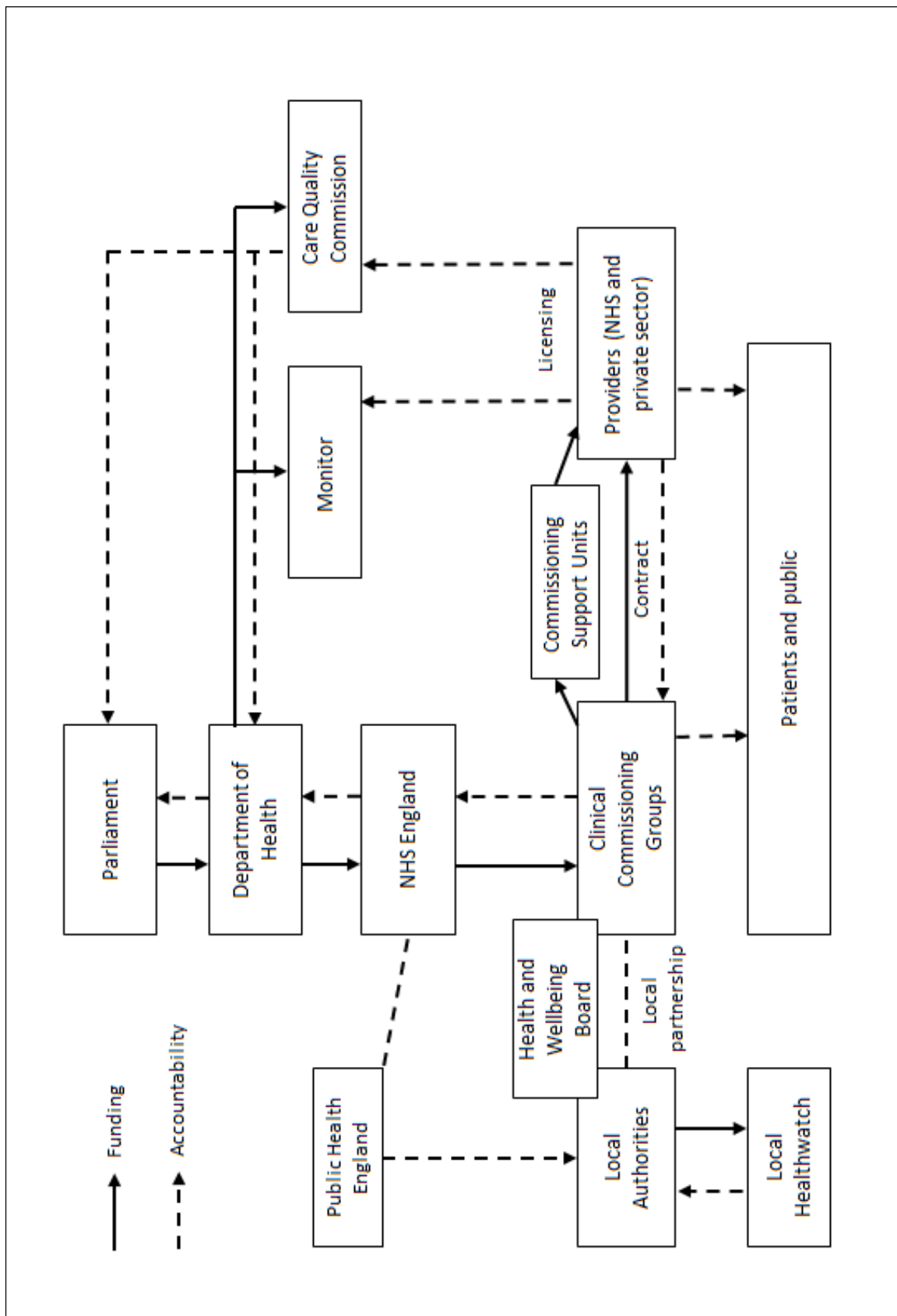
Modified from: Secretary of State for Health (1997) *The New NHS. Modern. Dependable.* Cm 3807, p.21. The Stationary Office, London



# The National Health Service, 2010



The National Health Service, 2013 (simplified)



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