10 Year Health Plan working group: accountability and oversight

Co-chairs' report

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Chair's overview

Effective and proportionate accountability and oversight play an important part in making the NHS better. Our current approach is not working and is ill-suited to the system we need to deliver the 3 shifts expected by government and the 4 purposes of integrated care systems and needs to change to a simpler, clearer and more effective model.

Good accountability and oversight should start from what matters to patients and the public, and that increasingly means supporting people with multiple mental, physical and social needs. As we integrate or join up care around people, we require a radically different approach to accountability and oversight. We will also need to tackle what we might term ‘unwarranted complexity’ - the accumulation of processes and bureaucratic ways of working that have blunted accountability and oversight. Some of this has been identified in the work undertaken by Penny Dash's Review into the operational effectiveness of the Care Quality Commission which the working group has found extremely helpful.

Most of the elements of an effective accountability system are already present in the system of today. We have a clear constitution that sets out the rights and responsibilities of staff, patients and the public, including national standards. We have providers with boards that are constituted with a duty to deliver high quality care and to collaborate in systems. We have systems made up of NHS organisations, local authorities and partners with an ultimate goal to improve outcomes and deliver value for money. And we have national financial and quality regulators, and Departments of State that oversee and assure, set policy and ensure accountability to Parliament. But radical improvement and realignment are required to get the right dynamics in place, and this will mean change throughout the system, including for national organisations. The group agreed that we must start with the person, the public and the patient. A golden thread of accountability for the offer to them must flow through staff contracts, to organisations and systems to the centre. We felt that provider boards and integrated care systems (ICSs) were the right structures to make oversight and accountability work, but that they would need to operate very differently and thus be held to account differently as well. We also agreed that local plans and planning processes need to be transformed into a much stronger load-bearing element of the system that gave a license to operate.

For provider boards this means both increased responsibility (making them responsible in practice for things they are sometimes only responsible for on paper) and a reduction in the burden of bureaucratic oversight from national bodies. This would be rooted in a development and capability offer for those boards that equips them to take on an enhanced role. For integrated care boards (ICBs) this means (as set out by Secretary of State last November) a clear and explicit role as a strategic commissioner and on developing plans to deliver national priorities, but which also really get underneath the skin

of what the local population needs. This too will require developmental support if we are to succeed. Effective local planning requires a financial and operational planning horizon of at least 5 years. We will need a new approach to prioritisation, with local plans bringing together a mix of mandatory national priorities, discretionary national priorities from a national menu and local system priorities developed from priorities at place level, closer to the people we all serve. Accountability and oversight would be as concerned with all 3 types of priority - with the accountability discussion centred around the following questions. Strategy and planning: what are you trying to achieve (and is it ambitious enough)? Delivery assurance: what progress are you making in delivering your plan? Improvement: what help do you need?

The objectives themselves and how they are measured will also need to change – with a much greater role for measures of user experience and of patient and population-level outcomes. This will need to be complemented by an improvement in analytical capability; by a clear focus on supporting boards with the tools to make decisions grounded in data and insight; and by a wholesale recommitment to transparency about experience, quality and outcomes at all levels of the system, from individual clinicians and teams at the frontline to system and ultimately national level.

Accountability ‘out’ into local communities will matter as much as ‘up’ to national bodies. Patient voices will play a much stronger role in shaping local plans and a reinvigorated NHS Constitution should set out the terms of mutual obligation and responsibility between the public, patients and staff.

Finally, our accountability and oversight arrangements should act as an enabler of improvement, incentivising organisations to do better and to seek patient and public value in all they do. Successful systems will operate with greater freedoms and flexibilities.

Taken together, these changes would create an accountability framework to enable the 3 shifts, empower local organisations and put patients and the public at the centre of what we do. They will bring a coherence that must be matched by process discipline and rigour.

As chairs of this workstream we have been immensely privileged to be able to draw on the insights, challenges and experiences of a truly excellent set of colleagues with a diversity of backgrounds and perspectives. We have sought to capture the breadth and depth of their views in this report while also seeking a reasonable (if not absolute) level of coherence and brevity. Any success we have had in doing so is entirely attributable to the first-class support we have received from a small and committed team of departmental officials, to whom we are most grateful.

Accountability and oversight in the NHS

Our systems and processes for accountability and oversight in the NHS should firstly, make things work better by working as a set of interventions for improving services and outcomes.

Secondly, connect the point-of-decision and point-of-care with the public and their representatives. These ambitions are not well supported by existing processes.

Effective accountability requires clarity of who is accountable for what, sufficient control over outcomes and information to judge performance, with a clear set of consequences (Accountability in modern government: what are the issues? Institute for Government). However, as highlighted by the Hewitt review and the Lord Darzi review, there is lack of clarity of roles and responsibilities at both system and national level. The effect of the current arrangements leads to duplication, confusion and accountability weighted too heavily towards national government rather than 'out' to local populations with limited headroom for leaders. This is further worsened by a set of hierarchical behaviours that fail to recognise the essential value of all component parts of the system. Ultimately, the current situation results in unclear accountabilities.

Some of this lack of clarity reflects greater levels of complexity and service and sector interdependence within the health and care system, and the move towards integrated care that better serves people. This is being attempted in a system that does not reflect the reality of health and care in 2025. Governance arrangements have become more complicated across health and local government due to their separate structures, accountabilities and funding arrangements. Provider boards have over time become disempowered, with fragmented accountability structures and more difficult financial climates. This occurred despite the Health and Social Care Act, which established a set of national bodies and aimed to drive choice and competition, but resulted in 'workarounds' as the health and care system sought to promote greater collaboration.

To deliver the vision for the 10 Year Health Plan, the system of accountability and oversight in the NHS (and its associated structures, processes and behaviours) needs to be simpler, clearer, focused on the longer term and on driving outcomes, nationally-driven when necessary, and with an increasing focus on accountability to local populations.

Definitions

We consider accountability to be the obligation of NHS organisations, leaders, and staff to take responsibility for our actions, decisions and use of resources. Accountability requires that we explain and justify our performance, ensuring transparency and responsiveness to the public, patients, regulators and policymakers. Within ICSs, mutual accountability is

where partner organisations hold each other accountable for their roles in delivering improvement and take collective responsibility for achieving their goals. This sits alongside hierarchical accountability to those outside a system. Importantly, accountability involves consequences, where we recognise success and take appropriate action to address underperformance.

Oversight encompasses the structures, processes and institutions that monitor and evaluate performance against standards and targets. It ensures that we comply with regulations, achieve set targets and continuously improve services. Oversight functions include financial auditing, performance monitoring, clinical inspections and strategic governance.

Throughout this document we refer to people, communities and patients. We have heard very clearly that it is important to ensure that we do not reinforce a paternalistic approach that disempowers people receiving care. We want people to have agency, control and choice over their care and to be partners in their care. We have heard that language matters in this regard and this is reflected in this report.

What we have heard from the vision workstreams and public engagement

The 4 vision working group reports focus on prevention, providing high quality effective care that is centred around the needs of people and communities and delivered by a fair and inclusive system. In this context, the service model will require a different approach, including developing an updated definition of quality, based on meaningful engagement with the public, patients and staff. Crucially, it must address how to build a clinical governance and risk management culture that supports different models of care and the different forms and ‘locations’ of risk this entails - while keeping people safe within it.

The broader accountability framework should include strands on funding and data and technology, including putting health equity at the heart of NHS and care data reporting. It will require cost-effective solutions that should be expanded nationwide and proactively reach those who would benefit most. Metrics for prevention activity should be identified and NHS performance rebalanced. It should focus on simpler, tighter arrangements, and joined up neighbourhoods, and at place level.

When thinking about the future, we have heard that the public wants much of the NHS to remain the same. This includes that it is free to all at the point of need, that staff remain warm and caring, and the high-quality care most experience continues. However, both staff and public feel the NHS is not getting the basics right.

The 10 Year Health Plan engagement exercise sought ideas on what changes need to be made across the health and care system. Suggestions focusing on accountability and oversight include a preference for a more standardised oversight of hospital performance to reduce variation in patient experience. Another idea is to have locally elected representatives with oversight powers, for example a supervisory board including staff and/or patients.

Separately, both the public and NHS staff support the 3 big shifts in principle. They feel the shifts will reduce pressure on the system, deliver better outcomes for patients and improve the working lives of staff. For example, when looking the shift of hospital to community, there are opportunities to enable people to access the services they need more quickly. However, they have concerns about a potential lack of governance and oversight.

What accountability and oversight arrangements should look like in 10 years

The 3 shifts require a fundamental change in the delivery of health and care with implications for accountability and oversight arrangements which we think need to cover both health and care.

We think the 10 Year Health Plan vision means active citizens participating in and in control of their own health; using more and better data; technology that automates significant numbers of interactions; and people that are enabled by choices that matter to them. Patients will access joined up services which are coordinated and supported at neighbourhood level in a neighbourhood health service, with specialist provision that meets national standards available as locally as possible.

This will be supported by good organisations with effective and empowered boards; and a strategic commissioner with the market management and organisational tools to ensure services reflect local need. These will be underpinned by a national framework of quality and finance. To achieve this, we need to think about accountability and oversight arrangements starting with the patient, people and communities.

A refreshed NHS Constitution (covering health and care) will set out the standards of access, quality and the genuine outcomes we want to achieve. These will be reflected in expectations of the public, staff, organisations and systems and will inform the work of regulators. There will be a clear set of accountabilities at every level of the system from patients and the public, through staff and up to national bodies. We have set out a framework for what this could look like.

We recommend a better balance between local and national in priority setting; a shift to longer-term planning and budgets; a focus on delivering outcomes (built on quality and

value) with patient experience ‘hard wired’ into arrangements. This can be done through rationalisation, simplification and clearer delegation of accountability. Our recommendations are not necessarily about introducing new structures. In some cases, we can make better use of existing mechanisms for involving the public or for aligning health and care partners behind shared goals. In other cases, we may need to change national functions and devolve more power to systems.

Successful implementation also relies on several enablers including:

- aligning workforce arrangements behind these arrangements
- strategic commissioning capability
- alignment of incentives across the 10 Year Health Plan
- more - and better use of data
- automated process and technology-driven systems
- appropriate variation in approaches to reflect population need

We recommend a phased approach that takes account of NHS and care recovery towards national standards since the pandemic; maturity in local systems and organisations; and progress in the above recommendations.

Our recommended framework for accountability and oversight

We believe a clearer framework is needed to help deliver the 3 shifts. This framework considers strategy and planning, delivery, assurance and improvement functions at each level of the health system and where they best sit.

This framework needs to facilitate working across health and care, taking account of local government structures that are themselves changing with the English Devolution White Paper. We also wanted to recognise the need for greater engagement with the public; the primacy of boards and the need to strengthen the important role of mutual accountability both between NHS and wider health and care partners.

We believe that a framework needs to set out accountabilities at different levels for improving outcomes (including tackling inequalities in health and healthcare), quality and money. It needs to be accompanied by a set of aligned incentives that encourage sustained improvement, with clarity on interventions in the event of poor performance.

Individuals

The citizen is the centre of our model of accountability, and the relationship between the public and the NHS and wider care system is the golden thread throughout. This starts with setting out a revised and clearer reciprocal relationship between the NHS delivering services to the public, and the public being empowered to manage their own health.

To begin this reset we recommend working with partners to reinvigorate and update the NHS Constitution using what we heard through public engagement on the 10 Year Health Plan and to better align this with a clear focus on outcomes. This will set the standards and expectations from which all else flows and drive significant engagement because it will be necessary to do so. This is a fundamental shift in the positioning of the NHS constitution, engagement with which is currently very low amongst the public and staff.

However, setting out expectations through a reinvigorated constitution alone will not go far enough to foster an active relationship between the NHS, people and their communities. Doing so will require the decisions of people, patients and communities to drive incentives and behaviours in the system; and will require the NHS to continually engage with communities to identify what is going well, what could be improved, and then work with them to implement changes. NHS England (NHSE) published statutory guidance in 2022 to support this. More is needed to hard-wire this approach into all levels of health and care planning, including the role of patients and carers in driving improvement in their care.

At present there are a variety of mechanisms for patient and public engagement at a local level. We support - although this was not a universally held view in the group - the Dash review's emerging recommendation to align Local Healthwatch and advocacy support for complaints to wider ICS functions and footprints to ensure patient and wider community input into the planning and design of services. We would suggest this goes further and that the consolidation of involvement and engagement functions at ICB level, also includes functions held by Foundation Trust (FT) boards of governors, so that we can strengthen citizen voice across the system rather than maintaining sub-scale organisational silos.

Teams

As important as strengthening the NHS relationship with the public is strengthening the relationship with staff. It is crucial to ensure that organisational priorities reflect system priorities and are incorporated into staff objectives. Going further, we recommend the NHS Constitution reset also considers national standards and expectations for the NHS workforce. These should be baked into contracts, objective setting and accompanied by an improved workforce offer, including one which tackles workplace inequalities, although we expect the 10 Year Health Plan's people group to set this out in greater detail. We wish to draw out the link here to contracts and incentives for staff. These may, in future, be much more closely linked to the experiences of people and patients, with income directly tied to

this. This happens in other systems internationally and should be given very careful consideration. In addition, transparency on performance and efficiency of teams could be considered as a means of driving improvement and increasing accountability.

Neighbourhoods

Embedding the principle of subsidiarity and shifting the focus to local systems should be accompanied by a greater sense of ownership by patients within community, primary care and adult social care structures, such as Integrated Neighbourhood Teams. This should be a key focus for delivering joined-up care closer to the patient as well as for developing plans for individual patient care. All parts of the health and care system will need to work closely together to support people's needs more systematically, building on existing cross-team working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community and social enterprise (VCSE) sector.

While ICBs will ultimately be accountable for delivery at neighbourhood level, incentives should be aligned to ensure we have a system where an individual may be 'discharged' from the community for an acute hospital stay, and where an avoidable emergency admission should be considered a failure within the neighbourhood infrastructure focused on that person's care and by the place-based partnerships who will be recognised commissioners in the system.

Places

Within systems, places will play a strong role in delivering integration and improving outcomes for people, drawing on expertise from place-level organisations and their knowledge of local communities. They should be enabled to reach a shared purpose and vision, aligned to the system vision but with clear shared outcomes for delivery at both place and neighbourhood levels. We have considered place-level to mean upper tier local authority level. This makes sense, given the statutory requirement for joint strategic needs assessments (JSNA) and health and wellbeing strategies to be produced at this level, as well as the local population recognising these as genuine places where they live.

Systems should create the conditions and expectations that enable places to thrive, building strong and collaborative cultures including partners from across health, local government and social care. They must recognise the role of each partner, including non-NHS organisations, and harness the range of their knowledge and responsibilities to address the wider determinants of health.

Alongside ICBs and local authorities, place-based partnerships will be recognised as commissioners within systems, operating with delegated budgets and accountability and supported to build capability.

The Department of Health and Social Care (DHSC) and NHS England will work together to build place considerations into national oversight of ICB plans and build a more robust assurance mechanism for delivery at place level. This will support the role of local health and wellbeing Boards (HWBs) and health overview and scrutiny committees (HOSCs) to bring a robust focus to delivery and outcomes at all levels within systems.

A further radical option emerging from group discussions was to merge healthcare commissioning into local authorities at place level over the long term, creating, integrated health and social care commissioning within locally elected authorities. Ultimately this was not adopted into the group's proposed framework as there was a view that we should not be mandating commissioning structures at place level, instead it was reflected that we should be removing the barriers to enabling this model to work where it makes sense and local areas wished to pursue it.

Existing local authority scrutiny arrangements were also discussed extensively by the group. There was a recognition that there were some examples of existing arrangements working well across the country and a view that we should make best use of existing mechanisms, however some of the group felt that more often than not the existing arrangements acted as a brake on innovation and change in a way which was not ultimately in the interests of patients and taxpayers. How to address the issue divided the group but there was recognition that local democratic input should be embedded into decisions about which outcomes are prioritised locally. However, the group did not reach consensus on whether this should mean the local authority (LA) scrutiny role is reoriented towards priority-setting rather than how services are delivered, or whether the service delivery role could be amended to give HOSCs a greater obligation to be involved in the design of solutions to concerns.

System

Through its Integrated Care Partnership (ICP), each ICS will continue to be accountable for developing its integrated care strategy. However, this will now focus on developing and reconciling national and local priorities, drawn from place, and unifying these in a shared local vision agreed by all system partners. Local priorities to inform the strategy should be developed with significant patient and local democratic input through streamlined engagement mechanisms, with a role for existing local government scrutiny mechanisms, such as HOSCs, to feed into priority-setting (as discussed later in the report).

ICBs will be responsible and accountable for the development of 5-year strategic commissioning plans to support delivery of priorities across the system within the resources available. Unlike at present, these plans will take on a significantly enhanced role in the system with ICBs robustly held to account at a national level for local plan quality and delivery. These plans will be backed by economically sound, long term

financial modelling, which will be rigorously tested. They will also require an improvement plan that describes how changes will be implemented, and this will be rigorously tested and actively supported.

To incentivise the development of high-quality plans and ensure a pathway to greater devolution, we recommend developing a more rigorous mechanism for assessing the performance of systems which is accompanied with a pathway for high-performing ICSs to be awarded greater freedom to determine local governance, commissioning arrangements and allocative freedoms - providing they are delivering on their agreed local plan. This would be a dynamic system where there should also be significant consequences for failure to meet plans, including revocation of freedoms awarded through it.

This will support ICBs in meeting the needs of their local population through better prevention, integrated commissioning (especially at place) and population health approaches to reduce inequalities in health and healthcare. We recommend that DHSC works with relevant national bodies and ICS leaders to design a framework outlining the criteria for these freedoms, with a clear and simple assessment process which minimises additional burdens on systems. However, there was recognition from some in the group of the risk of introducing too much bureaucracy within this new approach.

ICBs will need to work with providers to support the best configuration of services locally with an emphasis on delegation to place-based partnerships. As a group we discussed that to date providers have felt disempowered or devalued in the system. We fundamentally recognise that the role of the system is to ensure effective provision and drive better outcomes. But there was a sense that additional oversight and accountability had been introduced to substitute for effective board working and undermined providers. It is critical the primacy of boards in this system is respected and they are supported and given the tools to do their job well.

Providers will be responsible for delivery of commissioned services with an expectation that through provider collaboratives they may play a role in the shift towards neighbourhood health. Investment in support for provider boards to feel empowered and responsible for their role in delivery is critical. Continuous improvement should be a standard function within each provider and one which the board feel ownership of as part of their core functions.

To support the mutual accountability in delivery of local plans we recommend each system should be required to create a memorandum of understanding, partnership agreement or leadership compact between all health and care partners at each level in the system to support delivery of the agreed vision, including provisions for when things are not working well.

ICBs will take on a new role using their contractual levers to ensure that providers deliver outcomes for their population at expected levels. ICBs will act to address failure, at service rather than institutional level, where it arises, and should be given the tools as strategic commissioners to do so. ICBs will also play an assurance role in monitoring delivery across local providers against plans, with the ability to escalate this role to national bodies in the event of organisational failure

ICBs will be held to account, based on their local plans, by NHS England. Where systems are not performing to plan, NHS England will need to support improvement and/or manage failure.

National

At a national level, NHSE and DHSC will need clearer and more effective roles in respect of these 4 functions of strategy and planning; delivery; assurance and improvement. DHSC will continue to be accountable to Parliament and the taxpayer for the budget spent on health and care and for improving health and care outcomes. DHSC will continue to have an assurance role in financial management and oversight of its group arms-length bodies (ALBs).

DHSC has a strategy and planning role in aligning the health and care contribution to the government's public service reform commitments, particularly aligning work with departments who hold the levers for wider determinants of health, such as Department of Work and Pensions (DWP) and Ministry of Housing, Communities and Local Government (MHCLG). This should be considered when setting priorities in a mandate to NHS England. NHS England will be accountable to DHSC for delivering the mandate.

DHSC will have a strategy and planning role in setting priorities for systems, and national standards where appropriate. NHS England will hold ICBs accountable for their plan to deliver their outcome-based goals, with equal weighting given to nationally mandated outcomes; some discretionary national outcomes (for example drawn from a nationally agreed menu); and some local priorities drawn from places including through HWB and JSNAs.

NHSE will have an assurance role in overseeing strategic commissioners. This should comprise scrutinising local plans during formulation as well as monitoring delivery against plans. They will continue to deliver a backstop failure regime for both providers and ICBs who are or at risk of becoming failing organisations. NHS England should be organised to remove duplication between the new ICB role and regions current roles to maximise its effectiveness and make sure it has the right connection geographically to deliver its functions.

NHS England will continue to have an improvement role, supporting systems and providers. Further work is underway to look at the split of national functions in more detail, taking into account the recommendations of this workstream as well as the emerging findings of review of patient safety across the health and care landscape which has been led by Dr Penny Dash.

A further radical option in this area which emerged from group discussions was to support streamlining national roles and responsibilities by merging NHS England and DHSC in the medium term. In our final framework we recognised that organisational restructuring has significant financial and opportunity costs and if considered would need to achieve the desired change. This would be possible with a focus on simplicity, clarity and where the essential functions of national bodies were retained in any new arrangements.

Making this work in practice: key implications and enablers

Our recommended framework clarifies and sharpens accountabilities while devolving power out to local areas and ultimately putting more in the hands of the patient.

We did recognise that many of our recommendations might also apply to other public services. An option to go further could be to develop an oversight and accountability framework that applies to the wider public sector. However, we considered that beyond the scope of the working group.

Much of what is outlined above is therefore not new, but we have not been able to successfully deliver these models in the past, so we have considered what needs to be true and what enablers are needed to drive change this time. We understand many of these points will be developed in greater detail by other enabling workstreams and as such we haven't duplicated recommendations in these areas.

Longer-term planning horizons

Outcomes-based, strategic local planning requires a longer planning period. We recommend 5 years, with allocations and objectives set for this period. For this framework to work the planning process must be materially different and feel different, and longer planning periods will allow for this, with plans signed off well in advance of the financial year within which they start.

Local planning capability

This approach needs a significant shift in the quality of local plans and the mindset of those assuring systems, as well as political agreement to longer term planning and allocation horizons. This will require an important programme of work to develop the planning and strategic commissioning capabilities of ICBs and ICSs, and to support them to take on a stronger and more clearly defined strategic leadership role than at present. Further support is needed for leaders of providers (and provider collaboratives) to develop the leadership capabilities needed for effectiveness in an evolving environment and to do accountability well in all its forms.

Leadership and culture

Leadership and good governance at every level are a critical enabler of this framework and we should build on the strong recommendations set out in previous reviews such as the Messenger review on this, as well as the current work on leadership, management and regulation. We also recommend a more refined support offer for leaders including high-quality training covering education and skills development, system leadership and partnership skills and ongoing coaching for leaders. Such an offer will ideally be cross-sectoral. This should include demonstrable leadership on anti-racism principles and practice and being held accountable for delivering on them. Improving leadership capability should be an early priority for implementation.

Collaborative working

Good practice exists already. In many cases implementation will rely on bringing areas up to the level of the best and ensuring regulatory systems incentivise collaboration. In addition, it will be essential to create collaboration amongst providers horizontally in places to deliver integrated neighbourhood teams

Data

Data should be far more accessible to health and care organisations with a clearer sense on which metrics matter. National bodies will need improved analytical skills and expertise to present and share data so that it can be digested by boards. Intelligent use of data should guide commissioning decisions, drive improvement in providers, and support teams on the ground to do their job in the best way. More data and more transparent data should also be available to the public, to support better understanding of how different providers are doing.

Learning culture

Accountability and oversight should drive a learning culture in all system partners and enable future-focussed thinking.

Improvement support

Providers, as those closest to the patient, should have deployed through a national system of improvement that can be deployed at a local level. We should codify a national improvement offer to support those going furthest and to ensure systematic improvement on some issues. This will be different to intervening in a failing organisation, where separate rules will apply.

Financial flows

We need to ensure we have the right financial flows - and the mechanisms such as incentives that underpin this - that these and the accountability and oversight model are mutually supportive.

Phasing

We recognise that this framework cannot be delivered overnight, while some aspects (like clarifying national regulatory bodies) can be done quickly building the skills and capability in localities to deliver the plans needed will take time. We therefore suggest that we adopt a phased approach to delivering these recommendations with indicative timeframes below:

Phase one: system recovery, years 1 to 3

To allow for this system to succeed, the government will need to determine the balance between national requirements and local priorities, based on a realistic understanding of the implications. We know that it will be difficult to manage this if we aren’t in a more stable place on delivering key government and public priorities for example those on waiting lists, elective care, GP access and financial sustainability set in this year’s mandate.

There will also need to be time to establish the enabling features of this system, including the longer-term planning horizons needed, the framework for system progression, the agile data systems required to support local areas and the

NHS England is currently developing resources to support strategic commissioning and provider collaboratives from next year, suggesting a head start on some issues. These will be important to facilitate implementation in phase one. Leadership development should also be an early priority for phase one.

Consideration should be given during this period to some systems being able to go further faster, with the backing of local democratic institutions and national bodies. This precedes the next phase and will be necessary to demonstrate the art of the possible in self-improving systems and in a new health and care system. We should be ambitious here.

Phase 2: gateway opens to greater freedoms for systems, years 3 to 9

Once these enablers are in place and national standards recover, systems should be ready to progress collectively. There will need to be a recognition at this phase of the need to be flexible about the reality that some areas of the country will not be able to move as fast as others in this direction, and as such a gateway approach to greater freedoms and responsibility may be needed for a limited time. Once systems have met required standards for quality and delivery of local planning, they will be granted freedoms and flexibilities alongside that.

Phase 3: dynamic national monitoring of more autonomous local systems, year 10

At 10 years we will have moved to a new normal, but unlike under the FT regime, freedoms for systems once awarded will be revokable in the event of failure. However, this will require a dynamic national system to respond to failure.

Annex 1: list of recommendations

We recommend a clearer framework for role, purpose and accountabilities at each level of the health and care system considering respective accountabilities in relation to strategy and planning, delivery, assurance and improvement.

We recommend reinvigorating and updating the NHS Constitution using what we heard through public engagement on the 10 Year Health Plan to do so alongside a renewed focus on outcomes. This will help to ensure NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another, are central to accountability and oversight arrangements and should also be embedded in workforce contracts.

Systems should be held to account for delivery against a mix of mandatory national priorities, discretionary national priorities (for example, drawn from a nationally agreed menu) and local system priorities. These priorities should have equal weighting for assurance purposes but do not have to be equal in number. Local priorities could be drawn from places through HWBs, JSNAs, as well as other sources.

The discretionary national priorities should be set out as range of evidence-based options. This should support ICBs by providing transparent and clear metrics to allow comparison between areas. However, over time as local priorities take on stronger prominence and an evidence-base is developed there may no longer be a need for this middle set of priorities. ICP strategies should be the point of reconciliation and alignment (including difficult trade-offs) between national and local priorities with these then translated into ICB plans.

A key objective is for system priorities, and longer-term goals, to be as important as national, shorter-term ones, therefore ICB plans should be subject to greater scrutiny where scrutiny should focus on the entirety of the plan for delivering all priorities rather than only national. These priorities should be outcome-based targets and should be set and fixed over a minimum 5-year period.

The central focus of accountability and oversight priorities should be on outcomes - to better address inequalities in health and healthcare, quality (including patient experience) and value for money. These areas of focus should be clear at every level of the system.

The voice of the patient and citizens should be hardwired into objective setting mechanisms. We support the Dash review's recommendation to align Local Healthwatch and advocacy support for complaints to wider ICS functions and footprints to ensure patient and wider community input into the planning and design of services. We would suggest this goes further and that the consolidation of involvement and engagement functions at ICB level, also includes functions held by FT boards of governors, so that we can strengthen citizen voice across the system rather than maintaining sub-scale organisational silos, representing a sub-set of people, patients, carers and communities. This will be supported by better data on user experience which should be embedded into work and incentives at every level of the system from national organisations down to individual clinicians.

Local democratic input should be embedded in decisions about which outcomes are prioritised locally. This could be alongside revisiting the scrutiny functions set out in legislation. How best this input is secured and from whom will vary from area to area, and as the government's reforms to local government are progressed. The further development of directly elected mayors at strategic authority level was thought to represent an important opportunity by many but not all the group.

We recommend developing a more rigorous mechanism for assessing the performance of systems which is accompanied with a pathway for high performing ICBs to be awarded greater freedom to determine local governance, commissioning arrangements and allocative freedoms. Freedoms will be determined based on robust national assurance against local plans with significant consequences for failure. The system will be dynamic, and freedoms should be withdrawn if systems are failing to meet agreed plans.

We suggest the framework is designed and agreed collaboratively across the DHSC, NHS England, MHCLG and ICS leaders, to ensure it looks at the right indicators and incentivises the right behaviours. In designing the framework, due consideration should be given to the quality and depth of system working, and to what good strategic commissioning looks like

This is an end-state, and we recognise that a pathway to achieving freedoms cannot be delivered overnight. We have set out proposed phasing for this work.

ICBs will as strategic commissioners take on a new role using their contractual levers to ensure that providers deliver outcomes for their population at expected levels.

ICBs will act to address failure, at service rather than necessarily institutional level, where it arises, and should be given the tools as strategic commissioners to do so.

We recommend each system should be required to create a memorandum of understanding (MOU), partnership agreement or leadership compact between all health and care partners at each level in the system to support the delivery of the agreed vision but provide for when things are not working well. This MOU intended to support the planning process and provide clarity on roles and responsibilities.

Enabling recommendations

We should extend the planning horizon for local systems to a minimum of 5 years, with allocations and objectives set over this 5-year period.

We recommend a significant programme of work is undertaken to develop the planning and strategic commissioning capabilities of ICBs and ICSs and to support them to take on a strategic commissioning role more fully than at present.

We recognise that an improvement support function is needed in providers, and this should be complemented by national support where necessary. This is different to interventions in the event of failure.

We recommend a more refined support offer should be available to leaders including high quality training covering education and skills development and ongoing coaching for leaders. This should also include development of system leadership skills, to support leadership capability at system, provider and place level.

We recommend a similar development offer for provider boards to improve their capacity and capability.

Annex 2: current accountability and oversight arrangements in NHS

At present, there are several organisations and bodies with duties and responsibilities associated with healthcare provision in England. As a result, the accountability and oversight architecture have several formal and informal mechanisms in place.

DHSC, Ministerial duties and responsibilities towards NHS England

The Secretary of State's statutory duties and powers in respect of setting strategic direction for NHS England and holding it to account are set out in a number of pieces of legislation. Primary legislation provides a broad range of powers to the Secretary of State to direct NHS England. The Secretary of State has a duty to ensure that a mandate is in place, setting out objectives that NHS England should seek to achieve in the exercise of its functions.

NHS England's duties and regulatory functions and powers

NHS England's specific duties, regulatory functions and powers are set out within the National Health Service Act 2006, Health and Social Care Act 2012, and Care Act 2014 and related secondary legislation.

Commissioning services, including services that the Secretary of State can require NHS England to commission, primary care and dentistry services, services for members of the armed forces and prisoners, and high security psychiatric services. NHS England can also exercise the Secretary of State's public health commissioning functions either by agreement or where directed to do so.

The establishment, oversight and support of ICBs, including the duty to conduct annual performance assessments of ICBs, appointment and termination of chairs, the power to direct ICBs on their functions and exercise functions on their behalf where an ICB is failing or likely to fail to discharge its functions

The oversight and support of NHS trusts and FTs.

Accountability arrangements within integrated care systems

ICSs are formal partnerships comprised of an ICB and ICP. ICSs bring together a range of statutory and non-statutory organisations, such as ICBs, local authorities, NHS providers, the VCSE sector and adult social care providers population.

Accountability within an ICS is 2-fold - ICBs and NHS providers remain accountable to NHS England for the planning and delivery of health services whilst local authorities remain accountable to their electorates for the planning and delivery of adult social care.

The Care Quality Commission (CQC)'s LA assessments provide assurance on the delivery of their adult social care commissioning functions as set out in Part 1 of the Care Act 2014. CQC also has a new duty within the Health and Social Care Act 2008 (as amended by the Health and Care Act 2022), to review and assess ICSs with the aim of providing independent assurance to the public and Parliament of how well health and adult social care partners within an ICS area are working together to plan and deliver high quality care that meets population needs this work is currently paused.

Integrated care board oversight

NHS England has a range of statutory functions to oversee, regulate and support ICBs and NHS providers of health services (trusts and FTs). DHSC and NHS England also have a number of formal and informal accountability mechanisms to understand performance and intervene where necessary. The formal lines of accountability of both ICBs and providers are through NHS England.

ICBs are responsible for commissioning the significant majority of health services in their areas, hold budgets and hold providers to account for the majority of health services in their areas (the only exceptions are health services commissioned by NHS England, such as specialised care; or public health services, commissioned by local authorities).

NHS England has a legal duty to annually assess ICBs on the discharge of their functions, including on performance. NHS England also a range of powers to direct ICBs to support performance improvement. NHS England has a legal duty to annually assess ICBs on the discharge of their functions, including on performance. NHS England also has a range of powers to direct ICBs to support performance improvement. NHS England also produces, in consultation with the government, annual operational planning guidance for ICBs that sets out its priorities and expectations for the year ahead.

The NHS Oversight Framework (NOF) outlines NHS England’s national approach to overseeing and monitoring the performance of ICBs and providers. The NOF is based on metrics that track delivery against key national priorities, and allocates each ICB and provider to one of four segments, based on performance.

Provider oversight

Providers are overseen at the national level by NHS England and CQC. The NHS provider licence forms part of NHS England’s oversight arrangements, outlining the conditions providers of NHS-funded healthcare services in England must meet to help ensure that the

health sector works for the benefit of patients, now and in the future. All 21 NHS FTs and NHS trusts are required to hold a licence. NHS controlled providers and independent providers of NHS services are required to hold a licence unless exempt.

NHS England has extensive oversight and intervention powers over providers through the NOF (set out above). As the first line of oversight, ICBs monitor the performance of providers in their area and are responsible for challenging providers to work effectively together to drive improvement across the whole patient pathway.

NHS foundation trusts

NHS foundation trusts are held to account by their governors, who represent the interests of their membership and the communities they serve. The chair and board of directors of an NHS FT are responsible for the care and performance of the organisation. A FT's constitution must provide for all the powers of the trust to be exercisable by the board of directors on its behalf.

Non-NHS structures

Place based partnerships

Place based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services with other system partners, across the place and neighbourhood footprint. They include the NHS, local government and other local organisations such as VCSE sector organisations and social care providers.

Place based partnerships are required to have robust governance arrangements in place with most using the place board model (Health and social care integration: joining up care for people, places and populations). These place boards are established in various ways but the most common are formal committees of the ICB, consultative forums, or accountable business units.

Neighbourhood health - nested in places

There are many examples of effective neighbourhood health arrangements developing across the country, often building from the recommendations of the Fuller review.

Aligning services across organisations to work together for the same shared populations, enables those services to collaborate with each other to deliver more effective, coordinated care.

Local authorities

Oversight and accountability for LAs is achieved through various routes:

- LA is democratically accountable to local populations
- by itself and peers through LA corporate scrutiny
- by users through complaints, Local Government and Social Care Ombudsman and Judicial Reviews
- by MHCLG
    - best value spending controls and accountability framework
- by DHSC
    - ringfenced grant spending and conditions
    - memorandums of understanding for funding for example, Social Work Apprenticeships Fund and international recruitment
    - independent regulation of LA commissioned health services and social care
    - services as per the Care Act 2014 through CQC
    - publication of data for example the Adult Social Care Outcomes Framework
    - internal risk monitoring
    - policy specific approaches to assure improvement or hold to account

Specific functions of LAs including HWBs and HOSCs.

HWBs are statutory committees of local authorities, introduced by the Health and Social Care Act 2012. The 2012 Act sets out minimum membership requirements, with flexibility for HWBs or LAs to appoint additional members as appropriate. HWBs have statutory responsibilities for assessing the needs of their local populations through the JSNA and developing a strategy to meet these needs through the Joint Local Health and Wellbeing Strategy.

Health Overview Scrutiny Committees. LAs have powers to review and scrutinise any matters relating to the planning, provision and operation of health services in their area. These powers and duties are usually carried out by committees of LAs HOSCs. ICSs that

cover multiple LAs may have Joint HOSCs - bringing together representatives from all LAs in the system to undertake a scrutiny function across the patch.

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