System Leadership in the NHS: Learning from the North East and Yorkshire Region

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Summary

The North East and Yorkshire region has developed a distinctive approach to system leadership based on the regional director working closely with chief executives of the four integrated care boards (ICBs) in the region, known as the 4+1 arrangement.

In this arrangement, a team of teams provides leadership across the region and ICBs have adapted this way of working in their systems with many leaders and staff involved.

The regional team acts as a partner in its relationship with ICBs and works with and through them in overseeing the performance of NHS trusts.

The regional team and ICBs operate on the basis of subsidiarity with decisions taken in front-line teams, neighbourhoods, providers, places and systems and as close to the population as possible.

Leaders in the 4+1 arrangement emphasise the cultural change in this way of working with those involved seeking to build real trust, mutual respect and understanding, and collaborative behaviours.

System leadership was facilitated by the decision to create four ICBs covering relatively large populations with recognisable identities.

This helped attract experienced leaders to ICB chief executive roles and facilitated the building of capabilities required to exercise their functions.

Health services in the North East and Yorkshire perform well compared with other NHS regions using routine data on access to care and finances, albeit with more to do to improve some services.

Three of its four ICBs are among the highest performing in England and they are leading work to improve health outcomes, tackle inequalities in health, and involve a range of partners.

Much of this work is improvement-led drawing on the contribution of front-line staff and people with lived experience.

The benefits of system leadership were evident in the response to the Covid-19 pandemic and can also be seen in work led by ICB chief executives on regional priorities and innovations in each ICB described in this report.

ICB leaders emphasised their role in delivering NHS targets while also working towards longer term objectives with partners in local government and the voluntary and community sector.

System leadership as practiced in the North East and Yorkshire follows closely the aspirations originally set out for ICSs by NHS England and elaborated in its operating framework and the Hewitt Review.

Other regions and ICBs, as well as national leaders, may find it helpful to use learning from the North East and Yorkshire set out in this report to reflect on their own arrangements as they respond to the Darzi report.

Sir Chris Ham CBE, Emeritus Professor of Health Policy and Management, University of Birmingham and Co-Chair, The NHS Assembly

Foreword

"You don't learn to walk by reading a book" and the same can be said about system leadership.

System leaders across the North East and Yorkshire have been ‘learning by doing’ as we seek to enable improvement and reform of health and care services to deliver better outcomes.

The strength of self-improving systems is the ability to undertake a critical and objective appraisal and use this to inform leadership practice. When Richard Barker announced his retirement as regional director, we wanted to capture the learning from our work over the last eight years. Since we started the work, we have a new government and Lord Darzi’s report into the NHS.

Much prominence inevitably has been placed on structure since the establishment of statutory Integrated Care Systems (ICSs) in July 2022. Clarity of structure, roles and purpose is necessary: particularly as ICSs, with their Integrated Care Partnerships and Integrated Care Boards, are novel constructs in the history of the NHS.

The key lessons in this report show how all parts of our systems are changing – NHS England, ICSs, places, and providers – and that a focus on purpose, governance, structure, and incentives needs to be backed by an equal focus on effective relationships. If we get these right and pay constant attention to them then the structures can operate more effectively.

System leaders – wherever they sit – will be tested now and into the future. Recovering performance and maintaining safe, effective services will be tough. Improving outcomes will be even tougher. The Darzi report is clear about all these things.

We hope this report, researched and written by Sir Chris Ham CBE helps us in the region to increase our chances of success. We have worked with the NHS Confederation to share our work more widely as the NHS works to respond to the Darzi report.

Sam Allen, Chief Executive, North East and North Cumbria Integrated Care Board

Gavin Boyle, Chief Executive, NHS South Yorkshire Integrated Care Board

Stephen Eames, Chief Executive, NHS Humber and North Yorkshire Integrated Care Board

Rob Webster, NHS West Yorkshire Integrated Care Board

Introduction

Integrated care systems (ICSs) were established as statutory bodies in 2022 after six years in shadow form as sustainability and transformation plans and partnerships (STPs), set up to help deliver the NHS Five Year Forward View.

The four purposes of ICSs are to improve outcomes in population health and health care, tackle inequalities in outcomes, experience, and access, enhance productivity and value for money, and help the NHS to support broader social and economic development. In pursuing these purposes, ICSs work with different accountabilities: upwards to national government via NHS England (NHSE) and its regional teams through integrated care boards (ICBs), and outwards to local people through the work of integrated care partnerships within ICSs.

In planning for the creation of ICSs as statutory bodies, NHSE stated an intention that ICSs should have ‘increased freedoms and responsibilities’ based on the principle of subsidiarity. It also recognised that establishing ICSs as statutory bodies would require NHSE to consider its own functions to ensure that this ‘does not lead to duplication or create additional bureaucracy within the NHS’ (NHS England, 2021).

The decision to merge NHSE with Health Education England and NHS Digital and reduce their headcount by between thirty and forty per cent, announced in 2022, was consistent with these commitments. The headcount reduction applied to NHSE’s regional offices as well as central functions. It was followed by plans to reduce the running costs of integrated care boards (ICBs) - the Boards within ICSs responsible for NHS finances and performance – by thirty per cent by 2025 with at least twenty per cent to be delivered by 2024.

The Operating Framework

These reductions occurred in parallel with work led by NHSE on a new operating framework setting out the role of NHSE, ICSs and providers in the new structure (NHS England, 2022). The stated aim of the framework was to describe ‘how we do things around here’ with an emphasis on ‘giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context’. This included recognition of the need for ‘a cultural and behavioural shift towards partnership working’.

The leadership behaviours in the framework included an aspiration to ‘work as ‘one team’ across the NHS (ICBs, providers and NHSE)’ with partners in the team ‘being collaborative and empowering each other’ (NHS England, 2022). The framework recognised that NHSE had regulatory powers, including to intervene and direct both ICBs and NHS providers that were failing or at risk of failing to meet required standards or perform their functions and duties. It proposed that each ICB should agree a memorandum of understanding (MoU) with its regional team on how these regulatory powers would be used taking account of the NHS Oversight Framework.

Healthy scepticism

While the operating framework was broadly welcomed in the NHS, there was widespread acknowledgement of the challenges in translating its aspirations into practice verging on scepticism in some quarters. This was in part because the NHS has relied heavily on performance management led by national and regional bodies alongside inspection by the Care Quality

Commission. The promise of ICSs was that there would be greater reliance on partnership working and local leadership and less emphasis on management through the hierarchy, hence the emphasis on cultural and behavioural changes at all levels.

The operating framework proposed an organisational development and transformation programme to support the necessary changes. This included clarifying the roles and relationships between NHSE's regional teams and ICBs, for example in the use of regulatory powers and in providing leadership on key priorities. Concerns included the risk of duplication between regional teams and ICBs and confusion on who was leading oversight of provider performance, a concern also highlighted in the recent Darzi report.

While the regional tier has always played a key, albeit changing, role in the NHS, ICS leaders also expressed concerns that some regional teams exhibited an 'assumed superiority' in their dealings with ICSs in research conducted for the NHS Confederation (Ham, 2023a). This resulted in a feeling of being in an 'adult to child relationship', at odds with expectations of how regional teams would work with ICBs. The commitment in the operating framework that there should be 'one team' in future signaled an aspiration to work differently.

The Hewitt Review

The Hewitt Review underlined the need for ICSs to have far greater autonomy combined with effective and robust accountability. The following principles underpinned the review: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the time and space to lead; the right support, balancing freedom with accountability; and enabling access to timely, transparent, and high-quality data.

The Hewitt review proposed that ICSs should be supported to become 'self-improving systems' focused on a small number of national targets and priorities and with scope to identify and work towards local priorities. The review also suggested that, in the context of headcount reductions, there should be 'a significant move of resources into systems, supported by smaller, more experienced, and highly capable NHSE regions'. It added that regions 'should operate as equal partners with ICBs' and focus on improvement rather than performance management.

The Hewitt review went on to note that the North East and Yorkshire regional team made use of a leadership model bringing ICB and regional leaders together. It commended this model observing that it 'helps facilitate peer learning between ICSs to compare local approaches to delivering regional targets'. Patricia Hewitt added that 'I would expect all ICSs to continue co-designing arrangements for regional support that best support their continuing development' (Hewitt Review, 2023).

It might be added that each of the seven regions in England has developed its own way of working with ICSs reflecting the size of the region, the number and size of ICSs, the preferences of the leaders concerned, and other factors. In the absence of central prescription, this meant a variety of arrangements were put in place within the changing statutory context in which STPs, ICSs and ICBs evolved.

The Darzi investigation

The report of the Darzi investigation, published in September 2024 after the fieldwork for this report was completed, stated that 'the basic structure of a headquarters, regions and integrated care boards is fit for purpose' (Darzi Review, 2024). It also noted that the function and authority of ICBs 'remains unclear in some important respects' for example in performance management of providers. Another conclusion was that there were too many staff in national bodies,

notwithstanding recent cuts, and too many targets and demands on the NHS. This meant that senior leaders in the NHS spent too much time looking up and not enough looking outwards to their communities. The report argued that work was needed ‘at pace’ to resolve these issues.

The organisation of this paper

The rest of this paper describes experiences in the North East and Yorkshire drawing on around 25 interviews with members of the regional team, ICB leaders, national leaders, and other stakeholders. The paper also makes use of available data to explore the relationship between the leadership model, the performance of the region compared with other NHS regions in England, and the performance of the ICBs that make up the region. The principal purpose of the paper is to understand how system leadership works in the North East and Yorkshire and draw out the lessons for the wider NHS and its partners.

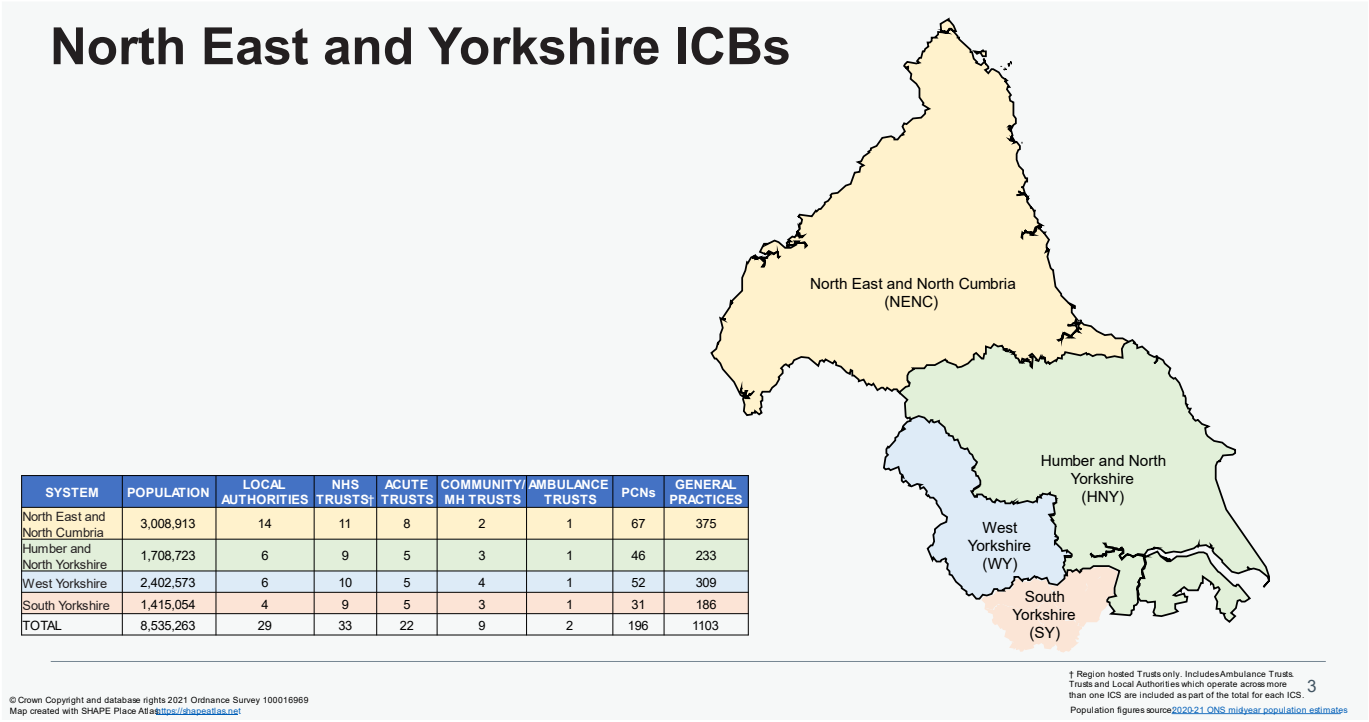
North East and Yorkshire's System Leadership Model

Origins

Richard Barker, NHSE's regional director for the North East and Yorkshire (at the time of the report), traced the origins of the region's leadership model to the creation of clusters of primary care trusts in 2011. This resulted in a significant reduction in the number of chief executives of these trusts and enabled the most experienced leaders to take on this role. As the then regional chief operating officer, Richard saw the benefits of relating to fewer trusts covering larger areas under the leadership of 'big hitters'.

Four STPs with experienced leaders

Learning from this experience informed the creation of STPs in the North East and Yorkshire in 2016 which evolved into ICSs and ICBs. Richard's knowledge of the geography and the disposition of the population and health services resulted in the establishment of four STPs each served by a major tertiary centre. The areas covered by these STPs offered the best option for the region because, in Richard's words, they 'were able to deal with almost 100 percent of patients' needs' in each system. Further details can be found in **Annex A**.



Richard saw it as essential to appoint experienced leaders as chief executives of STPs and ICSs. All of those appointed came from a background of running NHS trusts and they were attracted in part by the scale and size of STPs/ICSs in the region, typically bigger than in most other regions. The appointment of experienced provider leaders signaled the importance of these roles and was designed to ensure that those appointed were able to work effectively with NHS trust chief executives and other senior leaders in their areas, for example in local government and the voluntary sector.

Two of the four STP/ICS chief executives retired when ICSs became statutory bodies in July 2022 and their successors were similarly experienced leaders from other regions. Under the legislation, the ICB is the leadership forum responsible for NHS functions and budgets. The ICB chief

executives and regional director make up the 4+1 leadership team that is responsible for overseeing and managing NHS performance. The team works through weekly meetings and regular informal contact.

The 4+1 arrangement has turned out to be both a description of the top leadership team of the regional office and ICBs and a statement about how the regional office and ICBs have chosen to work together across the full range of their functions. In the case of the leadership team, participants described how the regional director shares updates and intelligence from the national leadership of the NHS at meetings.

The small number of those involved enables more open and honest discussions than might be possible in larger gatherings. Weekly meetings also provide the regional director with intelligence and insight into the performance of NHS services, and this supports his engagement with national colleagues. Regular communication in both directions helps avoid surprises and builds a collaborative way of working.

Memorandums of understanding

MoUs were agreed for each ICB in the North East and Yorkshire in October 2022. They set out:

- the principles that underpin how the ICB and NHSE will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services.
- the delivery and governance arrangements across the ICB and its partner organisations
- how NHSE, ICBs and NHS partner (foundation) trusts will work together to implement the requirements set out in the NHS Oversight Framework taking into consideration local delivery and governance arrangements, risks, and support needs
- how the ICB and NHSE will work together to address development-specific needs in the ICS and across the region.

The MoUs emphasised the importance of ‘system first’ in which actions were taken with and through ICBs rather than bilaterally between NHSE and individual provider organisations.

ICB chief executive leadership roles

An important element of the 4+1 arrangement is that each ICB chief executive has a leadership role across the region. Sam Allen from the North East and North Cumbria leads on mental health, learning disability and autism, Gavin Boyle from South Yorkshire leads on primary care and community services, Stephen Eames from Humber and North Yorkshire leads on digital health, and Rob Webster from West Yorkshire leads on workforce.

Work in each portfolio enables all the assets across the region to be drawn on, facilitates the sharing of best practice and learning, and provides a focus for delivery on high priority issues. Progress in taking forward this work is discussed further in section three of this report.

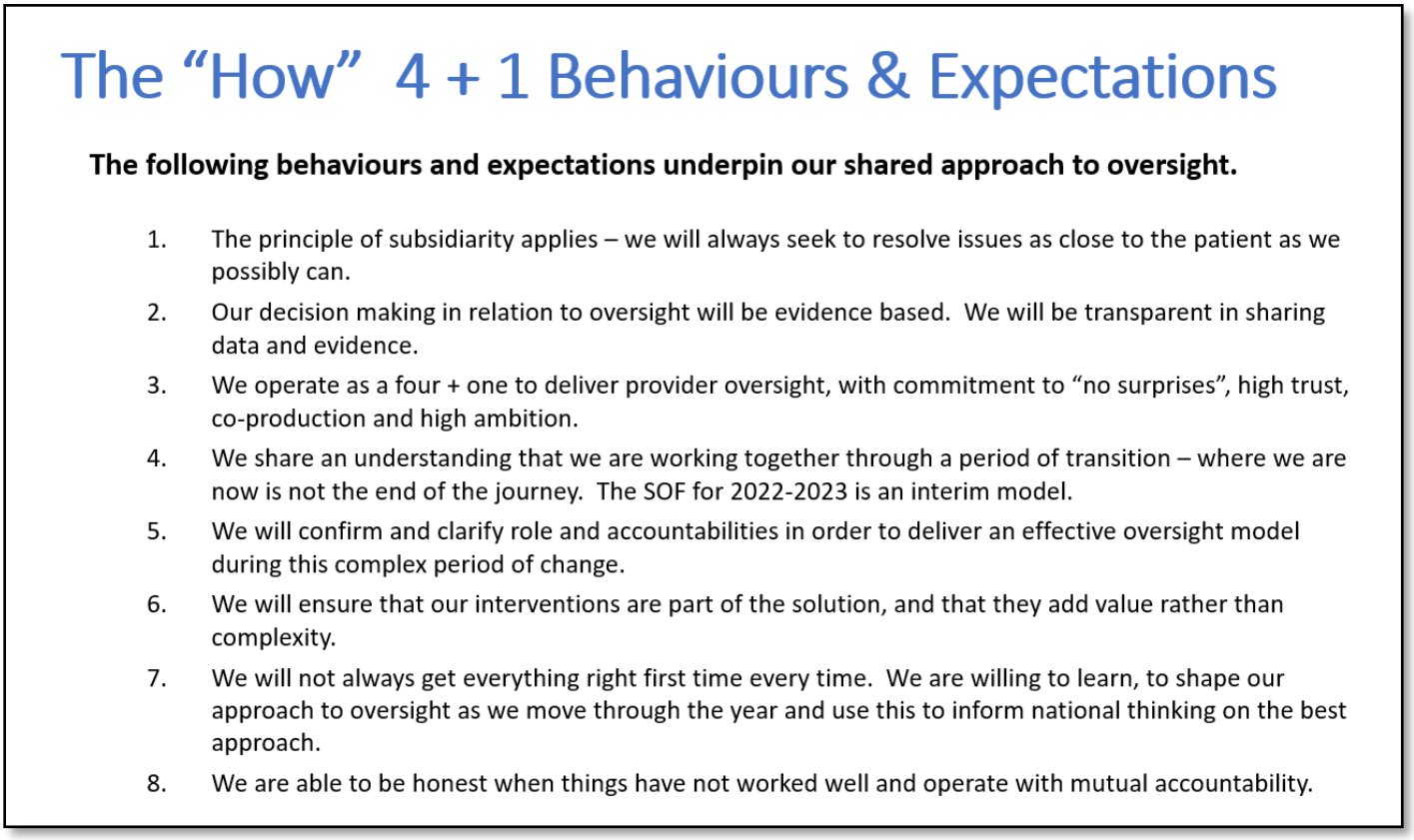
Principles and behaviours for system leadership

The 4+1 arrangement evolved into system leadership and was no longer about ‘homework marking’ in the words of Rob Webster. In this arrangement, team members take shared responsibility for performance, support each other in the delivery of plans, and seek to model the new behaviours expected of STPs/ICSs and their partners. Ways of working emerged in ‘the doing’ and are underpinned by a number of principles.

The principles include:

- build on what works.
- ensure clarity on roles and governance.
- work as locally as possible.
- operate at scale when necessary.
- embrace a learning approach.
- share intelligence through open dialogue, and
- adopt transparent ways of working.

The following behaviours and expectations outline the shared approach to oversight in the region:



The "How" 4 + 1 Behaviours & Expectations

The following behaviours and expectations underpin our shared approach to oversight.

1. The principle of subsidiarity applies – we will always seek to resolve issues as close to the patient as we possibly can.
2. Our decision making in relation to oversight will be evidence based. We will be transparent in sharing data and evidence.
3. We operate as a four + one to deliver provider oversight, with commitment to "no surprises", high trust, co-production and high ambition.
4. We share an understanding that we are working together through a period of transition – where we are now is not the end of the journey. The SOF for 2022-2023 is an interim model.
5. We will confirm and clarify role and accountabilities in order to deliver an effective oversight model during this complex period of change.
6. We will ensure that our interventions are part of the solution, and that they add value rather than complexity.
7. We will not always get everything right first time every time. We are willing to learn, to shape our approach to oversight as we move through the year and use this to inform national thinking on the best approach.
8. We are able to be honest when things have not worked well and operate with mutual accountability.

Provider chief executives may contact Richard Barker directly but for the most part their relationship with ICBs is seen as paramount. Gavin Boyle observed that by not getting involved routinely, Richard helpfully reinforced the role of the ICB, a view echoed by Sam Allen who reported that 'Richard lets us get on with things'. This way of working signals the primacy of ICBs in leading on performance issues with their partners while recognising the continuing regulatory role of the regional team. It also reflects the growing maturity and capability of ICBs.

An ICB chief executive with experience in another region reported that arrangements there are more formal and structured than in the North East and Yorkshire, in part because of the existence of a larger number of ICSs, and in part because in other regions the regional director retains a close relationship with NHS trust leaders. Richard is clear that ICBs should lead in tackling performance challenges in NHS trusts in their areas and he and regional colleagues are involved by exception and always in association with each ICB team.

ICB chief executives' views

Gavin Boyle described meetings of the 4+1 as 'collegiate' and felt they were important in signifying a 'cultural shift' in leadership behaviours. He added that the commitment to system leadership sent out a strong message about collaboration and set a tone for others to follow.

Similar meetings are held between senior leaders in the regional team and ICBs responsible for finance, performance, strategy, workforce, medical and nursing, and other functions, thereby reinforcing the cultural and behavioural shift involved in this way of working. In their meetings, the regional director and ICB chief executives may be joined by other regional and national colleagues as appropriate. ICB chairs attend meetings routinely and are able to raise issues of concern and learn from colleagues.

All participants reported that the 4+1 discussions involve a mix of mutual support and challenge. Hard conversations are not avoided but equally the meetings are not an appropriate forum in which individual participants are confronted directly about their systems. Sam Allen emphasised the importance of psychological safety in the meetings which enabled open discussions and sharing of information in an environment of trust.

The performance of each ICB is reviewed at structured quarterly meetings with the regional team. These meetings enable NHSE to discharge its regulatory role and explore performance issues in depth. ICBs and the regional team work on an understanding of there being 'no surprises', including ICBs volunteering any concerns and shortcomings and seeking ideas or support rather than waiting for them to be called out. Management cost reductions and associated 'delayering' have reinforced the value of assurance being seen as a shared responsibility.

Quarterly performance meetings enable the regional team to hold each ICB to account and agree what needs to be done to improve performance. They play a key role in ensuring upwards accountability *alongside* mutual accountability for performance through the 4+1 arrangement at the regional level and adaptations of this arrangement in each ICB. The ability of leaders to operate in this way demonstrates the need for agility in the complex adaptive systems they work in and a willingness to tolerate the tensions that may arise.

Stephen Eames recalled that the 4+1 'resolved early that we would be more effective if we worked collaboratively' and the team had 'matured as time has gone on'. Rob Webster reported that the relationship with the regional team was not directive and hierarchical 'because Richard gets systems'. This reflected the aspiration that ICBs as novel organisations should work differently.

Sam Allen reported that the 4+1 'don't always get it right' but the aim is 'we get behind each other' and 'we want the region to do well'. She added that there is 'a strong sense of solidarity' with members of the team actively supporting peers.

One of the benefits of the 4+1 arrangement is the opportunity it creates to plan and commission services that may cut across system boundaries, including ambulance services and services encompassed by specialised commissioning.

System leadership in the pandemic

Richard reported that the value of this way of working was demonstrated in the region's response to Covid-19. NHSE declared a level 4 national incident at the beginning of the pandemic, and this could have led to a reversion to hierarchical controls to deal with the national emergency. This did not happen and for the most part ICSs led the response which was coordinated through the 4+1 arrangement and the principle of subsidiarity. Shaun Jones, locality director for Humber and North

Yorkshire at the time, echoed these points arguing that the pandemic ‘took collaboration to a whole different level’.

Each ICS worked with partners in the provision of mutual aid and supported local resilience forums on issues such as the provision of personal protective equipment (PPE), testing, and delivery of vaccinations. The region led on issues where it was best placed to do so, for example Nightingale Hospitals and access to medicines. This way of working continued in recovery from the pandemic and helped deliver positive results across the region, discussed further below.

A number of interviewees reported that system leadership in the North East and Yorkshire was further advanced than in many other parts of the NHS.

Locality directors

A key early step in the evolution of the model was the decision to appoint four locality directors to the regional leadership team and embed them within STPs/ICSs. This was seen as a way of supporting the development of capabilities in STPs/ICSs, and also, crucially, building partnership between the regional team and each STP/ICS.

Embedding locality directors reduced the distance - physical and psychological - between the regional team and each STP/ICS and facilitated a cooperative way of working. Sam Allen, chief executive of North East and North Cumbria ICB, summarised this as ‘doing with and not doing to’. In practice, some embedded teams were reported to be more effective than others even though the principle was widely welcomed.

Both Shaun Jones and Anthony Kealy, formerly locality directors for Humber and North Yorkshire and West Yorkshire respectively, spoke of the ‘deliberate blurring of the boundaries’ between the regional team and leaders in STPs/ICSs from the outset. Embedding locality directors in ICSs and ICBs helped to build capacity and capability in planning and oversight of performance and cultivated ‘an open book and no surprises’ way of working. Boundary spanning roles are found in other parts of the system architecture in the region.

Dual accountability

Anthony described that as locality director his formal accountability was to Richard Barker but on a day-to-day basis he reported to ICB chief executive, Rob Webster, with whom he agreed objectives. Anthony recognised that his dual accountability could have created difficulties, but this did not happen because of the positive relationship with and between Richard and Rob. Shaun reported that under the 4+1 arrangement there was recognition that ‘we are in this together’ with locality directors acting as ‘go-betweens’.

When ICSs became statutory bodies in 2022, locality directors and their teams transferred their employment from the region to ICBs. By that stage, some teams had lost members to other roles, and others were affected by reductions in management costs in ICBs and regions. An exception was West Yorkshire where, in Anthony Kealy’s words, he and his team transferred from the region to the ICB ‘lock, stock and barrel’ in a smooth transition. Other ICBs whose teams had been depleted used the opportunity to recruit experienced staff with a track record in planning and performance.

Seeing through ‘the fog’

Leaf Mobbs, regional chief operating officer, reflected that it took time for new ways of working to evolve and spoke of ‘the fog of who is responsible for what’ in the early stages. Initially she and the regional team continued to intervene to tackle performance challenges where necessary, for

example when high profile issues like ambulance response times in some areas were attracting public and political attention. In doing so, she would invite ICS and later ICB colleagues to join meetings with challenged providers, illustrating Anthony Kealy's point that 'there is real skill in the region intervening directly with providers without undermining systems'.

Leaf explained that the aim now is for intervention to occur 'with and through systems' although there may still be occasions when national leaders and indeed health minsters reach over regions and systems to make direct contact with providers. Some national teams also routinely work directly with providers. Leaf, Shaun and Anthony all emphasised the value of weekly meetings of the system coordination group bringing together regional and system teams responsible for planning and performance.

A hierarchy of interventions

Tim Savage, regional finance director, reiterated that regional intervention in providers is with and through systems. He described a hierarchy of interventions ranging from ICBs leading on their own to the regional team leading in the most serious cases with the system involved. In between these extremes there might be joint leadership of an intervention through co-chairing of an oversight Board. Tim listed a number of examples of NHS trusts in the North East and Yorkshire that had required regional intervention and in so doing illustrated the continuing importance of the region's regulatory role.

Strong relationships and trust between finance directors in the regional team and ICBs and their staff, and regular communication, help avoid misunderstanding and conflict when this happens. Likewise, the regional oversight and assurance model, MoUs between the regional team and each ICB, and system oversight frameworks such as the one published by the North East and North Cumbria ICB in February 2023, make explicit how and when intervention and support will occur. The latter applies to the quality and safety of care as well as finance.

There is collective leadership on finance issues in other ways. These include systems taking the lead in developing the initial thinking on areas of policy development on behalf of the other systems within the region. As well, working groups think through key challenges and tasks with system and regional team representation. Tim meets with system leads on issues such as staff development and support and encourages the development of networks within systems to maximise reach and local oversight.

National directors are well briefed on finance issues in the North East and Yorkshire and are aware of the role of ICBs in overseeing performance in their systems. This has helped to build confidence in the regional and ICB teams and their ability to assess what actions are needed to tackle performance challenges. The role of 'account managers' in the regional finance team for each ICB is a key element in this way of working.

Filtering demands from the centre

A number of those interviewed spoke of the value of Richard and the regional team 'filtering' demands and requests from the centre to separate issues of real importance from other business. Lee Outhwaite, chief finance officer in South Yorkshire, described how the regional team provides 'air cover' for ICBs and the team's relationship with national NHS leaders make this possible. His experience is of 'adult to adult' relationships between ICBs and the regional team and he contrasted this with 'adult to child' relationships that his peers reported in some other regions.

From a different perspective, Tom Riordan, chief executive of Leeds City Council, described how Richard Barker 'treated people like adults' and was clear on his expectations of leaders in the

region. His longevity in post and track record of delivery had given him credibility and leverage both in relation to national NHS leaders and leaders within the region. Tom felt Richard Barker used meetings well and operated as much through informal networks as formal structures and accountabilities.

The proposed oversight framework

Some interviews expressed concerns that NHSE's proposed oversight and assessment framework published in May 2024 might be a backward step in this regard. The framework sets out how the performance of ICBs will be assessed with the stated aim that it 'is supportive, rewards strong performance, drives the development of mature systems' (NHSE board papers). ICB ratings will be based on an annual capability assessment and quarterly delivery scores.

Concerns about the proposed approach include the risk of a regulatory philosophy supplanting the 'inherent trust' on which collective leadership is based. In the words of Anthony Kealy, this might 'drive more transactional behaviour' and run counter to the cultural shift underway in the region, a view echoed by Shaun Jones. Much will depend on how the framework is used in practice and the balance between supporting improvement and exercising judgement.

NHSE has stated that the annual capability assessment will draw on each ICB's own self-assessment and comprehensive feedback from key system partners including health and wellbeing boards, Healthwatch, local authorities, and the Care Quality Commission, adding 'It will be supported by an evidence-based understanding of achievement against what good looks like and will operate within a national framework to ensure consistency'. This includes review by an ICB chair or chief executive from another region.

As this happens, it will be important to ensure that implementation of the oversight and assessment framework recognises the time needed to make progress on some of the ambitions of ICBs, particularly those relating to population health. The framework will also need to give due weight to intangible and hard to measure factors such as trust, relationships and behaviours and the role of mutual accountability.

Stakeholders' views

Reflecting on experience in the region, Sue Symington, chair of Humber and North Yorkshire, reported that the 4+1 arrangement was 'the common-sense solution' and 'just the way anyone would work anyway'. Her view was echoed by Pearse Butler, chair of South Yorkshire, who felt 'we are well connected to Richard Barker and the regional office'. Pearse emphasised the value of chairs meeting regularly as well as with the 4+1 and said system leadership was well established and would most likely survive any changes among leaders. His knowledge of other regions illustrated for him the benefits of this way of working.

Liam Donaldson, chair of North East and North Cumbria, and regional director of the NHS Northern and Yorkshire region between 1994 and 1998, reported that ICBs operated on a scale that enabled them to work effectively with NHS trusts and other partners. In his experience, NHS trusts accepted the role of the ICB in overseeing performance which was based on a commitment to collaboration. Liam added that there was an opportunity to streamline the upper tiers of the NHS based on the region's experience and we return to this issue in the final section of this report.

Stakeholders from outside the region with knowledge of its performance and leadership arrangements made a number of observations. One felt that the 4+1 arrangement worked because the region had been operating like this for several years. The small number of those

involved had helped build understanding and trust among leaders. His experience was that ‘ICBs are pretty capable’ in the region and their leaders understood the provider sector.

Another said that the main risk was that Richard Barker and his team might sometimes be ‘closer to ICBs’ and ‘feel too distant from providers’. This was echoed by a third external stakeholder who reported that trust chief executives in some regions felt they had been ‘cut adrift’ in not having as much direct contact with regional directors and their teams as in the past. Providers within the region did not feel this had happened in the North East and Yorkshire (see below).

An ICB chief executive from outside the region added that the 4+1 arrangement ‘enabled open and honest conversations’ between the regional team and ICB leaders but created a risk that relationships might become ‘a bit cosy’. This stakeholder and another interviewee emphasised the need for rigour in the oversight of provider performance. The implication was that ICBs needed to develop capabilities to deliver ‘the hard yards of performance improvement’.

Providers’ views

Phil Wood, chief executive of Leeds Teaching Hospitals NHS Trust, one of the largest and most significant providers in the region, reported that relationships with the region were ‘light touch’ and in his experience ‘perfectly strong’. In his view the 4+1 arrangement was valuable ‘because it helps avoid duplication of oversight and regulation’. Richard Jenkins, chief executive of NHS trusts in Rotherham and Barnsley, added that Richard Barker was accessible and ‘always helpful’. Most of Richard Jenkins’ dealings are now with Gavin Boyle and the South Yorkshire ICB team.

As a trust chief executive, Richard Jenkins said he found it difficult to comment in detail on the 4+1 arrangement because although he was aware of its existence the content and outcomes of meetings were not known to him. He would welcome greater transparency about its work and more communication about the team’s discussions. He saw the benefits of close relationships between the region and ICBs but was not always clear on ‘who does what’ on performance challenges. This included the role played by ICB leaders in discussions with the regional team on how to address these challenges. He added that Leaf Mobbs in the regional team had a good understanding of performance across the region.

Strategy directors’ views

Ian Holmes, director of strategy and partnerships in West Yorkshire, reported that there was genuine collaboration between ICBs and the regional team and this felt quite different from a parent to child relationship. Relationships did not feel cosy and were characterised by robust discussions, a view echoed by others working in the region. He noted that some national teams, particularly those responsible for cancer and mental health, continued to relate directly to NHS trusts rather than through ICBs, and ‘the region hasn’t been able to stop that’.

Ian also reflected that there could be differences between national, regional and system leaders on the model of improvement used. Put simply, the belief in performance management and leading change through the hierarchy was still firmly ingrained at a national level and some regional teams, whereas in North East and Yorkshire both the regional team and ICBs were embracing the aspiration to self-improvement articulated in the Hewitt Report and elsewhere. In his view, this helped explain external challenges to the 4+1 arrangement and underlined the importance of it continuing to deliver improvements in performance.

Jacqueline Myers, chief strategy officer in the North East and North Cumbria ICB, reported that after some ‘tricky discussions initially’ regarding the respective roles of the regional team and the ICB, a modus operandi had been agreed on who would do what in overseeing the performance of

NHS trusts. This involves the ICB leading with trusts in segments one and two and the regional team with trusts in segment three (there are no trusts in segment four). NHS trusts had responded 'generally well', and Jacqueline said that she found the regional team 'hugely supportive'.

Peter Kelly, regional director for public health, added that ICBs value having regional support on difficult issues. In his experience, 'working together through 4+1 was more effective than working separately', and 'ICBs might drift apart' if the arrangement did not exist. He also drew attention to Richard Barker's relationship with NHS trust chairs and his role in intervening when difficulties arise. Like some other interviewees, Peter questioned whether there were too many ICBs in England and suggested that fewer, larger systems might be needed.

Leadership within ICBs

The principles of system leadership have been adapted in each ICB. The details are different in each system and include:

- Working with and through *place partnerships* that take responsibility for improving health and care within systems and involve leaders from a range of partners including local authorities;
- Working with *provider collaboratives* that bring together leaders from NHS trusts and sometimes other organisations;
- Distributed leadership of *major work programmes* fronted by leaders within systems e.g. workforce, capital plans, elective recovery and urgent and emergency care;
- *System leaders' forums* comprising leaders of NHS organisations, local authorities, and others that form the authorising environment for work across the system;
- *Clinical leadership* through clinical networks in cancer and stroke care and in the work of clinical directors in primary care networks

The resulting arrangements can appear complex but reflect the reality (sometimes messy) of governance when there are several points of planning and decision making. As an example, Phil Wood of Leeds Teaching Hospitals Trust referred to the role he and colleagues play in the acute hospitals alliance in West Yorkshire and in the Leeds Place Partnership. He added that as chief executive of a tertiary centre he is also involved in working with colleagues in other tertiary centres in the north of England and in the regional office as the commissioner of specialist services.

Another example is in South Yorkshire where Gavin Boyle reported that NHS trust chief executives take responsibility across the system for work on urgent and emergency care, cancer, maternity, and mental health, learning disability and autism. The leaders concerned challenged their peers where appropriate in a system based on mutual accountability. Gavin argued that this way of working was more effective than challenge by the regional team and regulators because it enabled shared ownership of performance.

In Humber and North Yorkshire, leaders of the five sector collaboratives are members of the ICB. This helps maintain relationships and alignment and avoids the tension seen in some systems in other regions between provider collaboratives and ICBs on leadership of work across the system. The decision to set up a voluntary community and social enterprise (VCSE) collaborative (see below) illustrates the value attached to the voluntary and community sector in Humber and North Yorkshire.

Rob Webster added that clinical leadership across the region and its impact is mixed. In his view, more needs to be done to clarify the role of clinical networks in future, and to support their development in services where their contribution has been more limited. He argued that a clear

plan was needed building on work on cancer and vascular services where effective leadership and close alignment had resulted in positive changes.

What has system leadership delivered?

We have seen how leadership through the 4+1 arrangement in the North East and Yorkshire - and how it has been adapted in ICBs - is viewed mainly positively by leaders and stakeholders interviewed for this report. To be sure, questions have been raised about the risks of NHS trust leaders feeling 'cut adrift,' in the words of one interviewee, and of the relationship between the regional team and ICB chief executives being 'too cosy' in the words of another, although the evidence gathered for this report did not suggest that either was the case in the North East and Yorkshire.

There is also recognition that the arrangement is in line with NHSE's operating framework and its aspiration that there should be 'one team' across the NHS. In assessing the advantages of the arrangement and the potential risks involved, it is important to consider the performance of the NHS in the region and of its four ICBs. What do we know about how performance in the North East and Yorkshire compares with other regions in England, and is there any evidence that its ICBs deliver better or worse results for their populations than other systems?

Answering these deceptively simple questions can be addressed by using routine NHS data on finance and performance in relation to key indicators such as patients' access to care. Use can also be made of the ratings developed by NHSE to assess ICBs and NHS trusts. In the case of ICBs, performance can be understood in part by how they have taken on their responsibilities and the innovations that have resulted before and after they became statutory bodies in 2022.

None of these approaches is without difficulty. As one interviewee argued, the North East and Yorkshire has 'for many years' been 'a high performing region on standard measures', but this is principally because NHS trusts have, for the most part, performed well. It is too soon to isolate the impact of ICBs because they are of recent origin and methods for assessing their added value are still under development. Ideally, account would also be taken of population characteristics and health need in comparing performance across regions and systems, and this is beyond the scope of the present study.

Recognising these limitations, we now go on to present examples of innovations that have resulted from the work of ICBs to date, summarise key performance indicators and present NHSE's ratings of ICBs and NHS trusts in the region. More time and better data are needed before a more complete evaluation is possible.

a) *Innovations in ICBs*

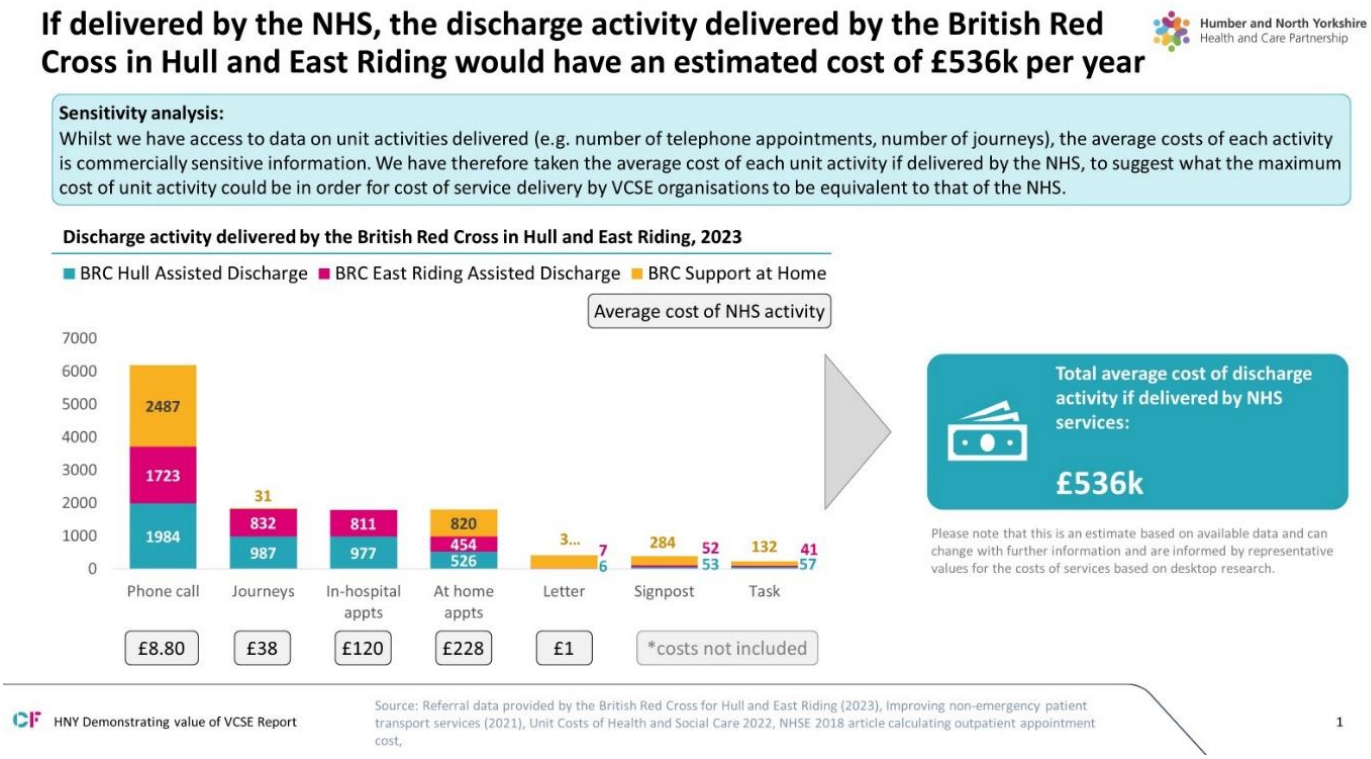
Working with the voluntary and community sector in Humber and North Yorkshire

Working closely with the VCSE sector is one of the hallmarks of the Humber and North Yorkshire Health and Care Partnership. Gary Sainty, head of VCSE at the Partnership, was appointed to his role in December 2021, and with a background in the voluntary sector was well placed to work with Stephen Eames and colleagues on helping to ensure there was understanding of the work of the VCSE in the ICB and the contribution it could make.

Gary recalls how soon after he took up post there was a realisation that the VCSE was in effect 'the fifth collaborative' alongside those for acute services, mental health, learning disability and

autism, Community Health and Care, and Primary Care. Two years on, he describes how the VCSE collaborative is now ‘very much embedded in the ICB’. He and colleagues are invited to leadership and planning groups and ‘we have a voice that is listened to in the ICB’.

Notwithstanding misgivings among some parts of the VCSE about becoming too close to the ICB and losing autonomy, there is recognition of the benefits of being embedded. VCSE partners are able to influence the work of the ICB and where appropriate work as a partner in tackling shared challenges. A good example is hospital discharge where VCSE organisations such as the British Red Cross are funded to work with the NHS and others to support people being cared for in the right place. An independent analysis shows the cost that the NHS would have incurred in delivering this service.



The diversity of the VCSE sector, and often its local orientation, means that involvement in the six places in Humber and North Yorkshire is particularly important. This involvement builds on local authorities having a long-standing commitment to funding the sector and working with it in most of these places. Alongside work on places the collaborative has established a number of workstreams on issues such as social prescribing, personal health budgets, volunteering and children and young people.

While not all 14,000 VCSE organisations in the system can be fully engaged, Gary and the small team working with him continue to use different channels to harness the expertise that exists including regular meetings, monthly updates and a VCSE Expo held in April 2024. Webinars also have a role, as in work on hospital discharge as a way of sharing work and achievements in the six places in Humber and North Yorkshire.

A critical factor in the progress made has been the support of the ICB and its leadership. In Gary’s words, ‘Stephen Eames and the executive team get it’ and Gary is able to contact Stephen whenever necessary knowing he will respond. Stephen and colleagues are also receptive to learning about the VCSE, for example by spending time in different places meeting representatives and hearing their views.

Work in Hull illustrates how the VCSE works with place partnerships. Erica Daley, ICB place director, works with a partnership board chaired by the chief executive of Hull Council. The partnership's priorities include establishing integrated neighbourhood teams, developing the workforce, and tackling health inequalities. It builds on a history of joint commissioning between the NHS and the council.

In the case of the VCSE, Erica explained that the place partnership always seeks to 'think VCSE first', as illustrated by the discharge collaborative. This is focusing on reducing the number of people in hospital beds who are ready to be discharged working with a range of organisations including Hull Home from Hospital Services, Age UK, Alzheimers UK, and bodies working with carers.

Jason Stamp, chief executive of Forum, an umbrella group of VCSE organisations in the city, has been a key partner in this work. Public funding has been used to support the organisations involved with the NHS and the council, moving away from one-off grants to sustainable funding and with less bureaucracy for all concerned. The discharge collaborative has helped reduce delayed transfers from hospital by drawing on the diverse contributions of the VCSE. In its first month, as an example, 94 people were supported to leave hospital sooner than otherwise would have happened, compared with the aim of 50 discharges per month.

Building a learning and improvement community in the North East and North Cumbria

The North East and North Cumbria Health and Care Partnership has been building a learning and improvement community to achieve improvements in health outcomes and the delivery of care. The community draws on a positive legacy, for example in the North East Transformation System, the Cumbria Learning and Improvement Community and work in partner NHS trusts. Its aim, in the words of Sam Allen, chief executive of the ICB, is to be 'the best at getting better', a phrase borrowed from Cincinnati Children's Hospital.

An inaugural event in September 2022 launched the community and identified seven priorities for improvement. ICB leaders are clear that their role is to act as the convenor and facilitator of the community, build trust among partners, invest in collaborative relationships, and foster networks to facilitate knowledge exchange. There is a strong emphasis on learning, experimentation, complexity, curiosity, and a commitment to create knowledge sharing systems, underpinned by an explicit theory of change.

Work on ambulance handover delays illustrates how this is being done. Areas experiencing longer delays visited areas with shorter delays to observe and learn from their peers. A new approach to handover, combined with enhanced streaming of patients was then agreed for the whole system, albeit with some flexibility on local implementation, and this helped to reduce delays. Rapid improvement events with staff 'doing the work' were at the heart of this initiative. The support of senior leaders was a key enabler of progress.

Another example is hospital discharge where a summit held in March 2023 drew on international as well as local experience. This has evolved into a Safe Transfer of Care Improvement Collaborative involving improvement leads from across the system. There was a strong focus on using data to understand and reduce discharge delays, standardising work processes where appropriate, and sharing good practice.

In the case of urgent and emergency care, improvement has focused on enhanced clinical triage, urgent primary care, and system flow. A combination of community of practice events and winter planning was used drawing on a philosophy of 'all teach and all learn'. Early results include reductions in falls-related admissions to hospital as a result of the community response service and reductions in NHS 111 call handling times.

The learning and improvement community currently has around 7,200 members from a range of backgrounds including the NHS, local authorities, the VCSE and the private sector. Contact has been made with neighbouring systems, including NHS Scotland, to facilitate shared learning. Support has also been provided by the Health Foundation to enable independent evaluation and help build improvement capabilities.

Challenges encountered include industrial action making it difficult to release staff and organisational autonomy which in some parts of the system can slow progress on collaborative improvement work. System leaders also recognise the time needed to embed new ways of working and deliver measurable results. Annie Laverty, former executive director of improvement and experience, emphasised the importance of celebrating successes and keeping 'fun' in the work.

Both Annie and Sam Allen highlighted the valuable contribution of people with lived experience as well as staff doing the work to the learning and improvement community.

Improving the health of children and young people in South Yorkshire

Compared to the national average, children in South Yorkshire are less likely to be breastfed at 6-8 weeks after birth, have slightly lower rates of school readiness, are more likely to be obese and have dental caries.

A child's earliest years have a profound impact on their development. The Integrated Care Partnership wanted to put the health of children and young people (CYP) at the centre of its strategy and focus on those in most need and where the biggest impact can be made, in children aged 0-5.

The Partnership, which is Chaired by Oliver Coppard, the elected Mayor of South Yorkshire, is uniquely placed to bring statutory and voluntary organisations together who have a major role in helping parents and guardians support the next generation of young people. In doing so, the Partnership draws on both national and international experience.

Nicola Ennis, CYP Alliance programme director, explained how South Yorkshire was selected as one of three systems nationally to join a Collaborative with the UK's largest children's charity, Barnardo's, and the UCL Institute of Health Equity (IHE) to improve the health of children and young people. This work is being led by the Children and Young People's Alliance, including the development of a Child Health Equity Framework in association with over 300 children and young people and testing an intervention based on the insights of children and young people, the VCSE and local data.

The 'test' Intervention

Aim
To improve mental wellbeing and build children's capacity for positive mental health by facilitating social connections, building trust in systems, create a sense of mattering, agency and confidence.

The intervention itself is comprised of multiple components. The specifics may change as the very nature of the intervention is to be co - produced and iterative in design

For children aged 9-10 years old who are at risk of missed school days/who are frequently absent from school, looked after children and those who may be more likely to have contact with the justice system.

- **The provision of a safe space**. In this intervention , we **refer to safe spaces here as both a safe physical and psychological space**
- **This safe space includes building trusting relationships** with adults trained appropriately in youth work **and the safe space to talk** building understanding amongst children about recognising when they feel safe, enabling conversations around mental wellbeing
- **The co-production of a set of activities** with the cohort of children involved , built around "life skills"
- **The delivery of activities** within the safe space or in trusted community spaces (if this is an ask of the children) – **frequency** to be determined by inputs from children, funding, and the provider which is Rotherham United Football Club Charity.
- **Enable the first cohort of children to return** and act as peer support for a second cohort – what this looks like depending on input from children in engagement activities.

The 1001 days from pregnancy to the age of two set the foundations for an individual's cognitive, emotional, and physical development. Work is in hand to develop a service delivery model based on experience in local places and family hubs. The service is being led by Barnardo's in partnership with VCSE organisations and takes a holistic approach offering a range of interventions.

In an initiative led by the Mayoral Combined Authority, South Yorkshire was also selected, along with 10 other cities and regions across the world, to work with the Bloomberg Harvard City Leadership Initiative. The initiative aims to improve public management, leadership, and governance, and it does so through research, training leaders and developing resources. Will Cleary-Gray, executive lead for the CYP Alliance, reported that it was through this initiative that the focus on ensuring every child aged 0-5 had a safe place to sleep was agreed. Cat Ross, chief executive of Baby Basics UK is closely involved in this work.

Behaviour is heavily influenced by our living conditions. Living in a street or place which encourages play and physical activity within daily life makes it much easier for children to develop healthy habits. Equally important is good quality sleep, something many people take for granted. South Yorkshire sees some of the starkest health inequalities in the UK, with 1 in 9 newborns in Sheffield alone requiring a safe place to sleep last year.

Beds for Babies, funded through £2.2m of investment over four years, was developed with government, voluntary, and private sector partners, including Baby Basics UK, Save the Children UK, Sheffield Hallam University, and Ikea. The team in South Yorkshire has built a different way of working at the community level to reach those who have historically been underserved and unheard.

The programme works through existing referral and delivery routes including pre-natal, post-natal and midwifery services, GPs, Family Hubs, Children's Centres and existing local VCSE organisations. To ensure learning from this approach is maximised, the programme will also deliver a test and learn pilot in four areas: Goldthorpe, Mexborough, Swinton and Gleadless, to build an evidence base of what works at community level and develop best practice.

The work being done will take many years to come to fruition, and it may take a generation to see the impact. But in an area where life expectancy is at least 18 months lower than the average, and people live in good health three and a half years longer in other parts of the country, the need to change is clear.

Tacking health inequalities in West Yorkshire

A comprehensive approach to tackling health inequalities is at the heart of West Yorkshire's Improving Population Health Programme. The Health and Care Partnership works closely with a range of partners including the Mayor of West Yorkshire and the West Yorkshire Combined Authority (WYCA). The Partnership is also involved with the national CORE20Plus5 programme and received funding of £10.7million in 2023/24 to support targeted reductions in health inequalities.

Much of the work on Improving Population Health is based in the five places that make up West Yorkshire. These places bring together NHS organisations, local authorities, VCSE sector organisations and others to understand the health needs of the population and agree how these can best be met. The Programme is led jointly by the ICB's medical director, the chief executive of Calderdale Council, and the Director of Public Health from Kirklees Council, and involves a large number of colleagues from across West Yorkshire.

They are supported by a core team who coordinate delivery of interventions to better understand and address inequalities at scale on behalf of the health and care system. The team includes Sohail Abbas, deputy medical director of the ICB and health inequalities lead, who argued that 'Only by working together across West Yorkshire can we effectively tackle inequalities. This collaboration is our top priority to ensure every community has the opportunity to thrive'.

The Programme's annual report for 2022/23 lists several achievements including:

- West Yorkshire becoming the first partnership of sanctuary for going above and beyond to welcome people seeking sanctuary, including through an animation to help refugees and asylum seekers navigate the NHS.
- Supporting Gypsy, Roma and Traveller communities on initiatives including suicide prevention, mental health and wellbeing, and early cancer diagnosis, now extending to the establishment of the West Yorkshire Inclusion Health Unit
- Developing the West Yorkshire Health Inequalities Academy as a forum to raise awareness, bring people together, and showcase interventions.
- Using communities of practice to aid collective learning on issues such as reducing serious violence and supporting people living with obesity.
- Instituting a fellowship programme to increase capabilities in areas such as adversity, trauma and resilience, climate change, health equity and suicide prevention.
- Providing funding to boost children's mental health support working with a children's charity.

The funding received from the national CORE20Plus5 programme was used in part to provide resources for the most deprived neighbourhoods to support targeted work on prevention. This work is informed by public health directors working through place-based partnerships. Interventions are intended to enable progress towards one of the Partnership's 'big ambitions', namely, to reduce the gap in life expectancy related to deprivation.

An example of progress is controlling hypertension in the adult population. All four ICBs in the North East and Yorkshire have returned more quickly than the rest of England to their pre-Covid position. West Yorkshire's Healthy Hearts Hubs have contributed to the progress made there.

Wan Abdullah, founder of Sanctuary Got Talents UK, praised work with refugees and asylum seekers, and the emphasis on reducing barriers to people accessing care. Ellie Rogers, chief executive of Leeds Gypsy and Traveller Exchange, reiterated these views and described progress in supporting people from the gypsy and traveller communities, for example in accessing vaccinations, screening, maternity care, and mental health support. Ellie reported that 'We are encouraged to be working with people so committed to reducing inequalities and who really wasn't to listen to those experiencing the worst impacts of those inequalities'.

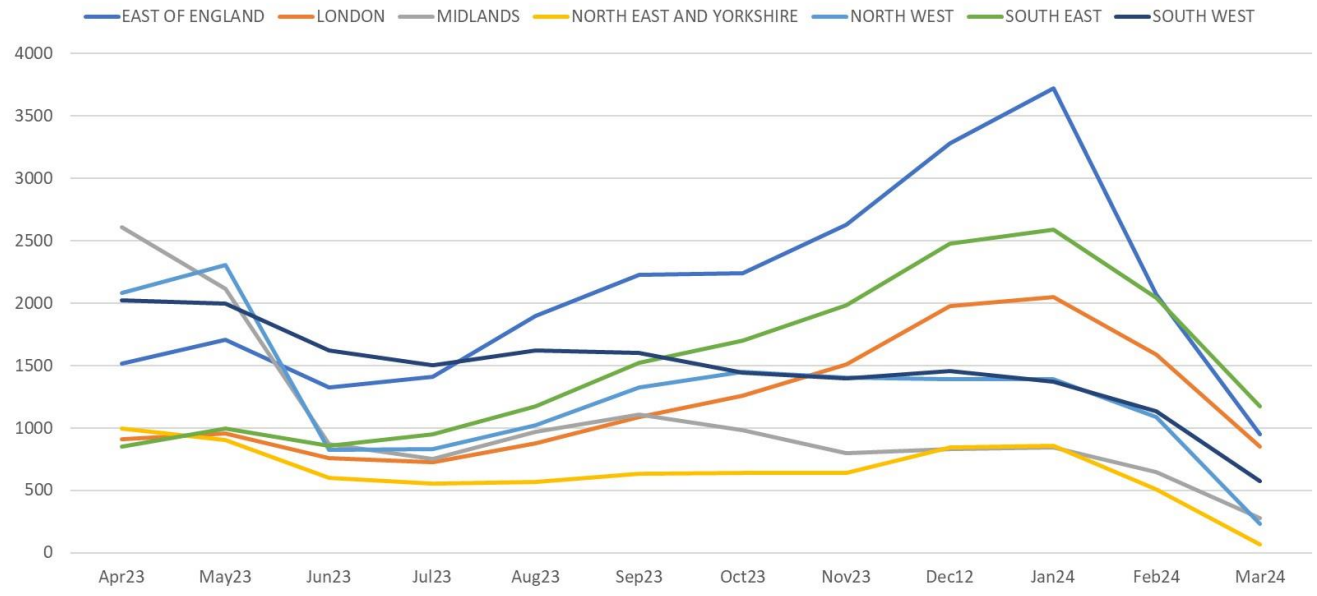
In 2022/23 Collaboration with the Mayor of West Yorkshire and WYCA has focused on the cost-of-living crisis as illustrated in this diagram. In 2023/24 this collaboration expanded with the creation of joint strategic roles to focus on fair work, inclusivity, creative health, and housing.

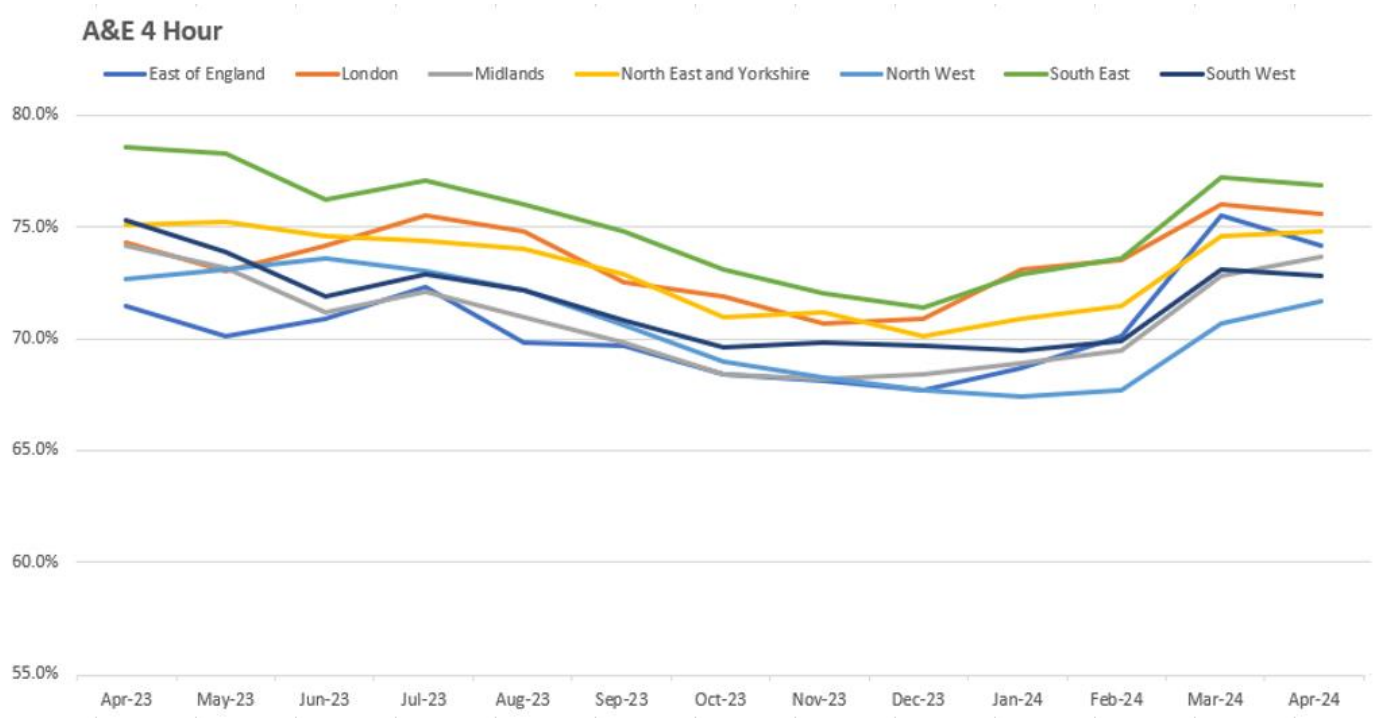
b) Performance data

A wide range of routine data collected by NHSE offer insights into performance in the North East and Yorkshire.

Richard Barker explained how in 2023/24, performance on key national targets such as the percentage of patients seen and treated in A&E departments within four hours and the number of people waiting for elective care for 78 weeks and over – two of the most significant targets used to assess performance – were among the best in England, as illustrated in the following figures.

78+ Week Waiters





Financial performance was also strong with three out of four ICBs hitting their targets for the year compared with 17 out of 42 nationally (Anderson, 2024). At this stage, whilst each system in England is currently projecting a financial deficit during 24/25, the level of deficit and required support (as a percentage of allocation) in the North East and Yorkshire is the joint lowest in the country.

Other data confirm these achievements, for example in falling numbers out of area placements for patients with mental health needs and the treatment of patients with high blood pressure in primary care having returned to its pre-Covid level faster than the rest of England. Results of the annual NHS staff survey show the region performing in line with the rest of the NHS in most of the areas covered by the survey. Less positively, the region has relatively high number of inpatients with learning disability and autism at a time when national policy has sought to reduce reliance on hospitals.

It is important to recognise that regional comparisons may mask variations in the performance of ICBs and indeed places within ICBs. Examples include South Yorkshire missing its financial target in 2023/24 and Humber and North Yorkshire having the lowest performance in the region on A&E waits of four hours. And while the North East and North Cumbria is a high performing ICB, north Cumbria faces greater challenges than the north east.

The attached figures show NHSE's performance ratings for NHS providers and ICBs and how they compare with other regions. The ratings for ICBs confirm the achievements of the North East and Yorkshire. Richard Barker argues that available data suggest that the region and its ICBs are delivering positive results, at least in part because of its approach to system leadership.

NHS Provider Segmentation – May 2024

North East and Yorkshire

Segmentation	NHS providers in segment	% NHS providers in Segment
1	2	6.1%
2	14	42.4%
3	17	51.5%
4	0	0.0%
	33	100.0%

England

Segmentation	NHS providers in segment	% NHS providers in Segment
1	29	13.8%
2	85	40.5%
3	75	35.7%
4	21	10.0%
	210	100.0%

NHS ICB Segmentation – May 2024

North East and Yorkshire

Segmentation	NHS ICBs in segment	% NHS ICBs in Segment
1	0	0.0%
2	3	66.7%
3	1	33.3%
4	0	0.0%
	4	100.0%

England

Segmentation	NHS ICBs in segment	% NHS ICBs in Segment
1	1	2.4%
2	14	33.3%
3	24	57.1%
4	3	7.1%
	42	100.0%

c) *Progress on regional priorities*

The picture painted by performance data can be supplemented by work in each of the priority areas led by ICB chief executives.

Digital health

On digital, Stephen Eames reported progress in delivering new or upgraded electronic patient records to providers in the region, with £150m invested over a three-year period. By the end of 2025/26, most of providers will have a mature electronic patient record and will have reduced the number of different systems across the region to support improved clinical integration.

The region is also leading the way in the implementation of patient portals and access to these via the NHS App, and in the use of data for discharge. Longer term, the aim is to better use data to support population health management and additional investment in digital and data is planned from 2025/26 to support improved productivity.

Primary care and community services

On primary care and community services, Gavin Boyle described progress in:

- Enabling the delegation of commissioning for Dentistry, Optometry and Community Pharmacy to ICBs.
- Preparation for Winter including the successful introduction of Acute Respiratory Illness (ARI) Hubs and development of our operational resilience and response arrangements.
- Workforce development including the wide adoption of Additional Roles Reimbursement Scheme (ARRS) roles and improving GP retention.
- Implementation of national recovery plans for primary care and dentistry.
- Developing clear priorities for community services.

Two region wide conferences have allowed frontline colleagues to showcase innovative work, spread the learning and engage directly with national leaders who have supported the events. Gavin explained that 'by coming together we can develop an approach which is coherent, where we can share learning and work collectively to find solutions at scale'.

Mental health, learning disability and autism

On mental health, learning disability and autism (MHLDA), Sam Allen reported facilitating a region wide session with NHS providers of mental health and learning disability services and following this progress made with:

- Improved data platform for the region for data at place / system level across the MHLDA work using statistical process control to identify change. This was described as a significant step forward. A regional data group continues to identify how data quality can be improved and data collection more meaningful to support improvement.
- A regional programme supporting inpatient quality transformation work. This has included a series of workshops sharing learning and good practice and progressing to use the national commissioning framework for inpatient services.
- A sustained focus on eliminating out of area placements and development of regional collaboratives and data packs to support improvement. This work has linked with the Association of Directors of Adult Services.
- Post Covid recovery of the targets, which includes those linked to physical health checks for serious mental illness in the majority of places, access for children and young people and early intervention.

Workforce

On the workforce, Rob Webster explained that before becoming statutory bodies, ICSs worked with the regional team on the workforce requirements to deliver the Long-Term Workforce Plan. A regional people board (RPB) was then put in place, co-chaired by an ICB chief executive and a trust chief executive. Examples of collaborative work, include:

- work on attendance and inequalities that described how the region has a one percent higher sickness absence rate than the England average, meaning 2,200 more staff are absent, the impact of this and a range of initiatives to tackle the issues;
- the codesign and development of a strategy on delivering broader participation in apprenticeships, linked to the national strategy;
- coordination of regional leadership development programmes to support the talent pipeline and broadening representation.

The work of the RPB has been affected by organisational change in NHSE, Health Education England and ICBs. Reductions in management costs and associated developments have taken senior HR leadership and capacity from the work.

More recently, the Board has focused on developing the social care workforce; coordinating, growing, and improving placements within all settings to support the expansion of training; developing system leaders at all levels; and focusing on equality, diversity and inclusion. This work involves all partners across health, local government and the third sector. It complements work done in systems and employers and seeks not to duplicate.

Recovery from the pandemic

Work on elective care illustrates progress in recovery from the pandemic. A regional task force on elective recovery was supported by the four ICBs and provider collaboratives, for example to share good practice based on Getting it Right First Time (GIRFT) principles, led by clinical leaders and supported by systems. This included colleagues visiting other systems and learning from these visits in developing their own approaches. System leadership of elective recovery contributed to elimination of 104 and 78 week waits and reduction in the numbers of patients waiting over 62 days for cancer treatment in the region.

The regional elective programme team leads, and provider collaborative elective programme leads meet every quarter to share learning and agree on areas for collaborative work across the region. This includes work to identify specialties that face particular challenges in sustainable elective recovery, for example complex endometriosis. Mutual aid has contributed to the reduction of long waits in a number of specialties, an example being Leeds Teaching Hospitals NHS Trust supporting York and Scarborough NHS Foundation Trust in work across two ICBs.

A different example of recovery that illustrates the benefits of subsidiarity and place-based working – key features of the 4+1 arrangement - is the integrated intermediate care system known as HomeFirst developed by the Leeds Health and Care Partnership (one of five place partnerships in West Yorkshire). The system involves the city council, Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, the ICB, primary care and VCSE sector organisations with the support of Newton Europe.

HomeFirst encompasses five interdependent projects: active recovery at home through community rehabilitation and reablement; reduced length of time in community bed settings: timely transfers of care from hospitals; reduced hospital admissions by offering enhanced care at home; and active system leadership. The overall ambition is to develop a sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence.

HomeFirst recently received attention in the general election debate as an example of how the NHS should work more closely with social care and other partners to deliver the right care in the right place at the right time.

What are the lessons from the North East and Yorkshire?

The decision to establish four ICBs covering relatively large populations and with recognisable identities was an important foundation for the 4+1 arrangement. This decision helped attract experienced leaders to ICB chief executive roles and began the process of building the capabilities required to discharge their functions. It also meant that system leadership involved five people rather than a larger and potentially more diffuse team. The role of ICB chief executives in leading work across the region contributed to the blurring of boundaries between the regional team and ICBs.

Another foundation was the secondment of senior regional staff to serve as locality directors in ICBs. These staff and their teams were instrumental in developing capabilities around planning and performance, recognising that some were more effective than others in these roles. Their key contribution was to facilitate the transfer of skills and experience and to act as a channel of communication between the regional team and STPs/ICSs in the early stages.

A recurring if unsurprising theme is the calibre of the leaders and staff involved in system leadership in the North East and Yorkshire. Their experience made it possible for ICBs to work as equal partners with each other and the regional team and take shared responsibility for the work reported here. It contributed to the commitment to co-production of the leadership arrangement and the change in culture described in this report.

The way in which the 4+1 arrangement has been adapted in each of the four ICBs means that there is a growing cohort of people involved in system leadership across the region. This matters because the commitment of top leaders may be necessary but is far from sufficient if the full potential of ICBs and Integrated Care Partnerships (ICP) is to be realised. The emerging and evolving social movement of system leaders in the region creates a strong foundation on which to build.

Richard Barker's long tenure in regional roles meant that he had a wealth of experience and insight on which to draw in developing system leadership. Importantly, colleagues with knowledge of the NHS described him as having a different style and personality to some other regional directors, for example in his commitment to collaboration and to building the 'one team' advocated in NHSEs operating framework. He also earned the respect of colleagues.

Richard's vision was warmly embraced by ICB chief executives. This entailed learning by doing in which time for reflection on how the arrangement was evolving occurred alongside doing the work. As this report has shown, the principles of system leadership were not limited to the 4+1 but also applied to colleagues working in finance, performance, and other functions, as well as within ICBs. As a result, the region has largely avoided the confusions on roles and accountabilities identified in the Darzi report, for example in the way in which performance management of providers is undertaken.

The 4+1 arrangement sheds light on and connects to other studies on leadership and systems working. They reinforce the findings of research by Peter Senge and colleagues who argue that 'transforming systems is ultimately about transforming relationships among people who shape those systems' (Senge et al, 2015). While these authors warn that 'many otherwise well-intentioned change efforts fail because their leaders are unable or unwilling to embrace this simple truth', the evidence presented here shows this is not inevitable.

The explanation may be found in part in Richard Barker's own leadership style. Richard explained that he was able to achieve more as regional director by sharing power and responsibility with STP/ICS chief executives than by holding on to it. In his words, 'if you delegate, you don't give away power, you become more powerful'. He had observed this at an early stage in his career in the North of England when working with an experienced regional chair and chief executive.

This is in line with Matthew Barzun's writings which argue that constellations of leadership are more effective in delivering public or private goals than power that is exercised through a hierarchy. Constellations eschew both top-down and bottom-up mindsets by working as flexible and dynamic networks in which there is no single point of control (Barzun, 2021). Several constellations played a part in the North East and Yorkshire including provider collaboratives and place partnerships. Taken together, they helped moderate the negative effects of silo working, described by Gillian Tett in her work (Tett, 2015).

Related to this, the 4+1 arrangement illustrates the value of establishing a ‘team of teams’ to lead change. This phrase was coined by General Stanley McChrystal to describe changes in the United States Army in response to new terrorist threats. It entailed breaking down silos, shortening lines of communication within the command structure, and decentralising managerial authority to enable ‘the disciplined practice of empowered execution’ (McChrystal, 2015).

Emily Lawson described how a similar approach was used in the Covid-19 vaccination programme that she led before she became chief operating officer in NHSE (Lawson,2021). Similar principles were evident in the NHS’s overall response to the pandemic, for example in the role of local resilience forums and other partnership bodies. The challenge is to build on this experience in the absence of an external threat such as Covid-19, and ensure ‘agile execution’, which research shows is a key characteristic of effective teams in complex systems (Edmondson and Harvey, 2017), is sustained.

Ralph Stacey’s work on leadership was cited by Stephen Eames in support of the 4+1 arrangement and specifically the value of mutual accountability for performance among leaders. As Stacey argues, leadership is less a rational, analytical process than an activity characterised by uncertainty, complexity, and negotiation. This underlines the importance of relationships between leaders, how they communicate with each other, and trust (Stacey, 1993).

An important distinction can be made between regulated trust and real trust to borrow from the analysis of Richard Reeves and Ed Smith (2006). Those involved in the 4+1 arrangement emphasised the role of real trust in contrast to some external stakeholders who questioned whether it would be sufficient in an NHS that has relied heavily on regulation to achieve its goals. The proposed oversight framework for ICBs risks tilting the balance back to regulation in the view of some interviewees.

The work reported here illustrates that change in the NHS can be delivered through self-improving systems, as advocated in the Hewitt Review and elsewhere, and does not have to be driven through a management hierarchy and performance management. Elinor Ostrom’s seminal research on ‘governing the commons’ is a reminder that self-organising systems work in conditions of complexity in which there are many sites of decision making, each with a degree of autonomy (Ostrom, 2010). These ‘polycentric’ systems, as Ostrom describes them, require leadership skills and practices that are uncommon in the NHS.

The 4+1 arrangement illustrates one way of developing and applying these skills and practices. The systems that make up the North East and Yorkshire region include other examples, such as the West Yorkshire Alliance of Acute Trusts and the leadership and improvement community in the North East and North Cumbria. Experience shows that real trust develops through repeated interactions between leaders to demonstrate the credibility of shared commitments and build confidence between peers, underpinned by psychological safety.

Where next?

What more can be achieved as the NHS seeks to move beyond the disruptive effects of the Covid-19 pandemic and industrial action - which account for around half of the time since STPs started the journey described in this report? More specifically, how can the benefits of system leadership be realised in more settled circumstances, and what would success look like?

Part of the answer is to create time and space both for the recovery of NHS services and realising the potential of ICSs in improving population health through ICPs. Both challenges call for an NHS that is improvement-led and not simply performance-led in line with the aspirations behind NHS Impact, NHSE's improvement model. The development of a learning and improvement community in the North East and North Cumbria is an advanced example of how this is beginning to happen and is not unique (Ham, 2023b).

Work to deliver NHS targets *and* longer-term objectives is a core challenge facing ICB leaders. Those involved in the 4+1 arrangement are clear that both are important with delivery of short-term priorities creating permission and time for leaders to work on long-term objectives. They also emphasised that the latter will only be delivered through a constancy of purpose in partnership with local authorities, VCSE organisations and others.

The case studies in this report illustrate the work being done to improve population health. They reflect the way in which the four purposes of ICSs are being pursued, as in work on the health of children and young people in South Yorkshire and health inequalities in West Yorkshire. The attention being given to population health in these, and other systems shows how ICPs, and ICSs are working on the determinants of health and wellbeing.

This is important because of the risk that the 4+1 arrangement, with its focus on NHS priorities through the regional team and ICB chief executives, might result in the wider responsibilities of ICSs and the role of other partners being relatively neglected. This has not been the experience to date and the leadership role of local authorities is evident not only in ICPs but especially in place-based partnerships within ICSs. The contribution of VCSE organisations is also apparent, for example in the Humber and North Yorkshire VCSE collaborative.

Gavin Boyle argued that the emphasis on subsidiarity in the North East and Yorkshire, in which place-based partnerships have a central role, is a counterweight to central direction and upwards accountability through the NHS hierarchy. In his view, the latter often overlooks other partners whose contribution is vital in addressing major challenges in areas such as urgent and emergency care, the assessment and treatment of people with neurodiversity, and out of area placements in mental health services.

From this perspective, devolved decision making, and local accountability are essential if non-NHS partners are to be fully engaged. Rob Webster echoed this point, arguing that elected mayors in West Yorkshire and other areas, together with devolution of decision-making, reinforce the relevance of the 4+1 arrangement and the development of system leadership in the North East and Yorkshire. Progress would be even faster if oversight and regulation by national bodies were reduced in line with the findings of the Darzi report to enable system leaders to look out more to their communities and reduce pressures on those described in the report as 'doing the work'.

The story of ICSs is one of discovery and not design with limited central prescription in the early stages. For the most part, there has been sufficient latitude for ICSs to determine how they work and the priorities they should pursue, rather than being required to follow a blueprint handed down by others. This places a premium on ICSs sharing their work, collaborating with peers, and lending their experience to support challenged systems – the peer learning advocated in the Hewitt

Review. Some of this has started to happen in the work of the NHS Confederation and the Q community.

Whatever direction these changes take, a case can be made for national NHS leaders to learn from the 4+1 arrangement by adapting it in their work with regions and ICBs and making the aspiration to work as ‘one team’ the reality at all levels. System leadership must be embedded throughout the NHS, supported by a structured organisational development programme of the kind promised, but not yet delivered, to support the new NHSE operating framework. A key lesson from the North East and Yorkshire is for leaders to commit time to making this happen and to build relationships and trust with their peers.

What then are the implications of the work reported here for the future roles of NHS regions and ICBs? As noted at the outset, concerns about potential duplication and confusion of responsibilities have been apparent for some time. The ability of ICBs to take on a wider range of functions and to work at scale suggests that a review of the number of regions and ICBs in England may be needed, not least given the need to keep management costs under control and ‘ensure the right balance of management resources in different parts of the structure’ as advocated in the Darzi report.

Liam Donaldson, chair of North East and North Cumbria, suggested that having four regions instead of seven and aligning ICBs with populations of between two and three million based on identifiable communities would have merit. As with any reorganisation, there are risks in embarking on changes of this kind, not least distracting leaders from focusing on finances, performance, and patient care at a critical time. These risks will need to be managed carefully if a decision to restructure is taken.

Last but not least, on any reasonable interpretation, the North East and Yorkshire has worked consistently in taking forward the plans set out by NHSE in its original prospectus for ICSs, and its elaboration in NHSE’s operating framework and the Hewitt Review. This report was commissioned and researched in the spirit of the NHS becoming a learning organisation and a belief that much can be gained by recognising the value of ‘all teach and all learn’.

It will have served a useful purpose if it helps leaders in the region reflect on their leadership arrangements and how they can be strengthened. Other regions may also wish to use the report to take stock of their arrangements. As the Darzi report noted, ‘The vast array of good practice that already exists in the health service should be the starting point for the plan to reform it’.

Annex A

North East and North Cumbria Health and Care Partnership is one of the largest and most geographically dispersed ICSs in England. Serving more than three million people across over 5,000 square miles, a size comparable to Wales and the largest in England, and with a budget of £6.6 billion, the Partnership comprises 11 NHS trusts, 64 Primary Care Networks, and 14 Local Authority areas. The quality of health and care services is consistently rated among the best in the NHS, and the system is rated as two in NHSE's outcomes framework.

West Yorkshire Health and Care Partnership is an integrated care system serving 2.4 million people in Bradford District and Craven, Calderdale, Kirklees, Leeds, Wakefield District, and their surrounding areas across over 783 square miles. With a budget of £5.3 billion, the Partnership comprises 10 NHS trusts, 52 primary care networks, two community interest companies, over 10,000 voluntary sector organisations and six local authority areas. Most organisations are assessed as high-performing, and the system was rated as two in NHSE's outcomes framework.

Humber and North Yorkshire Health and Care Partnership serves 1.7 million people across 4,000 square miles in Hull, York, North Lincolnshire and surrounding areas with a coastline that stretches for 185 miles. It is the second largest ICB by land size in England. With a budget of £3.8 billion, the Partnership comprises seven NHS Trusts, 42 primary care networks, four community interest/not for profit providers, six Local Authority areas, and 14,000 voluntary sector organisations. The performance of individual organisations is variable with some high performing and others experiencing challenges. The system was rated as three in NHSE's outcomes framework.

South Yorkshire Health and Care Partnerships serves 1.4 million people in Barnsley, Doncaster, Rotherham, Sheffield, and surrounding areas over 559 square miles. With a budget of £3.8 billion, the Partnership comprises seven NHS trusts, 36 primary care networks, four local authority areas, and over 6,000 voluntary sector organisations. Most organisations are assessed as high-performing, and the system was rated as two in NHSE's outcomes framework.

References

Anderson H (2024) Rise in ICSs missing financial plans despite NHSE claim more would deliver, HSJ, 3 June

Barzun M (2021) The Power of Giving Away Power, Harper Collins

Darzi A (2024) Independent investigation of the National Health Service in England

Edmondson A and Harvey J (2017) Extreme Teaming, Emerald Publishing

Ham C (2023a) Accountability and autonomy in the NHS in England, NHS Confederation

Ham C (2023b) Improving health and care at scale: learning from the experience of systems, NHS Confederation

Hewitt Review (2023) An independent review of integrated care systems

Lawson E (2021) Coronavirus: How to vaccinate a nation, Science Museum Group

McChrystal S (2015) Team of Teams: New Rules of Engagement for a Complex World, Penguin Random House

NHS England (2021) Integrated Care Systems: Design Framework

NHS England (2022) Operating framework for NHS England

Ostrom E (2010) Beyond Markets and States: Polycentric Governance of Complex Economic Systems, American Economic Review

Reeves R and Smith E (2006) Papering Over the Cracks? Rules, Regulation and Real Trust, The Work Foundation

Senge P, Hamilton H, and Kania J (2015) ‘The Dawn of System Leadership’, Stanford Social Innovation Review, Winter

Stacey R (1993) Strategic Management and Organisational Dynamics, Pitman Publishing

Tett G (2015) The Silo Effect, Little, Brown

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Interviewees (excluding those who asked not be identified)

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Gavin Boyle, CEO, South Yorkshire ICB

Pearse Butler, Chair, South Yorkshire ICS

Erica Daley, NHS Place Director Hull, Humber and North Yorkshire Health and Care Partnership

Liam Donaldson, Chair, North East and North Cumbria ICB and ICP

Stephen Eames, CEO, Humber and North Yorkshire ICS

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