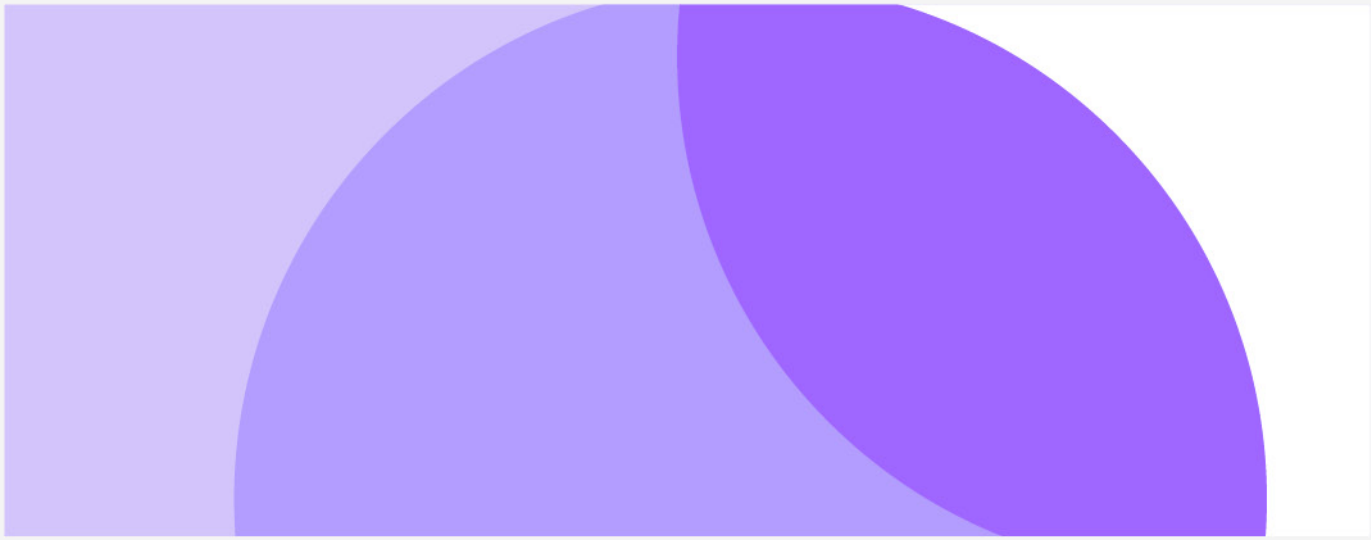

# Strategic Health Authorities and Regions

## Lessons from history

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# Contents

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# Introduction

In April 2019, NHS England and NHS Improvement aligned to operate as a single organisation, resulting in the creation of seven regional teams. We thought it would be useful to identify some of the lessons from the operation of previous incarnations of the intermediate tier – the structures that sit between the central headquarters of NHS England/ Improvement ('the centre') and local organisations.

We have looked for lessons in the period 1996–2012, when the structures and systems bore the most resemblance to those of the present. We have particularly focused on the period from 2002 as this appears to have the most similarity to the current arrangements. Because of their very brief existence, mostly concerned with appointments of strategic health authority (SHA) staff and setting themselves up, the Directorates of Health and Social Care are not considered in this report.

We have interviewed ex-chief executive officers (CEOs) or directors in the regional tier and a range of people who were in other parts of the system during the period under study. We have reviewed the rather limited literature in this area. We have also built on analysis of the history of the regional tier and its relevance to integrated care systems by the Policy Research Unit in Health and Social Care Systems and Commissioning (PRUComm).[1]

# A brief history, 1996–2012

The 1946 National Health Service Act established the regional tier in the NHS as regional hospital boards, and these were not reorganised until 1974 when 14 regional health authorities were formed. During the late 1980s/early 1990s, there was some rationalisation and the stripping out of a number of support functions such as architects, estates management and health promotion.

It was not until 1996 that major structural change was implemented when eight regional offices replaced the 14 regional health authorities. This was the first time that the regional tier in the NHS reported directly to the Department of Health rather than having a board and non-executive members. In 2002, the implementation of the 2001 Health and Social Care Act created 28 SHAs and four Directorates of Health and Social Care. The latter were created against the wishes of the then secretary of state and were rapidly abolished, lasting only 18 months.

The SHA CEOs were appointed after a wide-ranging search and selection process and did not represent much continuity with the previous regions, not least because some were allocated to areas they were not familiar with. A number of the new CEOs had previously

[1] Lorne C, Allen P, Checkland K, Osipovič D, Sanderson M, Hammond J and Peckham S (2019) *Integrated Care Systems: What can current reforms learn from past research on regional co-ordination of health and care in England?* PRUComm. https://prucomm.ac.uk/assets/uploads/PRUComm_-_Integrated_Care_Systems_-_Literature_Review.pdf

been CEOs of health authorities, large trusts and in one case a primary care trust (PCT), rather than having been regional-level staff.

However, many people from previous regions were redeployed into the SHAs and this meant that, in some places, particularly where there was a strong organisational culture associated with the region, many aspects of the previous region survived. But in general the CEO level was not made up of people with experience of navigating the national level or frequent work with policy makers and politicians, which required some rapid learning and sometimes led to problems.

In 2001, the report *Shifting the Balance of Power within the NHS: Securing delivery*[2] set out the role of SHAs, which included the following:

> *Strategic Health Authorities will provide strategic leadership to ensure the delivery of improvements in health and health services locally by PCTs and NHS Trusts within the national framework of developing a patient-centred NHS. They will lead the development and empowerment of innovative and uniformly excellent frontline NHS organisations. The wider span of control will enable Strategic Health Authorities to consider the overall needs of the health economy across primary, community, secondary and tertiary care, and work with PCTs and NHS trusts to deliver a programme to meet these needs.* (p. 16)

The main areas of activity were to be:

- 'creating a coherent strategic framework for the development of services across the full range of local NHS organisations' (p. 16)
- performance management
- brokering solutions where there were disputes
- building capacity and supporting performance improvement
- preparing and delivering cohesive strategies for capital investment
- working with workforce confederations (in some unspecified way)
- ensuring effective professional leadership across their area.

The initial conception for SHAs was that they were to be enabling and supportive rather than being in a strict hierarchical relationship with PCTs and hospital trusts. However, as a more performance-oriented approach asserted itself over time, a more hierarchical way of operating became the norm.

In parallel with the development of the SHA role, the period was notable for the number and scale of 'vertical' programmes designed to target particular areas such as cancer, mental health, cardiovascular disease and diabetes – and which therefore cut across the hierarchical structure of the rest of the NHS.
During the period 2002–06, the NHS made good progress in implementing the 2000 *NHS Plan*,[3] albeit with record increases in funding and at a pace that ministers found to be

[2] Department of Health (2001) *Shifting the Balance of Power within the NHS: Securing delivery*. Department of Health. https://navigator.health.org.uk/content/shifting-balance-power-within-nhs-2001. Accessed 30 March 2020.

[3] Department of Health (2000) *The NHS Plan: A plan for investment, a plan for reform*. Department of Health. https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960. Accessed 30 March 2020.

frustratingly slow. Hotspots of poor performance remained but there was a general and significant improvement in performance in areas such as waiting times. A view emerged at the top of the NHS that 28 SHAs was too many and, as CEOs left or were removed, the management of adjoining SHAs was merged.

A pivotal event seems to have been a loss of financial control in the NHS in 2005/06 and a failure of the management system to respond quickly or firmly enough. In its 2006 *NHS Deficits* report,[4] the House of Commons Health Select Committee concluded that: 'In recent years the NHS has veered from one priority to the next as the political focus has changed. It has concentrated on meeting targets with too little concern for finance' (p. 5). It said that there was 'evidence of a failure of financial management. The most basic errors have been made: there are too many examples of poor financial information, inadequate monitoring and an absence of financial control' (p. 5). It also noted that 'SHAs failed to monitor the trusts' activities adequately and the Department failed to check the work of SHAs' (p. 6).

This – combined with some ministerial ambivalence about the effectiveness of SHAs and a promise in the 2005 general election to reduce NHS management spending – led to a reduction in the number of SHAs to 10 from July 2006.

At the same time, there were other important changes that had implications for the functioning of SHAs:

- **Span of control.** The number of PCTs was reduced from 302 to 152 in 2002 (although there had been a continuous process of mergers). At the same time, an increasing number of providers were achieving foundation trust status. Both of these changed the nature of the relationships of the intermediate layer to local organisations.
- **Reporting relationships.** The roles of CEO of the NHS and permanent secretary of the Department of Health were separated and the reporting relationship for SHA CEOs moved to the CEO of NHS rather than to the deputy role.
- **Top team changes.** The top management team (consisting of senior officials at the Department of Health, SHA CEOs, clinical directors and others) was reduced in size from often being well over 50 people during 2002–06 to a much more manageable number. This was accompanied by the development of procedures to reduce the traffic of policies, instructions and requests for information to the service from the Department of Health (a 'Gateway' process). As part of their new roles, the SHA CEOs took responsibility for some areas of national policy or development work on behalf of the group rather than focusing on their geographical patch. This wider focus had also been a feature of the pre-2002 model on occasions.

After 2006, financial control was gradually restored by action at national, SHA and local levels and key targets for access and other areas were generally achieved. The Department of Health developed a 'single operating model' and, during 2009, SHAs were subject to an assurance process[5] to examine their performance and their role in developing their systems

[4] House of Commons Health Committee (2006) *NHS Deficits*. The Stationery Office. https://publications.parliament.uk/pa/cm200607/cmselect/cmhealth/73/73i.pdf

[5] Department of Health (2009) *SHA Assurance*. Department of Health. https://webarchive.nationalarchives.gov.uk/20130124054423/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114912.pdf

and to provide developmental feedback. David Nicholson, CEO of the NHS at the time, said that the recession was one of several factors that had changed the context: "Part of the reason for doing it is that the SHAs' responsibilities are changing as we speak."[6]

In this period, the Department of Health expected SHAs to develop a more directly strategic approach than was the case in the earlier period. This followed the launch of Lord Darzi's *NHS Next Stage Review* report in 2008.[7] There were some examples of successful strategic changes being introduced, for example the implementation of trauma networks, the redesign of stroke services in London and changes to the shape of services in Manchester. But many strategic issues remained unresolved. This was not helped by there being a general election during the period – in 2010 – followed by the introduction of stricter controls on reconfiguration by the incoming government,[8] restrictions of capital spending and then an almost two-year period of uncertainty after the government announced its intention to abolish SHAs in May 2010.[9] This led to SHAs being 'clustered' from 10 to four in October 2011.[10] They were finally abolished on 31 March 2013.

# Key lessons

The NHS has had some sort of unified regional tier for much of its existence and interviewees were very clear that, in a system as large and complex as the NHS, some form of intermediate tier is unavoidable. Indeed, other NHS-type systems in Europe often also have strong regional or intermediate bodies. The reasons for this relate to both the need to have a manageable span of control for reporting relationships and the need to be closer to the operational level than is possible in a large geography. The abolition of SHAs in 2013 demonstrated how the intermediate tier had, at its best, been adding value by creating coherence in local systems, providing objective information and giving strategic leadership, and how this was missed once they were abolished.[11]

# Clarity of purpose

The fact that there was a strong logic for the intermediate tier did not necessarily mean that it was always fit for purpose or that there was clarity about what its role was. This had

[6] Evans R (2009) 'David Nicholson warns SHAs not to be defensive over visits', *HSJ*, 4 June. www.hsj.co.uk/david-nicholson-warns-shas-not-to-be-defensive-over-visits/5002277.article. Accessed 30 March 2020.

[7] Department of Health (2008) *High Quality Care for All: NHS Next Stage Review final report*. Department of Health. www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report. Accessed 30 March 2020.

[8] West D (2010) 'NHS service change plans will face stricter controls', *HSJ*, 27 May. www.hsj.co.uk/acute-care/nhs-service-change-plans-will-face-stricter-controls/5015170.article. Accessed 30 March 2020.

[9] Gainsbury S (2010) 'Thousands of jobs at risk as strategic health authorities face axe', *HSJ*, 26 May. www.hsj.co.uk/thousands-of-jobs-at-risk-as-strategic-health-authorities-face-axe/5015194.article. Accessed 30 March 2020.

[10] Calkin S (2011) 'SHA clustering arrangements announced', *HSJ*, 14 July. www.hsj.co.uk/sha-clustering-arrangements-announced/5032560.article. Accessed 30 March 2020.

[11] Timmins N (2016) *The Chief Executive's Tale: Views from the front line of the NHS*. The King's Fund. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/The-chief-executive-tale-Kings-Fund-May-2016.pdf, p. 17.

to be purposefully designed, agreed with stakeholders and consistently enacted. The extent to which this was done was variable and the purpose shifted over time – for example from non-hierarchical overseer of a devolved system in the early 2000s to hands-on performance manager later in the period.

Interviewees thought that having a clear purpose was important but it was not always as clear as it needed to be. In the late 1990s, there was some uncertainty about the role of the regional offices, in particular whether they were regulators, managers or planners, and whether they should be supporting or facilitating trust mergers.[12]

The creation of SHAs took place during a more general major restructuring. This process seems to have been somewhat confused and Geoffrey Rivett comments that 'responsibilities were reallocated and the absence of clear guidance gave an impression of making things up as one went along'.[13]

This initial problem seemed to get addressed to an extent. The requirement for the new SHA CEOs to develop 'franchise plans' may have helped with this but the exact parameters of responsibility were not always clear, particularly when the issues were highly contentious. One CEO of a particularly troubled area said: "I was told you've got to fix all of this but it was not made clear what tools I had and what accountabilities I had to do it."

In addition, the multiple layers of the Department of Health, the NHS CEO and team, the Directorates of Health and Social Care (initially), SHAs, PCTs and a number of vertical programmes led to some confusion about who was responsible for what. This was particularly the case between 2002 and 2006 when there were tensions between the SHAs and the Modernisation Agency (created in 2001 to lead programmes of improvement) over responsibility for improvement and about how their work meshed with local priorities.

> *I think the greatest reason for all those tiers being ineffective is they can't work out what the value added is of that level and so they tend to then meddle in the level beneath's brief or even the level beneath that or they turn into a duplicative governance structure that just adds another layer of reporting, not usually the same reports that you've written for the previous level, so it turns into an industry in and of itself.*

Some SHAs took more direct control of this issue and had well-developed systems and schemes of delegation, which, combined with rigorous management processes, were seen as being an important source of effectiveness.

Consistency of purpose over time was also seen as important in delivering strategic change but also in developing relationships of trust with other stakeholders.

[12] Dopson S, Locock L and Stewart R (1999) 'Regional offices in the new NHS: an analysis of the effects and significance of recent changes', *Public Administration*, 77(1), 91–110. doi: 10.1111/1467-9299.00145.

[13] Rivett GC (no date) 'Chapter 6: Labour's decade', in *National Health Service History*. http://nhshistory.net/chapter_6.html. Accessed 30 March 2020.

# Starting points

## Context matters

The operating model that SHAs adopted was, in theory, meant to be quite standardised. However, in practice there was a lot of variation. This reflected important differences in their starting points in terms of the place, their history, size and external relationships. This variation reduced in the move from 28 to 10 SHAs but still the ethos, operating model and organisational design of each SHA varied significantly depending on the context and the personal preferences and style of the CEO.

This meant that some SHAs had to put much more time and effort into developing their operating model and building their organisation. In some cases, SHAs started without teams, offices or basic infrastructure, whereas others inherited almost completely functional organisations. This was not always taken into account. Speaking of the 2002–06 period, one CEO said "*nobody ever recognised where you started from; the context was always different, but they [the centre] assumed that you could all get to the same place at the same pace*".

## Place and history

Interviewees thought that the intermediate tier worked better when it was mapped to a geography that was coherent and made sense to people living in it. For example, the North East, while large and quite heterogeneous, was nevertheless recognised by those involved as having a community of interest and being a real place. Places that were less coherent and therefore often lacked a history of working together needed much more work to create a sense of a leadership community and shared approaches. Where this was the case, this process took considerable time. For example, the decision to split London into five SHAs meant that there was a significant loss of momentum compared with the period when there was just one authority for London.

The 10 SHAs often needed to divide their patch into a number of areas to recognise separate geographical identities and this too increased the amount of effort required to achieve joint working.

SHAs that inherited the shape of those that had gone before and where there was a strong organisational culture found that this persisted for quite some time following the creation of the new organisations. This had both positive and negative consequences depending on what was inherited and its fit with the new culture. For example, the North East had a strong culture of collegiate working, a focus on performance and independence. This seemed to survive multiple reorganisations.

## Size

As with other levels of the NHS, there is no ideal size of organisation that is appropriate for all the tasks that intermediate tiers are required to perform.

The advantage of the model with 28 SHAs was that the SHAs were able to have a degree of closeness to the issues, which helped inform decision-making and performance management. However, this came with a downside in risking becoming too involved in issues that should have been left to local management. It also created too large a span of

control for the Department of Health (often referred to as the 'centre'), which had too many organisations to oversee.

The move to 10 SHAs from 28 disrupted some of this closeness but interviewees thought it was possible to recreate mechanisms that allowed for CEO–CEO contact and an understanding of the local context but without some of the risks of being overly close that some of the 28 SHAs experienced. The reduction in the number of PCTs and the growth in the number of foundation trusts blunted some of the impact of the changes in structure on the span of control of the SHAs.

The larger footprints gave a little more detachment in difficult decisions on reconfiguration and were more appropriate for looking at issues that spanned large populations, such as the reconfiguration of stroke services in London or the planning and commissioning of specialised services.

### Individual style

Many interviewees commented on the extent to which the individual style and approach of the CEO influenced the whole approach of the organisation, although it was also the case that areas with a particular management culture tended to appoint CEOs who fitted with this. This was generally seen as unavoidable and not necessarily a problem as it allowed the approach to fit the local way of working.

The introduction of a 'single operating model' after 2006 regularised some aspects of operations but did not eliminate different styles and ways of interacting with the service.

## Relationships upwards

### Part of the centre and part of the service

Between 2002 and 2006, the 28 SHAs were, in the view of most of our interviewees and despite some rhetoric, outposts of the Department of Health. They reported to the deputy CEO of the NHS while still having a board and chair (see below).

Interviewees were all clear that they operated in a somewhat delicate space in which they had to manage upwards and downwards; and not withstanding their status as outposts, a number said that they were also clearly a part of and representative of the local system as well. This could be a source of tension but also brought some added colour to conversations about policy design and implementation – particularly as SHAs often took a lead in piloting or developing some policy ideas.

As noted above, the SHAs initially had limited experience of working with a direct interface with the Department of Health and, while they understood the importance of this, it was not necessarily easy to get clarity of direction, for example in the case of hospital rationalisation: "[A]s soon as I started pushing for parameters [for the changes being planned], the Department started backing away because they knew what's coming."

However, SHA CEOs in both periods did think that they had enough autonomy to allow them to act on local priorities and, in most cases, make some adaptations to national policy to fit local circumstances.

> *Having some sort of collective sense of what we were really going to work hard on this year, doesn't actually squeeze out local stuff. It might make it harder to pay attention to [it] depending on the situation of the SHA … in terms of money and performance.*

## The top team

The top team developed by NHS CEO Nigel Crisp from 2002 was very large and included a rolling cast of policy leads who understood that they needed to be there to influence and advance their policy area. An additional complication, discussed below, was the approach that different Secretaries of State took to their relationship with the service. While it might be expected that the early period of a new management structure will be difficult, the 2002–06 top team had longstanding problems characterised by a style that avoided conflict, low levels of trust and resistance to hearing difficult messages from the SHA CEOs and the service more generally.

During this period, the permanent secretary and CEO of the NHS roles were combined. As a result there was a view that, during the latter part of this period, Nigel Crisp was pulled into wider departmental and civil service issues at some cost to his NHS role.
The character and style of the secretary of state had a significant impact on the way the top team functioned. Alan Milburn was highly engaged and attended operational meetings, which he tended to dominate. Patricia Hewitt was concerned with policy. Others were less directly engaged.

From 2006, the 10 SHAs were more clearly part of the centre – while holding a strong brief for their areas, they were seen as equals in a smaller, more collegiate 'top team', with less competition between individuals and higher levels of trust than seemed to have existed before. The smaller size of the group appeared to have helped with this. Interviewees saw it as much more effective although not necessarily easy. David Nicholson's style seems to have allowed for more dissent and diversity of view:

> *He [Nicholson] had an incredibly diverse group of people to manage, which he clearly valued and would actively seek diversity in the team, even though there were moments when it was driving everyone mad, because everyone is so different. I'm pretty sure there were times where Nicholson adopted a solution and it wouldn't have been his first choice but because it built cohesion in the team, a better way forward.*

The calmer policy environment and lower level of spending also allowed for a more controlled approach to the development of policy, which, with the Gateway process (mentioned earlier), reduced the number of different objectives and created more clarity. One area mentioned by several interviewees was the crucial role of the deputy NHS CEO. This was John Bacon (2003–06) and then David Flory (2006–12). During John Bacon's tenure, the structure was designed so that the finance director reported to him and so was not on the board. The deputy role was probably over-burdened, having a number of central functions and 28 SHAs as direct reports. Both John Bacon and David Flory were highly

performance oriented but also had an important and helpful role in day-to-day liaison with the SHA CEOs. This was particularly the case with David Flory:

> *You can't expect to go and see the chief executive of the NHS every five minutes or be ringing him up all the time. It was very easy to just say to David, 'Look just level with me, what's happening with this? This is what I'm thinking, what do you think? Will you look over this? Will you talk to the team?' – that type of thing. He was a very, very good deputy, extremely good, very reliable and he accepted that we all had a direct relationship with David, he never tried to interfere in that and yet he was very happy to work as a colleague. And, he was also happy to work as David's [Nicholson] deputy and I think he managed the tension between those extraordinarily well.*

### Truth to power

In the period 2002–06, the SHAs sometimes had an important role in providing a reality check on some of the proposals, policies and targets emanating from the centre. During the later period, they were more part of the process and were more likely to be upstream so that there was less need for this. Interviewees highlighted incidents which suggested that this was not a comfortable process and unless done carefully it carried some risks. In 2003, concerns from the SHA CEOs about the feasibility of achieving waiting-time targets seem to have led to the secretary of state losing some confidence in their ability to deliver these key targets – particularly when this came during a period of record spending. In a second example, in 2005, concerns about the planning process and leadership approaches created splits within the group. Overall, the centre seems to have been uncomfortable with pushback on these issues:

> *If we decided en masse we will not put up with this … there was a real standoff because with the 28 of us saying no or yes … the centre really had to think very hard about how they dealt with that. … once we'd done that once or twice they didn't want that to happen again so they created agendas … in ways that avoided some of that real hard-edge debate and then there became less and less opportunity for the SHA chief execs to say 'well we think the agenda should have this on it'.*

The resistance to negative messages seems to have played a part in the late acknowledgement of the financial problem in 2005–06. Interviewees said that they had warned of a growing issue but this message did not seem to land with key members of the top team.

## System management

### Sense-making, buffering or censorship

In the 1980s and 1990s, the civil service saw some regions as a major block on policy implementation – selecting what should be implemented and ignoring directives that they did not think were relevant or useful. Our interviewees were clear that this was not generally the case and it was very rare for them to refuse to implement instructions from above. However, they did see that an important part of their role was prioritising and helping local leaders to interpret and make sense of the policies and directions being

received. Within the limits of policy that was sometimes over-specified, policy could also be adapted and modified but rarely subverted or ignored.

The implementation of 'Darzi centres' (in 2009) was an example where a policy was centrally imposed in a top-down and somewhat one-size-fits-all manner and where the SHAs found it difficult to adapt the policy to make it work due to the parameters that were set. Generally, targets that were apportioned to SHAs (or PCTs) on a simple basis without reference to the starting points of the areas in relation to the policy caused significant problems and cut across existing plans. There were, however, relatively few examples of this.

As noted above, both translation and prioritisation were important parts of the role and some SHA CEOs were keen to bring the conversation back to the patient or population:

> *[P]eople would say, 'Oh no, this is a political agenda', to which my response was always, 'Well how is relieving Mrs Snook of her pain or giving Mr Snook his eyesight back a political agenda?' And this was a function of the interpretation, so you could make all policies relate to the good of the patient, and once you got that, people got it.*

The sense-making role was valued by others, especially where it was combined with convening senior managers (CEOs, managing directors, directors of finance and so on) to discuss policy, debrief from national meetings and provide a steer on priorities. Providing a break on some of the ways that the centre approached performance management was also sometimes considered an important role:

> *[A]t times of pressure, the centre did basically adopt the default position of a sort of shouting-based performance management approach, and as I say, on occasions I took the decision whether I was going to pass that on or not depending upon the local organisation and the local chief exec but again I saw that as a legitimate part of my role.*

Being clear what to expect in the relationship was important and there was not always consistency:

> *One week you might have absolutely no contact with the Department, the next week you'd get 500 phone calls from different parts of the Department of Health, all clearly on their tick list of 'Have we checked up on this?' It was unfiltered everything and it was a big funnel and we were at the end of the funnel and one of our jobs it felt to me was to try and stop it from passing on out because if I'd have put that amount of stuff out into the field the PCTs particularly would have just collapsed I … it seemed to me that one of the markers of success of a regional level was managing that interface on behalf of the system you are responsible for.*

SHAs' ability to manage these pressures depended on their standing with the centre and their own performance record.

Poorly coordinated and highly burdensome requests for information is a consistent theme in any discussion of NHS performance management. Interviewees often said that they thought that the information requested was not being used or was simply about providing reassurance to the levels above, without adding any value to those who collected it. Often it would be in a format that was different from that requested by other regulators and did not

conform to what the organisation itself used. During this period, multiple reports were published[14] and repeated attempts to deal with this problem were made but largely do not seem to have made a difference. And the problem persists today, with the addition of long conference calls on emergency pressures that appear to add little value to the front line.

## Communication, convening and meetings

One important role of the SHA in both its incarnations was to bring together key players across local health care systems – from hospital CEOs and managing directors to directors of finance or nursing. This convening function meant that the SHA could be a useful conduit both for upwards communication to policy-makers in Whitehall and in transmitting messages from the NHS's central bodies down to local leaders. They also created a way for CEOs, managing directors, directors of finance and directors of nursing to meet and exchange ideas and intelligence. Meetings would cover performance issues but the style seems to have varied to the extent that individual organisations would be called out for good or poor performance. These meetings often seem to have been valued, as evidenced by the fact that many foundation trusts attended even though they were not required to. In addition, CEOs saw these as an important part of creating a local leadership community:

*We did our best work on improvement when we brought people together to develop solutions rather than just telling them what to do.*

## Financial brokerage

Financial allocations had been a regional responsibility but this power was not given to SHAs, with allocations being made directly to PCTs. Nevertheless, through a mix of informal and formal powers, SHAs did play an important role in smoothing financial issues. In some cases, PCTs were asked to 'voluntarily' agree to being top-sliced to create a development fund (for example in the North West from 2006) or, more controversially, to bail out organisations with serious financial problems or to allow for other brokerage (for example in London after 2008).

The financial freedoms that this created and the ability to invest or smooth the transition path of troubled organisations was seen as an important and valuable part of the SHA's role – even if the methods for achieving it were sometimes coercive. The SHAs themselves were also sometimes the recipients of this coercion:

*In 2005 when the financial wheels came off, everyone was told to do what Ian did, which was 'top slice' everyone… 'this' was an instruction…if you didn't put 'that' in your plan you would be challenged… we were just told it was happening…. Your job was to go and explain to your board why it was happening.*

It should be remembered that this was in the context of significant growth – the 'top slice' was new money on top of inflation.

[14] See, for example, NHS Confederation (2007) *The Bureaucratic Burden in the NHS*. NHS Confederation. www.nhsconfed.org/resources/2008/12/the-bureaucratic-burden-in-the-nhs. Accessed 30 March 2020; NHS Confederation (2013) *Information Overload: Tackling bureaucracy in the NHS*. NHS Confederation. www.nhsconfed.org/resources/2013/01/information-overload-tackling-bureaucracy-in-the-nhs. Accessed 30 March 2020. `

## Strategic change

The 28 SHAs were not initially seen as agents of major strategic change, not least because this was a period where the focus was on improvements in performance and implementing the 2000 *NHS Plan*.[15] During this period, a combination of the Modernisation Agency (established in 2001) and vertical disease programmes was perhaps more significant in driving change and this was sometimes a source of tension. The development of clinical standards in cancer (from 1999), for example, led to significant service changes and interviewees identified that a key role of SHAs was to broker agreements and try to overcome opposition to the changes from individual NHS organisations. This meant deploying a range of 'hard' (direct instruction and coercion) and 'soft' (support for capital spending, working through connections) influence, and this was one area where chairs had an important role.

The Independent Reconfiguration Panel – set up to consider contentious reconfiguration proposals in 2003 – provides a barometer of reconfiguration planning, as shown in Table 1.[16]

**Table 1: Independent Reconfiguration Panel activity**

| | |
|---|---|
| **2003/04** | Advice given to 5 areas (not including health and wellbeing boards) and 1 referral to the secretary of state |
| **2004/05** | Advice 5, referrals 3 |
| **2005/06** | Advice 4, referrals 7 |
| **2006/07** | Advice 7, referrals 10 |
| **2007/08** | Advice 10, referrals 10 |
| **2008/09** | Advice 13, referrals 8 |
| **2009/10** | Advice 26, referrals 5 |
| **2010/11** | Advice 20, referrals 7 (1 not on reconfiguration) |

As financial and workforce pressures grew, the SHAs had more direct involvement in strategic change, but the primary responsibility for planning this was still often located at PCT level, although it seems that NHS London took a more hands-on role. This is shown in the large increase in advice and referrals to the secretary of state over time.

Junior ministers had some relevance and influence during this period, particularly in the case of Lord Darzi (in post from 2007 to 2009), although this declined markedly over the period and in particular from 2010. Before this, ministers held a brief for a geographical patch as well as their own subject matter responsibilities. This and their position in the system meant that SHAs had an important role in supporting local systems making major strategic changes and, in some cases, leading these themselves. In this role they could provide a point of contact with national politicians. SHA chairs, depending on their

[15] Department of Health (2000) *The NHS Plan: A plan for investment, a plan for reform*. Department of Health. https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960. Accessed 30 March 2020.

[16] For more information on the Independent Reconfiguration Panel, see www.gov.uk/government/organisations/independent-reconfiguration-panel. Accessed 30 March 2020.

background and approach, could also be a useful second line in making the case for change. They could, up to a point, temper the wishes of the centre to impose politically palatable but clinically inappropriate solutions on local systems.

While there were some notable successes in the reconfiguration of services – such as the London stroke project – it appears that large-scale change at the local system level was more difficult and there were some notable failures here. Interviewees said that regional power was useful where the issues were big ones and the principles needed to be agreed but the detail could be worked out later.

The role of the SHA was to balance the interests of the many against those losing in the process, for example the PCT associated with a hospital losing its stroke service. The regional role ran into difficulties where the issues were very local, complex and the solutions needed local negotiation and adaptation. The distance of the SHA from the issues and nuances may sometimes have led to solutions being imposed that were not easy to implement or appropriate to the problem. The SHA could also act as an important filter for proposals and did not, as some politicians believed, necessarily have a pro-reconfiguration agenda:

> *When he left London, [David Nicholson] went round London and asked people about their proposals for reconfiguration and in total there were 74 … big change programmes that needed public consultation and the way he stripped those down was very simple but very effective. He [asked]: 'Right, introduce me to the doctors who are going to go on the telly and say that this is the right thing to do and if you can't do that you're not doing it' … so that cut the number down to about six. So [then] we had the job of trying to figure out, of these reconfigurations, which are actually really needed for safety reasons.*

It was clear that this type of large-scale change required planning rather than just the operation of market forces but that this was fraught with difficulties.[17]

A general lesson was that these changes took much longer than expected. Even where they appeared to happen relatively quickly, this often concealed some years or even decades of activity, dialogue with stakeholders and previous aborted attempts at change. For example, the relatively rapid changes at Chase Farm Hospital in north London, agreed in 2014, were the end result of a process that lasted more than 28 years.

## Performance versus interference versus improvement

As already noted, different SHAs had different styles, some emphasising a tough approach to performance management and others stressing quality improvement and organisational development. This raises the question of which style worked better. In fact, on close examination, the dichotomy between the two approaches was not so pronounced as it appeared. Some of the SHAs with a reputation as a strong performance manager also invested in improvement. Some seen as more developmental also delivered on performance.

[17] Palmer K (2011) *Reconfiguring Hospital Services: Lessons from South East London*. The King's Fund. www.kingsfund.org.uk/publications/reconfiguring-hospital-services. Accessed 30 March 2020.

An important lesson from the SHAs was that building the capacity of local NHS providers to drive up quality improvement should not be undermined by the work they were doing to performance manage the same local providers.

## The relation between regions and local bodies

Those interviewees who had worked in different SHAs, and in trusts or PCTs underneath them, described several dynamics between regions and local bodies that, at their best, made the SHAs effective system leaders by consent.

While most agreed that this varied greatly from place to place, many said it had been strong enough to make trust leaders regret the loss of SHAs, and to allow several regions to lead ambitious projects requiring extensive local cooperation at the limits of their formal roles. Examples include the work on reconfiguration described above.

One important factor was the perceived 'credibility' of the individuals who led and ran SHAs. Individuals were likely to be looked up to if they had done the most senior jobs of those they were managing, and if they were seen as high flyers or established figures with wide-ranging connections and a history of success. "You need to make sure that the people you appoint to the intermediate-tier chief exec jobs are highly respected practising managers," one former leader told us.

But this was not simply about the leader. One trust CEO told us what her local SHA CEO did well:

> *[S]he had people working for her who people respected.... So, you could, if you needed advice or some wisdom, find people that actually could contribute, and I think that's quite important, because as chief executive at one of the largest trusts of the country, if I need to go and talk to somebody, I need to go and talk to somebody who's got a degree of experience.*

Several described strong top teams where respected SHA directors of finance were seen as leaders by those in the same role in trusts. Directors of nursing were seen similarly. And so multiple lines of credibility and legitimacy connected trusts to regions.

The SHAs' perceived relationship with the centre was also a powerful source of authority, because it encouraged trusts and PCTs to see the region as a primary route to affect national policy and because it devolved on them the wide national powers of the centre. This was underpinned by high levels of perceived and actual regional involvement in senior management, particularly in the period of 10 regions. One interviewee described SHA CEOs as "David's representatives on earth [referring to David Nicholson]. Massive figures ... everyone knew they could kill a career." One such former leader noted that she had gone in person to argue to the secretary of state that a new target was undeliverable in her region, persuading him that this was the case.

This provided particular clout where the region had a degree of 'earned autonomy', with a strongly performing SHA essentially being given increasingly free rein to take major decisions in the region across the board on behalf of the NHS.

One former SHA leader summed up his view of where his influence had come from: "Levers!? That's a bit feeble really ... we had backing from the centre, we had good ideas and people around us and common purpose shared with people locally."

## Performance management and bullying

SHA CEO interviewees did not think that in general they presided over a bullying culture but they did acknowledge that those acting on their behalf could sometimes overstep the line between robust performance management and bullying:

> *It took most of us a few years to realise that, you know, we could resist the slightly bullying culture from the centre and try not to do that to our people but it took a while to learn that. I think once we learnt that performance improved even more, once you got into, you know, much more coaching, the supportive way of dealing with things, you moved things forward but sometimes there were issues that had to be dealt with, some people are not in the right roles for them or the world has changed around them and things have moved on.*

Those on the receiving end were less sanguine:

> *I think there was, and still is in some parts, a theory that in order to get organisations to improve their performance, you bear down on them with every tool at your disposal, including shouting, threatening, intimidating, giving unreasonable instructions, requiring unreasonable deadlines and targets, not treating people with basic civility, you know, setting a meeting whenever it suits you and then not turning up to it. So I think there was effectively a style of virtually institutional bullying, it wasn't called that, it was called performance management and I think the evidence of that as well is that it may produce a result in the short term but in the long term it certainly doesn't because you get much better commitment and hard work from people if they do it because they're inspired rather than because they're intimidated.*

The dissonance between the SHA CEO's view of what constituted acceptable performance management and the experience of some of its recipients, the role of ministers in setting the rather robust tone and the risks of the representatives of the intermediate tier operating in an inappropriate way are a frequent part of the discourse in this period. One interviewee did suggest that parts of the system operated in a more direct way than others:

> *[The SHA CEO] said look in this drawer. 'I have undated letters of resignations from every chair and every chief executive in my patch and that's my policy because if they ever stand out of line then I will just date them and sign them.'*

One ex CEO observed:

> *I regret now some of the behaviours I displayed then [during the 2005/6 financial problems]. I'm not proud of them… but that is how it felt you had to be.*

Others adopted a more facilitative approach:

> *One year we had a trust in financial difficulties and my chair and I went to every board, talking to them about how we would have to create a 1% reserve to try and manage everything, keep everybody's faces washed because that was in the long-term interest of all of us. That work is time consuming and hard but it really pays off and that built on those relationships as well and I think having a strong board and chair is also really important.*

Some interviewees raised "the concern … that the SHA was seen by PCTs to be overreaching themselves in terms of performance management and that carried across to other areas of their relationship". This risked meaning that even where a regional tier was also trying to take more supportive approaches, these could be drowned out by more confrontational relationships.

One repeated theme was that middle-level performance managers sometimes acted in ways that appeared to cross the line separating robust management and bullying. It is not clear how far this was thought to be sanctioned or was their interpretation of the required approach. One potential cause was that this behaviour was often in response to direct communication from the centre about performance issues which put these individuals under a lot of pressure. This raises important questions about the vertical relationships in the system.

# Vertical programmes

In addition to the quasi-hierarchical structure of SHAs and PCTs, there were a number of 'vertical' programmes designed to improve services. These included:

- cancer
- coronary heart disease
- mental health
- health care associated infection
- diabetes
- various improvement initiatives.

In a number of cases, these programmes had direct access to managers and clinicians in trusts and PCTs and in the case of cancer to networks that were making critical decisions about the location of some surgical procedures and services more generally. The directors of these programmes worked collaboratively with the SHA CEOs and there was an expectation that the programmes would work through a SHA lead or, where in direct conversation with providers, would ensure that the SHA was kept informed. Interviewees suggested that there were sometimes concerns if national programmes were involved in their patch and had a strong expectation that they would be kept informed and consulted on key decisions.

Potential conflicts between local strategy and the requirements of the vertical programmes were generally worked out in private conversation between the 'tsar' (national clinical director) and the SHA. The programmes were generally appreciated for bringing evidence and challenge:

> *I think having them [tsars] was really helpful where it was facilitative … you could get 200 people in a room … and you could get someone to say, 'This is why it's important, this is what works elsewhere', rather than a big taskforce coming in and probably telling you everything you know.*

The national director we spoke to confirmed this picture and said that, where they worked well, the SHAs were very helpful in facilitating conversations, unlocking blocks to change and coordinating across the system. They were careful to ensure that SHAs were involved in key issues relating to their area and the diplomatic skill of the individual national

director seems to have been an important factor as much of their impact was achieved by influence rather than direct instruction.

The extent to which the recommendations of the programmes were seen to be evidence based and to reflect the priorities of the clinicians involved also seems to have been important.

One clinical director suggested that there began to be a problem with the multiplication of vertical programmes and the ability of the system to work with them all. This may explain why the most problematic relationship seems to have been with the Modernisation Agency. This agency pre-dated the SHAs and had grown almost exponentially and somewhat chaotically. Its significant achievements did not outweigh the problems it was set up to address because a number of fiefdoms did not get on and behaved in ways that undermined the organisation and damaged relationships with important stakeholders in the service. Quotes from an unpublished history of the agency are telling.
Relationships were not managed well:

> *SHAs hated us with a vengeance, why, because of all, see previous. … you could lay personality over that, or you can lay politics or organisation, the line does not like people going and working in their organisations, particularly when you don't tell them, particularly when you succeed.*

> *The MA [Modernisation Agency] would often go in at individual organisation level and do some work without telling the SHA what it was doing. We had this system at one time where we each were the link for a particular SHA … That failed absolutely miserably … A complete nightmare.*

Resources were not directed in ways that worked for SHAs:

> *One of the SHAs said to me: 'I don't want the coronary heart disease stuff because my performance figures are that all my people get angioplasty and CABGs [coronary artery bypass grafts] within so many weeks. So, why do I want to spend a million quid on heart disease because, actually, my problem is delayed discharges and I want that money that Modernisation Agency's got for my patch to spend on delayed discharges.' But they couldn't do that and that was a big frustration to the service and I think one of the reasons that the service actually turned on the MA, if I would make one, was because there was too much money being centrally controlled.*

The Modernisation Agency was thought to be monopolising resources and staff:

> *I think the point at which the cardiac programme hired a grand piano for one of its meetings was when I realised [the MA] had too much money.*
> *There was too much money being centrally controlled and numbers being recruited into the MA were ridiculous.*

# Other relationships

One of the implications of having to invest significant amounts of time into building a leadership community within the NHS or of paying attention to performance management

is that external relationships can suffer. In terms of the SHAs, this mattered because of the role they could have in providing support and political air cover for large-scale strategic change.

In places with a large number of external stakeholders, such as London, the management of these relationships was particularly important and time consuming:

> *It's about creating a regional identity and building relationships between that identity to the regional NHS and other key public service players – so for example the higher education institutes, the universities, local authorities, local MPs for example – and that was important because as we both know, the NHS is part of the UK's political system … so building those relationships is crucial.*

One area that seemed to suffer from this was the development of relationships with local authorities and other non-NHS bodies:

> *I would meet the chief exec of X County Council, X City Council and talk about things. We would invite those people to our bigger leadership events. But it was pretty tokenistic on both sides I think. And social care, whilst important, did not become the issue that it is today.*

This was not universally the case and there were some examples of productive relationships and work between councils and the SHA but only a small number of interviewees mentioned them. There was a similar relatively low level of successful engagement with the regional development agencies. One interviewee commented that, as both the regional development agencies and the SHAs were effectively outposts, they could find few areas for joint working where they had a shared mandate.

# Sources of power

## Levers

The SHAs had access to fewer levers than those available to the regional health authorities, which had more control over funding for education, workforce development, research and –crucially – capital and overall allocation policy. Regional health authorities also had more direct influence over the appointment of chairs and CEOs. This could be quite overt:

> *Well the first thing that's worth saying, which I think is relatively absent now, I had a lot of power of hiring and firing so I think I moved eight chief executives in my first year … because simply people who either weren't, to be crude, they weren't competent, or people whose mindset wasn't collective, who, as David [Nicholson] put it, 'As soon as I say something, they see that as the start of a negotiation, not me telling them what they have to deliver.'*

However, more generally this was done more subtly and interviewees tended to point out that the formal levers were only part of the story. Personal influence, the creation of a leadership community, the use of talent management, the power to move CEOs in more positive ways and other methods of softer power were also very important. In fact, without the relationships the use of more levers could lack support and even legitimacy:

*I don't think the leadership in the intermediate tiers [often] sees the opportunity of the space that exists and most of us like to give room to manoeuvre as near to the coalface as possible because that's the best way of getting creative solutions. I think people who say, 'I didn't have many levers' – I just don't buy that. It's easy to hide behind that if you want to, is my view. A lot of it is about personal style, commitment and determination and an ability to work closely with people.*

As foundation status became more widespread, the willingness and incentives for trusts to be part of the wider system diminished and some trusts withdrew and were reluctant to cooperate with the SHA. Over time, however, SHAs regained some of this trust through being able to demonstrate their value in convening and sometimes in mobilising funding. In terms of formal levers, the ability to allocate even relatively small amounts of capital or development money created a slightly disproportionately high level of leverage due to the benefits that even small sums have for organisations often operating on the margin of financial balance.

### Boards

Views among our interviewees on the importance and usefulness of boards were mixed. The fact that both incarnations of SHAs were seen as outposts of the Department of Health rather than highly autonomous bodies raised questions about the role of the board, which were compounded by the rhetoric of devolution to PCTs and the growth of foundation trusts:

*I think it was awkward, the whole board and chair thing because … we were … overwhelmingly a managerial arm of the centre…. Chairs were very useful in two respects downwards, so one is their relationship with the chairs of trusts and PCTs. [I would say to my] chair: 'Would you have a quiet word with this chair about how performance is going here and what we need to see improved and whether we think Mr X is the right person to be leading that, what do they need, how are they feeling?'*

With some external stakeholders, the fact that the SHA had a board increased its legitimacy. Internally it was also seen as underpinning the scheme of delegation, collective decision-making and the management of difficult performance or political issues.

## Talent

### Talent in the wider NHS

Interviewees frequently mentioned the role of the regional tier in developing the leadership pipeline, managing talent and ensuring people were in the right place. Although, as mentioned above, sometimes this meant removing people who were not performing or were 'in the wrong job', a number of these people were rehabilitated or moved to a more appropriate role. Unfortunately, the logic behind the approach to talent management was not always apparent to those observing it:

*There were two attempts I know of to create a kind of formal talent management system, and that failed, but the informal thing of that was very powerful so a lot of effort was placed on, you know, personal contact relationships, understanding.*

The issue was that in a number of instances this created in-groups that tended to be homogenous in terms of point of view and management approach as well as gender and ethnicity.

In 2008, a large group of individuals identified as top leaders were put through an assessment of their leadership approaches, which, somewhat unsurprisingly, found that there was a strong predominance of 'pace-setting' approaches to management and a relative paucity of coaching and other more developmental styles. The 2008 *Next Stage Review*[18] and research by The King's Fund[19] argued that this had deterred clinical involvement in management, particularly at CEO level.

### Where do regional managers come from?

During the heyday of regional health authorities, regional managers were seen as an important part of the NHS management career ladder:

> *The regional tier had people who were at the height of their game, so the regional directors were your most experienced, your most talented and the people that worked with them were too. It seems to me that we are in danger of not having people of that calibre working at that level.*

Interviewees were not sure that this persisted after 2002:

> *It was not clear that SHAs were the pinnacle of a managerial career so arguably you didn't have the best managers coming to the SHAs. Some of the very best managers remained at trust level because of foundation trust status*
> *I think perhaps the calibre of people changed because they weren't seen as the prize jobs anymore and that running an FT [foundation trust], a big teaching hospital, was seen as a better career option and I think when bits started to be moved out into quangos so that when you had all of the power and all of the levers, people couldn't argue with you. When you didn't have any of them or some of them, then I think it started to dissolve.*

> *We lost what I would call some of those big people because, gradually, people started to separate that they only worked in providers or they worked in commissioning and they didn't have that rounded experience of doing both.*

## Insufficient attention

Interviewees identified a number of areas that had received too little attention – primary care, the workforce and, in a few cases, public health – partly due to the nature of the management agenda, but also in some cases as a consequence of the structure of the

[18] Department of Health (2008) *High Quality Care for All: NHS Next Stage Review final report*. Department of Health. www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report. Accessed 30 March 2020.

[19] The King's Fund (2012) *Leadership and Engagement for Improvement in the NHS*. The King's Fund. www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf

system. With the exception of London the connection of SHAs to the research and development agenda was very limited.

## Inbuilt weaknesses

Middle tiers in all organisations suffer from: allegations of blocking or failing to implement change from the top; and bullying and 'chateau general' insensitivity to local context from below. One interviewee neatly summarised a popular view of the regional health authorities in the 1990s:

> *The dead hand of the RHA [regional health authority] was in part true that, you know, there were good reasons why you might want to get rid of RHAs, those that had been around, and actually top-sliced far too much off the allocation, those people who were in essence petrified of change and used the levers to basically maintain the status quo at all costs and most of that would be a lack of effectiveness and a lack of efficiency cost …*

This is reflected in research by PRUComm, which found that in the mid-1990s:

> *[T]here was a widespread perception that regions were a cumbersome, overstaffed and ineffective mechanism for implementing central government policy. The Secretary of State for Health at the time, Virginia Bottomley, was cited in the BMJ as declaring the 'unfinished business' of regional reforms suggesting that regional health authorities having worked well for two decades their hands-on approach was now to be considered outmoded.*[20]

Highly centralised control has many dysfunctions that are well documented. These lead many stakeholders to view the intermediate layer negatively and they then call for decentralisation. Paradoxically, the centre may call for decentralisation because it could benefit from taking over roles from the intermediate tier that have significant power that may be centralised rather than devolved. Specialist commissioning, capital approval and financial allocations are examples of this process in the NHS.

This debate is a frequently repeated pattern in the NHS and in other health systems, which leads to a cycle of centralisation followed by a shift in rhetoric to devolution, decentralisation and power being given to the front line. In their research on decentralisation, Peckham and others suggest that the empirical and theoretical basis for this debate is not very strong:

> *[N]ational health care organisations need to develop a more sophisticated understanding of decentralisation processes and learn that simple assumptions about the benefits, or otherwise, should be avoided. Health care managers and practitioners should therefore give more explicit recognition to the*

[20] Lorne C, Allen P, Checkland K, Osipovič D, Sanderson M, Hammond J and Peckham S (2019) Integrated Care Systems: What can current reforms learn from past research on regional co-ordination of health and care in England? PRUComm. https://prucomm.ac.uk/assets/uploads/PRUComm_-_Integrated_Care_Systems_-_Literature_Review.pdf, p. 40.

*compromises/trade-offs between performance criteria (e.g. equity versus efficiency versus responsiveness, etc.) when developing strategies.*[21]

The gap sometimes seems to be filled with personal experience and extrapolation from current problems rather than having a strong theoretical or historical basis. It seems likely that this leads to some overshooting – that is, in periods of centralisation, the advantages of devolution and the mechanisms to achieve this are over-emphasised and the problems are underestimated, and vice versa.

# Conclusions

Some of the experience from 1996 to 2012 has direct relevance to the design of intermediate organisations in the present.

Clarity and consistency of purpose is important. This needs to be supported by a very clear scheme of delegation. It also needs to be accompanied by measures to stop different layers of the system overlapping and confusing responsibility and accountability. Failure to do this also has the potential to confuse relationships externally.

A number of contextual factors influence the establishment, culture and operating model of regional organisations and this in turn affects the speed with which they become recognisable entities with their own character and start to deliver effectively.

The leadership style of the CEO influences the character of the organisation but, where a region has its own existing culture or approach, it will be easier if there is a good fit between the two. Balancing being part of the system and being part of the top team is important. Having a significant divide between regions and the rest of the centre is not helpful but neither is co-opting them entirely.

The top team nationally needs to be of a manageable size and have high levels of trust and collegiate working. A good deputy CEO at national level can help with this but not at the expense of the CEO becoming detached and focused upwards. Ministerial behaviour has the potential to disrupt the proper operation of the system and the more executive their style the more difficult this problem can be.

Speaking truth to power is important but needs to be done skilfully. This may work better when the issue is about the implementation of policy rather than fundamental issues of policy design.

The role of the regional tier as a sense-maker, solution broker and convenor is very important. Making this relationship more one of a leadership community in a region rather

[21] Peckham S, Exworthy M, Powell M and Greener I (2005) Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an organisational model for health care in England. National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) programme. www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1318-067_V01.pdf, p. 9.

than a hierarchical one appears to be the most effective approach. The stereotype of the intermediate tier as a blocker is generally incorrect but nor is the tier just a simple transmission mechanism. Its role in interpreting policy and helping local systems understand priorities is also important. Ensuring that national targets are not just parcelled out without reference to the starting points and context of different locations is important and not always easy to achieve, particularly for ministerial priorities.

A lesson that is well understood but which often needs repeating is that strategic change takes a long time and requires skilled political management, and regional bodies can be helpful in providing support for this. Changes that look like they are relatively fast are often only a small visible part of a much longer process. Regions appear to be better when changes are in focused areas across a wide geography than when they are more local large-scale or general reconfigurations.

There is a fine line between performance management and bullying and care is required to ensure that the agents of a region are behaving in ways that are consistent with its values and approach. Ignoring bad behaviour or implicitly condoning it because it gets results is corrosive not least because it becomes well known but also because it may be transmitted down the system and have measurable effects on patients and front-line staff.
The need to control and minimise the burden of information collection is a consistent complaint from front-line organisations. While the SHAs did try to deal with this, they appear to have only been partially successful.

The intermediate tier has not always been very good at diagnosing the root causes of organisational failure, which has led in some cases to repeated failures and interventions in the same organisation. It is difficult to know when and how to intervene and to ensure that organisations that are in trouble are not swamped with 'help' or with very burdensome requirements to account for what they have been doing. The multiplication of support teams, regulatory roles, commissioning bodies and so on tends to increase the probability of being overwhelmed by help.

Rhetoric about non-hierarchical models of organisation will not be convincing if a hierarchy of power actually exists. The distribution of knowledge, insight or the ability to solve strategic problems is not necessarily correlated with position in the hierarchy and in some cases there appears to have been an assumption that higher tiers can see answers more clearly. Decisions need to be located at the right level. This will vary over time, by problem and is difficult to codify but the talk of devolution has often been little more than rhetoric. To some extent, this reflects the realities of a politically controlled system. One of our interviewees summarised the pattern of reforms and what this meant for the distribution of power:

> *I have been fascinated over the course of my career to notice that every reorganisation since – and including – 1982 has been clothed quite explicitly in the language of devolved decision-making. This being so, each reorganisation you might think was inescapably an acknowledgement of the failure of the last to achieve this chimaera, even when conducted by governments of the same colour. One is then forced to one of two conclusions: either those successively involved in design and implementation were incompetent clowns; or there was never any intention of honouring this rhetoric, and these reorganisations were in fact no more than efforts to bring an unwieldy system, causing increasing levels of political embarrassment, under better control. The last is of course the correct conclusion.*

The intermediate tier's relationship with vertical programmes can be helpful and positive but it requires careful management, communication and work on relationships. Ensuring that these programmes are aligned to the work of the intermediate tier and that they are sighted on its activities is important.

Levers help to make the regional tier more effective but on their own, without legitimacy and relationships to back them up, they are of much less value. Soft power, influence and establishing legitimacy and authority through behaviours such as consistency of approach, fairness, problem-solving and holding people to account are at least as important as more formal mechanisms.

Brokering agreements, smoothing financial issues across larger geographies and fixing elements of systems that are broken are things that are valued. However, sometimes this may mean that issues that should be brought to the surface are hidden. As with a number of the aspects of the role of the intermediate tier, achieving a balance between competing tensions of this sort is important but not easy.

The role of a board and chair in intermediate organisations can be somewhat uncertain and the more top-down the style of approach, the more people can perceive their relevance as questionable. Where there are boards, there needs to be clarity about what the board can do that is not replicated by existing lines of accountability, for example they have an important role in terms of relationships with non-executives in trusts. The question of how a chair of an organisation that has behaved in a way that is inappropriate or against the interests of the wider system can be dealt with is still an issue.

Overall, the regional tier does seem to have had an important and often helpful role in making the NHS more manageable and in translating policy ideas into action. Getting this role right is not easy and also requires frequent adjustment in style and approach and probably less-frequent changes of structures and people.

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