Integrated Care Systems Network
NHS Confederation

The state of integrated care systems 2023/24

Tackling today while building for tomorrow

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

For more information, visit: www.nhsconfed.org

Integrated Care Systems (ICS) Network

The The Integrated Care Systems Network is part of the NHS Confederation. As the only national network bringing together the leaders of health and care systems, we support ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda.

For more information, visit: www.nhsconfed.org/ics

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Key points

- Integrated care systems (ICSs) play an instrumental role in tackling the issues facing the health and care system today while building for tomorrow. This report examines progress made by local systems over the past year. Leaders of integrated care boards (ICBs) and integrated care partnerships (ICPs) reflect on their ambition for the future, the barriers and enablers that stand in the way and how the government and other national partners can better support them to succeed.

- Most ICS leaders are positive about the progress their local systems are making against their four purposes and will play a key role in delivering the government's reform agenda, including improving productivity and maximising available resources, enhancing devolution, supporting the development of a neighbourhood health service and shifting resources into prevention and closer to people's homes.

- However, they are struggling to marry their collaborative ambition with today's fiscal realities. Delivering against short- and longer-term priorities is a careful balancing act, and performance management conversations focused almost entirely on finances are crowding out the longer-term transformation ICSs were established to deliver.

- Over 90 per cent of ICS leaders surveyed are committed to shifting resource to allow more people to access more care closer to home. But they are struggling to match this ambition due to financial constraints.

- Over three-quarters of ICS leaders surveyed are concerned that financial challenges in the NHS and local government will impact their ability to deliver on their ambitions and negatively impact partnership working. In order to balance budgets today, they are being forced to cut back, delay or defer the programmes that will lead to tomorrow's financial sustainability as well as improved outcomes.

- Only 40 per cent of ICS leaders surveyed believe accountabilities are well defined between ICBs and NHS England's national team and there is clear variation in experiences of working with NHS England regional teams.

- But as the Darzi report highlighted, ICS leaders are held back by a lack of investment in capital as well as primary, community and social care services, performance standards focused on hospitals, unclear accountability arrangements, single-year budgets and politically driven short-term funding decisions. They need greater support from national government and arm's-length bodies to deliver transformation.

- ICS leaders welcome the opportunity to shape the future of the health and care system through active involvement in development of the government's ten-year health plan, which they are pleased to see will take a more expansive 'health' (not solely NHS) focus.

- On behalf of ICS leaders, this report makes several recommendations to national government and national bodies for consideration as part of the development of the ten-year health plan, including moving to multi-year funding settlements; changing to the payment scheme to support a focus on integration and prevention; evolving and embedding the new operating framework; ensuring oversight incentivises a balance between today and tomorrow; and giving ICBs levers to devolve decisions to place and neighbourhoods.

Introduction

The establishment of integrated care systems (ICSs) is ushering in a new era of collaboration and partnership to better support the health and wellbeing of people across England. Based on a strong understanding of their local communities and working closely with their partners, ICS leaders are focused on building the health of the nation and delivering their four core purposes:

- Improving population health and healthcare outcomes.
- Enhancing productivity and value for money.
- Tacking inequalities in outcomes, experience and access.
- Helping the NHS to support broader social and economic development.

But as they enter their third year as formal partnerships, ICS leaders continue to face a challenging operating context, with high and growing levels of demand for care, a depleted workforce, stark health inequalities and the ongoing legacy of austerity. The recent Darzi investigation of the NHS in England explored in some detail the impact of decisions outside the NHS's control that have impacted NHS performance, including austerity and deteriorating population health.

This third publication in the ICS Network's flagship annual report series, reflects the views of ICS leaders on the development and impact of ICSs. It aims to provide insight on their successes, challenges and what they might need from national partners to deliver for the local populations they serve.

The research is primarily based on a national survey of ICS leaders (ICB chairs and chief executives and ICP chairs), undertaken before the general election and was followed up with several interviews over summer 2024.

We would like to extend thanks on behalf of the ICS Network to everyone who participated, for their helpful insights and contributions. We are particularly grateful to the ICS Network Board for their feedback and guidance throughout the project.

A new political landscape

The election of a new government signifies a shift in the policy landscape with new opportunities to tackle longstanding challenges. Labour's manifesto outlined its plans for a health mission, which envisages three shifts towards care closer to home, prevention and digitisation.

ICSs play a key role in addressing some of the issues that matter the most to the public, such as primary care access, elective recovery and urgent and emergency care. At the same time they are committed to delivering the transformation needed to guarantee the sustainability of the health and care system. This includes more people accessing more care closer to home, a focus on prevention, embedding new models of care, driving social and economic development, devolving decision-making and harnessing the power of digital and data.

ICSs will therefore be instrumental in delivering the government's missions for health and growth and are uniquely placed to accelerate integration and address the wider determinants of health. ICS leaders also welcome the opportunity to shape the future of the health and care system through active involvement in development of the government's ten-year health plan, which they are pleased to see takes a more expansive 'health' focus, not solely an NHS focus.

A note on language

An integrated care system (ICS) brings together the health and care organisations in a particular local area to deliver joined-up health and care services. Each ICS is responsible for planning health and care services in the area it covers. There are 42 ICSs across England. Each one is made up of an integrated care board (ICB) and an integrated care partnership (ICP), along with NHS and social care providers and other partners, which will work in tandem to meet their four purposes.

ICBs are statutory NHS organisations responsible for developing a joint forward plan in collaboration with system partners to meet the health needs of their

population, managing the NHS budget and arranging for the provision of health services in their defined area. All ICBs include board members from local authorities, NHS trusts and/or foundation trusts and primary care.

ICPs are responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population. It operates as a statutory committee formed between the NHS ICB and all upper-tier local authorities that fall within the area, with membership of other partner organisations determined locally.

We refer to ICB and ICP leaders collectively as 'ICS leaders' and to all the bodies working together within the ICS geography as 'system partners' or 'the system' when talking about the entire range of activity that the ICS is working towards. At other times, we refer to the views of ICB and ICS leaders when we are writing more specifically about those entities.

At times we use the term 'the centre' to refer to national government and national bodies collectively, predominantly meaning the Department of Health and Social Care (DHSC) and NHS England's national and regional teams. However, this may also encompass other departments such as the Ministry of Housing, Communities and Local Government and national bodies such as the Care Quality Commission (CQC).

Methodology

The report is based on data collected through desktop research and quantitative and qualitative methods.

We invited leaders of the 42 ICSs in England to share their views on ICS development through a national survey, which was open to chief executives and chairs of ICBs and chairs of ICPs. The survey was open from 8 May to 13 June 2024. We received 62 responses overall, representing 36 out of 42 systems: over 85 per cent of systems.

Responses were split across 16 ICB chairs, 23 ICB chief executives, 13 ICP chairs and ten joint ICB/ICP chairs. All respondents were asked the same questions.

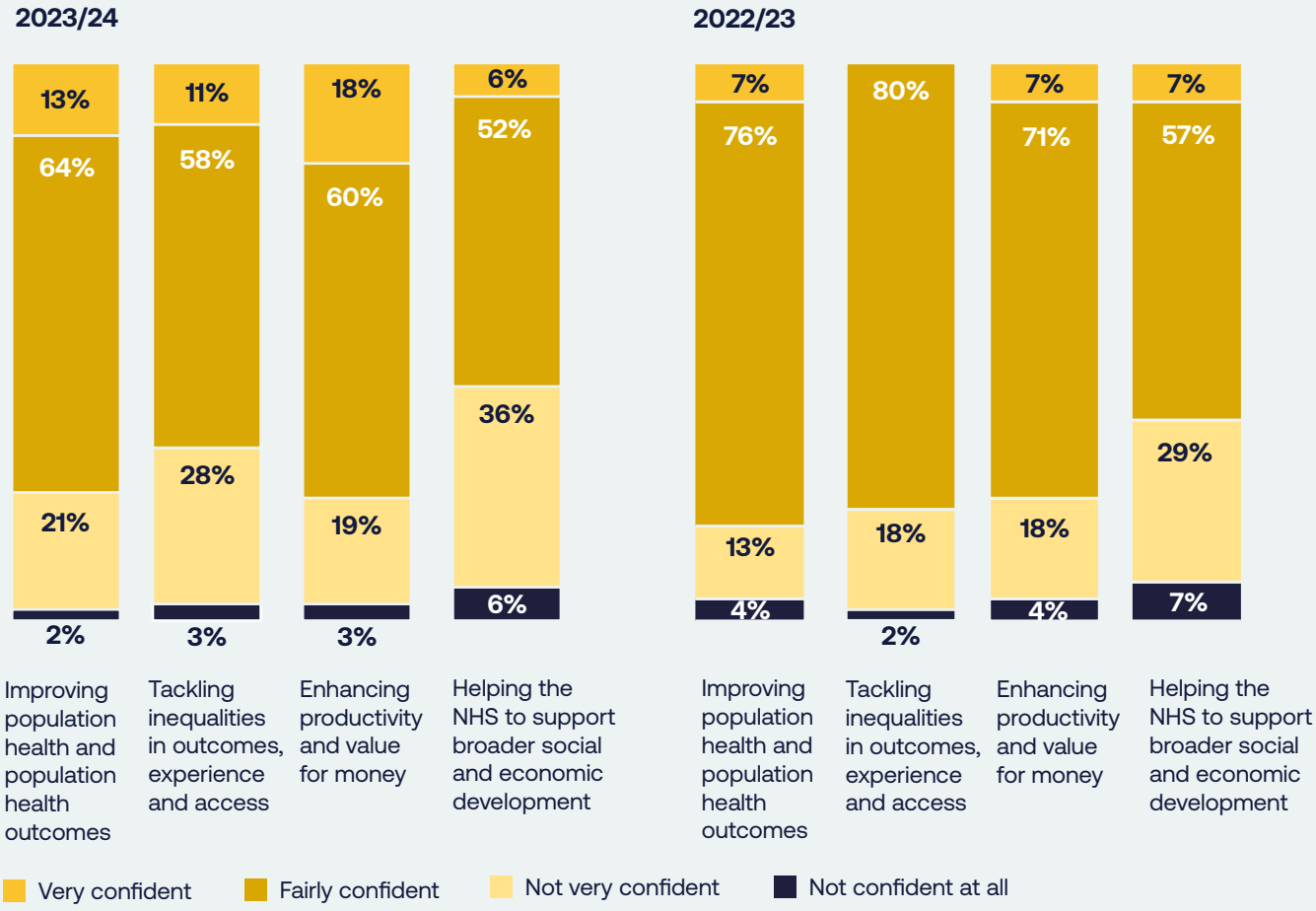
At times we have compared responses to last year's survey, but comparison is limited by different wording of questions and the individuals completing the survey. Qualitative responses were analysed using inductive thematic analysis to identify emerging themes. We also undertook individual interviews with nine leaders from various roles across ICBs, ICPs and place to discuss the findings and the wider context in greater depth.

Progress against ICSs' four core purposes

Confidence is still high among ICS leaders

Overall, ICS leaders feel confident their system is able to fulfil each of the four core purposes. When compared to last year's survey, the proportion of respondents who were 'very confident' has grown slightly across three of the purposes, from 6 per cent to at least 11 per cent. The proportion of those 'not very confident' has also seen a small increase.

"How confident are you that your system is currently able to fulfil each of the following four purposes of an ICS?"



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; n=62

Source: NHS Confederation | State of Integrated Care Systems Survey 2022/23; n=45

The reality of system working is making clear successes and areas for improvement. Each system has had a different starting point in terms of history of collaboration, size, level of deprivation, workforce challenge and waiting list backlog. Many are also tackling complex legacy issues as well as recovering from the significant impact of the COVID-19 pandemic on staff, patients and populations. ICS leaders' confidence is likely also linked to the scope they are given to focus on particular issues.

ICS leaders are most confident about enhancing productivity and value for money. This has been an enduring area of focus for the government and NHS England due to the current fiscal environment and lower productivity levels. It also reflects that many ICS leaders see opportunities to enhance productivity, although current NHS financial flows mean that at times these opportunities can be hard to realise.

Over three-quarters (77 per cent) of respondents were also confident their systems are improving population health and healthcare outcomes, which is the core and expected business of NHS leaders and many of their partners. ICS leaders feel they are making progress towards delivering their plans, although financial constraints mean they can struggle to reserve headspace to focus on innovation, digital transformation and shifting towards a preventative approach.

They described their work taking population health approaches, working closely with their partners and particularly public health teams, using data to inform decision-making and focusing on specific clinical areas such as cardiovascular disease, cancer, or children and young people's health. A number of respondents described work which focuses on the social determinants of health. One ICB chief executive said they had "downgraded our ability to impact because of external factors affecting our population: poverty, cost of living, etc."

Improving population health and health outcomes

Case study: **An integrated oral health service is improving access and outcomes for disadvantaged communities in Suffolk and North East Essex**

Residents in Suffolk and North East Essex (SNEE) were struggling to get a dental appointment, which was particularly impacting the system's most vulnerable groups. This had a knock-on impact in the acute sector, with a 45 per cent increase in 111 calls and an 100 per cent increase in GP contacts for urgent dental support.

SNEE ICB became responsible for the commissioning of NHS dental services in April 2023. To address these issues, it decided to think differently and develop an oral health service specifically for the most vulnerable people in the community. The Dental Priority Access and Stabilisation Service specification (DPASS) was developed with extensive expert input from the dentistry sector and the contract was awarded to 18 current high street dental practices and a new provider, the University of Suffolk Dental CIC. All are additionally contracted to provide more routine NHS dental appointments for the general public. The DPASS is a pilot and an evaluation in 2025 will inform future commissioning plans.

DPASS combines urgent and emergency care, and preventative care and treatment, while retaining units of dental activity (UDAs) and a range of metrics for measuring outcomes. The model seeks to improve access and outcomes from an equity lens by prioritising groups most at risk of poor oral health.

The University of Suffolk Dental CIC delivers an innovative contract comprising 100 per cent NHS care, with 80 appointments each week ringfenced for the unscheduled care of patients referred under DPASS. Other KPIs for the CIC focus on workforce recruitment and retention, quality and patient experience.

As part of the NHS dental recovery plan, the ICB has also invested in a mobile dental surgery which will serve deprived areas within Suffolk.

Tackling health inequalities

Tackling health inequalities continues to be a challenging area, with much variation across systems. After last year's survey, where it was the only area with no 'very confident' systems, the NHS Confederation undertook research into ICSs' approaches to tackling inequalities and produced a practical toolkit to support and scale successful approaches. Compared to last year's survey the proportion of respondents who are both 'very confident' and 'not confident' has increased. This may be explained in part by the large impact of the wider determinants of health on inequalities. It is promising in this context that Lord Darzi recommended this be an area of focus in the government's upcoming ten-year health plan.

One leader shared that they have strong strategies for tackling health inequalities and increased maturity in their relationships to deliver them, but that "progress to deliver results gets stuck, for example in long commissioning processes, or other discussions about money flows and sustainability. While there are many successes, the overall picture is one of slow progress."

Some of the successes shared by respondents include elective and dental recovery plans targeted towards inequalities, and delivering chronic obstructive pulmonary disease (COPD) support through local area partnerships.

Helping the NHS to support broader social and economic development

Case study: **The Bedford Borough Warm Homes project**

This project is funded by Bedfordshire, Luton and Milton Keynes Integrated Care Board, commissioned by Bedford Borough Council and run by the National Energy Foundation's warmth and wellbeing service Better Housing Better Health, to reduce health inequalities in the borough.

Over 1,600 patients were invited to take part, because GP records showed that they could be at risk of fuel poverty and they had a chronic health condition that could be made worse by living in a cold or damp home. An additional intended benefit of the scheme was a reduction in carbon emissions.

Fifty-three households with residents who have a chronic health condition in Bedford borough benefited. They were offered home improvements that could make their homes warmer and/or less damp, with an average cost of £2,500. The main products installed were replacement gas boilers, thermostatic heating controls and loft insulation. A further 320 households also received expert, impartial advice to help improve the energy efficiency of their homes and save them money.

The evaluation of the scheme is ongoing but it is expected the NHS will make savings of £358,000 against the total project cost, through reduced attendances at general practice and A&E. For example, residents whose chronic asthma was exacerbated by their cold or damp home are expected to see improvements in their health and need fewer appointments as a result.

Helping the NHS to support broader social and economic development

ICS leaders feel least confident to deliver their fourth purpose of helping the NHS support wider social and economic development. This is an area of work that has often been led by local government and the voluntary, community and social enterprise (VCSE) sector, which NHS bodies should support and build on. For example, through economic development approaches such as regeneration and affordable housing programmes. This may be new territory for some NHS leaders, who are shifting mindset from being providers of services to providers of employment and economic activity as part of a wider partnership.

One ICB chair shared that "the ICB is a relatively small direct player – the challenge is to make this high on every delivery organisation's agenda." Although ICS leaders feel they are not making as much progress as they would like, they emphasised work around anchor institutions and a focus on employment and education as areas of progress. This includes "working with partners in the education sector to train, employ and retain local people."

In particular, the awarding of £64 million WorkWell funding across 15 pilot ICSs has raised health and work up the agenda – an issue which is largely seen through ICSs' fourth purpose. This is a very positive development. The ICP was cited as a key vehicle for delivery across this purpose in general, given its breadth of connections and scope.

> "Our ICP has been established with representation from local authorities, voluntary sector organisations, education, police and fire services. We are focused on working across all organisations to improve workforce recruitment and retention and target local communities for job opportunities; to improve mental health, give children and young people greater opportunities and also improve social care provision and support."
>
> ICB/ICP chair

The NHS Confederation is continuing to provide expertise and support for systems to unlock social and economic development and is working with government to help formulate their approach. For example, in partnership with the IPPR Commission on Health and Prosperity, we have recently published some key principles for achieving this, based on engagement with five local areas. Upcoming work with the Local Government Association will explore how the government can help strengthen the role of ICPs within systems, which would bolster this important agenda.

The health and work agenda was mentioned in the Darzi report, which highlighted the potentially huge contribution the NHS could make towards national prosperity by improving access to care. Recent research conducted by the NHS Confederation and Boston Consulting Group highlighted the need for a whole-of-government approach to tackling the causes of long-term sickness and economic inactivity.

ICS leaders are also interested in leveraging the potential of devolution, which will be important for improving the health and prosperity of the nation. Under the previous government's plans, every area of England would have a devolution deal by 2030. This is likely to accelerate under the new government, which has already written to local government leaders committing to 'expand devolution further and faster'.

Based on promising early findings from several areas in England where ICSs and combined authorities are working closely, our report Prevention, Population Health and Prosperity: A New Era in Devolution urged the new government 'to place health at the heart of any future devolution deals, leveraging the growing

ICS – combined authority relationship'. On top of their close partnerships with county councils, in areas with devolution deals ICSs are partnering with combined authorities and metro mayors to co-develop and deliver programmes of work that benefit local communities, in particularly by contributing to wider social and economic development.

Helping the NHS to support broader social and economic development

Case study: **Partnership between West Yorkshire ICB and combined authority to address the wider determinants of health**

West Yorkshire ICB (WYICB), the West Yorkshire Mayor and West Yorkshire Combined Authority (WYCA) have a strong partnership built over a number of years, working together on health, socio-economic development, equity and inclusion. A memorandum of understanding has been in place since 2023 to formalise the partnership, linked to West Yorkshire's integrated care partnership with the aim of an inclusive approach on improving the physical, mental, economic and social wellbeing of people in West Yorkshire. The partnership aims to embed a 'health in all policies' approach with the combined authority and links to ICSs' fourth purpose. Strong partnership working is embedded in reciprocal governance arrangements between both organisations and joint initiatives such as Creative Health, Housing for Health and the Warm Homes scheme.

WYICB and WYCA have jointly appointed some senior roles, including an associate director of public health and West Yorkshire's inclusivity champion, which have supported influencing the strategic policy on areas beyond health and care including crime and policing, housing, transport, skills and local growth. Further, the mayor and WYCA chief executive are members of the ICP with local authority leaders, and ICB leaders sit on WYCA committees such as on climate change and place, regeneration and housing. This allows both bodies to mutually support and influence each other's decision-making and strategic planning and delivery.

Work is now underway on practical and more in-depth delivery. For example, a West Yorkshire Work and Health Partnership Group has been developed, which brings together local authority and combined authority leads from skills and public health alongside colleagues from the ICB, Department

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for Work and Pensions/local JobCentre Plus, and the VCSE sector. WYICB and local authorities with WYCA have signed up to the West Yorkshire Fair Work Charter, which was based on co-design with local communities and research into how workplace charters can reduce health inequalities for employees and create inclusive workplaces. Over 173 businesses have signed up to the Charter from across various sectors including the VCSE sector, manufacturing and food, police and public transport. A one-year review will be conducted to evaluate impact and support future implementation. Other projects underway include an apprenticeship levy, influencing inclusive growth and aligning infrastructure policy.

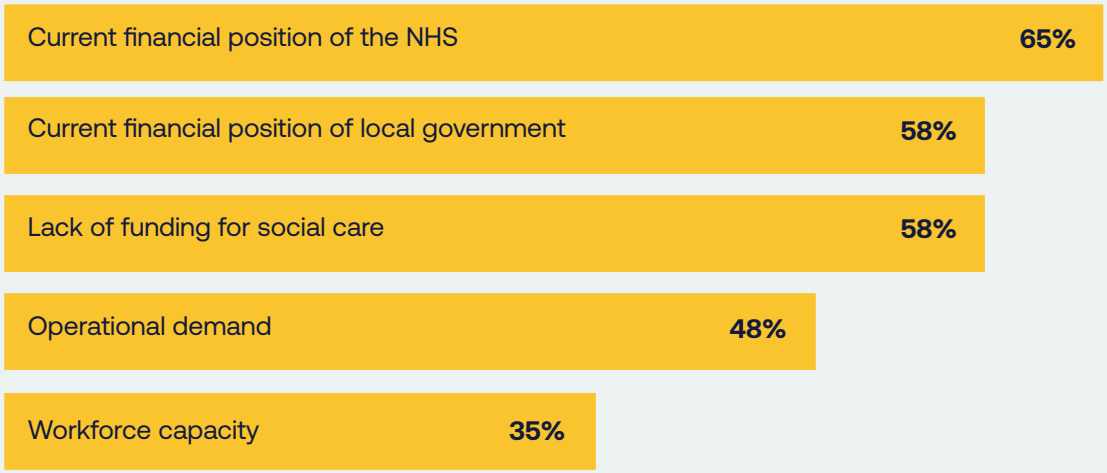
Barriers and opportunities

In their role as system conveners, ICS leaders are uniquely placed to understand the specific challenges facing their local population. This will include issues relating to the quality and safety of services, operational demand and acuity of the population and finances and workforce challenges. An ICB chief executive warned that "the scale of the challenge over the next one to two years cannot be underestimated."

In the context of these challenges, ICS leaders think that the current financial positions of the NHS and local government, as well as lack of funding for social care, are the biggest barriers to ICSs over the next two years. They also continue to sound the alarm on the capacity of their workforce across health and care, particularly in the context of rising operational demand.

This assessment is shared by national bodies. In July, the National Audit Office raised concerns that 'the NHS may be working at the limits of a system which might break before it is again able to provide patients with care that meets standards for timeliness and accessibility.' It highlighted that policymakers needed to address the 'potential growing mismatch between demand for NHS services and the funding the NHS will receive.'

Top five answers for: "What do you think will be the biggest barriers to your system's progress against the four core purposes over the next 24 months?"



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; Up to five options permitted to be selected from choice of 17; n=52

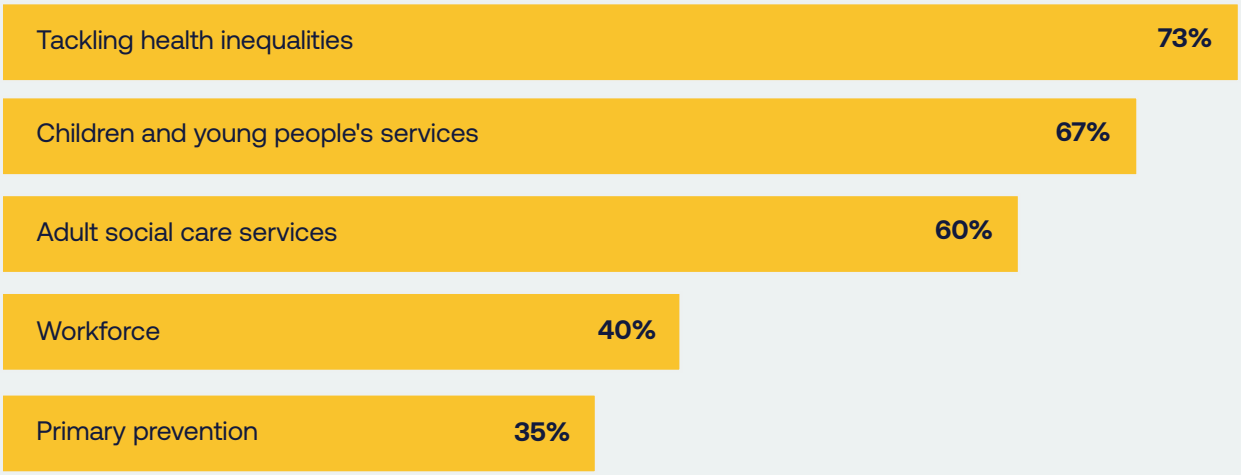
The delivery of the NHS Long Term Workforce Plan encapsulates a number of these issues. In the words of one ICB chief people officer we interviewed: "100 per cent we cannot deliver the ambitions in that plan with the resources we have."

ICSs are expected to achieve a difficult balancing act: simultaneously cutting costs while tackling workforce shortages and working much more closely with their local authority partners while meeting NHS imperatives from the centre that can challenge partnership working.

Workforce capacity is a barrier to integrated working not simply because of the overall number of health and care staff, but also in terms of having the right mix of roles, skills and experience in the right places. This can be challenging in areas of care that are seeing high shortages despite more activity and higher demand. For example, the number of GPs has fallen and there is a clear need for additional mental health staff. To tackle key issues in adult social care, ICS leaders are supportive of Skills for Care's adult social care workforce strategy.

At the same time, these areas of pressure are also where ICS leaders believe there is most opportunity for collaboration between NHS and local government.

Top five answers for: "What are the biggest opportunities for joint working between NHS and local authority partners?"



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; Up to five options permitted to be selected from choice of 20; n=52

Making an impact

We asked ICS leaders what one thing their system had achieved in the last 12 months that they are most proud of. Responses covered a broad range of areas, but some specific sectors stood out. For example, 20 per cent of respondents cited urgent and emergency care improvement due to partnership working as their proudest achievement, and 14 per cent cited activity in primary care. Using data capabilities to drive evidence-based decisions was cited by some as a key enabler of these successes.

Improving population health and health outcomes

Case study: **Data-informed decision making in Nottingham and Nottinghamshire ICS**

Nottingham and Nottinghamshire ICS faced significant challenges when trying to make financial efficiencies alongside a surge in emergency demand and prevailing and chronic inequalities among their population. These competing demands highlighted issues between organisations due to a lack of join-up data.

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In response to these issues, the ICB established the System Analytics and Intelligence Unit (SAIU). The unit's purpose is to support data-informed decision-making for ICS leaders and work alongside the ICS's Shared Care Record, which had already integrated and joined up GP data. This was enabled by a Section 251 order by the Secretary of State for Health and Social Care, which allowed pseudonymised data analysis and secure data sharing across NHS organisations, local authorities and VCSE partners.

The ICB has leveraged this new data capability in various ways to support its local population. For example, data insights contributed significantly to the reduction of discharge delays across the ICS, with one acute hospital gaining two wards' worth of space by speeding up patient discharges. Insights from the SAIU also informed cost-of-living interventions by mapping local authority data on fuel poverty against the prevalence of diabetes, frailty, and chronic obstructive pulmonary disease (COPD). Working alongside primary care networks, VCSEs and local authorities, the ICB could enable targeted initiatives such as warm spaces and food banks in the communities that needed them most and to provide effective signposting and offer vaccinations.

The SAIU has seen transformational results and plans are underway to roll the work out across all three acute hospital sites in the ICS and properly integrate VCSE partner data through collaborative efforts with the local VCSE alliance. The project has been recognised as national best practice by NHS England and DHSC.

A snapshot

ICSs making and measuring progress against their four core purposes

Integrating to improve outcomes

Frimley ICS

"Significant implementation of our whole-system approach to urgent and emergency care leading to major improvements in Type 1 and All Type activity."

Cheshire and Merseyside ICS

"Driving forward cancer recovery. First ICS to achieve the six-week diagnostic standard since the pandemic."

Humber and North Yorkshire ICS

"Establishing centres of excellence in tobacco control, end of life care and services for the elderly."

Enhancing productivity and value for money

Herefordshire and Worcestershire ICS

"Elective care waiting list reductions. Overall waiting list of those waiting more than 52 weeks reduced by 40 per cent."

Black Country ICS

"Building trust and relationships with all partners, evidenced by the agreement of a challenging financial plan, work ongoing with non-NHS partners to develop a single public estate."

Gloucestershire ICS

"Large investment in urgent and emergency care transformation is showing reduction in cost and significant performance stabilisation. Each part of the programme is taking a value-for-money approach with the use of quality improvement methodology."

Tackling health inequalities

Bedfordshire, Luton and Milton Keynes ICS

"Targeted cancer tests in young black men have so far identified 30 men with early stage prostate cancer."

Somerset ICS

"We are using deprivation and the core 20 analysis to target dental recovery activity."

Hertfordshire and West Essex ICS

"Developed a mental health crisis hub, providing better patient experience and care for acute mental health crises that works with one of our hospital emergency departments but also with VCFSE support."

Helping the NHS to support social and economic development

Dorset ICS

"Delivery of the health village concept, with outpatient assessment centres in Poole and Dorchester and two community wellness centres in Poole and Weymouth. These create a blueprint for a health and wellbeing campus that connects community assets across a town/place."

Surrey Heartlands ICS

"Focusing on 29 Surrey towns and villages and re-shaping integrated public services around them."

Northamptonshire ICS

"Apprenticeships, anchor network programmes, mentoring schemes for care leavers and voluntary programmes to get people back into work as well as social prescribing models."

Governance, strategy and partnership working – cutting across the four purposes

Greater Manchester ICS

"Developing a data and evidence-driven forward plan that aims not just to respond to today, but looks in detail at trend analysis over the next five years."

Buckinghamshire, Oxfordshire and Berkshire West ICS

"The board approved a primary care strategy for implementation at local level. Wide stakeholder engagement to the extent that local GP leadership, acute sector, community and public views sought and acted upon."

Staffordshire and Stoke on Trent ICS

"I am most proud of the behavioural compact we have developed and embedded. To achieve, our system must remain resilient in times of stress and challenge. The senior leadership team across all sectors has embraced this concept and the result has been a palpable improvement in relationships, ambition and creative challenge."

Balancing today's challenges and building for tomorrow

ICSs play an important role in addressing both short- and longer-term issues. Many see the ICS focus on the four core purposes and system perspective as the only way to shift the dial on integration and move care upstream into primary and community care, which is essential to overcoming the operational issues facing the health and care system.

ICSs' competing demands

Building and maintaining relationships in a complex adaptive system takes time and sustained commitment. When we asked ICS leaders what they hoped to achieve over the next 12 months, over a quarter focused on building relationships and leadership capability to better deliver on their plans:

> "Improved partnership working, contributions and relationships with local authority partner and across partners. [...] I would hope that if achieved, we can really make progress on improving urgent and emergency care. Without it I don't think we will."
>
> ICB chair

ICS leaders are also focused on delivering on their financial plans, productivity targets and productivity and prevention ambitions, as well as specific areas of work such as children and young people's services, service reconfigurations and delivery of integrated neighbourhood teams. These changes will depend on strong relationships and balancing the interests of many different partners who are committed to making progress against their short- and longer-term goals. One ICB chair would like to "demonstrate people and place at the heart

of all we do, with even more evidence of the advantages of a place-based approach."

In their qualitative reflections on accountabilities, around half of ICS leaders we surveyed shared concerns about the levels of NHS England top-down performance management of ICBs, focused on acute issues, without much support or focus on longer-term transformation. ICS leaders understand the need for accountability, but consider that this can be detrimental when it is overly cumbersome or drives focus towards a narrow set of issues.

> "We are not clearly held to account against our four objectives by the national team... And the things we need the centre to do – eg set out what good looks like, do detailed bottom-up modelling of what things should cost, build commissioning capabilities – don't happen."
>
> Joint ICB and ICP chair

ICB leaders are rarely asked about delivery against their four purposes at quarterly performance meetings and are regularly sent new directives on national priorities which tend to focus on short-term operational issues and finances. While these issues are important, system leaders want to simultaneously be held accountable for longer-term goals such as shifting towards prevention and care closer to home. These longer-term goals are not a 'nice to have', but essential to the sustainability of the healthcare system.

Responses from ICP chairs who are also local councillors reveal how performance management focused solely on NHS issues can impact partnership working, which is best summarised as 'challenges, bad feeling and disengagement'. One ICP chair bemoaned the "very short notice NHS England gives the ICB to get bids, reports, strategies, etc back to NHS England," suggesting that longer lead-in times would bolster partnership working.

Another reflected:

> "I am accountable to a 1.2 million electorate and the NHS is accountable to Amanda Pritchard. They are very different."
>
> ICP chair

An ICB chief financial officer explains how a relentless focus on NHS finances "today" can inhibit "building for tomorrow":

> "Finance absolutely dominates the agenda. We have more financial conversations internally and with NHS England than anything else at the moment. How do we get the balance back going forward? We need to deliver this year and look towards the future."

ICB leaders are clear on their duty to manage the money effectively but are concerned that micro-management from the centre and a short-term approach to financial planning does not effectively support financial sustainability. For example, NHS England's planning guidance for 2024/25 was published two working days before the start of the financial year. ICB leaders had to deal with a high level of uncertainty and made plans based on assumptions that then shifted. Revisiting and reworking financial plans in the same year as they are meant to be delivered has consumed a vast amount of ICB capacity, time and headspace, which is taken away from delivering service improvement and making best use of available funds.

The Hewitt review reiterated that the proliferation of 'penny packets' and 'non-recurrent' money that in practice becomes recurrent, makes it impossible to plan effectively. In reference to the planning process, an ICB chief financial officer reflected:

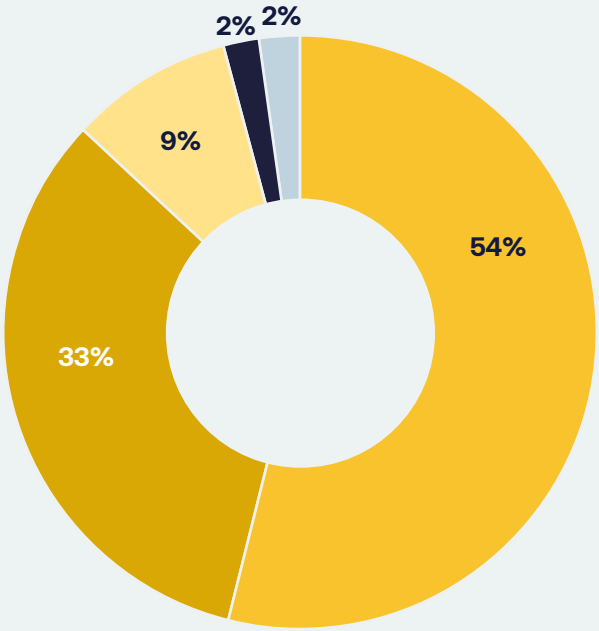
> "The earlier we can understand the information the better. Next year we're going to have to make some quite radical tough decisions. So can we have the information to make it?"

This is particularly important as ICBs are setting medium- and long-term financial strategies, working closely with NHS, local authority and voluntary sector partners to fund and deliver effective services for their populations. While some adaptation is needed, uncertainty over funding streams damages relationships and slows down delivery and the transformation needed.

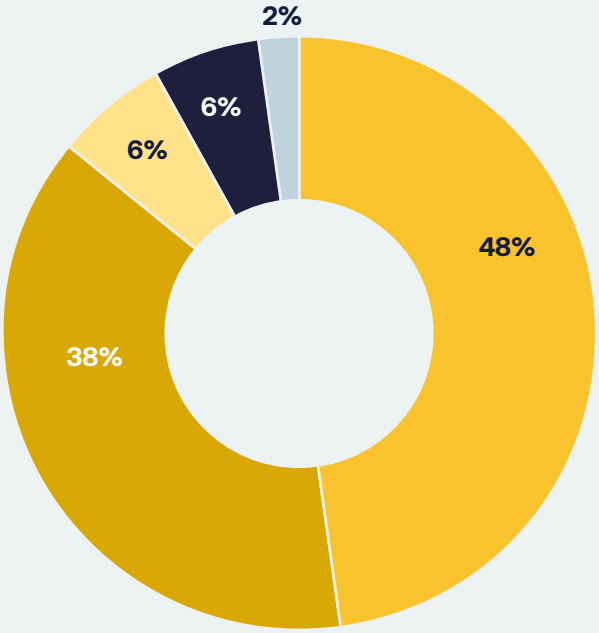
A constrained environment

There is a clear consensus that finances are a risk to the success of ICSs over the next year. More than three-quarters of respondents (over 85 per cent) are concerned that the financial position of their ICB and local authorities will affect the delivery of their ICS's ambitions. ICS leaders also chose the current financial position of the NHS and of local government as the two biggest barriers to their system's progress over the next two years. Some of these financial pressures are within their gift to tackle (eg total system agency spend), while others may be driven by wider decision-making and the external environment (eg pay awards and energy costs) and so less within their control.

"I am concerned the financial position of my ICB will affect the delivery of our ICS's ambitions."



"I am concerned the financial position of my local authority/local authorities will affect the delivery of our ICS's ambitions."



Strongly agree | Agree | Neither agree or disagree | Disagree | Strongly disagree

Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; Don't know/no opinion was an option, which received no responses; n=52

Leaders' concern in last year's survey that reductions to ICBs' running cost allowance would hinder system delivery has come to fruition. The requirement for ICBs to reduce their running costs by 30 per cent by 2025/26 continues to put pressure on their staff and makes it more difficult to balance attention given to progressing other priorities that are essential to delivering reform and achieving longer-term financial sustainability. This impact is felt by some ICBs more than others, often reflecting system size and legacy of whether predecessor clinical commissioning groups had merged or not.

The challenging financial environment for the NHS more widely is illustrated by financial planning for 2024/25, where nearly three-quarters of ICBs have submitted deficit plans to NHS England with a total overspend of £2.2 billion.

Our survey of NHS leaders in April 2024, demonstrated the pressure the sector is under to deliver efficiency savings. More than six-in-ten NHS leaders said they would need top-up funding from the government within the year to be able to hit their efficiency targets. Cutting spend on agency, locum and/or bank staff as well as freezing vacancies was the main way NHS leaders said they would achieve these savings. Given high levels of demand for care and pressures on staff, these decisions were not made lightly.

> "We've figured out how much we need to deliver, not even what we would like to deliver but what we think we should be delivering. And it's not the settlements that the NHS is offering us. And that's all over the country."
>
> ICB chair

Local government is also struggling, with a rise in local authorities issuing section 114 notices or 'declaring bankruptcy' over the past year. The Local Government Association has warned that councils face a funding gap of more than £6 billion over the next two years, in the context of a reduction in their real-terms spending power since 2010/11.

NHS spend is being driven by a range of factors, with variation across the country. Some are outside ICS leaders' control, such as higher inflation, energy and construction costs. Others are more within their grasp, such as driving medicines optimisation and addressing staff costs. The longstanding maintenance backlog has continued to increase, which is both a drain on productivity and a risk to patient safety. The expected pay award for NHS staff to settle industrial action was either not planned or cost much more than was budgeted for at the start of the year.

For local authorities, key cost drivers include an increased demand in SEND services and children's and adult social care. An ageing population and increased comorbidities also mean demand for health and care services will continue to rise. A number of regulatory decisions may also be driving up costs in particular areas such as staffing. For example, one chair shared an example of a CQC decision leading to an increase in midwives despite the birthrate in their system decreasing. This is one of the areas Dr Penny Dash, chair of North West London ICB, will be exploring in her review of the operational effectiveness of the CQC.

Tough decisions are testing partnerships

These financial constraints are testing relationships and partnership working within systems. Leaders across the country are making difficult decisions about what to prioritise. They are grappling with addressing current pressures and planning within their budgets while limiting the fallout from reducing services and programmes on staff and patients.

One ICB chief executive shared that they are "already cutting back, delaying or deferring the very things that will be the route to medium-term financial sustainability (and better health and healthcare), sacrificed on the altar of break-even today." This aptly demonstrates how a lack of funding and tightening of fiscal rules can undo efforts at reform, undercutting the new government's agenda.

Investment in health inequalities can be one of the first areas affected. NHS Confederation research into how systems used additional funding for health

inequalities demonstrated that leadership, governance and relationships were the key enablers in maintaining this investment.

The overall financial context can lead to retrenchment within organisations. For example, in one place-based partnership, an NHS trust can no longer commit to splitting funding of a public health team equally with the council as previously agreed. Its place leader reflected that 'if you don't stick to what you'd committed to, all you're doing is transferring that financial problem onto a partner. That's not partnership.'

For some, this is also an opportunity to make some radical choices and bold decisions:

> "The depth of the challenge is really making partners come together, face up to the structural deficit, and get on with making changes that have been ducked for the last decade or more. I'd much rather we weren't in this situation, but I suspect that without it we'd still be stuck in many of our old ways."
>
> ICB chair

Stepping up to the financial challenge

Despite financial constraints, system leaders are stepping up to the financial challenge and are creating value.

A system approach to maximising value for money

Each ICS faces its own history and context, including the local economy and labour market, provider history and levels of deprivation. For the most challenged systems, the road to financial sustainability will be incremental. Data also suggests that overall NHS productivity has fallen since 2019, despite an increase in staff and funding, with some areas seeing improvements. As the Darzi report highlighted, this does not mean that staff are not working hard, but rather that operational processes are not supporting staff to work efficiently, which is then impacting on their motivation and enjoyment of work.

Reflecting on this challenge, a third of respondents believe there are more opportunities to maximise available resources and improve productivity. In fact, nearly 80 per cent of respondents are confident that their system is currently able to enhance productivity and value for money. An ICB chief executive shared that "this is a prime focus in our system (as in many). The key will be consistent measures and getting behind the data in a way that helps staff engage." An ICP chair highlighted the need to take a targeted approach by focusing on "population need and a system approach to improving outcomes."

ICBs and ICPs have a vital role as convenors and catalysts for change. Together, they can identify areas of increased efficiencies and productivity, bring together partners and set a shared vision for the future. ICS leaders shared examples of system-wide, medium- and long-term financial planning and of working as one finance team across providers. For example, a joint ICB/ICP chair shared

that they "have a detailed financial improvement plan that all providers support and have signed up to, with a system improvement director and project management office to drive delivery of the identified improvements." One ICB chief finance officer made clear that the ICB had not set the plan but rather it was "agreed as a system, with all partners from the outset," which had brought them closer together.

Investing time to improve relationships by having honest conversations and creating a culture of financial transparency can support real improvement, as demonstrated by the experience of North West London ICS.

Enhancing productivity and value for money

Case study: **Addressing acute productivity and a longstanding deficit in North West London**

North West London ICS faced a longstanding deficit, difficult relationships in the system with productivity challenges across the system.

To tackle it, they undertook a needs analysis across the ICS in acute, community, mental health, primary care and Continuing Healthcare compared it with their areas of spend. This enabled them to identify gaps between resourcing and needs and where they were spending more than they needed to.

The system also analysed productivity levels, including cost-weighted activity across different sectors. One of the root causes of excess expenditure in the acute sector was low theatre productivity. To address this, the ICS focused on increasing grip and control and ensuring basic processes (such as scheduling) were as effective as possible improving productivity and financial planning.

This was enabled by improving ways of working, transparent reporting, operational challenge and decision-making. Being open and transparent about resources, financial plans and performance data and ensuring that all the directors of finance worked together is key. In addition to this, it

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ensures that all system financial decisions are made collectively, and that no organisation should be "left in distress" as a result of those decisions.

Overall system theatre utilisation moved from 70 per cent to 83 per cent and the system has consistently achieved over 80 per cent for 12 months. North West London ICB has also submitted a breakeven plan for 2024/25.

ICBs are looking at avoiding duplication and using economies of scale to complement local delivery. This applies to both corporate and frontline services. Sharing public estates is a key area of interest and systems are using tools such as SHAPE Atlas to map their existing estates and make strategic decisions. For example, in South Yorkshire, ICB staff have relocated to South Yorkshire Fire and Rescue headquarters, making better use of existing public property. Co-location is increasingly used by place-based teams to drive integration and improve service delivery.

Thinking holistically about the workforce and undertaking integrated workforce planning is also an area of opportunity. An ICB chief people officer explained that workforce teams within NHS providers and local authorities are focused on the operational, while the ICB has a remit, skills and expertise to take a wider approach:

> "Nobody else has got the bandwidth to think about that beyond the ICS. For me, that's part of our job."

Holistic thinking involves considering health and care needs, population health, system strategy and current capacity and skills within the system for a workforce for the future. ICSs are sharing and blending roles, for example in Greater Manchester, where integrating their workforce has provided better personalised wraparound care and improved staff experience and retention. NHS Employers' guide to integrated workforce thinking is a useful resource for ICSs on this journey.

ICSs are tackling issues such as elective care waiting lists, flow and discharge through strong collaboration between system partners, clinical and staff engagement and data analysis. For example, an ICB chief executive described

"bringing relevant senior clinicians together to tackle increasing surgical productivity across our three acutes," which has "led to further improvements in discharge rates and marked length-of-stay reductions for some procedures."

Systems are also using digital innovation and technology to drive the right type of activity. Cheshire and Merseyside ICS has implemented a high-impact waiting-list initiative across all its acute hospitals. The system has deployed an AI-backed decision support model to help find, prioritise and support some of the highest-risk patients on waiting lists. An NHS England assessment of the first 125,000 patients to be managed through the system found a two-thirds reduction for ICU for the highest-risk patients, 125 bed-days saved for every 1,000 patients on the waiting list, an 8 per cent reduction in emergency admissions and reductions in avoidable harm.

Leaders across the system want to learn from one another, especially as many experienced staff have left since the pandemic. The NHS Confederation is working with partners on the development of an analytics and knowledge network, to share best practice and use benchmarking to improve services and care and reduce unwarranted variation. One ICB chair shared that NHS England's Model Health System tool, which provides systems and providers with benchmarking quality and productivity data, is key to this. Based on a forecast of their system finances, "if they could get all of our acutes working fully to model hospital, we could halve the deficit." The NHS Confederation will continue to convene members from across the health and care sector to share learning and insights on a system approach to productivity.

The NHS can also learn from local government, which is strictly required to balance its budgets:

> "We are used to transforming services all the time. [...] I have said to our ICS to use those skills and experiences in local authorities."
>
> ICP chair

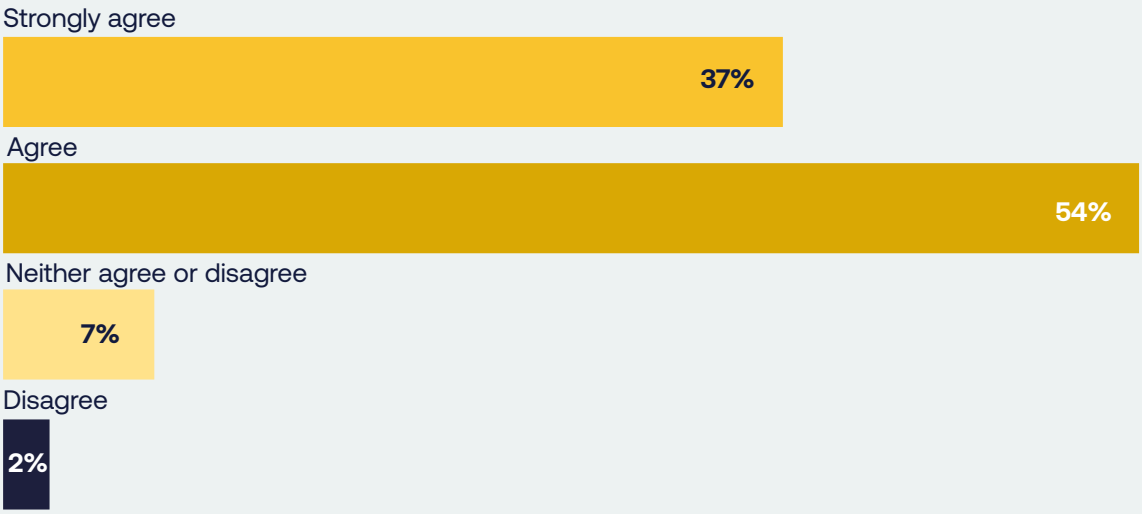
Shifting resource upstream

ICS leaders are not just focused on technical productivity and saving costs but creating better value for patients and improving outcomes by shifting resource upstream. This means increasing investment in primary care and community based services to prevent worsening ill health as well as designing new models of care. 91 per cent of survey respondents agree that their system has made a strategic commitment to shift the allocation of resources to allow more people to be treated in their local community and access more care closer to home.

> "While developing a value proposition for the NHS is important, if we do not fundamentally change the delivery model and place some focus on this, the NHS will become unaffordable."
>
> ICB chief executive

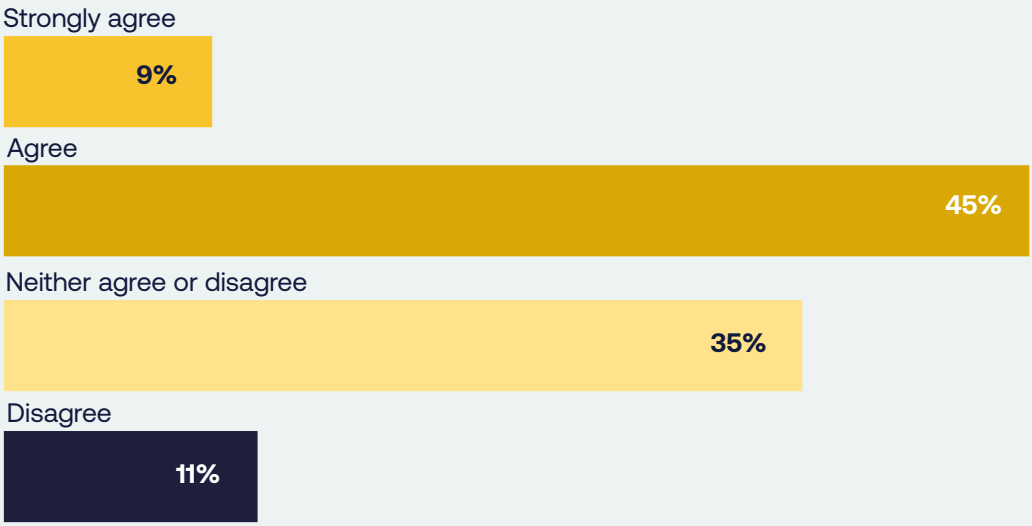
However, only 54 per cent of respondents agree that their system is making progress towards this and 35 per cent are unsure, highlighting the gap between ambitions and reality. This was reflected in the Darzi review, which made clear the longstanding dissonance between strategy and delivery of the 'leftward shift'. In fact, between 2006 and 2022, 'the share of the NHS budget spent on hospitals increased from 47 per cent to 58 per cent.'

"Our system has made a strategic commitment to shift resource to allow more people to be treated in their local community and access more care closer to home."



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; Additional options included Strongly disagree and Don't know/no opinion which received no responses; n=54

"Our system is making progress towards shifting resource to allow more people to be treated in their local community and access more care closer to home."



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; Additional options included Strongly disagree and Don't know/no opinion which received no responses; n=54

Nearly half of qualitative responses indicated that financial constraints, and particularly acute financial deficits, were holding back systems' ability to make this shift. One ICP chair remarked that "the right thing is still to move people out of hospital into another care setting. But somebody has to pay for the healthcare and that's the challenge that we're running into right now."

ICS leaders point towards the difficulty in freeing up money for transformation and shifting care upstream when their acute and mental health secondary care providers are financially challenged. An ICB chief executive shared that the "tightness of the overall financial position is driving us to slow down the (relatively small) investments needed to pump prime these changes." An ICB chief financial officer further highlighted the scale of the challenge that is slowing progress:

> "We can only shift resource if we can shift cost. So our focus is about how we move the cost base as opposed to the resource base."

However, they shared how they were able to make incremental progress:

> "If we can non-recurrently pump prime something, let's do something different and then we can take the savings out."

Current financial flows and contracts are fragmented and work against integration, with different parts of the NHS, primary care, community care and acute care not financially incentivised to work better together. According to one ICP chair, "most resource (money), is still needed in the acute system. Financial models and processes are needed to enable money to be spent in one budget that will deliver savings multiple years later, and possibly in another budget."

Other key barriers mentioned included a resistance to change from key stakeholders such as local politicians, lack of joined-up data to inform decision-making and the current GP contract, which can limit ICBs' ability to shape incentive regimes around local needs. The current one-year financial allocation process also limits the ability to shift resources over the long term, as discussed further in this report and highlighted by the Darzi report. These findings are reflected in upcoming research by the NHS Confederation into unlocking prevention in ICSs.

When systems do succeed in shifting resources in a different way, the positive outcome for their populations is clear. For example, in one ICS, "coming out of covid, we had 200 people waiting for care assessments for domiciliary care and we now have only two. We put more money into that system, and we do not have a waiting list for domiciliary care."

Improving population health and healthcare outcomes

Case study: **New GP funding formula in Leicester, Leicestershire and Rutland (LLR)**

The ICS has developed its own funding distribution formula to derive a Health Equity Payment to address problems with the Carr-Hill formula. Some of the characteristics are to:

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- compensate for inaccuracies in the Carr-Hill formula's assessment of need by levelling-up funding in low-funded practices
- use current, comprehensive, anonymised primary and secondary care
- invest in primary care so that no practice receives less than their Carr-Hill formula amount.

The LLR method bases the allocation upon case mix adjusted morbidity, deprivation, new registrations and communication issues. The Health Equity Payment is calculated using three main criteria:

- Core staff component, including a rurality element (41.3 per cent).
- Needs-related component (52.9 per cent), adjusted for multi-morbidity of actual patients; communication issues (complex needs and language barriers require longer consultation time to deliver equivalent care); list turnover (newly registered patients tend to use more GP time for a given morbidity).
- Deprivation, adjusted for IMD (5.8 per cent).

Analysis shows early positive outcomes. Uniquely, the model stratifies several independent databases according to its assessment of funding for need (GP Patient Survey [GPPS], CQC and primary care workforce data). Changes in GP Patient Survey indicators such as satisfaction with contacting the practice, overall experience of making an appointment, satisfaction with general practice appointment times, or frequency of seeing or speaking to preferred GP show a narrowing of the gap between the lowest funded practices in receipt of the payment.

This effect is not seen in practices assessed as better funded and not requiring payment. This indicates both that funding drives performance and that where you equalise funding according to the LLR model you equalise GPPS performance. It also seems to have mitigated long-term deterioration of patient experience in the lowest funded practices.

Improving system working

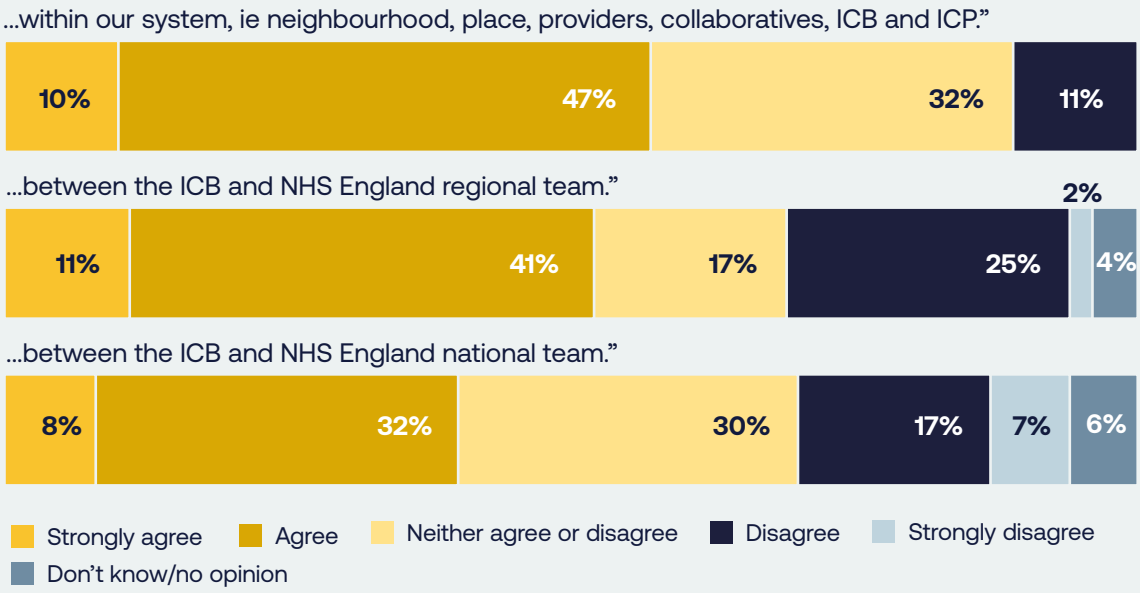
“Accountability is important. But too many people holding people to account, rather than doing the job, can be counterproductive.” The Darzi report

System leaders welcome appropriate accountability and recognise the important role played by regulation and oversight in healthcare provision, but highlight that the current framework is severely flawed. System accountability arrangements are multi-layered. Individual NHS providers (trusts, foundation trusts and primary care providers) are accountable to ICBs and national bodies, including DHSC, NHS England and the CQC. ICSs collectively are accountable to their local populations (foundation trusts are formally accountable to their local populations through council of governors) and partners within them are mutually accountable for the delivery of the integrated care strategy. ICBs are accountable upwards to national bodies. Balancing multiple masters can be challenging, as one ICP chair summarised:

> “The ICS is a multi-tiered arrangement that is both centrally controlled and responding to local demand. Progress can always be made but the current arrangements cannot optimise the outcomes for residents.”

There is a clear commitment from within the system, national government and regulators to get system oversight and accountability arrangements right, but our research shows that frustrations remain and more work is needed to provide clarity and consistency. An ICB leader described the accountability relationship between providers, the ICB and the centre as a “journey or a continuum away from individual sovereign organisations into system working.”

"System accountabilities are clearly defined...



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; n=53

Intra-system accountabilities are being embedded

Over half of ICS leaders (57 per cent) feel that accountabilities within their system are well defined. Qualitative comments revealed that ICSs are in the process of embedding an operating model across all system partners, with some further ahead than others. In the words of one ICB chief executive: "We have defined a system decision-making framework which articulates responsibilities and different levels and organisation." Almost half of respondents indicated that a system accountability framework is being systematically reviewed and evolved by all system partners.

A joint ICB and ICP chair described being on the panel for provider appointments as a helpful way to build system working into governance processes. In the words of one ICB leader: "We're working on the accountability issue on a weekly basis, sometimes almost three times a week when an issue arises and there's therefore a gradual shift toward more local decision-making with clear accountability hardwired in. That is the healthiest way to shift accountability more locally."

However, some felt there is still work to do to establish the operating model, for example between place and system programmes. Others reflected that even if accountabilities were defined, implementation did not always follow. In the words of one ICP chair:

> "System accountabilities are crystal clear but what is probably less clear is how those accountabilities are delivered at different levels."

A minority of ICS leaders flagged major concerns. One ICP chair said he didn't feel he was working "within a genuine partnership", and an ICB chair reflected that "too much central control and ring-fencing makes local accountability ambiguous."

ICB and NHS England ways of working

NHS England's operating framework clarifies that NHS England will work 'with and through' ICBs to deliver oversight of providers. Despite these encouraging words, our research suggests that the centre is yet to achieve the significant cultural shift needed to support a system that has moved from an organising principle of competition to one of collaboration.

ICS leaders shared mixed views on how clearly accountabilities are defined between the ICB and NHS England's regional team, ranging from clear agreement to duplication and confusion. Just over half of respondents (52 per cent) felt that accountabilities were well defined between the ICB and NHS England regional team in their patch. A number of respondents had positive reflections on ways of working with their NHS England regional team:

> "We have an excellent relationship with our regional director and team: it's 'with and through' in practice. Where there are hiccups, we can raise and resolve them quickly."
>
> ICB chair

> "There is an open and engaged conversation with a clear oversight framework. We have a regular and productive relationship with the regional team."
>
> ICB chair

Regional variation in experiences was notable. All ICB leaders responding to the survey from the North East and Yorkshire region (representative of all four systems in the region) agreed that accountabilities were well defined with their regional team. This reflects a model of true partnership with the region's four ICBs, known as the 'four-plus-one model' whereby the regional team works with and through them in overseeing the performance of NHS trusts. This is most akin to the model described in NHS England's operating framework which, for most of the country, remains an aspiration.

Some ICS leaders shared frustrations at duplication caused by NHS England regional colleagues not observing the arrangements set out in the operating framework. The consequences of this can be severe, leading to prolonged decision-making and adding to the regulatory burden on providers. As an ICB chief executive explains:

> "While accountabilities are defined, day-to-day working does not always result in 'system first'. There are examples of when NHS England bypasses ICBs resulting in duplication and confusion."

The most commonly cited example of this was regional teams liaising directly with providers in ways which disempowered ICBs.

> "I don't expect them to not speak with local providers – but I do expect them to let me know when they do – and why."
>
> ICB chief executive

Several ICS leaders called for more clarity on accountability and the levers and tools ICBs hold to perform their dual role in system oversight and as system convenor. An ICP chair described this as "an unresolved conflict both regionally and nationally where the responsibility for outcomes is devolved but the power to act locally at system level is not to the same degree." Another ICB and ICP chair referred to this as a "design flaw" which complicates system working, whereby the ICB has "accountability without authority and no levers." Some systems are facing the added challenge of significant leadership churn across NHS and local authority partners. These concerns align with the suggestion in the Darzi report that the roles and responsibilities of ICBs need further clarity.

ICS leaders were also split in their opinions and experiences of working with NHS England's national team. Only 40 per cent of respondents felt that accountabilities were well defined between the ICB and NHS England national team. Twenty-four per cent of ICS leaders surveyed disagreed, including 7 per cent who strongly disagreed.

Some respondents noted improving ways of working. One joint ICB and ICP chair reflected:

> "I believe that although it has been very challenging our accountability with the national team is clear and constructive in nature."

However, many ICB leaders shared instances of national directors directly approaching providers, bypassing the ICB and/or regional office, or contradicting what region/ICB/provider(s) have agreed. NHS England's policy and guidance is often experienced as overly bureaucratic, time consuming and out of touch with system working, with a prime example cited as being the development of guidance on the annual appraisal of trust and ICB chairs, which initially contained 64 questions. ICB leaders also highlight that directions from NHS England's national team can also sometimes be contradictory, for instance in delivering safe staffing levels while reducing staff numbers to cut costs and meet financial targets.

System oversight

NHS England and the CQC have worked hard since the 2022 act was passed to develop frameworks for system oversight that provide clarity, but the survey demonstrated that some ICS leaders feel that this has not yet been achieved. According to the draft NHS England oversight framework, NHS England will only delegate responsibility for provider oversight to ICBs with higher capability scores. NHS England's new oversight framework was described as 'convoluted and complex' and some questioned the subjective nature of measures used to calculate ICBs capability. To note, NHS England is still iterating the oversight framework in response to its formal consultation.

> "There is no clarity. [The NHS England regional team] increasingly expect the ICB to take on the oversight and assurance role, however no resources are being transferred to allow this, plus the ICB is expected to reduce running costs significantly. It is also unclear whether providers recognise the role of ICBs in oversight and assurance."
>
> Joint ICB and ICP chair

One ICB and ICP chair described the challenge of balancing an oversight and convenor role:

> "Everybody wants to have a very clear performance framework and accountability and wants partnership and shared leadership and all that kind of stuff. And I think it's very hard to manage both."

Balancing this dual role will be particularly challenging for ICBs in the current context of financial challenges explored in the section 'Balancing today's challenges and building for tomorrow' on page 23.

If the oversight framework is not administered correctly, it poses a big threat to partnership working. A survey of trust chief executives by NHS Providers demonstrated the strength of feeling about the burden placed on providers by multiple layers of regulation, including the ICB. Seventy-two per cent said that the burden of ICB regulation had increased, compared to 48 per cent from NHS England and 36 per cent from CQC. In the context of NHS England increasingly devolving an oversight role to ICBs, it is concerning that NHS England's regulatory burden did not reduce in parallel. This is evidence that the new operating model is not working in terms of role definition.

CQC's capacity to conduct assessments has also been called into question by Dr Penny Dash's review of the CQC. Her interim report, which was based on wide engagement across the health and care sector including CQC staff, found evidence of significant operational challenges. It highlighted major concerns around the CQC's single assessment framework, including a move away from a focus on outcomes, a lack of clarity around how different ratings are arrived at for each quality statement, and concerns around how data is used to inform judgements. In this context, any imminent roll out of the assessment framework for ICSs – including the use of one-word ratings – would be ill advised. In our research, ICS leaders shared concerns about duplication between NHS England and the CQC's role in system oversight. The next phase of the CQC review will look at the overall regulatory landscape and burden, which, as revealed in the Darzi review, has doubled in size in terms of staff numbers over the past 20 years.

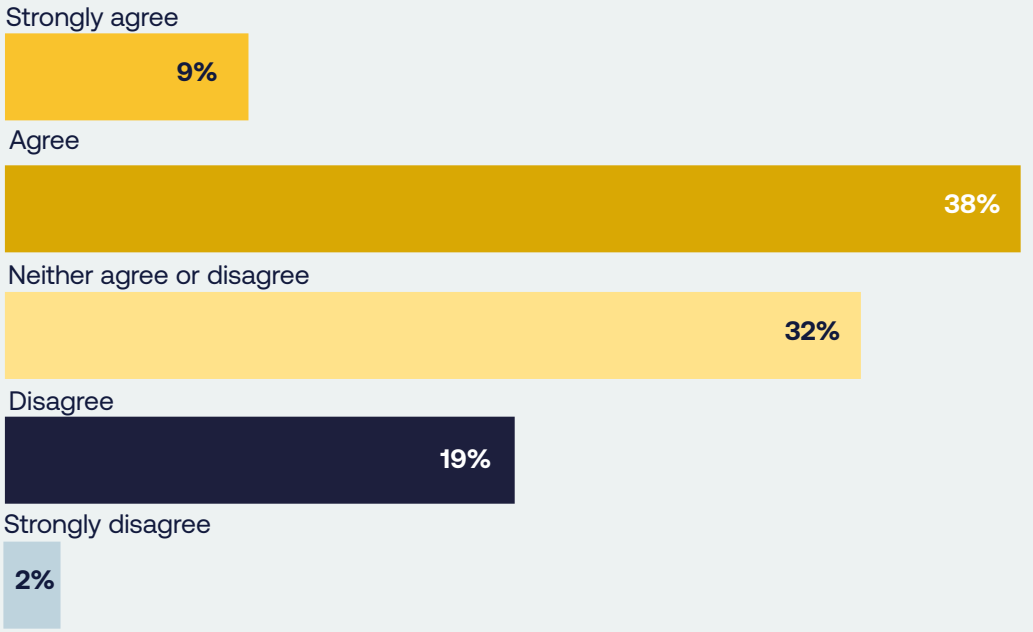
Supporting devolution within systems

As partnerships between the NHS and local government, ICSs will play a key role in supporting a more devolved model of health and care. They are part of a devolved accountability model, whereby functions previously held by DHSC or NHS England are, over time, delegated down to ICBs. In turn, ICBs delegate to other spatial levels within the ICS, including provider collaboratives, shared group models, place-based partnerships and neighbourhood teams. Alongside this, ICPs play a key role in bringing together the broad spectrum of partners with remits across both healthcare and the wider determinants of health to improve the health and wellbeing of their local population. The NHS Confederation is conducting research with chairs and chief executives in

shared group leadership models, which has highlighted that success depended on local leadership, devolution and ownership and the need for simplifying system governance and accountability arrangements to support cohesive decision-making.

Place is often the best spatial level for addressing service integration, for example in relation to urgent and emergency care. However, as our research reveals, the need to focus on financial and operational recovery has slowed the pace of devolved decision-making, which in turn drives service innovation, productivity and improvement: all crucial to long-term financial sustainability.

"My system devolves decisions to the most local level, as close to our communities as possible."



Source: NHS Confederation | State of Integrated Care Systems Survey 2023/24; n=53

Just under half of ICS leaders surveyed felt their system devolves decision-making to the most local level, as close to communities as possible. This response is similar to last year's survey, with an increase of only 3 per cent of those who agreed, indicating that little progress has been made. An ICB and ICP chair described the role of the ICB as "setting strategy, allocating resources, system oversight and assurance", with delivery being "the clear responsibility of places." Many others described a similar model but were at different stages of embedding this in practice.

A minority of systems have a more devolved model whereby resources and responsibility are delegated to place level, with governance arrangements that support this.

Case study: **A devolved operating model in the Black Country ICS**

The Black Country ICS has a clear operating model based on devolution that has been agreed by all system partners and its place-based partnerships are genuinely place led. All four places in the system – Dudley, Sandwell, Walsall and Wolverhampton – have established place partnerships involving local authorities, voluntary sector organisations, as well as those in wider partners including housing, which they have used to identify the key health and care issues to address in their respective places. Each place has an ICB managing director that oversees the budget and commissioning responsibilities. Simultaneously, the ICB and ICP have identified work that it is appropriate to undertake at a system level, or in some cases at a wider level, working with the West Midlands Combined Authority. This is underpinned by an outcomes framework that supports targeted investment and impact measurement.

Informal delegation was introduced with defined responsibilities, with the Health and Wellbeing Boards directing population health priorities. The ICB and the Place Integrated Commissioning committee acts as the commissioning vehicles, while the place based partnerships lead the transformation and strategy for integrating care. Place Based Partnerships and Neighbourhoods concentrate on local healthcare delivery, transformation and integration. Having a clear, delegated framework for strategy and service commissioning enables focused transformation of delivery of healthcare services across the system.

A place leader we interviewed described one of the barriers to achieving this level of delegation and offered an alternative way forward:

> "ICBs take a line from NHS England as a reason not to delegate, but even if you don't transfer the budgets you can delegate the management of the budget and the commissioning of services."

An ICP chair urged ICB colleagues to "allow other organisations to take the lead sometimes rather than feeling they have to do everything themselves."

Some respondents challenged the question and emphasised that devolution should occur at the right level and where appropriate. In the words of an ICB chair:

> "The challenge is working out, and building a consensus, around which decisions sit where."

ICBs are operating with reduced budgets and are being tightly managed on finances. This is reflected in our research, with financial constraints leading to centralisation as well as a lack of support from the centre cited as key barriers to devolved decision-making.

> "We have made more progress in one of our 'places' than the other. This is challenging as local partners want to pursue local agendas and that's a challenge in an era of so much top-down direction."
>
> ICB chief executive

Another explanation given for the slow pace of devolved decision-making is the need for improvements in the capability and capacity of local leaders at place, neighbourhood and in provider collaboratives to enable this to happen. There is also variation across places in terms of their capacity and readiness to take on more, exacerbated by the financial challenges facing all partners. A place leader we interviewed emphasised the need to protect committed funding in support of partnership working.

> "We drip, drip bits of responsibility and decision-making to them on the basis of more will come when maturity in our system working happens. Timing on this is critical because at the moment we've got a massive recovery job to do."
>
> ICB leader

A majority of respondents shared that they intended to accelerate devolution in the upcoming year to both places and emerging neighbourhood teams.

> "While there are still many neighbourhoods which are embryonic, the engagement with many is developing well, the primary care providers share the ambition, the voluntary sector is engaged through board representation and local initiatives – the year ahead will have particular focus on their development."
>
> ICB chair

The NHS Confederation is undertaking research to understand different models of place and neighbourhood working, which will make several recommendations to systems and national government.

How the centre can enable the change

ICSs need support from national government and arm's-length bodies to deliver on both their priorities for today and tomorrow. As was echoed in the Darzi report, across the health and care system there are areas, in particular capital and social care, where more money is urgently needed to boost overall system productivity. A new government provides new opportunities for improving ways of working in terms of oversight and financial planning and facilitating the shift to more preventative care. The government's upcoming ten-year health plan provides a springboard for action.

Addressing the funding gap in social care and capital investment

It is clear the government will likely need to plug this year's funding gap, meeting the Health Foundation's 4.5 per cent per annum increase for the rest of the parliament. But ICS leaders want to see increased investment in social care, local government and capital, not to just look at NHS finances in siloes.

ICS leaders warn that the lack of funding for social care is one of the biggest barriers to systems' progress over the next two years, which is especially concerning as this was seen as one of the biggest opportunities for joint working between NHS and local authority partners. They are keenly aware of the interdependencies between health and care, and the need to support a chronically underfunded social care system. In fact, the Darzi review pointed out that the 'impact of delayed discharges is equivalent to 12 per cent of all NHS beds.' Successive governments have repeatedly delayed reform, including recently scrapping the Dilnot reforms, demonstrating that social care has not been 'valued or resourced sufficiently.'

As one ICP chair shared:

> "We talk about one per cent of the NHS budget going into social care. If we could make it 5 per cent, that would be transformational. That's the sort of scale that says we're committed and means that we would necessarily have to change the way that we deliver NHS care."

In the context of local government's financial challenges, a funding solution for social care will be essential for ensuring continued integration between health and care services.

ICS leaders continue to highlight the gap in NHS capital funding and inefficiencies in the capital allocation process as a barrier to better productivity. In fact, lack of capital funding was a close sixth option when asked about their biggest barriers. The Darzi review sounded the alarm on the raiding of capital budgets and the overall shortfall, which means England falls behind comparator countries in terms of capital investment. The NHS Confederation has called for a £6.4 billion annual capital funding increase for the NHS at next year's three-year Spending Review and is working with members to identify new ways to raise capital funding and improve the capital allocation process.

Payment reform and better financial planning

A new government provides an opportunity to think radically about how money is allocated. This includes payment mechanisms as well as the financial planning and allocation process.

It is clear from our research and from the reviews by Patricia Hewitt and Lord Darzi that the current financial planning process is inefficient and inhibits partnership working. The centre should provide as much information and certainty to local leaders as possible to drive the right decision-making. Multi-year funding settlements are the only way for ICSs to deliver on their long-term ambitions – in particular changing models of care and improving population health.

Recommendation: **Multi-year funding settlements**

Instruct relevant departments – in this case the DHSC to NHS England – to outline Spending Review length funding allocations for both revenue and capital. This would bring the NHS in line with the government's commitment to give councils multi-year funding settlements. Allow for a proportion of this funding to be front-loaded to be spent in the first year for outcomes-based care for the length of a Spending Review and place a moratorium on further ringfenced non-recurrent funding. Instead, give ICBs and trusts the realistic full sum available for the year based on agreed outcomes, rather than delivering it piecemeal.

The current NHS payment system is also in need of urgent reform. NHS Confederation research into payment mechanisms highlighted that current payment mechanisms work against integration by incentivising more activity in the acute sector at the expense of other areas of care that intervene earlier to prevent worsening ill health and provide better value. Fractured financial flows make it difficult for different parts of the NHS to work together effectively Changing payment mechanisms can support both better technical productivity and allocative efficiency, in particular supporting ICSs to shift resources upstream, which they are committed to doing.

Future versions of the NHS Payment Scheme, including for 2025/26, are an opportunity to remove some of the current barriers and move towards the right incentives for integrated care, for instance towards outcomes-based payments in some settings. In the meantime, ICBs should be supported to experiment locally with their payment mechanisms. The NHS Confederation is committed to supporting systems to innovate and develop novel approaches. Looking ahead, and with the right building blocks in place, risk-weighted capitated payments could better support the ambitions of ICSs.

Supporting shifting resources upstream

Alongside better incentives for out-of-hospital care and multi-year funding settlements, ICS leaders want national partners to support the shift in resources upstream by improving sharing of learning and evidence and rebalancing priority-setting and oversight to incentivise such activity. For example, NHS England and the CQC could draw on locally developed outcome-based measures to oversee performance of providers and ICSs. While giving them the right autonomy, ICS leaders would find helpful some headline, long-term outcomes-based measures nationally to demonstrate the government is committed to making the shift towards prevention.

An ICB chair said they want national bodies to look beyond access and 'start to value and acknowledge these things.' Another ICB chair would like national partners to 'make at scale, the evidence case, building not just the direct health benefits but also wider and often greater economic and social benefits.' Other asks included tackling primary care contract reform, more management support in ICBs and investing in the public health grant. The latter could make a real difference according to an ICP chair: "Fund [the public health grant sufficiently so we can redirect people into proper prevention rather than just try to manage them when they enter the NHS system."

Strong partnership working with local authorities and the voluntary sector as well as better use of the Better Care Fund (BCF) were cited as local enablers that the government should continue to support. Recent revisions to the BCF to extend its cycle, put greater emphasis on integration and provide additional funding were a step in the right direction, but its implementation needs greater consistency and its funding protected. The timing of the BCF guidance and its funding allocations should be fully aligned with the planning cycle, for systems to use effectively and consistently in planning and delivering services and support.

Recommendation: **New payment scheme**

Ensure the 2025/26 NHS payment scheme, as well as future iterations, supports the shift towards integration and more preventative healthcare by incentivising out-of-hospital care and allowing more flexibility and local variation. Work with systems to pilot new payment systems and scale them where they prove valuable.

Empowering ICBs to deliver

System oversight arrangements have come under particular scrutiny this year, with NHS England consulting on its new oversight framework and a review led by Dr Penny Dash into the operational effectiveness of the CQC, much of which was highlighted in the Darzi report. This follows the review by Patricia Hewitt into ICSs' autonomy and accountability a year earlier. These reviews provide a helpful roadmap for a new government to ensure oversight incentivises system working and a more balanced focus on short- and longer-term goals. But examples from both ICB and ICP leaders demonstrate that there is still a lot of work to be done to provide clarity and consistency and to cement the ways of working that were agreed in NHS England's operating framework.

Recommendation: **Evolve and embed the new operating model**

Both the government and NHS England should embed the new operating model by working 'with and through' ICBs to tackle issues in the wider system. This should be done consistently across regions. NHS England should ensure its own role in oversight is proportionate to the level of oversight afforded to an ICB through the oversight framework to ensure it does not simply add a new layer. This should be iterated and evolved in close partnership with ICB and provider leaders.

When the health and care system faces extreme operational and financial challenges, now is a crucial time to get the basics right and ensure ICBs are empowered to deliver.

A first important step is ensuring that the system and the centre work together effectively as partners. The variability we uncovered in NHS England regional and ICB relationships is concerning and indicates that NHS England's operating framework is not being embedded evenly across regions. Moreover, experiences of both providers and ICBs are evidence that the new NHS England operating model is not currently working as effectively as it could in terms of role definition.

Oversight plays an important role in driving focus, but currently it does not incentivise an equal focus on short- and longer-term issues. One positive step would be to set out an expectation that ICBs will commission based on population health outcomes, not just activity. DHSC/NHS England could draw on locally developed, outcome-based measures to oversee performance of providers and ICSs. These should be used across NHS England's oversight framework, CQC's ICS assessments and DHSC's oversight.

Recommendation: **Oversight should incentivise a balance between today and tomorrow**

The government, NHS England and the CQC should hold ICBs to account on their four purposes alongside a small set of locally and nationally determined priorities. This applies both to formal oversight/accountability structures and in day-to-day working, for example by giving more time in performance meetings to focus on longer-term issues.

ICB leaders feel they are being handed more responsibility without being given the levers and tools needed to deliver. System leadership requires a different set of skills and competencies than the more traditional top-down NHS regime, focused on coalition-building and problem-solving across the partnership. ICS leaders need coordinated support for leadership and development and protected continuous professional development in line with the recommendations made in the Messenger review. Currently, leadership programmes provided by NHS England are predominantly focused on provider organisations, but ICS leaders also need tailored support. In some cases, they need further support and direction from national government

and national bodies to progress particular issues, with freedom to tailor this to fit local circumstances. Area ICS leaders want more support or guidance, include having appropriate levers for oversight and support for developing commissioning capabilities.

Recommendation: **Give ICBs levers to devolve**

DHSC, NHS England and other national stakeholders should consider how to give ICBs more levers to progress the devolution of decision-making to place and neighbourhoods, without prescribing specific actions or timelines. To support this, DHSC should make integration at place a key theme of its ten-year reform plan for health.

Conclusion and summary of recommendations

ICS leaders agree with the new government's assessment of the changes that are needed to stabilise the health and care system and improve outcomes, from shifting resources towards prevention and care closer to home, enhancing devolution including the role of mayoral combined authorities, to moving to a neighbourhood health service. ICSs and national government can be key delivery partners in making these changes, which are the only way to put the health and care system on a sustainable footing and improve the health and prosperity of the nation.

However, the operating context is challenging, particularly given the financial challenges facing the NHS and local authorities. A relentless focus on NHS finances risks crowding out the longer-term transformation ICSs were established to deliver. The unbalanced focus on short-term operational and financial issues risks undoing the progress that has been made in partnership working that is critical to integrating services for the benefit of the public. System leaders are doing what they can, trying to balance short- and longer-term goals, but there are some things they need from national government and national bodies to be able to be partners in change, from how money is allocated to the autonomy they are given to allocate money and deliver their statutory functions.

Based on our research findings, we make a number of recommendations to national government and national bodies, including for consideration as part of the development of the ten-year health plan:

1. Multi-year funding settlements

Instruct relevant departments – in this case the DHSC to NHS England – to outline Spending Review length funding allocations for both revenue and capital. This would bring the NHS in line with the government's commitment to give

councils multi-year funding settlements. Allow for a proportion of this funding to be front-loaded, to be spent in the first year for outcomes-based care for the length of a Spending Review and place a moratorium on further ringfenced non-recurrent funding. Instead, give ICBs and trusts the realistic full sum available for the year based on agreed outcomes, rather than delivering it piecemeal.

2. New payment scheme

Ensure the 2025/26 NHS payment scheme, as well as future iterations, supports the shift towards integration and more preventative healthcare by incentivising out-of-hospital care and allowing more flexibility and local variation. Work with systems to pilot new payment systems and scale them where they prove valuable.

3. Evolve and embed the new operating model

Both the government and NHS England should embed the new operating model by working 'with and through' ICBs to tackle issues in the wider system. This should be done consistently across regions. NHS England should ensure its own role in oversight is proportionate to the level of oversight afforded to an ICB through the oversight framework to ensure it does not simply add a new layer. This should be iterated and evolved in close partnership with ICB and provider leaders.

4. Oversight should incentivise a balance between today and tomorrow

The government, NHS England and the CQC should hold ICBs to account on their four purposes alongside a small set of locally and nationally determined priorities. This applies both to formal oversight/accountability structures and in day-to-day working, for example by giving more time in performance meetings to focus on longer-term issues.

5. Give ICBs levers to devolve

DHSC, NHS England and other national stakeholders should consider how to give ICBs more levers to progress the devolution of decision-making to place and neighbourhoods, without prescribing specific actions or timelines. To support this, DHSC should make integration at place a key theme of its ten-year reform plan for health.

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