The first days of statutory integrated care systems: born into a storm

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On 1 July 2022, integrated care systems (ICSs) finally arrived in statutory form, some five years after their initial conception through the first of the sustainability and transformation plans.

ICSs are partnerships that bring together NHS organisations, local authorities and others (/publications/integrated-care-systems-explained) to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 of them in England. They stem from a recognition (https://www.england.nhs.uk/five-year-forward-view/) that the traditional barriers between GPs, hospitals and community services, between physical and mental health, and between health and social care need to be broken down to provide care that is much better integrated. So that people with multiple health conditions, not just single diseases, are better supported. Integral to the concept is that a much stronger emphasis needs to be placed on prevention, on population health and on tackling socio-economic inequalities and the health consequences that flow from them – things that neither local authorities, nor the NHS can achieve on their own, even when working with the voluntary, community and social enterprise (VCSE) sector.

Following the 2022 Health and Care Act (/publications/health-and-care-act-key-questions), what in most places was a single non-statutory partnership board for an ICS has been replaced by two statutory parts: an integrated care board (ICB), responsible for NHS services but with much wider duties, and a statutory integrated care partnership (ICP), convened by local government and the NHS, which brings together local authorities, the VCSE sector and others concerned with health and wellbeing to develop a health and care strategy for the ICS. ICPs have until December to produce a draft of these strategies, which the ICB will be

required by law to take into account when commissioning and delivering NHS services. And the near alliteration between an ICB and an ICP operating as part of an ICS does not making explaining any of this to non-specialists easy, especially verbally.

The King's Fund has been following the development of integrated care systems since 2017. Over this time, we have conducted several pieces of research including interviews with senior system leaders (/publications/leading-integrated-care) as the concept has developed. To continue this work, over the summer and early autumn of 2022, we spoke to 25 chairs and chief executives of ICBs and chairs of ICPs, asking them to reflect on the creation of the new bodies, and their very earliest days as statutory entities.

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Context

It is only fair to open by noting that ICSs have been born into the mother of all storms.

- There has been huge political instability, with three prime ministers and three secretaries of state for health and social care, over the period these interviews took place.[1](#footnote1_tfq5ard)
- There has been massive economic instability.
- Record numbers are waiting for treatment and many, though not all, waiting times are getting worse.
- Inflation is hitting local government finances and eroding the real-terms spending increases that the NHS was meant to be receiving. There is talk of the entire public sector needing to produce more 'efficiencies', which threatens budgets further.
- There are big staff shortages in both social care and health.
- Ballots are being held, or being considered, for industrial action over NHS pay.
- NHS Digital and Health Education England are being merged into NHS England [with up to 40 per cent of their workforce expected to go](https://www.hsj.co.uk/workforce/6000-plus-jobs-to-be-cut-at-new-nhs-england/7032760.article) . That inevitably leaves NHS England's regional staff, among others, worried about their jobs.
- Over the summer, ministers have been introducing new rather than fewer targets.
- ICSs now have statutory duties to reduce health inequalities, and to improve population health. The cost-of-living crisis, however, looks certain to send those numbers in the wrong direction, at least in the short term.

For some, this is the burning platform that will force change. For all, it is deeply challenging. And so fast have circumstances changed that it already feels as though the world has moved on since some of the earliest of these interviews were conducted.

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1 (#footnote1_tfq5ard) Arguably four health and social care secretaries if you count Steve Barclay's return after an initial two-month stint in the summer.

Balancing competing priorities

The NHS and local government always face competing priorities. But the context outlined above, set against the new statutory duties to take greater account of population health and health inequalities, means that balancing 'the next five

minutes against the next five years', as one ICB chief executive puts it, feels particularly tough.

One effect of that, in the eyes of many of those we spoke to, is that the chairs of ICBs have a particularly crucial role to play.

All the ICB chief executives we spoke to are committed to, indeed excited by, the broader integration and population health goals that are at the heart of the ICS concept. But they are under huge operational and financial pressure over the day-out, day-in business of the NHS. They – and, very much, the chairs themselves – see a key role for the chair being to ensure the ICB keeps its eyes trained on the further horizon: the end goal of all of this.

This is explained most eloquently by one ICB chief executive, who says:

> *All my interview questions were about health inequalities, population health, social and economic wellbeing, and about how I was going to lead. A completely values-based interview. Which was brilliant. I want that. But that is not what the government wants us to be focused on at the moment. What I am going to be measured on is not those things. [I am] going to be [measured on] a safe winter, the money being delivered, waiting times, and basically getting performance there or thereabouts. So I completely agree that a core part of the chair's job is to make sure we retain the focus on our broader statutory duties.*

There must be a danger that the intense short-term pressures will undermine the longer-term agenda for which ICSs have been created. In some places, the fact that the chair of the ICB and the ICP is the same person, is seen as a guard against that – a point to which we return below.

Developing new forms of accountability

Accountability within the NHS

One of the bigger shifts that the legislation brings, at least in theory, is changes to accountability. Before exploring that, it is important to say that there is a lot of variation in terms of how developed ICSs are, precisely how they are operating, their relations with local government and their bigger providers, and in their relations with NHS regions and NHS England (again, a point to which we will return).

But the key point here is that up to now ICSs have essentially been coalitions of the willing. ICBs are now statutory organisations, with much NHS revenue flowing

through them, and with some influence over capital (or however much capital survives the coming spending squeeze). That, in theory, provides an authority over the constituent NHS organisations which, in systems where co-operation and joint ownership are already strong, has not really been needed. In others it puts a clear duty on NHS providers to work with the ICS – although, it must be said, several of our interviewees saw the continued relative independence of foundation trusts as a problem, and one ICB chair fears that the big provider collaboratives, particularly those centred on teaching hospitals, will be 'the cuckoo in the nest. They will eject the ICS'.

More positively, one ICP chair from local government says:

> *In my patch, I think the acute trusts have woken up to the fact that the ICB is actually where things are going to happen. And it's quite interesting sitting on the ICB board because – how shall I put it? – there is a bit of manoeuvring going on as you see the acute trusts trying to ensure that they still have the sort of influence that they're used to having.*

Or as one ICB chair puts it:

> *Quite simply, under the Act, the integrated care board is collectively accountable for the performance and the finances of the NHS in our system. So we're accountable for not just the money in the way that the clinical commissioning groups were as commissioners. We're accountable for the total system. But we don't own and run the providers.*
>
> *So establishing an understanding and a framework of mutual accountability and holding each other accountable inside the system is absolutely key. And that does include mutual accountability between the NHS and social care, with the performance of those two totally interdependent.*

It remains to be seen how far the legislation will, in practice, give the ICB teeth in those parts of the country where collaboration and integration within the NHS are weakest.

Accountability with local government

ICBs, are of course accountable to NHS England. But, under the legislation, they are also accountable to local government and the VCSE sector through ICPs and the strategic plans that are due in draft in December.

One ICB chief executive puts it this way: ‘I am accountable to both the ICB and the ICP – definitely.’ One ICB chair says: ‘If we and enough of the 42 systems do not have a lot of support locally, which we will only get by showing progress and involving people, then we’ll be swept away, and this huge opportunity will have been lost.’

It is far too early to be sure how, in the longer run, the new statutory arrangements will affect the relations with local government. Some ICPs did not have a chair when this round of interviews started, and many have had only one or at most two meetings.

One ICP chair says: ‘The big test will come when the ICP strategies are in draft form, as to what degree the ICBs will be ready to take mandates from the ICPs. And how far there are local priorities.’ Critical to that, he says, ‘will be the ICS view of subsidiarity’. This chair says he knows of one ICS ‘that is totally committed to subsidiarity and will delegate funds into each of the alliances that sit below. So that you have really locally based solutions. Another one is fairly committed, another is much more centrist.’

But while it is early days, some say that the move from coalitions of the willing to a statutory basis has seen greater engagement from some of the less-engaged local authorities. Indeed, the size of some ICB boards reflects a desire by some local authorities to ensure they have a seat where at least some of the real action may be.

One ICP chair says the fact that all this is now in statute ‘is definitely starting to change the conversation’. And given the population health duties of both ICPs and ICBs, this chair sees directors of public health, who are located in local government, as key to progress.

> *Public health is almost like a sort of honest broker between the NHS and local government. It should have various programmes to do with obesity and mental health et cetera, and to actually get the NHS to think beyond the acute, to actually think about health prevention. Getting to people before they become ill.*

The acid test, according to one ICB chair with a background in both local government and health, will be: ‘How much is the ICP going to be the ornamental part of the new arrangements and how much is it going to be an engine for change?’

One difference across systems is that in some, the same person chairs both the ICB and the ICP while in others, there are separate chairs. This is an area where the flexibility that characterised the way ICSs were originally set up has survived.

The debate is intriguing. Those areas that have gone for a joint chair argue that doing so helps demonstrate the NHS commitment – the ICB's commitment – to the work of the ICP. By contrast, where there are separate chairs, both the ICB chair and people from the local authority side argue that having a single chair would only fuel fears that the NHS will dominate the ICP. As one local government person puts it:

> *The NHS has all these targets and this top–down approach. And when you turn the old partnerships into statutory NHS bodies, with accountability through to the head of the NHS, that cannot be the vehicle for partnership. So it has to be done differently, with the ICP as a genuine partner.*

Time may tell which of these two approaches works best, although it may prove immensely difficult to assess that. And it may be that 'what works best locally' is indeed the answer.

Accountability for poor performance

Many of those interviewed believe that an absolutely key part of their accountability is to use the joint resources of the ICS to sort out troubled or failing institutions within it – at least in the first instance. This view was not universal. More than one feels that responsibility for that should lie with regional and national teams within NHS England.

Many, however, including some of the ICP chairs from local government to whom we spoke, believe this to be an essential role for the ICS – perhaps drawing on regional resources, but with those being the partner in the process, not the imposer.

One ICB chair says:

> *In the old system that didn't work. You'd have a troubled trust getting different requirements from different parts of the system. There would be the CQC* [Care Quality Commission] *report, the national improvement team bit, the regional bit and the CCG* [clinical commissioning group] *bit, with differing messages about what needed to be done, and none of it coherent. We have to bring coherence to that.*
>
> *We* [the ICB] *have to fill that gap, with a clear unambiguous plan for improvement and where people have to get to by when. We have to equip ourselves to be able to do it, and we have to be accountable for*

> *it. If ICBs are either incapable or unwilling to grab that space, they're not going to be around for very long. They will just have become another post box for the money.*

According to this chair, that is already happening with one trust in their patch that has a long-troubled history, with the region and the national improvement team working closely with the ICB to produce a single view of what is needed for recovery. But that collaborative approach is not seen universally, which brings us on to relations with national bodies and regional teams.

Recasting the relationship with NHS England and its regional teams

Both before and after the recent operating framework, ICB chief executives and chairs report continued direct intervention from NHS England with individual trusts, from both the centre and regions.

One says:

> *There has to be a different interface with the region and what they do and what they don't do, and the same applies nationally. But it is fair to say national can't help themselves from going straight to chief execs of individual trusts to beat them up about elective care or ambulance waits and generally forget to involve me or the ICB.*
>
> *I think in our region, they are trying their best to not to do that, but sometimes region doesn't know what NHSE is doing nationally. We do need to be clearer about what the role of region is going to be. I am certainly keen to step into the space of taking on a number of regional responsibilities.*

There was much support for Chris Ham's recent paper for the NHS Confederation (https://www.nhsconfed.org/publications/governing-health-and-care-system-england), which argues that if ICSs are to be a success much more decision-making has to be devolved to them, and by them to neighbourhoods and places, with a much less command-and-control approach – with the number of staff working at the centre and in regions reduced substantially to enable ICSs to fulfil their potential as system leaders. Or as one ICB chair puts it: 'We need a peer-to-peer relationship with the region, not an adult–child one.'

In the time available it has not been possible to return to earlier interviewees to get their view of more recent developments. But the impression is that central intervention has risen since the earliest interviews, not least since Therese Coffey

enunciated her ‘ABCD’ priorities of ‘ambulances, backlogs, care, doctors and dentists’. And that despite earlier NHS England guidance (https://www.england.nhs.uk/nhs-oversight-framework/) , and the operating framework, stressing a more devolved approach. Quite what Steve Barclay’s stance will be remains to be seen.

One ICP chair says:

> *The NHS is very command and control. In our area, regionally and nationally, the NHS and the Department of Health and Social Care are carrying on as before. And the NHS does like to control the narrative to the letter. I’m co-chair of the integrated care partnership and I’m really quite amazed at what the comms in the NHS put in front of me, as if they know exactly what I am going to say. And I’m not used to that as an elected member – at all!*

Relationships between ICSs, the regions and the centre, clearly do vary. One highly experienced ICB chief executive says:

> *We’ve got good senior people in the region and the regional director understands subsidiarity. So we just get on with it. We do things together. We decide which challenges we want to work on collectively. And the region often shields us from some of the stuff that rains down on them. And we'll call it out when, nationally, they intervene directly with organisations, or whatever. So, we tend to have a really good relationship with the region. But I appreciate it's different in other places, where they might have 11 ICSs to deal with and they take a more straightforward historical approach to performance management.*
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> *I do think Amanda* [Pritchard, Chief Executive of NHS England] *and the team have tried to get into this ethos of ‘It’s system by default, let's try and do things in the right way.’ I think they have been trying to put a stop to direct intervention without involving the ICS or ICB.*

Or, as others put it, it is the layers in between where the issue lies. One ICP chair says: ‘It is in middle management where I think we have the problem,’ while an ICB chief executive says: ‘It is not the top bods. It’s those thousands of people in NHSE where that’s their job. And either it is because there isn’t faith in the ICB team, and/or because the NHS regional team are threatened by not having an existence.’ Another ICB chair makes this point even more forcefully: ‘I personally have found really quite egregious the extent to which relatively junior people at a regional level have acted and used the authority of their regional position to completely undermine more senior people working within their systems.’

The role of national politicians and regulators

These are interviews only from the field, so to speak. Alternative views from NHS England, the Department, the minister, and others have not been sought. Nonetheless there were some clear asks from system leaders directed at ministers and the Department of Health and Social Care.

The local government chair of one ICP says:

> *One thing I would really encourage you to say is that government came forward with integrated care systems as a principle, and it is all now in law. But when you talk to some of the civil servants in the Department on the social care side, they are just a tiny little bit within the Department, and they have to really battle to be even heard by the health side of it. Within their own Department that transformation* [of better integration] *hasn't taken place. And in many ways it is holding back integration on the ground. Because if the NHS is still being given guidance, and having the big stick waved at individual organisations, not looking at it across the system like we need to, then that's not helping them to do what we want to do locally.*

Complaints about excessive targets and too many central initiatives are longstanding. But they remain, sometimes put most strongly by ICB chairs who might feel most at liberty to deliver them. As one chair put it most colourfully:

> *The way the centre and politicians think that they can have an impact is to set targets and launch initiatives. So there is a new discharge programme someone has discovered, or a great way of getting people through A&E and into hospital, or some other great new programme we want you to report on and a little sliver of money comes with it. And then the initiative and the money runs out. But they still want us to report on it and then some other numb-nut idea comes down from the centre. Politicians need to stop tinkering...* [they] *need to tackle the big issues of workforce, of adult health and social care, of integration and in my view solve the foundation trust problem. Stop promising the population short-term improvements. Stop saying 'A, B, C and D' – it just does not come down to something as simple as that.*

One emerging issue that is not yet at the top of most people's agenda, but is a worry, is how ICSs will be inspected and rated. Several ICSs have been working with the Care Quality Commission (CQC) on how to develop an inspection regime for systems – with most acknowledging that measuring how well integration is going will not be easy. There are questions, for example, about whether one

failing organisation in an ICS will produce a severe down marking. One ICB chief says:

> *It seems to me that you can't be an outstanding trust in a deficit system, or you can't be an outstanding trust if another organisation in your place is not. That is where the CQC could be really helpful in terms of driving collaborative behaviour. What better incentive would you want, as an ICS leader, to have everybody actually coming together to work on your weakest link? So if anything is inadequate in any bit of your place, nobody gets outstanding. Something like that would be incredibly powerful.*

Others take a very different view. That it would not be fair if one struggling organisation saw an entire system severely marked down when it was otherwise performing well.

Partnership working in local places

These interviews did not get into the detail of what is happening at a more local level through place-based partnerships (/publications/place-based-partnerships-explained) . The impression from these interviews, however, is that some quiet progress has continued there, even as the superstructure of ICSs has been changing. The picture is, however, enormously variable.

By way of example, one ICP chair says some local GP practices are very good at engaging the wider health community and council services:

> *...and that actually supports them, and takes some of the pressure off. Other GP surgeries just really want people to come in the door and go away again. They're not interested in what's going on beyond. And I think that's one of the prime targets for the ICP.*
>
> *We haven't, as an ICP, got any real power. But an ICP has soft power, and where we can see areas in the system that aren't working properly, we can start to have discussions about why not?*
>
> *We have one local partnership that is very good, all-singing, all-dancing. We've got one that's only really woken up to the fact that it exists. And over the next 12 months we want a real push to try and even them up a bit. Because that is where all the different aspects of health, with the community, the voluntary sector, the NHS and local government come together. The real integration.*

> *But many of the acute hospitals don't like it because it means that the focus will end up being taken away from them, including some resources. To put more resource at place. And to try to reduce the number of people that actually need an acute service.*

Managing the change

Creating statutory ICSs has been, for many, a bigger change than originally billed. Initially canvassed as mainly putting a statutory framework around what was already happening, it has, in many systems, produced significant (and very time-consuming) governance changes. Before the legislation, the 'top' of an ICS, so to speak, was in most places a single board that was a coalition of more or less willing partners from the NHS, local government and the VCSE sector. That has now been divided into two statutory boards – an ICB and an ICP, with the ICB required by law, when commissioning and delivering NHS services, to take into account the ICP's strategy (the first draft of which is due in December).

For the more advanced and mature ICSs, and despite the time spent on governance changes, this change to statutory status has been a relatively smooth evolution. As one ICB chief executive says:

> *Our ICB has been running since January, our ICP has been running since March, my exec team have been stable, and I've done a year's development with them. So in terms of the way we run our business, it's been exactly the same, and in terms of how I spend my day, it has been exactly the same.*

For others, the change has felt, and has been, much bigger.

Some ICSs have come through this with few changes of key personnel, whether as chairs, chief executives, non-executive directors or other senior personnel in the ICB. In others there has been large-scale change, both for ICBs and in creating the ICP's membership.

For some, this has been a deliberate refresh. For others, it has been a knock-on effect from the new arrangements. It is worth noting however that David Flory, a former deputy NHS chief executive and now chair of one of the northern ICSs, [once remarked that (/publications/worlds-biggest-quango-nhs-england)](), on looking back at multiple NHS reorganisations over 30 years, their relative success or failure depended much less on the structures than 'the personalities, the relationships, the behaviours and the degree of trust between individuals, or lack of it'. As true today, he says, as ever, 'if not more so'. Building new trust between individuals where there has been a significant change of personnel will take time.

Making the new structures work

The division into ICBs and ICPs, with the need for cross-representation from local government in particular, has for some produced some very large, and potentially unwieldy, ICB boards. In at least one system the ICB has become huge because the local authorities did not feel they could represent their views collectively and therefore all wanted to be represented individually.

For some, these large boards do not matter, so long as the committee structures beneath the board and the local place-based partnerships, where much of the real integration needs to take place, work. The hope among some others seems to be that the size of the ICB board will be slimmed down in time as trust is built that the NHS is genuinely pursuing better integration with local government and the VCSE sector, and is acting on the goals of reducing inequalities and improving population health.

However, there is a worry, that is not shared by all, that the landscape now looks decidedly crowded. In a very different way, the 1974 re-organisation (which itself sought to integrate NHS care better) became a case of '[tears about tiers (https://www.health.org.uk/publications/reports/glaziers-and-window-breakers)](https://www.health.org.uk/publications/reports/glaziers-and-window-breakers)': too many tiers. The issue here is not just the number of tiers but the number of players that need to be involved, and it isn't simple.

Currently there is the Department of Health and Social Care, NHS England, the regions, an ICS consisting of an ICB and an ICP, and their constituent partner organisations, which include councils, the VCSE sector and some private providers. Then there are place-based partnerships that will need to interact with [primary care networks (/publications/primary-care-networks-explained)](/publications/primary-care-networks-explained) and neighbourhood teams, and the continued role of health and wellbeing boards. Some do worry that there is risk of more talk than action. One ICP chair says: 'A lot of my colleagues politically say that to me, "Well, this will end up just being another talking shop." And my answer to them is, "You might be right, but if we don't engage, we'll never find out".'

Conclusion

ICSs, in their statutory form, have been born into deeply challenging times – politically, economically and in terms of performance. Workforce shortages abound in both health and social care and there are problems over pay.

No one has set ICSs up to fail. But there is [a significant risk (https://www.nao.org.uk/press-releases/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/)](https://www.nao.org.uk/press-releases/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/) that the context into which they have

been born makes it harder for the original vision of much better-integrated care to be fulfilled. The challenge is to continue to make progress to the destination even as the storms are weathered.

Given their history, there is a lot of variation in terms of how developed ICSs are, precisely how they are operating, and their relations with NHS regions and NHS England, which is itself undergoing a significant reorganisation. Not to mention differences in internal relations between local government, the VCSE sector and the NHS. There is much unfinished business.

If ICSs are to succeed, there needs to be a new and more consistent relationship with regional and national teams, and a willingness to allow forms of local and mutual accountability to take their place alongside the inevitable remaining vertical accountability to NHS England and national government. A willingness to let ICSs do the job for which they are envisaged. This new relationship appears to be developing in some places, but not all, and is under pressure from the context.

Now that ICSs are statutory, there are undoubtedly reports that, for some, the relationships with acute trusts are improving, that care is continuing to be better integrated, and that some parts of local government that were most sceptical have become more engaged. Compared to the early days of the sustainability and transformation plans, relations between local authorities and the NHS are, broadly speaking, much improved – even if it is, by definition, too early to tell how the interaction between the ICPs and the ICBs will play out in the long run.

Those we interviewed were, by definition, committed to the concept of ICSs. But their enthusiasm, and their belief that progress will be made was striking. ‘This is the only one of the many reorganisations of the NHS that makes sense,’ as one ICB chair puts it. Or in the words of a ICP chair from local government: ‘Do I think the ICS is a force for good and it's something we should be doing? Absolutely.’ Or in the words of another ICB chair, ‘We have to make this work. If we do not, it will be a huge lost opportunity.’

To succeed, ICSs need both space and oxygen. Space is tight, given the wider context and current performance pressures. Oxygen includes of course the money, but also the freedom of action to deliver what they have been set up to do. Both must be provided.

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