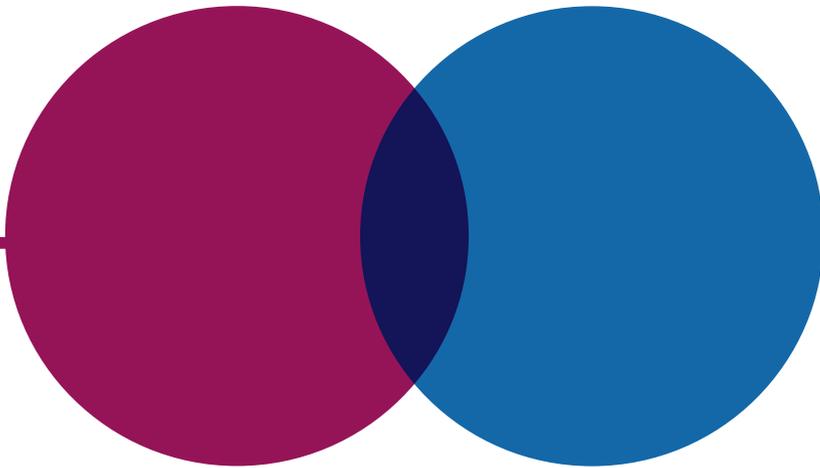




National Audit Office



REPORT

# Introducing Integrated Care Systems: joining up local services to improve health outcomes

Department of Health & Social Care

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SESSION 2022-23  
14 OCTOBER 2022  
HC 655

## Key facts

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**£113bn**

Integrated Care Boards' (ICBs') total financial allocation for 2022-23

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**£2bn**

value of ICBs' and provider trusts' one-off spending reductions needed to achieve a balanced budget in 2022-23

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**1.2% to 10.4%**

range of planned spending reductions by NHS providers as a % of their total budgets in 2022-23

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- 76%** of senior Integrated Care System (ICS) staff responding to our survey agree the move to ICSs is a good thing
- 77%** of senior ICS staff responding to our survey consider their ICS currently has an intention to invest in preventative measures to improve health outcomes
- 31%** of senior ICS staff responding to our survey consider their ICS has the capacity to improve prevention
- 9.7%** NHS vacancy rate in England in June 2022
- £9 billion** cost of tackling outstanding maintenance work on the NHS estate as of March 2021

# Summary

## Introduction

**1** Integrated Care Systems (ICSs) bring together NHS, local government and other partner organisations to plan and deliver integrated services to improve the health of the local population. There are 42 ICSs covering the whole of England, ranging in size from 542,000 people (Shropshire, Telford and Wrekin) to 3.51 million (North East and North Cumbria). Responsibility for healthcare is devolved to Scotland, Northern Ireland, and Wales, where different arrangements are in place. ICSs were introduced into legislation by the Health and Care Act 2022, the relevant provisions of which took effect from 1 July 2022.

**2** ICSs are the latest in a long line of restructures by the Department of Health & Social Care (DHSC) aimed at improving health outcomes and efficiency by joining up health, social care and other services. In each of the 42 areas, NHS bodies and local authorities come together to form two system-wide entities:

- An **Integrated Care Board (ICB)**, which is an NHS body, with members nominated by NHS trusts, providers of primary medical services, and local authorities. The ICB receives funding from NHS England (NHSE) for commissioning NHS services across the ICS area.
- An **Integrated Care Partnership (ICP)**, a committee jointly formed by the ICB and local authorities in the ICS area, with other invited bodies, for example third sector organisations. It creates an Integrated Care Strategy (**ICP strategy**) that sets out how the health and care needs of the local population will be met by the ICB, local authorities and NHSE. These bodies must then have regard to the strategy when planning and delivering services.

- 3** The four core purposes of ICSs are to:
- improve outcomes in population health and healthcare;
  - tackle inequalities in outcomes, experience and access;
  - enhance productivity and value for money; and
  - help the NHS support broader social and economic development.

### **Scope of this report**

**4** This report examines the setup of ICSs by DHSC, NHSE, and their partners and the risks they must manage. Unlike many National Audit Office reports, this is not an assessment of whether the programme has secured good value for money to date because ICSs have only recently taken statutory form. Instead, it is an assessment of where they are starting from and the challenges and opportunities ahead. We make recommendations intended to help manage those risks and realise those opportunities.

- 5** This summary provides our key findings, our conclusion on ICSs' likely success, and our recommendations. The rest of the report sets out:
- an introduction to ICSs, describing their structure, objectives, and governance arrangements (Part One);
  - an overview of the positions that ICSs are starting from, in terms of finances, staffing and activity levels, and some of the wider challenges facing the health and care sector (Part Two); and
  - an examination of government's efforts to improve population health through better integration and a focus on prevention, and our assessment of ICSs' prospects for success this time (Part Three).

## Key findings

The current position of health and care providers

**6 ICSs are being introduced at a time when health and care providers face longstanding financial and operational challenges.** NHS and social care providers have high levels of staff vacancies. Vacancy rates for NHS roles have been climbing since the start of 2021 and continue to increase. In 2019-20, the last year before extraordinary financial arrangements were put in place in response to the COVID-19 pandemic, around one quarter of both NHS trusts and Clinical Commissioning Groups (CCGs) overspent their budgets. Local authorities are facing increasing demand for care services and received 1.9 million requests from new clients in 2020-21, while local government spending power has reduced by 26% between 2010-11 and 2020-21. The value of outstanding maintenance work across the NHS estate as of March 2021 was £9 billion (paragraphs 2.6, 2.26, 2.29, and 2.35 to 2.37).

**7 The challenges NHS and care providers face have been exacerbated by the pandemic.** The number of people waiting for elective care in England doubled from two million to four million between January 2009 and March 2020, and increased to six million by January 2022. COVID-19 continues to put pressure on the NHS, most recently peaking at 14,044 people in hospital with COVID-19 on 18 July 2022 before falling to 4,540 as of 14 September 2022. The pandemic also shone a light on the health inequalities that exist for different groups, including people from an ethnic minority background, people with disabilities and those living in the most deprived areas. NHSE simplified funding and payment arrangements for NHS bodies during the pandemic by providing a fixed system budget and suspending some contracting requirements. This minimum income guarantee, plus top-up payments for COVID-19, gave providers more flexibility to respond to the pandemic. NHSE has since indicated it will be reinstating some of the incentives and penalties that were suspended between 2020-21 and 2021-22 (paragraphs 2.10, 2.13, 2.31, 2.33 and 3.10).

**8 There has been a long-standing issue with the way in which initial funding allocated to some NHS provider trusts then requires further supplementary funding later in the year to manage cost pressures. It is not yet clear what impact changes made since the beginning of the COVID-19 pandemic have had on this.**

Until 2020-21, NHS funding methods meant some providers required top-up loans. In the years before 2020-21, DHSC issued loans to bridge this gap. It wrote off £13.4 billion of these loans in April 2020 by converting the debt to non-repayable public dividend capital (PDC), a form of finance provided by government to NHS provider trusts. However, converting loan debt to PDC does not address underlying long-term financial sustainability issues faced by trusts. Trusts in deficit must adhere to stricter financial conditions and make higher than average efficiency savings. The revised financial arrangements and COVID-19 funding led to an improvement in NHS financial health. The cash held within NHS trusts grew from £6.8 billion in 2019-20 to £13.8 billion in 2020-21. NHSE has made several changes to the financial framework since 2019-20 intended to support systems and organisations to address deficits. The extent to which these fully address the underlying issues will become clearer as the additional COVID-19 funding is reduced and then removed (paragraphs 2.8, 2.9 and 2.12).

## Designing and introducing ICSs

**9 NHSE has consulted extensively in designing ICSs and, unlike the previous major set of reforms, their introduction is widely supported by the majority of stakeholders.** NHSE set out its ambition to develop new models of care in its Five Year Forward View in 2014 and tested several different models. The NHS Long Term Plan (2019) built on this approach by setting out an aim to establish ICSs across England. NHSE consulted widely with stakeholders and refined its plans and recommendations to government in response to feedback. Perhaps because of this approach, the introduction of ICSs is widely supported by many stakeholders. We surveyed ICS senior staff and 76% (228 of 301 responses) agreed that the introduction of ICSs is a good thing. By contrast, the reforms in the Health and Care Act 2012 proved controversial and attracted opposition in Parliament and from professional bodies (paragraphs 1.4, 1.5, 3.12, and 3.22).

**10 ICS senior staff we surveyed were more positive than negative about many aspects of the development support they received from NHSE, but noted guidance was not always available when ICSs wanted it.** NHSE provided support including training, guidance, ad hoc assistance and the Future NHS platform. Our survey of ICS senior staff found 27% (72 of 266 responses) agreed that NHSE had done a good job supporting the introduction of ICSs (22% disagreed). Respondents were most positive about the Future NHS platform (44% of 265 responses agreed this was effective, 12% disagreed) and NHSE's ad hoc assistance (40% of 266 responses agreed this was effective, 14% disagreed). Respondents were least positive about the timeliness of guidance (14% of 266 responses agreed this was effective, 52% disagreed) and the timeliness of development programmes and training (17% of 266 responses agreed this was effective, 40% disagreed). We asked whether respondents felt NHSE set realistic timescales for ICSs to make progress and 25% of 266 responses agreed, compared with 45% who disagreed (paragraphs 3.14 and 3.15).

**11 The scale of savings targets facing some ICSs will require even more effective partnership working to find and sustain the necessary efficiency gains.** DHSC and NHSE recognise that efficiency targets must be realistic. NHSE has agreed a core efficiency target of 2.2% with HM Treasury for 2022-23, but most ICSs and trusts have higher targets than this. The full efficiency requirement (which is 5% on average for ICSs) comprises both the withdrawal of specific additional funding for COVID-19, and the general efficiency requirement, which is 2.2% on average. The actual level of efficiency a system or trust must deliver depends on how far above or below its target allocation it is, so it may be more or less than 2.2%. Within ICSs, provider trusts have an average savings target of 3.7%, but for one provider it is as high as 10.4%. ICSs must make savings of £5.7 billion to balance the books and then maintain this lower level of spending. Of this £5.7 billion, ICSs have identified £3.7 billion in recurrent savings which they expect to maintain year-on-year. However, the remaining £2 billion savings are non-recurrent, one-off savings, and alternatives must be found to replace them next year. ICBs are responsible for delivering £1.7 billion of savings themselves but consider more than one third is at high risk of not being delivered. This is likely to include around a quarter of savings (worth £400 million) for which they have not yet identified a possible source (paragraphs 2.17 to 2.20, 2.22 and 2.24).

**12 Some aspects of the system for ICSs are still in their infancy or still being developed.** DHSC had hoped to put ICSs on a statutory footing from 1 April 2022, but in late December 2021 announced a delay to 1 July 2022. The financial plans and performance framework for the financial year starting on 1 April 2022 were only finalised in late June 2022. Care Quality Commission (CQC) has been testing and finalising its approach to reviewing and assessing ICSs throughout 2022, in preparation for its assessments of ICSs due to start from April 2023. In February 2022, government published *Joining up care for people, places and populations* a white paper on integration setting out further outcomes, accountability, and regulatory and financial reforms that it intends to begin trialling in spring 2023 (paragraphs 1.26, 3.16 and 3.18).

#### Delivering the intended outcomes

**13 NHSE has established arrangements for assessing whether ICBs deliver their core NHS objectives and is developing its approach to assessing their contribution to their ICP strategy, but it is less clear who will monitor whether integration between the NHS, local government, and others is working well, or what will happen if it is not.** Governance for the local system as a whole is complex, because it involves local government, national government and third-sector partners. Some aspects of the national oversight regime are well developed, and others are a work in progress. For example, NHSE has a detailed regime to monitor performance against core NHS objectives but has not yet set out how it will carry out its annual performance assessment of ICBs, which it expects will cover NHS organisations' contribution to shared ICP outcomes. It is less clear who will monitor the overall performance of local systems, and particularly how well partners are working together and what difference this new model makes, although from April 2023 CQC will periodically assess local systems. Work is still in progress in several areas: NHS regional teams and ICBs are in the process of agreeing memoranda of understanding setting out local priorities and how these will be monitored, and CQC is trialling its approach to assessing ICSs. DHSC intends to take an active interest in how well systems are performing, and to ensure that the right mechanisms are in place to support delivery. It has begun commissioning a programme of research to look at the impact of the changes made in the Health and Care Act 2022 and expects the first report in 2024. Our review of previous attempts to integrate services found it is important to be realistic about how long it will take for the changes to bed in before improvements in outcomes can be seen, although improvements in service quality and responsiveness may take less time. In our survey of senior ICS staff, 57% (172 of 298 responses) expect it will take between three and ten years for their ICS to significantly improve outcomes in population health and healthcare (paragraphs 1.6 and 3.18).

**14 NHSE and DHSC recognise that improving health outcomes cannot be achieved solely through healthcare, and has made progress in some specific areas, but government has made little progress on establishing a structured approach for addressing the wider factors affecting those outcomes.**

It is a well-established principle of public health theory, with which NHSE and DHSC agree, that while clinical care can make some impact on health outcomes, they are largely driven by wider factors such as healthy behaviours, social and economic circumstances, and the physical environment. At a local level, many of these factors fall within the remit of local government. However, making changes often requires changes to national policy or legislation. At a national level, policy responsibilities for the different factors are spread across almost all central government departments, so making changes requires effective cross-government working. The government's levelling up white paper describes ambitions relating to health, but the 132-page document does not refer to ICSs or describe how the changes it sets out would work alongside ICS reforms. Government has committed to publishing a white paper on tackling health inequalities later in 2022 which may provide clarity on how these challenges will be addressed (paragraphs 3.23 to 3.25 and 3.29).

**15 NHSE has asked ICSs to take a long-term approach focused on preventing ill health, in line with the NHS Long Term Plan, but in its oversight of NHS bodies over the past year it has focused on short-term improvements, principally elective care recovery.**

As far back as the Wanless report in 2002, successive governments have sought to reduce pressure on health services by preventing rather than only treating ill health. The NHS mandate for 2022-23 sets an expectation of "NHS working across different types of healthcare provision and with local government and other partners – through Integrated Care Systems – to achieve shared outcomes". ICPs and Health and Wellbeing Boards will be crucial in drawing relevant partners together in ICS areas to focus on prevention. However, our case study interviewees reported that NHSE's scrutiny of them so far has focused on financial management and tackling elective care backlogs, with prevention rarely mentioned. In our survey of ICS staff, 77% reported their ICS intended to invest in prevention, but only 31% felt they currently had the capacity to do so. NHSE commissions prevention services including immunisation and screening programmes at a national and regional level, at a cost of £1.4 billion in 2019-20, the last year for which data is available. NHSE has allocated £97 million across all 42 ICBs for efforts to improve prevention, compared with an additional £200 million for tackling health inequalities and £2 billion to tackle elective care backlogs. Where the NHS oversight framework for 2022-23 discusses prevention, it is in terms of clinical interventions primarily aimed at better management of existing conditions. There are no national objectives for working with partners to address the factors causing poor health, although NHSE has asked ICBs to develop plans to address prevention (paragraphs 1.12, 1.23, 2.14, 3.7, 3.22 and 3.23).

## The future role of NHS England

### **16 There is an inherent tension between the local needs-based ICP strategies and a standardised health service delivering the national NHS mandate targets.**

The NHS is a national health system – each year government specifies how much money is available and what national priorities it wants the system to deliver through the NHS mandate. ICBs then decide how to allocate resources to services to try and deliver both national and local priorities. NHSE has mechanisms to ensure the national priorities are delivered: its process for allocating funding, including ring-fencing funds; the operational and financial planning guidance it provides to NHS bodies; and the ongoing monitoring it carries out through the NHS Oversight Framework. Government also intends ICSs to set out local priorities and make progress against them, but there are fewer mechanisms and no protected budget to ensure this happens. ICBs are agreeing memoranda of understanding with NHS regional teams setting out what they will achieve, and NHSE’s planning guidance for ICSs sets an expectation that they make progress on prevention, including tackling the wider determinants of poor health, and other local priorities. While it would not necessarily be helpful to set spending expectations or provide national specifications for local priorities, there is a risk that national priorities, and the rigorous oversight mechanisms in place to ensure they are delivered, crowd out attempts at progress on local issues. ICSs must manage these tensions while achieving stretching efficiency targets and the national priorities NHSE has identified, particularly in recovering elective care backlogs, if they are to create capacity and resources to respond to local priorities (paragraphs 1.21 to 1.23, 2.4, 2.14 and 2.32).

**17 NHSE has set out its ambition to significantly reduce its size, in part to give ICSs “space to lead”. It is still in the process of determining the operating model and ways of working that will allow it to do so.** NHSE, Health Education England, and NHS Digital will merge into a single body by April 2023. In July 2022, NHSE announced that the successor body would have a headcount 30% to 40% lower than the current headcount of these organisations by the time it completes the transition in April 2024. The rationale for the change was partly to reverse the temporary expansion of NHSE in response to the COVID-19 pandemic, and partly in response to the creation of ICSs, which it considered needed “space to lead”. As part of the restructure, NHSE says it will focus on enabling and supporting change and empowering systems to lead locally, and simplify how it works internally and with the wider NHS. It expects to develop its plans by late autumn 2022 and implement the changes by the end of March 2024 (paragraph 3.18).

## **Value for money conclusion**

**18** The introduction of Integrated Care Systems in July 2022 marks another significant reorganisation in the way health services are planned, paid for, and delivered. The statutory Integrated Care Boards and Integrated Care Partnerships that form these systems are broadly welcomed by local service leaders. The *NHS Long Term Plan*, published a year before the COVID-19 pandemic, sought to join-up local services and grant more local autonomy to design services and invest in prevention to improve people's health and tackle the pressure on the NHS. The COVID-19 pandemic has put health and care services at every level under enormous pressure, and significantly increased the backlog of people waiting for treatment, care or support. The health and care system now needs to address these immediate pressures alongside its longer-term objectives.

**19** At present, the inherent tension between meeting national targets and addressing local needs, the challenging financial savings targets, the longstanding workforce issues and wider pressures on the system, particularly social care, mean that there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them. To address these risks, DHSC and NHSE will as a first step need to clarify what a realistic set of medium-term objectives looks like under current circumstances, building on the work done on core NHS objectives to ensure ICSs can make progress on prevention and local priorities. NHSE and DHSC also need to tackle those pressures on ICSs that require national-level strategies and solutions, including workforce shortages, NHS financial sustainability and pressures on social care. ICSs need the time and capacity to build relationships and work together to design services that better meet local needs. If DHSC, NHSE and partners can address these challenges, then ICSs could bring real improvements in the longstanding challenge of bringing health, social care and other services together with the ultimate aim of improving the health and well-being of the populations they serve.

## Recommendations

**20** To maximise the chances that ICSs can make meaningful progress against the four objectives government has set for them:

- a** DHSC and the Department for Levelling Up, Housing & Communities should, by April 2023, establish transparent arrangements across government and with wider stakeholders to tackle the drivers of poor health outcomes, including education, employment, benefits, and transport;
- b** to assist ICSs with their workforce planning, as well as providing public accountability on an issue crucial to the future of the NHS, DHSC should publish, by December 2022, both the Health Education England-led assessment of the strategic drivers for the health and care workforce, and the long term NHSE plan for growing and retaining the NHS workforce to support NHS service delivery. NHSE should then publish progress updates at least annually setting out whether and how the plan has changed in the past year, and what progress has been made against the plan's objectives;
- c** by April 2023, NHSE should set out plans to identify unavoidable cost differences in the provision of healthcare by different trusts and take account of them in the formula for allocating funding to ICBs. This should include a timetable for addressing them and changes it has made to the 2023-24 allocation process;
- d** by April 2023, NHSE should fully align its oversight of ICBs with the strategic objectives for ICSs. Specifically, it should:
  - agree with ICBs what they can realistically deliver against each of the four purposes, taking account of individual ICSs' local context and priorities;
  - ensure its annual assessments of ICBs' performance include an evidence-based assessment of the effectiveness of joint working and delivery with partners beyond the NHS, as well as their delivery of its core NHS national priorities; and
- e** NHSE should evaluate whether it can draw lessons from the simplified system of commissioning and contracting arrangements put in place for the NHS during 2020-21 and 2021-22, and streamline the requests made to front-line providers while retaining the information necessary for effective governance.