



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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National Audit Office

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

Department of Health & Social Care

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

27 September 2022

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Key facts

£113bn

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

£2bn

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

1.2% to 10.4%

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

- 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).

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.

Part One

Introduction to Integrated Care Systems

1.1 This part of our report introduces Integrated Care Systems (ICSs), including:

- ICS purposes and objectives;
- ICS structures; and
- key governance arrangements.

Overview of ICSs

1.2 ICSs aim to join up organisations providing health and care services at a local level and were introduced into law by the Health and Care Act 2022, which received Royal Assent on 28 April 2022 and the relevant provisions of which took effect on 1 July 2022. ICSs are made up of organisations involved in planning and providing health and care in a particular geographical area. This can include hospitals, GPs, local authorities, social care services, primary care providers, and independent and voluntary sector providers.

1.3 There are 42 ICSs in England (**Figure 1** on pages 16 and 17). The smallest is Shropshire, Telford and Wrekin, which covers 542,000 people, and the largest is the North East and North Cumbria, which covers 3.51 million people. This report covers the arrangements in England; health services are devolved to Scotland, Wales and Northern Ireland.

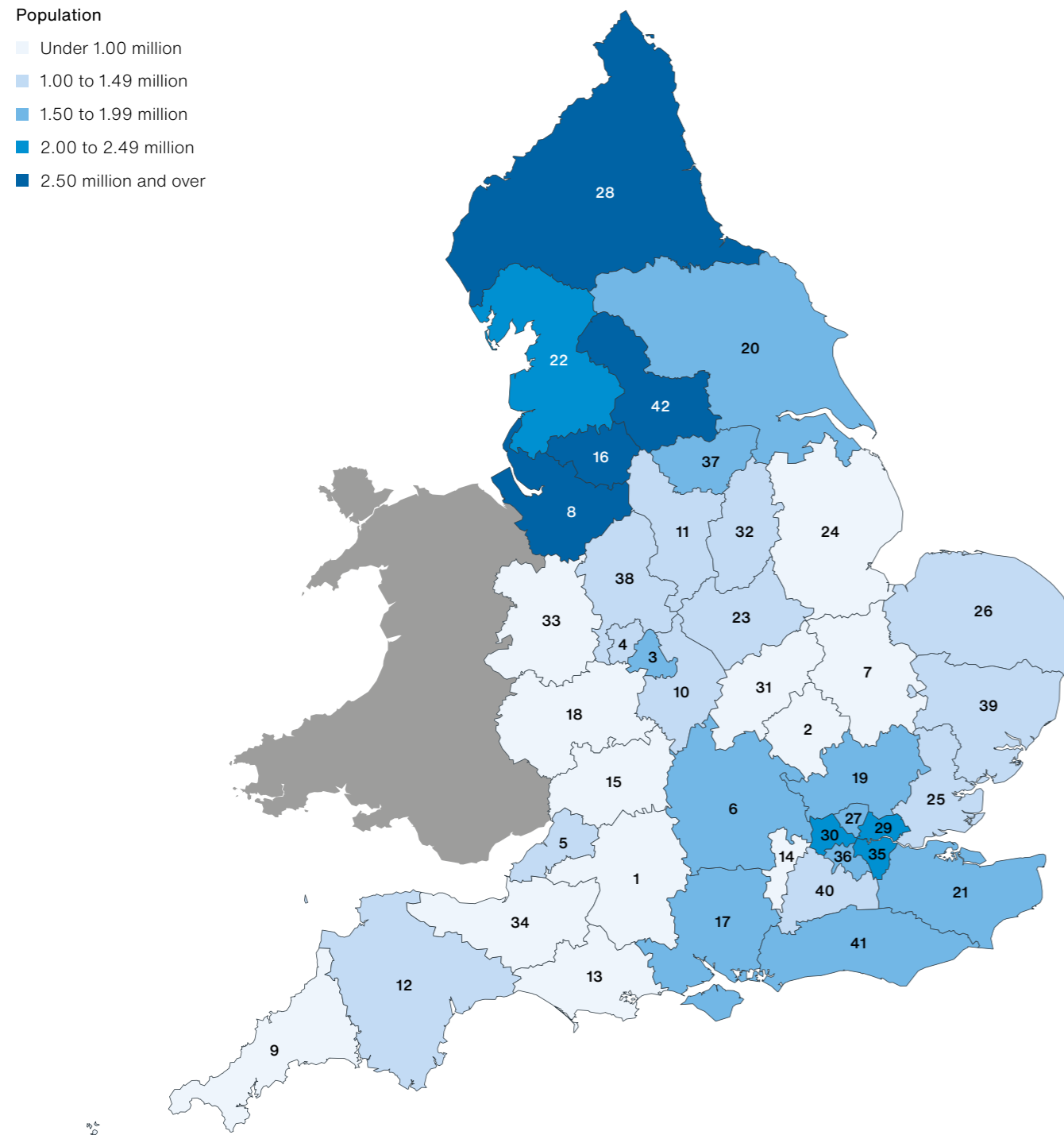
Previous reorganisations of health and care services

1.4 The introduction of ICSs is not the first time that government has reformed or reorganised health and care structures in an attempt to improve how services are provided. A summary of significant changes since 1990 is set out at **Figure 2** on pages 18 and 19.

1.5 The NHS has been testing approaches to improve integration and focus on prevention since the NHS Next Stage Review in 2008. These pilots have evolved through integrated care organisations, integrated care pioneers and vanguards, and are now taking statutory form as ICSs. The previous reforms of the Health and Care Act 2012 had proved controversial and attracted opposition in Parliament and from professional bodies. The legislation underpinning ICSs removes the previous requirement for competition in health services provision and strengthened an existing duty for health bodies and local authorities to cooperate.

Figure 1
Integrated Care System (ICS) populations in England

There are 42 ICSs covering England with populations ranging from half a million to 3.5 million people



Index	ICS
1	Bath and North East Somerset, Swindon and Wiltshire
2	Bedfordshire, Luton and Milton Keynes
3	Birmingham and Solihull
4	Black Country
5	Bristol, North Somerset and South Gloucestershire
6	Buckinghamshire, Oxfordshire and Berkshire West
7	Cambridgeshire and Peterborough
8	Cheshire and Merseyside
9	Cornwall and The Isles of Scilly
10	Coventry and Warwickshire
11	Derby and Derbyshire
12	Devon
13	Dorset
14	Frimley
15	Gloucestershire
16	Greater Manchester
17	Hampshire and Isle of Wight
18	Herefordshire and Worcestershire
19	Hertfordshire and West Essex
20	Humber and North Yorkshire
21	Kent and Medway
22	Lancashire and South Cumbria
23	Leicester, Leicestershire and Rutland
24	Lincolnshire
25	Mid and South Essex
26	Norfolk and Waveney
27	North Central London

Index	ICS
28	North East and North Cumbria
29	North East London
30	North West London
31	Northamptonshire
32	Nottingham and Nottinghamshire
33	Shropshire, Telford and Wrekin
34	Somerset
35	South East London
36	South West London
37	South Yorkshire
38	Staffordshire and Stoke-On-Trent
39	Suffolk and North East Essex
40	Surrey Heartlands
41	Sussex
42	West Yorkshire

Notes

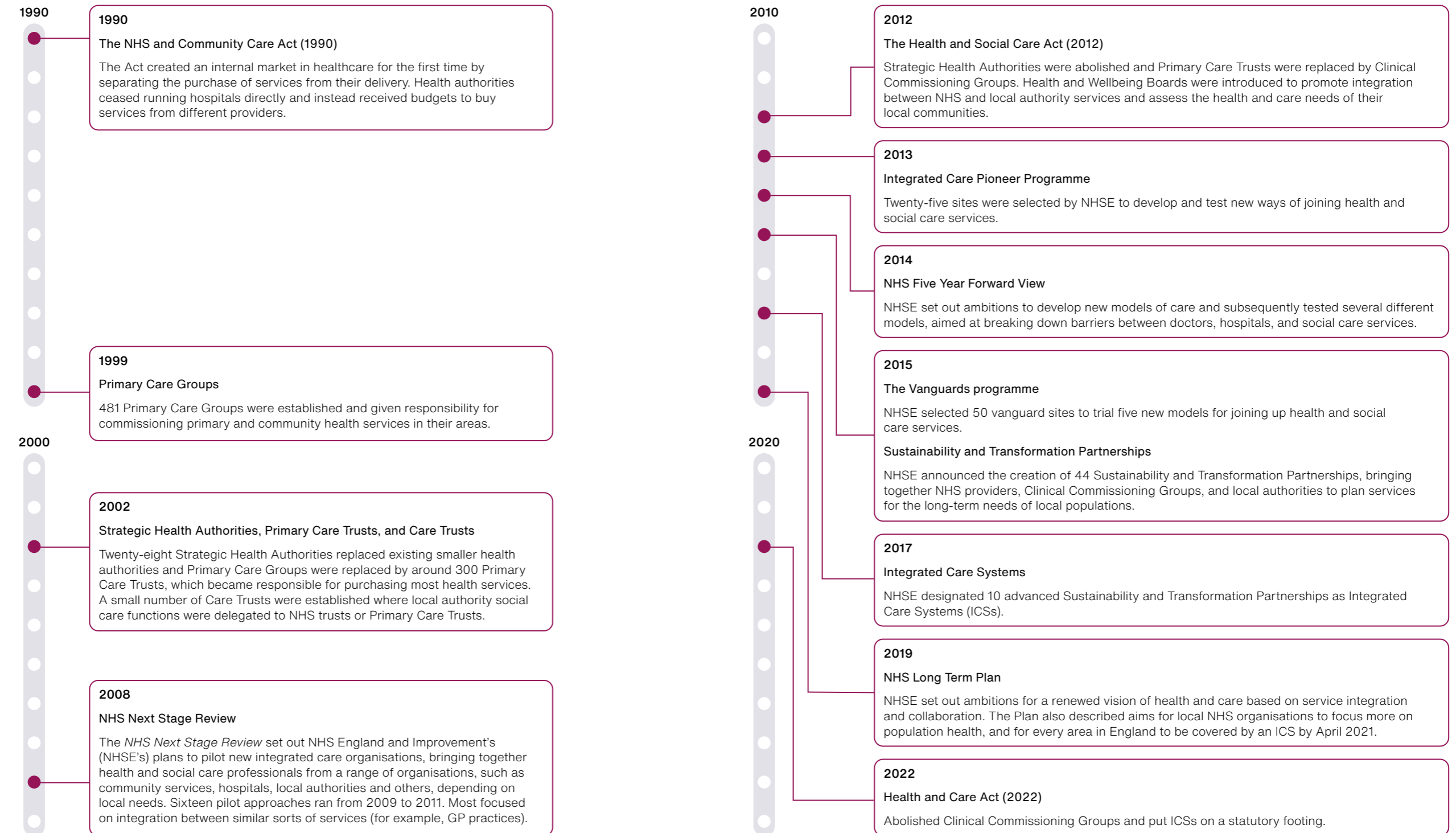
- 1 The Isle of Wight is part of Hampshire and Isle of Wight ICS.
- 2 The Isles of Scilly are part of Cornwall and Isles of Scilly ICS.

Source: NHS England weighted population data

Figure 2

Reorganisations of health and care services since 1990

The government has a long history of reforming how health and care services are organised



ICS purpose and objectives

1.6 ICSs bring health and care organisations and related services within a geographical area together to collectively plan and provide for the needs of their local populations. They have four core purposes, which 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.

Structure of ICSs

1.7 ICSs introduce new ways of planning and delivering health and care services both at different geographical scales and between providers of similar types. There are three key levels to an ICS: system-wide, place and neighbourhood (**Figure 3**).

ICS level

1.8 The core partners in each ICS are the NHS bodies and the local authorities in the ICS area. There are two new statutory structures covering an ICS area:

- An Integrated Care Board (ICB), which is primarily an NHS body.
- An Integrated Care Partnership (ICP), which is jointly formed by the ICB and the local authorities within the ICS area.

In broad terms, the ICP is responsible for creating a strategy that addresses the health and care needs of the population covered by the ICS. The ICB, alongside its partner local authorities, is responsible for planning and commissioning services to meet those needs.

ICB

ICB structure

1.9 The ICB is a statutory NHS body. It is led by a unitary board which must include three independent non-executive members (one of which serves as its chair), and at least one member each nominated by local authorities responsible for social care, NHS trusts, and general practices within the ICS area. Designate ICB chairs were appointed by NHS England (NHSE) and the majority started their roles in November 2021, under the employment of a Clinical Commissioning Group (CCG) or other NHS body.

Figure 3

The different levels within an Integrated Care System (ICS)

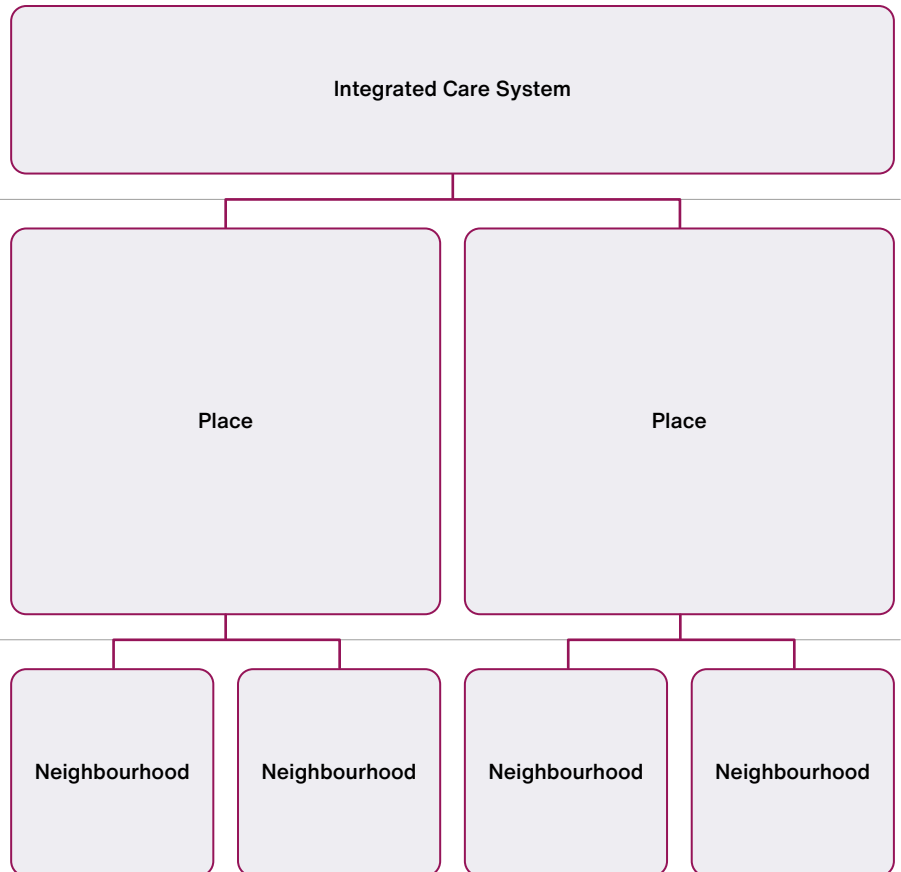
ICSs operate at three main geographical levels: system, place and neighbourhood

Key features

Comprising the:

- Integrated Care Board
 - Integrated Care Partnership
 - ICSs typically cover around one million to three million people
-
- There are usually multiple places in each ICS
 - The number of places varies between ICSs
 - Places often map to a local authority area
 - It is possible for an ICS to have a single place
 - Work at place level is co-ordinated through a place-based Partnership
 - Places typically serve populations of 250,000 to 500,000 people
-
- There are multiple neighbourhoods in each place
 - They operate at the same scale as existing Primary Care Networks
 - Neighbourhoods typically cover 30,000 to 50,000 people

Geographical level



Notes

- 1 This is an illustrative example and there is large variation in the numbers of places, and their constituent neighbourhoods, within ICSs.
- 2 Primary Care Networks are networks of GPs, community health, mental health, social care, pharmacy and other local health and care services.

Source: National Audit Office review of NHS England information

ICB responsibilities

1.10 ICBs are responsible for the overall day-to-day running of NHS services within the ICSs. They have taken on the assets, liabilities and commissioning functions that were previously the responsibility of CCGs, but have more flexibility to delegate functions and to commission or undertake activity jointly with other organisations. In planning services, ICBs must have due regard to ICP strategies when developing plans to meet the health needs of their population.

ICP

ICP structure

1.11 An ICP is a committee established jointly between local authorities and the NHS as equal partners. NHSE's guidance on ICS design reflected government's intention to provide significant freedom for ICPs to develop arrangements best suited to their local areas. However, as a minimum, an ICP's members must include local authorities with statutory responsibility for social care and the local NHS as represented by the ICB. They can also include voluntary and community groups and any other related organisations affecting health and care in the local area (for example, employers, social care providers, police or prisons).

ICP responsibilities

1.12 ICPs have a specific responsibility to develop an Integrated Care Strategy for their areas to meet the assessed health and social care needs of their population, and which should also address the wider determinants of health and wellbeing. This strategy must set out how commissioners will meet the assessed needs identified in Joint Strategic Needs Assessments and Wellbeing Strategies prepared by local Health and Wellbeing Boards. These are committees comprised primarily of local authority representatives, but also including representatives from commissioners and local Healthwatch, responsible for promoting greater integration and partnership between the NHS, public health and local government.

Place

1.13 DHSC continues to refine its guidance for ICSs at place level. Places within ICSs often (but not always) match local authority footprints. Some ICSs use existing Health and Wellbeing Boards to organise services at place level, while others have set up different structures. In February 2021, DHSC set out its expectation that place-based arrangements should be locally determined. In February 2022, it published a further white paper specifying the criteria that place-based governance arrangements should satisfy.

1.14 The ICBs within ICSs are expected to delegate some functions and decision-making to places, although NHSE has not itself set financial allocations at this level. Instead, it expects ICBs to agree how to deploy resources and ICBs are taking different approaches. For example, West Yorkshire and Harrogate delegates most decision-making to place level and only works at a whole ICS level in specific circumstances, such as when planning for a larger population would lead to better outcomes, or to tackle particularly complex or intractable issues.

Neighbourhood

1.15 There is no formal guidance for how neighbourhoods should operate and ICSs can largely decide for themselves. However, NHSE expects neighbourhoods to integrate front-line services using multidisciplinary teams and close working with the voluntary and community sector, for example, through social prescribing. Social prescribing allows health and care professionals to refer people to non-clinical services or activities to support their wider health and wellbeing. These activities could include volunteering, arts and crafts, gardening, cookery, or sports, among many others.

Integration between NHS providers

1.16 The introduction of ICSs is intended to support integration between different NHS organisations providing similar services. There are two main ways this is done:

- Primary Care Networks (PCNs).
- Provider collaboratives.

Primary care networks

1.17 PCNs are networks of GPs, community health, mental health, social care, pharmacy and other local health and care services. There are 1,250 PCNs across England and they have been a feature of health and care provision since 2019. They serve communities of 30,000 to 50,000 people so operate at a similar scale to neighbourhoods. A PCN is not a statutory body, but its members may form a legal entity allowing them to supply wider health services beyond core medical provisions.

Provider collaboratives

1.18 Provider collaboratives are partnerships involving two or more NHS trusts working across multiple places, or ICSs, to plan and deliver services, with the aim of enabling more coordinated decision-making and benefits from working at scale.

1.19 The ICB remains accountable to NHSE for any resources or functions that it delegates to places, collaboratives, or others; it cannot delegate accountability. More broadly, ICBs are accountable for delivering NHS priorities and their contribution to the integrated care strategies developed by ICPs, but constituent organisations, for example local authorities and NHS trusts, remain accountable for their own statutory responsibilities.

Governance of ICSs

1.20 Governance refers to the structures and responsibilities that set and monitor what ICSs try to do and how they do it. This part of the report covers:

- who decides what ICSs need to deliver;
- governance within an ICS; and
- governance of an ICS by other organisations.

Who decides what ICSs need to do?

1.21 There is both a ‘top-down’ and ‘bottom-up’ process for setting priorities for ICSs and one of the challenges they will face is how to meet both sets of requirements.

Priority setting for the ICB

1.22 The NHS is a national service, and each year to date, government has set out a list of things it wants the NHS to deliver through the NHS mandate. The 2022-23 NHS Mandate has five objectives:

- Managing COVID-19 impacts on health and care.
- Recovering wider NHS services and functions.
- Renewing focus on the *NHS Long Term Plan* and its broader commitments.
- Embedding population health management to prevent ill health and tackle health inequalities.
- Ensuring effective leadership and culture.

1.23 NHSE has several different mechanisms to set priorities for NHS services within ICSs. It uses annual operational planning guidance to set priorities in line with the NHS mandate. This guidance for 2022-23 was published in December 2021. Performance against these objectives is monitored through the NHS Oversight Framework. The Framework for 2022-23 was published in June 2022. It contains 53 performance indicators for ICBs and 35 for trusts. The NHS mandate for 2022-23 includes 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”. However, all the indicators in the oversight framework are focused on delivering NHS objectives and none relate to the wider ICS. For example, the sole indicator of ICB leadership and capability is drawn from NHS staff survey scores. Similarly, indicators for preventing ill health and reducing health inequalities relate to delivering NHS interventions (screening, vaccinations, managing long-term conditions) and not the challenge that NHSE has set for ICSs to work with partners to address wider determinants of ill health. The oversight framework requires ICBs to agree what their contribution will be to local priorities, and how progress against them will be tracked. ICBs are in the process of agreeing memoranda of understanding with NHS regional teams setting out what they will achieve. NHSE also intends to look at the ICBs’ contribution to partnership working as part of an annual assessment of ICBs. It has not yet set out how it expects to do this but intends to publish guidance on this in autumn 2022. In addition to the governance for ICSs, NHSE also sets priorities for different elements of an ICS through different funding streams. For example, for PCNs, there is an Investment and Impact Fund where, depending on performance against 40 different activities, they can score points and attract a share of the £225 million fund.

Priority-setting for local government

1.24 Local authorities provide a variety of services to their communities, both mandatory and discretionary. Services are mandatory where Parliament has created legal duties for local authorities. These include social care services to adults and children, waste collection, planning and housing services. Some mandatory services are subject to a great deal of central influence, most notably social care services. Legislation or statutory guidance describes duties in detail, and inspectorates monitor service quality. Local authorities have a broad discretion over the delivery of other mandatory services, however, such as libraries. Local authorities have the power to deliver discretionary services in line with their local priorities but are not obliged to provide them. Wholly discretionary services include sport and recreation, economic development, business support and additional provision that supports mandatory services.

Governance within the ICS

1.25 Within the wider ICS, the ICB receives a financial allocation based on its NHS population and is responsible for:

- developing a plan for the health needs of its population;
- allocating resources;
- establishing joint working and governance arrangements; and
- organising how health services are provided.

1.26 As set out above (paragraph 1.13), the February 2022 white paper *Joining up care for people, places and populations* described DHSC's plans to develop new outcomes, accountability, and regulatory and financial reforms. It intends to begin trialling these reforms by spring 2023. They include a shared outcomes framework focused on improving population health and reducing health disparities, and a single person accountable for delivering shared outcomes at place level across both health and social care.

Governance of the ICS by other organisations

1.27 The key government bodies involved in the oversight of ICSs are:

- DHSC;
- NHSE; and
- Care Quality Commission (CQC).

1.28 The governance structures around ICSs are set out at **Figure 4** on pages 27 and 28.

Figure 4

The key bodies and structures involved with Integrated Care Systems (ICSs)

ICSs bring together NHS organisations, local authorities and other partners

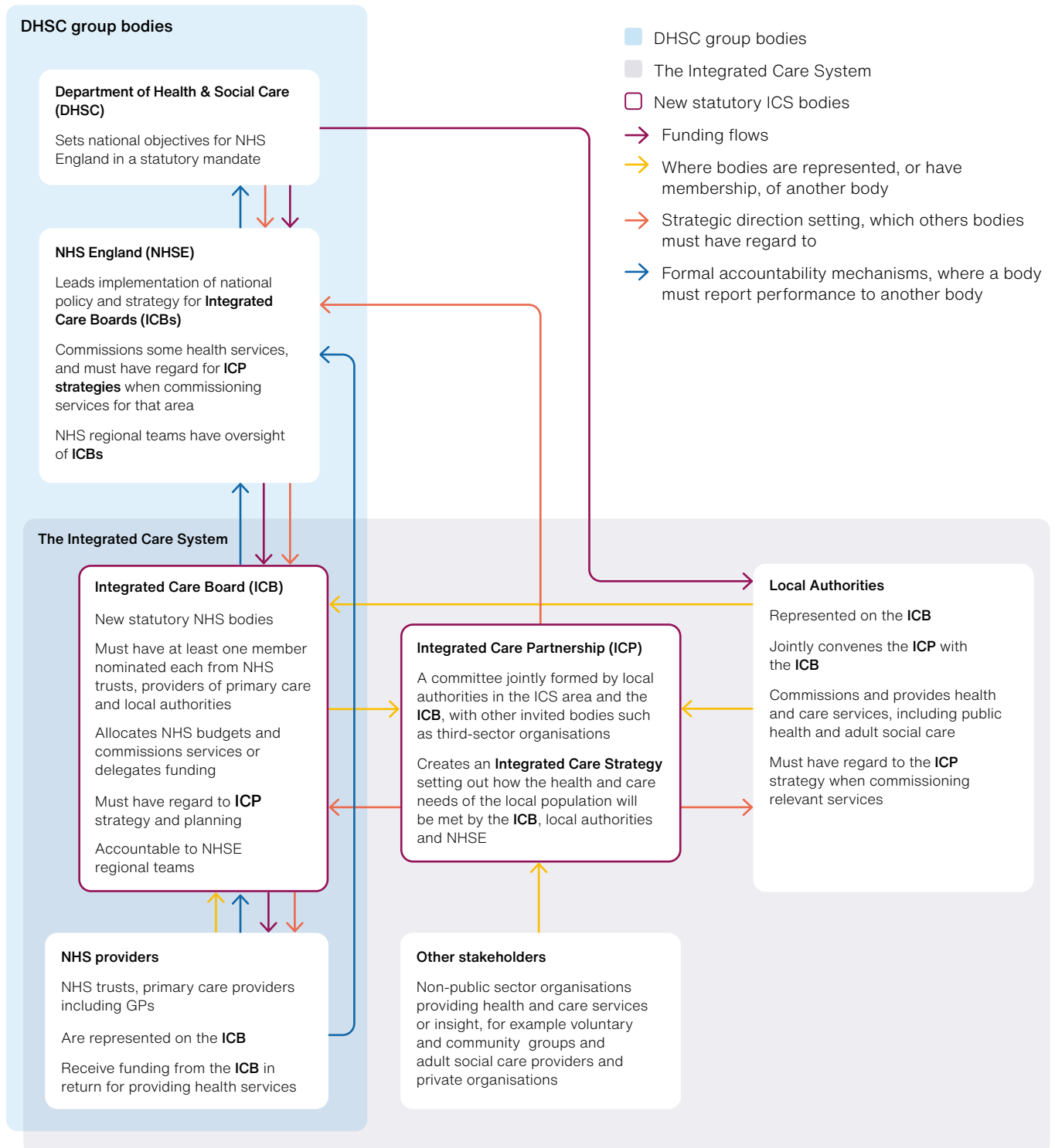


Figure 4 *continued*

The key bodies and structures involved with Integrated Care Systems (ICSs)

Notes

- 1 This figure provides an overview of arrangements for ICSs and does not set out differences between different types of NHS or NHS-funded organisations, or different types of local authorities, such as district, borough, city, or county.
- 2 This diagram does not include Care Quality Commission which will provide independent reviews and assessments of ICSs from April 2023 onwards, the Department for Levelling Up, Housing and Communities which provides funding and oversight of local authorities, or local authorities' democratic accountability arrangements.
- 3 **Funding:**
 - The DHSC provides funding to NHSE to commission health services for England. It also provides a public health grant to local authorities for public health services including for example, drug and alcohol addiction treatment, health visitors and sexual health services.
 - NHSE provides funding to ICBs.
 - ICBs use this funding to commission health services from NHS and other providers.
- 4 **Representation:**
 - ICBs must contain at least one member nominated by NHS hospital trusts, one nominated by NHS primary care providers, and one nominated by local authorities within the ICS area.
 - ICPs are a joint committee of the local authorities in the area and the ICB. They may also include representatives from other stakeholder groups, for example voluntary, community and social enterprise organisations or social care providers.
- 5 **Setting direction:**
 - The DHSC publishes the NHS mandate which sets out the priorities for the NHS. NHSE issues guidance to ICBs setting out the priorities it expects them to deliver. ICBs set priorities for NHS providers through its commissioning arrangements.
 - The Integrated Care Partnership sets the strategy for how the health and wellbeing needs of the local population can be met by NHSE, the ICB and local authorities. All these bodies are required to have regard to this strategy when commissioning services.
- 6 **Performance reporting and accountability**
 - NHS providers and ICBs must report performance against metrics set by NHSE through the NHS Oversight Framework and other mechanisms. ICBs are in the process of agreeing with NHS regional teams what their local priorities will be and how they will report against them.
 - There is no requirement for any of the bodies that must have regard to the ICP strategy to report their progress against it.

Source: National Audit Office review of NHS England information

NHSE

1.29 NHSE leads the implementation of national policy and strategy for ICBs within the NHS. It also works with local government representative bodies to develop guidance and deliver practical support, either directly or through its regional teams that engage with ICBs.

1.30 NHSE's seven regional teams have day-to-day oversight of ICBs and implement national requirements using their knowledge of local relationships and structures. They agree objectives with ICBs, hold them to account, support their development and intervene where necessary. NHSE regional teams adopt a scaled approach to oversight depending on the maturity of individual ICSs, with a lighter touch for those considered more developed. In July 2022, NHSE announced that it would undertake significant restructuring following its planned merger with Health Education England and NHS Digital in April 2023. The newly merged organisation will have a headcount 30% to 40% lower than the predecessor bodies. As part of this redesign, it is considering how to create space for ICSs to lead at a local level. This may result in some changes to the role and responsibilities of NHSE's regional teams.

1.31 As we set out at paragraph 1.23, NHSE uses the NHS Oversight Framework to monitor ICBs' contributions to the NHS mandate. It does not cover oversight arrangements for the wider ICS. The Framework sets out six key areas ICBs are assessed against. ICBs define one of these areas themselves in line with their local priorities and agree this with the relevant NHSE regional team. The Framework is used to assess ICBs' support needs according to four categories. In July 2022, NHSE assessed one ICB did not require any support at all and five ICBs needed mandated intensive support. Those needing mandated intensive support enter NHSE's Recovery Support Programme, which replaced its previous financial and quality special measures programme in 2021. In extreme cases, this may lead to changes to an ICB's board or executive team.

CQC

1.32 CQC will provide independent regulatory oversight of ICSs at the overall system level and advise NHSE of any required regulatory action. Under the Health and Care Act 2022, it has a new duty to review and assess each ICS, with assessments looking specifically at leadership, integration and the quality and safety of services. Unlike its regulation of health and care providers, CQC will not have direct enforcement powers over ICSs and its focus will be on monitoring, assessing and reporting. CQC's existing responsibilities to regulate the health and care providers that sit within ICSs, such as NHS trusts and foundation trusts, social care providers and general practices, remains unchanged.

1.33 CQC has committed to co-producing its approach with ICSs and undertook several consultative activities during 2022, such as convening expert advisory groups, and walk-throughs and test and learn events with selected ICSs. CQC expects to review and assess ICSs from 2023, which will include an estimated two-year period to establish a baseline view of all 42 ICSs.

Part Two

ICS starting positions and wider pressures

2.1 NHS bodies have expressed concern about their financial outlook. A survey of NHS trusts by NHS Providers in April 2022 found 98% felt their financial allocations for 2022-23 were insufficient to address inflationary pressures, and 86% stated they would not achieve financial balance. In May 2022, NHS England (NHSE) allocated £1.5 billion of funding to account for higher than anticipated inflation. Our own survey of Integrated Care System (ICS) senior staff found a majority of respondents were also concerned about securing the wider resources needed to fulfil their objectives, with only 15% (43 of 280 responses) confident their ICS had the required resources to fulfil its objectives. The resource shortages that were ranked the most pressing by our survey respondents was staff numbers, followed by skills and experience. This part of the report examines the financial and workforce position of the NHS and local government, in addition to some of the wider challenges facing ICSs following the COVID-19 pandemic. It covers:

- NHS financial sustainability;
- wider NHS pressures; and
- wider pressures on local government.

NHS financial sustainability

2.2 This section sets out:

- NHS finances prior to the COVID-19 pandemic;
- NHS finance during the pandemic; and
- financial plans for 2022-23 and beyond.

2.3 In 2018, the government announced the NHS would receive an annual funding increase of £20.5 billion within five years, equivalent to an average 3.4% uplift each year in real terms. The most recent Spending Review in October 2021 announced NHSE's annual core funding would grow to £163 billion by 2024-25, a real-terms increase of 3.8% over the Spending Review period. This growth rate excludes additional funding for COVID-19 from the baseline against which growth is measured. Of this funding, £8 billion is ear-marked for revenue spending to tackle the elective backlog over the period. However, inflationary pressures have risen considerably since the October 2021 Spending Review, and analysis by the Health Foundation in March 2022 suggested the government needed to top up health spending with £2.4 billion by 2024-25 to match its original ambitions.

NHS finances prior to the pandemic

How did the money flow through the system?

2.4 Each year the Department of Health & Social Care (DHSC) provided an annual budget to NHSE, a large portion of which flowed to local Clinical Commissioning Groups (CCGs). CCGs then paid local hospitals, GPs and other health service providers. In 2019-20, the last financial year before extraordinary arrangements were put in place in response to the COVID-19 pandemic, CCGs managed £91 billion, equivalent to around three-quarters of NHSE's total £125.4 billion budget. NHSE retained funding to directly commission high-cost specialised services from providers and some primary care services.

2.5 NHS bodies within local areas have been encouraged to manage resources collectively since 2016 when Sustainability and Transformation Partnerships (STPs) were introduced. This required CCGs and NHS provider trusts to meet their individual financial targets as well as a combined system or partnership target.

The financial health of NHS bodies in 2019-20

2.6 NHS bodies were showing significant and ongoing signs of financial stress in the years leading up to the 2020 COVID-19 pandemic. In 2019-20, around one quarter of all NHS bodies were in deficit:

- Among CCGs, 51 out of a total of 191 (27%), were in deficit. The combined deficit was £667 million against a budget of £90 billion, an overspend of 0.74%.
- Out of 226 NHS trusts, 53 (23%) spent more than the income they received. The total net deficit was £990 million against a combined budget of £92 billion, an overspend of 1.08%. Two trusts had deficits of more than £100 million.

The financial health of systems or partnerships in 2019-20

2.7 Combining financial performance on a partnership or system level does not of itself eliminate the underlying pressures that persist in some NHS bodies. When the performance of individual NHS trusts is restated in STP/ICS terms, NHS trusts in 27 out of 42 STPs operated a deficit in 2019-20. When CCGs' and trusts' financial performance is combined and restated by ICSs, there was a total net deficit of £1.7 billion, with 31 of 42 ICSs in deficit (**Figure 5** on pages 34 and 35).¹

Bridging the gap between income and expenditure: loans from DHSC

2.8 NHS trusts bridged the gap between income and expenditure with top-up loans from DHSC. Between 2015-16 and 2019-20, the loan balance of NHS trusts increased from £5 billion to £16 billion, of which £13 billion related to interim loans mainly used for day-to-day expenditure.

2.9 We previously noted the loan system was not fit for purpose and unsustainable because trusts' deficits prevented them from repaying the money they owed. In April 2020, a £13.4 billion balance of interim loans owed by NHS trusts was written-off by DHSC. The loans were converted into £13.4 billion of public dividend capital (PDC), which trusts do not have to repay (**Figure 6** on page 36). However, switching from loans to PDC does not address the long-term financial issues faced by struggling trusts with unsustainable deficits. NHSE has made several changes to the financial framework since 2019-20 intended to support systems and organisations to address deficits.

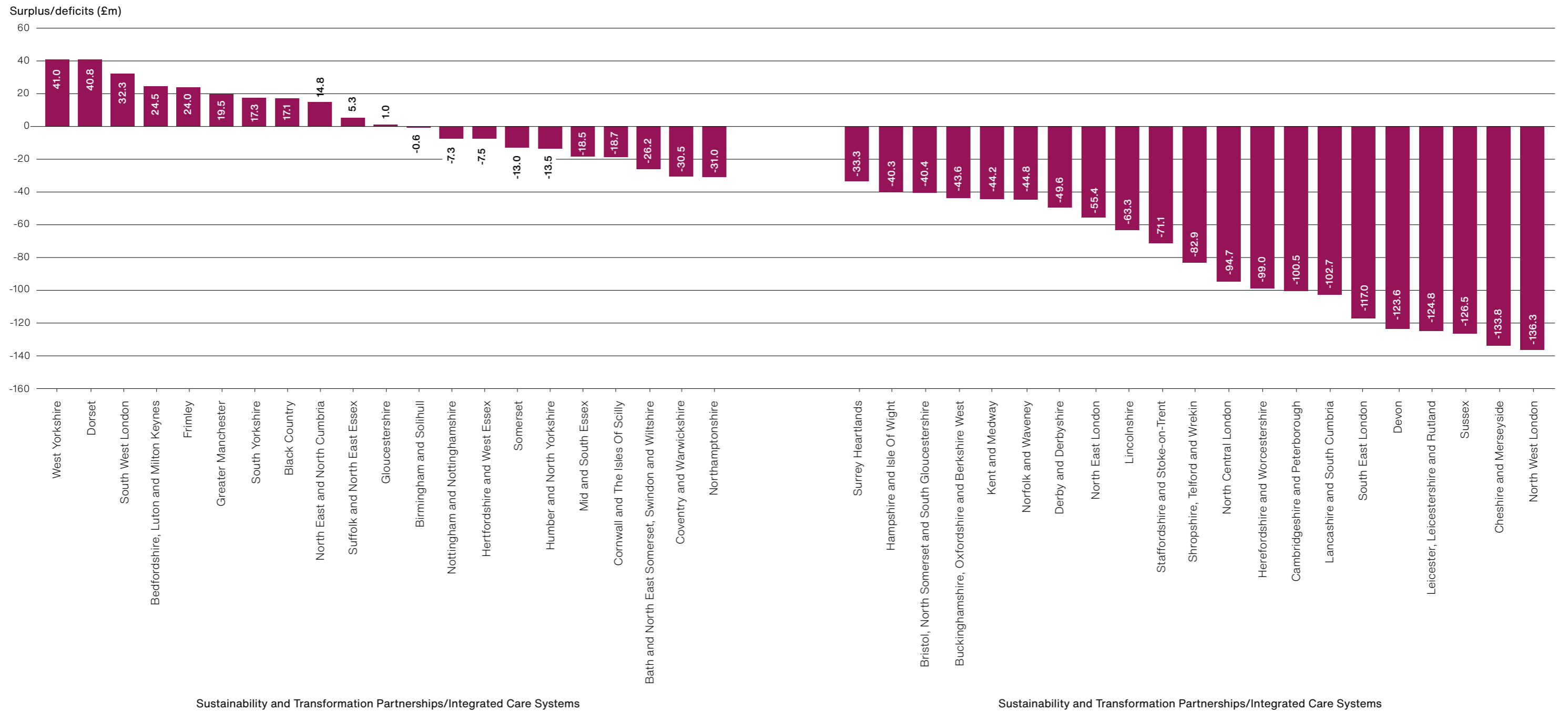
Financial arrangements during the COVID-19 pandemic

2.10 In March 2020, NHSE suspended much of the commissioning and contracting activities that occurred between itself, CCGs and NHS provider trusts. It replaced this with fixed system budgets and a system of top-up payments to recognise COVID-19 costs, whereby any COVID-19-related costs incurred by trusts during the pandemic were fully reimbursed. For the second half of 2020-21 and all of 2021-22, during which COVID-19 costs were still reimbursed but budgetary controls were beginning to be reintroduced, funding increased substantially but commissioning and contracting activities remained suspended to provide stable, predictable funding across the NHS. This minimum income guarantee plus top-up payments for COVID-19 gave providers more flexibility to respond to the pandemic.

¹ NHS trusts and CCGs were restated according to 2021-22 ICS boundaries.

Figure 5
Clinical Commissioning Groups' (CCGs) and NHS Trusts' combined surplus and deficits 2019-20, restated as Sustainability and Transformation Partnerships or Integrated Care Systems

There is a net deficit of £1.7 billion when CCG and NHS Trust finances are combined

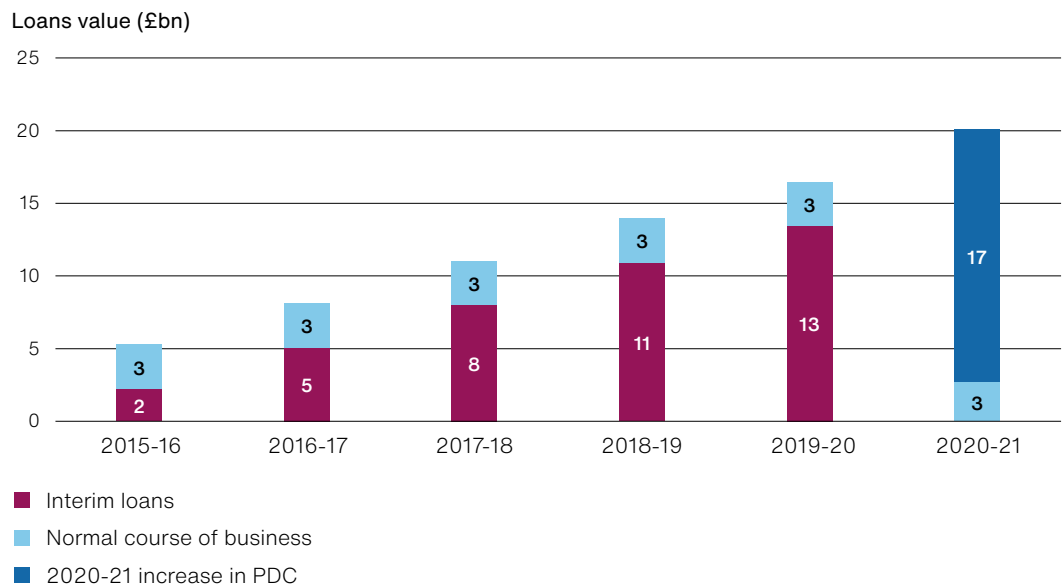


Source: National Audit Office analysis of NHS England financial data

Figure 6

Loans for NHS trusts, including write off to public dividend capital (PDC), 2015-16 to 2020-21

Although loans were written in April 2020, their conversion to a non-repayable form of debt does not address underlying financial pressures in NHS provider trusts

**Notes**

- 1 Interim loans refer to loans provided to continue delivering services, often on everyday spending such as salaries.
- 2 Normal course of business refers to loans provided during everyday business, for example investment in buildings.
- 3 PDC is a form of non-repayable finance provided by government to NHS trusts that represents a share of the trust owned by the public.
- 4 Interim loans were converted to PDC in 2020-21.

Source: National Audit Office analysis of NHS England financial data

2.11 The revised financial arrangements and COVID-19 funding during 2020-21 led to an improvement in NHS financial health. In the first half of 2020-21, all NHS trusts broke even due to these arrangements as they effectively eliminated day-to-day deficits and temporarily addressed some of the underlying financial pressures in certain NHS organisations. The cash held within NHS trusts grew from £6.8 billion in 2019-20 to £13.8 billion in 2020-21. In the second half of 2020-21, NHSE began reinstating funding linked to delivering elective activity and reducing waiting times. There continued to be fixed income support relating to COVID-19 in the first half of 2021-22, along with applying efficiency targets, both of which continued in the second half of 2021-22.

NHS financial management for 2022-23

2.12 NHSE expects Integrated Care Boards (ICBs) and their member bodies to work collaboratively to allocate resources within the system, with regulatory oversight and intervention retained by NHSE and other bodies such as Care Quality Commission. Although shadow ICSs and partnerships have existed since 2016, they are untested under new statutory arrangements. There is a risk they may continue carrying exposure to issues that cannot be managed effectively at local levels and which require intervention by NHSE. Trusts in deficits have stricter financial conditions placed upon them, which limits the extent to which their deficit can increase, but also gives them less flexibility to take action to address the reasons for their deficit.

2.13 ICBs must agree financial and operational plans with NHSE on behalf of their ICS.² NHS provider trusts continue to submit their own plans to NHSE, but these must match ICB plans. NHSE has also specified several new targets for ICBs and NHS bodies to meet, marking a return to some of the financial incentives and penalties that were suspended during the pandemic.

2.14 NHSE continues to control significant funding streams, such as for around half of primary care including pharmaceutical, ophthalmic and dental care for 33 ICSs. It also directly commissions public health services, complex procedures and specialist drugs. In total, NHSE has allocated £113 billion to ICBs out of its total budget of £154 billion. This £113 billion comprises £106 billion of recurrent funding and a further £6.9 billion of ring-fenced one-year funding for ICSs to make progress against their priorities. This includes:

- £2.2 billion of funding for COVID-19 costs;
- £1.9 billion for elective services recovery to tackle waiting lists built up prior to and during the COVID-19 pandemic;³
- £200 million to address health inequalities; and
- £2.2 billion for service development. This is allocated against individual priorities, including £97 million for efforts to prevent ill health.

2.15 Financial plans for the NHS in England for 2022-23 were not agreed by NHSE until 20 June 2022, nearly three months into the financial year. NHSE officials told us the delay was caused because the gap between the initial plans submitted by CCGs for ICSs and the money made available by NHSE was far wider than in previous years.

2 NHSE sets target financial allocations for each ICB using a statistical formula designed to make geographic distribution fair and objective. Some ICBs are above or below their target allocation level. NHSE applies a convergence factor such that ICBs furthest above target receive less funding growth, and those that are furthest below receive more funding growth.

3 This represents the ICB component of elective recovery funding only. Total elective recovery funding allocated for 2022-23 is £2.3 billion.

Financial targets and efficiency requirements

2.16 The Health and Care Act 2022 requires an ICB's annual expenditure to not exceed its income. NHSE expects all ICBs to deliver a balanced budget in 2022-23, and most have submitted plans to do so. Of the 42 ICBs, six are planning a deficit (ranging from £1,000 to £30.3 million) and a further six plan a surplus (ranging from £1,000 to £99,000). The remaining 30 ICBs are planning to deliver a balanced budget.

2.17 In March 2022, government set the NHS an efficiency target of 2.2%, but to agree balanced budgets, ICSs have had to identify much larger spending reductions. These range from 2.7% to 9.6%, with an average of 5% (**Figure 7** on pages 40 and 41). DHSC told the Committee of Public Accounts in 2018 that setting unachievable short-term efficiency savings was unhelpful. The efficiency requirement includes both the withdrawal of specific additional funding for COVID-19, and an increase in the general efficiency requirement to 2.2%, and for some ICBs an adjustment to bring them closer into line with their target allocations (see paragraph 2.13).

Recurrent and non-recurrent savings

2.18 Some financial savings are recurrent, meaning once in place they will reduce expenditure on an ongoing basis. This could include, for example, agreeing lower prices with a supplier. Other savings are non-recurrent, meaning they are one off reductions in expenditure (for example, delaying repairs and maintenance). ICBs will be expected to make further savings in future years, with the value of any non-recurrent savings made in 2022-23 added to their target in 2023-24. This places compounded pressure on ICS budgets.

2.19 On average, around one-third of ICS savings are non-recurrent, but this ranges from 55% in Greater Manchester to 3% in North West London (see **Figure 7**). In cash terms, non-recurrent financial savings are on average £47 million (mean) or £31 million (median) and range from £4.8 million in Somerset to £237 million in Greater Manchester. Overall, £3.7 billion of ICS savings are recurrent, and £2 billion are non-recurrent, equivalent to 3.3% and 1.8% of total ICS allocations.

ICB savings vs NHS provider savings

2.20 The total financial savings planned by ICBs are £1,674 million, including a £527 million reduction in spending with providers (made up of £188 million reduction in spending with NHS providers in ICS areas, £18 million reduction with NHS providers outside ICS areas, and a £321 million reduction in spending with non-NHS providers). Providers are planning financial savings worth £4,185 million. In total, ICBs are planning to save £5,671 million (£1,674 million of ICB savings, plus £4,185 million provider savings, less £188 million of ICB savings made through providers in their area, which would otherwise be double-counted). This is equivalent to 5% of their total budget for 2022-23.

Savings by NHS providers

2.21 In most ICSs, the majority of savings have been made by individual NHS provider organisations. On average (the mean), 29.5% were made by ICBs, and the remaining 70.5% were made by providers. This ranges from 35% of savings made by providers in Staffordshire, to 95% in Black Country.

2.22 The financial savings plans of individual NHS providers vary widely, and some look extremely challenging. The average level of savings is 3.7%, but targets for individual providers range from 1.2% at the Royal Berkshire Hospital in the Buckinghamshire, Oxfordshire and Berkshire West ICB, to 10.4% at Epsom and St Helier University Hospitals Trust in the South West London ICB. Across all NHS providers, 92% intend to make financial savings above the overall NHS efficiency target of 2.2%. The three providers with the highest intended level of financial savings (at 8.6%, 9.3% and 10.4%) are all in South West London. Looking at providers within ICS groupings, the average level of financial savings ranges from 1.86% in Shropshire, Telford and Wrekin to 6.75% in South West London. In 38 of 42 ICSs, the average level of financial savings required from providers exceeds the 2.2% overall efficiency target.

Risks to securing savings

2.23 ICBs may not be able to deliver all their planned savings. NHSE asked ICBs to provide an assessment of the risk to delivering the savings they planned. It did not ask for assessments of providers' savings, so does not know how likely it is that providers can deliver them. For ICBs, Surrey Heartlands has the greatest level of high-risk savings, equivalent to 3% of its total budget. Buckinghamshire, Oxfordshire and West Berkshire has flagged all its proposed savings (equivalent to 1.6% of its total budget) as high risk (**Figure 8** on pages 42 and 43).

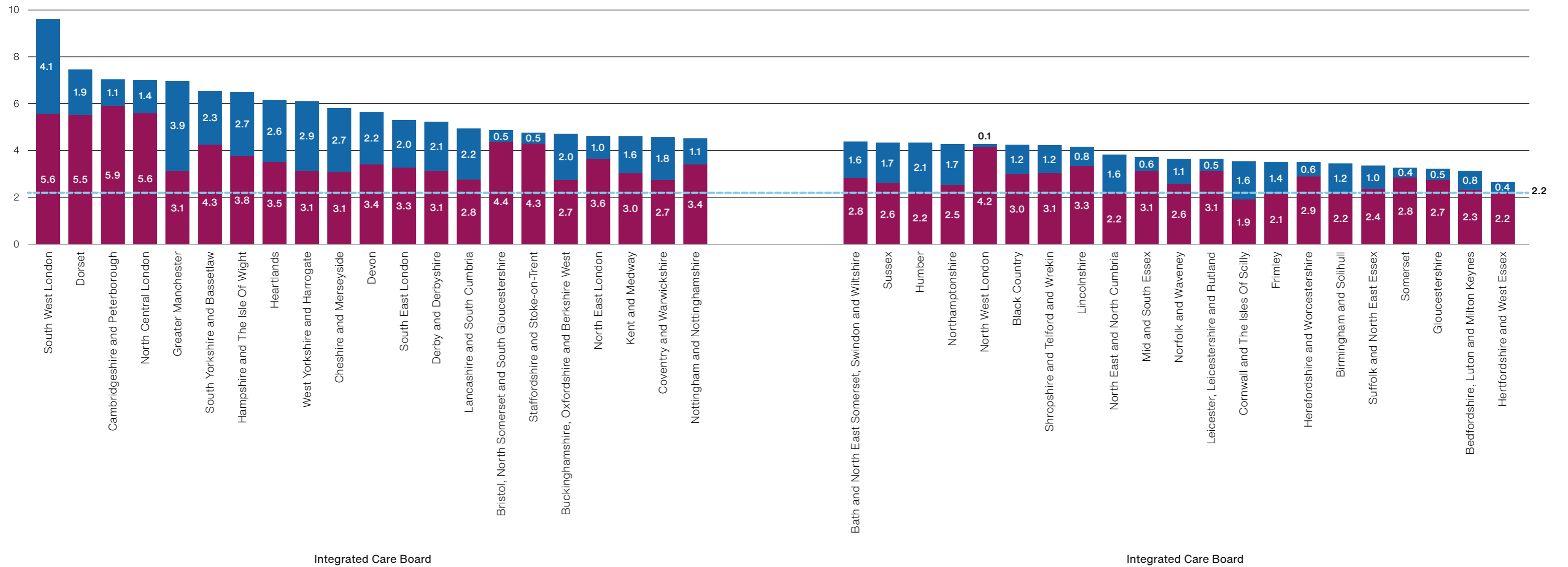
2.24 Overall, of the £1,674 million of financial savings ICBs plan to deliver, they assessed 36% (£605 million, or 0.53% of the total ICS budget) as high risk, 25% (£418 million, or 0.37% of the total ICB budget) as medium risk, and 39% (£651 million, 0.57% of the total ICB budget) as low risk. In addition to assessing risk, NHSE also asked ICBs to report their progress with making plans to deliver savings. Overall, ICBs reported that:

- plans were fully developed for 34% of savings (£562 million);
- plans were in progress for 24% (£408 million);
- they had identified an opportunity for 18% of savings (£303 million) but plans were not yet in progress for them; and
- they had not yet identified where savings would come from for 24% of the total (£400 million).

Figure 7
 Recurrent and non-recurrent planned financial savings as a percentage of Integrated Care Board (ICB) budgets in 2022-23

NHS England has agreed plans for financial savings for all ICSs at above the overall NHS efficiency target of 2.2%. They range from 2.7% at Hertfordshire and West Essex to 9.6% at South West London

Planned savings as a percentage of financial allocation (%)



Notes

- 1 Recurrent savings will reduce expenditure on an ongoing basis once put in place.
- 2 Non-recurrent savings refer to one off reductions in expenditure.

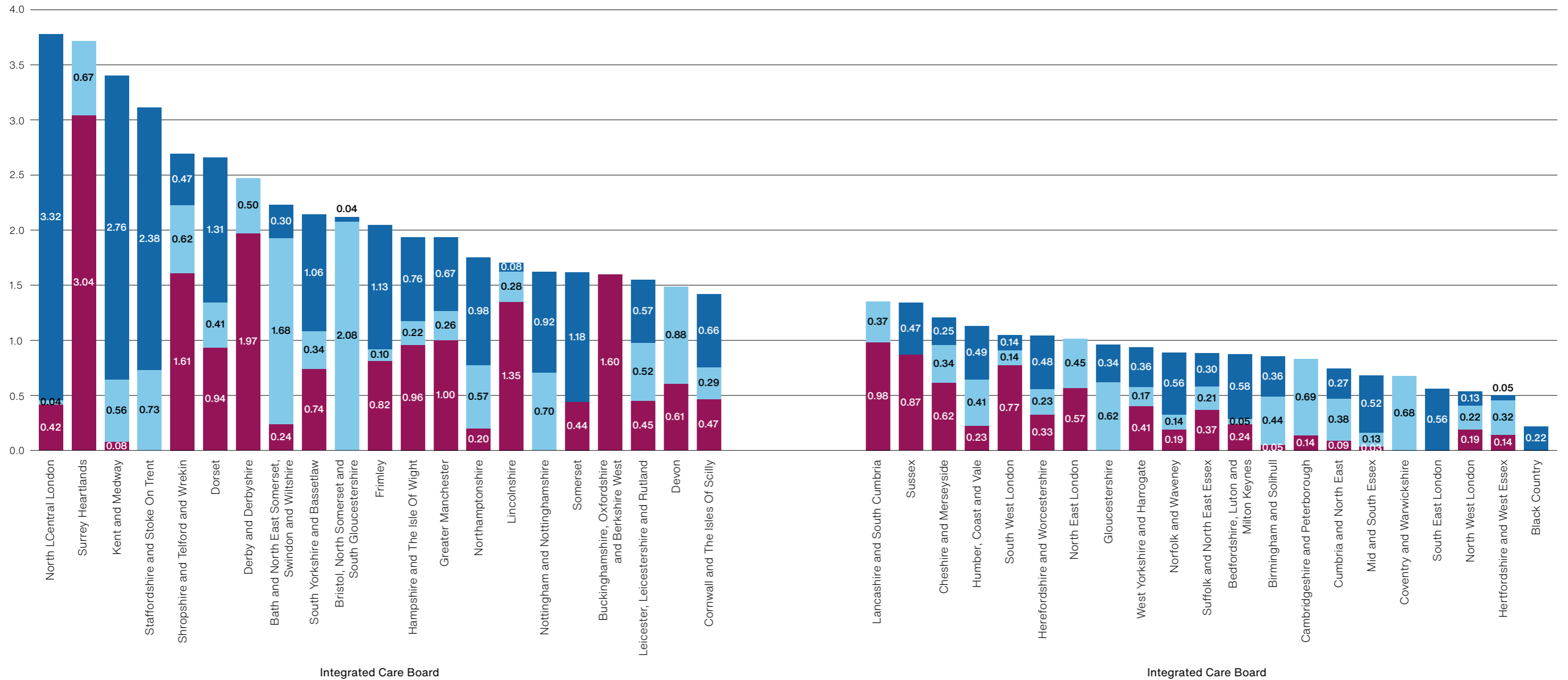
Source: NHS England financial data

- Recurrent savings
- Non-recurrent savings
- Overall NHS efficiency saving target

Figure 8
Risk to delivering Integrated Care Board (ICB) savings, shown as a proportion of the 2022-23 ICB budgets

Surrey Heartlands has the greatest level of high-risk savings, equivalent to 3% of its total budget, and Buckinghamshire, Oxfordshire and West Berkshire's proposed savings (equivalent to 1.6% of its total budget) are all high risk

Savings as a proportion of ICB budgets (%)



Note

1 ICBs were asked by NHS England and Improvement to assess the high, medium, and low risk of delivering the savings set out in their 2022-23 budgets.

- Savings assessed as high risk
- Savings assessed as medium risk
- Savings assessed as low risk

Wider NHS pressures

2.25 In addition to the conditions of the 2022-23 financial settlement, the NHS faces several wider challenges. These include resourcing difficulties (longstanding recruitment issues and the degradation of the estate) and the substantial backlog of work built up during the COVID-19 pandemic. Hospital cases of COVID-19 peaked in January 2021, but cases continue to rise and fall. This section of the report examines these pressures in more detail.

NHS vacancies

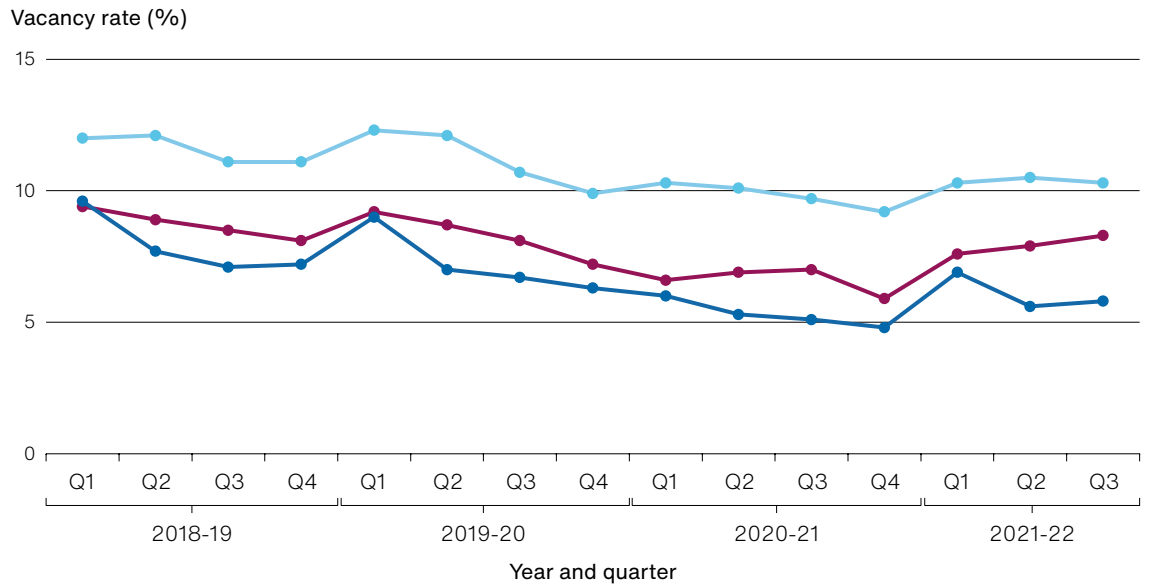
2.26 Vacancies across all NHS roles have been climbing since the start of 2021 (**Figure 9**). In December 2021, total NHS vacancies stood at 8.3% but this had increased to 9.7% by June 2022. Within ICSs, NHS vacancy rates during December 2021 varied between 4% and 12% (**Figure 10** on pages 46 and 47). Workforce was one of the most mentioned challenges from stakeholders and ICSs we spoke to.

2.27 ICSs can tackle some elements of the health workforce challenge, but there are other elements that only NHSE or other parts of government can address. For example, organisations within an ICS can pool staff which could lead to efficiencies, and control individual recruitment processes and some employment conditions. However, an independent pay review body makes recommendations to government on national NHS pay rates and NHSE sets targets along with mandatory service delivery requirements through a national contract. Health Education England (HEE), which will be incorporated into NHSE in April 2023, sets the number of training places for new doctors and nurses. Immigration rules, which are set by the Home Office, describe which roles, and which salary levels can be recruited internationally.

Figure 9

Vacancy rates for the NHS in England between Q1 2018-19 and Q3 2021-22

Vacancy rates for NHS roles have been increasing since the start of 2021



	Year and quarter														
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
● Total NHS workforce	9.4	8.9	8.5	8.1	9.2	8.7	8.1	7.2	6.6	6.9	7.0	5.9	7.6	7.9	8.3
● NHS registered nursing	12.0	12.1	11.1	11.1	12.3	12.1	10.7	9.9	10.3	10.1	9.7	9.2	10.3	10.5	10.3
● NHS medical	9.6	7.7	7.1	7.2	9.0	7.0	6.7	6.3	6.0	5.3	5.1	4.8	6.9	5.6	5.8

Note

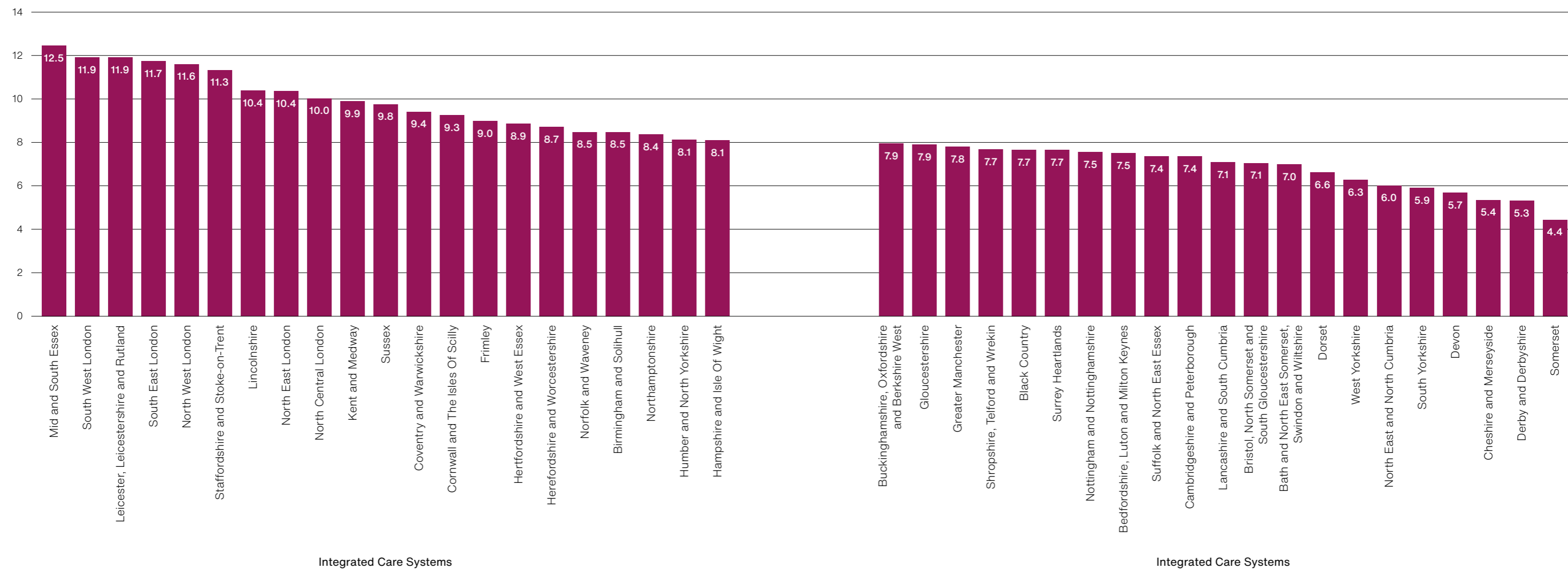
1 NHS vacancy rates are calculated from the number of full-time equivalent vacancies as a percentage of planned roles.

Source: National Audit Office analysis of NHS Digital data

Figure 10
NHS vacancy rates in Integrated Care Systems (ICSs), December 2021

NHS vacancy rates in ICSs range from 4% to 13%

NHS vacancy rate (%)



Note
1 NHS vacancy rates are calculated from the number of full-time equivalent vacancies as a percentage of planned roles.

2.28 Government has made several attempts to address the NHS workforce challenges, and it expects to have developed a clear plan by the end of this year. In June 2019, NHSE published an *Interim People Plan* which set out plans for making progress against some of the staffing challenges identified in the January 2019 *NHS Long Term Plan*. In July 2020, it published the *People Plan 2020/21: action for us all*, which set out some actions to be taken over the course of 2020-21 to build on the *Interim People Plan*. This document recognised that further work was needed and stated that “further action for 2021/22 and beyond is expected to be set out later in the year.” No further updates have since been published, although DHSC, NHSE and HEE have two pieces of work in progress which should set out government’s ambition for NHS staffing, and its plan for achieving it:

- In July 2021, DHSC commissioned HEE to develop a *Long-Term Strategic Framework for Health and Social Care Workforce Planning*. The purpose of the work was to look at the key drivers of workforce demand and supply over the longer term, and how they may affect the requirements for the future health and social care workforce. This was expected to be completed in spring 2022, though it has not yet been published.
- In January 2022, DHSC commissioned NHSE to produce an assessment of the size and type of workforce the NHS would need over the next 15 years, including workforce projections and a plan for securing it. This will build on the analysis in the HEE-led Framework, which NHSE has also been involved in supporting. The NHSE assessment will contain the details of the number and broad type of posts the NHS would need to create and fill, and its plan for doing so, including the impact on training places for healthcare professionals.

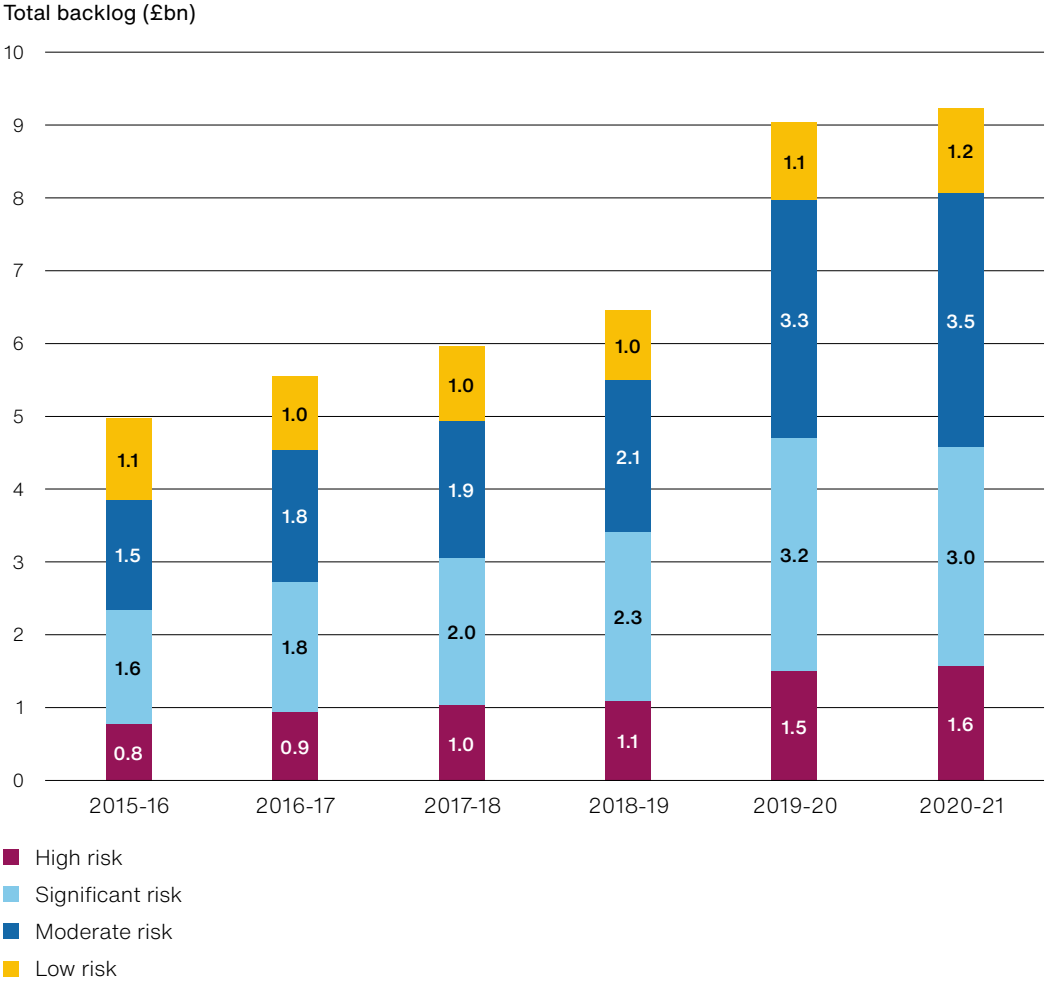
Both documents could be helpful to ICSs as they consider their workforce requirements at a local level, as they would provide expert assessment of the likely future pressures as well as an indication of the national plan for addressing them.

Estates and infrastructure

2.29 NHS provider trusts must fund continual repairs and maintenance on their estates and a backlog of this work has built up. The value of the total backlog across the entire NHS estate increased from just under £5 billion in 2015-16 to more than £9 billion in 2020-21, of which £4.5 billion related to high or significant risks (**Figure 11**).

Figure 11
 Total estates backlogs across all NHS trusts, 2015-16 to 2020-21

Estates backlogs data shows a consistent build-up of risk within the NHS estate



- Notes**
- 1 Risk categories are calculated by assigning a consequence score and a likelihood score to the failure of an element of the estate and multiplying these together.
 - 2 The monetary value for risks is based on how much it would cost to bring an element of the estate up to an improved condition for five years, based on information from local partners, the Department of Health & Social Care, and professional bodies.

Source: National Audit Office analysis of NHS England financial data

2.30 NHS providers consider that the annual capital investment budget allocated to them is not sufficient to support required improvements to their infrastructure. Their annual assessments of capital investment needs has been, on average, £1.1 billion higher than spending limits in each year from 2016-17 to 2018-19. In addition, when in 2020 we examined digital transformation in the NHS, we found that investment in digital transformation had not been sufficient to deliver the national ambitions, despite being higher than in previous years.⁴

Elective care backlogs

2.31 The number of patients waiting for elective care in England was steadily increasing before the pandemic and stood at 4.2 million in March 2020, compared with 2.3 million in January 2009.⁵ By January 2022, the number of patients waiting had reached 6.1 million and increased further to 6.7 million by June 2022 (**Figure 12**). Since April 2013, NHS regulations have included a statutory requirement for 92% of patients on the waiting list to start treatment (or be seen by a specialist and leave the waiting list) within 18 weeks. Nationally, the proportion of patients waiting less than 18 weeks decreased from 94.8% in May 2013 to 62.2% in June 2022, with a low of 46.8% in July 2020. Within individual ICSs, in June 2022 waiting lists ranged from 47,748 to 403,887 patients, and the proportions starting treatment within 18 weeks varied from 75% to 50%.

2.32 Reducing elective backlogs is a pressing national priority. ICSs were required to set out in their 2022-23 plans how they would meet targets specified in the NHS's February 2022 plan for tackling the backlog, including eliminating waits of more than 18 months by April 2023 and delivering 104% cost-weighted elective activity against 2019-20 baselines. However, much of these plans will depend on the wider enablers within ICSs, such as workforce, capacity and funding. Stakeholders raised concerns with us that the intense focus on national elective recovery makes it harder for ICSs to achieve their other objectives, particularly to develop services that meet other local priorities.

⁴ Comptroller and Auditor General, Department of Health & Social Care, *Digital transformation in the NHS*, Session 2019-21, HC 317, National Audit Office, May 2020.

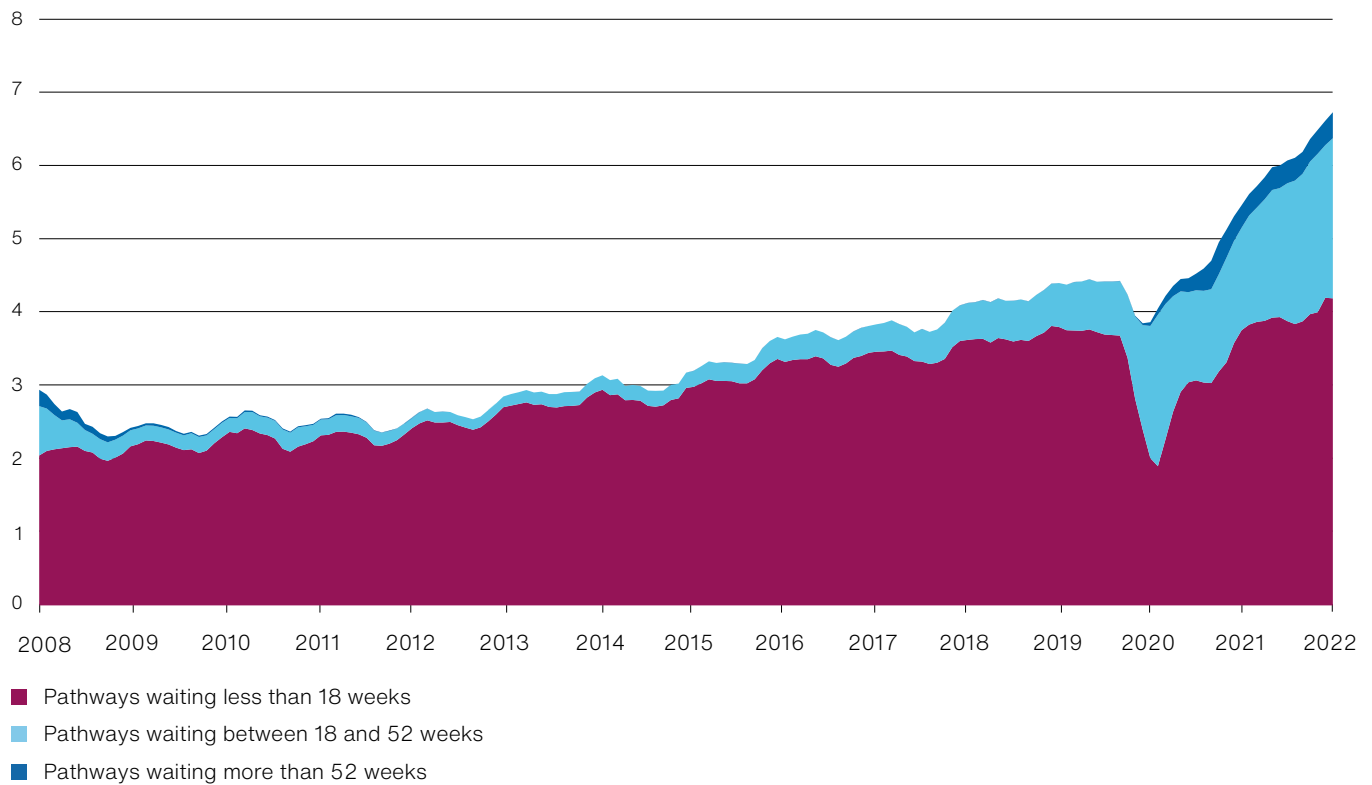
⁵ The elective care system counts the number of pathways which have started but not yet completed, rather than the number of people. Patients may be on more than one elective pathway, so the total number of individuals will be lower than the number of incomplete pathways. We have followed the convention of referring to 'the number of patients' on the elective waiting list because of uncertainty over how the ratio of pathways to patients may have changed over time.

Figure 12

National waiting times for elective care, January 2009 to January 2022

The number of patients on the elective waiting list has been climbing since 2009, with the proportion waiting more than 52 weeks significantly increasing from April 2020

NHS waiting list patients (m)



Note

- The elective care system counts the number of pathways which have started but not yet completed, rather than the number of people. Patients may be on more than one elective pathway, so the total number of individuals will be lower than the number of incomplete pathways. For this figure, we follow the convention of referring to 'the number of patients' on the elective waiting list because of uncertainty over how the ratio of pathways to patients may have changed over time.

Source: National Audit Office analysis of NHS England data

Ongoing COVID-19 pressures

2.33 While the number of patients in hospital with COVID-19 is substantially lower than the peak of 34,336 in January 2021, cases continue to rise and fall. The most recent peak was 14,044 on 18 July 2022 and as of 14 September 2022, there were 4,540 patients in hospital with COVID-19 (around 5% of adult general, acute and critical care hospital beds), equivalent to approximately 8 cases per 100,000 people. Across ICSs, hospital cases per 100,000 people ranged from 2.0 to 19.5 people on 31 August 2022 (**Figure 13** on pages 54 and 55). Stakeholders we spoke to noted that the ongoing requirement for enhanced infection prevention and control for COVID-19 patients was a constraint on improving hospital productivity.

Wider pressures on local government

2.34 ICSs include NHS and local government bodies as well as wider partners including organisations from the voluntary and community sector. Local authorities commission social care. While DHSC has policy responsibility for social care, it is delivered by a mixed economy of local government and privately funded provision. The stability and resilience of local care services directly impacts the NHS, both in terms of keeping people healthy and out of hospital and supporting patients who are medically fit to leave but require additional support. This part of the report looks in more detail at local government finances and social care.

Local government finances

2.35 Local authorities continue to face significant financial pressures. The government has reduced funding for local authorities since 2010 and their spending power declined by 26% between 2010-11 and 2020-21 (**Figure 14** on page 56). While council tax has increased substantially in real terms since 2016-17, if its effects are removed, local authority spending power funded by government fell by more than 50% between 2010-11 and 2020-21 in real terms. DHSC provides local authorities with the public health grant, an amount ringfenced for spending on public health areas. However, analysis by The King's Fund shows public health spending also fell in real terms by 15% between 2013-14 and 2019-20.

2.36 Local authorities also continue to face increasing demands for care services and received 1.9 million support requests from new clients in 2020-21, an increase of 6% since 2015-16. The amount of local authority net spending (funded by council tax, government grants and business rates) on care in 2020-21 was at its highest level since 2015-16, and overall spend on local authority arranged care was 7% higher in 2020-21 than 2010-11 in real terms.

Social care workforce

2.37 Adult social care vacancies in England have increased in recent years, from 4.4% in 2012-13 to 7.5% in 2018-19. While they decreased briefly in 2020-21 to 6.7% (**Figure 15** on page 57), they rose again in 2021-22 to 9.2%. New starters from outside the UK also fell between 2018-19 and 2020-21. Within ICSs, adult social care vacancies vary from 5% up to 13%, and turnover of roles range from 23% to 37%.

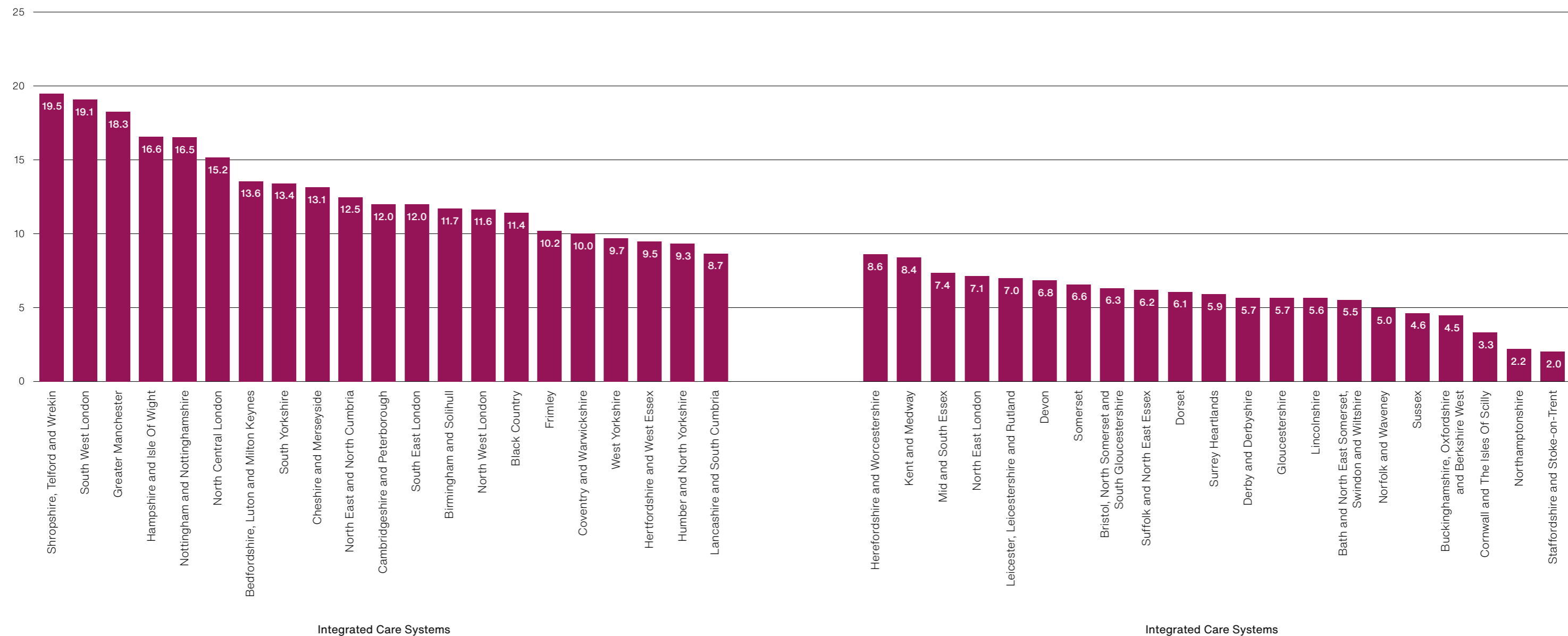
2.38 DHSC has overall policy responsibility for the adult social care system, including its workforce. However, social care providers within ICSs are autonomous businesses responsible for recruiting and training their own employees. The social care workforce is a key area of reform previously identified by multiple stakeholders in local government. DHSC had lacked a social care workforce strategy since 2009. It told the Committee of Public Accounts in 2018 it was developing such a strategy. In December 2021, DHSC published *People at the Heart of Care*, a white paper on adult social care reform that contained several commitments related to the social care workforce alongside a £500 million investment. DHSC told us that chapter five of this white paper represents its workforce strategy. Other government departments affect the social care workforce at a national level. This includes the Department for Business, Energy & Industrial Strategy on pay and employment issues, the Department for Education on skills and training, the Department for Work & Pensions on recruitment and wider labour market support, the Home Office on international recruitment, and the Department for Levelling Up, Housing & Communities on wider social care funding reforms.

2.39 The ambition for ICSs is that by bringing together the services that affect people's health, they can improve health outcomes, reduce inequality, and improve value for money and efficiency. The final section of our report looks at how they have been set up and their prospects for success.

Figure 13
 COVID-19 hospital cases per 100,000 people in Integrated Care Systems (ICSs), 30 August 2022

Across ICSs, hospital cases due to COVID-19 vary from 0.4 to 19.5 per 100,000 people

COVID-19 hospital cases (per 100,000 people)



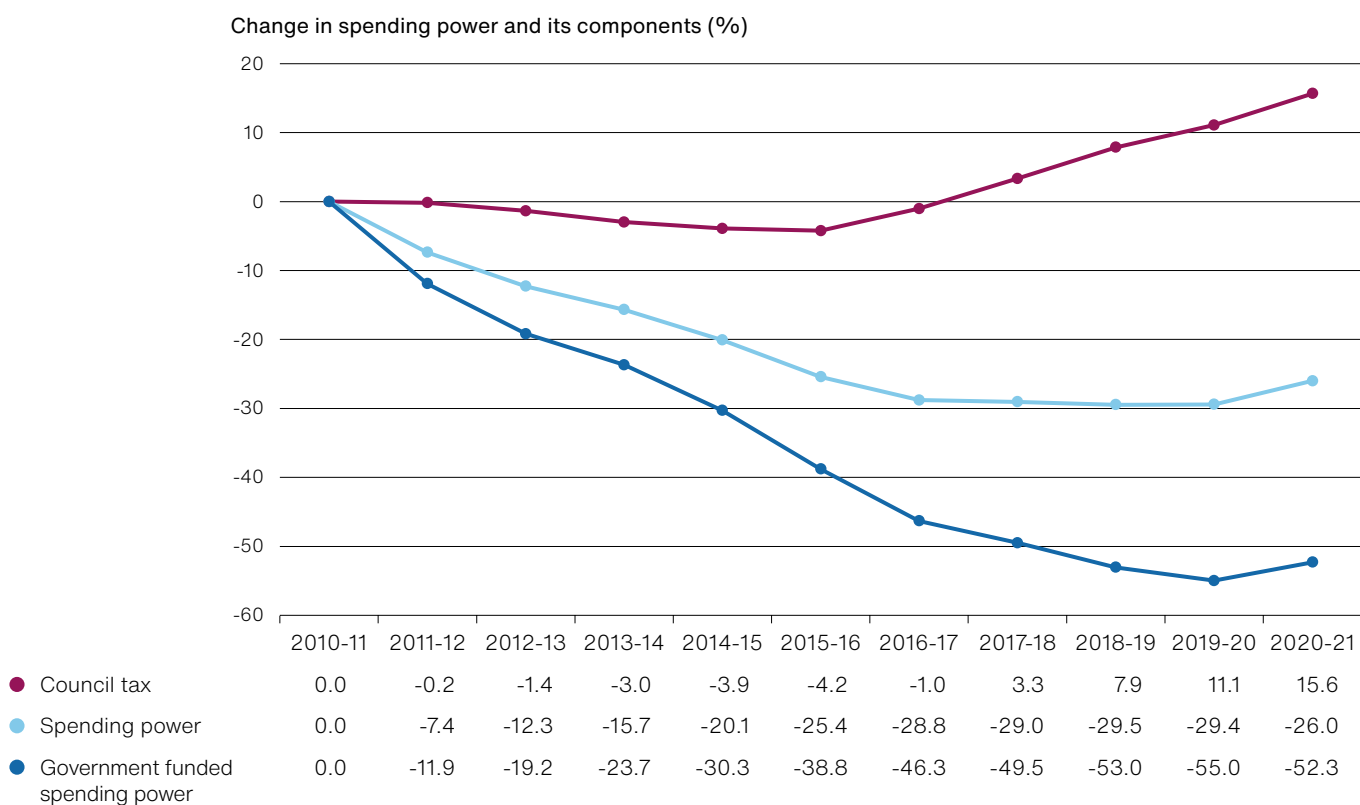
Notes

- 1 These data show the number of people currently in hospital with confirmed COVID-19.
- 2 Confirmed COVID-19 patients are those who tested positive for COVID-19 in the past 14 days through a polymerase chain reaction test.

Source: National Audit Office analysis of data published on the UK Coronavirus Dashboard, <https://coronavirus.data.gov.uk>

Figure 14

Indexed percentage change in components of local authorities' spending power, 2010-11 to 2020-21

Local authority spending power has reduced by 26% since 2010-11**Notes**

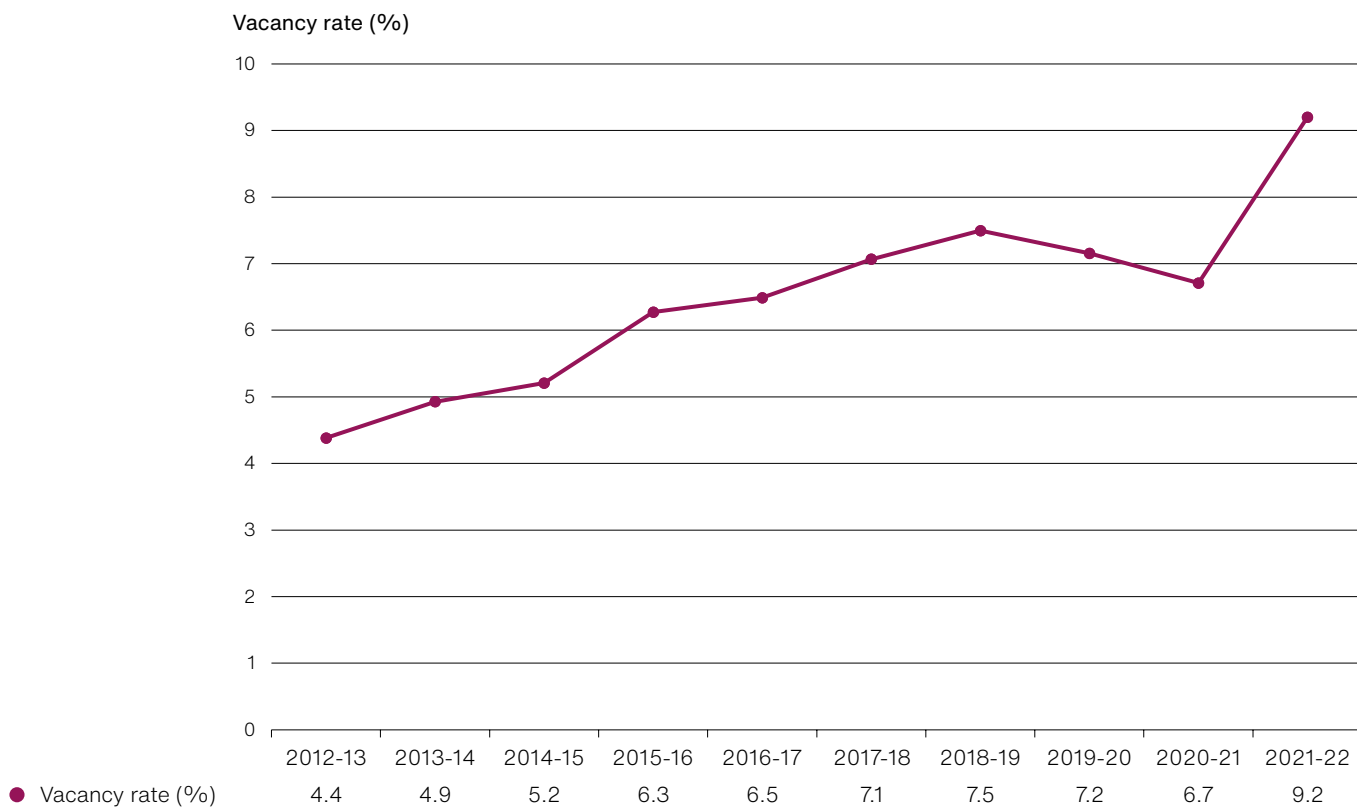
- 1 Spending power is a government measure of the revenue resources made available to local authorities (from 2015-16 government refers to 'core spending power').
- 2 Funding for the public health grant, the original Better Care Fund and NHS funding for spend on social care that also benefits health is excluded, as this funding was removed from the Department of Health & Social Care's definition of spending power from 2016-17 onwards.
- 3 A weighted index is used to enable a like-for-like comparison despite significant changes in the duties placed on local authorities and the way financial data were reported in the period 2010-11 to 2015-16. Accordingly, the index cannot be used to estimate absolute changes in funding.
- 4 Change in spending power and its components is indexed with 2010-11 at zero and in real terms at 2019-20 prices.

Source: National Audit Office analysis of Department for Levelling Up, Housing & Communities data

Figure 15

Adult social care vacancy rates in England from 2012-13 to 2021-22

Vacancy rates rose to 9.2% in 2021-22



Note

1 The vacancy rate is the number of vacancies as a percentage of the sum of directly employed staff and vacancies.

Source: National Audit Office analysis of Skills for Care data

Part Three

Government's efforts to improve population health through better integration and prevention

3.1 This part of the report sets out:

- the design of Integrated Care Systems (ICSs) and implications for achieving their objectives;
- the introduction of ICSs, including NHS England (NHSE) and the Department of Health & Social Care's (DHSC's) work to support this; and
- our assessment of the prospects for ICSs' success.

The design of ICSs

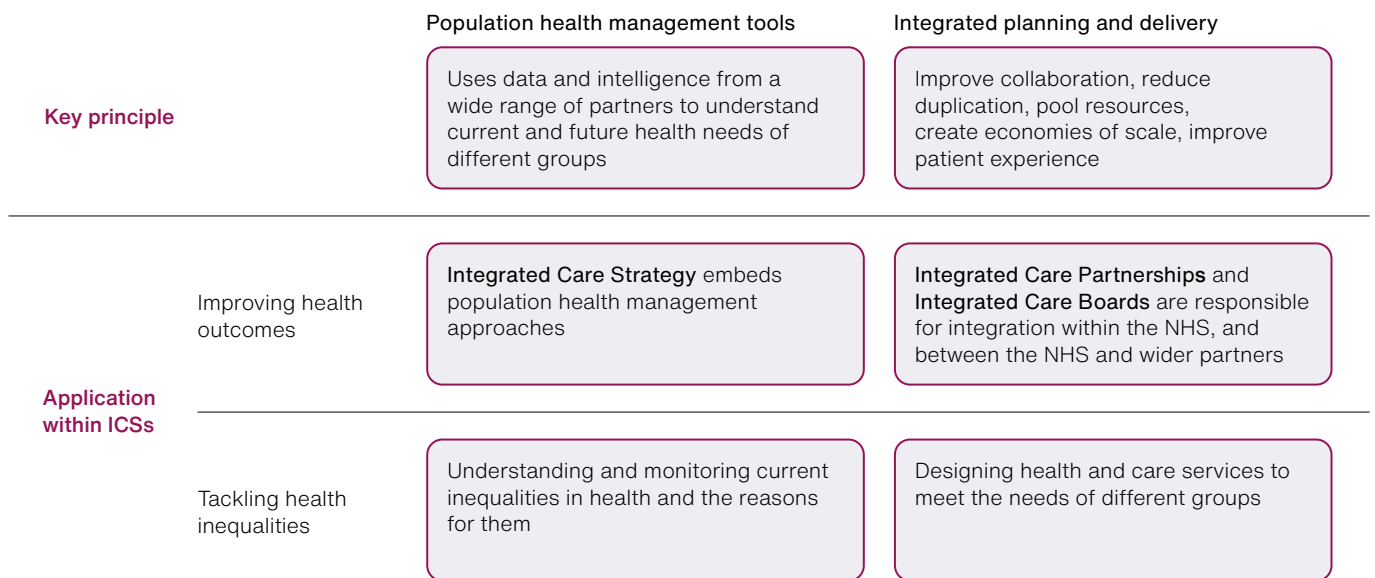
3.2 As we described in paragraph 1.6, NHSE has set out four main purposes for ICSs, which are to:

- 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.

3.3 This part of the report examines how ICSs are designed to achieve these objectives through better integration and use of population health techniques. These approaches are intended to come together in ICSs to deliver improved health outcomes for local populations (**Figure 16**).

Figure 16
Key principles of Integrated Care Systems' (ICSs) design

ICSs are designed to use integration and population health management to tackle inequalities and improve health outcomes



Source: National Audit Office analysis

Population health

3.4 A population health approach is the view that a population's health outcomes are affected by a wide range of factors beyond health and care services, and that different groups within the population are affected by different factors and have different needs. Population health management uses joined-up data from a wide range of partners and analytical techniques such as population segmentation and risk modelling to understand the current health and care needs of different groups and proactively plan for their future needs. Preventing ill health is a crucial part of this because actions to keep people healthy minimise the requirement for future interventions, which are often costlier. A population health approach is embedded in ICS design through the creation of Integrated Care Partnerships (ICPs), which bring the NHS and local authorities together with other stakeholders that can contribute to improving population health, and by the requirement to create Integrated Care Strategies that set out how services can meet the health and wellbeing needs of the local population.

Integration

3.5 Better integration of health and care services can help remove barriers to collaboration, reduce duplication, create economies that increase cost-effectiveness and efficiency, and improve patient experience. Such integration supports wider population health management approaches and could entail:

- joint planning and delivery of services, to reduce gaps or overlaps in provision and bring related or complementary services together;
- pooling resources and budgets across different geographical boundaries or service types, or joint commissioning projects that meet shared aims;
- functional integration of resources, for example, staff and workforce, back-office functions, capital items such as buildings and equipment, or sharing of information and digital assets; and
- reducing patients' touch points with services and ensuring continuity of care, supported by timely patient data accessible to all partners.

3.6 ICSs primarily aim to strengthen three types of integration:

- Integration within the NHS, to increase collaboration between health bodies and provide more efficient, better patient care.
- Integration between health and social care services, where this would improve the quality of outcomes or services or reduce inequality.
- Integration between the NHS, local government and other partners, for example, voluntary and community groups, to tackle wider determinants of health. The National Health Service Act 2006 gives local government a specific statutory responsibility to "take steps as it considers appropriate for improving the health of people in its area". As described in paragraph 3.24, many of these wider determinants sit outside health provision and are the national policy responsibility of other government departments (see Figure 21 on page 71).

Previous attempts to use these tools

3.7 Successive governments have recognised the importance of preventing ill health rather than just treating it, and ICSs are the latest incarnation of this:

- Derek Wanless' report of 2002, *Securing our Future Health: Taking a Long-Term View*, noted that better public health measures could significantly reduce future demand for healthcare.
- In 2010, Sir Michael Marmot's *Fair Society, Healthy Lives* review concluded that reducing health inequalities required action across all the social determinants of health, including from central and local government, the NHS and private and community voluntary groups.
- The Health and Social Care Act 2012 established statutory Health and Wellbeing Boards, bringing NHS, public health and local authority partners together to produce evidenced-based strategies that address local population needs (Joint Health and Wellbeing Strategies).

What happened during the COVID-19 pandemic?

3.8 The pandemic saw many organisations from health and wider sectors coming together, often with very little notice, to support the COVID-19 response in their areas. This was a positive experience for many as it helped break down previously perceived barriers to joint working. Our case study participants highlighted many examples of this, such as local authorities in Medway working with health colleagues to consolidate health and care data, which helped simplify patients' needs assessments.

3.9 Government took steps to support closer working between the NHS and other sectors during the pandemic. In March 2020, it published guidance and provided £1.3 billion of funding in 2020-21 to support the discharge of patients into care settings to free up hospital space. It provided further funding in 2021-22, but national funding for the programme ended in March 2022. On 22 September 2022, DHSC announced that it was launching a £500 million Adult Social Care Discharge Fund to support discharge from hospital into the community.

3.10 The pandemic also shone a light on many existing health disparities due to its disproportionate impact on different groups. People from deprived areas, ethnic minorities, and those with learning disabilities have all experienced poorer outcomes relating to COVID-19. In January 2021, NHSE established the National Healthcare Inequalities Improvement Programme, with responsibility for setting the direction for tackling healthcare inequalities.

Introducing ICSs

3.11 This section looks at DHSC and NHSE's work to introduce ICSs. It covers:

- stakeholders' views on the introduction of ICSs;
- NHSE's support to ICSs; and
- our assessment of the key elements of effective integration.

Views on the introduction of ICSs

3.12 ICSs are strongly welcomed by the majority of stakeholders we engaged. More than three-quarters of respondents to our survey of senior ICS staff (228 of 301 responses) agreed the introduction of ICSs was a good thing, and organisations we spoke to highlighted the potential for ICSs to address wider determinants of health, to reduce health inequalities, and for more collaborative working to lead to better health outcomes.

3.13 NHSE was committed to building wide consensus for ICSs and had a detailed engagement strategy for working with different stakeholders. It took a consultative approach to developing ICSs through testing and learning and then adjusting in response to feedback. For example, it consulted with regional teams, Integrated Care Board (ICB) chairs and wider stakeholder groups on the new NHSE operating model and how it can best work with ICSs. In our survey of senior ICS staff, 39% (104 of 266 responses) felt they had opportunities to contribute views during the implementation process (71 responses, or 27%, disagreed).

NHSE's support to ICSs as they developed

3.14 NHSE provided a wide range of support to ICSs during their development, such as formal guidance, good-practice and case study examples, seminars, workshops and training events, access to peer and learning networks, and ad hoc assistance. Much of this support was curated through NHSE's online Future NHS platform. The support offered has primarily focused on NHS participants although some was available to local authority staff, notably the Future NHS platform and programmes to support population health management and place development.

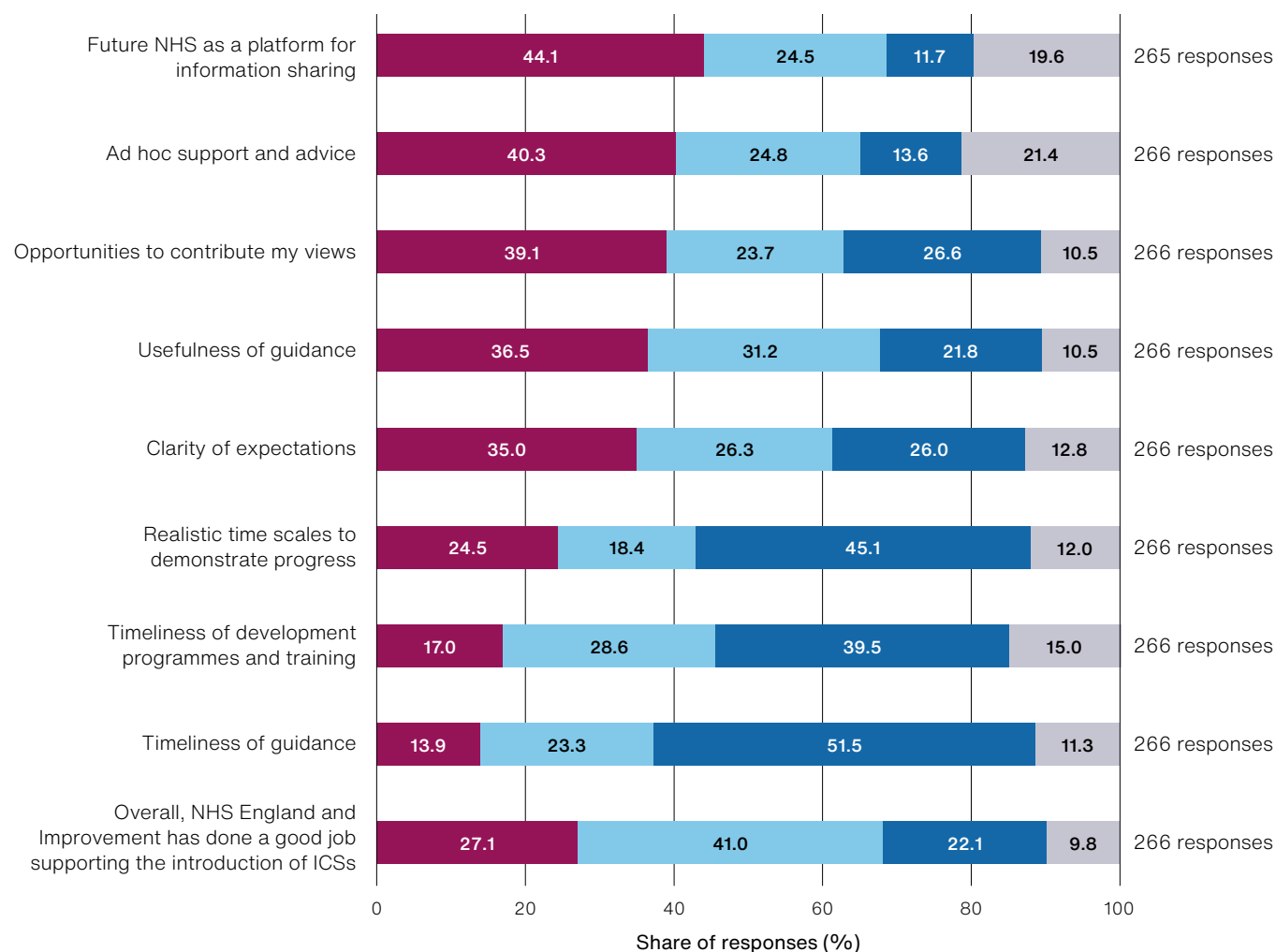
3.15 Stakeholders we spoke to were largely positive about implementation to date, particularly regarding NHSE's support and guidance, the flexibility to develop arrangements best suited to their needs, and the clarity of the expectations for ICSs. Our survey of senior ICS staff found 27% (72 of 266 responses) agreed that NHSE had done a good job supporting the introduction of ICSs (**Figure 17**), compared with 22% (59 of 266 responses) that disagreed.

Figure 17

Survey respondents' views on NHS England's (NHSE's) support during Integrated Care System (ICS) implementation

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

NHS England and NHS Improvement provided effective support to my ICS during the implementation process in terms of:



- Agree and strongly agree
- Neither agree or disagree
- Disagree and strongly disagree
- Don't know or not applicable

Notes

- 1 Data were collected between 28 March 2022 and 15 April 2022. The survey was started 362 times and completed 259 times, representing a completion rate of 72%. Responses were received from 36 of 42 ICSs.
- 2 Since our survey was carried out, NHS England and NHS Improvement formally became NHS England. Our survey questions referred to NHS England and Improvement (as it then was) but the figure title uses current title (as it now is).

3.16 Stakeholders expressed frustrations about some aspects of implementation. This included comments about the volume and timeliness of some guidance, delays and shifts in the timetable (DHSC originally hoped to put ICSs on a statutory footing from 1 April 2022, but in late December 2021 announced this would be delayed to 1 July 2022), duplication of effort for some ICSs, and that certain requirements were unnecessarily complicated. NHSE told us that it published guidance as soon as it was able to.

3.17 Despite the government's aim to be flexible regarding how ICSs are set up and run, stakeholders noted what they considered to be unhelpful prescription in some areas, such as the highly specified and NHS-focused nature of the outputs and performance indicators for ICBs in the NHS Oversight Framework, and restrictions on how funding can be used. Such prescriptive requirements may limit ICSs' ability to plan and deliver services that meet the specific needs of their populations.

Key elements of effective integration

3.18 Drawing on our back catalogue, wider literature, and input from subject matter experts, we identified 10 key elements for effective integration in health and care, and assessed ICSs' implementation against these elements (**Figure 18** on pages 66 and 67). Our assessment is based on current plans, and we note some aspects are still subject to change:

- Care Quality Commission is still finalising its assessment approach for ICSs.
- In April 2023, NHSE will merge with Health Education England and NHS Digital. On 7 July 2022, NHSE announced its intention to reduce the headcount of the new body by 30% to 40% compared with the predecessor bodies. Part of the rationale for this change is to reverse the temporary expansion of NHSE in response to the COVID-19 pandemic. As part of the restructure, NHSE will simplify how it works internally and with the wider NHS. It expects to develop its plans by late autumn and implement the changes by the end of March 2024. The changes are also intended to create space for ICSs to lead at local level. NHSE is currently working through what this will mean in practice.
- In February 2022, government announced in its white paper on integration its intention to develop a further set of outcomes measures for health and care integration. This would consist of a framework of national priorities and an approach to prioritise shared outcomes at a local level that focused on individual and population health and wellbeing, with the implementation of shared outcomes beginning from April 2023. It is not clear how this can fit with ICPs' timetables for finalising the integrated care strategies setting out their local population health needs by the end of 2022, and ICBs' five-year plans for addressing them by the end of March 2023.

3.19 We ranked the elements according to the level of residual risk we felt they posed to the future success of ICSs:

- a High risk** for areas where we considered the element was likely to be important to the success of ICSs, but we could not see it had been considered and fully addressed in establishing ICSs.
- b Medium risk** where we considered the risk had been considered and partially addressed, or where it was less likely to be central to ICSs' success.
- c Low risk** where we considered that the risk had been fully considered and addressed or where it was less likely to be central to ICSs' success.

Assessment of ICSs' prospects for success against their objectives

3.20 As we set out at paragraph 3.2, NHSE set out four objectives for ICSs. This final section of the report contains our assessment of their prospects for success against each of them.

Improving outcomes in population health and healthcare

Current performance

3.21 The current national picture on key public health outcome metrics is mixed. There has been positive progress in some areas, such as under-75 cancer mortality, while others, such as obesity rates, have become worse (**Figure 19** on page 68). Within ICSs, there is expected variation, but the range of some indicators show a significant distance from national trends. For example, under-75 cancer mortality rates vary in ICSs between 102 to 152 deaths per 100,000 people, compared with 125 nationally. Similarly, under-75 cardiovascular mortality rates vary between 22 and 152 deaths per 100,000 people, compared with 74 nationally. The scale of these differences mean some ICSs have much further to travel to improve health outcomes, and this will be reflected in variation across their individual priorities and work programmes.

Figure 18
Our assessment of Integrated Care Systems (ICSs) against key elements of effective integration

We assessed four out of ten key elements of effective integration as high risk

Key element	National Audit Office assessment of current status	Risk
Clarity of objectives	<p>It is not yet clear what ICSs are expected to deliver. NHS England (NHSE) has set out four high level purposes for ICSs but not articulated what improvement it expects to see against these objectives or by when it expects to see them. It has set out detailed expectations for the performance of NHS organisations against NHS priorities.</p> <p>The Department of Health & Social Care (DHSC) has started a programme of work to assess the benefits of the Health and Care Act 2022 and commissioned research in May 2022 to assess the benefits of moving to ICSs.</p> <p>Government plans to introduce a further set of outcome indicators in April 2023, shortly after Integrated Care Boards (ICBs) have set their five-year plans.</p> <p>The premise of moving to ICSs is to allow health and care systems to collectively respond to local population needs, but at present NHSE continues to provide very detailed scrutiny and oversight of individual NHS trusts as well as ICBs, including setting many very detailed performance metrics. This may change as NHSE implements the new NHS Oversight Framework under which ICBs will lead oversight of NHS trusts with NHSE only intervening where necessary.</p>	High
Sufficient resources	<p>NHSE did not agree final ICB financial plans for 2022-23 until nearly three months into the financial year. Some of the efficiency targets seem extremely challenging, and almost all ICSs and NHS providers are being asked to make efficiency savings well above the 2.2% core NHS target.</p> <p>NHSE has not provided ICBs with a budget for work they identify as necessary for achieving their local priorities. To free up funding for new initiatives, ICBs would need to make efficiency savings beyond those already agreed with NHSE.</p> <p>Local government and social care continue to face significant financial pressures.</p>	High
Good governance and accountability	<p>The financial framework for ICSs for the year starting April 2022 was only finalised in June 2022 and as of 5 September 2022, the Future NHS platform lists a further 20 pieces of guidance still under development, including guidance on joint commissioning arrangements, and quality and risk management.</p> <p>Stakeholders told us governance is still unclear in some areas, for example, how ICSs will function alongside existing local government Health and Wellbeing Boards and how accountability differences between NHS and local authority bodies will be resolved. The DHSC published draft guidance for Health and Wellbeing boards in July 2022, following publication of the Health and Care Act 2022.</p> <p>In its February 2022 white paper on integration, government set out criteria for place-based governance arrangements to be implemented by Spring 2023. This seems to run contrary to the ambition to allow ICSs to develop the approach that best meets their requirements and comes very late in the process of preparing ICSs.</p>	High
Capacity to balance other priorities	<p>There is a risk that other national health priorities such as elective backlogs and COVID-19 make it difficult for ICSs to also make progress on other priorities.</p> <p>Stakeholders expressed concern that NHSE retains significant influence and control over individual providers and that ICSs are too focussed on health services.</p> <p>The NHS Oversight Framework focusses on current performance rather than longer term population health management.</p>	High

Note

1 These key elements were identified through reviewing previous NAO reports on integration in other parts of government, reviewing wider academic and sector-based literature, and through input by NAO specialists and external subject matter experts from the Health Foundation, The King's Fund and Nuffield Trust.

Source: National Audit Office analysis

Key element	National Audit Office assessment of current status	Risk
Shared purpose and vision	<p>NHSE has taken a highly consultative approach to developing ICSs, but stakeholders told us some uncertainty remains on what ICSs are expected to deliver and by when.</p> <p>In our survey of ICS senior leaders, respondents from the NHS and local government were similarly supportive of the introduction of ICSs and their expectations of the benefits that would be delivered. Responses from third sector leaders were only slightly lower.</p>	Medium
Openness to innovation	<p>ICSs have greater theoretical flexibility in organising services, but budgetary pressures may limit their willingness to take risks.</p> <p>In our survey of ICS senior staff, 61% of respondents (167 of 276 responses) feel their ICS is willing to try innovative approaches (11% disagreed).</p>	Medium
Strong leadership and relationships	<p>Stakeholders we spoke to highlight the importance of personal relationships, openness and trust for establishing ICSs. This is very hard to measure or mandate and so remains an area of inherent risk.</p> <p>Fifty-five per cent of respondents in our survey of ICS senior staff (163 of 298 responses) agree most people in their ICS work in the interests of the whole ICS as well as their organisation (20% disagreed).</p>	Medium
Time (realistic timescales)	<p>Neither NHSE or DHSC has set out what benefits they expect from the move to ICSs, or by when.</p> <p>Improvements to outcomes resulting from more effective population health planning and preventative measures can take many years to materialise.</p> <p>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 improve outcomes in population health and healthcare. This compares with 3% (9 of 298 responses) that think it will take less than a year, and 10% (30 of 298 responses) that think outcomes will not change in the foreseeable future.</p>	Medium
Understanding local needs and context	<p>Integrated Care Partnerships (ICPs) are intended to bring together all organisations that can have an impact on the wider determinants of health in local areas.</p> <p>ICP strategies will set out how services can meet the needs of the local population, as assessed in the Joint Strategic Needs Assessments that local authority Health and Wellbeing Boards carry out.</p> <p>The three-tiered structure of ICSs (system, place and neighbourhood) should allow ICSs to understand the needs of different communities.</p>	Low
Effective data-sharing and use of digital assets	<p>ICSs were expected to have plans for digital and data strategies in place by April 2022, but there is variation in ICSs' progress with this. Nottingham and Nottinghamshire has used data innovations as an enabler for population health management, while other areas acknowledge they have capability gaps in digital.</p> <p>NHSE created a good practice framework to help health and care leaders digitise and transform services, and its support for cybersecurity has been well-regarded.</p>	Low

Figure 19

Summary of national trends since 2015, and recent Integrated Care System (ICS) outcomes, across key public health indicators

Some indicators at ICS level, such as rates of under -75 cancer mortality and under -75 cardiovascular mortality, show a significant distance from national trends

Public health indicator	National trend since 2015	Recent ICS outcomes
UK life expectancy	Between 2015 and 2020, UK male life expectancy remained at around 79 years, and female life expectancy remained around 83 years.	Male life expectancy ranges from 77 to 82 years, and female life expectancy ranges from 81 to 85 years (data covered the period between 2018 and 2020).
Under -75 cancer mortality	Between 2015 and 2020, under -75 cancer mortality decreased from 136 deaths per 100,000 people to 125 deaths per 100,000 people.	Under -75 cancer mortality ranges between 102 to 152 deaths per 100,000 people (in 2020).
Percentage of population overweight or obese	Between 2015 and 2021, obesity rates increased from 61% to 63%.	Obesity rates range between 52% and 69% (in 2020-21).
Under -75 cardiovascular mortality	Between 2015 and 2020, under -75 cardiovascular mortality decreased slightly from 74.0 deaths per 100,000 people to 73.8 deaths per 100,000 people.	Under -75 cardiovascular mortality rates range from 22 to 152 deaths per 100,000 people (in 2020).
Smoking prevalence	Between 2015 and 2019, smoking prevalence in adults decreased from 17% to 14%.	Smoking prevalence in adults ranges from 10% to 17% (in 2019).
Deaths from drug misuse	Between 2015 and 2020, deaths from drug misuse increased from four deaths per 100,000 people to five deaths per 100,000 people.	Deaths from drug misuse ranges between three per 100,000 people and nine per 100,000 people (data covered the period between 2018 and 2020).
Alcohol-specific mortality	Between 2015 and 2020, alcohol-specific mortality increased from 10 deaths per 100,000 people to 13 deaths per 100,000 people.	Alcohol-specific mortality in ICSs ranges from seven per 100,000 people to 18 per 100,000 people (data covered the period between 2017 and 2019).

Source: National Audit Office analysis of NHS England and Office for Health Improvement and Disparities data

The role of prevention in improving health outcomes

3.22 The *NHS Five Year Forward View* (2014) and the *NHS Long Term Plan* both referred to prevention as a key strategic objective to improve health outcomes. DHSC published a consultation on prevention in July 2019 seeking views on tackling the causes of preventable ill health in England, but has yet to publish its response since closing the consultation in October 2019. In our survey of ICS senior staff, 77% (229 of 298 responses) reported their ICS intended to invest in prevention, but only 31% (91 of 298 responses) felt they currently had the capacity to do so. As DHSC guidance sets out (**Figure 20** overleaf), there are different forms of prevention activity. NHSE provides some funding for each type, although at a much lower level than funding for other ICS objectives. For 2022-23, NHSE is providing £27 million to the 42 ICSs to invest in tobacco cessation (primary prevention), and a further £70 million for targeted lung health checks (secondary prevention). By comparison, it has provided £2 billion for elective backlogs (paragraph 2.14). Our case study interviewees reported that in 2021-22, NHSE scrutiny focused on financial management and tackling elective care backlogs recovery, with prevention rarely mentioned. For 2022-23, NHSE has asked systems to develop robust plans for the prevention of ill-health as part of an overall objective to “continue to develop our approach to population health management, prevent ill-health and address health inequalities”, which is one of 10 priorities it has set for ICBs in 2022-23.

3.23 In addition to the funding to ICSs, NHSE undertakes a significant amount of prevention work at national and regional level. It has allocated £43 million for national or regional prevention schemes, including £25 million for diabetes management (tertiary prevention). It is also commissioned by DHSC to carry out some public health activities that contribute to prevention, including screening programmes (for example, for certain cancers) and immunisation programmes (for example HPV vaccinations and seasonal flu immunisations). This amounted to £1.4 billion in 2019-20, the last year for which data is available. NHSE expects that the equivalent figure for 2021-22 will be £1.5 billion, plus additional COVID-19 costs.

Figure 20

Primary, secondary, and tertiary prevention as tools to improve population health

The Department of Health & Social Care defines prevention activities according to three categories

There is no single definition for what constitutes preventative activity, and this can range from wide-scale whole-population measures aimed at promoting health and wellbeing, to more targeted, individual interventions aimed at improving skills or functioning for one person or a particular group or lessening the impact of caring on a carer's health and wellbeing. There are three categories of prevention activity, all of which are essential:

- **Primary prevention:** population-wide interventions to promote wellbeing or prevent disease or ill-health before it occurs, for example smoking cessation, social prescribing, reducing loneliness or isolation.
 - **Secondary prevention:** early intervention that slows down or reduces any further deterioration including through detection of early disease and preventing disease progression, reoccurrence or relapse by reducing the impact of a disease that has already occurred (including screening), for example home adaptations, cancer screening, and addiction services.
 - **Tertiary prevention:** formal intervention aimed at managing or reducing the impact of lasting illness or injury, for example chronic disease management programmes/services, rehabilitations and reablement, or supporting their carers.
-

Source: *Guidance on the preparation of integrated care strategies*, Department of Health & Social Care, July 2022

Cross-government action to improve health outcomes

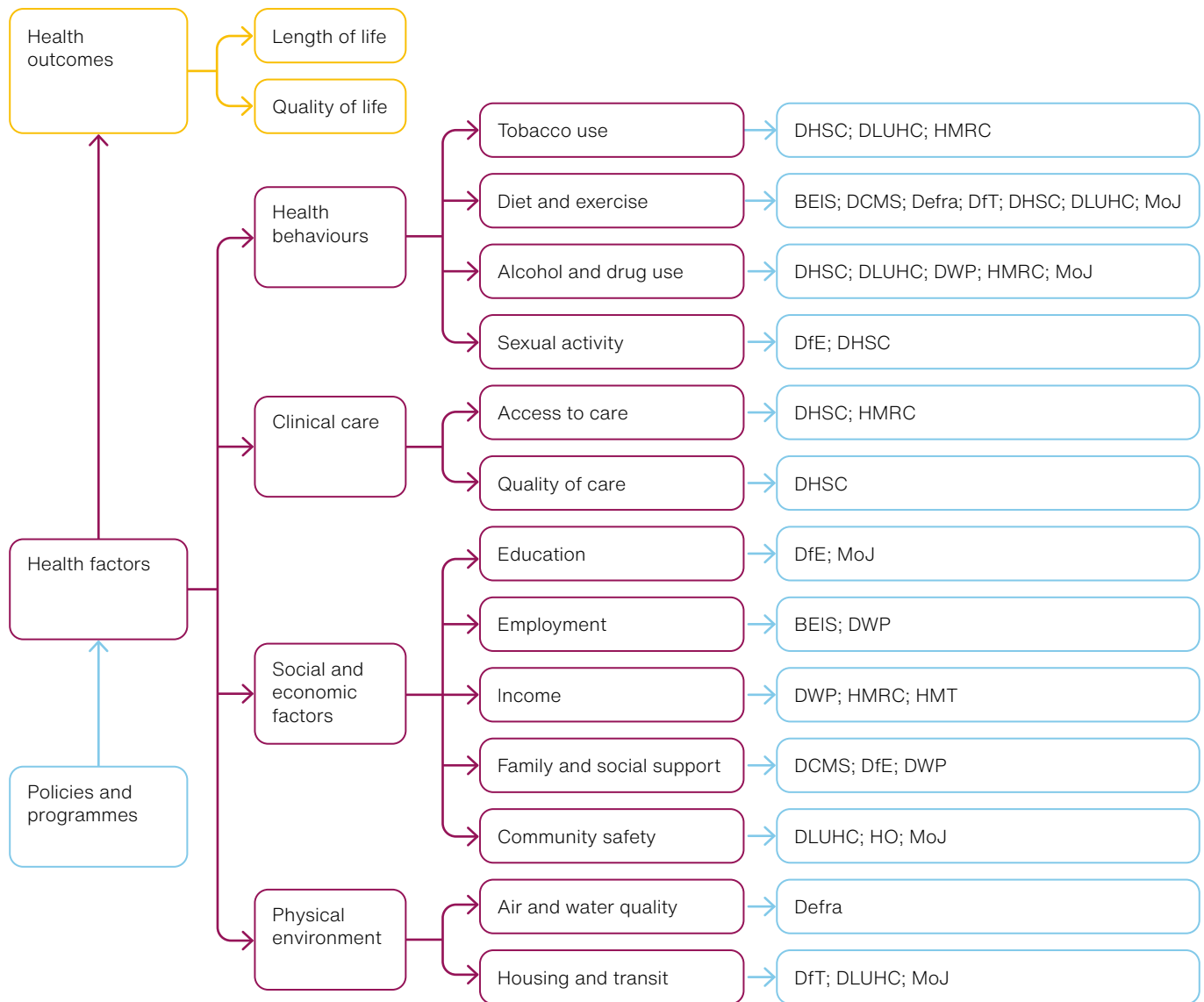
3.24 A core tenet of the population health approach is that there are a wide range of factors that affect health and wellbeing, beyond health and care services. NHSE considers that only around 20% of health outcomes are the result of clinical interventions. We assessed these wider factors and identified 12 government departments with a policy responsibility that affect on peoples' health (**Figure 21**).

3.25 In October 2021, DHSC announced the creation of the Health Promotion Taskforce as a Cabinet Committee to drive cross-government efforts that improve the nation's health, support economic recovery and levelling up, and reduce health disparities. The standing members of this committee were Secretaries of State who could take decisions that were binding across government. However, details of Cabinet Committee meetings are not published, to allow space for open discussion before a collective position is agreed. This meant that the taskforce could not (and was not intended to) bring together stakeholders outside central government, or articulate government's priorities. This committee was dissolved in autumn 2022 and a new Home Affairs Committee now considers health matters as part of its remit to consider matters relating to home affairs, including tackling crime, migration, health, and public services and to consider constitutional issues.

Figure 21

Departmental responsibilities for factors influencing health outcomes

Twelve government departments have policy responsibilities that could affect peoples' health



→ Health factors affecting health outcomes → Government policies and programmes affecting health factors
 → Health outcomes

Notes

1 Department of Health & Social Care – DHSC; Department for Levelling Up, Housing & Communities – DLUHC; Department for Business, Energy & Industrial Strategy – BEIS; Department for Digital, Culture, Media & Sport – DCMS; Department for Education – DfE; Department for Environment Food & Rural Affairs – Defra; Department for Transport – DfT; Department for Work & Pensions – DWP; HM Revenue & Customs – HMRC; HM Treasury – HMT; Home Office – HO; Ministry of Justice – MoJ.

2 The list of government departments is not exhaustive and there may be other overlapping areas of policy. The purpose of this figure is to highlight the necessity of effective cross-government working.

3.26 The Office for Health Improvement and Disparities (OHID) was established in October 2021. It is a part of DHSC incorporating some previous functions and staff from Public Health England. Its remit is to improve the nation's health and to reduce health disparities. Officials from OHID engage with teams across government on specific topics which influence health, but this work is ad hoc and not visible to partners outside central government. It is still in the process of developing its overall approach and is well-placed to build on this work to take forward the co-ordination across government that DHSC and NHSE recognise is necessary to secure their ambitions for improving people's health, but which is not currently happening.

3.27 If DHSC wants to make progress in improving health outcomes for the whole population, as well as those on waiting lists, it will need to address the fact that drivers of poor health can be affected by policies from many government departments, as well as stakeholders beyond government, and put in place effective arrangements to systematically address them. This should complement work being done by ICSs at local level, and NHSE could have a role in ensuring insight and experience emerging from ICSs is aggregated and used to inform this cross-government approach.

Tackle inequalities in outcomes, experience, and access

3.28 Significant health inequalities exist in the UK with wide variations in outcomes between ethnic groups. Black women are four times more likely to die during pregnancy or childbirth in the UK, and South Asian and black people are two to four times more likely to develop type 2 diabetes than white people. Estimates of disability-free life expectancy are 10 years lower for Bangladeshi men living in England than for white men.

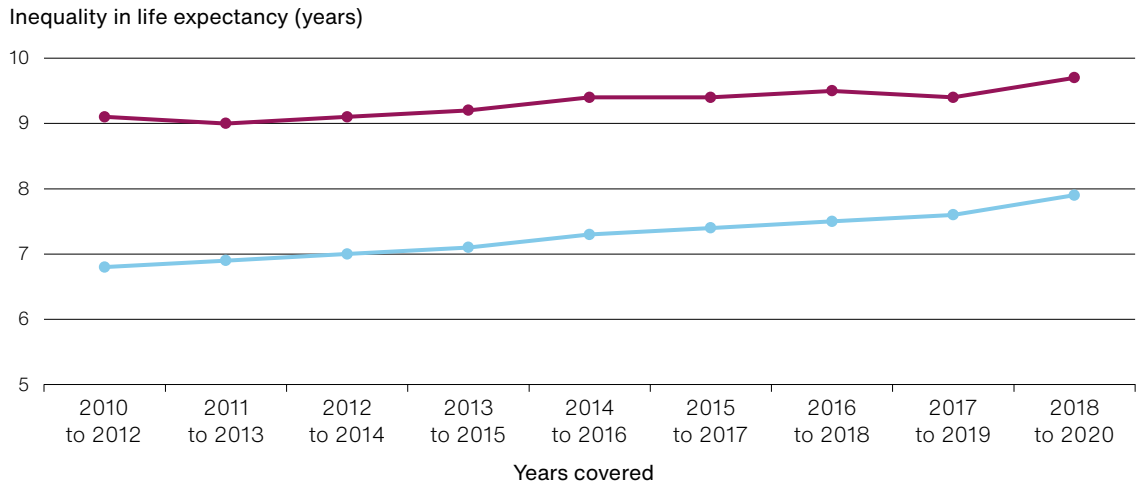
Inequality in life expectancy

3.29 Inequality in life expectancy at birth is defined as how much life expectancy varies between the most and least deprived areas. Male inequality in life expectancy increased from 9.1 years to 9.7 between 2010 and 2020, and for women it increased from 6.8 to 7.9 years (**Figure 22**). Inequality of life expectancy varies between ICSs. For men, it is six years in Buckinghamshire, Oxfordshire and Berkshire West, compared with 11 years in North East and North Cumbria. For women, the gap is four years in Norfolk and Waveney, compared with nine years in Cheshire and Merseyside.

Figure 22

National inequality in life expectancy at birth for both males and females between 2010 and 2020

The difference in life expectancy between the most and least deprived populations across England has increased for both males and females between 2010 and 2020



● Male	9.1	9.0	9.1	9.2	9.4	9.4	9.5	9.4	9.7
● Female	6.8	6.9	7.0	7.1	7.3	7.4	7.5	7.6	7.9

Notes

- 1 Figures calculated by Office for Health Improvements and Disparities using mortality data and mid-year population estimates from the Office for National Statistics and Index of Multiple Deprivation scores.
- 2 Inequality in life expectancy at birth is defined as how much life expectancy varies between the most and least deprived areas.
- 3 Life expectancy at birth is a measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a new born baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout their life.
- 4 Data points overlap and cover two years each.

Source: National Audit Office analysis of Office for Health Improvement and Disparities data

Work to tackle health inequalities

3.30 The government has several initiatives under way to improve health and address inequalities:

- NHSE's Population Health Management Development Programme provides training, peer support and engagement from a central team to enable ICSs to embed a population health management approach. This includes tailoring health interventions for specific groups.
- DHSC published a white paper on adult social care reform in December 2021, setting out how £5.4 billion of funding from the Health and Social Care levy will be used to transform adult social care and support in England, including addressing inequalities relating to access and quality of care. Government has since announced that the levy will not now be introduced, but that the additional funding for the NHS and social care services will be maintained at the same level.
- The government published a white paper on Levelling Up in February 2022, which recognised the wider factors that can affect health, such as education, skills and the economy, and set out an explicit aim to narrow the gap in healthy life expectancy between different areas. Two of its 12 aims relate 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. This white paper also set out government's commitment to publish a further white paper on health disparities during 2022.
- DHSC published a white paper on proposals for health and care integration in February 2022, which included its approach to developing a shared outcomes framework, a single person accountable for delivering outcomes across health and social care, and wider enablers and regulatory mechanisms to support joining-up of care.
- In February 2022, DHSC announced independent reviews into ethnic inequalities related to medical devices and tobacco control.

3.31 NHSE has taken several actions in recent years to tackle health inequalities, including creating the NHS Race and Health Observatory and a national programme, and appointing a national director for healthcare inequalities improvement. It also established the Core20PLUS5 approach in 2021, which combines a focus on five key clinical areas of health inequalities for the most deprived 20% of the population, with flexibility for ICSs to identify their own priority groups based on local population health data, including the healthcare inequalities dashboard. The National Healthcare Inequalities Improvement Programme established five further priority actions for systems to address. These are to:

- restore NHS services inclusively;
- mitigate against digital exclusion;
- ensure datasets are complete and timely;
- accelerate preventative programmes; and
- strengthen leadership and accountability.

3.32 There is a significant amount of work to do to tackle health inequalities, but NHSE has put in place the building blocks (including training, a national programme and support for local programmes and access to data) that should enable it to start to make progress in this area.

Enhance productivity and value for money

3.33 As we set out in Part Two, NHSE has a history of setting some NHS providers financial targets they do not meet and asking DHSC to top up budgets with loans. In 2020-21, loans were converted to public dividend capital which trusts do not have to repay. NHSE has core efficiency requirement of 2.2% in 2022-23, and in addition the amount of COVID-19 funding it receives is reducing, meaning it must make further spending reductions, at both ICB and national level. Some of the efficiency targets for providers look extremely challenging. NHSE will need to carefully manage the return to an expectation of annual efficiency improvements, particularly given the other financial pressures on NHS organisations (including increases in inflation and energy costs), the ongoing uncertainty of the future impact of COVID-19 on the NHS, and the other wider challenges we discussed in Part Two.

3.34 Government has committed to producing guidance to facilitate better joint working, for example on pooled budgets. A focus on prevention and integration has the potential to improve value for money, for example by helping people to stay healthier and so improving health outcomes while reducing demand on services. However, most of the ICS staff we surveyed reported that they do not have the capacity to make progress on prevention, and NHSE's focus in its oversight conversations during the past year has been on shorter-term priorities.

Help the NHS support broader social and economic development

3.35 In the *NHS Long Term Plan* published in 2019, NHSE set out how the NHS can support wider social goals in health, employment, justice and the environment, and how these can in turn benefit health outcomes. Neither the NHS operational planning guidance or the NHS Oversight Framework sets out what ICSs are expected to do to make progress on this or how NHSE will assess whether NHS organisations are contributing to this objective. Some stakeholders we spoke to told us they were unclear what was meant by it and that NHSE did not refer to it in oversight meetings.

3.36 NHSE has taken steps to support peer learning on this topic: working with the Health Foundation, it has established a Health Anchors Learning Network for participants to share ideas, knowledge and skills about how to make ICS bodies 'anchor institutions'. The Health Foundation describes anchor institutions as "large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities". They can affect their communities in several ways, for example through their procurement and employment strategies. More recently, guidance from DHSC on preparing Integrated Care Strategies, which it published in July 2022, advised that "Integrated Care Strategies should explore the role that local government, NHS, other large employers, providers and partners can play as anchor institutions ... and the potential to use their spending power and significant assets to benefit communities and enhance socio-economic conditions".

3.37 Given the varied socio-economic conditions in ICSs across England it would not be appropriate for DHSC or NHSE to set detailed metrics for performance in this area. However, they could increase the chance of progress by ensuring it is included in monitoring (for example, in regional teams' oversight conversations, and NHSE's annual ICB assessments) and using these channels to identify and share good practice and identify areas in need of support.

Appendix One

Our evidence base

- 1** Our independent conclusions on the Department of Health & Social Care's (DHSC's) and NHS England's (NHSE's) preparations and support for the introduction of Integrated Care Systems (ICSs) were reached by analysing evidence collected primarily between October 2021 and June 2022.
- 2** The analytical framework underpinning our conclusions considered how far DHSC and NHSE had determined or considered what success looked like for ICSs, whether it had identified the conditions necessary for ICSs to succeed, and the actions it took to ensure these conditions were in place.
- 3** Local authorities are a key component of ICSs, but this report has not examined their role in detail because local authorities' responsibilities extend much wider than ICSs, and oversight of local government is provided separately by the Department for Levelling Up, Housing & Communities.
- 4** An online data visualisation presenting metrics and indicators collected during fieldwork for this report aggregated to 2021-22 ICS boundaries is available at: www.nao.org.uk/reports/integrated-care-systems-visualisation

Interviews

5 We conducted 27 virtual interviews with representatives from DHSC, NHSE, other government bodies, and wider stakeholders to inform our audit:

- **Structured interviews with DHSC and NHSE.** We interviewed officials from DHSC and NHSE to discuss ICS policy and strategy, finances, system partnership working, oversight and governance, health inequalities, and the support and guidance offered to ICSs. During fieldwork, we also held regular meetings with the NHSE team leading ICSs' implementation, where we triangulated our understanding of other evidence sources.
- **Structured interviews with other government bodies.** We interviewed officials from other government bodies to understand their roles and responsibilities with ICSs and the extent of cross-government working. We met with Care Quality Commission, NHS Digital, the Department for Levelling Up, Housing & Communities, and Office for Health Improvement and Disparities.
- **Semi-structured interviews with wider stakeholders.** We interviewed representatives from health and care stakeholder organisations to understand wider views on the introduction of ICSs. We met with the Association of Directors of Adult Social Services, the Chartered Institute of Public Finance and Accountancy, the Health Foundation, The King's Fund, the Local Government Association, the NHS Confederation, NHS Providers, and Nuffield Trust.

Document review

6 We reviewed more than 250 published and unpublished documents, of which around 100 had been requested from DHSC or NHSE. This included internal planning documents, guidance and good practice guides, case studies, reports, board papers and minutes, previous National Audit Office (NAO) reports, online articles and think tank pieces. We reviewed these documents to inform our understanding of the policy context and history of integrated working across health and care, to assess the wider operating environment ICSs were being introduced into, and to understand various aspects of ICSs' implementation, including governance, oversight and financial arrangements, the support and guidance provided to ICSs, and DHSC's and NHSE's forward plans.

Case studies

7 We engaged with five ICS case study areas to gain an in-depth understanding of the day-to-day realities of ICS activities at the front-line. We selected case study areas to capture views from different types of ICS, based on criteria that included a high-performing system, a system subject to financial stress, and a system impacted by boundary changes.

8 For each case study, we held an initial meeting with senior representatives to develop our understanding of the ICS area. We followed these up with requests for further meetings to dive deeper into themes and topics identified during the initial discussion. In total, we interviewed 24 participants across our five case study areas. We met with designate ICS chief executives and Integrated Care Board (ICB) chairs, finance directors, representatives from Clinical Commissioning Groups (CCGs) and NHS trusts, local authority chief executives and directors for public health and adult social services, and representatives from voluntary and community groups, among others. The notes from our meetings were incorporated into the broader evidence base informing our wider conclusions. We are very grateful for the time generously provided by our case study participants.

9 Our five case study areas were:

- Greater Manchester Health and Social Care Partnership;
- Kent and Medway;
- Nottingham and Nottinghamshire;
- South East London; and
- West Yorkshire Health and Care Partnership.

Survey

10 We surveyed senior ICS officials and staff to gather evidence on their experience of ICS implementation and their views of the key challenges and opportunities ahead. We designed and administered the survey online and employed a snowball sampling approach by distributing the survey to designate chief executives at all 42 ICSs and requesting they forward it on to senior individuals involved with the set-up of their ICS. Our sampling approach meant the survey population was unlikely to be representative, but we added basic demographic identifiers allowing us to attribute responses by respondent's broad role and primary area of work. Nearly 60% of survey respondents had an NHS role (31.3% from NHS commissioning and 28.2% from NHS providers), 19.3% had roles in the voluntary and community sector, and 17.4% had a local government role.

11 We consulted with NHSE and NAO survey specialists during the survey's planning, and their comments were reflected in its final design. We also tested the survey with senior front-line ICS contacts. The survey ran from 28 March 2022 to 15 April 2022. It was started 362 times and completed 259 times, representing a completion rate of 72%, and we received responses from 36 of 42 ICSs. We sent follow-up prompts to ICSs where our monitoring highlighted relatively low response rates, and we also extended the original closing date by a week to boost responses. We note the risk that people who are less engaged with ICSs did not respond to our survey.

Financial analysis

12 We analysed financial information to understand the current and historical financial performance of NHS bodies and ICSs, and the causes and scale of underlying financial pressures. We reviewed consolidated trust accounts and CCG returns from November 2021, loan data from December 2021, estates backlogs data from November 2021, and data on ICB financial allocations from June 2022. These data were provided following requests to NHSE or accessed via online NHS resources. There was minimal adjustments or treatments applied to these data other than aggregating historic NHS trusts' and CCGs' financial information at ICS level. We grouped trusts' and CCGs' accounts into ICSs based on a mapping provided by NHSE for 2021-22 to reflect ICS boundary changes in 2021. However, this may not line up exactly with past or future groupings due to changes to ICS boundaries over time.

13 We used the same definitions of loans, estate backlogs, and other terms as used in the ICB plans. We refer to CCG overspend as deficits for ease of understanding for a lay reader. For trust deficits in 2020-21, we report surplus/deficit before impairments and transfers, as this is more in line with NHSE reporting than the historic control total measure, which did not apply in 2020-21.

14 For future ICS plans, NAO data analytics specialists assisted us to extract financial data from all 42 individual plans relating to non-recurrent spending and efficiency savings. When analysing these plans, we considered the fact that ICSs have identified savings in two ways: first, savings at an ICS level from the ICB budget, which may involve commissioning fewer services (from hospitals, GPs or community health services) or paying less for them; and second, savings from individual NHS providers (including hospitals, mental health trusts and ambulance trusts). Savings made at ICS level may impact at provider level, for example, if the ICB commissions fewer services from a hospital. The financial impact on providers was therefore netted off against ICB savings to avoid double-counting the savings.

15 We analysed ICBs' funding allocations from the NHS. We did not analyse local authority funding because there is no equivalent mechanism for ICSs to receive budgets and distribute them to local government.

Quantitative analysis

16 We analysed local and national data across a range of metrics and indicators to understand the scale of operational challenges faced by ICSs and their current activity and performance levels. We collected data on national NHS and adult social care vacancies, local authority spending power, elective care backlogs, COVID-19 prevalence and hospital cases, and health outcomes data. These data were accessed from public sources except for NHS trusts' vacancy data at ICS level, which NHS Digital helpfully collected and provided to us. The health outcome indicators we selected were based on established public health measures such as inequality in life expectancy, under-75 cancer mortality, obesity rates, under-75 cardiovascular mortality, smoking prevalence, deaths from drug misuse, and alcohol specific mortality.

17 We aggregated local authority-level data up to ICSs using a mapping file provided by NHSE for 2021-22 to reflect ICS boundary changes in 2021. There were a small number of cases where some local authority data had to be weighted according to Lower Super Output Area population statistics to apportion data across ICS boundaries.

Key elements of effective integration

18 The analytical framework underpinning our conclusions was informed by 10 key elements we had identified as important for effective integration in health and care. We identified these key elements through reviewing previous NAO reports on integration in other parts of government, reviewing wider academic and sector-based literature and through input by NAO specialists and external subject matter experts from the Health Foundation, The King's Fund and Nuffield Trust. We are grateful for the contributions provided by these external experts. The key elements were used to frame our overall assessment of ICSs (for example, in Figure 18) and our understanding of what a good ICS might look like, in addition to informing selected questions in our survey of senior ICS staff.

CORRECTION SLIP

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SESSION 2022-23

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Correction One:

In the Summary on page 13 the sub-heading above paragraph 18 reads Value for money conclusion, it should read Conclusion.

It should read:

Conclusion

1 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.

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