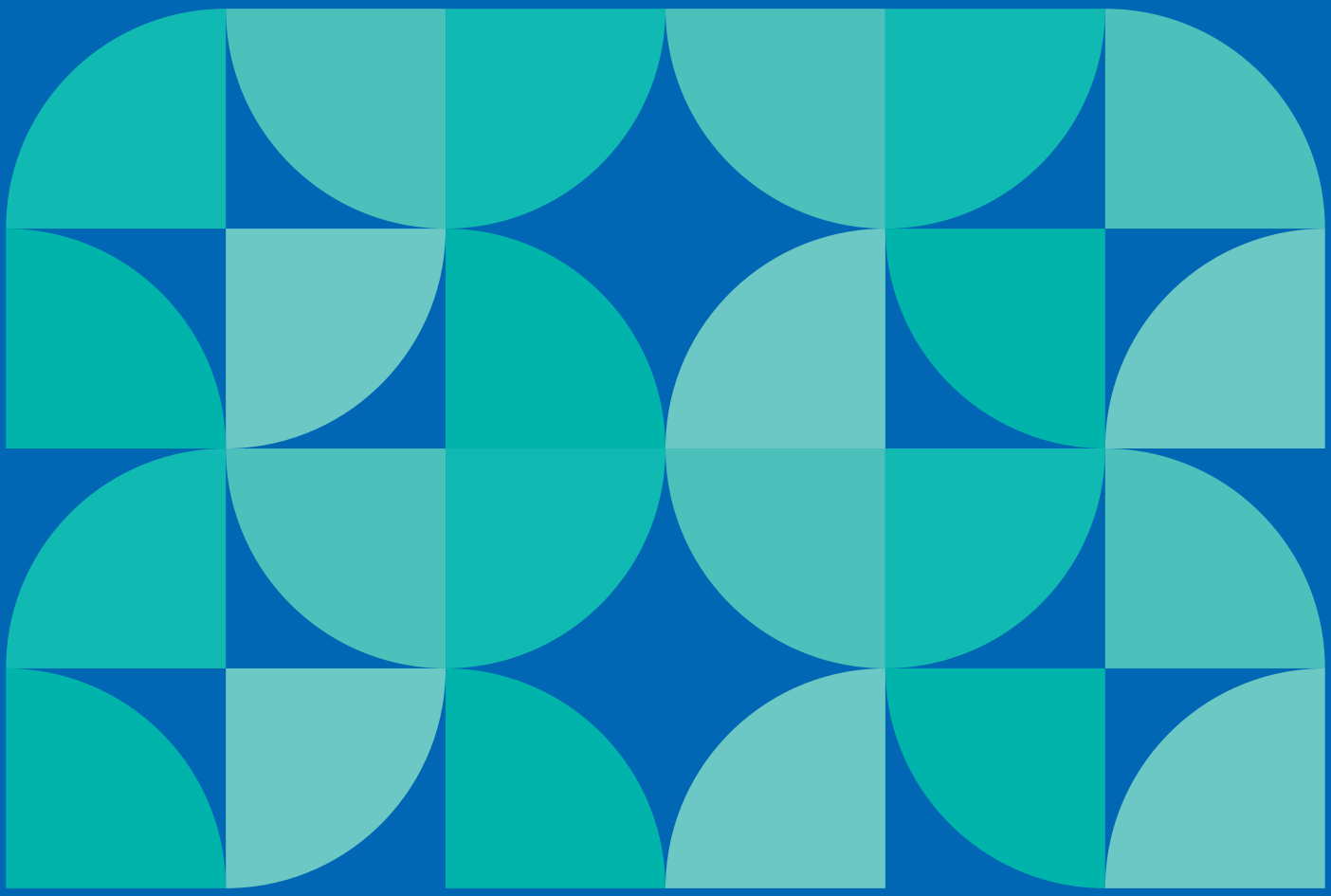
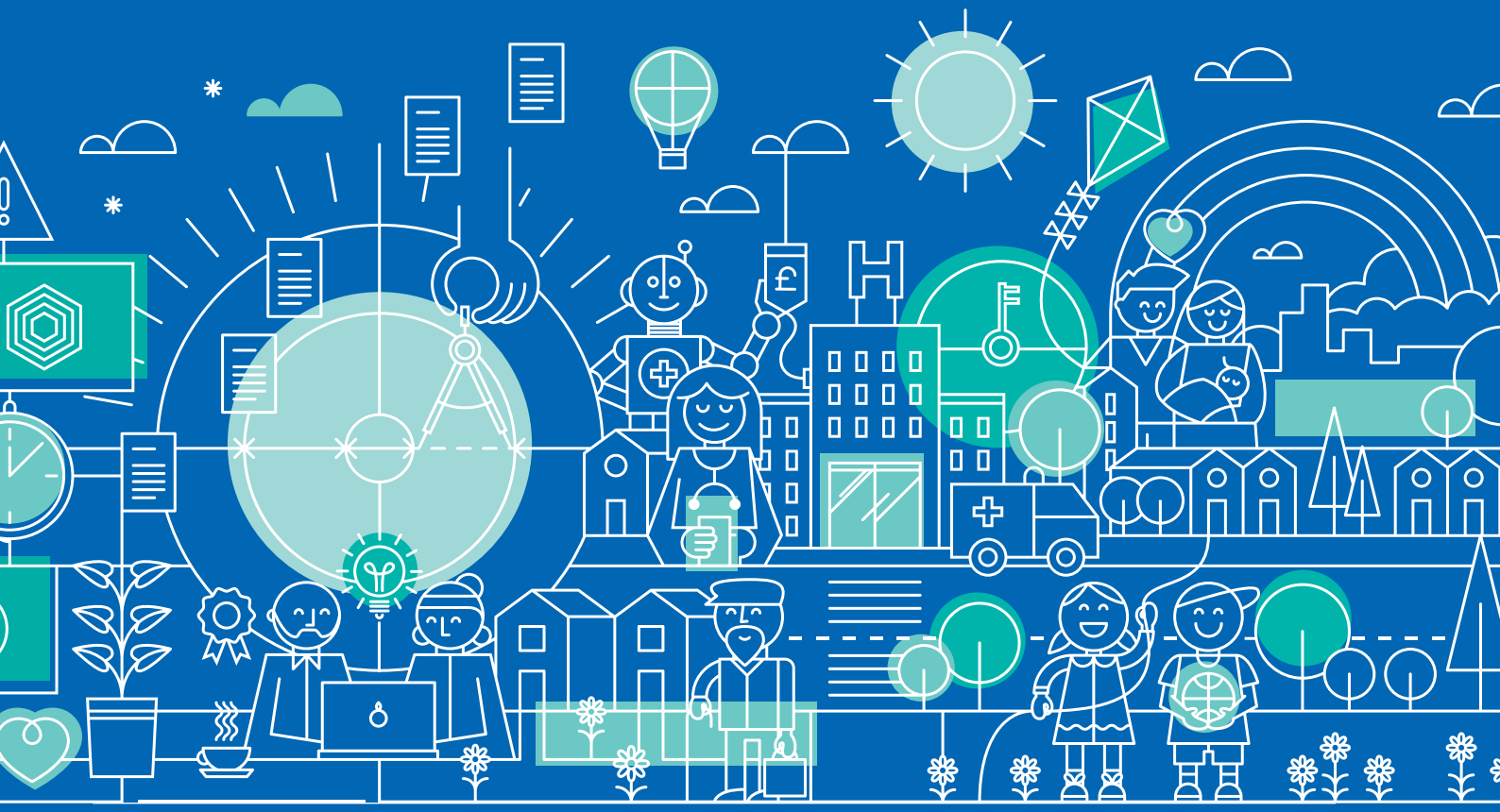
IMPOWER

NOVEMBER 2022



The evolving role of county authorities in Integrated Care Systems

CCN
COUNTY COUNCILS NETWORK



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Introduction

The NHS and local authorities in England are facing immediate and immense pressures as we head into winter. Systems are handling intense demands in managing recovery from Covid against a backdrop of a cost-of-living crisis, rising demand across services, profound workforce challenges and funding restraints.

These pressures and the pandemic itself have highlighted the importance of collaborative working between health and social care services. Be it discharge pathways, population health management or their roles as anchor institutions for communities, the mutual dependencies between councils and local NHS services are in sharper focus than ever before. The formal introduction of Integrated Care Systems (ICSs) in July 2022 offers a path forward for driving greater collaboration between councils, the NHS and the voluntary, community and social enterprise sector.

Given the significance of the changes that ICSs bring for their members, the County Councils Network (CCN) asked IMPOWER to review the emerging role of county authorities within these systems and provide a stocktake on progress. We were delighted to accept. As a company we are acutely aware of not only the challenges that organisations face in working together but also the inspiring results that can be achieved when they overcome these barriers.

ICSs have been considered extensively from the perspective of the NHS. However, we believe that this report is the first to consider these systems from the perspective of councils, whose role is central to the integration agenda. While the statutory basis for ICSs is now fixed, how they operate in practice will continue to evolve over the next few years. Our research covers three key themes which will be crucial to that evolution: governance, strategic delivery planning and culture. We hope that the findings and recommendations in this report are useful to councils, their NHS colleagues and central government, as partners in ICSs continue to grapple with shared challenges to provide the best outcomes for their citizens.

About IMPOWER

IMPOWER holds a profound belief in the innate value of public services; a better public sector is the cornerstone of a better society. We exist because public services can be – and should be – improved. We also believe that better outcomes cost less.

Founded in 2000, we have spent the past two decades developing a deep understanding of the complexity of public services, recognising that a different kind of challenge needs a different type of approach.

Our EDGEWORK® approach drives better outcomes across complex systems, radically improving performance and saving millions of pounds as a result, and leaving our clients financially and operationally resilient in their most challenging areas:

- Health and Social Care Interface
- High Needs and SEND
- Children's Social Care
- Adult Social Care
- Housing and Homelessness
- Climate Change
- Whole Council Transformation

Delivering better outcomes is at the heart of what we do and is the key to large scale savings and long-term financial sustainability. We aim to put humanity at the heart of public service reform.

About The County Councils Network

Founded in 1997, the County Councils Network is the voice of England's counties. A cross-party organisation, CCN develops policy, commissions research, and presents evidence-based solutions nationally on behalf of the largest grouping of local authorities in England.

In total, the 23 county councils and 13 unitary councils that make up the CCN represent 26 million residents, account for % of England's GVA, and deliver high-quality services that matter the most to local communities

The network is a cross party organisation, expressing the views of member councils to the government and within the Local Government Association.

Glossary of key terms and abbreviations

LOCAL AUTHORITY – LA
This refers to all types of council – two-tier county and district councils, metropolitan district councils, unitary authorities and London Borough Councils.

COUNTY AUTHORITY
We use this to refer in broad terms to 23 county councils in England and 13 CCN unitary authorities. We recognise the differences in the two types of councils, however use this term for accessibility.

INTEGRATED CARE SYSTEM – ICS
We use this to refer to all of the systems and organisations involved in planning and delivering joined-up health and care as a whole in an area, as well as the geography that is encompassed by each system.

INTEGRATED CARE BOARD – ICB
The statutory organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the ICS area.

INTEGRATED CARE PARTNERSHIP – ICP
The statutory committee jointly formed between the NHS Integrated Care Board and all upper-tier local authorities that fall within each ICS area.

PLACE-BASED PARTNERSHIP – PBP
The partnerships in ICSs that will lead the detailed design and delivery of integrated services at a "Place" level, involving councils, the NHS and other local partners. In practice these are referred to differently in different ICSs.

INTEGRATED CARE STRATEGY – IC STRATEGY
The strategy that ICPs are required to produce, setting out how local partners are to meet the assessed health and wellbeing needs of the population in the ICS area.

HEALTH AND WELLBEING BOARD – HWB
The statutory committees of local authorities charged with producing joint strategic needs assessments and joint health and wellbeing strategies for their local population.

NHS ENGLAND – NHSE
We use this term to refer to the NHS organisation that leads the NHS across England.

CENTRAL GOVERNMENT DEPARTMENTS:

- Department of Health and Social Care – DHSC
- Department for Levelling Up, Housing and Communities – DLUHC
- HM Treasury - HMT

Summary and key findings

Local authorities and NHS organisations have been working together on shared challenges since the inception of the NHS after the Second World War. Their responsibilities and structures have developed extensively since then, creating a complex system of interdependencies and local working arrangements. This has resulted in two sets of organisations that, in structural terms, exist largely independently of each other, despite close alignment in their overarching policy objectives, with one reporting to central government and the other to locally-elected politicians. As Nye Bevan noted in 1946 "there exists in the medical profession a great resistance to coming under the authority of local government"[1].

Integrated Care Systems (ICSs), formally established in legislation by the Health and Care Act 2022, represent a major attempt by central government to bind LAs and local NHS provision together more closely in formal structures, primarily through the creation of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).

ICSs are however at a very early stage of their development. Even in areas that were frontrunners of this approach, the formal structures and mechanisms that were put in place by the legislation have yet to be fully tested. As such this report does not – and indeed cannot yet – provide a comprehensive assessment of their immediate or eventual effectiveness, as ICSs will continue to evolve. Instead, the report aims to support that evolution by setting out our baseline view of the system as it is today as well as recommendations for where it could be strengthened.

Our research covered three key themes which we tackled according to three questions:

1. Governance – Are CCN members genuine partners in ICSs?
2. Strategic Delivery – Do ICSs have a shared purpose with deliverable plans that tackle CCN member priorities?
3. Culture – Are CCN members and the NHS able to work effectively together?

Our detailed findings are set out further in this report, however there were several factors which were true across all three themes.

1. CENTRAL GOVERNMENT POLICY HAS NOT ADAPTED TO THE LOCAL FLEXIBILITY THAT IT ARGUES IT PROMOTES

Our research demonstrated time and again that the level of variation in how LAs work with the NHS is immense, with both sentiment towards ICSs and their local implementation varying enormously from ICS to ICS and council to council.

> **"If you have looked at one ICS, you have looked at one ICS." ICB Chair**

Examples of this variation include: the number of joint posts between organisations; shared commissioning practices; mutual scrutiny arrangements; the role of local politicians, and; local priorities and who will lead on their implementation - though the list is extensive. This variation is the product of multiple factors including, but by no means limited to, the strength of relationships between senior leaders in systems, the extent to which joint-working arrangements were already in place pre-ICS, and the boundaries around which ICSs have been set.

1. https://hansard.parliament.uk/commons/1946-04-30/debates/62dd8934-2b79-4a9b-9b51-94e812c79fab/NationalHealthServiceBill

In this report we have attempted to provide some order to this variety by introducing a typology for local authorities depending on their local ICS arrangements (see page 18). We have also set out where we think that these arrangements are unsustainable or ineffective. But this typology only scratches the surface of the different arrangements that councils are putting in place.

To a degree, variation between local areas is to be welcomed as a natural consequence of giving LAs and local NHS bodies the freedom and flexibility to deliver local services in a way that best meets the needs of the local population. However, in the longer term this level of variation represents a challenge for national policy if it continues to be dictated from the centre. We heard regularly about central government attempts to control outcomes either through central guidance or ringfenced, short-term funding pots which don't match local priorities. In a world of increasing delivery diversity, this level of prescription will become ever less effective.

2. GENUINE PARTNERSHIP WORKING IS YET TO BE EMBRACED ACROSS THE FULL ICS SPECTRUM

Our research indicates that local government and the NHS are in broad agreement on the overall aims of ICSs as set out by central government[2] and the benefits that they can bring. We found several fantastic examples of partnership working in our research and mutual respect between the two sets of organisations is high, particularly after the pandemic.

Figure 1: Where LAs and ICSs can work together, what are the top three priority issues for your ICB?[5]

	LAs	ICB Chairs
1	Hospital Discharge	
2	Hospital Admissions Prevention	
3	Mental Health	Public Health

However, there are significant challenges to overcome before councils can consider ICSs a truly "partnership" arrangement. Half of the councils who responded to our survey said that partnership working was "about the same" following the creation of ICSs.

> **"ICBs are looking to use their influence to shape council services to solve their problems rather than population health management. Their focus is on issues like discharge as this helps the NHS."**
> **Council Chief Executive**

For many LAs, ICSs simply do not feel like a paradigm shift towards delivering truly local priorities based on local engagement, and the question remains as to whether they are "joint" endeavours or NHS bodies with some local government participation.

The key issue that was raised repeatedly is that ICBs in particular are still seen to operate primarily to tackle immediate "NHS issues" rather than address local priorities. This is reinforced across the three themes of our research by:

- Accountability structures for ICBs which lead to NHSE and the Secretary of State for Health and Social Care and not to local organisations, as reiterated in October's "Operating Framework"[3]
- Regular directives from "the centre" which require senior ICB leadership to focus on immediate NHS operational issues such as "ABCD"[4].
- A "command and control" culture that jars with collaboration and local political leadership.

2. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
3. https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf
4. https://www.gov.uk/government/news/health-and-social-care-secretary-to-set-out-new-plan-for-patients-and-call-on-public-to-play-a-part-in-national-endeavour

Councils recognise the need for ICBs to tackle immediate issues, most of which are causing real pressures on NHS services. However, there is concern that in the medium term it will be difficult to shift focus onto overarching, long-term system issues such as investing in preventative measures, which both NHS and council leaders recognise are essential to "shifting the dial" on population health.

We also heard concerns that ICBs are beginning to act in areas that were previously the domain of councils, such as commissioning their own adult social care (ASC) services which could lead to distortions in the local market.

Similarly, there is a risk that central policymakers begin to see ICBs as responsible for all elements of a system, as seen in the recent ASC Digital Transformation Fund being routed through ICBs rather than local authorities[6].

ICPs are seen as a much more collaborative space which can focus on longer-term issues such as prevention and integration of services. However, there is a large degree of scepticism from senior leaders in councils that these will drive significant new policy decisions in the face of NHS operational orthodoxy and tight budgets, particularly as decision-making and financing control rests with the Integrated Care Board.

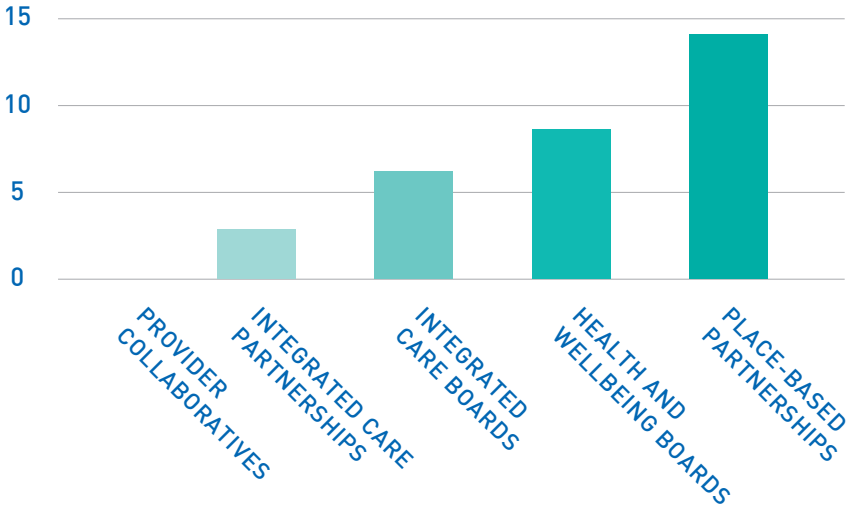
3. THE PRIMACY OF "PLACE"

For many LAs the essence of partnership working still takes place in relationships outside the formal arrangements of the ICS. Furthermore, the structures of ICBs represent a significant burden on their time, particularly for those required to work across multiple ICSs. Instead, their focus is on Place Based Partnerships (PBPs).

73% of councils who answered our survey felt that PBPs were more important to delivering their priorities than ICBs and 85% said the same of ICPs, with all of the exceptions being where the ICS is more or less entirely within the council area. This is true even at the most senior levels, including some LA Chief Executives who choose to attend Place meetings, but not their local ICBs.

> **"Outside the formal constructs of the ICS there are great conversations between LAs, Trusts, ICBs etc. But this is not because of the ICS, which is too focussed on governance and numbers rather than the things which are going to shift the dial". Council Chief Executive.**

Figure 2: Organisational structures that LAs ranked highest in terms of delivering priorities within the ICS[7]



5. IMPOWER survey of CCN members and ICB chairs
6. https://www.digitalsocialcare.co.uk/funding-opportunities/adult-social-care-digital-transformation-fund/
7. Survey – "In terms of importance to delivering your council's priorities in the ICS how would you rank the following"

Despite this, there is little focus on "Place" in national policy. Just one of the 14 pieces of guidance on ICSs issued by NHS England addresses "Place"[8] and no guidance since September 2021 has significantly addressed "Place". It is not referred to in ICS legislation. NHS partners are keen to emphasise the importance of "Place", however we found very few examples of clear delegation plans of either funding or power, and "Place" in many areas acts largely as the continuation of existing informal arrangements. The definition of "Place" also varies significantly – in some ICSs, it may mean an entire county of 800,000 people whereas in others it may be defined by a small group of Primary Care Networks comprising only 85,000 people.

The LAs we spoke to generally felt that "Place" is the engine room of effective integration and improved services for citizens across the boundaries of the NHS and local government. For councils who share an ICS with other LAs, "Place" is essential for developing and delivering truly local strategies.

There are however two risks to this focus. Firstly, the lack of formal delegation to "Place" creates a risk that decision-making may be pulled upwards away from local areas and into the ICB. Some councils felt this was already happening, for example as more local CCGs were "agglomerated" into ICBs. Secondly, in statutory terms the bulk of NHS decision-making power, including budget setting, sits squarely with ICBs within ICSs. A focus on "Place", without clear delegation, could mean that LAs lose some of their ability to drive the major actions they need in their area, such as a focus on 'out of hospital' care, which would also need to be driven at ICB level.

A plan for action

On balance, our research suggests that councils still have cautious optimism about ICSs and their roles within them, despite clear challenges. NHS partners also recognise the opportunities from new ways of working. However, success in this agenda needs to be based on trust. LAs are making significant time commitments to ICS work and, without decisive action from local NHS and council leaders and central government, there is a very real risk that that optimism turns to disengagement and ICSs come to be seen as just another NHS reorganisation to be worked around - without delivering the step change in preventative and community care that is needed to create a 21st Century health and care system. Winter and budget setting ahead of the next financial year are likely to be "crunch points" at which real progress will be judged.

We found many examples of actions that local leaders, in both the NHS and local government, are already taking to deliver real change. In this report we set out several recommendations to go further, aimed at members of ICBs and ICPs as well as central government and NHSE.

There are four key steps that we believe will be essential to the future success of county authority participation in ICSs:

1. **DHSC and NHSE need to fundamentally review the levels of centrally mandated activity and targets in policies and funding requirements,** particularly in shared policy areas, to ensure that they are consistent with the principle of locally-driven strategies.
2. **In further developing integration policy, DHSC and NHSE should review mechanisms to strengthen local, rather than national, lines of accountability,** for example through further devolution deals.
3. **The role and future of "Place" needs to be refined locally by ICBs and local government, with clear delegation plans that support the principle of subsidiarity** – that issues should be tackled at the lowest level possible to handle their resolution. This is particularly important for ICSs with multiple LA partners.
4. **Council and local NHS leaders should agree a small number of specific and achievable inclusive ambitions ahead of the next financial year, through their ICP,** to build partner confidence in ICSs' ability to deliver real change.

8. https://www.england.nhs.uk/publication/integrated-care-systems-guidance/
9. https://publichealthscotland.scot/publications/scottish-health-service-costs/scottish-health-service-costs-high-level-costs-summary-2020-to-2021/

Overview of recommendations

Strategic policy recommendations

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4. **Council and local NHS leaders should agree a small number of specific and achievable inclusive ambitions ahead of the next financial year, through their ICP.** This should build partner confidence in Integrated Care Systems' ability to deliver real change.

Expenditure and outcomes

5. **ICBs and LAs should report together annually on 'out of hospital' health and related expenditure. NHSE should also report annually on out of hospital expenditure, by spending type.** This will enable local benchmarking and is already occurring nationally in Scotland[9].

6. **DHSC/NHSE should agree, in consultation with local government, a small number of proportionate metrics to track performance of services at the margin of integration nationally.** These should be quality assured for consistency. ICBs and LAs should agree and report on their own local metrics for local priorities.

Governance

7. **ICBs should make clear arrangements for oversight of major decisions with local authorities, as a minimum covering budget allocations and significant service reconfiguration.** This is needed to protect council partner members from conflicts of interest in their roles on ICBs and LAs and is particularly necessary for councils sharing ICSs with multiple other councils. It is also needed to ensure that decisions have sufficient political input.

8. **DHSC and NHSE should review ICS boundaries after a year of the legislation coming into force.** In particular, for councils spread over multiple ICSs some arrangements will become less and less workable over time.

9. **LA Scrutiny Committees should set out their expectations to ICBs, considering joint sessions where they share an ICS with other councils.** ICBs should be clear on the information that they will provide to local scrutiny committees. Each LA and ICS will need to agree its own arrangements, but scrutiny should be proportionate, co-ordinated and useful. There may, for instance, be occasions when it is appropriate for scrutiny committees to meet with NHS and LA colleagues simultaneously to discuss shared issues.

10. **NHSE and its regional teams should be clear on the role of LA feedback in ICB chairs' appraisals.** The ICB chair role carries significant power in ICSs and can only be changed with the Secretary of State for DHSC's approval. As such, LAs should be able to provide feedback on the work of the chair.

11. **ICB chairs should review ICB membership annually, drawing on experience from other boards.** We found no reason for membership to remain static and that lone council voices on ICBs felt overlooked in discussions which could undermine their input. For LAs working with multiple other councils, a lack of local representation is felt to be particularly problematic. Decisions on political representation were often taken based on outdated central government guidance and this should reasonably be revisited.

12. **DHSC should review the statutory requirements of Health and Wellbeing Boards and ICPs to allow for pragmatic working arrangements that minimise duplication.** In the interim, where possible, LAs should agree clear divisions of responsibility between ICPs and HWBs, as well as rationalisation of their roles to minimise duplication.

Strategic Delivery Planning

13. **ICPs should agree a small set of achievable priorities for partners in ICSs for 2023-24.** Trying to do too much initially when decision-making and delivery are yet to be tested is a significant risk to long-term system engagement. Focussing on a narrower set of aims will generate confidence in the ability of system partners to deliver meaningful change and create a virtuous cycle for further action. In each case the "positive externalities" that integrated approaches will bring should be quantified for each partner. What this could mean in practice is set out separately.

14. **ICPs should agree in advance with ICBs and LAs how they are expected to demonstrate "regard" to the IC Strategy.** One option would be to ensure that the chair of the ICP is a full member of the ICB. There is a risk of disengagement with the ICP if strategies are not seen to drive real change, particularly in budget setting. For the NHS, IC Strategies should act as a local counter-balance to demands on ICBs from NHSE and DHSC.

15. **DHSC and DLUHC should clarify the future approach to pooled funding and grant allocation between councils and ICBs.** Recent evidence, such as the ASC Digital Transformation Fund and £500m for hospital discharge, suggests that central government funding for ASC services may be routed through ICBs rather than going to LAs or pooled funds such as the BCF. This undermines the principle of partnership working between the NHS and councils.

16. **ICB chairs should review ICB agendas and ensure these are appropriate and sufficiently focussed on the long term.** ICB time should meaningfully focus on non-operational, strategic and transformational issues that take advantage of the expert skills and knowledge of attendees. Core NHS operational issues should be delegated to sub-committees where necessary.

17. **ICBs should define the geography, role and medium-term future of place-based partnerships including delegation, in agreement with LAs.** Formal delegation may not be appropriate, however certainty over medium-term arrangements will support planning and this is particularly important for councils sharing their ICS with multiple other councils.

Culture

18. **ICBs and ICPs should carry out proportionate board development exercises.** There is clear value in these and where we found examples in our research, they were welcome, however these need to be proportionate. Our research indicates that there would also be particular value in improving NHS partners' understanding of councils' resources and responsibilities.

19. **LAs and NHS/ICB partners should focus organisational development at the management level.** This level appears to be a key point of tension across boundaries and local leaders need to develop a vision with shared values and priorities. Core to this is building trust between the different organisations.

20. **Councillors should agree parameters with ICB chairs for regular engagement outside of formal governance arrangements.** This should enable an exchange of views on LA and NHS priorities as well as how to manage these in the local political environment. It is also essential to developing the trust required for effective partnership working. ICB chairs and ICP chairs should make information available that explains their work to local politicians, enabling councillors and MPs to be able to justify and explain the work of these bodies to their various constituents.

Methodology

The aim of this project has been to develop a deeper understanding of how ICSs and their component parts – ICPs and ICBs – are developing in terms of their relationships with county and CCN unitary authorities. This covered three key themes of governance, strategic development planning, and culture, as well as an analysis of available expenditure and outcomes data.

We have set out our findings through the lens of the following questions:

GOVERNANCE

"Are CCN members genuine partners in ICSs?"

STRATEGIC DELIVERY PLANNING

"Do ICSs have a shared purpose with deliverable plans that tackle CCN member priorities?"

CULTURE

"Is the NHS able to work effectively with CCN members?"

As part of our approach, IMPOWER undertook a two-month period of qualitative and quantitative research between September and October 2022. This included interviews across seven 'deep dive' councils, roundtables with ICS participants, surveys, and desk-based research as set out below.

'Deep dive' interviews

At the outset of this work, with CCN support, we identified seven CCN member councils to act as 'deep dive' areas for research. We conducted a total of 34 interviews of between 45 and 60 minutes with representatives of these councils as well as reviewing a selection of documents relevant to this research. For each 'deep dive' council, we spoke to at least one representative from each of the following groups:

- Elected councillors
- Council officers
- "NHS" members of ICBs (typically chairs and CEOs)

Roundtables

We co-ordinated three roundtable discussions with the following groups:

- Local Authority Chief Executives
- Directors of Adult Social Services and Directors of Public Health
- ICB Chairs

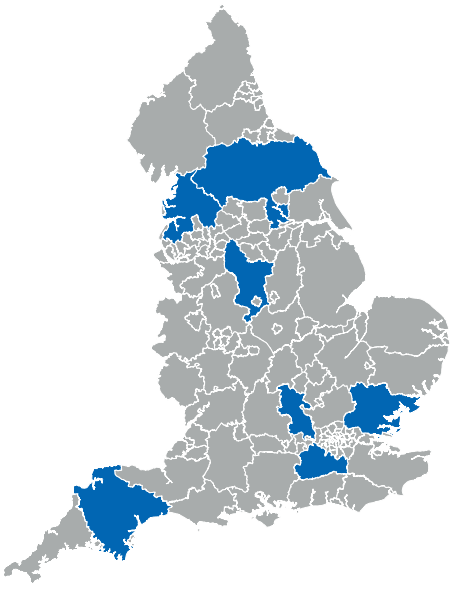
CCN also facilitated group discussions with three of their member forums, including:

- Health and Wellbeing Planners Network
- Directors of Adult Social Care and Directors of Public Health Forum
- Directors of Children's Services Forum

'Deep dive' local authorities

- Buckinghamshire Council
- Derbyshire County Council
- Devon County Council
- Essex County Council
- Lancashire County Council
- North Yorkshire County Council
- Surrey County Council

Figure 3: 'Deep dive' local authorities (highlighted in blue)



Surveys

We designed a survey of CCN member councils which ran for three weeks between 22 September and 14 October and contained 32 questions. Each council was asked to nominate a lead to provide one response for each ICS that it worked with. In total, we received 33 responses from 26 different councils, plus two duplicates where we excluded the later response, generating a total of 1565 data points. The responses represented 72% of all CCN members and as such we believe that they represent a reasonable view of the position of CCN's members in aggregate.

We also designed a survey for ICBs which ran for the month of October and contained 18 questions. Each ICB chair was asked to ensure that one response was provided for each ICB. The survey received 13 responses, plus one duplicate where we excluded the later response, generating 574 data points. The responses represent 40% of all ICBs that work with county authorities. We have used findings from this research in this report, though recognise that the sample size is likely to be less representative than our LA survey.

Where possible, we asked the same questions of LAs as ICB chairs, however we recognised that it would not be appropriate to ask ICB chairs some of the more subjective questions about perceptions of their ICS. A full list of questions is available on request.

Desk-based research

IMPOWER's analytics team also conducted research into ICB/ICP representation, the different overlaps between LA and ICS boundaries and expenditure and health outcomes. The majority of this used publicly available data and sources are cited in this report. Published data on ICP membership is limited, and we have used data provided to us by the NHS Confederation to analyse ICP membership.

Summary

In aggregate through this research we have spoken to 76 individuals in leadership positions in LAs and ICSs. All of this research was conducted under "Chatham House rules" in order to solicit honest reflections and as such we have not named the individuals that we have quoted in this report.

LIMITATIONS TO THE RESEARCH

Our qualitative research was limited to the availability of participants. In particular, we recognise that we have had greater engagement with LA representatives than NHS representatives and have made every effort to balance our findings accordingly.

The membership lists of ICPs have not been consistently published online, meaning a full analysis of ICP membership has not been possible. Nationally, there is only limited local data on NHS out of hospital expenditure, making it difficult to complete a full expenditure analysis.

ICSs are still in the start-up phase, and within that there is significant variation across the country. It is not therefore possible to do a full analysis of plans and outcomes at this stage.

This research was primarily conducted through a strategic and leadership lens, and time limitations prevented us from full engagement with operational leads. The focus was on the role of county authorities in ICSs and as such the report does not cover the more NHS-oriented work of Integrated Care Boards such as commissioning of core NHS services and integration within NHS services.

Context

THE NEED FOR THIS RESEARCH

The aim of this research is to better understand the progress and development of ICSs specifically in county and rural areas. However, we expect many of its findings to be applicable to local government more widely. It aims to gauge how NHS and local government are responding to the need to better integrate health and social care services and identify key opportunities or challenges that these ICSs are facing as they are becoming established.

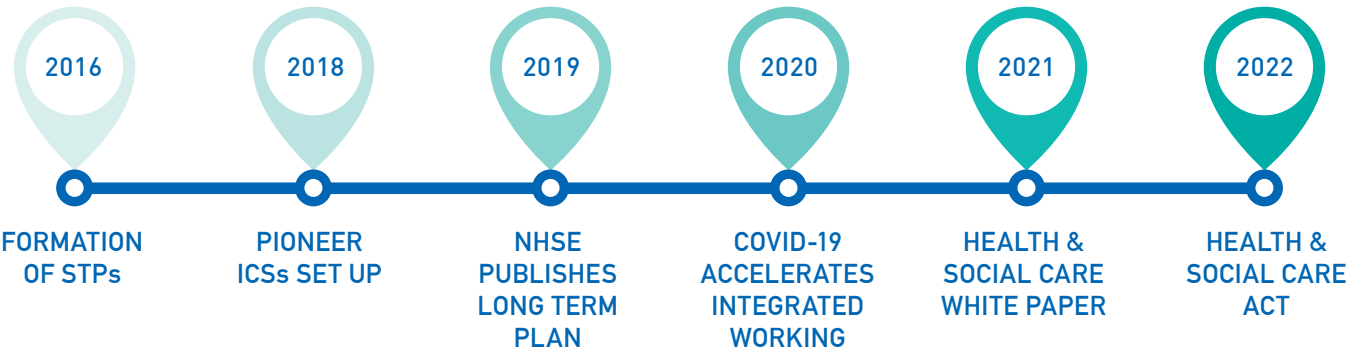
As set out in our "Outcomes and Expenditure" and "ICS Typology" sections, there are clear differences in the characteristics of county authorities and non-county authorities as these relate to ICSs. It is hoped that the findings and recommendations will help CCN's member councils to gain a fuller perspective of the experiences of peer councils as ICSs continue their development. This report also aims to support the understanding of central government decision-makers, including within DHSC, NHSE, DLUHC and HM Treasury of how integration can best be facilitated, and inform next steps for policy development.

POLICY ENVIRONMENT

In July 2022, ICSs formally came into being under the Health and Care Act (2022), replacing Clinical Commissioning Groups (CCGs). They represent the most significant change to the health and care policy landscape for ten years since the reforms following the Health and Social Care Act 2012. They are a key building block for the delivery of the NHS Long Term Plan, published in 2019.

While ICSs statutorily came into being in July, they are the product of a journey that has covered the majority of the past decade focused around the better integration of care. The formation of Sustainability and Transformation Plans (STPs)[10] in 2016 was a significant step in testing and cultivating local relationships, structures and behaviours. A further step forward was the establishment of 25 pioneering ICSs in 2018 – covering areas such as Cheshire and Worcestershire, before the NHS Long Term Plan laid out the comprehensive vision for health services in 2019, and the 2022 Health and Social Care Act then formally enacted Integrated Care Systems. This research recognises the importance of these steps in the development of systems as they are now, and the locally-led determination of these.

Figure 4: Timeline of ICS formation



10. https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
11. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

WHAT ARE INTEGRATED CARE SYSTEMS?

Integrated Care Systems (ICSs) are "partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area"[8].

There are 42 ICSs, varying in terms of population, from 500,000 (NHS Shropshire, Telford and Wrekin ICS) to 3 million (NHS North East and North Cumbria ICS).

Their four core purposes are to:[11]

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

Included in each ICS there is an:

- **Integrated Care Board (ICB):** "A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area."[12]
- **Integrated Care Partnership (ICP):** "A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICS area."[13] The ICP is responsible for producing an Integrated Care Strategy for the ICS. Although the shape and size of membership varies, they include a broad range of partners – from District Councils to Police and Emergency Services – who are concerned with improving the care, health and wellbeing of the population.

Alongside the new ICB and ICP structures, a number of other decision-making or integrated forums have been developed:

- **Place based partnerships (PBPs):** "Collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector (VCSE), people and communities (people who use services, their representatives, carers and local residents)."[14]
- **Provider collaboratives:** Collaboratives which "bring providers together to achieve the benefits of working at scale across multiple places and one or more ICSs, to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers."[15] All acute and mental health trusts are expected to be part of at least one provider collaborative.

It is important to recognise that ICSs build on existing relationships and structures, such as Health and Wellbeing Boards and local Healthwatches, with local areas working through how the new structures best support what is already in place. For example, the difference between the roles and responsibilities of Health and Wellbeing Boards and ICPs have been a point of discussion within each ICS.

12. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
13. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
14. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

HEALTH AND WELLBEING BOARDS AND INTEGRATED CARE PARTNERSHIPS – WHAT'S THE DIFFERENCE?

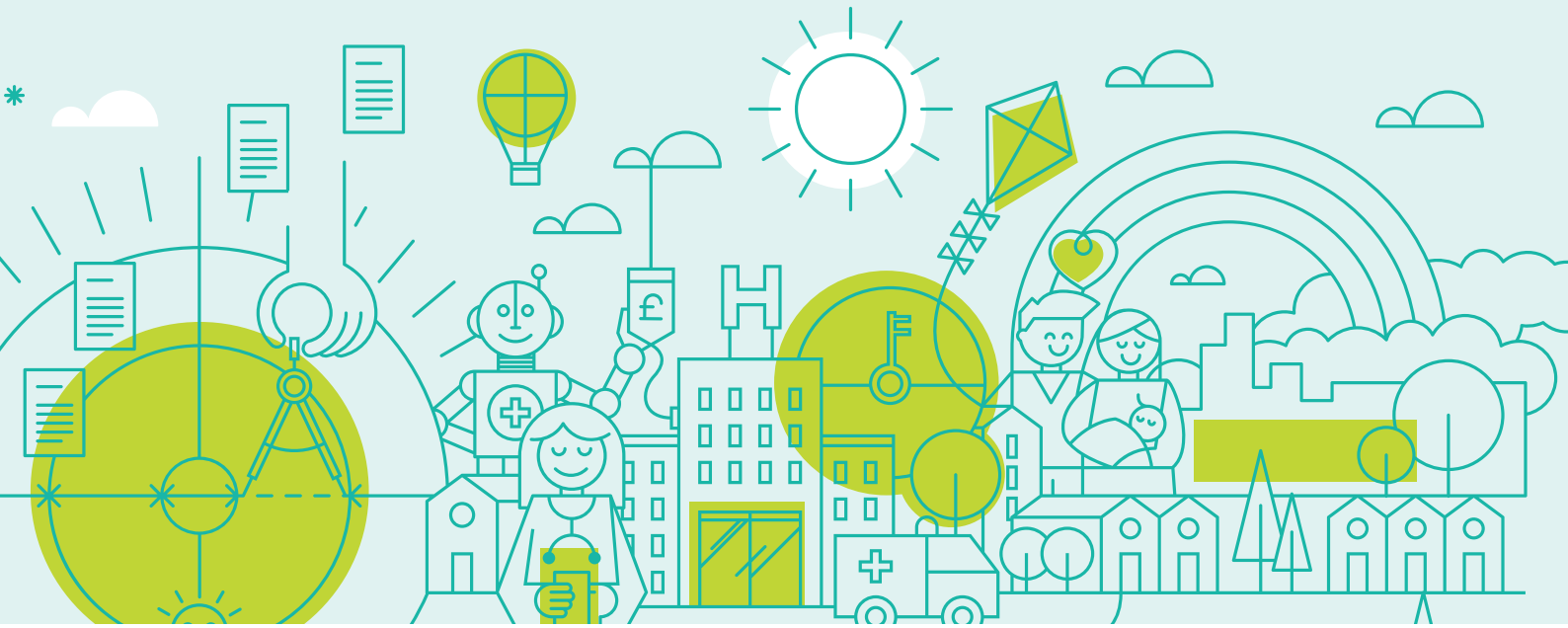
Formed under the Health and Social Care Act 2012, the **Health and Wellbeing Board** is a statutory committee of a council which acts as a forum in which those who are responsible for improving and protecting the health and wellbeing of local populations and communities, can do so in a joined up, effective way.

The functions of Health and Wellbeing Boards are:

- To prepare and publish a Joint Strategic Needs Assessment
- To prepare and publish a Joint Health and Wellbeing Strategy
- To agree a joint plan, with the NHS, for use of the Better Care Fund

The **Integrated Care Partnership** is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on an integrated care strategy, but it does not take on functions from other parts of the system.

The function of Integrated Care Partnerships is to develop an Integrated Care Strategy – using Joint Strategic Needs Assessments and building on the work of existing Joint Health and Wellbeing Strategies.



Over 2022/23 the priorities for ICSs were ten-fold, focused on managing operational recovery, investing in the workforce and establishing integrated ways of working. On the latter, ICBs are required to develop their five-year system plans by March 2023 and establish governance. ICPs are required to publish a draft Integrated Care Strategy by December 2022[16]. Furthermore, these activities are taking place within the context of wider reviews and policy change, including:

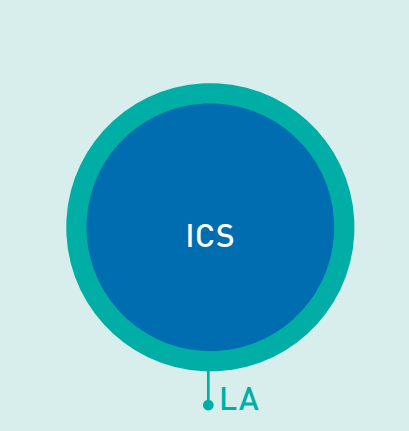
- Adult social care reforms and CQC regulation
- The Integration White Paper
- The Fuller review, which provides recommendations for integration of primary care

15. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf
16. https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf

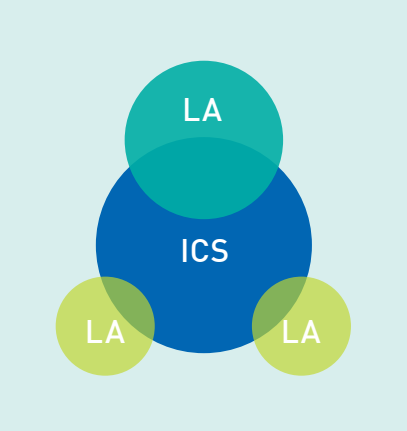
Local authority ICS typologies

ICSs do not align neatly to LA boundaries. Our research suggests that how boundaries are framed, i.e. whether a council shares its ICS with others or is split across multiple ICSs, has a significant impact on working arrangements. As such, we have attempted to categorise local authorities in terms of their relationship to local ICSs[17].

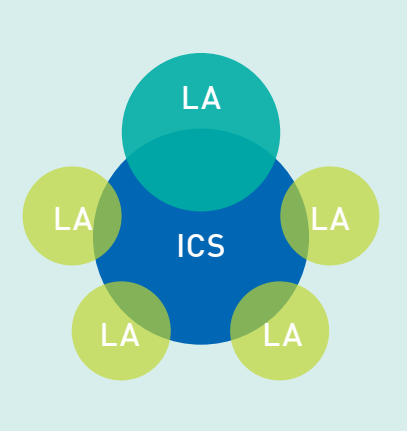
Figure 5: Local authority ICS typology



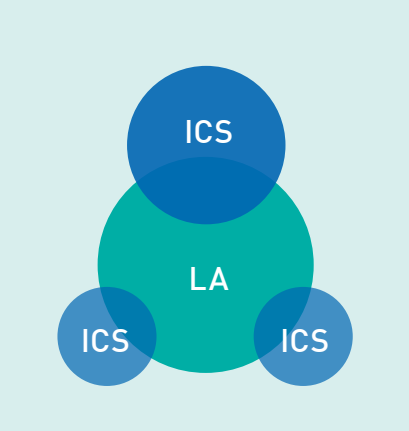
Type 1 – Coterminous. 95%+ of LA population in one ICS, comprising 95%+ of the ICS's total population.



Type 2 - ICS shared with 1-2 other LAs. 95%+ of LA population in one ICS which also serves 1-2 other LAs.



Type 3 - ICS shared with 3+ other LAs. 95%+ of LA population in one ICS which also serves 3+ other LAs.



Type 4 - LA is split over multiple ICSs. 5%+ of LA population is in an additional ICS.

Type of LA	All LAs in this category	County authorities	County examples
Type 1 - Coterminous	4	4	Cornwall, Lincolnshire
Type 2 - Shares ICS with 1-2 other LAs	51	20	Lancashire, Dorset
Type 3 - Shares ICS with 3+ other LAs	91	7	Buckinghamshire, Northumberland
Type 4 - Spread over multiple ICSs	6	6	Essex, North Yorkshire, Surrey

These definitions are a useful indicator of LA-ICS type. However it is worth noting that some councils have characteristics of other types, if not directly in that category. For example, North Yorkshire ("Type 4") is split across three ICSs, two of which it shares with five other LAs (a "Type 3" characteristic) and one of which represents just 0.97% of its total population. By contrast, 85% of Surrey's (also a "Type 4") population is within one ICS which is itself nearly entirely within Surrey County Council's borders (a "Type 1" or coterminous characteristic). Within this report we use the typology above to note trends, though flag nuances where appropriate.

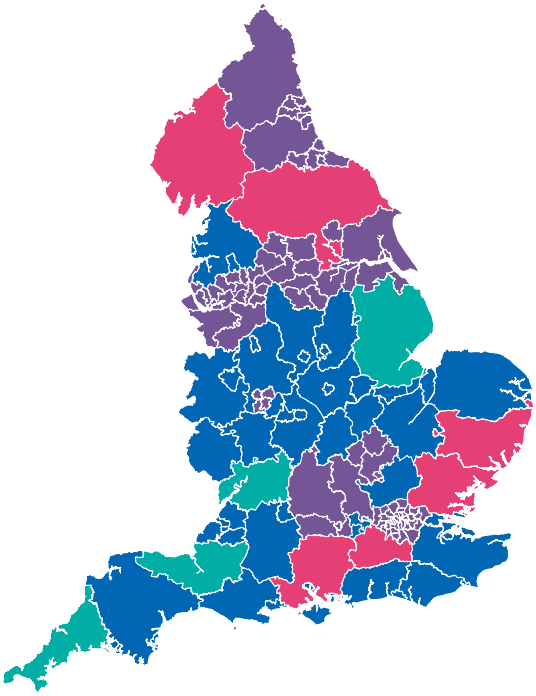


Figure 6: Upper tier authorities by ICS type

Type 1 2 3 4

ICS TYPOLOGIES – KEY FINDINGS

- **There is significantly more variation in LA-ICS relationships in counties than in other LAs.** Nationally, just 19% of county authorities share their ICS with three or more other councils ("Type 3"), though this is the norm for 73% of non-county authorities. Coterminosity ("Type 1") and being spread over multiple ICSs ("Type 4") only occurs in county authorities.
- **Coterminosity ("Type 1") is rare and only occurs in counties.** Just four ICSs are coterminous, though three other county authorities demonstrate strong coterminous characteristics (Kent, Norfolk and Surrey which all comprise over 85% of the population of a single ICS). Our research suggests that coterminous councils have much stronger links with ICBs and ICPs. For example, in our survey only five of 33 responses ranked ICPs higher than Place-based Partnerships in terms of importance to delivering their objectives, all of them from within this group of seven authorities.
- **Being split over multiple ICSs is also rare and only occurs in counties.** Nine upper tier authorities (all counties) are split over multiple ICSs, but in only six of these is there a significant split where more than 1-2% of the population is in another authority. Our research was clear that those councils working across multiple ICSs face significant additional challenges in working with partners in ICSs, both administratively and also in terms of substantive delivery.
- **Essex County Council is the only council that is meaningfully split across three ICSs.** 56% of its population is in Mid and South Essex, 23% in Suffolk and North East Essex and 21% in Hertfordshire and West Essex. North Yorkshire is the only other council operating in three ICSs, though under 1% of its population is in a third ICS. Our research suggests that this level of complexity across Essex is unsustainable in the medium to long term and should be addressed.
- **The majority of non-county authorities share their ICS with 3+ other councils ("Type 3"), but only a very small number of county authorities are required to do this.** As the map demonstrates, "Type 3" councils are the norm in cities but rare in counties. Our research indicated that for several "Type 3" county authorities, ICSs are seen to have added complexity onto already large footprints.

17. For population estimates matching LAs to ICBs across this report we have used ONS LSOA population data: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates combined with ONS LSOA to ICB geography data: https://geoportal.statistics.gov.uk/documents/lsoa-2011-to-locations-to-integrated-care-boards-july-2022-lookup-in-england/about

Expenditure and outcomes

SUMMARY

This research reviewed publicly available data to understand trends and outcomes in services at the interface of NHS and council services. We also asked councils in our survey whether they were confident that their ICS had a clear process for monitoring success against its primary objectives. Only 18% felt it did.

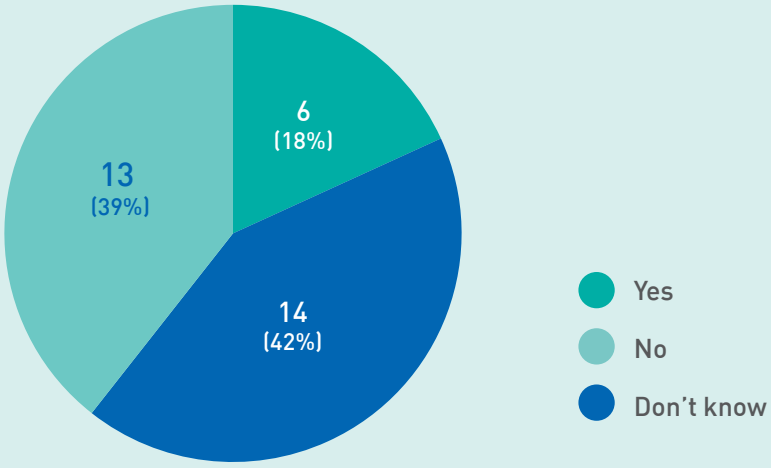
Our review suggested that, at a national level, there are significant data gaps at the interface between health and social care. Existing metrics tend to have a narrow focus on outcomes and expenditure that reflect silos of services rather than the wider complex system and the overarching outcomes for people as they move between those services.

Many of the national datasets are inconsistent. In particular, the balance of spending on community and preventative services and the need to accelerate flow from hospitals into social care receive regular national attention. However, there is an absence of national data on NHS spending out of hospital, and published data on length of stay is of a very low quality.

As such, data in the ICS space is still in its infancy in terms of both expenditure and outcomes. Local areas will need to prioritise the data they need to monitor success, however, there is a clear need for proportionate national policy in this area to support local systems - for example, for benchmarking purposes. The Government's Integration White Paper[19] indicated a direction of travel in this space through shared outcomes, though there has been no update to this since February.

Where data is available, we have explored key metrics across the health and social care interface to provide background and context to any differences between county authorities and non-county authorities. These findings are set out below.

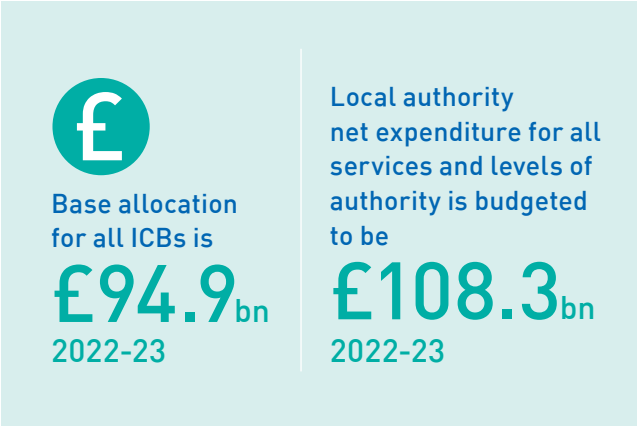
Figure 7: Are you confident that the ICS has a clear process for monitoring success against its primary objectives?[18]



15. https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations
16. https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2022-to-2023-budget
17. https://www.england.nhs.uk/publication/allocation-of-resources-2022-23/
18. IMPOWER survey of CCN member councils

EXPENDITURE

Figure 8: Local authorities and ICBs have similar overall levels of spending power[20 21]



Across the country as a whole, councils and ICBs in England have a broadly comparable spending power. Breaking down ICB base allocation on a population basis shows that non-county authorities have a marginally higher base allocation per head, reflecting the NHS models used to determine base allocation and variations in who commissions services.

ICB base allocation is **£1,649** per person in county authorities

ICB base allocation is **£1,717** per person in non-county authorities

There is a significant national gap in data showing NHS expenditure on out of hospital services.

Many respondents in our interviews told us about the need to increase investment in community and preventative services. The NHS Long Term Plan also recognised the need to rebalance spend from acute to community and primary services with "a new guarantee that over the next five years, investment in primary medical and community services will grow faster than the overall NHS budget [...] worth at least an extra £4.5 billion a year in real terms by 2023/24"[22].

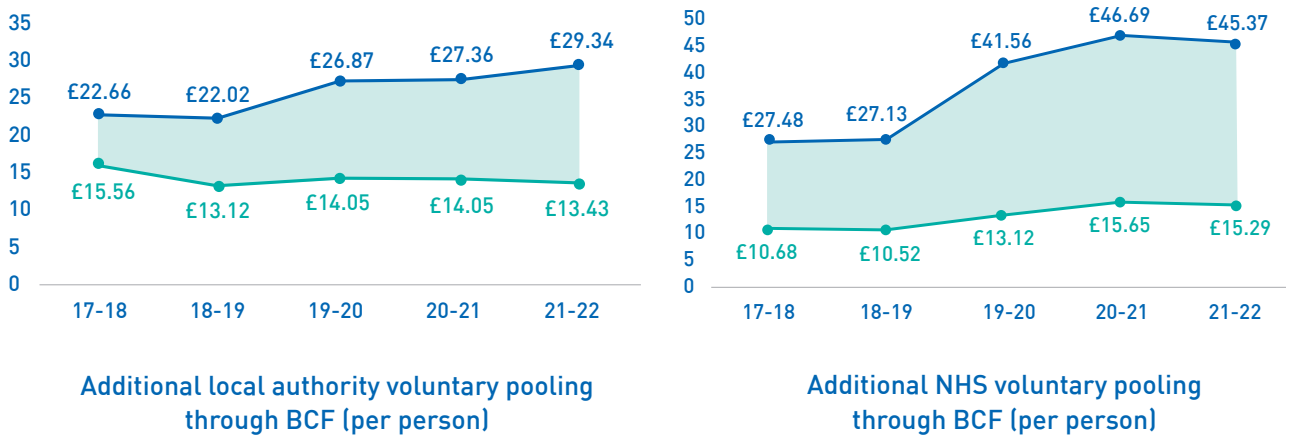
Despite this, we were unable to find any consistent, publicly available datasets on NHS expenditure on out of hospital services, particularly community services. One of the experts we contacted in relation to this issue referred us to a Parliamentary Question response from 2019[23] as an indication of the split.

Another pointed us to consolidated NHS Provider Accounts[24]. The NHS Digital website[25] provides an estimate that £10bn per year is spent on community services but provides no evidence to support this (this page has been taken down since the start of our research).

Against this lack of information, it is difficult to understand how areas are meant to benchmark progress in this area, nor how the NHS nationally is to measure its Long Term Plan commitment to increasing spend on community and primary care services faster than the overall NHS budget.

19. https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations
20. https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2022-to-2023-budget
21. https://www.england.nhs.uk/publication/allocation-of-resources-2022-23/
22. https://www.longtermplan.nhs.uk/online-version/overview-and-summary/

Figure 9: County authorities pool much less with the NHS through the BCF than non-county authorities[26]



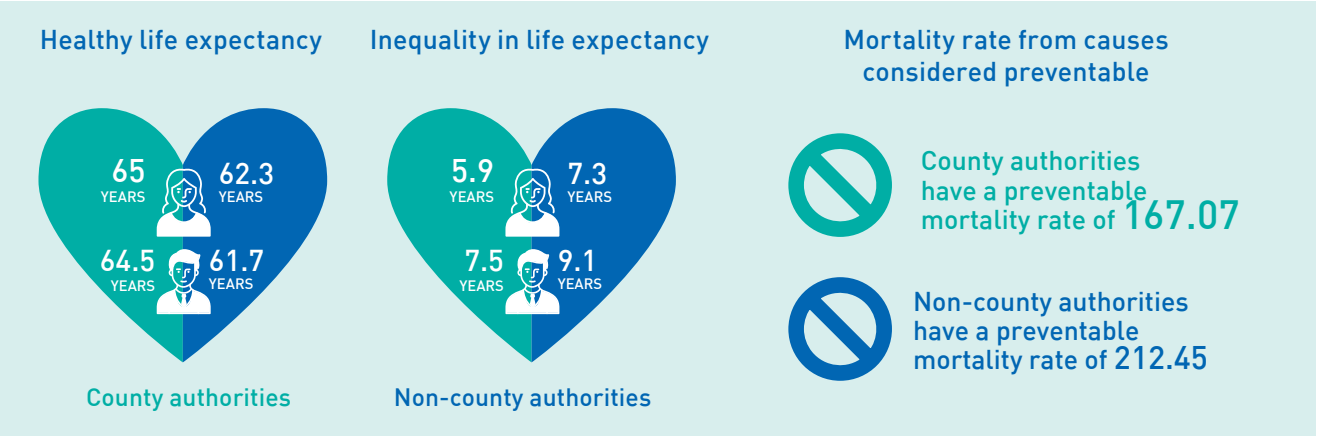
The Better Care Fund (BCF) requires the NHS and LAs to pool funding to jointly commission services. Through a combination of grants and ringfencing, LAs and the NHS are both required to pool a minimum amount of funding into the BCF, but can voluntarily pool more. Nationally BCF planned pooling in 21-22 was £9.9bn, of which £3bn consisted of voluntary additional contributions.

Our research suggests that the level of voluntary pooling by county authorities (£13.43 per head) is less than half that of non-county authorities (£29.34 per head). This is matched by relatively lower voluntary contributions by NHS counterparts. Similarly, whereas the level of voluntary pooling by non-county authorities has increased by 29% per person since 17-18, in county authorities, this has decreased by 14%. This finding is explored further ahead in this report.

OUTCOMES

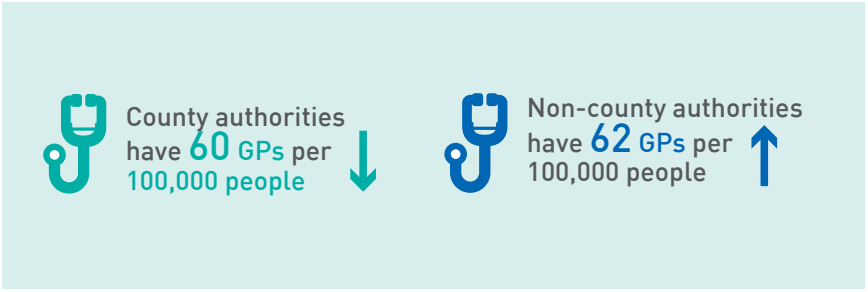
We explored five key factors to understand differences in outcomes between county authorities and non-county authorities at the interface between health and social care.

Figure 10: People who live in county authorities are more likely to live longer healthier lives[27]



23. https://questions-statements.parliament.uk/written-questions/detail/2018-12-20/204632
24. https://www.england.nhs.uk/wp-content/uploads/2022/02/Consolidated-NHS-provider-accounts-2020-21.pdf
25. https://digital.nhs.uk/data-and-information/data-insights-and-statistics/community-services-team
26. https://www.england.nhs.uk/publication/better-care-fund-2021-22-planning-data/
27. All data available here: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare

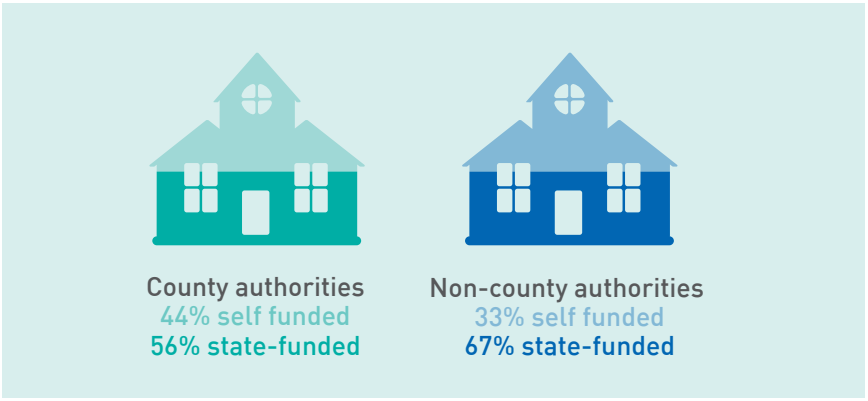
Figure 11: County authorities have fewer full time equivalent (FTE) GPs per 100,000 than non-county authorities[28]



Despite having slightly fewer GPs per person, the percentage of appointments made on the same day as first contact with GPs is broadly the same in county authorities (41.24%) as non-county authorities (41.80%)[29].

Figure 12: Fewer older people (65+) in county authorities are having their needs met by residential or nursing homes[30]

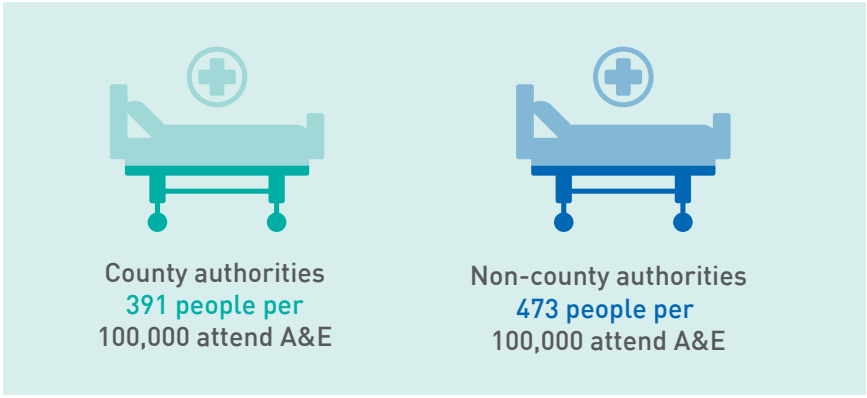
Figure 13: County authorities have a higher rate of self-funders in residential care homes for older people than non-county authorities[31]



This may suggest that county authorities are more effective than non-county authorities at supporting older people to maintain their independence, though another factor could be that more people in counties self-fund their own care.

28. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2022
29. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice
30. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof
31. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles carehomesandestimatingtheselffundingpopulationengland/2021to2022

Figure 14: A&E attendance in county authorities was lower than in non-county authorities in Q2 22-23[32]

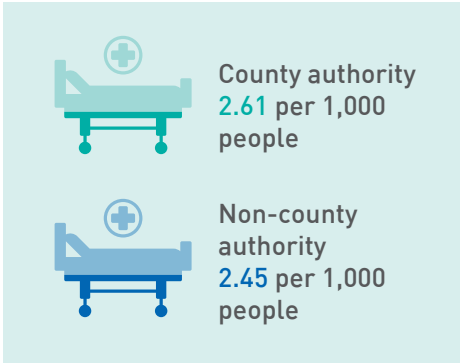


Lower levels of A&E attendance in county authorities may be indicative of people finding it easier to access community or primary services or more effective diversion of avoidable demand into A&E. However, it could also be a result of lower accessibility to A&E departments in rural areas.

Figure 15: Average bed days lost per week to people with length of stay of 14+ days in September 2022

Bed days lost to people with length of stay of 14+ days is broadly consistent between county authorities and non-county authorities, though the data is limited.

The published data for bed days lost[33] shows enormous variation between ICSs. For example, the data suggests two ICSs did not lose a single bed day as a result of patients with a "length of stay" of more than 7 days on w/c 26 September 2022 (or any other week in September), while the other ICSs lost an average of 4,000 bed days to people with this length of stay. This level of variation is almost certainly the result of data quality given the issue's complexity, making benchmarking very challenging, despite its national priority.



RECOMMENDATIONS

5. **ICBs and LAs should report together annually on 'out of hospital' health and related expenditure.** NHSE should also report annually on 'out of hospital' expenditure, by spending type. This will enable local benchmarking and is already occurring nationally in Scotland.[34]

6. **DHSC/NHSE should agree, in consultation with local government, a small number of proportionate metrics to track performance of services at the margin of integration nationally.** These should be quality assured for consistency. ICBs and LAs should agree and report on their own local metrics for local priorities.

32. https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2022-23/ by https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/analysisofpopulationestimatestool data from 2022-23

Governance

Exam question: Are CCN members genuine partners in Integrated Care Systems?

Answer: Not universally. In many areas, LAs have worked closely with NHS colleagues to build new structures building on existing partnerships. However, these structures are yet to face the difficult decision-making which will test the extent to which CCN members are able to shape the system's agenda.

SUMMARY

Our research indicates that in most cases, CCN member LAs feel that they are "in the room" in ICSs. In particular, they are generally felt to be playing a key role in ICPs. There is cautious optimism that ICS structures could improve integration. However, there is a sense that the work of the ICB remains the preserve of "the NHS", with councils "at the table" as guests rather than key partners. LAs do however recognise that the ICB does have a wide range of NHS responsibilities which it must exercise, often largely independently of council involvement.

Ultimately the ICB will have the decisive say on key strategic issues that affect council services and their citizens, such as funding allocations and service redesign.

We found mixed experiences of these boards. In most areas there was clearly a genuine attempt by ICBs to work in partnership with councils, however, our work indicated that this was largely dependent on goodwill given the NHS dominance of ICBs. We heard a small number of examples of ICBs making unilateral decisions on issues that could have a significant impact on councils and their citizens.

ICBs have so far made few difficult decisions. However, over winter and ahead of budget setting for 23/24 tensions are likely to rise between the different partners on ICBs. The legal framework for governance means that the decisive say on key issues will rest with the chair, who is accountable to NHSE and the Secretary of State, rather than local partners. This may strain relationships between ICB partners and may, over time, lead to disengagement.

Most LAs appreciate the opportunity to be "in the room" and recognise the challenges faced by the NHS. However their ability to shape the direction of the ICB is limited by three key factors:

- The level of control that central bodies (NHSE, its regional teams and DHSC) retain over ICBs
- Their limited presence on the board relative to "NHS" membership
- The potential for conflicts of interest for local government partner members in major decisions

The Integrated Care Partnership (ICP) is seen much more as a collaborative space between different elements of the ICS, with LAs taking more of a leading role. LAs were generally positive about these partnerships, though there is a risk of duplicating some of the work of Health and Wellbeing Boards. We found concern about how much tangible impact the ICP's work will have, particularly as the NHS faces calls from elsewhere as to its priorities.

For most councils not largely coterminous with one ICS, "Place" was seen to be the most important factor for delivering priorities, particularly for "Type 3" councils. "Place" is evolving differently in different areas, though is largely based on existing partnerships or council (inc. district) boundaries. For some councils, particularly "Type 4" LAs split over multiple ICSs and "Type 3" LAs sharing one ICS with 3+ other councils, the way boundaries are drawn is presenting multiple complex and burdensome working arrangements which are likely to be unsustainable in the long run.

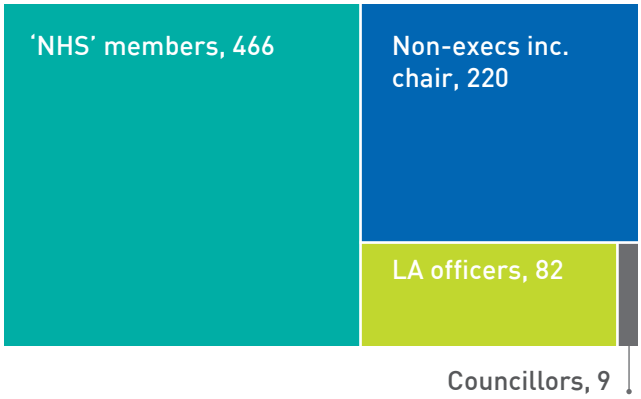
33. https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-discharge-data/
34. https://publichealthscotland.scot/publications/scottish-health-service-costs/scottish-health-service-costs-high-level-costs-summary-2020-to-2021/

DEEP DIVE FINDINGS

1. Local authority membership of ICBs and ICPs

In our survey of all CCN member LAs, only three out of 33 respondents (9%) reported that their council was not sufficiently well represented on ICBs. 11 of 13 ICB chair survey responses said they felt ICBs had a good balance of NHS and LA representation, with the remaining two suggesting more LA representation would help. Across England, most ICBs (31 out of 42) have more than one full LA member (excluding participants) with an average of 2.3 per board. Only seven ICBs have representation from politicians (17%), with the remainder being council officers. Councils and ICB members regularly referenced national guidance in deciding membership and the need to review membership in due course.

Figure 16: Breakdown of ICB membership by type[35]



Where there were concerns over representation, the ICB chair had the decisive role in deciding the level of local authority membership. We also found examples of ICBs attempting extensive interview processes for LA members, though in most cases these processes were reduced after concerns were raised.

Just one respondent of 33 councils reported being under-represented on their ICP in our survey, and 12 of 13 ICB responses felt there was a good balance of LA and NHS representation on ICPs. We were not able to conduct the same level of research on this membership as most ICPs have not, as of October 2022, published their membership online.

However, our interviews and roundtables, as well as research by NHS Confederation[36], highlighted the following trends:

- High levels of LA membership, comprising just under 50% of all members
- ICPs often chaired or co-/vice-chaired by LAs - research suggests 9/20 ICPs chaired by LAs
- LA membership is primarily political, supported by officers
- Significant variation in size, ranging from under 15 to over 40 members
- Close alignment with existing Health and Wellbeing Board membership

Figure 17: NHS Confederation research into ICP membership

ICP Members	"Average" ICP	Range
Total	27	7-73
ICB Members	4	1-8
NHS Providers	4	0-22
VCSE	2	0-3
Elected LA Members	8	2-20
LA Officers	5	0-16
Primary Care	1	0-12
Place	5	0-18
Public/patient	2	0-5
Other	7	0-15

Most areas we spoke to indicated that ICP membership was likely to change significantly as the role of the partnership becomes clearer over time.

2. Administrative complexity

Our survey results indicate that 79% of CCN member councils have experienced an increase in their organisation's time commitment to working with NHS colleagues since the creation of the ICS, with over a third (36%) describing this as a "significant increase". Half of responses (50%) indicated that this was somewhat or fully justified, though 55% of LAs felt that ICSs created too much governance.

These findings were reinforced in our interviews where the time commitment for senior council leaders was seen as a major barrier to effective engagement, particularly when much substantive discussion at ICBs was focussed on acute NHS issues and local authority resources are under pressure. One council had carried out a comprehensive study of their collective senior (Director-level and above) time commitment to working with the various structures of a single ICS, estimating that the commitment was between eight and 12 days per month. This was consistent with estimates for other councils.

We also found that for councils spanning multiple ICSs, this time commitment could be doubled or tripled, as set out in our case study from Essex County Council. Councils and ICS counterparts are working pragmatically around these issues, but some duplication is inevitable and over time, without change, this is likely to lead to disengagement with the process as a whole.

Figure 18: Has the creation of the ICS increased or decreased your council's time commitment to working with NHS colleagues?

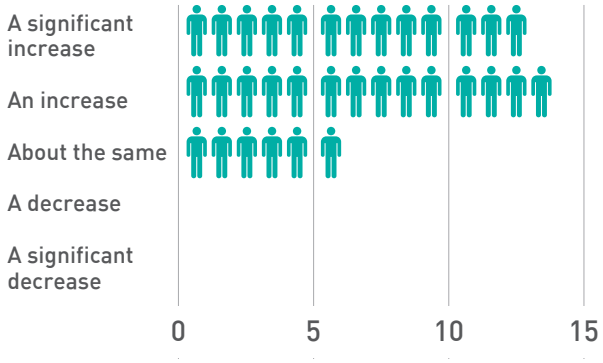


Figure 19: In your opinion is this time commitment justified in improved joint working and outcomes?

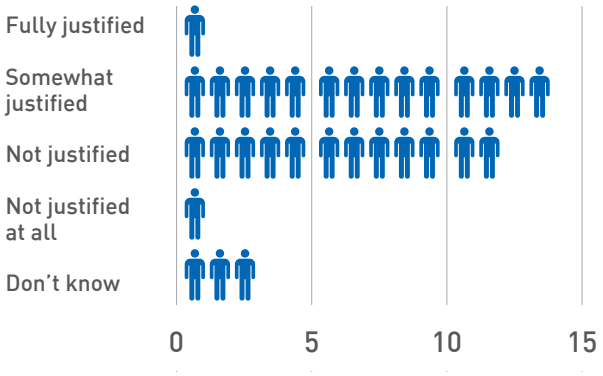
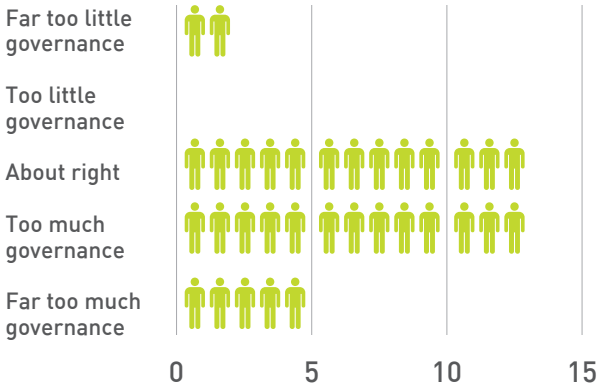


Figure 20: Thinking about the ICS as a whole, to what extent do you feel the level of governance is proportionate?



35. Source: ICB websites, correct as of September 2022. Full members only – excludes "participants".
36. NHS Confederation research conducted on 20 draft ICP plans in August 2022. Further information is available on request from Ian.Perrin@nhsconfed.org.

CASE STUDY

Essex County Council (ECC)

Essex is unique in having large parts of their population split over three Integrated Care Systems:

- Mid and South Essex, shared with Southend and Thurrock, which covers 56% of ECC's population
- Suffolk and North East Essex, shared with Suffolk, which covers 23% of ECC's population
- Hertfordshire and West Essex, shared with Hertfordshire, which covers 21% of ECC's population

The council and ICS partners have made real efforts to make the new arrangements work for citizens with some notable successes. However, a number of substantive issues remain:

A potentially inconsistent offer for citizens. Essex's population will be covered by a single Health and Wellbeing Plan but three different Integrated Care Strategies, three workforce strategies and three digital strategies, making it difficult for ECC and system partners to assure citizens and regulators at CQC and Ofsted that there is a consistent offer to residents.

Keeping plans aligned is bureaucratic and limits local flexibility. ECC must align its own Health and Wellbeing Plans with three separate IC strategies, each of which also cover additional adjacent councils. In theory one change to an adjacent council's plan could require a revision of the relevant IC strategy, then ECC's Health and Wellbeing Plan, then the other two IC strategies in Essex and onto the plans of all of its neighbours. ECC also needs to negotiate and agree how BCF funding will be used with three different ICBs, each with potentially different priorities.

Joined-up working is inhibited as ECC attempts to align its working practices (e.g. pooling funding, workforce and estates) with those of three ICSs, two of whom are largely based outside Essex, potentially creating significant organisational inefficiency.

There are real practical issues created by requirements of the legislation. For example, the creation of a shared care record for the Essex population requires a consistent approach across three ICSs. This has already led to real difficulties where ECC needs to be consistent in its approach to information governance on the data it shares but one system has not been willing to sign up to the same governance as the other two systems.

Senior council capacity is stretched thin to attend and properly engage in the work of three sets of ICBs and ICPs. The meetings and preparation alone for the constituent elements of one ICS (ICB, ICP, Workforce Boards etc) alone can amount to c.10 days work for senior officers in a month. In Essex this requirement is multiplied threefold.

Logistical issues where geography means that getting to just one ICB or ICP meeting may involve a round trip of hundreds of miles. Senior leaders are regularly required to manage clashes and prioritise meetings for one ICS over another. This acts as a disincentive to greater engagement.

3. Role of systems and place

In our survey, almost half (45%) of respondents felt that place-based partnerships would be most important in delivering their priorities through the ICS. None of the seven largely coterminous LAs ("Type 1" councils as well as those where the council makes up over 85% of an ICS's population) felt that "Place" was most important. Our interviews and roundtables indicate that this is for three main reasons:

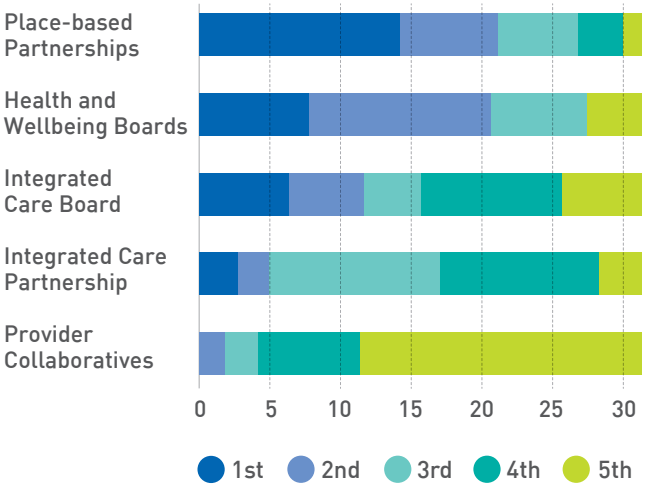
- "Place" helps areas to align with the principle of subsidiarity, as decisions can be taken across a single set of decision-makers.

- "Place" is where existing relationships and existing governance structures between council and NHS were strongest.
- "Place" can align with boundaries that make sense to local partners.

The definition of "Place" varies significantly and does not necessarily align with NHS guidance[37]. In some ICSs, it corresponds to entire upper tier council footprints, potentially with additional arrangements beneath. In other ICSs, "Place" is defined by primary care networks, district councils or acute hospital catchment areas. The population covered by each "Place" also varies widely and we found examples from 85k to 805k. Generally, we found that "Place" definitions had been agreed between LAs and ICBs, however we did find examples of "Place" being defined without LA agreement.

We found very few examples of clear delegation to "Place" either in terms of funding or responsibilities, with a few notable exceptions (see case study). Most areas indicated a willingness to move towards more formal delegation, particularly of "community" spending, though this varied by area. In practice, Place-based Partnerships currently act as a convening body for NHS and council partners, driving the majority of practical integration "on the ground", though can be required to seek implementation approval through separate channels.

Figure 21: In terms of importance to delivering your organisation's priorities in the ICS how would you rank the following:



CASE STUDY

Delegation to "Place" in Suffolk and North East Essex ICB (SNEE)

SNEE have created three Place-based Partnerships in their ICS, referred to as "Alliances", in West Suffolk, Ipswich and East Suffolk and North East Essex.

Each Alliance is led by an ICB Alliance Committee, comprising an independent chair and Director-level representatives from all providers, county and district councils and voluntary sector leaders.

Alliances function at strategic, operational and tactical levels for forward planning as well as immediate demand management/ response.

Expenditure on all community, medicines and primary care services has been delegated to these Alliances, representing c.40% of SNEE ICB's budget. ICB Alliance Committees have delegation to sign off spend up to £3m without reference to the ICB.

Within each Alliance, Integrated Neighbourhood Teams (of primary medical care, community, social care and mental health services) will deliver integration of services at a neighbourhood level.

The ICB will provide scrutiny of performance against place-based ICB core KPIs and budgets, as well as managing improvement planned through the ICB's Executive Delivery Groups.

37. https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf p.2

4. The role of local politicians in ICSs

The role of local politicians in ICSs is still evolving. Just nine of the 91 LA ICB members nationwide are councillors and in most ICBs it is unclear how politicians will be involved in major decision-making. Early guidance, subsequently amended from NHSE[38], indicated that councillors would not be eligible for ICB membership and this was felt in many cases to have limited political representation. Political representation on ICPs is generally much higher, with early NHS Confederation research suggesting that elected councillors make up the largest single "bloc" on ICPs and that they chair 45% of ICPs. This was consistent with our interview findings.

There was recognition of the importance of local politicians in contributing to significant decisions. However, we found few examples of clear arrangements for how local politicians would be involved in key ICS decisions that would affect their populations and service delivery, for example, service reconfiguration or funding allocations. Participation of council officers and elected members on ICBs and ICPs will not be sufficient to manage this tension and most areas felt these discussions would happen informally at the discretion of ICB leaders. As of yet, these arrangements have not been tested given the early stage of ICS development.

> **"[As LA representation on ICBs is weak] we want the Integrated Care Partnership to be strong to make sure the local authority voice is strong and not marginalised." Councillor**

Our interviews and roundtables indicated a willingness from NHS partners to engage with local authority scrutiny. However, again we found few examples where a clear process had been set out, which is leading to frustration. ICB members indicated their concern that scrutiny was burdensome, particularly across multiple LAs, while local councillors were frustrated that they did not have clear line of sight to, or information from, the Integrated Care Board. Some joint scrutiny boards are being established, though these are largely informal at present.

5. Accountability

The legislation is clear on ICB accountability and this has been reinforced by the latest version of NHSE's operating framework[39]. The ICB and its work is accountable to NHSE through its regions and ultimately to the Secretary of State for Health and Social Care. There is no formal accountability within ICSs either to the ICP or LAs. The Care Quality Commission will also have a role to review the provision of health and social care within ICSs, as well as how the ICB and partners are working together, though detail of how this will work in practice is still to be published.

In roundtables and interviews there was concern that despite the intentions of ICSs to be collaborative, ultimately accountability structures meant the ICB's focus would return to NHSE and demands coming from "the centre", rather than on local priorities. This point was made most often by councils but was also made by ICB leaders who recognised the tensions in their role.

We saw that in the (few) instances of conflict between LAs and ICBs discussed in interviews and roundtables, the view of the ICB chair was decisive and not open to formal challenge. More difficult decision-making for ICBs is likely to occur over winter and ahead of setting next year's financial plans. Accountability lines give an indication of how the system will respond under duress, for example should existing central funding for discharge be withdrawn. One ICB chair felt that losing the confidence of LA leaders in their ICS would mean considering their own resignation, however this was a matter of personal honour rather than any formal process.

This leaves the ICP in a complex position. Both the ICB and local authorities must have regard to the strategy the Partnership produces,

38. https://www.hsj.co.uk/integrated-care/nhse-must-allow-councillors-to-sit-on-integrated-care-boards-says-government/7031878.article
. https://www.england.nhs.uk/wp-content/uploads/2022/10/B2068-NHS-England-Operating-Framework.pdf

however our interviews indicated that ICS members were concerned that this may be seen as 'optional' in the face of other statutory responsibilities. We did not find examples of clear processes for ensuring oversight of delivery of Integrated Care Strategies.

6. Role of Health and Wellbeing Boards

Fewer than half (42%) of council respondents to our survey indicated that they felt the respective responsibilities of Health and Wellbeing Boards (HWBs) and Integrated Care Partnerships (ICPs) were clear in their areas. Our interviews and roundtables indicated that while production of Joint Strategic Needs Assessments (JSNAs) was clearly the responsibility of HWBs, there was much less clarity over setting the strategic direction for local areas. JSNAs in particular were regularly referenced by both councils and NHS partners as an essential basis for setting local strategies.

> **"We have created something new [the ICP] rather than capitalising on what already exists." Council Director**

Duplication of effort was a specific concern. ICPs and HWBs often have overlapping membership and similar objectives and guidance indicates that the two should support each other[40]. In some areas the work of the ICP and HWB have been refined, though this is easier in coterminous geographies. In most areas there is a clear overlap between the membership of ICPs and HWBs and duplication has a significant impact on leadership capacity.

> **"We need to look at Health and Wellbeing Boards again to make sure they're adding value in the light of the ICS." Councillor**

The need for Integrated Care Strategies and Health and Wellbeing Strategies to be aligned creates challenges, particularly for LAs working with multiple LA partners or within multiple ICSs ("Types 3" and "Types 4"), where a change to one of these documents in theory may require a change to several others in order to ensure alignment (see Essex case study, page 28). In our survey only five LAs out of 35 who provided a response felt that ICPs were more important than HWBs in delivering their priorities in the ICS. All five of these were operating in ICSs where the LA population constituted over 85% of the total population of the ICS.

Our interviews and roundtables supported these findings, as it was felt that in complex ICSs, HWBs offered the primary option for setting genuinely local strategy. As a result, there is a risk that members begin to disengage with one of these processes and our research indicates that, without further guidance from DHSC, it is likely that in most areas the HWB will continue to be seen by councils as the most important of the two.

7. Conflicts of interest

The ICB functions as a unitary board and partner members for councils are not there to represent "their" LA but rather the "local authority" view as a whole. Guidance states that the role of the LA representative is to provide subject matter expertise. In practice, this is likely to become more difficult as partners are required to provide input on issues that may conflict with their (statutory and non-statutory) duties to their "home" local authority as well as the political priorities of councillors.

We regularly heard how difficult it was for an individual LA representative to speak for other councils, particularly on issues including:

- Funding allocations by ICBs
- Policy decisions such as the provision of fertility services
- Service reconfiguration resulting in the closure of services in another local authority

These issues were largely restricted to "Type 2" and "Type 3" local authorities (who share an ICS with other councils) and are particularly acute where councils do not have any members on ICBs who can represent a partner council.

40. https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

IMPOWER

None of our interviewees had yet faced an outright conflict of interest. However as decision-making by ICBs increases, the possibility of significant conflicts increases as the participation of partner members in theory makes them accountable for any decisions. We did not find examples where ICBs had put in place clear arrangements to manage these concerns.

> "You are bound legally and constitutionally by the requirements of the unitary board... And when that's tested going forward, we think that might be problematic and complex... I think we will be declaring an interest on just about every decision. So we would not want to be associated with how the NHS uses its money in one part of [the council] and not another part of [the council]. An officer shouldn't be making those decisions independently without steer from the Council [but] the Constitution of the ICB says they have to act independently..." Local Authority Director

RECOMMENDATIONS

7. **ICBs should make clear arrangements for oversight of major decisions with local authorities, as a minimum covering budget allocations and significant service reconfiguration.** This is needed to protect council partner members from conflicts of interest in their roles on ICBs and in LAs and is particularly necessary for "Type 2" and "Type 3" councils. It is also needed to ensure that decisions have sufficient political input.
8. **DHSC/NHSE should review ICS boundaries after a year of the legislation coming into force.** In particular for "Type 4" councils spread over multiple ICSs some arrangements will become less and less workable over time.
9. **LA Scrutiny Committees should set out their expectations to ICBs, considering joint sessions for multiple "Type 2" and "Type 3" LAs.** ICBs should be clear on the information that they will provide to local scrutiny committees. Each LA and ICS will need to agree its own arrangements, but scrutiny should be proportionate, co-ordinated and useful. There may, for instance, be occasions when it is appropriate for scrutiny committees to meet with NHS and LA colleagues simultaneously to discuss shared issues.
10. **NHSE and its regional teams should be clear on the role of LA feedback in ICB chairs' appraisals.** The ICB chair role carries significant power in ICSs and can only be changed with Secretary of State for Health and Social Care approval. As such, LAs should be able to provide feedback on the work of the chair.
11. **ICB chairs should review ICB membership annually, drawing on experience from other boards.** We found no reason for membership to remain static and that lone council voices on ICBs felt overlooked in discussions which could undermine their input. For "Type 3" LAs working with multiple other councils, a lack of local representation is felt to be particularly problematic. Decisions on political representation were often taken based on outdated central government guidance and this should reasonably be revisited.
12. **DHSC should review the statutory requirements of Health and Wellbeing Boards and Integrated Care Partnerships to allow for pragmatic working arrangements and minimise duplication.** In the interim, where possible, councils should agree clear divisions of responsibility between ICPs and HWBs, as well as rationalisation of their roles to minimise duplication.

Strategic delivery planning

Exam question – Do ICSs have a shared purpose with deliverable plans that tackle CCN member priorities?

Answer – They appear to have a shared purpose in both the short and long term, shifting focus into communities and prevention, however, it is generally unclear whether and how this will be converted into deliverable plans.

SUMMARY

Council and NHS partners appear to have a shared sense of what they want to achieve from ICSs at a high level. In the short term both sides recognise that there is an immediate need for ICBs to focus on shared issues including hospital discharge and admissions prevention. In the longer term the aim is also broadly clear - more and better out of hospital, preventative services which provide a seamless integrated approach for citizens and tackle inequalities while, particularly for the NHS, maximising the benefits of scale that ICSs bring. The challenge is putting this longer-term ambition into practice in the face of tight budgets, new decision-making structures and other system priorities. Our work encountered a significant degree of scepticism as to whether this will happen.

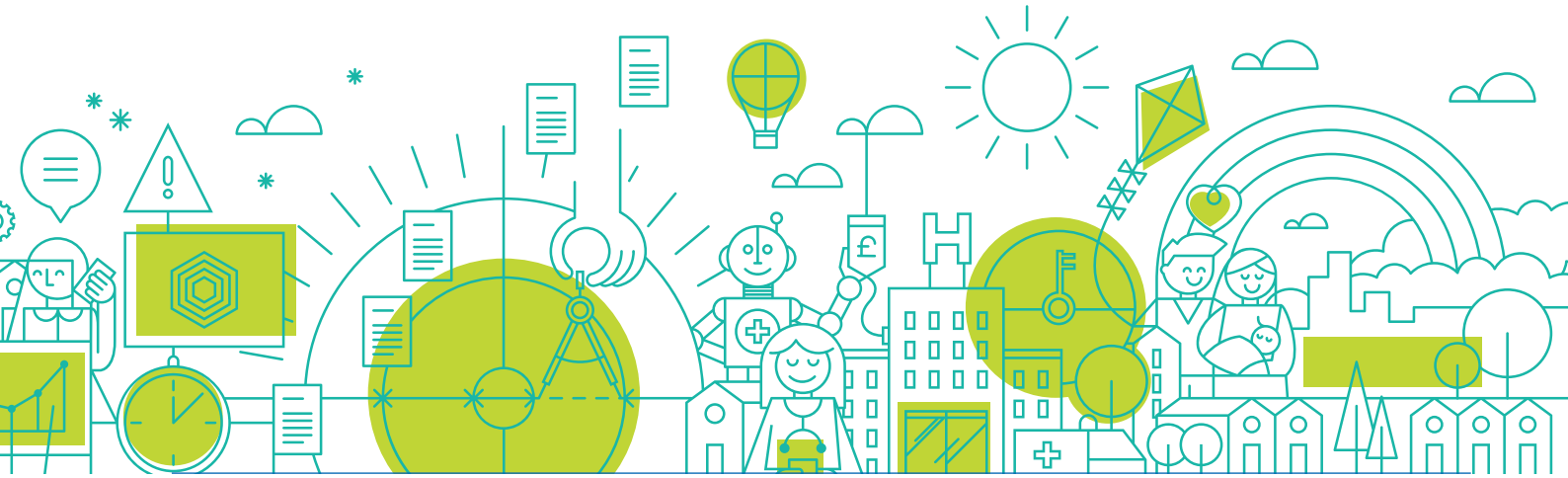
> **"The Integrated Care Strategy will be an articulation of what everybody already knew they needed to do." Director of Public Health**

The trade-offs between treatment and preventative activity are well established at a high level in health policymaking and there is optimism that ICSs will help to move the balance between the two toward more preventative activity. We found real ambition to put the citizen at the centre of the ICS approach.

However we did not find clear examples of how the fundamental tensions between organisations over who pays and delivers, who benefits and over what timescales have been resolved.

In particular, the work of the ICP in producing Integrated Care Strategies is felt to be important in bringing partners together under a common cause. However, putting these into action and demonstrating the system benefits will require ICBs and local authorities to prioritise resources into this space, and our interviews indicated significant variation as to how this is expected to happen in practice in view of other priorities.

Closer partnership working will help to make sure the right discussions happen, but real change is not yet guaranteed at this stage.



DEEP DIVE FINDINGS

1. Priorities for Integrated Care Boards and Integrated Care Partnerships

In theory the work of the ICB will be guided by the work of ICPs which are developing IC Strategies. Most respondents to our survey felt confident that they would be able to produce an IC Strategy by December (see figure 22). 79% of councils surveyed felt they would be an active partner in shaping the ICS's plan.

Our survey and interviews were largely unanimous in feeling that ICBs would be focussed on nearer-term operational issues, with ICPs focussing on longer term preventative services (see table).

> **"The only legal entity in an ICS is the ICB, not the ICP. Ultimately decisions lie with the ICB as they are statutory." ICB Chair**

In practice though, we found variation in the approach to the ICP and the creation of a strategy. Some councils have opted for a minimalist approach of amalgamating existing Health and Wellbeing Strategies given the limited time available, while others have divided the respective roles of HWBs, ICBs and ICPs. For example, in Derbyshire, the ICP leads on tertiary prevention (reducing the impacts on people who are already ill) and the HWB secondary and primary prevention (preventing illness before it occurs and reducing the impact when it does), though there is naturally some overlap.

1- Proportion of survey responses that included the issues mentioned among the top three.

Survey responses from both LAs and ICB chairs indicated that hospital discharge and admission prevention should be among the top three shared priority issues for the ICB. LAs were more likely to flag mental health services as a "top 3 priority" as well as elderly care and community rehab and reablement.

For ICPs, over half of LA and ICB chair responses flagged "Public Health" as a top 3 priority and it was the most common response for both. As for ICBs, LAs were more likely than ICB Chairs to highlight mental health services as a priority for ICPs.

Figure 22: How confident are you that the ICP for this ICS will be in a position to produce an Integrated Care Strategy by December?

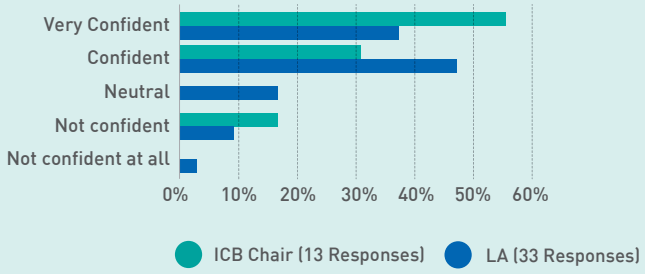


Figure 23: Thinking about where councils and ICSs can work together, what are the top three priority issues for your ICB?[1]

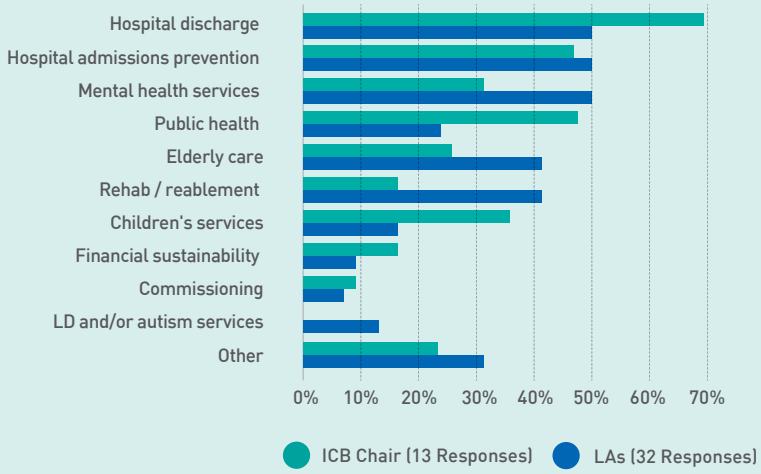
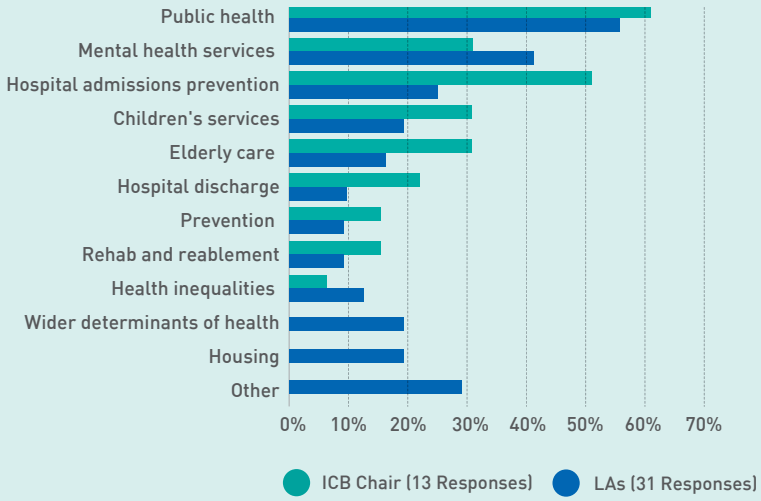


Figure 24: Thinking about where councils and partners in ICSs can work together, what do you see as the top three priority issues for the ICS's ICP?



In Essex the ICP is the "why", the ICB the "how" and the ICS as a whole is the "what". This work is also set against the backdrop of a huge number of existing strategies across local government, the NHS and VCSE.

> **We feel the dead hand of NHSE, DHSC and HMT on us in performance management." ICB Chair**

This variation in approach has a natural knock-on effect on setting priorities. For most areas, the ICP will not be setting specific priorities and is seen as "soft power" as one councillor put it. It lacks decision-making power but can provide a convening function to bring together key partners including VCSE. In other areas, leaders are pushing for the ICP strategy to set out 2-3 key priorities for all partners to get behind that are outside the usual individual focus of the NHS and LAs. Without this level of focus, there is a risk that IC Strategies end up being too broad to drive meaningful change, as one ICB Executive told us "at the moment I would be worried about putting effort into [the IC Strategy] if I was a council".

2. **Balancing "operational" and "strategic" focus**

Most people we interviewed believe that the core aims of an ICS as a whole should include driving local integration, improving out of hospital services and tackling health inequalities. However, there is a significant degree of scepticism as to whether this will happen in practice, as ICBs focus their efforts on immediate operational issues that matter most to "the centre" (DHSC and NHSE) and LAs tackle their own immediate pressures.

As set out in the governance section of this report, ultimately an ICB's accountability is through NHSE and into the Secretary of State for Health and Social Care. This, coupled with extensive guidance and target setting from central bodies, was felt by many interviewees to mean that the ICB prioritised the "hospital" elements of its role over the longer-term shifts that could proactively manage demand and improve population health via early intervention and prevention.

> **What we're always at risk of doing in this space, both local government and the NHS, is trying to boil the ocean. It's important that we are very clear about the two or three things that we can only do if we do them together, instead of pretending we're responsible for fixing everything." LA Chief Executive**

> **I'm always struck that with the economy and transport we talk about 2050. With the NHS we're lucky if we look beyond next week." LA Director**

Similarly, several local authority ICB partners commented that the board's work was largely focussed on short term "NHS" operational pressures such as waiting lists and ambulance response times. This was understandable in the circumstances but was felt to crowd out the longer-term thinking which should be a priority for a strategic board. As one LA Chief Executive put it: "the ICB is the NHS, nothing more".

NHS interviewees generally recognised some of this characterisation. However, several chairs were keen to stress that they are attempting to move away from a "hospital-focussed" approach and that the daily pressures of the system mean that a focus on hospitals is essential, with or without interventions from "the centre". There is also a necessity to consider issues that sit squarely within the "NHS" remit, such as service realignment within the ICS footprint.

"

We feel the dead hand of NHSE, DHSC and HMT on us in performance management." ICB Chair

Ultimately the ICB will only have to "have regard" to the IC Strategy and the extent to which it will genuinely shape the board's decision-making, including on allocation of funding, will be tested ahead of the start of the next financial year. This same test will apply to councils who face similar competing tensions and the same duty to "have regard" to the IC Strategy.

3. Trade-offs and positive externalities in a constrained fiscal environment

It was recognised by nearly everyone we spoke to that services which intersect both NHS and local authority responsibilities are essential to delivering better outcomes to citizens and also maximising the use of public funding in aggregate. The challenge is that the benefits for organisations do not align with their own investment of resources, and they need to be brought together to maximise overall system benefits. In a time of constrained resources and pressing service requirements this will create major challenges to partnership working.

The level of prescription in central government funding is another barrier to managing these trade-offs. Grants are felt to be short-term and accompanied by specific conditions that mean that cash needs to be spent on specific, centrally mandated, priorities. For example, in recent months the government has announced £500m for adult social care[41], though at the time of writing is yet to indicate how or when this will be allocated, except that it must be spent on discharge. This makes designing long-term policy solutions at a local level difficult.

"

[Our council] is looking at a black hole that we've never looked at before... We're going to need to make some difficult decisions, which will affect our NHS colleagues because we might not be able to do as much partnership working as we would like." Councillor

There is also concern that central government is planning to allocate funds that had previously been routed via councils or pooled pots to ICBs instead. The £500m for discharge is a case in point, as this is felt to sit squarely within the (shared) Better Care Fund (BCF) but may now be routed to ICBs. Similarly, a recent Adult Social Care Digital Transformation Fund[42] of £25m in 22/23 – announced as part of the overall investment in *People at the Heart of Care*[43] – is being routed through ICBs rather than councils, despite seeming to be a core adult social care responsibility. Given the level of NHS control over ICBs, councils are concerned that this reflects a new trend in funding allocations that does not support the spirit of partnership working.

Interviews and roundtables with both the NHS and councils indicated a degree of cynicism that the "other side" should be doing more to help them deal with their pressures. As one ICB chief Executive said "everybody wants to be interested in NHS business [and having a view about] how the NHS should spend its money. But where's the equal partnership?"

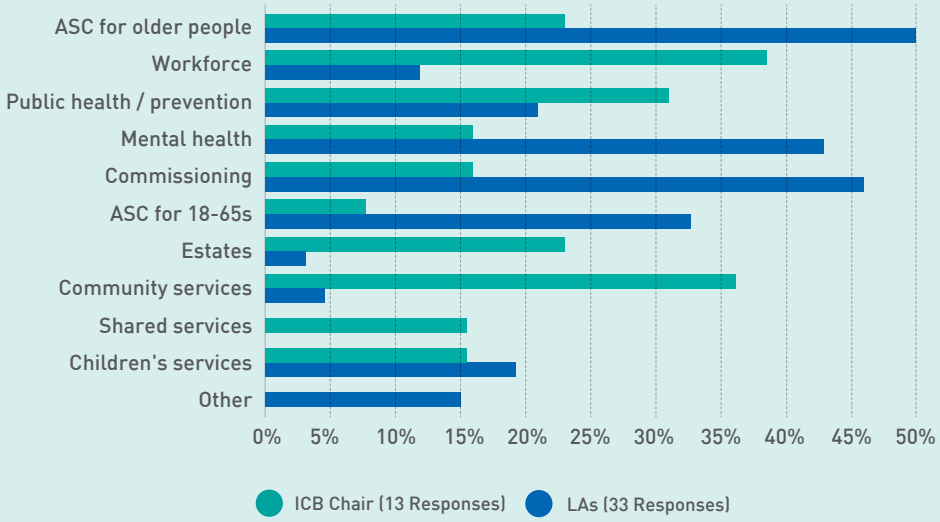
We did not find clear examples of ICBs or councils who had managed to fully square this circle. ICBs and LAs do not themselves have sufficient organisational power to compel each other to act in particular ways, and interviews indicated that strong senior relationships are key to unlocking silo working. However, it is likely that ICSs will need stronger processes to manage these tensions.

4. Limited appetite for financial pooling

Our survey indicated that under half (45%) of all LAs and 69% of ICB chairs have plans to pool more resources with other ICS partners relative to the start of 22/23, with most pooled resources focussed primarily on ASC for older people. A further 15% of councils indicated further pooling is under consideration.

41. https://www.gov.uk/government/news/health-and-social-care-secretary-sets-out-plan-for-patients-with-new-funding-to-bolster-social-care-over-winter
42. https://www.digitalsocialcare.co.uk/funding-opportunities/adult-social-care-digital-transformation-fund/

Figure 25: Do you have plans to pool additional resources (vs start of 22/23) with ICS members in any of the following areas?



Our survey did not indicate strong alignment between LAs and ICBs in where additional pooling should take place (see figure 25). For example, the top three areas for additional pooling for councils were adult social care (ASC) for older people, commissioning and mental health. Only ASC for older people was in ICB chairs' top three responses, behind workforce and public health.

Our interviews and roundtables painted a more cautious picture of the potential for resource pooling. The majority of councils we spoke to indicated that they would be very cautious about pooling further resources with NHS colleagues. The primary reason given for this was nearly always that pooling resources with the NHS created significant spending risks as the NHS did not have the same attitude towards managing overspends (this is covered in further detail in the "Culture" section of this report). This was echoed in our surveys where governance and accountability were seen by both ICB Chairs and LAs as barriers to resource sharing (see chart). "Technical" barriers such as legal, procurement and tax were seen as much less relevant to resource sharing.

A decrease in BCF pooling may be a particular county authority effect – nationally these councils planned to pool less per head through additional contributions to the BCF in 21-22 (£13 per head) relative to 20/21 (£14 per head), whereas non-county authorities' voluntary contributions increased over the same period (£27 to £29 per head) (see expenditure and outcomes section for further information).

Nationally under half of all LAs (48%) make voluntary contributions to the BCF, a figure that has decreased since 17-18 (51%)[44].

Our survey also indicated more optimism for the benefits of greater integration from ICB chairs than from local authorities. Councils were more likely to answer "maybe" as to whether further integration could create more efficiencies or better outcomes for citizens. When asked where integration could improve outcomes (open text) both ICB chairs and councils flagged prevention, discharge and reablement as opportunities. When asked where integration could improve efficiencies, workforce, prevention, estates and digital came out as key themes.

43. https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform

"

[Spending] needs more openness and transparency to be confident that if you're pooling resources, you're paying your fair share and not subsidising the other party." Council Leader

5. Challenges to non-financial resource pooling

While pooling funding on shared services appears to be decreasing, county authorities indicated that aligning budgets and "joint roles" was increasing, particularly at place level where we found several examples of "Place" being led by joint council/ICB appointments. Over half of LA respondents to our survey (55%) indicated that there were joint roles in their ICS, funded by both councils and ICBs.

Our survey indicated that willingness for further non-service resource pooling was generally higher among ICB chairs than LA respondents. For example, 38% of ICB chairs were considering pooling further workforce vs 12% for councils and similarly for estates (23% vs 3%). Given the findings of the Fuller Stocktake[45] this indicates there is still further to go in this space. However, as indicated above, the open responses leaned more towards workforce, estates, and data and digital as opportunities for greater efficiencies.

In discussions, both the NHS and LAs recognise that there is more they would like to do in this space, however there are real practical barriers, with workforce cited as a common example. In our surveys, "Workforce terms and conditions" was cited by 42% of local authorities and 46% of ICB chairs as a "main barrier" to resource sharing between organisations. Our interviews and roundtables reinforced this concern, noting that the low pay and terms and conditions of the adult social care workforce relative to the NHS workforce create a range of barriers to resource sharing and integrating services. This includes:

Figure 26: What do you see as the main barriers to sharing resources between organisations?

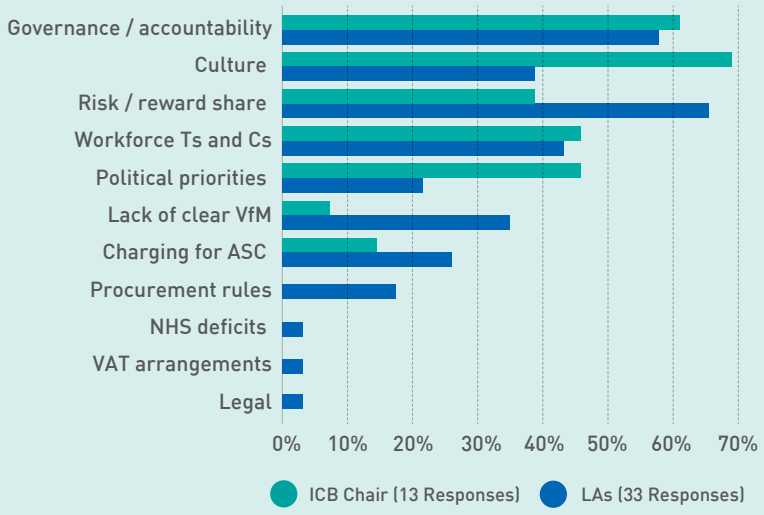


Figure 27: Do you believe that further integration within the ICS could create more efficiencies?

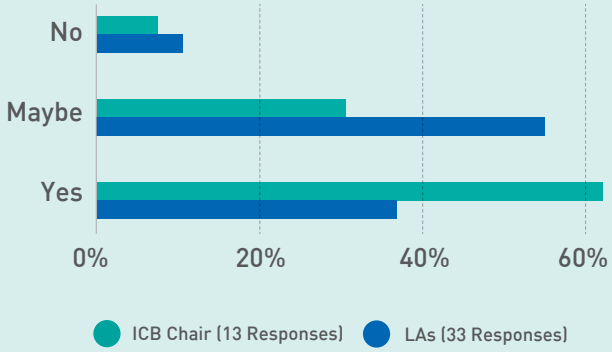
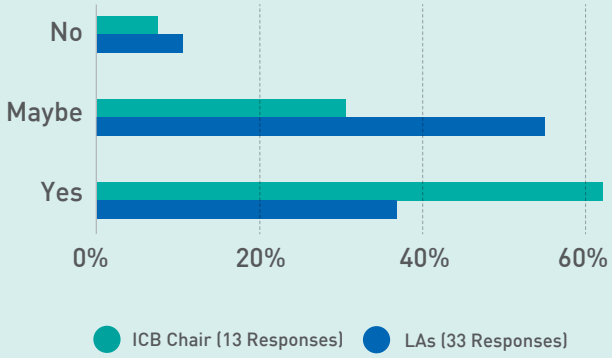


Figure 28: Do you believe that further integration within the ICS could create better outcomes for your citizens?



44. https://www.england.nhs.uk/publication/better-care-fund-2021-22-planning-data/https://www.england.nhs.uk/publication/better-care-fund-2017-19-planning-data/
45. https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

- Limiting opportunities to create a genuine single workforce and recruitment campaigns
- Creating unhelpful incentives within systems for workers to move towards the NHS rather than equally important care services

6. Dispersed decision-making

70% of LA responses to our survey indicated that governance was either clear or very clear in their ICS, but just 36% felt that decision-making was clear. Our interviews indicated that some areas have made great efforts to be clear about responsibilities and for many larger councils the need to work with several CCGs has been made much easier by having a single ICB.

Despite these efforts there is still significant confusion across systems. The ICS legislation and frameworks have created a number of potential "power points" and our perception from interviews is that these vary significantly by LA and ICS and will continue to evolve as the system is tested. Some LAs indicated that they felt that ICBs were looking to "hoard" decision-making that had previously occurred at a "Place" level between councils and NHS partners and it was unclear what this meant for pre-existing arrangements. This is creating confusion over where organisations should be placing their effort and what the process might be for realising change.

RECOMMENDATIONS

13. **ICPs should agree a small set of achievable priorities for partners in ICSs for 2023-24. Trying to do too much initially when decision-making and delivery are yet to be tested is a significant risk to long-term system engagement.** Focussing on a narrower set of aims will generate confidence in the ability of system partners to deliver meaningful change and create a virtuous cycle for further action. In each case the "positive externalities" that integrated approaches will bring should be quantified for each partner. What this could mean in practice is set out separately.

14. **ICPs should agree in advance with ICBs and LAs how they are expected to demonstrate "regard" to the IC Strategy.** One option would be to ensure that the chair of the ICP is a full member of the ICB. There is a risk of disengagement with the ICP if strategies are not seen to drive real change, particularly in budget setting. For the NHS, IC Strategies should act as a local counter-balance to demands on ICBs from "the centre".

15. **DHSC and DLUHC should clarify the future approach to pooled funding and grant allocation between councils and ICBs.** Recent evidence, such as the ASC Digital Transformation Fund and £500m for hospital discharge, suggests that central government funding for ASC services may be routed through ICBs rather than going to LAs or pooled funds such as the BCF. This undermines the principle of partnership working between the NHS and councils.

16. **ICB chairs should review ICB agendas and ensure these are appropriate and sufficiently focussed on the long-term.** ICB time should meaningfully focus on non-operational, strategic and transformational issues that take advantage of the expert skills and knowledge of attendees. Core NHS operational issues should be delegated to sub-committee where necessary.

17. **ICBs should define the geography, role and medium-term future of place-based partnerships including delegation, in agreement with LAs.** Formal delegation may not be appropriate, however certainty over medium-term future arrangements will support planning and this is particularly important for "Type 2" and "Type 3" LAs.

Setting an "inclusive ambition"

Setting an inclusive ambition is about supporting a group of people, teams and/or organisations to establish a joint aspiration towards which they can all work. It does not mean all parties have the same ambition – it is instead about identifying an ambition that all partners can sign up to. An inclusive ambition will often be the goal of a system leader, who might have an existing appetite to widen the lens to tackle known system challenges by getting others on board. For the ambition to be set, partners need to recognise that they exist within one system – not separate parts.

For example, even though many ICP strategies are likely to be jointly presented and explain a shared problem, an actual joint ambition is missing, in part due to the different priorities of its constituent members. Social care may focus on managing demand to remove cost; hospitals are trying to manage demand to free up hospital capacity. These two aims are worthy, but counter each other. By widening the lens, there could be a joint ambition between ICS partners, for example, to reduce hospital admissions by X%, or to increase preventative spending by Y%.

In the case of ICPs, inclusive ambitions are key to generating buy-in for overall system approaches. IMPOWER would recommend only a small number of ambitions in year one and these should be on a trial basis initially to test and measure potentially complex propositions – for example the system value of preventative measures such as additional blood pressure checks or new discharge pathways.

There are four steps to setting inclusive ambition:

1. **Create the case.** The system leader (e.g. ICP Chair) needs to be clear what the potential inclusive ambition is and generate a clear case for change, including the potential costs and benefits for system partners, as well as interactions with existing system plans.
2. **Understand the ambitions of individuals within the system.** The system leader should then meet with partners in "safe spaces" to discuss their individual ambitions and how they could realistically align with the wider inclusive ambition.
3. **Establish the groundwork.** Bring partners who have decision-making power together to discuss programmes of work. A key goal is to bring clarity to who will be responsible for what, and agreement on how and where the potential costs and benefits are expected to land.
4. **Set an inclusive ambition.** The resulting ambition needs to be as specific as possible and leaders and relevant managers must commit to it as a priority.

Culture

Exam question – Are the NHS and county authorities able to work together effectively?

Answer – Yes in most instances, but significant, ingrained, cultural barriers remain which council and NHS leaders need to acknowledge and address to improve trust and partnership working.

SUMMARY

Of the three themes that we explored as part of this report, "culture" was the one which produced the most consistent responses across partners, and it is essential to delivering the objectives of ICSs. There is a great deal of mutual respect between LAs and their NHS colleagues. In our discussions both sides regularly recognised the pressures that their opposite numbers were facing as well as how joint-working during the pandemic in particular brought them closer together.

> **"This [ICSs] really isn't just about money [...]. Actually this is about getting people into a new space and new way of thinking and doing things, and the NHS has found this very, very difficult to do." ICB Chair**

Despite this, there are significant longstanding cultural differences between the two types of organisation. In particular, in many areas the NHS tends to act as the "host" organisation for many of the ICSs' structures and its "managerial" approach can undermine the underlying partnership aims of ICSs. At the same time it is felt that LAs could do more to support the NHS to make the most of local democratic engagement and designing local approaches through engagement, including with the VCSE sector.

There are also fundamental tensions between the two sets of organisations that are largely the result of their different accountability structures. The "command and control" nature of the NHS compared to councils' local political leadership and the relative priority both sides give to living within financial constraints were particular and repeated points of tension, which will need to be worked through in every area.

If ICSs are to be effective, partnership working is essential, and this will ultimately be the result of trust, not formal legal and governance structures. ICB chairs, ICP chairs and NHS and council leaders have a key role to play in setting the right tone for their organisations to make sure that cultural differences do not become barriers to effective joint working.

DEEP DIVE FINDINGS

1. The "command and control" nature of the NHS relative to councils

The NHS is seen by LAs as being primarily directed by "the centre" as opposed to councils which respond to local political leadership. The level of involvement of the "centre" has been covered in other sections, but it is worth reiterating that our interviews indicated that the sense that the NHS focussed on priorities from the "centre" created significant scepticism that they would be able to respond to priorities generated locally.

This view was not restricted to LAs, with ICB representatives recognising the management challenge. In several conversations we noted that ICB leaders were keen to try to address different ways of working and considered this part of their leadership task.

Another consequence of the "command and control" tendency was reflected in the way that the NHS elements of ICBs have approached partnership working. We heard examples of councils who felt NHS colleagues were "taking over" forums that councils had approached from a partnership perspective.

Examples include the NHS providing the secretariat for ICPs and leading conversations towards NHS priorities or insisting on formal interview processes before accepting LA members onto ICBs. As one LA Director told us "ICBs believe they are the system. They're not".

2. Different approaches to spending control

LAs consistently raised the fact that NHS providers do not feel constrained by budgets in the same way as LAs. Our interviews made clear that LAs felt as though it was acceptable to overspend in the NHS, while the spending regime in councils was much more rigorous. There is a clear link to the statutory framework in which the two sets of organisations operate. Several council leaders set out a view that the NHS could do more to tackle inefficiencies, learning lessons from local government over the last decade.

Some ICB leaders we spoke to acknowledged this perception but highlighted the different operating environment that councils did not, perhaps, fully appreciate. As set out in the strategic delivery planning section of this report, these differing approaches were seen to limit the willingness of LAs to pool resources with NHS organisations.

3. LAs are felt to understand the NHS better than the NHS understand LAs

In our survey we asked both councils and ICB chairs the extent to which they felt they understood each other's priorities and statutory responsibilities and resources (financial, workforce, capital and data). The results were surprisingly clear.

Figure 29: LA perceived understanding of NHS

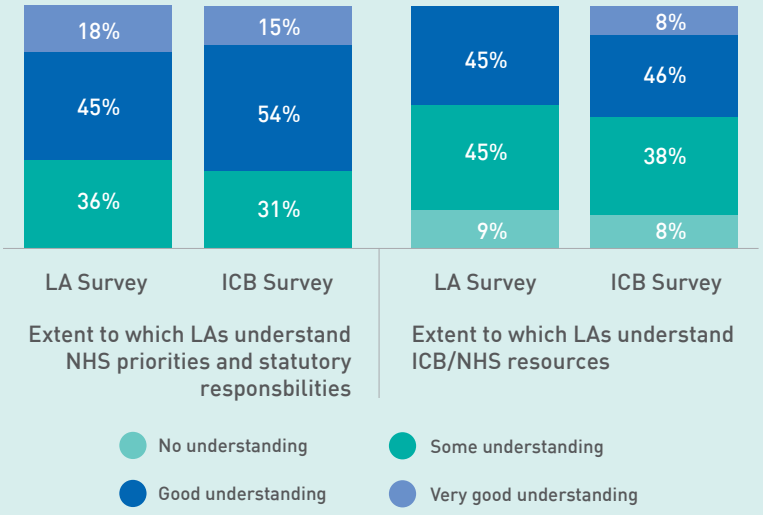
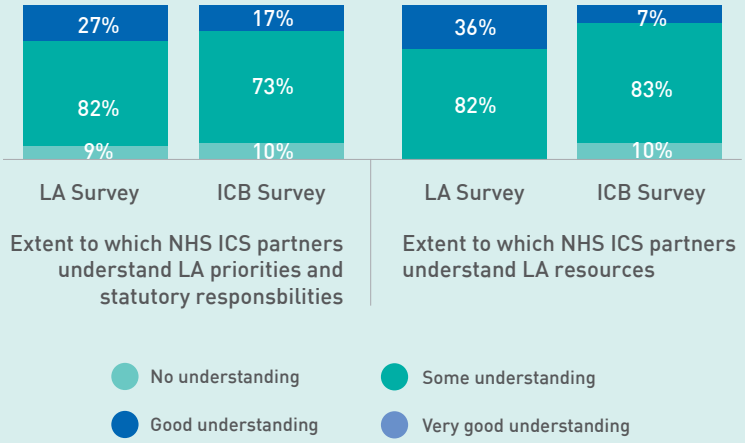


Figure 30: NHS perceived understanding of LAs



> If culturally the ICB was told "this is your budget and you've got to live within it" as local government does, you would see a change overnight because they would have to address their cost base." Council Leader

Firstly, LAs and ICB chairs provided remarkably similar responses for what was a highly subjective question, indicating that they have a shared picture of the gaps in understanding.

Secondly, councils are felt to understand the NHS better than the NHS understands councils. Very few responses indicated the NHS had even a "good" understanding of LAs. Not a single response from either councils or ICB chairs indicated that they felt NHS partners had a "very good" understanding of either councils' priorities or resources.

Thirdly, there is clearly some way to go to develop levels of mutual understanding on both sides. Even though councils are seen to have a relatively better understanding of the NHS, only a very small proportion of responses indicated that councils had a "very good" understanding of the NHS.

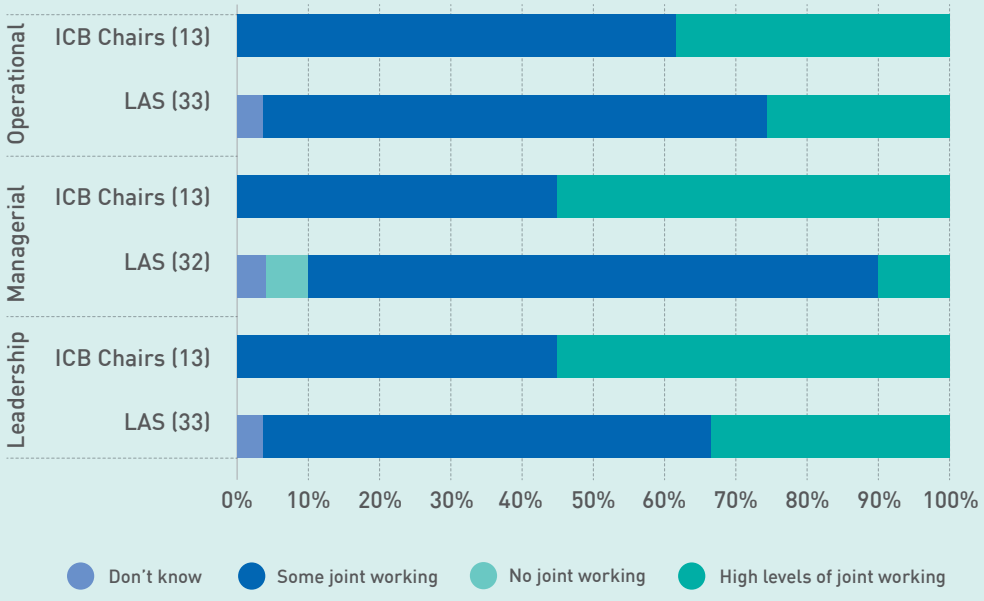
Mutual lack of intelligibility was a common theme in interviews and roundtables. LA leaders regularly referred to extremely dense NHS management information in ICB boards, and we regularly came across examples of both councils and NHS partners highlighting that the other side failed to understand the constraints within which they were operating. At the same time we were made aware of attempts to address this cultural divide - for example, through board development work.

4. Joint working appears to be weakest at managerial level

Our survey indicated that, at most levels, there is joint working between organisations, with ICB chairs and LAs providing broadly comparable responses for joint working at leadership and operational level. However, for LAs joint working appears to be lowest at managerial level (9% of responses saying there were "high levels of joint working" at this level), while for ICBs it was seen to be highest at this level (54%).

We found evidence of this in interviews and roundtables. Several council interviewees commented that ICBs tend to be staffed by people from CCGs who were still working with the same people from councils on similar issues, leaving pre-existing organisational tensions in place. We did not find significant evidence of schemes to increase levels of joint-working at a managerial, rather than leadership level.

Figure 31: Within the ICS, to what extent do you feel there is a culture of joint working at each of these levels?



5. Political engagement

In general, the NHS representatives in interviews and roundtables recognised the value that local politicians could bring to the work of ICSs, particularly when managing difficult or contentious decisions. This was felt to be best managed informally between senior leaders. However, our interviews with councillors did not always demonstrate that they felt that sufficient engagement was taking place, and there remains some scepticism that "the NHS" does not value local politicians' input, as demonstrated by the initial NHS draft constitution that "disqualified" councillors from being members of ICBs. This advice was later rescinded[46].

There is also a worry that in some areas ICB leaders feel that the involvement of LA representatives on ICBs and ICPs is sufficient to manage political engagement. Given the lack of political representation on ICBs and in many cases the lack of representation from all councils involved, this cannot be the case. We also found evidence that the organisation and purpose of ICSs is not well understood by politicians at both local and national level. In some cases, this was generating suspicion towards the work of ICSs, as they were seen to be just another bureaucratic intervention, limiting the opportunity to generate local momentum for priorities.

> "I've noticed a small change, not dramatic. The problem is that at the top and on the ground of organisations they understand the change, it's the management in the middle that doesn't grasp it. There's some convincing to do." Councillor

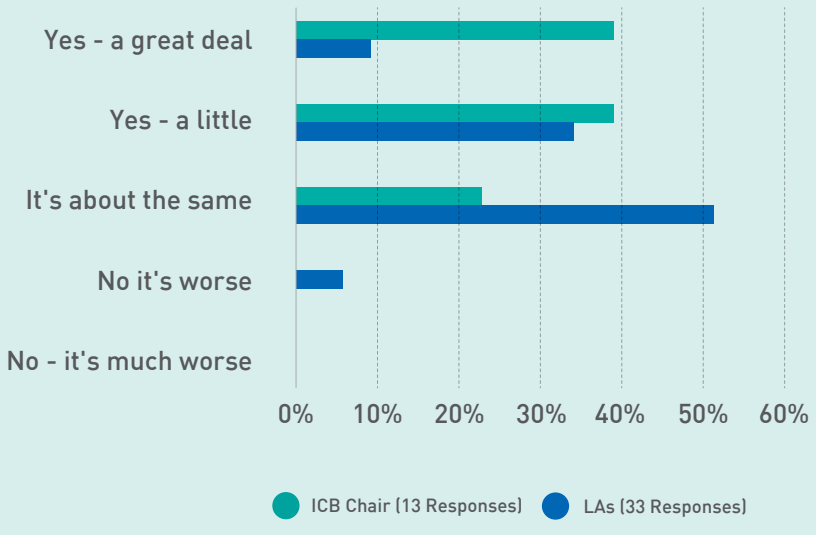
> "We're going to need local authority support because if we start moving money around, we expect the environment to become noisy." ICB Chair

6. The changes introduced by ICSs may feel more significant for the NHS than local authorities

Over half (52%) of LAs surveyed indicated they felt that partnership working was about the same since the creation of ICSs, with 42% saying it had improved a little and just 9% a great deal. ICB chair responses were notably more positive with 77% noting an improvement and 38% saying it had improved a great deal.

From our conversations, the shift at the top for the NHS created by ICSs feels very significant. But for LAs working through Place-Based Partnerships, many of their existing, pre-ICS arrangements have continued, working with similar colleagues. This change therefore feels less profound.

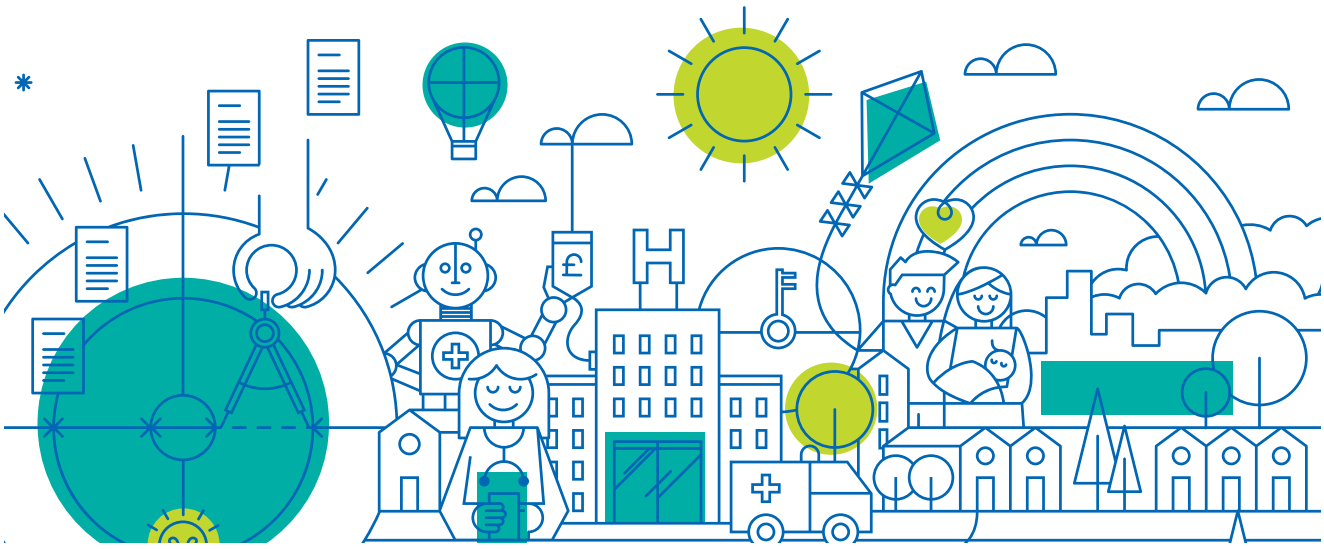
Figure 32: Has the creation of the ICS improved partnership working between the different organisations involved in health and care?



46. https://www.hsj.co.uk/integrated-care/nhse-must-allow-councillors-to-sit-on-integrated-care-boards-says-government/7031878.article

During roundtables and discussions we regularly heard from local government that ICSs are just another NHS reorganisation and that there was no guarantee that this one would last longer than the others. As one council Director put it:

"We roll our eyes [at the latest NHS reorganisation] then we roll up our sleeves". As such there is a need nationally for NHS ICB leaders to continue to make the case for these arrangements if they want them to last.

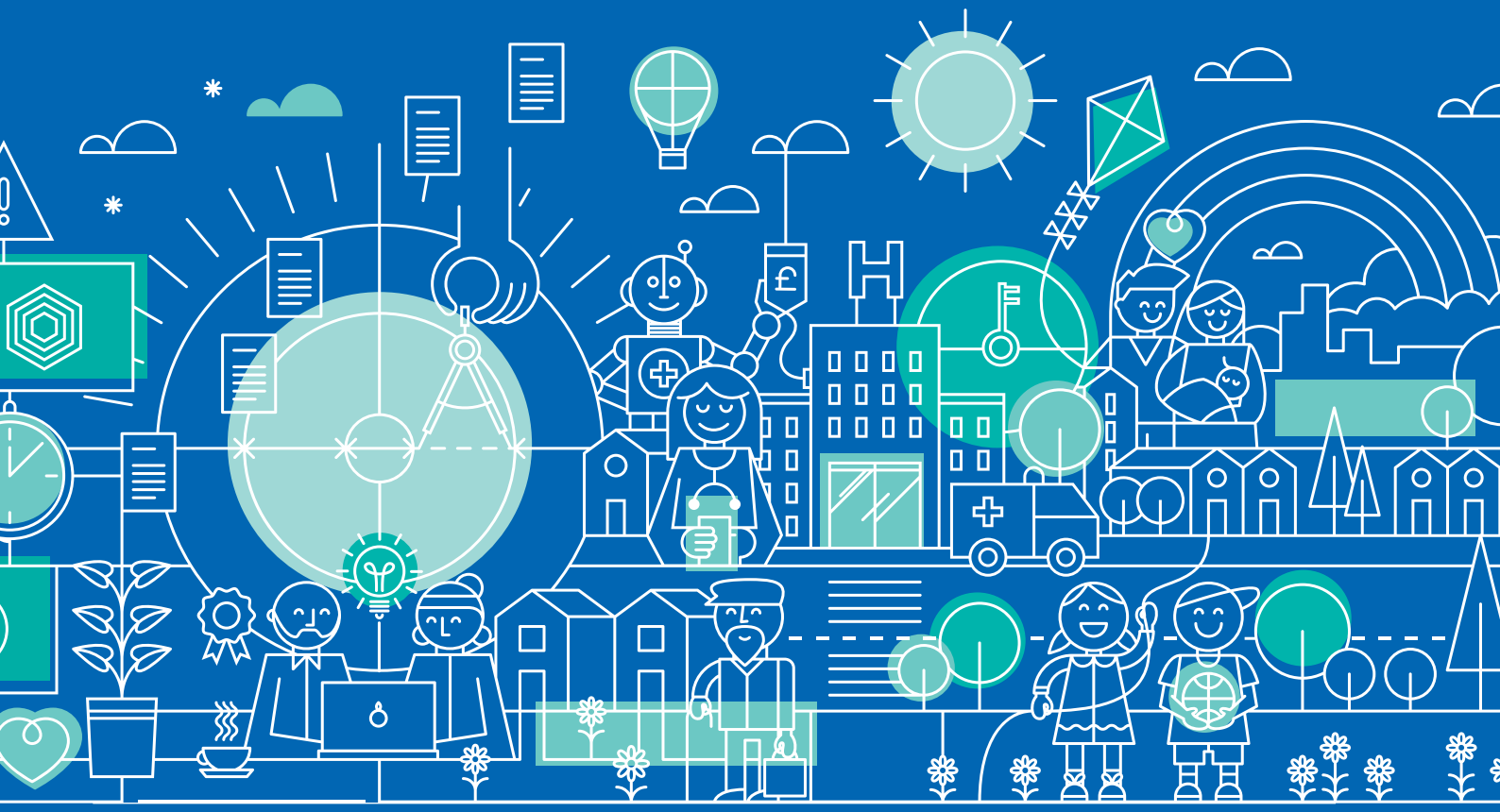


RECOMMENDATIONS

18. **ICBs and ICPs should carry out proportionate board development exercises.** There is clear value in these and where we found examples in our research, they were welcome, however these need to be proportionate. Our research indicates that there would also be particular value in improving NHS partners' understanding of councils' resources and responsibilities.

19. **LAs and NHS/ICB partners should focus organisational development at the management level.** This level appears to be a key point of tension across boundaries and local leaders need to develop a vision with shared values and priorities. Core to this is building trust between the different organisations.

20. **Councillors should agree parameters with ICB chairs for regular engagement outside of formal governance arrangements.** This should enable an exchange of views on council and NHS priorities as well as how to manage these in the local political environment. It is also essential to developing the trust required for effective partnership working. ICB chairs and ICP chairs should make information available that explains their work to local politicians, enabling councillors and MPs to be able to justify and explain the work of these bodies to their various constituents.



Thanks and acknowledgements

We would like to thank all those who took part in this research. Your time and insight was invaluable.

Thanks in particular to the seven councils and ICBs who took part in our deep dive interviews. Thank you to the County Councils Network for commissioning and supporting this research, and to NHS Confederation for their contributions and assistance in seeking views from NHS colleagues and providing data on ICP membership.

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