# Post Implementation Review of the Health and Care Act 2022

## *Phase 1: Interim Report*

### **Non peer reviewed Working Paper**

Working Paper

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## Executive Summary

### Study aims, objectives and methods

The Health and Care Act 2022 (HCA 2022) aims to strengthen collaboration between organisations providing health and social care and expand the scope of decisions made through Integrated Care Systems (ICSs). The HCA 2022 gave ICSs a statutory basis consisting of an Integrated Care Board (ICB) (focused on integration within the NHS and accountable for NHS resources) and an Integrated Care Partnership (ICP) (focused on integration between NHS, local government, and wider partners). ICSs represent a shift in health care policy in England from an emphasis on organisational independence, separation between the functions of commissioning and provision, and competition between providers, to focusing on collaborative working, collective planning of services, and collective accountability. ICSs are expected to achieve improved health outcomes in local populations, reduce health inequalities, enhance productivity and value for money, and help the NHS to support wider social and economic development. However, the evidence base linking inter-organisational collaboration to improvements in performance and outcomes is unclear. It is important to understand the impact of the HCA 2022 on collaboration and what changes as a result.

The 'Post Implementation Review of the Health and Care Act 2022' is a three-year study which commenced in October 2023. It aims to establish an evidence base concerning the development of collaboration in ICSs, identify appropriate metrics for assessing the impact and outcomes of this collaboration, disseminate findings to support local ICS practice, and support Ministers and policymakers with future policy. This Working Paper details the findings from Phase 1 (Year 1) of the study. The Phase 1 research questions (RQs) are:

**Theme 1: Collaboration, leadership, and governance**

- RQ1a: How are governance structures and leadership arrangements developing to facilitate co-ordination?
- RQ1b: How are accountability relationships developing within systems (including between diverse statutory, independent, and community-based organisations and bodies), and with regulators, to facilitate the achievement of system aims?
- RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?
- RQ1f: What functions, responsibilities, and roles are evolving in place-based partnerships and provider collaboratives, and are different types of commissioning functions evolving at different system levels?

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**Theme 2: Use of resources and outcome metrics**

- RQ2a: Are systems making use of joined-up/pooled budgets? How are they doing this and under which circumstances?
- RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?

**Theme 3: Experiences of people**

- RQ3a: How are ICSs incorporating patient and public perspectives into their development and operation?
- RQ3b: What groups are most likely to benefit from improved collaboration?

**Theme 4: Health and wellbeing inequalities**

- RQ4a: How is the duty to tackle health inequalities embedded within the ICB governance structure, and how are broader wellbeing inequalities being addressed by ICBs and ICPs?

Phase 1 consisted of scoping activities to establish a national level evidence base to inform Phase 2 activities. We summarised the national legislative and policy context, and interviewed 15 policy stakeholders from a variety of organisations, including those responsible for steering the development of the HCA 2022 and associated policy. We investigated governance arrangements in ICSs through an analysis of all 42 ICB Governance Handbooks and interviewed 17 ICB directors. We surveyed local Healthwatch regarding the extent of their engagement with local ICSs. Additionally, we identified metrics suitable for a future impact evaluation of the HCA 2022 and commenced work examining the spending patterns of ICBs in their first year as statutory bodies to assess whether ICSs are changing the allocation of resources and bringing their local health and care economies into financial balance.

## Summary of findings

This section presents our findings in relation to our Phase 1 research questions.

**RQ1a: How are governance structures and leadership arrangements developing to facilitate co-ordination?**

The permissive nature of the HCA 2022 and associated policy is reflected in the development of governance structures and leadership arrangements in ICSs. In most cases, ICBs are adopting a centralised approach by retaining ultimate control of resources and decision-

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making. The majority of ICBs are not using formal mechanisms, such as the delegation of formal commissioning functions to place and provider collaboratives, preferring to designate a more informal or advisory role to these forums at this point. There is a risk that collaborative forums within some systems are potentially duplicative, particularly in relation to the roles of places and provider collaboratives. The expanded governance structure of ICSs was presenting a problem to Healthwatch when trying to engage with ICSs, with limited resource to service this. It was suggested the latent power of ICPs is not currently being realised, due in part to ICPs perceived lack of ability to hold ICBs to account.

**RQ1b: How are accountability relationships developing within systems (including between diverse statutory, independent, and community-based organisations and bodies), and with regulators, to facilitate the achievement of system aims?**

Accountability relationships within systems, especially between ICBs, local government, and NHSE, are complex and evolving. Clarity regarding accountabilities and who was responsible for what within Systems was perceived as lacking, leading to inefficient governance processes and detracting from delivery-focused activities. ICBs face significant pressure from NHS England (NHSE) to focus on financial and performance metrics, which some ICB directors felt shifted the ICB role towards performance management. This focus risks transforming ICBs into "mini regulators" and may hinder collaborative dynamics within systems. ICPs were seen as lacking authority over ICBs, potentially reducing them to discussion forums without substantive impact. In light of concerns regarding the Care Quality Commission (CQC)'s proposed evaluation framework there was a suggestion that this function might concentrate on considering the extent to which ICSs are meeting their individual locally specified and meaningful strategies and objectives.

**RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?**

ICBs are currently making limited use of the delegation flexibilities granted by the HCA 2022. Our analysis found no examples of ICBs transferring functions to other bodies under section 65Z5 of the Act. There are a small number of joint commissioning arrangements between ICBs. In terms of 'internal' delegation within ICBs, delegation of commissioning responsibilities to place-based partnerships and provider collaboratives was rare. Some ICBs assigned limited budgetary and decision-making powers to place-based committees/sub-committees or ICB executive directors to facilitate decision-making in relation to specific budgets rather than commissioning of services.

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Our analysis reveals that local context strongly influences governance arrangements. While some ICSs have optimal conditions to support delegation (e.g. coterminosity of place and local authorities, or alignment across the provider landscape), other local contexts presented barriers to delegation, such as non-alignment of local authorities and providers, or where budgets were difficult to separate across places. Additional factors affecting decisions include the maturity of relationships, financial risk concerns, governance complexity, and potential conflicts of interest. Accountability and oversight pressures are also factors militating against delegation of functions. Some ICB directors highlighted other ways of achieving subsidiarity, such as including representatives of place on the ICB and other decision-making forums, and the establishment of advisory working groups. Some directors suggested that place-based partnerships needed enough freedom to make spending decisions, but did not require the delegation of formal commissioning decision-making.

**RQ1f: What functions, responsibilities and roles are evolving in place-based partnerships and provider collaboratives, and are different types of commissioning functions evolving at different system levels?**

There was a sharp contrast between the limited delegation of formal commissioning decision-making and budgetary responsibilities to place-based partnerships and provider collaboratives, and the significant roles which ICB directors said that they thought place Committees and provider collaboratives should play in the new system. Most ICB directors interviewed told us that they viewed place-based partnerships as essential for system functioning, suggesting that they should be responsible for leading health and care strategy, service planning, transformation and relationship management rather than orchestration of budgetary decisions. However, it was unclear how these functions could be carried out by place-based partnerships in the absence of clear decision-making scope.

While provider collaboratives are increasing in number and diversity, some are seen as too nascent to effectively contribute to system objectives. Established collaboratives typically focus on reducing outcome variations, improving service access, and enhancing system resilience, often emerging from bottom-up initiatives, resulting in significant variation in their functions. For some, this variation was concerning, raising questions regarding whether it would be more beneficial to have greater consistency, including within systems, regarding the role of provider collaboratives.

ICB directors expected a substantive shift in commissioning practices from CCGs, with some defining commissioning as any conversation about service planning. While some services are being commissioned at a pan-ICB level, other ICBs use specific committees for targeted

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commissioning. Without formal decision-making power, place-based partnerships and provider collaboratives often play advisory roles, feeding intelligence and aligning priorities with ICB committees. This raises questions about the potential for duplication, especially where decision-making structures are ill-defined. Concerns regarding conflicts of interest in place-based partnerships complicate the delegation of formal responsibilities.

**RQ2a: Are systems making use of joined-up/pooled budgets? How are they doing this and under which circumstances?**

The findings from interviews with ICB directors suggested that usage of joined-up/pooled budgets had not changed greatly to date. It appeared that ICB leaders were concerned with ensuring such funds were used effectively, and were engaged in trying to understand how such funds were being used in order to target them more effectively.

**RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?**

We used qualitative and quantitative methods to identify metrics to monitor outcomes and impact of the HCA 2022. Using the WHO Health System Performance Assessment framework to guide selection of indicators under various health functions and outcomes, we identified 97 indicators with complete data that may reflect system change related with the HCA 2022. National policy stakeholders suggested relevant metrics and indicators including alignment of local objectives across system partners and establishment of integrated teams, with emphasis on tailoring metrics to local needs.

We also mapped ICB financial flows, examining 2022-23 spending patterns to set a baseline, using 37 ICBs spending data for 2022-23 (9 months). We identified spending patterns across entities involved (services purchased from NHS vs non-NHS bodies) as well as spending across different service areas (acute, mental health, community care, etc.). This research will continue during Year 2.

**RQ3a: How are ICSs incorporating patient and public perspectives into their development and operation?**

We conducted a survey with Healthwatch leaders nationally as a proxy for patient and public involvement. The survey revealed variations in how ICSs incorporate patient and public perspectives, influenced by evolving governance structures across ICSs and places. Healthwatch's influence often depended on personal relationships rather than a systematic engagement approach, with some respondents perceiving their input as tokenistic, with

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financial constraints driving ICB decisions. This led to disillusionment with ICSs and scepticism about their long-term value for patients and the public.

While a few respondents noted small service improvements influenced by the Healthwatch, the majority reported limited engagement from ICSs, feeling undervalued and preferring to focus their efforts at the place level where they have a stronger presence and patients engage more actively with local services.

**RQ3b: What groups are most likely to benefit from improved collaboration?**

National-level policy stakeholder interviewees were asked to identify patient and population groups most likely to benefit from increased collaboration and service integration. It was suggested that any patient groups that generally experienced poor access or outcomes seem to be likely beneficiaries of increased collaboration and service integration. Patients who frequently use services, or combinations of services, spanning multiple providers, particularly when these crossed community, primary, secondary and specialist 'boundaries' were identified. These patient groups include: people with long-term conditions, frail older people, people with learning disabilities, and rough sleepers.

**RQ4a: How is the duty to tackle health inequalities embedded within the ICB governance structure, and how are broader wellbeing inequalities being addressed by ICBs and ICPs?**

Our analysis of ICB governance arrangements shows that 37 ICBs have established committees focused on improving population health and reducing disparities in healthcare access. While some ICBs have dedicated health inequality committees, others integrate this responsibility into broader committees such as commissioning or place-based committees.

## Discussion

ICSs are built upon the principles of subsidiarity (that decisions should be taken closest to whom they affect), local flexibility regarding decision-making arrangements, and consensus. The HCA 2022 is 'silent' regarding governance arrangements in ICSs beyond statutory ICBs and ICPs, in order to allow local ICSs to develop arrangements best suited to local circumstances. Our findings indicate that, for some, there may be a lack of clarity regarding who is responsible for what in ICSs. Within ICSs there appears to be particular potential for overlap between the roles of places and provider collaboratives. There is also a lack of clarity in relation to the role of the ICB itself, which some saw as shifting towards a regulatory role, with an expectation from NHS England regional teams that ICB leaders should hold providers to account for performance. This can be seen as a shift from horizontal accountability relationships between partners in ICSs, to a vertical accountability relationship through which

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ICB leaders hold the rest of the system, including individual providers, to account. This apparently shifting role of ICBs not only potentially duplicates the role but risks NHS providers feeling over-regulated and may lead to the disruption of partnership working between peers on which ICSs were based. It may be that the additional measures introduced by the HCA 2022 to strengthen mutual accountability, such as the duty to collaborate, are in danger in some systems of being weakened by emerging vertical accountability relationships.

In relation to the principle of subsidiarity, guidance suggests that ICBs should be delegating significant responsibilities to place and provider collaboratives. Our research found limited delegation of decision-making, commissioning functions, and corresponding financial authority to local levels (e.g., resource allocation, procurement, and contracting). This lack of delegation was due to attitudes toward financial risk, perceptions of the strength of collaborative relationships, and views on formal governance structures and related administrative burdens, as well as local geographical contexts that were seen as being not conducive to delegation. This latter finding is somewhat surprising, given that ICBs had the freedom to establish place-based committees across geographies that made sense locally. The fact that such geographies are now said to be unconducive to delegation suggests that renegotiation of place boundaries might be needed if the desired subsidiarity is to be achieved. Despite the absence of formal delegation, place-based partnerships were said to have a fundamental and crucial role in system functioning, suggesting that meaningful decision-making at the place level is necessary. Our findings indicate that while formal delegation of commissioning responsibilities at the place level is lacking, places are still contributing to commissioning processes. Whether such arrangements that allow place-based partnerships to contribute to the commissioning process, without holding ultimate decision-making responsibility, can satisfy the principle of subsidiarity is unclear, and further research is required to explore whether this leads to duplication in commissioning processes. In terms of procurement and contracting activities, concerns around conflicts of interest were raised, as making these decisions at the place level was said to potentially introduce 'too many' conflicts. However, the role of providers in ICBs means that conflicts of interest are likely to arise at whatever level decisions are made, suggesting a need for a re-evaluation of conflict of interest policies.

Our findings suggest that there may be too much flexibility and permissiveness regarding how governance arrangements are structured in ICSs, and not enough flexibility and permissiveness regarding what systems can do. The Act's flexible approach grants ICSs considerable freedom to shape governance structures and delegation to system partnerships,

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allowing diverse governance forms to develop based on local needs. While some ICBs effectively leverage this flexibility to establish complex, coordinated governance, others find the lack of standardised models leads to duplicative and unclear roles. Some ICB directors expressed concerns that such flexibility may result in overly complex governance, becoming 'an industry in itself'. Conversely, some stakeholders argued that excessive national control limits local planning and collaboration, with performance targets and short-termism overshadowing local planning and solutions. In order for ICSs to realise their longer-term goals, our study suggests that a better balance is required between the potential for too much flexibility regarding how things should be done, and too much control regarding what needs to be done.

The HCA 2022 did not make any fundamental changes to the nature of co-ordination in ICSs. Collaboration is a voluntary, consensual, non-binding model of coordination, and providers, including NHS organisations, remain separate organisations with their own organisational interests and accountabilities, and freedom to dissent. While the Act encourages ICS partners to prioritise system over organisational interests, some ICB leaders fear that partners may not adhere to decisions which are perceived to be against organisational interests. Financial pressures heighten these tensions, particularly in resource-constrained systems facing deficits. This situation complicates reaching consensus on difficult decisions, raising questions about the sufficiency of the consensus-based approach to drive through hard decisions in difficult contexts. In low-performing systems, a return to centralisation and command/control decision-making is often seen as the conventional response.

In Phase 1 of the research, we commenced an initial consideration of potential patient group beneficiaries of, as well as prospective metrics for assessing, integration and collaborative activity via ICSs. The findings reveal that that stakeholders consider a broad spectrum for potential beneficiaries and metrics. While this may be argued to be a reflection of the broad health and socio-economic aims of ICSs, it does suggest that a degree of caution is required in terms of the scope of what ICSs and system-based collaboration might realistically be hoped to affect and achieve, and the logic underlying how actions might realise the intended benefits through implementation.

### Phase 2 Plans

Phase 2 will take place between November 2024 and October 2026. During Phase 2, in Work Package (WP) 2, we will continue the formative analysis regarding ICB financial flows and resource allocation within in ICSs, and scoping metrics useful for monitoring outcomes of system working. We will further explore the identification of population groups most likely to

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benefit from improved collaboration. Additionally, in WP3, we will use case studies of two ICSs to explore in detail how the HCA 2022 is being operationalised. We will use interviews, focus groups and meeting observation to develop a detailed picture of how design, commissioning and delivery of services is evolving across system, place and neighbourhood spatial scales in light of the HCA 2022, and how health and care services are being experienced by patients. Our case study design will capture the complexity of the new system, 'studying through' arrangements by focusing particularly on two tracer populations: older people with frailty, and children with complex needs. In Phase 2, we will revisit the Phase 1 research questions and we will also explore the following additional research questions:

- RQ1d: How are ICBs using evidence, including evidence from research, in their decision making?
- RQ1g: How are systems utilising the flexibilities of the Provider Selection Regime to deliver more joined up services?
- RQ2b: How are ICPs and place-based partnerships influencing ICB decisions on financial allocations?
- RQ2c: How are systems approaching workforce planning, management and development, including across diverse statutory, independent and community-based organisations and bodies, and how is this changing use of resources?
- RQ2e: Are ICSs able to change the allocation of resources and bring their local health and care economies into financial balance?
- RQ3c: What do tracer group service users say about changes in their experiences of using services, and to what extent might these be attributable to the development of ICSs?
- RQ3d: Have frontline staff experienced any changes in their experiences of delivering care for tracer group service users that might be attributable to changes made by ICSs?

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## Glossary

| | |
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| Alliance agreement | An NHS alliance agreement overlays but does not replace existing service contracts. It brings providers together around a common aspiration for joint working across the system, setting out shared objectives and principles, and a set of shared governance rules allowing providers to come together to take decisions |
| Better Care Fund (BCF) | A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities |
| Blended payments | A holistic blended payment model comprising a fixed element with a quality/outcomes-based element, a risk sharing element and/or a variable payment to encourage providers and commissioners to adopt cost effective, joined up approaches |
| Block contract | The NHS payment system under which a healthcare provider receives a lump sum payment to provide a service irrespective of the number of patients treated |
| Clinical Commissioning Group (CCG) | The statutory bodies responsible for planning, organising and buying health and care services for their population prior to the establishment of statutory ICBs |
| Care Quality Commission (CQC) | The independent regulator of quality of all health and social care services in England |
| Committees in Common | An approach to co-ordinated decision making across organisations, by which multiple organisations establish their own committee with delegated authority to make certain decisions, which meet at the same time, with the same remit, and where possible identical membership to co-ordinate decisions. Each committee remains accountable to its own board |
| Department of Health and Social Care (DHSC) | The Ministerial department of the UK Government responsible for developing health and social care policy |
| Foundation Trust (FT) | NHS trusts which were created in April 2004 and were given more autonomy over capital borrowing, selling of assets, retaining annual surpluses, and developing their own systems for managing and rewarding their staff |
| Health and Wellbeing Board (HWB) | A formal committee of a local authority, which has a statutory duty, with ICBs, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for the local population |
| Healthwatch | Statutory organisations established as part of the Health and Social Care Act 2012 to represent local communities' experiences and voices to health and care partners. This includes local Healthwatch organisations, and Healthwatch England, a national coordinating body for local Healthwatch<br><br>NB: The plural of Healthwatch is Healthwatch |
| Integrated Care Board (ICB) | A statutory body responsible for planning and funding nearly all NHS services in its area |

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| Integrated Care Partnership (ICP) | A statutory committee of ICBs and local authorities including a wide range of partners such as NHS organisations, local authorities, the voluntary, community and social enterprise (VCSE) sectors, and other local partners. The main function of ICPs is to produce and then monitor a five-year Integrated Care Strategy |
|---|---|
| Integrated Care System (ICS) | Partnership of organisations that come together to deliver four objectives: improvement of health and care outcomes, tackling inequalities, enhancing productivity and value for money, and supporting broader social and economic development |
| Joint committee | An arrangement where the participating organisations use their statutory powers to establish a statutory joint committee. The committee has delegated functions or decision-making powers in respect of all the parent organisations collectively. Decisions do not need to be referred back to the boards of the participating organisations. Decisions are made by the committee collectively and it has a single terms of reference |
| Lead contracting | A contractual configuration where one provider organisation holds a service contract with NHS commissioners and subcontracts part of its performance to other organisations |
| Local authority (LA) | An administrative body in local government |
| Memorandum of Understanding (MoU) | A document that records the common intent and agreement between two or more parties. It defines the working relationships and guidelines between collaborating groups or parties |
| NHS England (NHSE) | Executive non-departmental public body of the Department of Health and Social Care. Responsible for overseeing the funding, planning, delivery, transformation, and performance of NHS healthcare in England |
| Payment by Results (PbR) | The payment system relying on national tariffs for certain HRGs |
| Place-based Partnership (PBP) | Collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community |
| Primary Care Network (PCN) | Introduced in the NHS Long Term Plan (2019), and bring together a number of GP practices to work collaboratively in a geographical area covering a population of 30,000 – 50,000 patients. They are non-statutory primary care collaboratives |
| Provider Collaboratives | Non-statutory partnerships of two or more NHS provider trusts to work at scale to deliver care |
| Provider Selection Regime (PSR) | A set of rules for procuring health care services in England that NHSE, LAs, ICBs, and NHS trusts must adhere to |
| Scheme of Reservation and Delegation | A reference document showing what authority a board has delegated to committees, other volunteers or staff under the powers of their constitution |
| Sustainability and Transformation Partnerships (STPs) | System level partnerships developed between health and care partners as a precursor to ICSs to support the delivery of the NHS Five Year Forward View (5YFV) at scale |

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| System control total (SCT) | Annual NHS financial target for an ICS area, based on the sum of individual organisation control totals |
| Voluntary, community and social enterprise organisations (VCSE) | A non-governmental organisation with a primary function of serving civil society |

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## 1. Introduction

This Working Paper presents findings from Phase 1 of the 'Post Implementation Review of the Health and Care Act 2022' project. Funded and directly commissioned by NIHR as part of the Policy Research Programme, this is a three-year research programme taking place between November 2023 and October 2026.

The Health and Care Act 2022 (the HCA 2022) aims to strengthen collaboration between organisations providing health and social care and expand the scope of decisions made through Integrated Care Systems (ICSs). Policy and guidance focus upon the potential for ICSs to effect change, but the evidence base linking inter-organisational collaboration to improvements in performance and outcomes is unclear. It is important to understand the impact of the HCA 2022 on collaboration and what changes as a result.

The aim of the research is to establish an evidence base concerning the development of collaboration in ICSs and associated impacts under the HCA 2022. More broadly, the research seeks to:

- Build an independent and robust evidence base on, and a national and local picture, of efforts to deliver integrated care and support across the newly established ICSs in England;
- Support Ministers and policymakers understand how the system is evolving following the legislative changes, and so inform future policy development; and
- Help the Department of Health and Social Care (DHSC), NHS England (NHSE), and other national organisations to better support ICSs

The specification asked that the research take a formative and process evaluation approach to exploring how collaboration and integration is developing at a system, place and neighbourhood level, and invited some early consideration of the range of potential impacts and outcomes where feasible, with suggestions of how these may be assessed. Additionally, the specification suggested that the study be delivered as a multi-phased project. Our research adopted a design split across Phase 1 (Year One), and Phase 2 (Years Two and Three). This report comprises our Phase 1 findings and reiterates our proposals for Phase 2 of the research, together with any proposed amendments in the light of Phase 1 findings. Phase 2 begins in November 2024 and concludes in October 2026.

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### 1.1. Policy background

Collaboration has always been an important behaviour in the English NHS, as illustrated by many empirical studies which describe the persistence of collaborative behaviour among commissioners and providers of NHS services since the establishment of the internal market (Bennett and Ferlie, 1996, Allen, 2002, Frosini et al. 2012, Porter et al. 2013). However, while cooperation was always a feature of NHS policy and legislation, the development of ICSs has accompanied a shift away from the architecture of the internal NHS market to foreground collaboration as the dominant mode of coordination. Accompanying the shift is an assumed link between collaboration and various ends, including the delivery of integrated services. It is hoped that increased collaboration in ICSs will lead to improved outcomes in population health and healthcare, reductions in inequalities in outcomes, experience and access, and enhanced productivity and value for money, in addition to helping the NHS to support wider social and economic development. In practice, the link between collaboration and impact on services is often unclear. As noted in the recent Darzi report, collaboration and integration should not be conflated (DHSC, 2024).

Previous legislation, the Health and Social Care Act 2012, had brought wide ranging changes to the NHS, and made a direct correlation between competitive behaviour in the NHS and competition law (Den Exter and Guy, 2014, Allen et al. 2015). During 2014, however, there was a significant policy development with the publication of *The Five Year Forward View* (5YFV) (NHS England, 2014), which did not emphasise the use of markets or competition between organisations and instead focussed on how organisations in the NHS need to cooperate with each other. The 5YFV proved an important indication of the direction of travel for the NHS. Alongside a focus on collaboration the FYFV also backed "diverse solutions and local leadership" facilitated by the emerging policy environment and national support (Checkland et al. 2019). Subsequently, although the legislative context remained unchanged, NHS policy explored various new care models which sought to achieve better co-ordination both within the NHS and with wider partners, such as Vanguards (see Checkland et al. 2019), Integrated Care Pioneers and the Primary Care Home model. These programmes all concerned developing innovative models to integrate health and social care, or different parts of the health service more effectively. For example, the Vanguards programme focused on various models, including integrated primary and acute care systems, multi-speciality community providers and enhanced health in care homes. Co-ordination between health and social care via the merging of funds was also encouraged by the Better Care Fund (BCF), which was introduced in 2013 and encourages integration by requiring ICSsand Local

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Authorities (LAs) to enter into pooled budget arrangements and agree an integrated spending plan.

Sustainability and Transformation Partnerships (STPs) were introduced in the English NHS in 2016 to bring together local NHS organisations and LAs (county/unitary councils) to develop joint plans to improve health and the quality of care to provide better services for patients in the areas they serve. ICSs were originally envisioned as an 'evolved' version of an STP, whereby NHS organisations would work together (often in partnership with LAs) as a locally integrated health system (NHS England, 2017, NHS England and NHS Improvement, 2018). STPs were in existence until April 2021 when the last remaining STPs in England gained ICS status.

The development of ICSs has accompanied a fundamental shift away from the architecture of the internal NHS market. The White Paper *Integration and Innovation: working together to improve health and social care for all* (DHSC, 2021) was published in February 2021, which contained the legislative proposals for the Health and Care Bill 2021. The subsequent HCA 2022 formally removed competition as the primary co-ordinating force in the NHS by changing the following key aspects of NHS systems: how competition law applies to the NHS; procurement requirements; and how the payment system operates. Until July 2022, ICSs had functioned as loose and informal networks and did not have any legal grounding. After the introduction of the HCA 2022, which came into effect on 1st July 2022, ICSs were formed of two legal entities (Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs)) with statutory functions and obligations.

**The operation of ICSs and system working under Health and Care Act 2022**

ICSs are partnerships between NHS organisations, LAs, and voluntary services, which are responsible for planning and delivering joined up health and social care services in England. There are 42 ICSs, covering populations from one to three million people. ICSs represent a shift in health and care policy in England from an emphasis on organisational independence, separation between the functions of commissioning and provision, and competition between providers, to focusing on collaborative working, collective planning of services, and collective accountability. Integrated care services are seen as a necessity in a context of people living longer with many long-term conditions and needing joined up care. The policy is expected to achieve improved health outcomes in local populations, reduce health inequalities, enhance productivity and value for money, and help the NHS to support wider social and economic development.

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A key feature of ICSs is collaboration between commissioners and providers in their local areas to improve population health and tackle inequalities. ICSs are three-tier arrangements, in which each ICS or 'system' area (population size 500,000 – 3 million) contains 'places' (population size of 250,000 – 500,000) and 'neighbourhoods' (population size of 35,000-50,000) within it. Because ICSs cover large geographical areas, they are not well suited to designing or delivering service changes to meet the distinctive needs of local populations. Service reconfiguration and integration is therefore expected to be driven by partnerships in smaller geographical areas, such as 'places' and 'neighbourhoods'. Neither places nor neighbourhoods are statutory bodies.

'Places' or 'place-based partnerships' (PBPs) operate typically at borough/LA level with LAs having a key role to play in collaborative commissioning decisions with health and care providers about population health, service redesign and long-term planning implementation (NHS England and NHS Improvement, 2019; NHS England, 2019). PBPs are considered 'foundations' of ICSs, building on existing local relationships and ways of working. Policy guidance intends ICSs will delegate commissioning decision-making and resources to PBPs (DHSC, 2021). It leaves it up to the partners of each ICS, however, to determine the footprint for each PBP, the leadership arrangements and the functions they will carry out (NHS England and NHS Improvement and Local Government Association, 2021). 'Neighbourhoods' (population size of 35,000-50,000) are based around Primary Care Networks (PCNs). PCNs are non-statutory and involve groups of GP practices within places, agreeing to work more closely with each other, as well as attempting to integrate better with community health care services and other local health and care organisations.

ICSs are comprised of two key statutory components: Integrated Care Boards (ICBs) which are statutory bodies responsible for planning and funding nearly all NHS services in their area, and Integrated Care Partnerships (ICPs), which are statutory committees of ICBs and local authorities and are formed by a wide range of partners such as NHS organisations, LAs, the voluntary, community and social enterprise (VCSE) sectors, and other local partners. The main function of ICPs is to produce and then monitor a five-year Integrated Care Strategy. ICBs are responsible for the NHS functions of their ICS, while ICPs are responsible for the wider population health targets.

ICBs have replaced Clinical Commissioning Groups (CCGs), the previous commissioners of NHS care. They have taken on the commissioning functions for acute, primary and mental health services in their local areas, as well as many of NHS England's commissioning functions (e.g. primary care, dentistry, optometry). Prior to becoming legal bodies, ICBs had to publish a

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constitution which had to be approved by NHSE and in which they described their board membership. They are unitary boards which, apart from certain mandatory membership specifications, have great flexibility and freedom to make decisions on further board representation and governance arrangements that best suit their local area. As a minimum, their membership must include a Chair, a Chief Executive Officer (CEO), and representatives from NHS acute care trusts, general practice, and LAs. They also must make sure that at least one board member has knowledge and experience of mental health services, and that they have appropriate clinical advice when making decisions.

ICPs are tasked with promoting partnership for developing a strategy which addresses the wider health, public health, and social care needs of the system. The system NHS organisations and LAs must have regard to the ICP Integrated Care Strategy when making decisions.

A further emerging structure in the new NHS architecture are provider collaboratives, which are non-statutory partnerships involving two or more health care providers to work at scale for the benefit of their populations, and which may operate at supra-ICS level, or may partially cover multiple ICSs. Provider collaboratives are further evidence of the shift in national policy from promoting organisational autonomy and competition to mandating collaboration and partnership working. From July 2022, all NHS trusts providing acute and mental health services were required to be part of a provider collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, are meant to be offered the opportunity to join a provider collaborative if it will benefit patients and make sense for the providers and the system (NHS England and NHS Improvement, 2021). Individual providers may be involved in more than one collaborative. NHS providers have been collaborating for many years. The difference now, however, is that collaboration is mandated, rather than encouraged. The HCA 2022 further supports system working by enabling NHSE to modify licence conditions to enable co-operation, and by introducing the 'Triple Aim' duty (a duty on NHS organisations to consider the effects of their decisions on the better health and wellbeing of everyone, the quality of care for all patients, and the sustainable use of NHS resources).

For many years, collaboration between providers was meant to exist alongside competition. The NHS Act 2006 had given all NHS bodies, including Foundation Trusts, a statutory duty to co-operate with each other. The HCA 2022 strengthened the duty to collaborate by extending it to local authorities and by removing the Secretary of State and NHSE's duties to promote provider autonomy, which had also been granted by the NHS Act 2006. In addition

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to a move from competition to collaborative working, the new policy guidance rests on the principle of subsidiarity and devolution of functions to local levels. ICBs are given the freedom and flexibility to delegate commissioning decision making and budgets to places, provider collaboratives or individual organisations (although accountability for system performance will rest with the ICB). Decision-making within the system may be also shared between the ICB and other organisations through the use of joint committees, joint appointments, and pooled funds. This means that many decisions for which ICBs are accountable will potentially be made at a level not referred to in the legislation. The Explanatory Notes to the Health and Care Bill 2021, indicated that no further legislation will address the issue of delegation or devolution of ICB functions to various system forums, with the expectation NHSE will work with ICBs on different models of delegation. After the HCA 2022, NHSE published guidance on delegation and joint working (NHS England, 2022d).

Another development to facilitate collaborative working is the changes to the procurement mechanisms. In order to stop enforced competition and utilisation of competitive tendering, which led to disruptive bureaucracy and fragmentation of services, Section 75 of the Health and Social Care Act 2012 has been repealed and replaced with a new system – the Provider Selection Regime (PSR). This new approach to procurement was first indicated in the Health and Care Bill 2021 and enacted in the provisions of the HCA 2022. The PSR gives NHS commissioners a wider range of options when commissioning health and care services and came into force in January 2024.

ICBs are responsible for the oversight of most NHS services and are directly accountable to NHSE for NHS spend and performance in their systems. They are also meant to provide strategic direction and facilitate collaborative working among ICS partners. Importantly, they have a duty to achieve a system financial balance by meeting the system financial objectives, known as system control totals (SCTs). Although ICBs cannot direct providers, the HCA 2022 created a new duty of providers to have regard to the system financial objectives, so both providers and NHS system bodies are collectively accountable for achieving financial control at system level.

The legislative changes gave ICBs stronger decision-making authority, and increased accountability for system performance. However, organisational sovereignty and the functions and duties of separate statutory bodies remained unaffected. It is also the case that, while allowing great potential freedom and flexibility to ICSs, the HCA 2022 also allows multiple opportunities for NHSE to withdraw or amend these freedoms. Furthermore, although the CQC – the quality regulator – is still responsible for assessing individual

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providers' performance, the HCA 2022 has extended its remit to a duty to carry out reviews and assessments of whole systems for the provision of NHS care and adult social care services. Importantly, the HCA 2022 allows the Secretary of State (SoS) to exercise a large degree of control over the running of the NHS in general, and NHSE in particular, for example, the power of SoS intervention in cases of major local service reconfiguration.

The new NHS architecture is a complex network of governance arrangements and accountability relationships. The permissive approach of the HCA 2022 and policy guidance allows great flexibility in the design of system governance arrangements and implementation of delegation of functions, consequently it is to be expected that there will be wide variation in the development of system partnership working.

### 1.2. ICS development post Health and Care Act 2022 – Empirical studies

A limited number of empirical studies have examined the development of ICSs in the period since the HCA 2022. As will be explored in more detail below, these studies indicate that ICSs are finding it challenging to achieve their objectives, as finances and performance management are crowding out longer term transformation work. LAs and wider partners are keen to increase the consistency and depth of their engagement with ICSs. Additionally, studies identified a lack of clarity regarding roles and responsibilities within systems, and between NHSE regions and ICBs.

Recent research examining the development of governance, accountability and decision-making in ICSs found that collaborative decision-making arrangements in ICSs are still under development (Sanderson et al. 2024). The research, based on case studies of three ICSs, found that forms of collaboration in systems were in transition, and the eventual nature and purpose of ICBs, ICPs, PBPs and provider collaboratives were largely undecided and speculative, and intentions regarding delegation of responsibilities to places and provider collaboratives were not settled. The proliferation of governance forums risked duplication and lack of clarity, and there were concerns regarding the blurring of accountability lines. Furthermore, the highly resource-constrained environment of the NHS coupled with the continuing financial performance management of individual provider organisations risked a retreat into organisational self-interests.

In their report detailing ICS leaders' view on the progress of ICSs in the year 2023/24, Bliss et al. (2024) found that while most ICS leaders were positive about the progress their local systems are making, there was frustration that performance management conversations focused almost entirely on finances were crowding out the longer-term transformation ICSs

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were established to deliver. ICS leaders were committed to shifting resource to allow more people to access more care closer to home but were struggling to match this ambition due to financial constraints. Additionally, there were concerns from leaders that accountabilities were not well defined between ICBs and NHSE's national team.

Two studies of ICSs in the period after the HCA 2022 have focused on the ICS role in relation to health inequalities. The pervasive influence of national policy on local collaboration in ICSs was also highlighted in a study examining how system partners are collaborating to reduce health inequalities (Alderwick et al. 2024). While leaders were committed to working together to reduce health inequalities, they faced a combination of conceptual, cultural, capacity, and other challenges in doing so. It was also the case that the national policy context was reported to be a hindrance to local efforts to reduce health inequalities. A further study focusing on the role and potential impact of ICSs on tackling inequalities (Checkland et al. forthcoming) noted that the governance structures to support health inequalities were well established in ICSs. However, some ICBs were cautious about distributing funding to places to allow them to tackle inequalities, asking places to bid for funding or distributing funding on an earned autonomy basis.

Other relevant studies suggest that success in focusing on prevention, population health and reducing health inequalities can be greatly facilitated by involving the local authorities and the VCSE sector in the structures of ICSs (Impower/County Council Network, 2022, Tiratelli and Naylor, 2024, Binks and Cunnet, 2023). In relation to Provider Collaboratives and VCSE organisations, Binks and Cunnet (2023) recommended that VCSE organisations should be engaged as early as possible to help them be recognised as transformational strategic partners within provider collaboratives, and that it is important to identify dedicated budget and resource to support the VCSE sector in playing an active part in provider collaboratives.

The role of LAs in ICSs was the subject of two studies (Impower/County Council Network, 2022, Tiratelli and Naylor, 2024). Tiratelli and Naylor (2024) drew on case studies to demonstrate that district councils are carrying out significant preventive work, which is being effectively harnessed by some ICSs, and suggest that this work now needs to be universally integrated across all ICSs to maximise its benefit.

A further study of the role of LAs put forward three main findings (Impower/County Council Network, 2022). Firstly, that central government attempts to control outcomes through central guidance or short-term funding was increasingly out of kilter with the growing diversity of arrangements between LAs and ICBs. Secondly, from the LA perspective the

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question remains as to whether ICBs are 'joint' endeavours or NHS bodies with some local government participation. Thirdly, for many LAs the most important partnership working occurs in places and the ICP, rather than the ICB.

Multi-layered leadership in ICSs was the focus of a further study (Bolden et al. 2023), which found that complexity of ICS structures and the competing priorities faced by their leaders made multi-level leadership both challenging and productive at the same time.

A survey of Directors of Public Health (The Association of Directors of Public Health, 2024) found that ICSs were still maturing and needed to ensure that ICS priorities were embedded within their work. The nature of 'prevention work' needed to be clearly understood by all partners and be accompanied by sufficient investment. The report also concluded that ICS partners should understand the wider landscape of health and wellbeing, including the work of Directors of Public Health, and the role of the voluntary and community sector.

In their study of how ICSs have developed since July 2022, Care England (2024) found that ICS leaders described significant change within their respective systems as a result of the HCA 2022, mainly owing to the required governance and accountability changes, but in particular the creation and divide between an ICB and ICP. ICBs' ability to quickly adapt was related to the maturity of partnerships, as well as the previous relationships and structures which existed. A recognised barrier to driving the integration agenda forward was the limited, or omissive, engagement with the adult social care sector.

### 1.3. Wider context

Phase 1 of this research was conducted during a time of significant change. During the fieldwork period in May 2024, a UK General Election was called. Following the change of government in July 2024, the Darzi report on the state of the NHS in England was published in September 2024 (DHSC, 2024). The implications of these events for our fieldwork are detailed in Section 2 (Methodology).

### 1.4 Research design

Phase 1 (Year One) of the research consisted of scoping activities to establish a national level evidence base to inform Phase 2 activities. In Phase 1 we undertook to: summarise the national legislative and policy context; interview national level leads responsible for steering the development of policy; investigate governance arrangements in ICSs; map baseline patterns of spending by ICBs; survey local Healthwatch regarding the extent of engagement with local ICSs; commence our scoping of potentially valuable outcome measures and

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datasets; and identify population groups most likely to benefit from better system collaboration. Our methods are described in more detail in Section 2, and in the Work Package (WP) findings in Sections 5 and 6.

Our plan for Phase 2 (Years Two and Three) includes in-depth qualitative case studies in two ICSs in WP3, exploring the operationalisation of the HCA 2022 and 'studying through' geographical levels and contexts. In addition, we will continue and develop the quantitative analysis commenced in Phase 1 WP2, focusing on: tracking resource allocation; considering how impacts could be measured; and identifying population groups that may benefit from increased collaboration and integration. Case studies will use 'exemplar' tracer populations requiring collaboration across multiple health and LA services (older people with frailty, and children and young people with complex needs) to explore co-operation, governance, leadership, accountability, population health management, workforce planning, service delivery and use of evidence in decision-making. Interviews will capture views across all ICS activities from ICB/ICP leaders and senior managers of system partners to frontline staff and patients, along with meeting observations and documentary analysis.

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# 2. Methodology

## 2.1. Aims and research questions (RQs)

The overarching aims for the project are to:

- Build an evidence base concerning the development and governance of collaboration in ICSs;
- Identify appropriate metrics for assessing the impact and outcomes of this collaboration;
- Disseminate findings to support local ICS practice, and;
- Support Ministers and policymakers with future policy

In service to meeting these aims, the following sub-aims and associated research questions, organised thematically below, will be addressed:

**Theme 1: Collaboration, leadership, and governance**

| **Aim:** Understand how governance and leadership arrangements are evolving to facilitate co-ordination across systems (between the ICB and ICP in each ICS, and between partner organisations (statutory and independent), and places and provider collaboratives) in different system contexts. |
|---|

RQ1a: How are governance structures and leadership arrangements developing to facilitate co-ordination?

RQ1b: How are accountability relationships developing within systems (including between diverse statutory, independent, and community-based organisations and bodies), and with regulators, to facilitate the achievement of system aims?

RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?

RQ1f: What functions, responsibilities and roles are evolving in PBPs and provider collaboratives, and are different types of commissioning functions evolving at different system levels?

RQ1g: How are systems utilising the flexibilities of the PSR to deliver more joined up services?

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In Phase 2, the following RQ will also be addressed:

RQ1c: How are organisations balancing system needs and organisational roles, responsibilities, and accountabilities? How are the new structures (ICBs and ICPs) and requirements of HCA 2022 facilitating the development of shared priorities?

RQ1d: How are ICBs using evidence, including evidence from research, in their decision making?

**Theme 2: Use of resources and outcome metrics**

**Aim:** Understand how ICS partners are working collaboratively to make better use of resources, and how impact and outcome of system collaboration might be measured.

RQ2a: Are systems making use of joined-up/pooled budgets? How are they doing this and under which circumstances?

RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?

In Phase 2, the following RQs will also be addressed:

RQ2b: How are ICPs and PBPs influencing ICB decisions on financial allocations?

RQ2c: How are systems approaching workforce planning, management and development, including across diverse statutory, independent and community-based organisations and bodies, and how is this changing use of resources?

RQ2e: Are ICSs able to change the allocation of resources and bring their local health and care economies into financial balance?

**Theme 3: Experiences of people**

**Aim:** Understand the experiences of people delivering and using services in the light of multi-level system changes made by ICSs.

RQ3a: How are ICSs incorporating patient and public perspectives into their development and operation?

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RQ3b: What groups are most likely to benefit from improved collaboration?

| In Phase 2, the following RQs will also be addressed:<br><br>RQ3c: What do tracer group service users say about changes in their experiences of using services, and to what extent might these be attributable to the development of ICSs?<br><br>RQ3d: Have frontline staff experienced any changes in their experiences of delivering care for tracer group service users that might be attributable to changes made by ICSs? |
|---|

**Theme 4: Health and wellbeing inequalities**

| **Aim:** Understand how ICBs and ICPs are addressing the duty to tackle health inequalities. |
|---|

RQ4a: How is the duty to tackle health inequalities embedded within the ICB governance structure, and how are broader wellbeing inequalities being addressed by ICBs and ICPs?

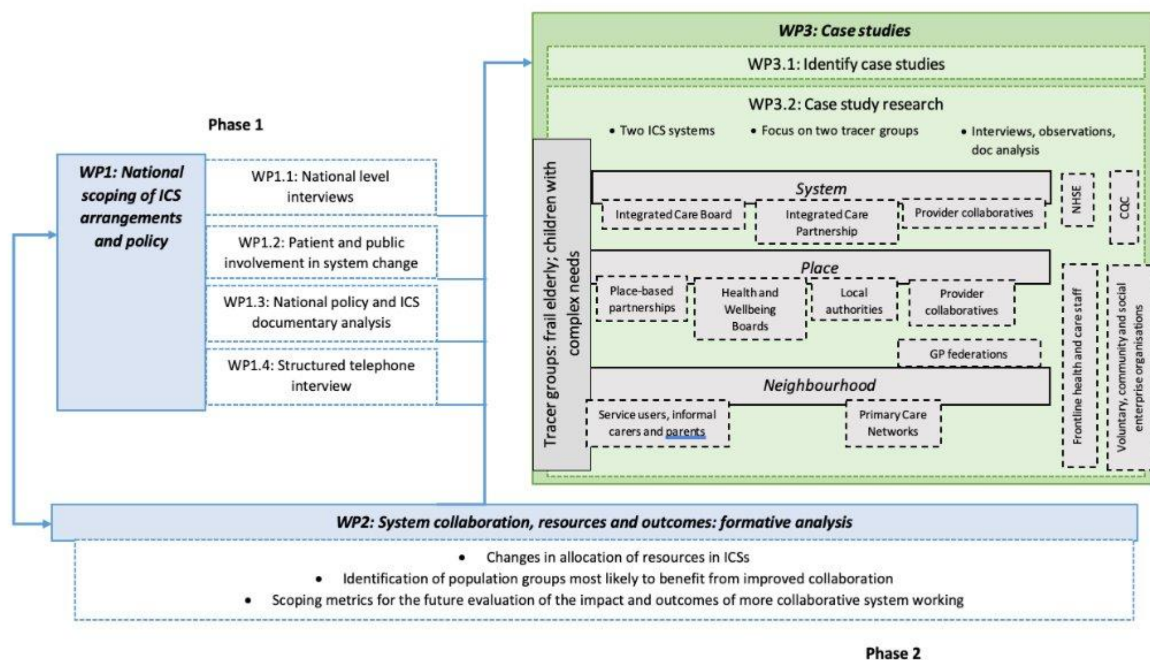


Figure 1: Health and Care Act 2022 Post-Implementation Review project overview diagram

This research project adopts a mixed-methods approach conducted across two Phases and three Work Packages (WPs) (see Figure 1). This methods section is concerned with Phase 1, which is focused on the national level. During this Phase, evidence was gathered relating to the views of policy stakeholders about the HCA 2022 and related policy, the varying nature of ICS governance arrangements, including delegations ICBs are making, approaches to public and stakeholder engagement, and potential patient group beneficiaries of enhanced collaborative activity. Potentially valuable outcome measures were scoped and collated, and work commenced mapping ICB financial flows.

Phase 1 of this study consisted of two WPs. WP1 spanned the entirety of Phase 1 and involved summarisation of the developing national legislative and policy context, together with some exploration of how arrangements are developing in ICSs. WP2 commenced in Phase 1 and will continue into Phase 2 until November 2025 (Years One and Two). It focuses on identifying a set of metrics that are useful to monitor outcomes of system working under the HCA 2022. In Phase 1, we adopted a broadly realist approach, which involves identifying and explicitly articulating 'programme theories' associated with the HCA 2022. These represent arguments made within policy documents and articulated by policymakers as to what the underlying problems in the health system are, and how the changes of the HCA 2022 are intended to address those problems. These are elaborated using the realist constructs of contexts, mechanisms and outcomes (Pawson and Tilley, 1997) in Section 4 (and developed further in Section 7.3.). This approach allowed us to understand programme theories embedded in the HCA 2022 and associated policy, assumptions underlying these changes, and how these theories of change have informed the design of the Act and policy.

## 2.2. Ethical approval

NHS research governance approval from the Health Research Authority (HRA) was granted on the 27th April 2022 (IRAS ID: 331742; Protocol number: 2024-KEP-1046; REC reference: 23/HRA/4345). Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine internal ethics committee on the 13th February 2024 (Ref: 29818). We participated in a streamlined NHS research governance approval process. Due to the low burden nature of this study and the seniority of the research participants, we were not expected to separately notify this project to the Research and Development office of each NHS organisation from which we sought participation. The seniority of the research participants meant that the research participants were themselves the most appropriate parties to confirm whether they were willing to participate.

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## 2.3. Timeframe of research

The main data collection activities took place between May and October 2024. Below table shows the timeline for each WP:

| **Work Package 1: National scoping of ICS policy and governance arrangements** | |
|---|---|
| WP1.1 National level interviews | May – October 2024 |
| WP1.2 Patient and public involvement in system change | May – June 2024 |
| WP1.3 National policy and ICS documentary analysis | April – September 2024 |
| WP1.4 Structured telephone interviews with ICB Directors | September – October 2024 |
| **Work Package 2: System collaboration, resources and outcomes: formative analysis** | November 2023 – October 2024 |

Table 1: Timeline of data collection activities during Phase 1

Work Packages 1.1 and 1.2 were interrupted by the General Election, which was announced on the 22nd May 2024, and took place on 4th July 2024. Between these dates, research activities for WP1.1 and WP1.2 were suspended in line with advice from DHSC and NIHR. For WP1.1, we stopped conducting interviews during this period but continued to arrange them for the post-election period. We resumed the interviews after the election. For WP1.2, the nationwide survey of Healthwatch leads to understand patient and public involvement in system change was closed prematurely, ten days earlier than the planned date. The option to re-open the survey following the election was discussed but the team decided that was not practically feasible, owing to the other project activities to be completed, or necessary, given a high number of early responses already collected.

While the interruption of the study did not affect the data quality, it has led to delays in conducting the interviews, which eventually tightened the timescale for the analysis of the data. The following section briefly discusses methods used on each WP. More detailed methods are given in each of the findings sections (Sections 5 and 6).

## 2.4. Phase 1 methods

Methods for WP1.1-1.4 and WP2 are reported in detail in their respective findings sections (Sections 5 and 6). For clarity and accessibility, the RQs addressed by each WP and the section reference for their methods are presented below:

- WP1: National scoping of ICS policy and governance arrangements (months 1-12)
  - WP1.1 National level interviews (RQ1b, 1e; RQ2d, RQ3b); Section 5.1.2

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    - WP1.2 Patient and public involvement in system change (RQ3a); Section 5.2.2
    - WP1.3 National policy and ICS documentary analysis (RQ1a, 1e, 1f; RQ4a); Section 5.3.4
    - WP1.4 Structured interviews with ICB Directors (RQ1e, 1f, 1g; RQ2a); Section 5.4.2
- Work Package 2: System collaboration, resources and outcomes: formative analysis (Months 1-24; RQ2d,e, RQ3b); Section 6.1. and 6.3.2

### 2.5. Deviations from the original research design

Included in the original research design was the intention to conduct five in-depth interviews with local Healthwatch leads as a follow up to the national Healthwatch survey undertaken in WP1.2. Respondents who expressed an interest in taking part were contacted, however no interviews were secured due to non-response by potential participants, non-attendance at scheduled interviews by the interviewee, and inability to schedule interviews within the timescales required due to the interviewees' availability. More in-depth engagement with Healthwatch leads – and patients and the public directly – will take place as part of the original Phase 2 plans.

In relation to WP1.3 we undertook to collate content from ICS plans which related to the tracers which will be use in Phase 2 of the research (older people with frailty and children and young people with complex needs). We investigated whether the collation of content from the ICB Joint Forward Plans would possible, however we chose not to commence this work as the information in the Joint Forward Plans was generally not presented at the right level of specificity to allow us to draw any meaningful conclusions as a result of this collation.

In relation to our research questions we originally undertook to address RQ1g: 'How are systems utilising the flexibilities of the Provider Selection Regime to deliver more joined up services?' in Phase 1 of the research. However, due to the complexity of this question and the relatively recent introduction of PSR, we decided to defer this question to Phase 2 of the research, where it will be addressed as part of the WP3 case study research.

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## 3. Patient and Public Involvement and Engagement

The team are committed to patient and public involvement and engagement (PPIE) throughout the project. This is operationalised at two levels: as strategic partners across Phases 1 and 2, and in Phase 2 in the WP3 case sites.

### 3.1. Recruitment

The Centre for Health Services Studies (CHSS), University of Kent, led the PPIE work. CHSS has a standing PPIE group - the 'Opening Doors to Research group' (ODRG)[1]. In November 2023, two members of the public from this group responded to an expression of interest to join the research team. They were selected based on their interest in health and social care policy and experience in relation to our tracer groups (older people with frailty, and children and young people with complex needs).

### 3.2. Activities completed in Phase 1

A meeting structure was agreed with our PPIE members consisting of monthly online meetings with the PPIE lead and quarterly online meetings with the research team, as well as email correspondence. The purpose of the first meeting was to meet the team, gain an overview of the project, negotiate roles, activities and timelines, and agree payment arrangements. The PPIE members requested and received a summary of definitions and acronyms to enable them to participate in the ongoing discussions. Activities so far have included:

- Written feedback on the national level policy stakeholder interview schedules (WP1.1)
- Feedback on the Healthwatch survey (WP1.2)
- Feedback on the Phase 2 ethics and governance application

PPIE members are also members of the project's Research Advisory Group which has met twice since the project started. We are keen to ensure that members feel supported to take an active role in these meetings. Therefore, we held a pre-advisory group meeting for the first meeting to talk through the membership of the group, its purpose and terms of reference, with the option of a follow-up meeting or 'debrief' if necessary. PPIE members have access to a suite of training materials provided by the ODRG. Re-numeration is paid according to national guidelines.

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[1] CHSS ODRG https://research.kent.ac.uk/chss/patients-carers-the-public-and-research/opening-doors-to-research-group-2/

### 3.3. The impact of PPIE

There is little documented evidence on the impact of PPIE in national policy research and we are keen to capture this. To do this, we created an impact log to record and monitor activities. This includes a record of PPIE comments and contributions, the research team's reflections on those contributions, and the impact on the project. Items are cross-referenced to the NIHR UK Standards for Public Involvement[2] of inclusivity, impact, support and learning, governance, working together, and communication. For example, feedback on the Healthwatch survey linked to inclusivity, support and learning, working together, and communication.

As part of capturing impact and ongoing feedback, four researchers, including the two Co-Principal Investigators, and the two PPIE members were asked to assess the value of PPIE in the project. In particular, what has worked well and whether there are any challenges that need to be overcome. A summary of responses is outlined in Appendix A. [n. b. redacted in the working paper v1.2]

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[2] NIHR UK Standards for Patient Involvement https://sites.google.com/nihr.ac.uk/pi-standards/home

# 4. Realist-informed National Policy Document Analysis

## 4.1. Introduction

This element of Phase 1 forms part of WP1.3, which focuses on national policy and ICS documentary analysis. Section 5.3. addresses ICS documents specifically but the national policy document analysis holds broad relevance across the other WPs presented and will thus be considered here separately in order to provide context for subsequent sections of the report.

Policy document analysis fulfils a number of purposes in research of this kind, including: establishing a foundational understanding of the policy's aims and mechanisms, how these and related content may change and develop over time, and how the policy is presented to stakeholders. It can also serve as a basis for comparison with, and interrogation alongside, other data sources such as interviews and observations. Of particular analytical value are the insights into what explicit or implicit expectations might underly a policy, including how it is intended to realise the objectives associated with it, and what potential tensions or assumptions might feature in these. Adopting a broadly realist approach to policy analysis (Pawson and Tilley, 1997) offers a conceptual tool kit for this. This involves identifying and explicitly articulating 'programme theories', i.e. the arguments made within policy documents and articulated by policymakers as to what the underlying problems in the health system are, and how proposed changes will alleviate those problems. These can then be elaborated using the realist constructs of contexts, mechanisms and outcomes (CMO). In keeping with our previous large scale health reform evaluation projects (Checkland et al. 2018) in this study we define these constructs as follows:

- Context: the case for change and the issues to be addressed;
- Mechanism: policy provision and properties of new system intended to deliver certain results; and
- Outcome: the desired or expected results of relevant changes

In this report, this approach will allow us to understand programme theories embedded in the HCA 2022 and associated policies overall. In Phase 2, we will explore how these translate to enacted programme theories within systems. As such, this is a multi-scalar approach from the 'national' or policy level through the different tiers of systems and the realities of practice on the ground. Over the course of the project as a whole, it will allow us to demonstrate how

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theories implicit in national policy create conditions for implementation challenges and complexities, which we will study through our case studies and tracer groups.

The policy analysis presented here draws on engagement with a broad range of policy and guidance documents, including the HCA 2022 itself, as well as web pages and video content. These sources are specified in Appendix B.

### 4.2. Programme theories underlying the Health and Care Act 2022 and the introduction of Integrated Care Systems

We first set out an overarching CMO configuration derived from the HCA 2022 and the associated policy framing relevant to ICSs and collaboration. From a broad realist analysis perspective, breaking this down into context, mechanisms, and outcomes can be understood as addressing the questions 'What is the context of the Act and this broader policy and, in particular, what are the problematic aspects of this that are intended to be addressed?'; 'What details of the Act and associated developments will lead to change?'; 'What are the expected and desired results associated with implementing these changes?'

| Context (the case for change) |
| --- |
| Demographic and social changes in England, including an increasing older and multi-morbid population, mean that the health and care system needs to adapt to be able to respond effectively.<br>The response to the COVID-19 pandemic highlighted the need for a more integrated and efficient health and care system.<br>Health inequalities are increasing and need different ways of working to tackle them more effectively. |
| **Mechanisms (changes that will enable desired results)** |
| The three key themes of the Act, which derive from the Long-Term Plan, contain broad mechanisms:<br>Working together and supporting integration: The establishment of Integrated Care Systems (ICSs) will foster collaboration across health and social care, breaking down silos and promoting joint decision-making.<br>Reducing bureaucracy: Streamlining processes to minimise administrative burdens, including via the reduction of forces of competition, allows healthcare professionals to focus more on patient care.<br>Ensuring accountability and enhancing public confidence: Measures to ensure that healthcare organisations are accountable to staff and service users are intended to enhance transparency and responsiveness. |
| **Outcomes (desired results)** |
| The overarching aim of these changes is to support the system to help people to live healthier, more independent, longer lives. The outcomes supporting this are improved |

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| patient care, reducing health inequalities, and creating a more responsive and efficient health and care system. ICSs will support health and care organisations to collaborate to more effectively tackle complex challenges.<br>ICSs themselves are explicitly intended to:<br>• Improve outcomes in population health and healthcare<br>• Tackle inequalities in outcomes, experience and access<br>• Enhance productivity and value for money<br>• Help the NHS support broader social and economic development |
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Table 2: Overarching Health and Care Act 2022 and ICS CMO configuration

This broad CMO configuration can be broken down further, or rather the mechanisms within the key themes can be split out and addressed individually (albeit with some overlap between them) as central elements of their own CMO configurations. This is undertaken for each of the three key themes in Tables 3-5 below. Note that the mechanisms in bold are those that specifically feature in the HCA 2022 itself. In the Figures below we break down these CMO configurations to focus more specifically on the overall aims of the project, particularly around how partner organisations in ICSs are working together. We recognise that other provisions within the Act, and related policy, also have relevance and significance to understanding these three themes in a broader sense and at different scales. We recognise also that these CMO configurations are not exhaustive. Rather, we have included those elements of the Act which link most closely to our overall aims and research questions.

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| Context (the case for change) | Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
|---|---|---|
| • Health and social care provision is fragmented<br>• Collaboration needs to be strengthened as an organising principle both within the NHS, and between NHS organisations and local government<br>• Insufficient collaboration will particularly affect people and communities with the greatest need | • Establishing Integrated Care Boards (ICBs) in law and requiring the establishment of Integrated Care Partnerships<br>• New shared duty requires those NHS organisations that plan services together to have regard to the 'triple aim' of better health and wellbeing for everyone, better quality of services for all individuals, and sustainable use of NHS resources (including having regard to inequalities in health and wellbeing and inequalities in the benefits from services<br>• The CQC will assess each system for how well it provides healthcare and adult social care in each ICB (including how well partners work together).Duty to co-operate between NHS bodies, and between NHS bodies and local authorities<br>• Joint appointments between organisational types (e.g. commissioning and providing orgs; NHS and LAs).<br>• Joint Committees, collaborative commissioning and delegated functions<br>• ICP creates an Integrated Care Strategy to allow people, communities and a range of local organisations to develop evidence based, system-wide priorities. This will set out how assessed local needs will be met by the ICB, local authorities, and NHSE<br>• Prescribed ICP membership makes health and social care equal partners, and Local Authorities will have a role in nominating members to the ICB<br>• Place-based Partnerships will play a central role in planning and improving health and care services, identifying and responding to population need<br>• Provider Collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements | • Formalisation of collaboration through establishment of ICBs and ICPs will enhance collaboration<br>• Triple aim will encourage bodies to work collectively, and in the best interest of the wider population<br>• CQC reviews will help improve systems by identifying their strengths and the challenges they face, and bring greater transparency in the quality of care provided in ICSs<br>• Duty to co-operate will strengthen the impetus for individual organisations to work together and requires them to consider how to cooperate effectively<br>• Increased freedom to make joint appointments across organisational types can help to foster joint decision making, enhance local leadership, reduce management costs, engender collective responsibility and improve the delivery of integrated care<br>• Increased ease for bodies to discuss integrated care without workarounds<br>• Collaborative strategy development will identify transformative change to tackle challenges. Priorities of collaborative strategy will drive a unified focus<br>• Prescribed membership of ICP and ICB makes health and social care equal partners<br>• Local Authority participation will drive integration through pooled budgets and joint working arrangements<br>• The health and care system will be more cohesive as a result of increased resources pooling and more effective service co-ordination. This will improve patient outcomes, reducing duplication, and improve efficiency |

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| | • Principle of subsidiarity: that decisions should be taken closest to whom they affect. Stakeholders within systems will collaborate at sub-system levels (places and neighbourhoods) to meet the distinct needs of local populations | • Improved integration will allow health inequalities to be addressed<br>• Place-based Partnerships will improve the quality, co-ordination and accessibility of health and care services to better meet the needs of people and communities, and build coalitions across a range of community partners<br>• Provider Collaboratives will reduce unwarranted variation and inequality in health outcomes, access to services and experience, improve resilience by, for example, providing mutual aid, ensure that specialisation and consolidation occur where this will provide better outcomes and value<br>• Decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes<br>• Collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity, local flexibility will allow systems to identify the best way to improve the health and wellbeing of their populations |

Table 3: Working together and supporting integration CMO configuration

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| Context (the case for change) |
| --- |
| • Collaborative working approaches and models between NHS and other partners have been established, but these are hamstrung by complex accountability arrangements connected to the Health and Social Care Act 2012 and quasi-market provisions<br>• Legislative provisions around competition can be inflexible and a barrier to collaboration within the NHS<br>• Centralised decision-making |
| **Mechanisms (changes that will support realising desired results)** |
| • Repeal S75 of the Health and Social Care Act 2012 and created new Provider Selection Regime<br>• Shift from competitive retendering to collaborative delivery models as part of an overall increased emphasis on collaboration and de-emphasis of competition<br>• Removal of the Secretary of State and NHS England's duties to promote provider autonomy<br>• Changes to National Tariff<br>• Removal of Monitor's competition functions (rather than moving them to NHS England)<br>• Merging of NHSE and NHS improvement<br>• Provisions to support greater flexibility in delegating and jointly exercising statutory functions across NHS bodies and local government |
| **Outcomes (desired results)** |
| • Reduced bureaucratic fragmentation leading to more efficient resource use and more joined up provision<br>• Swifter, more efficient decision-making processes in Systems<br>• Regulatory arrangements and oversight simplified, aligning a more integrated national landscape with more integrated local systems and creating clearer lines of accountability for the bodies underneath it<br>• Reduced need to 'workaround' rules and provisions<br>• New pricing and payment approaches that move beyond simple activity-based prices will support moves towards collaboration and integration within the NHS<br>• Delegation and joint exercise functions will streamline decision-making and reduce duplication of efforts<br>• Allow NHS England to focus more on improvement in the quality of care and use of NHS resources, and on the development of integrated care<br>• Increased staff morale and retention, as well as improved patient care, as healthcare workers can dedicate more time to clinical duties rather than administrative tasks |

Table 4: Reducing bureaucracy CMO configuration

| Context (the case for change) |
| --- |
| • The Health and Social Care Act 2012 resulted in complex accountability mechanisms at local and national level |
| **Mechanisms (changes that will support realising desired results)** |
| • Establish ICBs and ICPs in legislation<br>• NHS Digital, NHSX and Health Education England are incorporated into NHSE. NHS Trust Development Authority (TDA) and Monitor functions are incorporated into NHSE<br>• NHSE and NHS Improvement merged (largely completed pre-HCA 2022)<br>• Care Quality Commission reviews of ICSs |

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| • Secretary of State new powers to direct NHS England and intervene in local service configurations, aiming to ensure that national and local health bodies are accountable for their performance<br>• New shared duty requires those NHS organisations that plan services together to have regard to the 'triple aim' of better health and wellbeing for everyone, better quality of services for all individuals, and sustainable use of NHS resources (including having regard to inequalities in health and wellbeing and inequalities in the benefits from services<br>• NHSE to conduct and publish a yearly performance assessment of each ICB in respect of each financial year, including an assessment of how well the ICB has discharged its duties concerning the improvement in quality of services, reducing inequalities, obtaining appropriate advice, public involvement and consultation, financial duties and the duty to have regard to assessments and strategies<br>• NHSE given power to set an annual capital expenditure limit for NHS Foundation Trusts where there is a risk they might breach the local spending envelope |
| **Outcomes (desired results)** |
| • Embed accountability for system performance and delivery into the accountability arrangements of the NHS to Government and Parliament<br>• A broad range of health and care organisations will be more accountable to staff and service users<br>• CQC reports will provide an independent assessment of how well areas are performing providing decision-makers and the public with information about the quality and care and joint working within each area.<br>• NHSE/Improvement merger will enhance corporate governance and clarify accountability to Government and Parliament<br>• Foundation Trust spending will be limited where necessary in order to make better overall use of capital investment |

Table 5: Ensuring accountability and enhancing public confidence CMO configuration

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### 4.3. Discussion

This section represents the first stage of an ongoing realist-informed analysis process. The results from the sections that follow, which address the specific Phase 1 WPs, will be used to consider these CMO configurations further in Section 7.3. The CMO configurations developed here provide an initial insight into how key elements of the HCA 2022 were intended to meet policy aims, although it should be acknowledged that the connection between mechanism and outcome is not always clear in policy documents. It should also be emphasised both that (a) a range of mechanisms can be associated with the objectives aligned with each of the three themes, and (b) mechanisms may be mutually reinforcing or contingent, i.e. the ability to successfully enact some may depend on the successful enactment of others. This is made explicit in the 'Health and Care Act 2022: core measures impact assessment' (DHSC, 2022a) What is presented above is a distillation that focuses on mechanisms most

closely associated with specific outcomes in the documents overall, omitting others in the interest of clarity.

This developing realist-informed analysis of the policy will be carried through into Phase 2 and the case study work in systems and reported with additional depth and detail in the final project report. This overall approach facilitates an examination of seen and unforeseen potential conflicts, complexities, and relevant synergies across scales (from the national policy-setting level to neighbourhood level).

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# 5. Work Package 1: National scoping of ICS policy and governance arrangements

## 5.1. Work Package 1.1: National level interviews

### 5.1.1. Introduction

This sub-WP involves national level interviews with a variety of policy stakeholders including some responsible for steering the development and implementation of the Act and associated policy, particularly individuals from government departments and arm's-length bodies, as well as a range of stakeholders from other organisations and representative groups, advisors, regulators, and thought leaders.

WP1.1 primarily addresses the following RQs:

- RQ1b: How are accountability relationships developing within systems (including between diverse statutory, independent, and community-based organisations and bodies), and with regulators, to facilitate the achievement of system aims?
- RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?
- RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?
- RQ3b: What groups are most likely to benefit from improved collaboration?

This sub-WP also presents an opportunity to refine and develop the realist-informed national policy document analysis in Section 4 above. In the Discussion in Section 7.3, the CMO configurations developed previously are considered further calling on some of the findings presented thematically in this section.

### 5.1.2. Methods

Fifteen (15) interviews in total were conducted remotely (by JH, MSan, MSur; via Microsoft Teams) between May – October 2024. Interviews typically lasted 50-60 minutes. Interviewees were asked to reflect on: their interpretation of the purposes of the HCA 2022 and ICSs; how these aims might be addressed to; their understandings of how systems are working in practice currently, accountability relationships and dynamics, delegation arrangements; what metrics might appropriately reflect ICS activity related outcomes; and what patient population groups might most feasibly stand to benefit from increased integration and collaboration associated with ICSs and the HCA 2022. The

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emphasis on questions relating to these, and connected, areas, varied between interviews according to the role, experience, and expertise of the interviewee.

Interviewees included individuals that worked in roles of relevance to the creation, implementation, and/or developments associated with the HCA 2022. They were employed by Government departments, arm's-length bodies, and various stakeholder organisations. Due to the relatively small cohort of interviewees in WP1.1, findings from these interviews are reported without additional detail regarding the employer or role of interviewees, either here or in the extracts presented in the results below. Direct extracts from, and references to specific points made, in interviews are denoted with a four-character interviewee pseudonym code and the month and year that the interview took place, in square brackets, e.g. [IG30, May24].

Interviews were audio recorded and professionally transcribed. Transcripts were pseudonymised and uploaded to NVivo for analysis. A coding framework was developed collaboratively by JH, MSan, MSur, PAV. In the initial phase of analysis, a handful of transcripts were double coded by the team, and the utility of the initial coding frame was discussed, leading to its iteration and development.

### 5.1.3. Results

Findings are presented here according to themes developed iteratively through a process of engaging with topic guide focal areas, the content of interviews, and sensitivity to the relevance of the policy documents analysed as part of WP1.3. and presented above in Section 4. These themes are: 'HCA 2022 aims, mechanisms and structures'; 'Governance, accountability and oversight'; 'Delegation, subsidiarity and place'; 'Flexibility, permissiveness and variation'; 'Commissioning'; 'Patients and population'; and 'Outcome metrics and indicators.' The themes connect and interact in various ways and should not be thought of as distinct containers. Instead, they provide a frame primarily to support the accessibility of the findings.

**The HCA 2022 aims, mechanisms and structures**

Interviewees were asked to explain their understanding of what problems the HCA 2022 was intended address and what it might achieve, with a particular focus on ICSs in terms of the legislation itself and the broader policy environment. They were also asked to reflect on mechanisms and structures of the Act and associated guidance and policy, and how these may support the realisation of policy intentions.

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Central to interviewee responses about the Act's aims was the shift away from competition towards collaboration as a central animating force within the health and care system [W570, Jul24; Q6N2, Aug24]. This specifically included the removal of legislative barriers, particularly those associated with the Health and Social Care Act 2012 [A01D, Sep24] (the 2022 Act was described by one interviewee as an "unwinding" of the 2012 Act [JE40, May24]), which necessitated certain workarounds within Systems [Q6N2, Aug24]. Thus, the HCA 2022 was seen as an effort to facilitate the collaborative work that was already going on within systems to more effectively provide services for changing population demographics and needs [HD90, Aug24; JE40, May24]. The response to the COVID-19 pandemic was seen as an important part of the context driving this move towards more explicit collaboration [SOPL, Sept24]. Changing procurement rules with the introduction of the PSR to de-emphasise the role of competition (yet retain it as one of a range of tools that may be used in service orchestration) was also cited in this context [JE40, May24]:

> "The provider selection regime was another element, although I think really, if you like, the primary legislation, rather unusually, was a sort of enabling, very broad enabling power, and then we did a lot of the heavy lifting through the regulations, which took quite a long time to kind of work up and negotiate across government, but which are now in place. And that again, introduces [...] quite a lot of flexibility, it also, you know, there's a lot of rigor in there as well." [Q6N2, Aug24]

There was also a broader character to this objective articulated by interviewees, i.e. that the HCA 2022 had an important role in giving stakeholders within systems 'permission' to instil collaboration as a key operating principle. As such, it was a 'signal' to NHS organisations and stakeholders that this was an entirely legitimate and reasonable way to proceed [Q6N2, Aug24] and embeds in statute that integrated working is desirable [IG30, May24; Z3PH, Sep24], setting "...a different kind of context or tone" [FIJ1, Sep24]. There was a suggestion from one interviewee that it was important to make sure systems felt that they were empowered to operate more in this way, even when the barriers to doing so already might not have been as firm as perceived:

> "...very often people think there are technical and legal barriers in the way to do things, that actually there aren't when it comes down to it" [HD90, Aug24]

The HCA 2022 and related guidance reduced this ambiguity and allowed system stakeholders to operate collaboratively with more confidence.

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Interviewees highlighted the four purposes of ICSs: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience, and access; enhancing productivity and value for money; helping the NHS support broader social and economic development. In some cases, there was recognition that, although these do not feature in the legislation, they have been widely recognised as fundamental to the endeavour and "taken to heart" [Q6N2, Aug24] by a broad range of stakeholders within the NHS and thus are aligned with its overarching aims [FIJ1, Sep24; A01D, Sep24]. There was a particular lack of specificity about the means or mechanisms for realising broader social and economic development beyond general aspirations to improve the health of the population and thereby contribute to improvements in economic productivity levels [OD20, May24; FIJ1, Sep24, Z3PH, Sep24].

One key mechanism was highlighted as the duty to collaborate [FIJ1, Sep24], and with that the HCA 2022 is used to "...deliberately blur responsibilities" to make addressing entrenched health inequalities for a given population all stakeholders' responsibility within an ICB [20T3, Sep24], i.e. more closely binding stakeholders together in terms of responsibility and decision-making [OD20, May24; 20T3, Sep24; HD90, Aug24]. Collaboration, however, was not seen as "... hardwired into the ... way of working in the system" at large [Q6N2, Aug24]. As one interviewee noted:

> "The law can't make people behave, I mean it can a bit, but you can't just decree thou shall collaborate from the centre and people will work together, it doesn't work like that. I think what it did was give the people who wanted to do more collaboration, the people who wanted to start thinking of systems, ammunition in that argument and was a very clear marker that the way the government was viewing the health service had changed. That it was no longer a competition-y, market-y place and it was in a much more collaborative place." [SOPL, Sept24]

Importantly, successfully embedding collaboration requires setting out clear expectations and requirements of organisations around joint working so that they do not drift back towards focusing primarily on addressing their local organisational accountabilities at the expense of collaboration (this is explored more in 'Governance, accountability and oversight' below) [Q6N2, Aug24]. The Act was seen as facilitating collaboration in various ways, however, such as making the formation of joint committees and joint appointments easier [JE40, May24].

It was highlighted that the HCA 2022 made delegation possible, and the policy emphasises the importance of subsidiarity, i.e. that decisions should be taken closest to whom they affect



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(see ‘Delegation, subsidiarity and place’) [20T3, Sep24]. Facilitating broad and diverse membership of ICBs (in contrast with CCGs which were GP membership organisations), which are then linked to a broader set of strategic partnerships via the ICP, was also presented as a particular advantage of the changes [W570, Jul24].

ICPs were identified as an important structure introduced via the Act, crucial to delivering its holistic objectives [FIJ1, Sep24; A01D, Sep24; Z3PH, Sep24], and their Integrated Care Strategies a helpful requirement in pursuit of improving population health [JE40, May24]. Having a forum that brings together a wider range of partners – and provides a key space for local government and NHS organisations to come together – was highlighted as a positive development [OD20, May24; A01D, Sep24]. As was the fact that the ICP allows all relevant LAs to be involved, something which was perceived as too difficult to achieve within an ICB [SOPL, Sep24]. Clarity is lacking, however, about what their specific role is and there is some confusion about exactly how they relate to Health and Wellbeing Boards and ICBs themselves, according to one interviewee [OD20, May24]. In some cases, they are perceived as duplicative of the Health and Wellbeing Board, and there is a lack of specificity about the ICP should be doing beyond writing the Integrated Care Strategy for a system [I310, Apr24]. One interviewee suggested that the acronym soup of ICSs, ICBs, and ICPs had fuelled ambiguity and conflation around the entities and their respective roles and responsibilities [Z3PH, Sep24].

There was a broader opinion that ICPs have struggled to find their purpose and identity, and exercise power in relation to tackling the wider determinants of health, particularly in a context of financial pressures within systems [IG30, May24]. There is a danger that in some Systems, the ICP operates more as a “talking shop” [PV50, Jul24] and “lacking teeth” [A01D, Sep24], due in part to the minimal expectations of them in the guidance. Addressing this may require a different approach from DHSC and NHSE [IG30, May24], and the ICP’s lack of an ability hold the ICB to account in some way was argued to be regrettable [PV50, Jul24]. It was also argued, however, that ICPs hold significant latent power via their role in developing the Integrated Care Strategy, to which other system stakeholders are obligated to have regard, and which has the potential to set a significant strategic direction for the system [SOPL, Sep24]. The exercise of this power is contingent, to an extent, on the degree to which LAs are able and motivated to think about and steer healthcare matters [SOPL, Sep24].

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**Governance, accountability and oversight**

This theme relates to issues of governance and accountability both within ICSs, i.e. 'horizontal', and the more 'vertical' dynamics and relationships relating to ICBs, and their constituent organisations, and central bodies.

Some interviewees noted that the provisions in the HCA 2022 regarding the composition of ICBs were deliberately intended to blur boundaries of commissioning and providing by getting the relevant organisational stakeholders together as much as possible [Q6N2, Aug24]. The requirement that members be drawn from local providers such as NHS trusts and Foundation NHS trusts, but also ensuring the financial health of the system was a shared responsibility [20T3, Sep24], were specifically highlighted in relation to this.

There was reportedly an intention from some policymakers during the HCA 2022's development to find a way to establish shared accountability structures across NHS organisations and local government in service to this 'binding together.' It was argued by some that to deliver health and care improvements for populations via improved integration, it was necessary to meaningfully connect NHS service provision with social care and prevention (which largely sits with local government as part of the public health function) through such shared structures:

> "…unless we get a significant change in the way the NHS relates to other bits of the public health and particularly social care, but also prevention, we are unlikely to have a sustainable health system into the long-term, which you will find many people, in various ways, agreeing with. They might have different conclusions about what they do, but that's a reasonable hypothesis.
>
> But in the end, that sort of single structure, we couldn't make it work, basically. NHS England were worried about the accountability consequences of it" [Q6N2, Aug24]

As the extract suggests, these aspirations were relinquished during the development of the Bill due to specific concerns. These concerns include local governments' established governance processes around local democracy and decision-making, and the "fuzzy" accountabilities and potentially unhelpfully divergent views of LAs sitting as ICB members [SOPL, Sep24; Z3PH, Sep24]. It was seen as important not to legislate in a manner that could impede, or be seen as interfering with, these processes and conventions [HD90, Aug24]. Consequently, there was a recognition that the HCA 2022 did not alter the fundamental accountabilities of NHS bodies and local government with regard to each other and that integration of health and social care remained a stubborn challenge for various reasons:

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"...the reality is it's still very, very difficult to integrate health and social care after the '22 Act. Because, as you know, it was separate budgets, separate planning cycles, separate political accountability, separate provider landscape, separate staff career structures, the list goes on and on and on." [JE40, May24]

Multiple interviewees highlighted the lack of clarity around governance arrangements within ICSs as being problematic. This is a key issue when attempting to operate in a more networked governance mode, such as ICSs are. It creates particular challenges around representation and uneven influence amongst stakeholders, and this inherent inequality in terms of the power to shape decisions is not being fully and explicitly engaged with within systems [W570, Jul24]. In this, ICPs were recognised as lacking in strength and influence because they did not exert control over finances [PV50, Jul24]. Where systems are in financial difficulties, ICPs' presence and influence may be diminished because the direct accountabilities of NHS organisations to NHSE around performance and finance dominate and shape actions to such a large degree [W570, Jul24].

The introduction of CCGs in the Health and Social Care Act 2012 was associated with a development process and specific requirements around governance with time and strategic support allocated for this. ICBs and ICPs, in contrast, were established with fairly minimal stipulations around board and committee constitution [JE40, May24]. There was little in the way of structured guidance about what a whole system needs in order to function successfully, particularly in terms of governance and collaborative dynamics. There was a suggestion that those systems that are particularly struggling financially are partially correlated with those that have been less successful in establishing robust governance arrangements [W570, Jul24].

One interviewee suggested that the perceived proliferation of accountabilities (e.g. within systems, and between ICBs and NHSE), and the lack of clarity around accountability arrangements and their inter-relationships, was leading to uncertainty and inefficiency:

"I think in a lot of places these multiple accountabilities, multiple different governance arrangements, cause confusion, cause disconnect... And you spend more time in governance forums debating about who's responsible for stuff than actually getting on with delivering" [W570, Jul24]

A disconnect was identified between the intentions of the HCA 2022, particularly around collaboration and integration, and the NHS performance targets that are the basis for holding ICBs to account, including deficit reduction, urgent and emergency care recovery, elective

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activity levels, and A&E wait times. Part of the issue, one interviewee identified, is "…what's measured, gets done" [I310, Apr24] and if the state of national finances make financial performance a Government priority, then NHSE will focus on holding ICBs to account for delivery against those priorities over and above others. The intense focus on financial position was perceived as forcing decisions in some systems seen as directly running counter to ICSs' ability to work towards meeting their four core aims [FIJ1, Sep24].

> "There is an emotional nervousness of decision-makers in the centre, both NHS England on one side but also ministers […]. If they can measure something, if they can see it all on the data, that's the same as accountability and that makes them feel reassured. I think if you asked ICSs whether they were being held accountable for that, whether it was the right thing to be held accountable for and whether it made them better, I think you would get a unanimous set of noes, so I think there is an anxiety there." [SOPL, Sep24]

Another interviewee commented that NHS trusts have statutory duties around, for example, financial balance and care quality, and ICBs have duties around meeting the needs of their populations, the quality of the services they commission and achieving financial balance, which is essentially all clear and straightforward. What is less clear is who is responsible for ensuring the system's success (and also presumably who is responsible if things go wrong), and how those system accountabilities can be shared with clarity for all involved because currently the system accountabilities sit "on top" or are "supplementary" (in a way that may require further attention) [JE40, May24].

This relates to issues in the vertical dimension within systems themselves. The challenging financial context and ICB accountabilities for financial performance, specifically vested in the CEO, was acknowledged as a factor that militated against ICBs delegating control over budgets to places. More broadly, divesting control without also divesting accountability was seen as an unrealistic expectation because of the impetus for individuals to keep control of those matters for which they are held to account directly [20T3, Sep24].

One interviewee suggested that oversight arrangements were unclear [FIJ1, Sep24], and another noted that without a national oversight and assessment framework (which specifically addresses delegation), there would likely not be any meaningful delegation of responsibility to places [20T3, Sep24].

Multiple interviewees, however, emphasised that some of the accountabilities specified in the Act were very clear, particularly the relationship between providers to NHSE, and ICBs to

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NHSE. However, where responsibility sat between NHSE nationally and regionally was often a source of confusion and friction for some ICS [FIJ1, Sep24]. This was linked to a sense that the operating framework set out by NHSE, which specifies how NHSE will operate with regard to ICBs and what that relationship will be like, is reportedly not being delivered consistently across the country. This includes NHSE engaging directly with providers rather than going through the ICB itself [FIJ1, Sep24].

What was also unclear was the nature of the relationship, and the accountability dynamics, between ICBs and local providers [FIJ1, Sep24]. This led to variation in the perceived role and identity of ICBs vis-à-vis providers, with some adopting more of a performance management (albeit without the formal levers to enact that role robustly [FIJ1, Sep24]) and others behaving more as convenors for members and local stakeholders [OD20, May24; SOPL. Sep24]. Relatedly, the role of systems leader in ICSs was highlighted due to its inherent complexity and differentiation from the requirements of leading a provider organisation in a pre-ICB time period:

> "I think we are seeing that much greater kind of recognition around the importance of system leadership and the skill required to be an effective system leader. And that is different skillsets to that that was required ten, twenty years ago, to be an effective Chief Executive in that environment [...] With a much more top-down [leadership], you're a delivery mechanism for targets that are set nationally, and your role is to make that happen locally, rather than negotiating with partners, making prioritisation decisions, thinking about how you can make best use of your shared resources across the system." [FIJ1, Sep24]

It was noted by some interviewees that the centre had limited tools to affect change in ICSs because of a lack of financial levers in the current context of financial constraint:

> "...we are limited in our control and the levers we have over Integrated Care Systems [...] there is no money and that's the biggest lever, isn't it?" [I310, Apr24]

Other potential levers that were highlighted included further specification of policy and guidance about what was expected and required of ICSs, and further legislative levers which were recognised as time consuming and challenging to realise. The desirability and feasibility of using these tools was frequently framed in relation to the complexity and variation between systems and not wanting to constrain or disempower individual ICSs from collaborating in a way seen as locally meaningful [I310, Apr24]. A related issue was a sense expressed that there was a disconnect between DHSC and NHSE in terms of information



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about the state and status of ICS activity and performance. There was a lack of clarity about the reason for this. This information gap was seen as contributing to making policymaking, and consideration of appropriate tools and levers to be used, particularly challenging and additional transparency was seen as important [IG30, May24].

The CQC's role in ICS assessments was discussed. One interviewee emphasised the importance of having regulatory mechanisms fit for understanding and assessing systems [RKX7, Oct24]. Another had concerns, however, that the proposed evaluation framework was problematic. There was a suggestion that a useful approach might be for the CQC to focus on the specific, bespoke strategies and plans of ICBs and ICPs, looking at how they were developed and how stakeholders were involved, and then assessing the approach to delivering those plans [JE40, May24].

**Delegation, subsidiarity and place**

The Act emphasises the desirability of subsidiarity and contains provisions to enable the delegation of decision making by ICBs. Associated guidance, including the guidance for ICSs on developing the ICB's Joint Forward Plan, highlights the importance of supporting subsidiarity in the interests of making decisions as locally as possible to those populations that will be most affected by them.

There was a wide recognition amongst interviewees that actual delegation from ICBs was somewhat limited currently, with one interviewee suggesting that there had been minimal evidence of financial delegation, specifically, beyond existing Section 75 arrangements related to the Better Care Fund (voluntary contributions to which may be falling). This view aligns with the findings of WP1.3 and 1.4 regarding the lack of widespread delegation of decision-making and financial authority from ICBs in practice (see Sections 5.3. and 5.4.). In terms of delegating control over budgets and decision-making to places, this was seen as lacking:

> "So, I don't think we're seeing a lot of, if any, financial delegation to place. I think in some ICSs, they recognise that the place is a strength and they've got place-based leads and they've got Place-based Partnerships and ... to varying degrees, those voices are recognised and listened to and trusted. But I don't think we've seen real concrete delegation to those place leads" [IG30, May24]

The significance of place for effective integration was emphasised by multiple interviewees, who argued that place was where the "...real magic of integration happens..." and "...the engine of change [as] it's where the real integration between local authorities, social care providers and housing providers" occurs [I310, Apr24] and where most care is delivered [20T3, Sep24]:



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> "I think the legislation and the Act does the right thing, I think what it is missing is a place, so what we're seeing and hearing is that place is where integration happens, in terms of delivery and actually where partners come together." [I310, Apr24]

As the second extract suggests, there is some concern that the HCA 2022 does not sufficiently provide support to systems to drive integration via places. It was suggested that place leads saw their role as focussed on managing relationships within places, shaping place identity within the system, and working with system-wide contracts and financial structures, rather than having ownership of place budgets and contracts [IG30, May24]. A number of potential reasons for this and the lack of delegation to PBPs were highlighted, particularly: a lack of senior and organisational bandwidth to drive such developments; practical challenges of carving out a vertical place-based budget niche within the broader environment of contracts and budgets organised horizontally across an ICS area; accountability related concerns from senior ICS leaders and how they would manage a perceived lack of control or detailed knowledge when asked to account to the centre should system performance worsen when significant elements of the budget have been delegated to places. (Rationales given by ICB directors themselves for the lack of delegation are discussed in Section 5.4.3. for WP1.4) ICBs neglecting to support and invest autonomy in their places was also hypothesised as potentially due to running cost reductions creating the impetus to operate more efficiently by aggregating activities up to system level [JE40, May24], or nervousness from system leaders about relinquishing too much control away from the system level, which in itself was 'trickling down' from a controlling top-down accountability that created a sense of fear for ICB leaders should they not demonstrate sufficient "grip" [IG30, May24; FIJ1, Sep24].

> "You know, so that…that idea of subsidiarity is the…it's a…it's a goal to aim for. But I think very few places are actually achieving it because they…their attention is necessarily, kind of, constrained on how to control costs from the top-down." [W570, Jul24]

> "I think […] most systems would argue, that actually the reason you're delegating is because you can make change happen, you know, that actually where a lot of the improvements will be made, is through place-based partnerships, that's where a lot of services will be kind of designed and re-looked at in a different way[…] but in an environment where the focus and the attention on operational performance and finance is so high, and so political, actually, over the last kind of 12 months, I think there's been quite a high degree of caution about moving forwards in that area." [FIJ1, Sep24]

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There was a view expressed that ICBs have the power to delegate collaborative commissioning to place level via PBPs and that they should be making better use of this ability. It might be that this requires increased system support from NHSE around place or additional requirements for activity targets and reporting pertaining to place (with a recognition of the need to preserve permissiveness and reduce oversight elsewhere to compensate) [IG30, May24]. This was coupled with the idea that local determination over place-based commissioning arrangements, as a “bottom-up” process, was an important principle to protect because a top-down, imposed approach would lack the appropriate local sensitivity and awareness [OD20, May24]. Indeed, diversity between LAs was framed as part of reason why it is not feasible to make some kind of place model “uniform”:

> “Where you have whole metropolitan borough councils or unitary authorities, it’s really different to where you have a county council and the unitary as well […]And then it’s really different in terms of the structure of the trusts. So, […] the discussion about place is a perfect example. Quite often you hear a desire to make place uniform, but actually it’s not uniform at all, and it’s not uniform at all partly because of local authority structures, but also just because of provider footprints and so on. And how GPs like to aggregate themselves and they have their own views, don’t they, about how they want to work together. So, I think you do need to have the activities to improve care, but I think if we said, okay, this is the model for place and you all have to follow this model, it just…it wouldn’t work everywhere.” [JE40, May24]

A related challenge to developing effective PBPs was raised regarding the different ways that places are understood and constructed as meaningful areas by NHS organisations and other partners, particularly local authorities:

> "The way that the NHS understands place, again, will be quite different to the way that local government understands place. Particularly, I'm just thinking about Place-based Partnerships, and the different providers that are there, the trusts, the delivery of care at that level, but then you've got place that's understood at a local authority level, of that being the local authority area, economic growth teams, when they talk about place, they're probably talking about a town or a city. So, there's different languages and different understanding of how things are working." [Z3PH, Sep24]

**Flexibility, permissiveness and variation**

A key theme centred on the perceived permissiveness and flexibility that the HCA 2022 facilitated for local systems – highlighted as a particular strength [JE40, May24; FIJ1, Sep24]

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– and contrasted with the more structural restrictions and collaborative barriers associated with the Health and Social Care Act 2012, which were seen as unhelpful and creating unnecessary work. This was explained implicitly as a cultural shift amongst policy makers, described by one interviewee as a process of collective recognition, whereby the teams involved in creating relevant policy all orientated to the goal of facilitating flexibility for ICSs:

> "...well if this isn't the route to value, if it is perfectly alright for providers and commissioners, or providers and planners as we might call them now, to sort of get together and work in joint spaces, then why can't we just take down all the walls, and kind of be very, very, very permissive about all of this, and so we almost became competitive with each other about how permissive we could be." [Q6N2, Aug24]

This process was influenced by system stakeholders that had experience of trying to find ways to collaborate and integrate within the pre-HCA 2022 policy environment. Those stakeholders had reportedly appealed to policy makers not to "...make this too homogenised, don't try and kind of work out what the ideal version of this is [...] let there be a bit of flexibility and diversity in the way that we do this, within some defined parameters" [Q6N2_Aug24]. During the Health and Care Bill's progress, there were lobbying efforts to ensure systems had flexibility in how they established themselves (board composition etc), but agreement with the overarching common vision for what ICSs were intending to achieve in terms of their core purposes [FIJ1, Sep24]:

> "And we do hear the message again and again and again from systems, please can we maintain the permissive approach, because we are all different, and so much of this rests upon relationships and leadership and you can't make those happen from the centre, you've got to be enabling and encouraging." [JE40, May24]

The Health and Social Care Act 2012 reportedly created mistrust of Government policymaking. With the work preceding the HCA 2022, policy stakeholders told us that it was seen as necessary to establish trust with those working within systems, which was done in part by contrasting the proposed approach with that taken in 2012, and leveraging the views of system ambassadors who argued that the permissive approach would be helpful in supporting their continued progress locally without being unhelpfully restrictive [Q6N2_Aug24]. The expectation was that it would be sensible to move from a system animated by levers to promote competitive process intended to generate an effective market and in which energy was lost trying to overcome rigidities through workarounds. Instead, a legislative context which allowed effort to be poured into more productive activities would be

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sensible, i.e. the unnecessary and unhelpful bureaucracy associated with this would be reduced [Q6N2_Aug24]:

> "We, fairly late in the process, it must be said, kind of came to the conclusion that... putting ICSs on a statutory footing was the right thing to do. There was quite a debate about that, and the debate sort of centred around this thing about permissiveness. So the idea of kind of not damaging that fragile flower of local initiative that we thought we'd nurtured to some extent you know, if you start putting things in statutory form, can we be trusted to resist the temptation to turn this into some kind of horribly restrictive and overly structured framework?" [Q6N2_Aug24].

This point, that many systems had been doing partnership working for some time and so it was important to not hamper them [HD90, Aug24], was emphasised repeatedly. Instead, the approach of the Act was to create 'building blocks' that systems could decide to assemble differently and use to best effect to serve their local population and address national priorities. This was seen as leading to various examples of innovative and valuable work, such as care pathway re-design through meaningful collaborations, in local areas but these are likely specific to those local contexts and thus not something that can be scaled or transplanted to other systems [OD20, May24]. Although, there was recognition that "...because everybody has been running, basically on empty and firefighting, there is not really any systems where they've yet had the break space and the bandwidth to think about what as a system could our health and care offer look like in a much more strategic way" [SOPL, Sep24]. This driving principle of permissiveness was seen as relevant to the revision of plans to develop a Shared Outcomes Framework after some system stakeholders argued that they had developed their own local frameworks and the imposition of a national framework, requiring them to disrupt adapt their current processes to fit it, would be unwelcome. This instead resulted in the Shared Outcome Toolkit, which draws together learning and suggestions from those systems perceived as more 'advanced' about effectively developing shared place level outcomes [Q6N2_Aug24].

While the HCA 2022 does bring more autonomy and freedom in theory, there is a lack of evidence of that such freedoms are being used effectively by systems overall [JE40, May24]. This may be because, while the Act has legislated for collaboration it does not specify minimum levels and the fact that ICSs are not being held to account against such activity means that there is a disconnect [I310, Apr24]:

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> "Do we legislate for that or do we put statutory guidance out for that or do we just let systems do what they want because some systems have been doing it for a number of years, some systems haven't even got started and a patient's experience of those two systems is going to be vastly different.  So, variation is a huge problem, a huge problem." [I310, Apr24].

Furthermore, the experience of many system leaders is reportedly not currently one of empowerment to go and deliver the broad vision for ICSs, rather it is one characterised by a sense of constraint and restriction which stems partly from the uncertain accountability arrangements and relationship with NHSE, in particular, as outlined above [FIJ1, Sep24]. (The experience of ICB directors in this regard is detailed in Section 5.4.3 (WP1.4).

There were also concerns that, in contrast to the development agenda and processes for CCGs when they were first introduced, there was less emphasis in the establishment of ICSs on the structures and processes they needed in order to operate most effectively. This was largely left up to individual ICSs to decide [W570, Jul24]. Crucially, the HCA 2022 was seen as that "final piece" for ICSs rather than a starting point for enabling integration, and thus preserving the diversity of arrangements that were seen as working well locally was seen as important [HD90, Aug24] to reflect a the fact that no one approach would be appropriate for all systems [20T3, Sep24] because "...different geographies are different..." [SOPL, Sep24]. The point was also made, though, that permissiveness in the Act would likely result in increasing variation in the way that ICSs organised and orchestrated services and that this in turn may create variation in patient and population outcomes between areas over time. To what extent such variation might be tolerable politically was open to question. It was suggested that political and electoral considerations relating to this may in turn shape the direction of relevant policy in the future [OD20_2May24].

**Commissioning**

One of the central objectives of the HCA 2022 was presented as facilitating collaborative working by making commissioning pathways more coherent by reallocating responsibilities held by CCGs and NHSE to ICBs [JE40, May24]. Furthermore, it was emphasised that while the Act does not abolish the purchaser-provider split (and Ministers involved in developing the Act were explicit about this), the intention was to de-emphasise competition and make the split work in a more collaborative way through commissioning [Q6N2_Aug24]. The nuance of commissioning as a multi-dimensional activity, and the skill involved in doing it effectively, was highlighted. As one interviewee stated, there are questions regarding the

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extent to which commissioning is recognised in this way, and commissioners supported and developed appropriately, from the centre:

> "...ICBs are commissioning organisations and commissioning is a complicated skill, requires different ways of thinking, it requires creativity, it requires innovation and are NHSE teaching ICBs how to be commissioners? Are they getting in there and really helping them commission differently, shape markets, influence, nudge." [IG30, May24]

The dynamic between DHSC and NHSE and the objectives driving action in each organisation were highlighted in relation to this:

> "...So, I'd love to see NHSE really just take off the blinkers a little bit but that does also require the department to expect something different from NHSE and it requires [DHSC] to be really clear, which of the widgets that ministers absolutely need counting and where can you stop widget counting. [...] NHSE are nervous to do that because [DHSC come] along and say, but we need to know about those widgets. So, I think it does require shifts all the way through the chain, but I think NHSE could, within their current working relationship, they could go further. They could look at commissioning, they could look at creative innovative commissioning. They could look at how their leadership programmes work and they could step more proactively into ICP spaces and working with different government departments and different stakeholders on the relationships between ICBs and ICPs and for me, that's holding us back." [IG30, May24]

One interviewee provided an example of how the introduction of ICSs and the changes to commissioning and contracting arrangements could be disruptive to established place-based commissioning relationships arrangements. In this case, the ICB sought to rationalise and centralise the management of a particular sectoral set of contracts. This created inefficiencies due to adding an additional layer of contract management and diminished the sensitivity, and intelligence relating, to local needs and variations [I310, Apr24]. The lack of progress in the development and proliferation of provider collaboratives, which NHSE was promoting, was also highlighted and framed as resulting from local politics and power dynamics between providers in the geographical areas of systems [I310, Apr24].

**Patients and population**

Interviewees were asked to reflect on what patient or population groups stood to benefit particularly from improved collaboration and/or integration potentially associated with ICSs. Those groups of patients that frequently used services, or combinations of services, spanning

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multiple providers – particularly crossing community, primary, secondary and specialist 'boundaries' – were commonly suggested as possible beneficiaries of the changes to provision dynamics within systems [I310, Apr24; IG30, May24; OD20, May24], as were any sections of the population at risk of poor access and/or poor outcomes [FIJ1. Sep24]. This includes people with long-term conditions [JE40, May24] such as older people with frailty [I310, Apr24; OD20, May24], and people with learning disabilities [Q6N2, Aug24] but also populations such as rough sleepers [IG30, May24]. There was also recognition that variations in how ICSs prioritised service orchestration to meet the needs of their specific population was likely to shape the prospective beneficiary groups [OD20, May24]. More broadly, there were aspirations expressed that ICSs would improve the experience of care for those living in deprived areas and reduce inequalities, although this was seen as partially contingent on improving services for younger generations in those areas and thus may take many years to reach visibility as population health benefits [IG30, May24]. Conversely, one interviewee cautioned that any assumption that ICSs could feasibly impact the broader determinants of health to shape population health more broadly was likely overly optimistic [JE40, May24].

While the expectation was that most patients were likely to be entirely unaware of the ICS that their care was occurring within, there was the prospect of patients' experience of their care being more seamless and inter-connected. This may include, for instance, experiences characterised by the absence of activities that are repetitive, or perceived as frustrating or unhelpful, such as having to repeat one's history multiple times to different service providers [OD20, May24].

**Outcome metrics and indicators**

Interviewees were also asked to identify metrics that might be suitable to consider to help inform an understanding of the impact that ICS activities were having on populations, and indicators that integration and collaboration was occurring in a meaningful and desirable way. Over a short-term time frame, some of these were specifically defined and clearly articulated, such as: managing and reducing the ICB financial deficit [I310, Apr24]; and the targets associated with NHSE's planning guidance, i.e. elective recovery, urgent and emergency care performance, meeting cancer targets [OD20, May24].

Others were more speculative or broader suggestions for further consideration. One interviewee suggested that indicators of meaningful integration, including the agreement of local outcomes between local system partners, were important:

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> "So, we need to decide what good integration looks like, what systems should be doing now, with minimum expectations but we've left it wide open. So, could it be that for short-term metrics, we want to see evidence of, like I said before, these integrated neighbourhood teams, discharge teams, shared outcomes agreed at place level." [I310, Apr24]

Another suggested that investment in elective hubs, or cross-service provision such as children and young people's mental health services, might be appropriate [FIJ1, Sep24]. There was also interest in understanding the extent to which community or primary care providers were challenging acute providers in the context of system collaboration [SOPL, Sep24]. Integration activity markers were seen, however, as important to consider locally, rather than as part of some kind of de-contextualised national comparison which would lack meaning, in order to assess local improvements over time [L060, Jul24].

Similarly, there was a proposal for an indicator that assessed the degree of coherence of a system vision, consistent with budgetary decision-making, amongst diverse partners. This was coupled with a proposal for some kind of marker that indicated the prominence of primary care and social care providers in shaping spending and activity, and another to assess whether proactive care related activity was increased [IG30, May24]. There was also a proposal for developing a patient experience target of some kind [PV50, Jul24].

For longer-term metrics, there was a range suggested. Some of these were framed in relation to the realisation of the core purposes of ICSs, particularly quality of life and healthy life expectancy [I310, Apr24], but also socio-economic factors such as the proportion of the working age population in employment [OD20, May24]. Assessing the extent to which ICSs were addressing health inequalities was important, but there was recognition that measuring and attributing ICS activities to improvement in population health outcomes and addressing health inequalities was challenging because of the extended time period involved and the issue of disentangling contributory factors [OD20, May24; Q6N2, Aug24]. Novel approaches to combining and using data across diverse providers were also suggested, for example: using socio-economic data and intelligence used to inform decisions about waiting list priorities which may then have an impact on health inequalities [FIJ1, Sep24].

The Integration Index under development by NHSE was identified as a promising development in terms of assessing ICS progress on integration itself, but this was framed in relation the related objective of increasing organisational co-operation and the potential benefits of that, too, such as the sustainability of services and the quality of services [JE40,

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May24]. The point was made, however, that it was still somewhat 'early days' in terms of what could be expected of them:

> "And it's important to be mindful that ICBs are two years old on 1st July, they've been going through a restructure to reduce their running costs, they were very new organisations anyway. So, they're at the early stage of a journey." [JE40, May24]

### 5.1.4. Discussion

This section presents findings from interviews with a range of national level policy stakeholders with perspective important to understanding the development and implementation of the HCA 2022 and related policy. Interviewees were identified using the existing knowledge of the research team regarding relevant interviewee candidates, as well as snowballing (i.e. participants were asked to assist in identifying other potential interviewees) and intelligence gathered from contacts regarding appropriate individuals to approach. It should be noted, of course, that this can only ever construct a partial picture as presented above. There was, however, a high degree of consistency in the perspectives reported on salient issues, including from across and between stakeholder organisations, which lends strength to the validity of the picture. Furthermore, interviewees were successfully recruited from the full range of organisations considered most relevant to addressing the research questions by the research team.

There are a number of aspects that warrant brief emphasis here, most of these are explored further in Section 7.2, where the research questions themselves are addressed, and 7.4. Firstly, the significance of history and previous legislative reform was highlighted regarding the development and content of the HCA 2022 and related policy. Specifically, the Health and Social Care Act 2012 was important in shaping attitudes towards the acceptability of central prescription, the need to address perceived inefficiencies and workarounds of current legislative structures, and policymaker perspectives around control and flexibility. The health and care system's response to the COVID-19 pandemic was also a contributory factor. Engaging with and understanding this historical context is valuable in supporting understanding the HCA 2022, the positions, perspectives and motives of different stakeholders, and a range of factors around policy enactment.

Secondly, and relatedly, there is a tension between the policy drive for flexibility and permissiveness regarding local arrangements, and the fact that the resultant lack of uniformity and structure, may drive increased variation in terms of activity and outcomes across geographical areas. This is picked up further in Section 7.4.

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Thirdly, bottom-up discretion over collaboration and place-based commissioning arrangements to ensure they are locally sensitive and meaningful is seen as reasonable, but many ICBs are controlling commissioning arrangements from the system level. This undermines the argument regarding the importance of preserving local discretion and informed judgement because of the diversity of populations within and between places in an ICS. The challenges around delegation, accountability, and flexibility identified by stakeholders reflect underlying tensions which have been identified through empirical research and in policy commentary already (see Section 1.2). This research adds strength to the evidence base on these matters.

Fourthly, several interviewees either directly referred, or alluded to, a sense of disconnect between NHSE and DHSC in terms of information and intelligence about the experiences and performance of ICSs on the ground. The reason(s) for this are unclear based on these interviews, but addressing such issues with the policy landscape relating to ICSs and collaborative activity may require a more co-ordinated approach between government department and arm's-length body.

Fifthly, interviewees suggested a huge breadth of potentially meaningful outcome metrics and indicators of integration for ICSs. Many of these reflect the four core aims of ICSs, which in themselves cover a significant territory including population health, inequalities, and generating economic value. The mechanisms by which ICSs might result in changes some of these broad aims may be somewhat under-specified currently, and it will be important for guidance, incentives and other dynamics to clearly align towards the achievement of some of these, such as reducing health inequalities, if the chance of addressing them successfully are to be maximised.

Finally, as noted, WP1.1 addresses RQ1b; 1e; 2d; and 3b. The overarching report discussion – Section 7 – will draw together the relevant findings presented in Sections 5 and 6 and address each RQ in turn in detail

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## 5.2. Work Package 1.2: Patient and public involvement in system change

### 5.2.1. Introduction

This component of WP1 involved engaging with Healthwatch organisations in England to understand more about their experiences of engaging with the health and care system in the landscape created by the Act. This includes their involvement with ICSs and places. WP1.2 was developed to address the research question:

- RQ3a: How are ICSs incorporating patient and public perspectives into their development and operation?

The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to require the establishment of local Healthwatch organisations as a forum to advocate for local people in the health and care system.

Their roles may include:

- Conducting research into peoples' experiences of health and care services
- Representing the voice of local people to decision-makers
- Providing impartial advice to patients and the public regarding accessing and navigating health and care services (Healthwatch England, 2022)

Healthwatch consists of two key components: local Healthwatch organisations, and Healthwatch England. The former are statutory parts of the health and care system in each local area, funded by their respective LA. Healthwatch England acts as a network providing support, leadership, and a joined up national voice to all 151 local Healthwatch (Healthwatch England, 2022).

For the purpose of Phase 1, we have used local Healthwatch as an overall representative organisation of patient voice, aligning with the current Healthwatch England strategy which sets out local Healthwatch role listening to, and representing the public, amplifying the voice of seldom-heard communities, and inputting patient voice into local and national health and care policy decisions (Healthwatch England, 2021). We acknowledge that engaging with local Healthwatch leads should not be conflated with more in-depth engagement with the public directly, which will follow on to build upon patient and public perspectives in the case studies in Phase 2.

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### 5.2.2. Methods

A survey of ten core questions was developed by the research team. These questions were grouped into three areas: the geography of your Healthwatch; extent of engagement with ICSs; and experiences of working with ICSs.

The questions comprised a mixture of multiple-choice options, Likert scales to rate experiences working with ICSs, and open free text responses. All closed questions offered an optional section for further comments. A final question offered a free text option for any additional comments participants wished to share that had not been explicitly addressed in earlier questions.

The draft survey was shared with individuals working for Healthwatch England in their membership and engagement teams, following previous contact with them regarding the study. This relationship was fostered to seek advice and support on the most effective way to engage with individual Healthwatch organisations, and to situate the study in the context of the work Healthwatch England may be doing in relation to the Act. This was of particular importance due to the planned circulation of Healthwatch England's national survey which was likely to seek to ask questions on similar themes in summer 2024. During regular engagement with Healthwatch England throughout spring 2024, we were able to agree staggering the surveys and refining their content to minimise duplication as well as discussing the sharing of both surveys' results for mutual benefit. Further dissemination of this study's findings and engagement with Healthwatch England is planned upon the finalisation of the Phase 1 interim report.

The survey was developed using Qualtrics to generate a secure, anonymous weblink for use by participants. The introduction to the survey gave an overview of the post-implementation review and the research aims of this work package. The approved consent form was integrated into the survey, with participants needing to agree to this to be able to proceed to the questions. The survey weblink, in addition to a short background to the project was circulated through Healthwatch England's weekly bulletin to all Healthwatch nationally. The survey went live in mid-May 2024 and was anticipated to stay open for one month, with a reminder sent by Healthwatch England one week before closing. However, due to restrictions arising from the pre-election period, we were asked to suspend the survey on 11th June 2024, ten days earlier than planned. The option to re-open the survey following the election was discussed but agreed to be unfeasible and unnecessary due to the project's timescales and a good response rate, in addition to a potential clash with Healthwatch England's national survey over the summer.

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Following the closure of the survey, the data was exported from Qualtrics into a spreadsheet. The data was manually checked to exclude any duplicate, test, or spam responses, leaving 38 verified responses. It is important to note that as the survey was anonymous, this does not necessarily correspond to one response per Healthwatch.

The results could be filtered by question, or by respondent ID. The quantitative responses were also exported, and high-level analysis generated by Qualtrics to show the proportion of respondents selecting given options for the multiple choice and Likert scale questions. The qualitative data was analysed by MSur using the coding framework used throughout WP1.

The initial research protocol included a second stage of data collection which would include a small number (n=5) of follow up interviews with respondents who expressed an interest in taking part in these. All of those who provided contact details were contacted by email, with three initially responding. However, it was not possible to conduct these interviews, either due to non-reply when making arrangements, non-attendance of the interviewee, and rescheduling which did not align with the project's timescales. We anticipate engaging in a more in-depth manner with local Healthwatch during the Phase 2 case study work.

### 5.2.3. Results

Thirty-eight (38) verified responses were received. The data was exported into a framework grouping responses by question for comparison.

**Geography of Healthwatch**

Respondents were asked to identify how their Healthwatch mapped to their respective ICS(s). Initial discussions with Healthwatch England also identified that some Healthwatch considered to be working within a "complex" geography had appointed a coordinator to support collaboration between multiple Healthwatch. Different Healthwatch set up options include:

- A single Healthwatch covering the same area as an ICS (21%, n=8)
- A group of Healthwatch covering the same area as an ICS (39%, n=11)
- A single Healthwatch operating in a geographically complex ICS (37%, n=14)
- A single Healthwatch covering multiple ICSs (5%, n=2)

Three respondents (8%) selected "other", highlighting that their geographical arrangements were not represented by any of the above options. Where a Healthwatch worked with more than one ICS, they were asked to respond based on the ICS they worked with most frequently.

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Our initial scoping with Healthwatch England on the development of the survey suggested that individual Healthwatch vary greatly in terms of how they work together on a bigger geographical footprint. One response detailed a formal agreement between the different Healthwatch in an ICS with regards to collaboration and representation. This consisted of a collaboration agreement between the four Healthwatch covering their particular ICS, and a Memorandum of Understanding between this collaboration and the ICB, setting out shared representation of the four Healthwatch on the ICB by a single representative [R020]. However, other respondents described looser partnership working between Healthwatch, for example working jointly on reports or projects or more generalised "close working" [R009; R019].

Given that Healthwatch were set up to align with LA boundaries (Local Government Association, 2012), much of their emphasis is on place-based services and relationships, which one respondent suggested reflected patient interest in the health and care issues in their immediate area:

> "Partnership working is easier at place and the public respond and are more interested in their city than across the region." [R012]

The same respondent shared public scepticism about the relevance and permanence of the new arrangements:

> "ICBs are inconsistent in size and are not operating in natural geographic footprints that the public identify with. People may suspect they are temporary and will be rearranged soon." [R012].

The complexity of reconciling LA boundaries, PBPs, provider trusts and ICSs was apparent in some responses:

> "Our ICB and ICS area covers three local authorities. The local authorities have very different profiles. We work closely with [Healthwatch X] and [Healthwatch Y] on areas of mutual interest especially in relation to our acute hospitals who have a very wide patient footprint totally unrelated to the ICB footprint." [R022]

**Extent of engagement with ICSs**

Responses demonstrated a varied extent of engagement between Healthwatch and their respective ICSs. Some respondents shared positive sentiments in relation to their representation within the ICS structures, including feeling "welcomed and valued" [R010], "included in every aspect" [R011], and a "valued addition to the [integrated care] board"

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[R009]. In contrast, other respondents felt a strong relationship between their Healthwatch and ICS was yet to develop: "I do not feel like our Healthwatch has a relationship with the ICS" [R002]; "Has and continues to be a little disjointed as not all boards are fully set up yet" [R036].

This varied engagement was also evident in the wide range of committees and governance fora that Healthwatch representatives were part of. This included key groups set out in the Act such as ICBs, ICPs, and PBPs, as well as other groups that form part of the ICS infrastructure such as quality committees and working groups overseeing transformation projects. The quantitative data summarised in Table 6 below shows a mixed picture of representation of these key committees:

| Committee | Capacity | Number of respondents |
|---|---|---|
| ICB | Voting | 4 |
| | Attendance only | 18 |
| | **Total** | 22 |
| ICP | Voting | 8 |
| | Attendance only | 17 |
| | **Total** | 25 |
| Place board/committee | Any | 19 |

Table 6: Healthwatch survey respondents' representation on ICBs, ICPs, and place boards

Overall, Healthwatch appear to be most represented on the ICP, and demonstrate more voting privileges in the ICP versus the ICB. It should also be noted that 18 of the respondents reported sitting on both the ICB and ICP, although sometimes in different capacities (e.g.

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voting privileges on one and in attendance only at the other). Half of all respondents reported attending their place board or committee.

Only one respondent [R006] reported their Healthwatch being a member of their local Health and Wellbeing Board. Two respondents [R020; R002] reported the establishment of specific committees referencing experiences of care and community engagement which they were a key member of, however these were the only dedicated fora for patient and public involvement identified by survey respondents. Other fora respondents reported being part of included quality committees [R002; R010; R011], workstream or programme specific groups [R002; R010], a joint management committee [R013], and primary care committees [R020]. Differing processes for allocation to these committees and differing capacity were reported, with one respondent covering two ICSs reporting that they were asked how they wanted to engage with one of their ICSs, whilst being allocated a role in the other by ICS management [R021]. Another respondent expressed dissatisfaction with the non-voting role they were allocated on the ICB and ICP, suggesting they are "akin to sitting as members of the public" [R014].

Respondents were asked to share their experiences of engaging with the ICS governance structure. Some respondents described their Healthwatch being a formal part of committees, with commissioned projects on their behalf and scheduled updates to the ICB [R009; R038; R004]. One respondent reported a Memorandum of Understanding between the collaboration of local Healthwatch and the ICB [R020]. However, it was noted the approach to committee membership being "a bit random what we are and aren't part of" [R010]. This was reinforced by another respondent who suggested the arrangements for Healthwatch engagement in their ICS are "clunky and inelegant" [R005].

Practical issues surrounding engaging with ICSs were a key theme in the survey responses. This included the increased number of meetings and subsequent work programmes since the creation of ICSs. The ability to attend and prepare for meetings was identified as a key challenge: "Papers arrive soon before meetings and are 100s of pages long" [R010]. The potential geographical challenge of Healthwatch needing to engage on a larger scale was also raised:

> "I have a real problem with face-to-face engagement as the meetings tend to be held in venues that are inaccessible by public transport and over an hour's drive away." [R002]

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"Without any extra funding to attend these myriad of meetings, it is very difficult to find capacity to attend and prepare in advance by reading the papers." [R026]

The impact of this on the patients Healthwatch work with was noted:

"There are lots of things that haven't worked so well, like holding a meeting for a sub-region patch for people with cognitive impairment and their carers over an hour away inaccessible by public transport." [R002]

Whilst some respondents were positive about being involved in ICS committees and being commissioned to undertake system-level work, a recurring theme was a lack of increased funding to support the resource to do this:

"The ICS model in our region heavily leans towards VCS [the voluntary and community sector] and if we receive any amount of commissioned work it has a quick turnaround which due to our small and limited capacity feels half-baked." [R001]

"The ICB has funded the four Healthwatch for a number of projects and programmes but doesn't provide any financial support for infrastructure to support the required capacity to collaborate and coordinate at ICS level" [R020].

Furthermore, eight respondents said they receive no funding at all from the ICB and others reported a reduction or expected withdrawal of funds due to ICB cost pressures [R010; R018] or delayed payments from the ICB [R024].

Some ICBs appear to be funding a Healthwatch 'network coordinator' at system level [R014; R012; R027], however similar proposals in another ICSs were rejected or not progressed [R037; R018; R013]. Many respondents expressed that the additional task of coordinating amongst several Healthwatch in an ICS, or across several ICSs to effectively engage at system-level was not funded and done on a voluntary basis as an unresourced responsibility [R020; R013]. There was a sentiment that Healthwatch would like to engage more with ICBs but a lack of resourcing limits their ability to do this: "We would like to be more involved but without more resources we simply cannot attend and be present" [R007]. The potential positive impact of additional resource to support system-wide coordination and engagement by Healthwatch was outlined clearly by R017:

"We have two dedicated posts for collaborative cross-Healthwatch activity funded by the ICB: "We sit on 12 committees and sub-committees and are an active voting member on 11 of these. We meet bi-weekly with our contract holder at the ICB, who

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is the Head of Patient and Public Engagement. We have a monthly collaborative Healthwatch meeting that all chief officers attend and our ICB contact, facilitated by one of the [ICS]-wide posts. We have a strong ability to influence some strategies. It is less clear how influential we are in the actual implementation of those strategies." [R017]

Even in Healthwatch receiving funding, the short-term or piecemeal nature of these funding awards were identified as a limiting factor, often restricting Healthwatch ability to plan more strategically for the longer term or look at the bigger picture [R020; R036].

**Experiences of working with ICSs**

Respondents described a varied range of experiences of working with ICSs and other structures established by the HCA 2022. 29% (n=11) of respondents considered their ability to influence decisions made by the ICS as six or above out of ten on the Likert scale, where one represented no influence, and ten represented strong influence. 34% (n=13) rated their ability to influence ICS policy and strategy as six or above. Some respondents were able to describe tangible examples of where their Healthwatch's work had influenced service change and ICS priorities [R002; R009]. However, other respondents expressed disappointment in how their Healthwatch's work was received, citing slow, absent, or generic responses from the ICB, and a lack of feedback on the impact patient engagement has had on decisions [R010; R015]. It was noted that often positive platitudes were expressed by the ICB, but this did not progress into meaningful action:

> "We get a good reception and openness to our ideas and priorities, but this takes a long time to be translated into action." [R010]

Some respondents expressed a feeling of engagement with Healthwatch, and wider public engagement being a "tick box exercise", with the skills and input from Healthwatch not being valued [R018]. It was also speculated that the actions of ICBs were largely driven by financial challenges which limited the influence of Healthwatch [R027]. There was a sentiment of tokenistic engagement expressed by some respondents: "We seem to be tolerated and patronised rather than seen as an equal and important partner" [R037]. Others reported positive results from engaging with their ICS:

> "We have seats on so many boards, committees and working groups that we have fully fed into their five-year strategy and timeline re health inequalities workstreams." [R023]

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> "In certain areas the influence is considerable as we were involved in ICB and ICS design during shadow running and help with the recruitment and selection of ICB staff." [R022]

However, there was scepticism expressed regarding the influence on strategy documents, speculating that "these were essentially drawn up to meet NHSE requirements" [R021]. It was also suggested that given resource constraints, Healthwatch may need to consider "whether we should spend so much time involved in committee/subcommittee level where we hear high-level overview of engagement work that has already been completed or is already in progress to a point that it is difficult to influence" [R017], or prioritise efforts on engaging more meaningfully with specific work programmes and their teams.

**Navigating the structural changes of the Act**

A recurring theme from the survey was the confusion for Healthwatch in navigating their roles and responsibilities in relation to place, their ICS(s) and how this wider partnership role sits alongside core contracted activity by local authorities. Some respondents suggested the role of Healthwatch is poorly understood by the different parts of the health and care system and their potential to contribute not recognised [R009; R018]. Uncertainly regarding the degree of meaningful integration between health and social care made navigating the different system partners and prioritising responsibilities challenging. It was highlighted that different partners approach patient and public engagement differently, with local authorities exhibiting stronger "democratic scrutiny" [R022]. Responses painted a picture of additional, often unfunded NHS-focused demands being made of Healthwatch by ICSs, pulling them away from funded projects focused on local authority commissioned services such as social care and public health [R020; R022; R018]. The changing commissioning landscape mandated by the HCA 2022 exacerbated the workload for Healthwatch to service the new system infrastructure. Some respondents were generally positive with regards to their previous relationships with CCGs at place-level:

> "We have found it more difficult to engage with the ICS/ICB than previously with the CCG. It was easier to get to know individuals and their area of responsibility and have a less formal relationship with them... previously we worked very closely with the CCG on workshops, events etc. This has not happened since becoming an ICS." [R007]

A perceived reduction in locally-focused resource and patient engagement at a local-level – as opposed to the system-level – was mentioned:

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> "Since CCGs were merged our partnership working has become more complex...resource allocated is deployed across the region and there are fewer staff to undertake engagement. There have been some events but when they are not local it can be more difficult to get people interested." [R012]

This lack of 'local' focus on the footprint that Healthwatch were established to operate – i.e. place – was a recurring theme. Where work programmes were being led at system-level, this sometimes ignored local connections and knowledge Healthwatch could facilitate [R002], and there was poor awareness throughout the ICS of the support Healthwatch could offer [R008]. One Healthwatch reported being "completely excluded" from the new structures, with all patient engagement coordinated through a separate group within the ICS structure that Healthwatch were not included in [R005]. Some positive experiences were reported related to place-based structures and local authorities, who are the main commissioners of Healthwatch [R014, R019]. This included good representation on place committees and other local project groups, and strong individual relationships locally. However, the strength and impact of these relationships at system-level remained to be seen. As one respondent noted, "It does not feel that we would notice if the ICS stopped existing" [R014].

### 5.2.4. Discussion

The data collected from the survey of Healthwatch leads paints a varied picture of how ICSs are engaging with the public and patients, using the work of Healthwatch as a proxy measurement for this in Phase 1. As will be discussed further in Section 5.3. (WP1.3) and Section 5.4. (WP1.4), the governance infrastructures of individual ICSs and places differ greatly, as does Healthwatch participation in these. This participation appears to be further complicated by the complexities in geographical footprints and Healthwatch alignment to these. With Healthwatch generally aligning to LA footprints (as per the 2012 Act), their role, remit, and resourcing in the new collaborative structures such as PBPs and ICSs remains unclear. This lack of clarity also led to many respondents feeling ignored or undervalued by key decision-makers such as the ICB, and attempts at patient and public engagement tokenistic, with decisions or priorities already determined, often driven by financial constraints in the health and care system. It was clear from responses that systemic engagement between ICSs and Healthwatch is underdeveloped, and positive experiences were largely dependent on enthusiastic individuals within the health and care system fostering relationships. The undervalued sentiment was reinforced by ongoing practical concerns, such as physical accessibility of meetings, ability to adequately prepare and attend these, and stagnant or reduced funding to support Healthwatch capacity and capability to

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work on a larger scale. Furthermore, some respondents showed scepticism as to the longevity of ICS structures such as ICBs and ICPs, and questioned the relevance of these to patients and the public, many of whom appeared – in Healthwatch view – to be more concerned with local, place-based services and provision.

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## 5.3. Work Package 1.3: National policy and ICS documentary analysis

### 5.3.1. Introduction

This section describes the formal governance arrangements which have been put in place in each of the 42 ICBs. It addresses the following research questions:

- RQ1a: How are governance structures and leadership arrangements developing to facilitate co-ordination?
- RQ1e: How are ICBs exercising the flexibilities of HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?
- RQ1f: What functions, responsibilities and roles are evolving in PBPs and Provider Collaboratives, and are different types of commissioning functions evolving at different system levels?
- RQ4a: How is the duty to tackle health inequalities embedded within the ICB governance structure, and how are broader wellbeing inequalities being addressed by ICBs and ICPs?

These research questions are addressed through an analysis of the 42 ICB Governance Handbooks. Governance Handbooks are important documents which record the formal arrangements that ICBs are using to structure collaborative decision making.

### 5.3.2. Background

Before presenting the analysis of the Handbooks, it is necessary to explain the context relating to ICB Governance Handbooks and the information they include. As outlined in the Introduction to this report, system working is underpinned by two important principles: subsidiarity (that decisions should be taken nearest to those they affect) and permissiveness (freedom for ICSs to structure their own decision-making arrangements).

The HCA 2022 granted statutory ICBs responsibility for ensuring the provision of services for their geographical population. No requirements for governance arrangements were specified beyond the requirements for the constitution of statutory ICBs and ICPs. While guidance suggests that the principle of subsidiarity is expected to be embedded in these arrangements, with responsibility for the planning and delivery of integrated services delegated to geographical places (NHS England and NHS Improvement, 2019), no further legislation will address the issue of delegation or devolution of ICB functions to system forums (House of Commons, 2021). Consequently, ICBs have been free to structure arrangements beyond the

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board itself in a way that best allows them to achieve the integration of care for local populations.

ICBs have many possible formal governance options which may be used as a route to achieve locally shaped decision-making arrangements. The HCA 2022 served to remove barriers to shared decision making by enabling new collaborative working arrangements which ICBs and other bodies may choose to adopt. These new powers were designed to give organisations greater flexibility to collaborate in exercising their statutory functions, either through delegation or joint exercise of those functions. Section 65Z5 of the HCA 2022 provides new powers for statutory NHS bodies. Relevant bodies (NHSE, ICBs, NHS Trusts and NHS Foundation Trusts) are allowed to delegate their functions to each other, and to LAs and combined authorities. Section 65Z5 also enables these relevant bodies to jointly exercise their functions with each other and/or with LAs and combined authorities; and to form joint committees and pool funds to do so (under s65Z6). However, these relevant bodies cannot use these provisions to delegate to, or form joint exercise arrangements with, any organisations other than those within the scope of s65Z5 (NHS England, 2024a).

These newly available mechanisms complement pre-existing mechanisms which could be used to support collaboration such as pooling of funding through Section 75 arrangements or the establishment of committees in common.

ICBs (and other relevant bodies within the scope of the new s65Z5 powers) have three options for carrying out their functions under the new legislation. They can: carry out the function themselves (including through 'internal' delegations to individuals and committees); delegate responsibility to one or more organisations; carry out their functions jointly with other organisations (such as by forming joint committees and pooling funds) (NHS England, 2024a). Currently, NHSE expects that ICBs do not seek to use the powers of delegation of statutory functions to NHS providers, citing the potential complexity of such arrangements, associated risks, and the significant operational and financial pressures facing systems (NHS England, 2024a). As the statutory guidance highlights, organisations should carefully consider how to structure collaboration under the HCA 2022, and should be guided in local shaping of governance arrangements by a consideration of the collaborative benefits such arrangements will bring:

> "Organisations must therefore carefully consider the potential benefits from collaboration – taking into account the duty of cooperation and, for ICBs, the duty to promote integration and how they can be continually assured that these benefits are

being realised; and how all organisations recognise that the models of collaboration best suited to local circumstances may change over time – before they enter into such arrangements." (NHS England, 2024a)

Given the permissive national context, the increased mechanisms available to support collaboration, and the principle of subsidiarity, it is to be expected that ICBs will differ in the local decision-making arrangements which have been established. Examining the formal arrangements which have been put in place across ICBs can tell us how, and to what extent, ICBs are choosing to use the formal arrangements made available to them by the HCA 2022 to structure collaborative decision-making. We have examined these arrangements through an analysis of all 42 ICB Governance Handbooks, a document which ICBs are required to publish. Handbooks bring together ICBs' governance documents in a single place. This analysis, together with the explanations of the rationale for the adoption of governance models given in structured interviews with ICB directors (see Section 5.4), provide a national picture of ICB formal governance arrangements and the considerations which may be underlying these arrangements.

### 5.3.3. Contents of ICB Governance Handbooks

NHS England issued guidance on model ICB constitutions and governance arrangements in May 2022 (NHS England, 2022d) in preparation for the establishment of ICBs. This was updated in July 2024 (NHS England, 2024a). In addition to specifying the mandatory elements of the ICB constitution (which is subject to NHSE's approval), the guidance provided a list of documents which ICBs are required to publish in the form of a Governance Handbook. The purpose of the Governance Handbook is to describe how the ICB makes its decisions. The Handbooks should specify where ICB functions are being enacted, and which mechanisms are being used by ICBs to structure collaboration. The Handbooks therefore fulfil an essential role in ensuring the transparency and clarity of decision-making arrangements. The NHSE guidance specified the documents and arrangements which ICBs were required to include in Governance Handbooks. These documents include the Scheme of Reservation and Delegation (which sets out any arrangements the board has agreed to delegate the responsibility for exercise of its powers and functions (NHS England, 2021)); the Functions and Decisions Map (a high-level diagram which sets out where decisions are taken and outlines the roles of different committees/partnerships (NHS England, 2024b)); Standing Financial Instructions (which explain the financial responsibilities, policies and procedures adopted by the ICB); Terms of References for all committees and sub-committees that exercise ICB functions (including any joint committee of the ICB and another ICB, NHSE, an

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NHS trust, NHS Foundation Trust, LA, combined authority, or any other prescribed body in accordance with Section 65Z6 of the NHS Act 2006). In addition, the NHSE guidance specifies that Governance Handbooks should specify delegation arrangements for all instances where ICB functions are delegated, in accordance with Section 65Z5 of the 2006 Act, to another ICB, NHSE, an NHS Trust, NHS Foundation Trust, LA, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act (NHS England, 2024a).

### 5.3.4. Methods

We analysed the content of 42 ICBs' Governance Handbooks to identify key arrangements across all ICBs as shown in Table 7 below. We created a framework of relevant variables. The framework was shaped by our research questions and mandatory requirements of Governance Handbooks as stated in 'Guidance on integrated care board constitutions and governance'. (NHS England, 2024b). Table 7 summarises the information gathered, and the relevant sources used.

| Information gathered | Source |
|---|---|
| Place structures<br>• How many places are there?<br>• Are places constituted as Committees/Sub-committees of the ICB?<br>• If they are committees, which ICB functions do they exercise?<br>• If not Committees/Sub-committees of the ICB, are place governance arrangements clarified? | Functions and Decisions Map, Terms of Reference, Standing Financial Instructions, Scheme of Reservation and Delegation |
| Provider Collaboratives<br>• Are Provider Collaboratives constituted as Committees or Sub-committees of the ICB which exercise ICB functions?<br>o If yes, how many Provider Collaboratives and type?<br>o If yes, what ICB functions do they exercise?<br>o If not, are Provider Collaborative governance arrangements clarified in the Governance Handbook? | Functions and Decisions Maps, Schemes of Reservation and Delegation |
| Commissioning<br>• Is there a Committee(s)/Sub-committee(s) of the ICB which has formal responsibility for the ICB commissioning function? | Terms of Reference, Schemes of Reservation and Delegation, Standing Financial Instructions |

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| Information gathered | Source |
| --- | --- |
| | |
| Health inequalities<br>• Is there a Committee/Sub-committee of the ICB which has formal responsibility for health inequalities? | Terms of Reference |
| Delegation arrangements<br>• Financial authorisation limits for places, Provider Collaboratives, joint committees and individuals linked to these bodies<br>• ICB functions delegated to another ICB, NHSE, an NHS trust, NHS Foundation Trust, LA, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations<br>• In the case of delegation functions listed above, what are the reporting arrangements to the ICB? | Schemes of Reservation and Delegation, Standing Financial Instructions |

Table 7: Summary of information collected from Governance Handbooks and the relevant sources

We downloaded Governance Handbooks from each ICB’s website during April 2024. Any amendments made after that date are not included in this analysis. For Governance Handbooks in the form of webpages, we used the information available online at the time of the analysis. Due to the format, we were not able to note any changes made during the analysis period. We based the analysis solely on the information in the Governance Handbooks; any formal arrangements that are not part of the Handbooks but indicated on other resources such as ICB websites were not taken into account in the analysis.

We used the framework detailed above to extract the information to an Excel spreadsheet. PAV conducted the analysis of the Governance Handbooks. MSan undertook additional analysis of selected Handbooks in case of ambiguity in presented information. MSan and PAV reviewed the analysis at regular intervals to reach to a consensus in the analysis. JH and MSur reviewed one Handbook each to check the robustness of the framework.

### 5.3.5. Results

Governance Handbooks varied in structure, content, and level of detail. Most were available on ICB websites in PDF format, while others were published as webpages. Some Governance Handbooks included content in draft form that was yet to be updated, such as Terms of References, diagrams, Schemes of Reservation and Delegation, that were not up to date or

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missing. For instance, one Handbook did not have a Scheme of Reservation and Delegation despite a requirement in NHSE guidelines that ICBs are required to include it to their Governance Handbooks. Seven Governance Handbooks still referred to pre-ICB arrangements such as referring to CCGs as existing entities. In rare cases, some Governance Handbooks contained internal contradictions, possibly due to outdated content. For instance, referring to places as ICB Committees in one section, where this was inconsistent with the rest of the Handbook documentation. Consequently, these variations and contradictions raised questions about accuracy of the information presented which we will discuss at the end of this section.

**Governance at place scale**

According to the guidance on ICB constitutions and governance, ICBs are not obligated to provide details regarding governance at place scale. Hence, we found varying information about places – more information was available in Governance Handbooks for the ICBs where places were committees or sub-committees with delegated ICB functions.

Thirty-nine (39) Governance Handbooks indicated the number of places within the ICS, which ranged from two to 12. In four ICBs, a 'place' was not formed due to the lack of a geographical area that fits the terminology set out in the NHSE national guidance. Furthermore, two ICBs chose to use different terminology to refer to geographical scales with systems.

In our analysis, we used Governance Handbooks to determine whether places were constituted as ICB committees to which ICB functions were delegated. NHSE guidance requires ICBs to include a Terms of Reference for all committees and sub-committees which exercise ICB functions. Committees are established by and accountable to the ICB, and sub-committees are established by the relevant parent committee and accountable to the parent committee. Where places were not constituted as committees or sub-committees of the ICB, we sought to identify any alternative place governance arrangements which were described in Governance Handbooks. Out of 42 ICB Governance Handbooks, 11 indicated that places were designated as committees or sub-committees of the ICB. We occasionally encountered ambiguity in the documents, where places were described as committees throughout the Governance Handbooks but did not have corresponding Terms of Reference included in the Governance Handbook. Since Terms of Reference establish formal mechanisms for delegation and accountability and are a Handbook requirement stipulated by NHSE for all ICB committees, we did not count these cases as 'committees'.

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Where places were not committees or sub-committees of the ICB, we investigated whether the Handbooks revealed any information on the governance model. Two Governance Handbooks provided detail on governance arrangements for such cases, in both cases indicating that places were consultative forums informing decisions of statutory bodies, with accountability to the ICBs.

**Governance of Provider Collaboratives**

As is the case with governance of place, ICB Governance Handbooks are only required to include information about provider collaboratives if they have been formed as ICB committees or sub-committees with delegated functions. Our analysis of Governance Handbooks suggests only one provider collaborative has been constituted as a committee or sub-committee of an ICB (North East London ICB). Details of the functions delegated are given in relation to the 'internal' delegation of functions below.

The 41 ICBs where provider collaboratives were not formed as committees were not required to include any details regarding the governance arrangements for provider collaboratives in the ICB Governance Handbooks. Four ICB Governance Handbooks offered further clarification of provider collaborative governance arrangements. The description in the respective Governance Handbooks suggests that in each of these four ICBs had established a collaborative leadership structure, typically in the form of a board or executive group, to drive joint decision-making and system-wide transformation. These boards were primarily accountable to their respective provider organisations, with some collaboratives also reporting to their respective ICBs for broader alignment.

**'Internal' delegation of ICB functions to Committees/Sub-committees: places and Provider Collaboratives**

We wanted to establish which ICB functions had been delegated to places and provider collaboratives as ICB committees and sub-committees and whether places and/or provider collaboratives had the authority to make financial decisions. In relation to the 'internal' delegation of ICB functions to an ICB committee or sub-committee, we interpreted this as ICB functions identified in the ICB Scheme of Reservation and Delegation as delegated to place-based ICB committees or sub-committees or provider collaborative ICB committees or sub-committees.

Our review identified eleven ICBs which had established ICB committees or sub-committees with a responsibility for place. Nine of these were committees (Mid and South Essex; Suffolk and North East Essex; South West London; South East London; Birmingham and Solihull,

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Shropshire, Telford and Wrekin; Greater Manchester; West Yorkshire; South Yorkshire) and two were sub-committees (North East London; North Cumbria). We reviewed the delegation of functions to these committees and sub-committees, by reviewing the ICB Schemes of Reservation and Delegation.

An alternative route to achieving 'internal' delegation of decision-making to PBPs, is via delegation to an individual (either a board member of the ICB or employee). In three ICBs (Black Country; Cheshire and Merseyside; Humber and North Yorkshire) where places are not formed as committees, place directors were delegated financial decision-making on healthcare and non-healthcare contract awards, Section 75 arrangements, individual packages of care, procurement decisions in line with the PSR.

In three of the ICB Schemes of Reservation and Delegation (South West London; South East London; Birmingham and Solihull) we did not identify any ICB functions which had been delegated to the ICB place committees/sub-committees. The other eight ICB Schemes of Reservation and Delegation indicated functions had been delegated by the ICB. The functions that were delegated fell within three categories of functions (as described in 'List of Statutory Functions to be considered for delegation and joint working arrangements' (NHS England, 2022a)). Firstly, functions which could be categorised as **corporate**, such as establishing governance arrangements at place scale, and contributing to and agreeing plans. Secondly, functions which could be categorised as **ancillary**, such as ensuring consultation, involvement and engagement on place delivery plans, developing arrangements to embed collaboration and integration. Thirdly, functions which could be categorised as relating to **commissioning** such as the allocation of resources, and putting contracts and agreements in place to secure delivery of plans.

In relation to commissioning activities, we examined the nature of the commissioning responsibilities that had been delegated to ICB place committees or sub-committees according to the Schemes of Reservation and Delegation. We also examined the Financial Scheme of Delegation or equivalent, where available, to understand the scale of financial delegation which had been made to place. This analysis suggests that six ICBs had delegated commissioning functions concerning the allocation of NHS resources to their ICB place committees. In three ICBs these responsibilities related to specific services, which could broadly be characterised as continuing healthcare, personal health budgets, primary care, dental and pharmacy services. In one case, the functions delegated also concerned joint leadership of commissioning of learning disability, mental health and children and young people's services (Suffolk and North East Essex).

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In a fourth ICB (South Yorkshire), the Scheme of Reservation and Delegation indicated that ICB place committees had been delegated responsibility for the allocation of resources to deliver strategic plans, determining what resources should be available to meet population need and setting principles for how they should be allocated across services and providers (both revenue and capital). For this ICB, there was not a corresponding Financial Scheme of Delegation available.

The Scheme of Reservation and Delegation for the final two ICBs indicated that both had delegated commissioning responsibility for a wide range of services to place committees, together with details of the budgetary authorisation limits. The first ICB (West Yorkshire) had delegated responsibility to ICB place committees for the arrangement for the provision of health services through a range of activities including: putting contracts and agreements in place to secure delivery of its plan by providers; working with LA and VCSE sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care; and approving decisions on the review, planning and procurement of primary medical care services. The Financial Scheme of Delegation indicated that significant budgetary responsibility has been delegated to place committees including commitment of recurrent and non-recurrent expenditure up to £20 million; decisions to obtain tenders and approval of procurement methodology equal to or over £5 million, and signing of contracts equal to or greater than £1 million for health care services.

A second ICB (Greater Manchester) indicated in the Scheme of Reservation and Delegation that the ICB place committees had been delegated responsibility for the allocation of resources to deliver the local plan at place, determining what resources as delegated by the ICB should be available to meet population need in place and setting principles for how they should be allocated across services and providers (both revenue and capital).The Financial Scheme of Delegation indicated that significant budgetary responsibility has been delegated to the place committee, including full approval of all delegated budgets up to the value of £5 million, and procurement up to £500,000.

The analysis of Governance Handbooks (as at April 2024) showed that only one ICB (North East London) had delegated functions to provider collaboratives. In North East London ICB, two provider collaboratives – the Mmental health collaborative and community health collaborative – were sub-committees of the ICB. The acute collaborative was a joint committee of the ICB and the NHS trust providers established under Section 65Z5 of the NHS Act 2006 (see also section describing the Joint Exercise of Functions below). ICB

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functions had been delegated to these collaboratives in the domains of planning, leadership and engagement and governance. There was a great degree of commonality in the functions delegated to each collaborative.  The responsibilities identified in this regard in the Terms of References were greatest for the acute collaborative joint committee. These concerned, in relation to acute services: making recommendations regarding and contributions to key ICB plans;  planning and overseeing the implementation and delivery of these within their respective domains; development, approval, implementation and delivery of collaborative plans; reviewing place plans;  engagement with partner organisations; leadership on matters relating to their services; oversight of service user and citizen engagement; and development of collaborative governance.

**Joint exercise of ICB functions (under S65Z6)**

As part of our analysis of ICB Governance Handbooks, we sought to identify instances where ICB functions were being jointly exercised in a joint committee of the ICB and other relevant bodies in accordance with Section 65Z6. We expected such arrangements to be documented in Governance Handbook Terms of Reference, the Scheme of Reservation and Delegation and Standing Financial Instructions. We excluded the ICPs from our analysis. We also excluded delegations under Section 75 of the 2006 Act and the associated partnership arrangements for any delegation/joint exercise of health-related LA or CA functions, in order to focus on the use of the new flexibilities introduced by the HCA 2022.

We identified four joint committees which had been established between multiple ICBs in order to jointly commission services. The West Midlands Joint Commissioning Committee, a joint committee of six ICBs and NHSE, had been established with a remit relating to the commissioning and management of pharmacy, ophthalmology and dental services, and specialised services. A similar arrangement of a joint commissioning committee across multiple ICBs was also noted in the East Midlands and the North West. The fourth joint commissioning committee our review identified related to the commissioning functions associated with the commissioning of emergency ambulance services across multiple ICBs in the South of England.

Additionally, our review identified a two joint committees which had been established between an ICB and NHS trusts and Foundation Trusts. Hereford and Worcestershire ICB established a Mental Health Joint Committee with a trust, with aims including the review and approval of plans and resourcing decisions, and the assure the attainment of clinical standards. North East London ICB established an acute provider collaborative as a joint

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committee between the ICB and the boards of three acute trusts with respect to planning, leadership, engagement, and governance.

**Delegating responsibility to another organisation**

We found no examples of ICBs delegating functions to other relevant bodies under Section 65Z5.

**Commissioning**

We examined how Governance Handbooks describe the organisation of commissioning responsibilities within each ICB. To explore this, we first investigated whether these responsibilities are delegated to an ICB committee. Commissioning responsibilities were explicitly assigned either to a committee, multiple committees, or directly to the board of the ICB. Out of 42 ICBs, six had a single ICB committee or sub-committee responsible for the entire commissioning function of the ICB. The responsibilities of these committees covered contracting, procurement, and wider activities relating to commissioning such as redesigning health services and innovative activities related to commissioning. 20 ICBs had committees dedicated to primary care commissioning. 17 ICBs have committees responsible for commissioning functions other than primary care. This includes the six ICB place committees discussed in the preceding section.

As noted in relation to the arrangements for the Joint Exercise of Functions above, we identified four arrangements for the joint exercise of commissioning functions between ICBs. Additionally, we identified a committee in common arrangement whereby Frimley ICB undertakes the pharmacy, optometry, dental commissioning on the behalf of the six ICBs in the South East region.

**Health inequalities**

ICBs have a duty to tackle health inequalities and improve population health and healthcare. To understand how this duty is integrated within ICBs' governance structures, we examined the bodies and identified individuals responsible for this duty as recorded in the ICB Governance Handbooks. 37 ICBs have one or more committees dedicated to addressing health inequalities. While some of these committees specifically focus on population health and health inequalities, others, such as ICB commissioning and place committees, also take on this responsibility. In eight of the 42 ICBs, there are named individuals in the Governance Handbooks who are accountable for health inequalities. In two of these cases, although a named individual is identified, there is no corresponding committee listed in the Governance Handbooks as responsible for addressing health inequalities. In cases where ICBs form joint

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committees to identify and set strategic priorities in service provision, they also undertake the duty to tackle health inequalities such as West Midlands Joint ICB Committee and Joint Committee of the East Midlands ICBs.

**Delegation from the NHS England to ICBs**

**Pharmacy, Optometry, Dentistry:** Most of the ICBs have pharmacy, optometry, and dentistry services delegated from the NHSE, except three ICBs with do not specially mention their delegation arrangements in their Governance Handbooks

**Specialised commissioning:** 14 ICBs have been delegated specialised commissioning responsibilities from the NHSE as outlined in their Governance Handbooks. When delegation occurs, specialised commissioning is often organised at the regional level with all relevant ICBs collaborating under joint committees. Examples of such collaboration include: West Midlands Joint Commissioning Committee, East Midlands Joint Commissioning Committee, North West Specialised Services Joint Committee (see section describing Joint Exercise of Functions above).

### 5.3.6. Discussion

Through this analysis we sought to address research questions concerning: the development of governance structures and leadership arrangements to facilitate collaboration (RQ1a); the manner and degree of delegation from ICBs (RQ1e); the evolution of functions in PBPs and provider collaboratives, and the evolution of commissioning functions (RQ1f); and how the duty to tackle health inequalities is being embedded in ICB governance structures (RQ4a). To help us address these questions we used Governance Handbooks to identify governance and delegation arrangements at places, provider collaboratives, and joint committees, commissioning arrangements, and ICBs responsibilities to tackle health inequalities.

Before addressing the research questions, it is important to reflect on the Handbooks themselves. The HCA 2022 and associated policy have not made ICB governance arrangements subject to NHSE approval. Our analysis of 42 Governance Handbooks highlights differences between Handbooks in structure, content, and level of detail, reflecting the freedom available to ICBs to structure these documents as they see fit. Nearly all of the Handbooks satisfied the mandatory requirements for the information which should be included. The requirement of policy (NHS England, 2024b) was to describe the formal governance arrangements only, and consequently Governance Handbooks tended not to include details of governance of place and provider collaboratives where these were not constituted as ICB committees or sub-committees. For example, where places were not

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designated as ICB committees, only two ICBs detailed alternative governance models, indicating that such places functioned as consultative forums without formal decision-making responsibilities. As around two-thirds of ICBs had chosen not to structure places and provider collaboratives as committees or sub-committees at the point of our analysis, this led to a lack of detail in Handbooks concerning decision making in these important forums.

The findings relating to our analysis of the Governance Handbooks should be considered in the light of the quality and reliability of the information contained within the Handbooks. We found that in some cases the documents in the Handbook were inconsistent, missing or out of date. In our review, we required consistency of information in order to be able to record a particular governance arrangement as being in place. As a result of the internal inconsistencies in some Governance Handbooks it is possible that our review in some instances does not present an accurate picture of the governance arrangements in practice. For example, in order to record the delegation of ICB statutory functions to a ICB place committee or sub-committee we required the delegation to be recorded in the Scheme of Reservation and Delegation. It is also the case that the inconsistencies in Governance Handbooks raises questions about the clarity of governance arrangements, and the implications of this for accountability and oversight.

Given these limitations, together with ongoing development of governance arrangements in ICBs, it is probable that in some cases the Governance Handbooks do not reflect the reality of decision-making arrangements in ICBs. It is therefore important to complement this examination of formal arrangements with an examination of ICB governance arrangements in practice, including addressing the rationale underlying the choice of governance structures, examining how decisions are made in practice, and the developing roles of places and provider collaboratives. Our Phase 1 findings from the structured interviews with ICB directors allow us to some understanding of the rationales behind the adoption of governance models in greater depth, and the roles of PBPs and provider collaboratives (see Section 5.4). As our plans for Phase 2 of this study indicate, the two ICS case studies will allow us to develop a deeper understanding of how decision-making is working in practice in two contexts.

Turning to the RQs, in terms of the overall development of governance structures, we found that the majority of ICBs are not using formal governance mechanisms to facilitate collaboration at place and provider collaborative scale, and the preference appears to be to designate a more informal or advisory remit to these forums at this point. Formal decision-making in the majority of ICBs is retained by the ICB itself, or delegated to ICB committees or

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sub-committees with specific remits such as finance, quality, and commissioning, rather than grouping these functions together on a geographic basis. We found that some ICBs are using the new flexibilities of the HCA 2022 to form joint committees. The majority of these related to joint delivery of ICB commissioning.

Regarding the delegation of ICB functions, formal delegation of ICB functions to places and provider collaboratives appear to be very limited according to the Governance Handbooks. Of the 11 ICBs we identified as establishing committees or sub-committees with a place remit, six ICBs were formally delegating functions to these committees and sub-committees as detailed in the Scheme of Reservation and Delegation. Of these, six ICB Handbooks indicated that decision-making regarding the allocation of resources had been delegated to places, and of these only two Governance Handbooks indicated that what appeared to be 'full' commissioning responsibility for local populations had been delegated to place committees, together with budgetary responsibility. In terms of provider collaboratives, only one ICB had provider collaboratives established as ICB sub-committees, with delegated functions relating to planning, engagement, governance, and assurance.

There is a contrast between the formal delegation to places and provider collaboratives in Schemes of Reservation and Delegation and the significant role that senior ICS leaders sat that place committees, and PBPs in general will perform (see Section 5.4). On one hand, formal delegation might be more common than our analysis suggests, for example our interviews with 17 ICB directors (WP1.4 detailed in Section 5.4 of this report) suggest that 'internal' delegation to an individual may be more commonly used than our Governance Handbook analysis indicated to enable decisions to be taken at place and provider collaborative scale. It was difficult to pick up this information consistently if it was not clearly signposted in the Scheme of Reservation and Delegation. Alternatively, it may be the case that formal delegation is not judged to be necessary to allow places and provider collaboratives to play a central role in collaboration and satisfy the principle of subsidiarity. In this scenario places and provider collaboratives would be able to shape health and care services for the needs of their local populations sufficiently through recommendations and advice regarding commissioning decisions, and by focusing on the delivery of services to the population. However, as yet this assertion is untested, and as ICB director interviews indicate, it may also be the case that there are barriers to delegating responsibility for functions in places. We will be looking at the role of place in practice in Phase 2 of the research in our WP3 case studies.

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Commissioning refers to a wide-ranging set of activities including objective setting and decision making, management of partnerships, supporting patient choice, information collection, service design, resource allocation, procurement and, contracting (Wade et al. 2006, Checkland et al. 2024). In terms of the evolution of commissioning arrangements in ICBs, our analysis indicates a proliferation of forums with some sort of commissioning responsibility. Where places and provider collaboratives were not delegated formal decision-making responsibilities, they were often ascribed important advisory roles relating to the planning and provision of services to their local population, such as providing leadership and acting as the focal point for shaping priorities, aligning priorities and gathering intelligence, which would feed into an ICB committee. Checkland et al. (2024) conclude, in their recent review of the literature concerning effective commissioning for integrated service delivery at place-level, that there is a need for clarity around the scope and scale of local responsibilities. In light of the split in commissioning between formal and informal responsibilities at multiple scales in ICBs, it is important to ensure that these arrangements are clearly documented and clearly understood by those involved. This is particularly important with regard to decision-making, as there is a danger that lack of clarity will lead to duplication.

Our analysis suggests that arrangements in ICBs are evolving to establish the optimum scope and scale of commissioning activities for particular services. We found multi-ICB arrangements which had been established through the establishment of joint committees to commission specialised services, or services which are already organised on a large footprint, specifically ambulance services. Interestingly, we found that in relation to primary medical services, and pharmacy, optometry, and dental commissioning examples of organisation at multi-ICS scale, and delegation to individual ICB place committees.

When addressing health inequalities, the analysis shows that 37 ICBs have established committees focused on improving population health and reducing disparities in healthcare access. This reflects findings of other research which noted that the governance structures to support health inequalities were well established in ICSs (Checkland et al. 2024).

Overall, our findings from WP 1.3 suggest that there is a need to study governance arrangements in depth to understand the developing roles of places and provider collaboratives, and how decisions are made in practice in ICBs. The following section presents the findings from 17 ICB directors regarding why arrangements in their ICB have been structured as they have, and how collaboration through these structures is working in practice. Additionally, our Phase 2 plans for two ICS case studies will allow us to study structures being used to support collaboration in much greater depth.

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## 5.4. Work Package 1.4: Structured interviews with ICB directors

### 5.4.1. Introduction

This section of the report concerns the development of structures to support collaboration in ICBs. While the preceding analysis of ICB Governance Handbooks described the formal governance arrangements which have been put in place in all 42 ICBs, this section explores the views of 17 ICB directors regarding why arrangements in their ICB have been structured as they have, and how collaboration through these structures is working in practice.

The section addresses the following research questions:

- RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?
- RQ1f: What functions, responsibilities and roles are evolving in PBPs and Provider Collaboratives, and are different types of commissioning functions evolving at different system levels?
- RQ2a: Are systems making use of joined-up/pooled budgets? How are they doing this and under which circumstances?

This section describes how commissioning is being organised in the ICBs, whether ICBs use of joined up/pooled budgets has changed from the period prior to the HCA 2022, the role of PBPs and provider collaboratives in relation to system objectives, arrangements for the delegation of ICB functions to places and provider collaboratives and the reasons for this, and challenges facing ICBs in collaborating to achieve system goals.

### 5.4.2. Methods

Seventeen (17) interviews in total were conducted remotely (by PAV, MSur, LWG, JH; via Microsoft Teams) between September - October 2024. Interviews typically lasted 30 minutes.

We interviewed ICB Directors of Strategy, or nearest equivalent if no such postholders existed in a particular ICB. We obtained names and email contact details for the Director of Strategy or nearest equivalent in all 42 ICBs via information available on ICB websites. Where this information was not available, we phoned the ICB to ask for a name and contact details. Where this could not be supplied we used the generic email address for the ICB.

We emailed all 42 ICB directors to ask if they would participate in a 30-minute telephone interview regarding the development of structures to support collaboration in their ICB. The email contained a Participant Information Sheet. Potential participants were emailed three

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times regarding participation in the study, with approximately one week between emails. When potential participants agreed to participate in the study, we emailed a consent form and arranged a convenient time for the interview. 17 Directors of Strategy agreed to participate, out of the 42 who were emailed. ICBs from all seven NHSE regions were included in the participants.

The interviews followed a structured format, with a mixture of open-ended and multiple-choice questions. We shared a draft of the topic guide with an ICB director to check understandability of the questions and refined the questions as a result. Additionally, we added a question about priorities in the ICB Joint Forward Plan after the first two interviews, and refined it after using it in four interviews, as some interviewees were finding it difficult to answer the question as it was too broad. In three interviews, interviewers skipped this question due to time constraints.

Interview questions concerned the number of PBPs and provider collaboratives in the ICB, their governance structures and the reason for their adoption, the role PBPs and provider collaboratives play in the achievement of ICS priorities, where commissioning decisions are taken, use of joined up/pooled budgets, challenges to effective collaboration and collaboration to achieve priorities of the Joint Forward Plan.

Before each interview, the interviewer checked the Governance Handbook analysis for that ICB so our understanding of place-based governance arrangements could be checked with the interviewee. Interviews were audio recorded and professionally transcribed. Responses to questions were input into a framework based on the topic guide during the interview and additional answers were added later from the transcription of the interview, and this framework was used for the analysis. PAV, MSur, JH and MSan met to discuss the data and emerging themes.

The information in the framework from the 17 interviewees was cross checked against the information gathered in the Governance Handbook analysis (see Section 5.3). Any discrepancies were investigated by rechecking Governance Handbooks to ensure we had accurately recorded the information they contained.

To protect anonymity of interviewees, all interviewees are denoted with a four-character interviewee pseudonym code.  Where quotes are used and the arrangements being described in them make the ICB potentially identifiable, we have not included a pseudonym code for the interviewee.

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### 5.4.3. Results

**Commissioning in ICBs**

As noted in Section 5.3, commissioning refers to a wide-ranging set of activities including objective setting and decision making, management of partnerships, supporting patient choice, information collection, service design and resource allocation and procurement and contracting (Wade et al. 2006, Checkland et al. 2024). While the fundamental architecture of services governed by contracts between a provider and a commissioner (or purchaser) was left intact by the HCA 2022, it is envisioned that commissioning under statutory ICBs will bring together providers and commissioners to plan and deliver services for their geographical population in a more collaborative way. There are also policy expectations that significant decision making should be devolved, including to PBP and provider collaboratives (NHS England and NHS Improvement, 2019).

We asked the 17 ICB directors how commissioning was organised in their ICB, where formal commissioning decisions were being made, and why the reasons these arrangements had been put in place.

Some interviewees reflected on the nature of commissioning under ICBs. They suggested that, although the Act had not fundamentally changed the structure of commissioning, the concept of commissioning was in flux. One interviewee commented that commissioning needed to "re-find its place in the new world" [U280], and ICBs were still developing understanding of the implication of a collaborative approach to commissioning and the new rules about procurement. Another suggested that 'commissioning' as an umbrella term was being replaced by its constituent parts, with an emphasis on the collaborative approach:

> "We don't really talk about commissioning anymore, we talk about service planning and prioritisation, integrated service planning, transformation and those are activities that we do in partnership with providers. So, the functions of commissioning, understanding what your population needs, buying services and ensuring that we're delivering services to an agreed standard." [TC01]

The transfer of commissioning responsibilities from CCGs to ICBs had led to practical challenges, and it was suggested that ICBs may be undergoing a process of review of contractual arrangements. One director highlighted that "there's a lot of work to do" to understand of the activity that underlay the ICB contracts. This work was necessary in order to move towards more activity-based agreements which could drive productivity and

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efficiency gains: “We need to really strip down what we're getting for the allocations we get at the moment” (DXLE).

We asked ICB directors where formal commissioning decisions were made. From the 17 ICBs that participated in our study, eight ICB directors indicated that formal commissioning decisions were made by the ICB itself. In other cases, commissioning was split between the ICB and its committees, including PBPs. Division of responsibilities were by service area (e.g. committees with responsibility for acute/community/mental health), geography and scale (e.g. place-based decision making), or by activity (e.g. management of partnerships, service design and resource allocation, procurement and contracting). Some ICBs were delegating some commissioning responsibilities to place committees or to Executive Directors of ICBs. These arrangements are explored below.

**Use of joined up and pooled budgets**

Joined-up and pooled budgets arrangements are considered an important way to reduce fragmentation of services and facilitate more joined-up care that wraps around patients' individual needs (DHSC, 2022c). These can be delivered through joint working and pooled fund arrangements under Sections 65Z5 and 65Z6 (inserted by Section 71 of the HCA 2022), and/or the provisions relating to arrangements between NHS bodies and LA under Section 75, which is the route through which the Better Care Fund (BCF) is delivered. (DHSC, 2023). We asked interviewees whether the use of joined-up or pooled budgets had changed, compared with the previous commissioning arrangements. Overall, it appeared that ICB leaders were concerned with trying to make the use of such funds more effective, and were engaged in trying to understand how such funds were being used in order to target them more effectively.

Most interviewees (13/17) indicated either that the use of joined-up/pooled budgets had not altered, or they were not sure. A common explanation was there had been no change as ICB staff were trying to understand what was being paid into the funds and what they were being used for, in order “to make sure we've got the right money in the right place for people” [TND9]. In one such example, the ICB director was hoping that better use could be made of the pooled funds as a result:

> “I see a bigger opportunity for us to pool budgets with the local authority, but if I'm honest at the moment the pooled budget does nothing to achieve an outcome. We have cases where we technically have pooled budget - BCF for example - but we're just not maximising the value because the pooled budget is more about putting things

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in a common pool but actually what we're not doing is powering that up and dissolving the boundaries." [OSLM]

One ICB director commented that the value of pooled funds had decreased. This was because in this ICB the CCG budgets had been pooled with LA money, and following the creation of the ICB the acute funding was administered at ICB scale. In the two ICBs where the purpose of the joined-up/pooled fund had altered, one indicated the ICB and LA were identifying specific purposes for the fund, such as bed brokerage as this was thought to be the most effective approach. Only one ICB director indicated that the ICB had increased the value of a joined=up/pooled budget, indicating that it was investing in relation to prevention, early intervention and supported discharge.

**Role of PBPs in relation to system objectives**

We asked interviewees about the role PBPs were playing in the attainment of ICS objectives. Overall, PBPs were said to fulfil a very significant role in system working, constituting a "critical component" [6KXZ] which was "fundamental" [TC01]. It should be noted that while PBPs were thought to be of crucial importance among most of our interviews, four ICSs nationally do not contain places as it was argued that the geography is not conducive to this, and this situation was represented among our interviewees.

The main roles ascribed to PBPs are summarised in Table 8 in relation to the potential activities and approaches of PBPs identified in 'Thriving Places' guidance (NHS England and NHS Improvement and Local Government Association, 2021). It was argued that PBPs were central to the achievement of ICSs four core objectives. They were described by ICB directors as leading health and care strategy and planning at place, service planning, and service delivery and transformation, and acting as a convenor of place partners. Less frequently, responsibilities in relation to population health management and the general promotion of health and wellbeing were identified as core responsibilities.

| Potential activity of place-based partnership | Examples from interviewees |
| --- | --- |
| Health and care strategy and planning at place | • Development of priorities at place scale, and contributing to the 'bottom-up' development of system priorities<br>• Tailoring of system priorities to suit the local population<br>• Development of strategies for the place population |
| Service planning | • Delivery of agreed strategy in relation to place |

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| Potential activity of place-based partnership | Examples from interviewees |
|---|---|
| | • Decision making for delegated functions and financial resources<br>• Strategic commissioning for pooled budgets<br>• Site of all delivery infrastructure |
| Service delivery and transformation | • Decision making responsibilities primary care (GP, dental, optometry, pharmacy, community health services, and medicines management)<br>• Operational management of some ICB contracts and BCF<br>• Performance oversight and delivery, in terms of standards, quality and financial performance<br>• Integration of care<br>• Driving forward improvements in urgent emergency care<br>• Commissioning through place-based Executive Directors<br>• Address challenges in local delivery, such as waiting lists, A&E, finance<br>• Focus on specific areas in consultation with population health management team (e.g. cardiac, smoking, maternity) |
| Population health management | • Ensure and deliver that proactive, preventative care, and enact the actions that are necessary to address the full range of determinants of a population's health. |
| Connect support in the community | • Convening place-based partnerships<br>• Overseeing the development of integrated neighbourhood teams<br>• Supporting and enabling primary care<br>• Building relationships with primary care and general practice<br>• Developing relationships for delivery<br>• Co-ordinating of voluntary, community and faith sector<br>• Linkage with local communities |
| Promote health and wellbeing | Not referred to |
| Align management support | Not referred to |

Table 8: Roles of PBPs described by ICB Directors in relation to the 'Thriving Places' guidance

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### Governance of PBPs

We asked interviewees to choose which option from a list of governance approaches best described the relationship of their PBPs to the ICB. The options were drawn from the 'Thriving Places' guidance (NHS England and NHS Improvement and Local Government Association, 2021) and are detailed in Table 9 below, together with the responses we received.

Eleven (11) of the ICBs represented in the interviews had adopted a structure for PBPs which could facilitate some sort of delegation of functions and financial decision-making to the PBPs (i.e. 'internal' delegation to committee/sub-committee of the ICB or individual ICB members or employees). In the other six ICBs, PBPs either had consultative status, or in the case of one ICB, PBPs had not been formed. Most of our interviewees indicated that there were similar or identical governance arrangements across the PBPs of the their ICS. This is in contrast with the arrangements described in relation to provider collaboratives (see below). The delegation of functions and financial decision making from ICBs to place based partnerships and individuals 'sitting' in places will be discussed below.

| Governance arrangements | Number of ICBs adopting these arrangements for place-based partnerships |
|---|---|
| Consultative forum informing decisions of statutory bodies | 4 |
| Individual Executives or staff with delegated authority to exercise delegated ICB functions | 2 |
| Committee or sub-committee of the ICB | 5 |
| Joint committee of the ICB and other statutory bodies | 0 |
| Lead provider with a lead responsibility for service delivery at place level | 0 |
| Other | 6 (see Table 9.2 below for breakdown) |

Table 9.1: Breakdown of place-based governance arrangements in ICSs

| | |
|---|---|
| 1 | Individual Executives or staff with delegated authority to exercise delegated ICB functions<br>committee or sub-committee of the ICB<br>Joint committee of the ICB and other statutory bodies |
| 2 | Elements of all the options (unspecified) |
| 3 | Individual Executives or staff with delegated authority to exercise delegated ICB functions<br>committee or sub-committee of the ICB |
| 4 | Consultative forum<br>Individual executives or staff with delegated authority to exercise delegated ICB functions |
| 5 | 'An informal grouping of public sector organisations with objectives in common' |
| 6 | No places in the ICB |

Table 9.2: Breakdown of 'other' place governance arrangements

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As indicated in Table 9.2, in the case of six ICBs the governance arrangements for PBPs did not fit into the options. In four cases, this was indicative of a 'layering' of governance arrangements, combining elements of the various options. For example, in one ICB, PBP governance arrangements included individual Executives or staff with delegated authority to exercise delegated ICB functions, a committee or sub-committee of the ICB, and a joint committee of the ICB and other statutory bodies:

> "And [place-based delivery] is executed through the [place-based partnership], but the true governance of that, from an ICB perspective, is through an Executive Place Director. So, we have Executive Place Directors in our system, in our ICB, which is quite unusual compared to other ICBs. But they enable us to have a delegation through that individual, into the partnership. The true governance that connects [places] directly into the ICB is through a sub-committee, so they are a formal sub-committee of the ICB Board…And that sub-committee also has a Non-Executive member that is part of our ICB as well … we've also got formally constituted joint arrangements with our local authority as well." [Identifier withheld]

In addition to the above, there were some other noteworthy aspects of the governance arrangements described by interviewees. While we were interested in governance arrangements between ICBs and PBPs, one interviewee identified arrangements whereby a PBP was classified as a consultative forum in relation to the ICB and had formal governance links with provider organisations through sub-committee arrangements. It was also reported, in relation to another ICB, that PBPs reported into Health and Wellbeing Boards, to reflect the statutory nature of Health and Wellbeing Boards and the similar motivation of the two bodies in relation health and wellbeing of a particular population.

**Delegation of resource allocation decisions to PBPs**

We asked interviewees about the formal arrangements for delegation of decision-making to PBPs. This could be achieved both through delegation to PBPs as a committee or sub-committee of the ICB, or through delegation to an individual ICBs could delegate responsibilities including commissioning functions and financial decision-making responsibilities.

We asked interviewees where commissioning decisions were made, and what proportion of the commissioning budget was delegated.

Seven of the ICB directors indicated that mechanisms had been adopted by their ICB to enable commissioning decision making at place scale. Three interviewees indicated that the

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ICB had made delegations to place-based committees or sub-committees of the ICB and were using this structure to delegate some commissioning decision-making to places. Of these, one interviewee indicated that “pretty much all financial resources had been delegated to place” through delegation of commissioning responsibilities and financial decision-making to place as a committee of the ICB [TC01]. Two other interviewees indicated that some commissioning functions had been delegated to place committees/sub-committees, with one estimating that 15% of the overall ICB commissioning budget was delegated to place [2ZHE]. In the other, the interviewee indicated that it was solely decisions relating to the Better Care Fund which were taken at place, with all other commissioning decisions being taken by the ICB [JS1V].

For the other four ICBs, interviewees suggested that delegation had been made to an individual Executive who was an ICB employee who then sat in a place-based forum to enable delegated decisions to be made at place scale. In some instances, this individual sat on the PBP, however this was not always the case, and subsidiarity was also achieved in other ways. In one ICB, it was reported that the individual Executive sat on a ICB commissioning sub-committee which had been established at place scale. A different interviewee indicated the individual Executive was an ICB employee but jointly accountable to local government too. The degree of responsibility delegated to individual Executives was not clear from the interviews, however an ICB director indicated that this mechanism was used to allow decision making in relation to a budget, for instance in relation to dedicated projects, rather than enabling commissioning decisions.

In another ICB it was reported that the ICB had decided ‘smaller’ commissioning decisions should be made in places, but larger contracts should be decided at the ICB, although PBPs and other collaboratives were involved in these commissioning decisions through working groups.

**Rationale for adoption of place-based governance structures**

We asked interviewees why these models had been adopted.

For some interviewees, governance arrangements made a statement to ICS partners, indicating ICS values and intentions. One director noted that place had been constituted as a committee of the ICB to send a clear signal to partners that place was a formal part of the system, and that the system was upholding the principle of subsidiarity:

> “I think it’s just around good governance and futureproofing. I also think it’s about giving it primacy. We’ve got some very clear values - things should be clinically and professionally led, they should address inequalities, but there should also be an

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element of subsidiarity. Actually if we don't set the organisation up to recognise that, then we're, kind of, being deferential to what our strategic intent is. That's why we went down that route of, let's lock them in." [JS1V]

Another ICB director stated they had used governance structures for PBPs to reflect the vision that PBPs and the ICB were part of the same mechanism. The ICB had formed PBPs as a committee of the ICB and layered this together with Executive and Non-Executive Directors who sat on both the ICB and the PBP. This arrangement signalled that PBPs and the ICB were a single entity, with a difference in focus:

> "So, they're not independent, they're engrained in our organisation. People look at place and the ICB as two different mechanisms. They're not, we're all one thing, it's just that they look after the population of their place." [JU64]

A further ICB director reported the ICB had chosen to adopt the committee model because the objectives of ICSs could not be achieved without the delegation of functions and budgetary responsibility to place:

> "And that objective around the contribution of ICSs, so the social and economic development of the place, are the set of connections that come together in that place model. So, we don't think it's possible, in the context of a place like [our ICB] to achieve the statutory objectives of an ICS without a foundation in neighbourhood and place-based working." [2ZHE]

In this example, the PBPs delegations were associated with the discretionary primary care, continuing healthcare and the complex packages of care that would normally be done through joint arrangements with local authorities.

The local context – encompassing factors like geographical footprint, coterminosity, location and number of acute providers – was highlighted as an important influence on choice of place-based governance approaches. In an ICB where significant delegation was occurring, the director commented this was facilitated by factors such as the footprint of places ("it's a good geographical unit to build relationships", with "natural partnerships" [TC01]) and coterminosity between place and LAs: It was also suggested that the size of the ICB area made a difference, particularly in relation to the question of whether to delegate from the ICB.

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> "I imagine if you are in a smaller ICB, then it's probably a different question about what you delegate to places but for us as a large system, it just made logical sense and was in line with what we had done previously." [TC01]

A director based in a smaller ICB suggested that effective collaboration could be achieved without delegation to place, in a system which had coterminosity with LAs and where the ICB could accommodate all key partners around the table:

> "Now the collaboration and the integration model in the [smaller ICBs] of the world are so fundamentally different from the [larger ICBs]. And we're in that fortunate position where we're small enough to be able to collaborate fully with all of our partners in the ICB. We have the council as partner members, all [number] NHS trust Chief Executives or managing directors as partner members, the lead GP from each place, the most senior GP as a partner member. So, every single significant organisation. That works on our patch. So therefore, whenever we talk about integration, development you know, anything like that, the ICB, every single partner is around the table taking part in the discussion. So that just fundamentally changes the whole concept of integration, and how the Health and Care Act operates on the ground in our patch. So, I think that's just really important to be clear around that". [B1RE]

One interviewee warned about the importance of understanding local context in relation to choice governance structures, particularly guarding against the assumption that it is possible to 'lift and shift' structures linked to successful collaboration to another area. In their view, structural change can be helpful but is secondary to other concerns such as local relationships and culture [L3UY].

A further interviewee suggested that where places looked to the same large acute provider, it would be technically difficult to split the acute budget to delegate to place. This ICB was described as undergoing a "developmental or evolutionary journey" because of the scale and complexity of some of its places, and because of this were not delegating budgets and functions [JS1V]. However, it is perhaps surprising that dividing budgets to places is technically difficult given that budgets were previously admitted at smaller footprints in relation to CCGs. It is important to note that ICSs had a choice as to how their places were constituted; the 'scale and complexity' referenced is therefore choices made by the ICB. We will return to the issues in the Discussion (Section 7).

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Two other directors pointed out that to delegating significant commissioning responsibilities to them would not be a cost-effective model as it involved a duplication of resources and capabilities in relation to procurement and contracting. A further barrier to delegation of commissioning decisions to place-based partnerships for some was that it was perceived to be a conflict of interest:

> "So, there's too much conflict. So, we couldn't have a provider commissioning its own services. And if you delegated it to place, you've got too many conflicts on the Place Board. So, it is better to be done at the ICB, that's the reason why we've done it that way." [JU64]

This issue of conflict of interest was also raised by an additional interviewee, who agreed that the elements of commissioning should be separated, keeping the central team to conduct the contracting and procurement function. This was driven not only by conflicts of interest but also economies of scale [U2XD]. However, it is important to note that ICBs themselves include provider representatives, and issues of conflicts of interest may therefore also arise in ICB commissioning.

Another ICB director said that lack of statutory footing to place prevented the delegation of commissioning:

> "Because our PBPs are not yet mature enough and because they don't have a statutory footing, which has always been the issue. I think if we could create a situation where PBPs could be a form of provider collaborative, that would enable us to do that. But other than that, they don't have a formal legal…they're not a formal legal entity, to be able to give them delegated commissioning authority." [5WOD]

Governance arrangements in places were considered complex by some ICB directors. The view was presented by one ICB director, in an ICB where place was constituted informally, was that "place-based governance is bureaucracy the NHS doesn't need" [X1Z5]. In this view, formal delegation of significant responsibility created too much burden in terms of infrastructure and governance requirements distracted from efforts to achieve integration of services:

> "We would argue very much the opposite, that often it's a helpful distraction to other people to find something to do, because they are finding the real job of transformation too difficult to deliver. So we've really, really tried to avoid going into complex delegations in governance because, frankly, for us it would just be a complexity that wouldn't help us do the day job. I think if you create something called place, and then

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> you decide it's going to have delegated decision-making responsibilities and delegated budgets, suddenly you have to put statutory assurance around it. So, like, does the place need a [Chief Financial Officer] now to assure the budget that's being held on a delegated basis? And has it got to have a Committee or Board, with a capital letter, which meets in public and has minutes that can be scrutinised, or its decisions subject to judicial review and independent assurance and unpicking? Before you know it, you then need a secretariat, you then you need to have minutes and papers that are published a week in advance on the internet. It becomes an industry in itself, all of which could be fine if anyone could prove the case that you couldn't achieve what you wanted to achieve without doing that thing." [X1Z5]

In this ICB, where investment decisions or statutory decisions around change needed to be made they would be made by the Health and Wellbeing Boards, and other relevant local government structures or the ICB. PBPs served a convenor function, bringing stakeholders together to design and implement work.

A similar view was put forward by another interviewee who did not believe that the delegation of budgets would achieve much in their ICB:

> "But I don't see the need to go, here's 300 million pounds, go and do what you want with it to try and achieve those objectives. I just think it will be a less efficient resource allocation model. It'll be a more complicated governance structure and I don't think fundamentally it would make any difference to the way in which things work." [B1RE]

Interviewees identified various advantages in constituting PBPs as consultative committees. One interviewee suggested that the consultative committee was a suitable form in periods of significant transition at the ICB scale, such as changes in number of PBPs, the appointment of new senior staff including place leaders, and in the early stages of the development of a strategy for place [TND9].

A further governance option being used by the ICBs represented in the interviews was delegation to individual directors. This arrangement was described as being used to give some autonomy at place scale regarding financial decision-making, but on a more limited basis than delegating responsibilities to a place-based ICB committee or sub-committee:

> "Delegation is through those individuals into the PBPs, we haven't, as yet, reached a place where we've got full delegation into the place-based partnerships." [S50F]

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Delegation of some financial decision making from the ICB to individual Executives was described as a way of "giving control back to our communities….in a managed way" [5SOF]. Delegation to an individual was described as a way of retaining control over decisions at place through a direct managerial relationship: "our Place-based Executives are my Executives on my ICB, so the [number of] people report into me anyway. They are budget holders in their own right." [JU64].

According to one ICB director, the decisions made at the local level under these arrangements allowed for budgetary control but did not extend to full commissioning authority:

> "They make decisions around some of the allocated budget that's been identified. For example, around dedicated projects like the community mental health provision. So, how they want to deliver that. And there's some responsibility around the budgets, but it's not the same as commissioning them in the same way as you would commission a wider service. I think it's having the decision making around the budget." [5WOD]

For some interviewees, delegation of this nature to an individual Executive was a step on the way to 'full' delegation. A common position among interviews was that the means of achieving subsidiary and 'full integration' was that "the nature of that integration has got to be dictated by the requirements or the unique requirements of each place" [S5OF].

The issue of 'maturity' was raised by some interviewees, as a barrier to delegation of more decision making to place. This interviewee explained more about what was meant by maturity:

> "It's about timing and evolution. So it's about stability and maturity of the organisation. It's about the stability of those partnerships that need to be developed at place. So, unless we've got stable, mature, functioning PBPs, it's a very big risk to delegate down." [JS1V]

However, this view was disputed by another interviewee, who suggested 'complex' governance arrangements should not be equated with maturity, rather attention should be focused on what can be achieved through transformation [1BDM]. The question of 'maturity' is interesting in light of the development of partnership arrangements in systems since the establishment of ICSs from 2018 onwards, and of prior organisational inter-relationships, for instance with CCGs. This issue is returned to in the Discussion (Section 7).

The financial risk of delegation was a common issue cited which acted as a barrier to delegation. For one interviewee, despite "genuine collaboration and genuine shared

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understanding of some of the challenges” the ICB were not currently where they wanted to be in relation to delegation [6KXZ]. The root in this ICB was seen as the financial situation, where all partners were experiencing financial challenges:

> “So, it just makes things difficult in terms of that, sort of, oversight and control and sharing of financial risk and things like that, when you start investing in these formal place-based partnerships and collaborative models. But again, I’m very much of the view that we should get to a place where those responsibilities are delegated in that way with that autonomy to act within a financial envelope and things. But we’ve got to be able to do it in a way that sustainably stacks up in terms of our system.” [6KXZ]

Another interviewee described how the worsening financial position had led the ICB to “bring up a bit of the drawbridge and regroup” [TND9]. Consequently, ICB leaders had decided not to delegate due to financial pressures, despite their original intent to do this: “we don’t want to delegate a deficit, in essence” [TND9].

For another ICB director, the constitution of place as a consultative forum was forced on the ICB because of its position as a Category 4 system in the NHS Oversight Framework. This category is for ICBs and trusts that have longstanding and/or complex issues that are preventing agreed levels of improvement, a significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan or a catastrophic failure in leadership or governance that risks damaging the reputation of the NHS (NHS England 2022b). Organisations in this category participate in the national Recovery Support Programme (RSP) which provides focused and integrated support. In this case although the director believed that place directors could safely manage place spending, the ICB was described as forced to take a ‘centralist’ approach and was not allowed to delegate due to strict controls over spending:

> “We even have to ask permission to spend anything over £50,000… And although there are five elements to the national oversight framework, finance is probably the biggest one for [the ICB], to be honest, because of the historical overspends that all of the providers have had. And then secondary to that is the [particular performance target] performance, which up until quite recently was very poor across a number of our acutes in particular. So, we couldn't delegate out any responsibilities whilst we're subject to monthly regulatory oversight meetings.” [Identifier withheld]

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**Provider Collaboratives**

In relation to provider collaboratives we wanted to establish the different types of collaboratives in each ICB, the governance model, and the role provider collaboratives were playing in the achievement of ICS priorities.

Across the 17 ICBs that participated in the study, 47 collaboratives were identified. These consisted of: ten acute provider collaboratives; 13 mental health provider collaboratives; seven community provider collaboratives; six mixed service provider collaboratives; five primary care collaboratives; four VCSE collaboratives (including one joint with community providers); one cancer provider collaborative; and one hospice provider collaborative. One ICB did not have any provider collaboratives, due to the limited number of providers within its boundaries.

We found a great deal of variation regarding both function (the role of provider collaboratives in relation to ICB priorities), and form (the governance models) of provider collaboratives, including within ICBs. Many of the 17 ICBs that were represented in the study had a mixture of models across their provider collaboratives. Some of these collaboratives were noted to be embryonic. Both form and function were often described as reflecting the perceived 'maturity' of the relationships in each collaborative. The degree of variance between form and function of provider collaboratives was commented on by some interviewees, with reference to work at a regional and ICB scale to clarify what was wanted from provider collaboratives, identify synergies between them and decide whether there should be more uniformity between them:

> "[NHSE region] looked at all of the development of provider collaboratives across [region] to try and look at what synergies there were and to be clear about what we want from our provider collaboratives in [region]. I think we are all working in quite different ways…
>
> …So we have created a really complex operating model in [ICS] and each of the collaboratives, it's been quite a bottom-up process in terms of them determining what they wanted to focus on and how they were going to operate. I think some of what we want to do now is just look at that to see whether a higher degree of consistency would be better for us as a system. Because my personal view is if you create a really complex system then things like transaction costs are really high because it's got to do things differently all the time. And if we've got [number] collaboratives and [number] places then there's an awful lot of interactions across the system, so is there an

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opportunity to just make some consistency in some areas where appropriate." [Identifier withheld]

Interviewees were asked to identify the contribution that provider collaboratives were making to ICB priorities. These are indicated in Table 10, grouped by the specific types of 'benefits of scale' that are identified in guidance as being relevant to provider collaboratives (NHS England and NHS Improvement, 2021). Five ICB Directors commented that one of the provider collaboratives in the ICB were in early stages of development and therefore did not make a significant contribution to ICS priorities at the present time.

| Benefit of scale | Examples of activities |
|---|---|
| Reductions in unwarranted variation in outcomes and access to services<br><br>Reductions in health inequalities | • Design and delivery of end-to-end pathway transformation<br>• Support the reduction in unwarranted variation<br>• Collaborate to organise care and drive quality improvement in doing so<br>• Focus on, standardisation, what can we do once and do it well across the system? |
| Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures | • Leadership responsibilities for key priorities like elective recovery,<br>• Review of pathology, diagnostics, and fragile services<br>• Support resilience and mutual aid<br>• A series of transformation programmes<br>• Lead on different workstreams across the system |
| Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans | Not referred to |
| Efficiencies and economies of scale | • Developing the sharing of back office corporate functions<br>• Work programme which plays into the financial turnover situation as well as efficiencies<br>• Work at scale around mental health |
| Consolidation of low-volume or specialised services | Not referred to |
| Other: Formulation of strategy and policy | • Distillation of national priorities to help formulate ICB strategy and policy |
| Other: Organising collaborative members to articulate a shared voice or deliver joint activities | • 'Corral' members for delivery |

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| Benefit of scale | Examples of activities |
| --- | --- |
| | • Provides a joint voice for providers in that sector, to influence strategy and an approach to delivery of the Integrated Care System overall |
| Other: Delivery of ICS priorities (unspecified) | • Service improvement priorities<br>• Delegated responsibility for delivering specified aims<br>• Integrated part of the leadership infrastructure with specific roles<br>• Goals and measures that are in the strategic plan<br>• Responsible for all mental health services apart from commissioning<br>• Supports the delivery of our programme of work, linked to the national must dos around mental health but our strategy for mental health |

Table 10: Examples of activities with potential benefit of scale

In terms of governance structures, we asked interviewees which of the models identified in guidance best described the provider collaboratives. These were: 'provider leadership board' (where Chief Executives or other directors from participating trusts come together with common delegated responsibilities from their respective boards); lead provider contract (for an agreed set of services); and 'shared leadership' (of the trusts involved in the collaborative, such as CEO or Chair). We found that these models often did not adequately describe governance arrangements in practice. One interviewee did not know what governance structures had been adopted in provider collaboratives.

Three ICB directors indicated that their ICB included a provider collaborative(s) in which one provider held a lead provider contract for an agreed set of services. All of these arrangements focused on mental health services, with specialised services and community health also mentioned.

Ten ICB directors indicated that one or more of their provider collaboratives had adopted a Provider Leadership Board model. Only one interviewee indicated that these collaboratives involved the formal delegation of responsibilities from the respective provider boards to the Provider Leadership Board.

Five ICB directors indicated that one or more of their provider collaboratives could be characterised as having a shared leadership model. However, only one of these arrangements clearly adhered to the policy definition of 'shared leadership' where a single Chair or CEO had a leadership role across all the trusts involved in the collaborative. The arrangements in the

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other ICBs appeared to be that leadership of the collaborative was shared between participants, without using a lead provider contract arrangement or having the status of a board with formal delegation of responsibilities. Interviewees referred to arrangements in collaboratives for leading workstreams across multiple organisations. For example, Executives of NHS trusts and Foundation Trusts e taking a lead for particular pieces of work:

> "And then we've got a leadership, what I would call a leadership model. It is a leadership model in governance terms, where we've delegated an objective to a leadership model. For example, delivery of elective care and elective performance is through a leadership model, where an executive of a trust, so a CEO, will take the lead in a partnership, or a sort of leadership partnership arrangement with other providers that have got a common interest." [U280]

Two ICB directors indicated that the provider collaboratives were constituted as leadership forums. Therefore, in total, it is likely that in six of our ICBs one or more of the provider collaboratives were constituted fairly informally.

**Rationale for choice of governance model in provider collaboratives**

Many interviewees acknowledged that currently provider collaboratives were quite a long way from being able to take on budget responsibilities or delegated functions. Relationships were a sticking point for the development of some provider collaboratives, and the strength of relationships often differed in the various collaboratives in a single ICB, with some being thought of as 'mature' and others not. The term 'mature' was used to refer to whether the providers could collaborate without ICB oversight:

> "The acute service collaborative is not anywhere near as mature as we would want it to be. And it is still very much a ICB and provider relationship, which is not really where we want it to be. But that's something we're developing. And the primary care collaborative is probably somewhere in the middle." [DXLE]

Interviewees reported that until relationships improved, the ICB would not be able to delegate functions or responsibility for budgets to collaboratives:

> "It's relationships between our two acutes that needs further work to enable that collaboration to turn into a collaborative. But that is the ambition. And at that point we would have a more serious conversation about devolving certain duties and budgets and whatever down to that collaborative in a way that we're starting to do with our mental health, [County 2] collaborative. But that's I think some time off until I

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think we’ve resolved some of the relationship and cultural issues between the two trusts.” [L3UY]

A possible barrier to the success of provider collaboratives was the lack of alignment of the policy requirement for formal provider collaboratives with the complex nature of collaboration between providers in practice. One ICB director described the difficulty the ICB had encountered trying to enact the requirement to establish provider collaboratives, within the complex existing landscape of collaborative activities between providers:

> “Yeah, this is really complex... I don't know whether you've come across this in other places as well, because NHSE originally said, every place has got to have a provider collaborative and there was this kind of, oh God, we've got to have a provider collaborative, how are we going to do this? We were doing it because we had to have a provider collaborative, whereas it didn't, it doesn't really work as simply as that. So it's not a simple structure the way in which NHS England envisaged it when they described all systems having to [have collaboratives], or all trusts having to be part of a collaborative. Most of them are part of multiple collaboratives.”[B1RE]

Furthermore, the interviewee believed that the requirement for formal provider collaboratives was distracting from a focus on task driven collaboration:

> “The provider collaborative element I strongly believe that the most important thing is about collaborating on the right things, rather than having a collaborative that is formally drawn up and defined in structure. So in [Place2], what we really need the two trusts to do is collaborate on the urgent care pathways. As long as they collaborate effectively on the urgent care pathways, they don't need to be the same trust, they don't need the same chair. But if they don't collaborate effectively on supporting people to leave hospital or running community services to avoid people from leaving hospital, going into hospital, then we fail. I think collaboration is more important than formal collaboratives per se.” [B1RE]

Others felt that there should be more clarity and precision about the expected role of provider collaboratives. For one director the role of provider collaboratives was ‘muddy’ and needed to be clarified:

> “I think it’s really hard to expect providers to work well together and deliver well together when they’re constantly being pulled into spaces of ICB and also places. It’s almost like we need to have a really clear ask of provider collaboratives, whatever they are, and allow them to get on with, you know, delivering that and actually giving them

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> the wherewithal to do it. And what I mean by that is, if we recognise that they've got a budget to live within, and they've got a set of objectives to deliver on, I think we need to be really clear about that and I don't think we are quite yet. I think it's still quite muddy for provider collaboratives at the moment." [U280]

For some this clarity could be achieved locally, through a clearer articulation by the individual ICB regarding 'what it wants and why' and leaving provider collaboratives 'to get on with the how' [JSIV]. Others however, suggested this clarity should be centrally provided.

**Challenges to system collaboration and the realisation of system priorities**

We asked interviewees what they considered to be the challenges in realising effective collaboration in ICSs, and realising the priorities of the Joint Forward Plan. The main areas identified were finances, clarity of roles, central control, organisational sovereignty and relationships with wider partners. While highlighting challenges, a common theme was overall support for the collaborative approach and lack of appetite for any fundamental or large-scale changes to the status quo:

> "It would not be helpful to have change. I think change needs to come from us now rather than any more top-down change that means that we need to review how we're working or structures and things like that. It's really early days still for what was a really fundamental change from [number] CCGs into one new Integrated Care System, and we need a bit of headroom or whatever the phrase is to work that through and to feel that we've got a grip of our system. That's what we're really keen to do. We want to take charge really. We really understand our population health needs. We're trying to review how we operate so that we can get ourselves in the best position, and we just need a bit of head space to get on with that I think." [1BDM]

**Financial situation**

The financial position presented a significant challenge to collaboration and the achievement of priorities. The financial problems of the public sector across the board were seen as a backdrop which threatened to disrupt collaboration, with the potential to weaken previously strong collaborative relationships:

> "And all of the great work we've done over the years here in the ICS has been built on the strength of relationships and our investment in culture and leadership and OD, collectively. I think when money gets really tight those things start to fray at the edges. So the top thing, the bedrock of collaboration and the relationships that underpin that collaboration I think could be really significantly hampered by statutory

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bodies having to start squabbling with each other for money, rather than putting the resident at the heart of it and accepting some time you'll win, sometimes you'll lose financially. And, yeah, it's a worry, it's, of course, it's a really big worry." [X1ZS]

Alternatively, the possibility that scarcity could spark collaboration in times of crisis was also raised [2ZHE].

Financial challenge was a common difficulty cited when interviewees considered the challenges they faced in the achievement of the priorities of the Joint Forward Plan. Interviewees tended to mention finance as an ongoing contextual problem rather than pinpointing specific problems which financial difficulties caused. One interviewee described how financial challenge presented problems in relation to the achievement of Joint Forward Plan priorities:

> "So the biggest issue we've got at the minute is the money. That is the biggest issue. So, if we need to invest in the community to get that out of hospital, we haven't got the money to invest. We're an organisation that's currently got a 40 million deficit control total. So that is an issue. If we need to invest more money into health inequalities, we haven't got any money to do that. So, I think finances are a massive challenge." [JU64]

**Clarity of roles**

Lack of clarity regarding the roles of the various collaborative forums, partners and statutory bodies operating within systems threatened to disrupt collaboration. In particular, interviewees highlighted lack of clarity about the role of ICBs as an area of concern, along with the potentially duplicative roles of ICBs and NHSE.

Interviewees suggested that the role of the ICS had shifted over time, as a result of oversight from NHSE and the changes of the HCA 2022. There had been a shift from developing ICSs as partnerships between NHS and local government to being held account, as statutory ICBs, as part of the NHS hierarchy. Interviewees described ICBs as "vehicles for NHS assurance in local systems" [2ZHE], and "positioned as the intermediate tier between national and local provider organisations… part of the NHS performance management chain" [TC01]. ICBs were perceived to have been given primacy over the other (NHS) partners in the system, which was held to be "anathema to the ethos of ICSs":

> "ICSs should be genuine equal partnerships, which are non-hierarchical and are relationship led. And if you take the ethos of an ICS to its fullest end-point, you actually wouldn't need to have an ICB because the work would be naturally

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> progressed by the partners within the system. Instead what you've created is a body which is designed to be a mini regulator to hold the rest of the NHS to account over more of your geographical area…so it is the opposite of what I think integration should be." [X1ZS]

One interviewee explained the difficulty in practice for ICB leaders of moving between an oversight role and facilitator of collaboration:

> "I think that in an ICB, at the moment you've got to wear multiple hats, you've got to be policeman, you've got to be counsellor, you've got to be convenor, and everything in between….But I do think that the oversight roles or expectations that are informally placed on ICBs at the moment can get in the way of the collaboration piece. Because it's very hard, if you're at a provider now, so if I'm speaking to you going, you need to sort those ambulances out in the next two minutes or there's big trouble, kind of thing. And then in two minutes, we go onto another meeting and I'm, like, right I'm keen to work with you to develop what a place-based offer is for this." [6KXZ]

Interviewees suggested that the focus of ICBs on oversight and assurance, had led to duplication of function with NHSE and an imbalance between those conducting oversight and those being overseen:

> "NHSE will be leading meetings, I'll be leading meetings. And there'll be about 20 people on each of those meetings and, you know, we're all pointing our finger at the same person, kind of thing, that's what it's like. So, I think clearing up how that relationship, that statutory relationship for providers and provider collaboratives works is going to be important." [BKXZ]

It was suggested that this imbalance of oversight was accompanied by a corresponding imbalance of resources. In particular, there were concerns that there was not the right leadership capacity at place level to ensure design and delivery at a local level, while there were too many people monitoring delivery.

Interviewees articulated calls for greater clarity regarding roles on a number of fronts. Firstly, a call for greater clarity about the role of NHS regions in relation to ICBs, specifically who holds responsibility for performance management [DXLE]. Secondly, greater clarity was called for regarding the vertical accountability relationship between NHSE, ICSs, PBPs and provider collaboratives, as "we're all tripping over each other a little bit at the moment" [6KXZ].

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The landscape within systems also had the potential to become duplicative. This was primarily raised in relation to the potential overlap between provider collaboratives and place-based partnership roles. It was also noted that there was a further layer of complexity and potential duplication of effort in relation to pre-existing and new networks, including those not necessarily directly connected to system working:

> "At some point someone's going to have to decide is it we're going for collaboratives or are we going for [PBPs], because it doesn't work trying to do both. Then the networks, it doesn't work trying to do all three. Then if we have national collaboratives, which are coming, there's going to be four big ones of those, that starts cutting across everything. So it's a crowded picture at the minute and it just needs streamlining." [U2XD]

**Command and control management**

Many of the ICB directors interviewed were concerned that a focus on performance management targets and national 'must do's' was crowding out the focus on the four core purposes of ICSs. It was argued that ICBs should be refocused onto partnership development, driving change at the strategic level, the development of place-based working and population health [BKXZ], and this misalignment should be enabled by a refocus of the wider 'infrastructure':

> "The regulatory infrastructure has got to also be focused on that, national infrastructure has also got to be focused on that, what we can't do is have this kind of schizophrenic approach where we talk about integrated care systems and the four purposes and then you revert back into performance and challenge. It becomes about general performance, financial performance and stuff like that which is all very, very important, I get it but we'll never get out the woods of that unless we start to have a different conversation in terms of those more strategic transformation type conversations around delivering those core purposes." [S5OF]

In respect of the performance management of ICBs, multiple interviewees objected to a 'command and control' approach taken to the management of the NHS. This was seen to be in tension with the collaborative ethos, which was centred on permissiveness and local autonomy:

> "Anything around leadership and around how you enable organisations to effectively deliver, will say to you, be really clear about what you're asking an organisation or

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group of organisations to do. Make sure they've got the resources and the wherewithal to do it and then let them get on with delivering it." [U280]

It was argued that policy should focus on the delivery of outcomes, rather than seeking to standardise inputs. For example, when funding was allocated to systems for a particular service area or problem, it was argued that local systems should be allowed to tackle challenges differently rather than being told how money should be spent [5WOD]. In relation to the achievement of Joint Forward Plan priorities, one interviewee pointed out that the breadth of national asks and priorities made the identification of a set of core ICS priorities difficult:

> "To be frank, there's too many, and a lot of that is driven, if I'm honest, by the national set. And to be fair to [NHSE senior leaders] and team, they've radically reduced the next set of annual priorities over the last two years, but it still remains the case that there is so many asks from each of the teams at NHS England that it's difficult to determine what is the absolute priorities versus the fact that there is so many things that we're now expected to do, partly because of the breadth of the NHS and our responsibilities. So it's really hard to get down to these are the core set." [L3UY]

Other concerns were that the Joint Forward Plan priorities were distributed among too many incremental small changes, rather than focusing on fewer areas which could make a bigger overall impact.

**Organisational sovereignty**

An enduring underlying issue raised by multiple interviewees in relation to the key challenges of collaboration was that of organisational sovereignty. It appears that, despite the mechanisms of the HCA 2022 which are aimed at strengthening the commitment of statutory organisations to collaboration, ICB leaders are still concerned that partner organisations will backtrack on commitments made or indeed will not agree at all to decisions that are against direct organisational interests.

> "But I always think the sticking point is the fact we are still single…we're all our own organisation and when things can get tough, people revert back to their own organisation. And how we overcome that, unless you've got some authority or power over it, I'm not sure because they're all single statutory organisations…. and I think we do make it work really well but there are times where it can get challenging and tricky, yeah." [JU64]

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The challenges presented by organisational sovereignty were also raised in relation to the attainment of Joint Forward Plan priorities, with concerns that organisations' drive to deliver their own financial targets and ambitions might stand in the way of the achievement of system targets [JU64]. The risks to collaboration presented by organisational sovereignty were considered to be exacerbated by the volume of system partners who were required to reach consensus. It was also suggested that the threat of the loss of sovereignty in provider collaboratives in particular could be an issue as collaboratives developed:

> "Are you going to relinquish your organisational sovereignty and identity into a collaborative and be led, or perceived to be led, by a bigger trust. So I think there'll be some sensitivity and politics surrounding the loss of sovereignty and individual identity?" [JS1V]

It was suggested that these issues would persist unless a significant change was made to the context, for instance making places or provider collaboratives statutory bodies [JU64], or strengthening the accountability of place and provider collaboratives to NHSE.

**Relationships with wider partners**

It was noted that while the HCA 2022 had contained mechanisms to foster close collaboration between the NHS and LAs, this closer relationship was not apparent in practice. A few explanations were offered for this phenomenon. One reason given for this was financial pressures being experienced by both parties. Another was that ICBs were being driven to focus on NHS problems such as access to GPs and elective recovery. Another contributory factor suggested by one interviewee was about levels of decision making, specifically that some ICBs have chosen to commission services at a bigger geographic level, than local authority footprints thereby weakening partnership working [TC01].

One solution suggested for this imbalance of focus between NHS and LAs was to focus on encouraging ICPs to thrive. By clarifying the role of the ICP, many challenges facing NHS could be addressed:

> "So, the ICP is there to drive that prevention agenda, that proactive management agenda, condition management agenda. It's there to drive that improved quality agenda because you've got all of the right partners around the table. So, I would say the ICP is the game changer for me but unless we get that right, all of these other things here, we won't get right." [S5OF]

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### 5.4.4. Discussion

The interviews with ICB directors had multiple aims – to explore the rationale for choice of governance arrangements in ICBs (in particular regarding the relationship between the ICB and place-based partnerships and provider collaboratives), to explore how commissioning and use of pooled funds are developing, and to highlight current challenges facing ICBs as they collaborate to achieve their aims. Before discussing the findings in relation to the research questions. it is necessary to highlight the limitations of this analysis. These primarily concern the number of interviewees. We approached directors of all 42 ICBs for an interview and secured interviews with 17 in total, therefore slightly under half of all ICBs participated. While we achieved a good geographical spread of ICBs, with at least one from each NHSE region represented, it may also be the case that those who agreed to be interviewed did so because they held strong opinions about how governance arrangements should be structured in ICSs, or because they felt their ICB represented best practice in this regard. Therefore, our findings may not be representative of arrangements across all ICBs.

This analysis addressed three research questions. The first of these concerns the manner and degree of delegation from ICBs, and the extent to which ICBs are exercising the flexibilities of the Act in this regard. We asked interviewees about the governance arrangements in PBPs and provider collaboratives. Our interviews largely reflected the findings of the Governance Handbook analysis (Section 5.3) that there is a small cohort of ICBs who are delegating significant commissioning decision making functions together with delegated budgets to PBPs. The majority of ICBs have enacted more limited delegation to PBPs or chosen not to formally delegate decision-making functions. In relation to provider collaboratives, none of the ICBs had delegated commissioning decisions. The main area of difference between the findings of the ICB director interviews and the analysis of Governance Handbooks is that the ICB director interviews suggest that delegated functions and financial decision making to ICB Executive Directors appeared to be a more commonly used option. The interviews also revealed additional nuance in ICB governance arrangements in relation to PBPs. Specifically, it showed a layering of multiple mechanisms in some cases, where mechanisms had been combined, such as delegation to an individual, committee status, and place leads sitting on the ICB itself. These variations reflect the permissive nature of the HCA 2022 and associated policy.

We were interested in finding out the reasons for the way PBPs and provider collaboratives have been structured in relation to the ICB. Local context can clearly influence decisions around how to achieve the principle of subsidiarity in decision making, with some PBPs

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having optimal conditions in terms of (for example) coterminosity, provider landscape and size to support the development of shared aims among place partners and the consequent delegation of commissioning functions and financial decision-making. Conversely, it was argued the local context of other ICBs made delegation unrealistic or unnecessary, such as where all parties can be involved in decision-making at system scale, or where budgets were difficult to separate. However, it must be borne in mind that place geographies were locally determined by ICBs; the complexities and difficulties referred were there designed (and could be changed) rather than externally determined. Putting local context aside, there were other rationales. Firstly, there was anxiety around delegation of responsibility where place relationships were not considered 'mature' enough to be entrusted with significant decision making- Secondly, concerns around financial risk and concerns about a loss of control, this was particularly prominent where the ICB had financial difficulties. Thirdly, a belief that the administrative burden of complex governance arrangements outweighed the benefits which might accrue from formal delegation. Fourthly, concerns that conflicts of interest were too great in PBPs to allow devolution of contracting and procurement.

The second question asked which functions, responsibilities and roles are evolving in PBPs and provider collaboratives, and whether different types of commissioning functions were evolving at different system levels. There was a sharp contrast between the limited delegation of formal commissioning decision making and budgetary responsibilities to PBPs and provider collaboratives, and the significant roles which ICB directors said they felt place committees, and provider collaboratives could fulfil. PBPs were considered fundamental to system working. They were described by ICB directors as leading health and care strategy and planning at place, service planning, and service delivery and transformation, and acting as a convenor of place partners. Less frequently, responsibilities in relation to population health management and the general promotion of health and wellbeing were identified as core responsibilities. However, the extent to which these roles could be fulfilled in places without formal responsibilities was not clear from our interviews. This issue will be addressed in Phase 2.

Provider collaboratives were proliferating in number and variation of membership. Some were said to be too embryonic to contribute to system objectives. The most common responsibilities of more established collaboratives were working to reduce variations in outcomes and improve access to services, collaborating to achieve greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures, collaborating to improve efficiency and improve economies

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of scale. Provider collaboratives were commonly thought of as bottom-up developments, and this was reflected in the great degree of variation in form and function. For some, this variation was concerning, raising questions regarding whether it would be more beneficial to have greater consistency, including within systems, regarding the role of provider collaboratives. It was suggested there were a need for increased clarity about what the 'ask' of provider collaboratives was, particularly in the light of possible duplication or lack of definition regarding the remits of places and provider collaboratives.

In relation to commissioning, some ICB directors suggested that commissioning should be substantively different in ICBs from CCGs. Some felt commissioning was an activity taking place wherever there were conversations regarding service planning. Arrangements in ICBs were evolving to establish the optimum scope and scale of commissioning activities for particular services. Some services, such as ambulance services, were being commissioned jointly at a pan-ICB scale. For other services, some ICB had established service specific commissioning committees. Where PBPs and provider collaboratives were not delegated formal decision-making responsibilities, they were often ascribed advisory roles relating to the planning and provision of services to their local population, such as providing leadership and acting as the focal point for shaping priorities, aligning priorities and gathering intelligence, which would feed into an ICB committee. There appeared to be a trend towards locating the procurement and contracting function centrally with the ICB due to economies of scale and value. As noted above, some concerns were raised by ICB directors regarding conflicts of interest, which were perceived to be too great in place-based partnerships to allow formal commissioning decisions to be taken.

The third research question related to whether systems were making use of joined-up/pooled budgets. Overall, we found that usage appeared to not have changed greatly to date. It appeared that ICB leaders were concerned with trying to make the use of such funds more effective, and were engaged in trying to understand how such funds were being used in order to target them more effectively.

Additionally our interviewees suggested a number of underlying challenges facing ICBs as they sought to achieve their aims. Firstly, the financial pressures facing system partners and the potential of this to destabilise collaborative relationships. Secondly, a lack of clarity of roles, both in terms of the internal system landscape particularly the potentially duplicative roles of places and provider collaboratives, but also regarding the unwelcome shift of ICBs towards performance management roles. Thirdly, a concern that a focus on performance management targets and national 'must do's' was crowding out the focus on the four core

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purposes of ICSs. Fourthly, concerns relating to organisational sovereignty, that partner organisations will backtrack on commitments made or indeed will not agree at all to decisions that are against direct organisational interests.

These issues will be returned to in the Discussion (Section 7) of this report.

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# 6. Work Package 2: System collaboration, resources and outcomes: formative analysis

## 6.1. Introduction and methods

WP2 primarily addresses the following RQs:

- RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?
- RQ2e: Are ICSs able to change the allocation of resources and bring their local health and care economies into financial balance?
- RQ3b: What groups are most likely to benefit from improved collaboration?

RQ3b will be addressed in the first year of Phase 2.

The HCA 2022 supports the development of ICSs to pursue better care for all patients, better health and wellbeing for everyone and sustainable use of NHS resources. This Work Package provides formative analysis focused on changes in allocation of resources in ICSs, identification of population groups most likely to benefit from improved collaboration, and scoping metrics for the future evaluation of the impact and outcomes of more collaborative system working.

- During Phase 1, we aimed to address RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change? Our goal is to identify a set of metrics that are useful for monitoring outcomes of system working under the HCA 2022. This identification process considered suitable metrics from existing frameworks for evaluation of health system performance as well as those identified in earlier evaluation of previous integrated care reforms. We looked at the health system functions that are affected by whole system reforms, and through that impact system level outcomes. This approach was introduced by the World Health Organisation (WHO) as the Health Systems Performance Assessment (HSPA) framework (Papanicolas et al. 2022), and it provides a structure for assessing the relationship between health system functions (e.g. service delivery, financing), intermediate objectives (e.g. effectiveness, access), and final goals (e.g. health improvement). During phase 1, we also initiated work on RQ2e: Are ICSs able to change the allocation of resources and bring their local health and care economies into financial balance? We started with studying baseline expenditure patterns at ICB level in their first year since becoming statutory bodies. We will continue this work in Phase 2, by identifying changes in expenditure levels in the following years.

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## 6.2. What metrics are most suitable for monitoring outcomes and impact of multi-level system change? (RQ2d)

### 6.2.1. Background

This section addresses RQ2d which asks what metrics are most suitable for monitoring outcomes and impact of multi-level system change.

System-wide reforms, such as the changes of the HCA 2022 in relation to system working in ICSs, have broad objectives which are not often clearly defined at the outset, and can have multi-dimensional impacts within the system (Fatimah et al. 2023). This can present a challenge in evaluation of such reforms. Decentralisation reforms (transferring responsibilities and resources from national to sub-national governments) and integrated care (joining up of different local partners of health and social care to improve care delivery) are both relevant examples here.

Since the main objective of the HCA 2022 is integrating care, it is expected that the Act should lead to improvements in population health and patient experience, and associated policy targets such as the targets of the NHS 2022/23 priorities and operational planning. System working and partnerships should foster increased collaboration which will likely lead to improvements in the aforementioned outcomes. Although the link between integration and collaboration is not entirely clear, the Act aims to reduce the barriers to collaboration, which might be the catalyst for enabling integrated care delivery, which in turn could lead to improvements in population health and health system outcomes (DHSC, 2022b). However, it remains to be seen as how these improvements would be measured and which processes as well as outcomes are suitable for this purpose.

Difficulties in linking outcomes to integrated care has been a challenge for earlier initiatives (such as STPs) (House of Commons, 2018). The HCA 2022 allows local leaders the flexibility to set up arrangements according to the needs of the local population. Thus, ICSs of different sizes and/or with variations in pre-existing inequalities/complexities etc. will approach these differently. This further compounds the issue of measuring the effect of ICS collaborations across the country.

Our goal is to identify a set of metrics that are useful for monitoring outcomes of system working under the HCA 2022. The Act supports the development of ICSs to pursue better care for all patients, better health and wellbeing for everyone and sustainable use of NHS resources. This identification process will consider suitable metrics from existing

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frameworks for evaluation of health system performance as well as those identified in earlier evaluation of previous integrated care reforms.

### 6.2.2. Health Systems Performance Assessment Framework

Following previous work on identifying metrics for assessment of Greater Manchester devolution (Fatimah et al. 2023), we look at the health system functions that are affected by whole system reforms, and through that, impact system level outcomes. Fatimah et al. (2023) indicate that suitability of the WHO HSPA framework for the purpose of whole-system reform evaluations stems from its wide coverage of dimensions of performance, consideration of causal pathways, and easy adaptability to different health systems. The HSPA also acknowledges the importance of the political, cultural, and socioeconomic contexts in shaping health systems.

As per the framework, health functions consist of governance, resource allocation, financing and service delivery. While each is a function on its own, the governance function also affects the other three functions. Financing affects both resource generation and service delivery, and resource generation affects service delivery. Objectives of health systems may be intermediate (such as access and effectiveness) which in turn pave the way for final outcomes for health systems, such as health improvements, equity and efficiency of the system. Importantly, it is only the service delivery function that affects intermediate objectives (such as access, effectiveness).

In the context of ICSs, collaborative working is used to plan and deliver services in each area based on local needs. Collaborative working to agree how to plan and deliver services may occur at system-scale (for the whole population of the ICS), or at place-scale. Additionally collaborative working can take place in many collaborative forums within the ICB, including through committees/sub-committees of the ICB, and through place-based partnerships and provider collaboratives. Collaborative working around the planning and delivery of services might take place on a geographic scale for groups of the ICS population (e.g. through places), might focus on services provided by a group of providers (e.g. through provider collaboratives) or might be focused on a particular service, pathway or patient group (e.g. through workgroups or specialist committees or sub-committees of the ICB). This should affect all four functions of the health systems. However, indicators of outcomes might capture the performance of these functions and the system more widely, and yet not be specific to collaboration and integration.

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As Dwicanksono and Fox (2018) found in their review of the evidence relating to the effect of decentralisation on health service performance and outcomes, system-wide reforms can affect health system inputs (such as resource allocation), performance (e.g. immunisation coverage rates) or outcomes (such as infant mortality). Another example of system-wide reforms are integrated care programmes, i.e, programmes that consider a joined-up approach to care delivery in ways that improve patient experience and outcomes through becoming more person-centred. As integrated care programmes are complex interventions they can be expected to impact several outcomes on many levels, including those related with processes, patient and staff experiences, patient well-being, quality of life, mortality etc. (Tsiachristas et al. 2016, Kelly et al. 2020).

Therefore, Papanicolas et al. (2022) suggest indicators of structure are more useful in assessment of integrated care delivery. Structural indicators refer to intellectual, human and material resources needed to deliver healthcare. Example indicators of structure across three service areas are: access to public health (e.g. prevalence of populations using unsafe or unimproved water sources), access to primary care (e.g. percentage of the number of pieces of essential equipment needed to provide effective and safe essential health services that are available and functioning), and specialist care (e.g. proportion of the population without access to surgery).

Outcomes relevant to studying integrated care systems also depend upon the population they are directed at.  Some integrated care programmes are targeted to improve delivery of care services towards certain population groups such as older people (65+) and /or those with multimorbidity. Liljas et al. (2019) through a systematic review demonstrate integrated care targeted at the older population may lead to reductions in hospital admission rates and length of stay. However, their study uncovers a lack of robust evidence for any effect upon mortality, which they contend may be a relevant outcome for younger cohorts where longer follow-up durations will allow for the effects to manifest. Whereas, evaluation of population-based integrated care initiatives will need a multifaceted approach (Tsiachristas et al. 2016).

We will next look at what measures have been considered in evaluation of previous integration programmes/system-wide reforms in England and subsequently discuss these in the specific context of ICS objectives.

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### 6.2.3. Measures from previous evaluation studies

Overall, previous impact evaluation studies have considered various outcome measures of the service delivery function.  These are focused upon intermediate outcomes related with system effectiveness (e.g. length of stay, hospital admission rates and delayed discharges).

Since 2008, three integrated care programmes have been piloted in England: Integrated Care Pilots, Integrated Care and Support Pioneers and New Care Model Vanguards. These programmes shared similar high-level aims, such as reducing barriers to collaborative working across providers, improving user-centred approach to care delivery and providing more services in a community setting (Lewis et al. 2021). The Vanguards programme involved 50 sites across England which were tasked with developing and testing new care models to integrate services more effectively over a three-year period. These models included integrated primary and acute care systems, multi-speciality community providers, and enhanced health in care homes. While in their initial stages Vanguards were not required to meet any specific target outcomes, by the final year of the programme their continued funding became contingent upon showing reductions in hospital admissions. Impact evaluation studies found small reductions in emergency hospital admissions which emerged in the final year (Morciano et al. 2020) and continued for a short while after programme discontinuation (Wattal et al. 2024). Those sites that were involved in both Pioneer and Vanguard initiatives, experienced slower increase in emergency admissions (Morciano et al. 2021).

Through co-ordination of care services, integrated care programmes aim at easing the load on hospitals. For example, the Better Care Fund was introduced in 2015 to incentivise improved co-ordination across the NHS and the social sector to facilitate greater support for high need patients post hospital discharge. In this context, Fernandez et al. (2018) found that for elderly patients who have undergone hip surgery, post-operative length of stay is higher, the greater the number of or variability in LAs, a single hospital discharges its patients to. They suggest that this may be due to greater costs faced by the NHS in setting up appropriate co-ordination systems across organisations.

These costs of co-ordination are eliminated with vertical integration models. Vertical integration means having a single entity with complete ownership and control of all stages of production. In Scotland, a full vertical integration of health and social care was evaluated against two of its primary performance objectives – delayed discharges and premature mortality (Alonso and Andrews, 2022). In this case, the study found that integration demonstrated improved performance of delayed discharges (an indicator of improvements

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in administrative efficiency and patient experience), but not for premature mortality which remain unchanged. Evidence from integrated care in international settings shows improved patient satisfaction, quality of care from staff and patient perspective, and patient access to care (Baxter et al. 2018). The common thread running through these previous evaluation studies, is that depictable effects are often evident in measures of system effectiveness in the short run. This on the one hand, may reflect the fact that several of the integrated care programmes have been piloted over a shorter duration (at least in England) and therefore, render long-term outcomes such as mortality unsuitable in this setting. But it may also be the case that indicators of population health, given complex underlying pathways, may be less tractable to discrete policy interventions.

### 6.2.4. Potential outcomes for ICS

There are a few relevant frameworks that consider a broad set of metrics/indicators that monitor system performance. For instance, NHSE has devised an oversight framework for ICBs, NHS trusts and Foundation Trusts, which includes oversight metrics that align with NHS Long Term Plan (NHS England, 2022b, NHS England, 2022c). There are five broad oversight themes and these are further divided into various areas corresponding to the NHS Long Term Plan as shown in Table 11 below.

| Oversight theme | NHS Long Term Plan areas |
|---|---|
| Quality of care, access and outcomes | Elective care, cancer, outpatient transformation, urgent and emergency care, maternity and children's health, primary care and community services, mental health services, learning disabilities and autism, personalised care, safe high-quality care |
| Preventing ill health and reducing inequalities | Reducing inequalities, prevention and long-term conditions, screening, vaccination and immunisation; |
| Leadership and capability | Leadership |
| Finance and Use of Resources | Finance |
| People | Looking after our people, Belonging in the NHS, Growing for the future |

Table 11: NHS oversight themes and the NHS Long Term Plan

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The NHS Outcomes Framework (NHSOF), developed by DHSC provides national level accountability for outcomes that the NHS delivers. The outcomes are grouped into 5 domains: preventing people from dying prematurely, enhancing quality of life for people with long-term conditions, helping people to recover from episodes of ill health or following injury, ensuring that people have a positive experience of care. and treating and caring for people in a safe environment and protecting them from avoidable harm. These are measured at population level and reported at England level. Example indicators are: Under-75's mortality rate from cardiovascular disease, unplanned hospitalisations from chronic ambulatory care sensitive conditions, patient experience of GP services or hospital care.

The Public Health Outcomes Framework (PHOF) sets out objectives for public health. The framework is focused on two high level outcomes: increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities. These outcomes are part of a longer-term vision for population health. The framework has overarching indicators that refer to these high-level outcomes, and supporting indicators across four other domains; wider determinants of health, health improvement, health protection and healthcare and premature mortality. While not designed as a performance management tool, it is envisaged that PHOF data will be useful for local areas to benchmark their own outcomes and to compare them with other local areas.

The HCA 2022 sets out the broad requirements for statutory ICBs and ICPs such as duty to improve quality of services, duty to reduce inequalities, system partners and the ICB are guided by national priorities such as improving responsiveness to urgent and emergency care, access to primary care, etc. However, given the variation in local contexts and starting points, progress will likely look different for each ICS (Dunn et al. 2022). In this vein, accountability models for ICSs now includes delivery of shared outcomes at local level.[3] An example of a patient centred shared outcome for mental health would be that those individuals with mental illness are living well in the community, as measured through Patient Reported Outcome Measures (PROM) (NHS England, 2022c). Correlated with PROMs are Patient Reported Experience Measures, which focus on patients' views and experiences of receiving care. These latter measures have been reported in several integrated care studies (Kelly et al. 2020), since coordination of services may lead to improved experiences of care delivery.

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[3] https://data.parliament.uk/DepositedPapers/Files/DEP2023-0824/toolkit.pdf

Any suitable measures must be captured at ICS level or lower levels that can be aggregated to ICS level. There are some examples of currently available indicators that might be related to domains such as co-ordination of services (emergency admissions, emergency readmissions within 30 days of discharge), elective care recovery (size of waiting lists, percentage waiting more than 52 weeks), or population health and inequalities (under 75 mortality from cancer/cardiovascular disease) (Dunn et al. 2022). Performance of emergency care departments (such as A&E waiting times) might also be related with coordination of care at ICS level (NHS England, 2023). ICSs also have a vital role in disease prevention among the population by tackling various risk factors. However, there may be other indicators of patient outcomes which may be captured at LA level and cannot be mapped to ICS level.

More recent studies have also suggested that it may be more valuable to consider a continuous outcome variable that enables identification of shifts in health status (Beard, 2024). Thus, impact evaluation of ICSs could possibly map trajectories of the health outcome variables, which would be particularly relevant in the context of older people and/or those with complex health needs.

NHSE or DHSC have not set out specific benefits that are expected from ICS reforms and the timeline for the same (House of Commons, 2023). However, the NHS oversight metrics do include both short- and long-term metrics. There have been concerns about ICSs ability to achieve long-term aims (such as population health management and preventive care), since short-term priorities (such as reducing elective and emergency care backlogs) are pressing.[4]

Next, we show how various indicators/outcomes were selected using the HSPA framework, while closely following the methodology adopted by Fatimah et al. (2023). Our study expands the scope of the paper by Fatimah et al. (2023), in a few ways. We separate measurable outcomes under national priorities and those that would be embedded under local priorities and thus vary across the country. We also separate outcomes by time horizon that would likely develop measurable impacts over short-term vs long-term goals. This is particularly relevant since evaluation of previous integration initiatives have indicated that evidence in the immediate term can be limited to a select set of outcomes (Morciano et al. 2020, Wattal et al. 2024). Next, we also identify specific structural indicators that are not included in the frameworks but might be relevant for measuring impact of the HCA 2022. Lastly, we identify

[4] ICSs were required to set out in their 2022-23 plans how they would meet targets specified in the NHS's February 2022 plan for tackling elective care backlog, including eliminating waits of more than 18 months by April 2023 and delivering 104% cost-weighted elective activity against 2019-20 baselines . NATIONAL AUDIT OFFICE 2022. Introducing Integrated Care Systems: joining up local services to improve health outcomes. Department of Health and Social Care (DHSC).

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indicators by availability of data in the public domain. Braithwaite et al. (2017) follow a somewhat similar methodology generating cross country comparisons.

The Act supports the development of ICS to pursue better care for all patients, better health and well-being for everyone and sustainable use of NHS resources. Thereby, the aim of this research is to identify outcomes that are under the ambit of NHSE and/or DHSC, while excluding social determinants of health (such as housing, education).

### 6.2.5. Selecting outcomes

Initially we compiled a list of indicators from the NHSOF, NHS Oversight Framework (NHS England, 2022b) and PHOF. We also drew on Ham et al. (2015) which includes CCG performance indicators from sources other than the NHSOF, NHS Oversight Framework and PHOF. A total of 425 indicators were identified from these sources.

All PHOF indicators are categorised under one of five headings:

- A group - overall indicators;
- B group - wider determinants of health;
- C group - health improvement;
- D group - health protection; and
- E group - healthcare and premature mortality

Similar to Fatimah et al. (2023), we identify outcomes that meet the following criteria, i.e. they are Relevant, Extensive, No-overlap, Measurable, Interpretable, and Transparent (RENOMIT).

As mentioned earlier, we focus on identification of outcomes that are under the ambit of NHSE and/or DHSC and exclude social determinants of health that fall outside their scope. Accordingly, we excluded 46 indicators of wider determinants of health (B group) that were captured by PHOF (such as those related with crime, school readiness, homelessness etc.). We also dropped measures that captured employment of those with medical conditions. At this stage 376 indicators remained.

We looked for duplicate indicators, i.e. those that were captured in multiple frameworks. This was done by identifying indicators with keywords (such as elective activity, waiting times, mortality, preventable, etc.). The process is described below:

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1. Elective activity is captured by total elective activity, number of patients waiting more than 52 weeks for consultant-led treatment, and number of cancelled elective operations due to nonclinical reasons.

2. Cancer as a core area - has at least 8 indicators of waiting times for cancer related diagnosis and/or treatment. However, some of these are now outdated (for example, the two week for suspected diagnosis was removed as a timeframe as of October 2023) or are very narrow measures[5].

3. There are 22 indicators for overall mortality for separate conditions (e.g. under 75 mortality from liver disease, excess under 75 mortality rate in adults with serious mental illness, etc) which occur in multiple frameworks. We instead focus on preventable mortality as an intermediate outcome (for e.g. Under 75 mortality rate from liver disease considered preventable; Under 75 mortality rate from cancer considered preventable, etc.) as well as in-hospital mortality indicators.

4. Duplicate entry for CQC provider ratings

5. Exclude duplicates for healthcare related infections such as MRSA and C.difficile which were captured in both NHS Outcomes and Oversight Frameworks

6. Exclude five indicators measuring one- and five-year survival from all or specific cancers, as these were captured in preventable mortality indicators for cancer.

7. Exclude all eight indicators that include the keyword inequality, since they are included in other measures such as (hospital waiting times, preventable hospitalisation, in-hospital mortality, etc.). Ham et al. (2015) also included 2 other indicators - cancer patient survey data and deprivation score (IMD) which are excluded because they do not specify measurable health related outcomes.

[5] For example, the 62 day standard has the following available metrics from the CCG delivery dashboard (Ham et al., 2015) - Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer; Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers; Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patients (all cancers). We instead use the overall indicator (NHS England, 2022a), i.e., Total patients waiting over 62 days to begin cancer treatment compared with baseline.



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8. Exclude 13 indicators from the Mental Health Expert Working Group (as captured by Ham et al. (2015)) which were either not relevant or were included elsewhere (e.g., delayed transfer of care (mental health))

9. Exclude the proportion of people with a learning disability receiving and annual health check as covered in NHS Oversight and alternate sources in (Ham et al. 2015).

10. Exclude indicators of number of permanent admissions of 65 and over population to a care home facility, and staff survey indicator.

11. A number of PHOF category C indicators were those for healthy behaviours (such as smoking prevalence, obesity, etc.) which we exclude.

As per the HSPA framework, we classify the indicators into health system functions, intermediate or final outcomes (see Figure 2 below).

Figure 2: Classification of indicators into functions, intermediate goals, and final goals

Papanicolas et al. (2022) suggest that health system functions are resources, financing and service delivery for public health, primary care (which includes mental health) and specialist care (which includes secondary and tertiary care).[6] They further classified intermediate outcomes into the following domain areas for this: Quality (Effectiveness, Safety, User experience) and Access. NHS long-term goals overlap with some of these areas and include additional indicators for mental health and dental care and domains such as Prevention. We

[6] Although they also acknowledge that due to levels of complexity and specialization along with the mode of service delivery, such boundaries are not always clear-cut. For example, primary care centres could provide specialised clinics for diabetes. Moreover, integrated systems of service delivery will likely continue to blur these boundaries.



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include these into our framework. Finally, Ham et al. (2015) provides classification for a number of indicators into the aforementioned domains, which we incorporate into our study.

We remove all effectiveness indicators that are too specific to diseases/conditions (e.g. percentage of five year olds with experience of visually obvious dental decay, excess winter deaths index (age 85+), GP prescribing indicator (mental health), hip fracture (incidence), etc.). Similarly access indicators that were too specific were dropped (e.g. delayed transfer of care (mental health), A&E data on outcomes for people attending with self-harm and/or four hour breaches involving mental health, people with diabetes diagnosed less than a year referred to structured education, etc.). A number of prevention indicators include vaccination coverage among separate population groups and/or for multiple diseases, and as far as possible we have classed them together as a single indicator. We identified a total of 117 indicators for measuring intermediate outcomes/goals. In Appendix C we compile the list of indicators for final goals, health system resources and intermediate goals. The source of each indicator is either PHOF, NHS Oversight Framework, NHS Outcomes Framework or from Ham et al. (2015). Finally, indicators for financing health function are captured in the NHS Oversight Framework and include financial efficiency (variance from efficiency plan, financial stability, variance from break-even), achievement of mental health investment standard, and agency spending.

### 6.2.6. Data availability

As a final step for evaluating suitable indicators, we consider whether data is available at Trust/provider/local authority level. We also note whether the data is available since the HCA 2022 (i.e. July 2022). We identify the data source for each indicator in the tables below. Indicators with incomplete data (because it is no longer being collected, but is available for a part of the period since July 2022) are indicated with *I*, but if it is currently in development or not available it is marked as *NA*. In instances, where the statistic reported is historic (pre-July 2022) it is marked as *NA*. Complete data was available for 97 of 129 indicators.

### 6.2.7. Discussion

Health system related outcomes may be affected by a wider set of changes that are not directly related to integration efforts. Therefore, Papanicolas et al. (2022) suggest measuring indicators of structure which would be a more clear and obvious way to quantify performance of integration efforts. We have identified a subset of these structural indicators related with workforce mentioned in Appendix C. We put this also in the context that NHSE requires ICSs

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to focus on long-term goals of preventing ill-health, while allocating £97 million in 2022-23 across the 42 ICBs towards this goal. In comparison, it allocated £200 million for tackling health inequalities and £2 billion to tackle elective care backlogs, which are the pressing short-term national priorities (National Audit Office, 2022). It is quite difficult to set out national specifications for performance on local priorities for the ICS, and therefore each ICB has responsibility for tracking progress against local priorities. For example, Black Country ICB mentions some indicators against their local priorities[7] such as increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies, and increase percentage of patients with hypertension treated to NICE guidance.

On the other hand, the Greater Manchester ICB lists among its local priorities to scale up and accelerate development of people-centred neighbourhood model which includes actions such as more social prescribing and creative health activity.[8]

In this sub-Work Package, we have considered a set of outcomes following the overall change that the HCA 2022 brings about which can be set with national objectives. These would include functions and outcomes for each area of service delivery: primary care, community care dental care, mental health, specialist care (including acute care) and public health. We also consider that wider determinants of health are included under the broad objectives of the HCA 2022, and as such these are meant for ICS to embed in their local priorities. There may be other ways to identify whether ICBs are meeting their local targets by following variations in allocation of local resources.

Finally, any future evaluation of integrated care systems hinges upon on data availability of suitable metrics. Currently a few indicators do not have available data. For example, personalised care is a key driver of the NHS Long Term Plan, but currently there is s no available data to measure this target. This is an area where ICSs will be highly relevant to delivering person-centred interventions and therefore, identification of a suitable measure, as well as data collection process will be crucial.

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[7] See: https://blackcountry.icb.nhs.uk/about-us/our-priorities/ our-5-year-joint-forward-plan
[8] See: https://gmintegratedcare.org.uk/greatermanchester-icp/ icp-strategy/joint-forward-plan/#Our_Missions

## 6.3. Are ICSs able to change the allocation of resources and bring their local health and care economies into financial balance?

### 6.3.1. Introduction

This section relates to RQ2e which asks whether ICSs are able to change the allocation of resources and bring their local health and care economies into financial balance. Our goal in this element of WP2 is to examine the spending patterns of ICBs in their first year as statutory bodies under the HCA 2022 to identify their baseline positions. In subsequent stages which will take place in the first year of Phase 2of the research, we would expand upon this to examine changes to the spending patterns and whether ICBs are able reallocate resources within the local areas aligning with the broad priorities identified by the Act. We will complement this with examining changes in the allocation of resources to ICBs since implementation of the HCA 2022.For much of the last decade, NHS trusts have been struggling under financial pressures, with growing variation in their financial performance (House of Commons, 2023). The National Audit Office (2022) noted that combining financial performance on a partnership or system level (such as ICSs) did not eliminate the persistent financial problems of some NHS bodies, since 31 out of 42 ICSs reported deficits, that added up to £1.7 billion in 2019-20. During the pandemic, commissioning and contracting were suspended and special financial arrangements were made with fixed system budgets and top payments for COVID-19 related expenses. During this period, NHS trusts saw improvements in their financial health.

With gaining statutory status, ICBs are faced with stricter financial regulations. The provisions under the HCA 2022 do not permit ICB's annual expenditure to exceed its income. It was expected that all ICBs deliver a balanced budget in 2022-23, and most submitted plans to do so (except 12 ICBs) (National Audit Office, 2022). However, as of March 2024, three ICBs are receiving assistance from NHSE's Recovery Support Programme due to financial troubles which points to deeper underlying issues (National Audit Office, 2024). In addition, NHSE is also providing support under this programme to 21 trusts. Though it is not yet clear, how the flow of public funding at ICB level has changed post-the HCA 2022.

At the time of their establishment, ICBs were asked to develop plans that reflect the national priorities of NHSE along with local needs-based priorities. NHSE outlined the following as its national priorities for 2022-23 (NHS England, 2022b):

- Invest in our workforce
- Respond to COVID-19 ever more effectively
- Tackle elective care backlog

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- Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity
- Improve timely access to primary care
- Improve mental health services and services for people with a learning disability and/or autistic people
- Continue to develop our approach to population health management, prevent ill-health and address health inequalities
- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
- Make the most effective use of our resources
- Establish ICBs and collaborative system working

NHSE allocates funds that are ring-fenced towards meeting its national objectives. However, there is no secured budget for ICBs to make progress towards their local priorities (National Audit Office, 2022). Therefore, an understanding of how ICBs allocated resources across sectors within their systems to meet these joint objectives is crucial towards unpacking the impact of the HCA 2022.

Our goal in this sub-Work Package is to examine the spending patterns of ICBs in their first year as statutory bodies under the HCA 2022 to identify their baseline positions.

Mapping financial flows has previously been carried out by Moss et al. (2023) at CCG level following the devolution of Greater Manchester. To analyse financial flows, their study considers an adaptation of System of Health Accounts (SHA) framework (Eurostat and World Health Organisation, 2017). We follow this direction and expand the scope further by including variation in service categories (acute, mental health, community care, etc.) across different entities (NHS trusts, ICBs, independent and voluntary sector, LAs). For example, one of the goals of the HCA 2022 is to reduce barriers to collaboration among various NHS and non-NHS bodies, like LAs and the voluntary sector. Through a study of spending patterns, we would be able to identify whether there is increased collaboration reflected in expense towards different service categories with non-NHS bodies. Additionally, we will identify outliers and specifically map the changes in their financial flows over time.

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### 6.3.2. Data and methods

We use data published by ICBs on their detailed expenditure patterns for amounts over £25,000. We extract the monthly data from July 2022-March 2023. Since ICBs were formally established beginning July 2022, many ICBs do not report data for the first quarter of the financial year (April-June 2022). Moreover, due to boundary changes, it would be difficult to compare pre-July patterns with later periods.

The data was not available in a complete fashion for all 42 ICBs. Instances with incomplete information were the following: Leicester ICB only reports data beginning June 2023, North East London ICB has no data available for the year 2022-23, Staffordshire ICB has a missing file for July 2022. We also drop Kent and Medway ICB and South East London ICB because these did not have complete information on expense categories. We thus rely on complete data available for the entire period of nine months from July 2022-March 2023 from 37 ICBs. The data was extracted and cleaned in STATA17 for analysis.

The data includes information on expense type, expense area and the expenditure amount corresponding to each month. Since the expense types and categories are highly specific, we assign them to broader categories. This categorisation is based on the approach set out in Moss et al. (2023) for financial flows at CCG level. Here to identify broad entities whom the services were purchased from i.e., NHS trusts and/or Foundation Trusts, non-NHS bodies (independent/commercial sector, voluntary sector as well as LAs), Social care providers, or from other ICBs, CCGs or devolved administrations (Wales, Scotland). We call this 'type of purchase'.

We expand on Moss et al. (2023) to show various expense categories across different types of purchases. We cross reference this with expense categories in the annual accounts of ICBs, although these slightly vary across individual ICBs, the broad and common area categories included are: acute, mental health, community, continuing care, prescribing, primary care and other.[1]We call this 'area of expenditure'. While most prescribing costs (including social prescribing) are at primary care level, some are captured at trust level as well as at independent/commercial sector.

Where expense type could not be classified as purchases made to either trusts, social care, non-NHS bodies, or other ICBs etc, they are classed as 'other'. These correspond to administrative/running costs. They may pertain to specific expense areas such as administrative costs linked with primary care or mental health etc, or more general, such as estates and facilities costs.

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To identify the categories, we use keywords in expense type and area variables shown in Tables 12 and 13 below:

| Type Category | Keywords |
|---|---|
| Services from trusts | Expense type contains any of the following: "Trust", "Trst", "NHSFT" |
| Purchase of healthcare from non-NHS bodies | Expense type contains any of the following: "Independent Sector", "Commercial Sector", "Othe Public Sector", "Not For Profit", "Clinical&Medical-Commercial", "Clinical&Medical-Othe Public", "Clinical&Medical-Independent", "Voluntary Sector","Local Authorities" |
| Services from Social Care | Expense type contains any of the following: "Social Care", "Soc Care" |
| Services from Services from other ICBs, CCGs and NHS England, devolved admin | Expense type contains any of the following: "ICB", "CCG", "Clinical&Medical-Devolved", "Hcare Srv Rec Oth-NHS" |
| Other | If the entry falls into none of the above. |

Table 12: Identification of type of expense

| Area Category | Keywords |
|---|---|
| Acute | Expense area contains any of the following: "Acute", "Planned care", "clinical assessment and treatment centres", "ACUTE", "PLANNED CARE", "CLINICAL ASSESS- |

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| | |
|---|---|
| | MENT AND TREATMENT CENTRES” |
| Mental health | Expense area contains any of the following: “MENTAL”, “mental”, “Mental”, “PSYCHOLOGICAL” ,“DEMENTIA” ,“COUNSELLING”,<br><br>“ADHD”, “LD AND AUTISM” |
| Community | Expense area contains any of the following: “PALLIATIVE”, “CARERS”, “COMMUNITY”,<br><br>”Community” |
| Continuing care | Expense area contains any of the following: “CON-<br><br>TINUING CARE”, “CONTINUING HEALTHCARE”, “Continuing Care”, “CHC”, “FUNDED<br><br>NURSING CARE” |
| Prescribing | Expense type contains any of the following: “Prescribing costs” , “High Cost Devices”, “Dressings”; or<br><br>Expense area contains “PRESCRIBING” along with any of the following<br><br>TypeCategory=“Purchase of healthcare from NON-NHS bodies”, TypeCategory=“Services from Trusts”, expensetype==“Sterile Products”, expensetype=“Clinical&Medical-Drugs” |
| Primary care | Expense type contains any of the following: Expense type= “PMS”, “APMS”, “GMS”, “GP”<br><br>“PCN”, “NCD”, “LOCAL INCENTIVE” |
| Other | If the entry falls into none of the above. |

Table 13: Identification of expense area categories

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### 6.3.3. Analysis

We now present the descriptive analysis for the baseline positions of spending patterns in the first nine months of ICBs being statutory bodies. In Figure 3, we show average expenditure across ICBs by type of purchase and the variation of expenditure area therein. The most expenditure from ICBs to NHS trusts correspond to the acute care category (about £1100 million), followed by mental health and community care. ICBs purchases of social care are majorly (about £21 million) from local councils and include community-related expenses such as those towards community equipment and adaptations, reablement services, etc. The other category of social care related expenses includes bed-based care services, domiciliary care, learning disability services, etc. Whereas ICBs purchase from non-NHS bodies similar amounts across acute care, community and continuing care. The other category of payments from ICBs to non-NHS bodies include administrative costs, but also other services such as bereavement service, out of hours service, hospices, children services, etc. Finally, ICBs also purchase some services for different areas such as community and acute care from other ICBs, other NHS bodies, NHSE or devolved administrations. When a type of purchase is classed as 'other', we show the distribution of costs across different areas in Figure 4. As mentioned earlier, these tend to include administrative/running costs incurred across different areas such as acute care services, primary care. We find that the average share of these costs is the highest around 59% that correspond to acute care services.

Next, in Figure 5 we show the average share of ICB expenditure in each category. We note the largest expense category is for acute care and the smallest linked with prescribing. Primary care is about 9.1% on average.

To examine variation across expenditure among ICBs we first group them by quantile of total expenditure by ICB. With the first quantile reporting the lowest expenditures and the 5th quantile the highest (Figures 6-10). The quantile groupings could reflect many factors including the size of ICBs themselves. Across all figures the highest share of expense is for acute services and the lowest is for prescribing (less than 1% and therefore nearly not visible).

Variations in other categories across ICBs may signal varying local need-based priorities. In the first quantile group in Figure 6, mental health is the second largest expense area in Herefordshire and Worcestershire ICB as well as Lincolnshire ICB. Whereas community care is the next highest category in Gloucestershire and Shropshire, Telford and Wrekin. Gloucestershire also has the least spend in acute care (less than 50%). In Figure 7 for the ICBs in the second quantile, primary care appears to be the second highest expense category followed by community care in Northamptonshire ICB, whereas the reverse in Bath, North

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East Somerset (BANES), Swindon and Wiltshire, and Cambridgeshire and Peterborough ICBs. We uncover similar variations in Figure 8. In almost all cases, continuing care appears to have a small share except, Buckinghamshire, Oxford and Berkshire West ICB and North Central London (see Figure 9). Whereas North Central London ICB appears to have the highest share of spend in acute services. Nearly all of this expense is for acute services purchased from NHS Trusts.[2] In Figure 10, for ICBs in the fifth quantile, Cheshire and Merseyside ICB have the highest share of spending on primary care (8%). Overall, share of primary care spend is highest (above 12%) for Cambridgeshire and Peterborough and Lincolnshire ICBs.

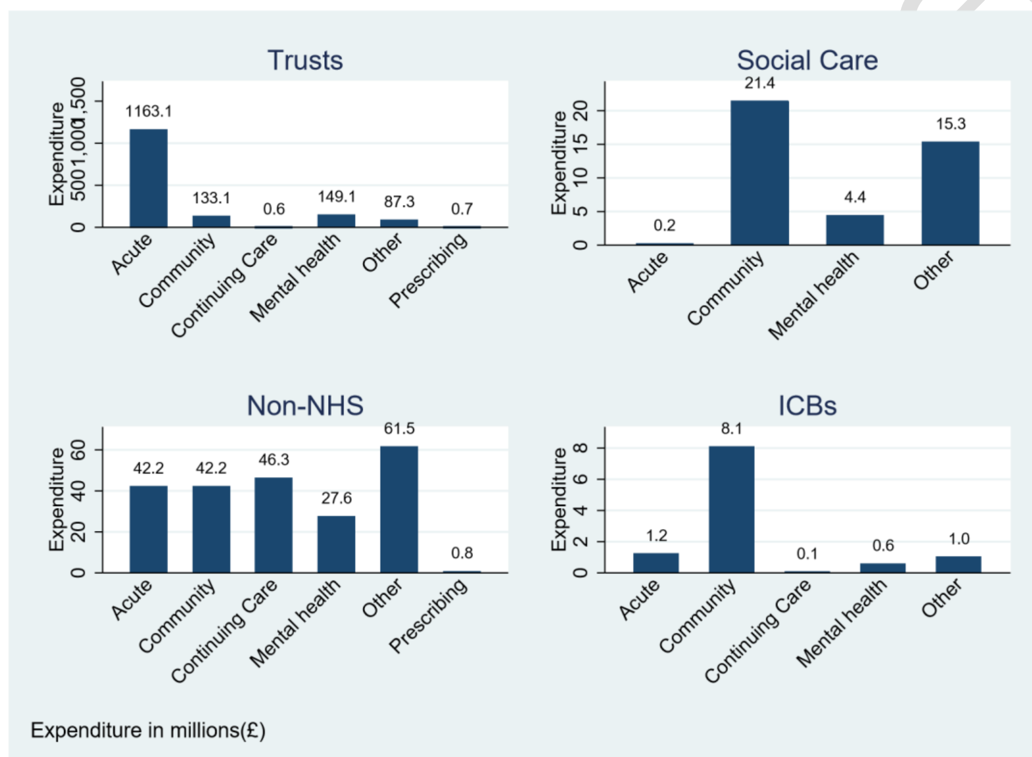


Figure 3: Expenditure by type of purchase

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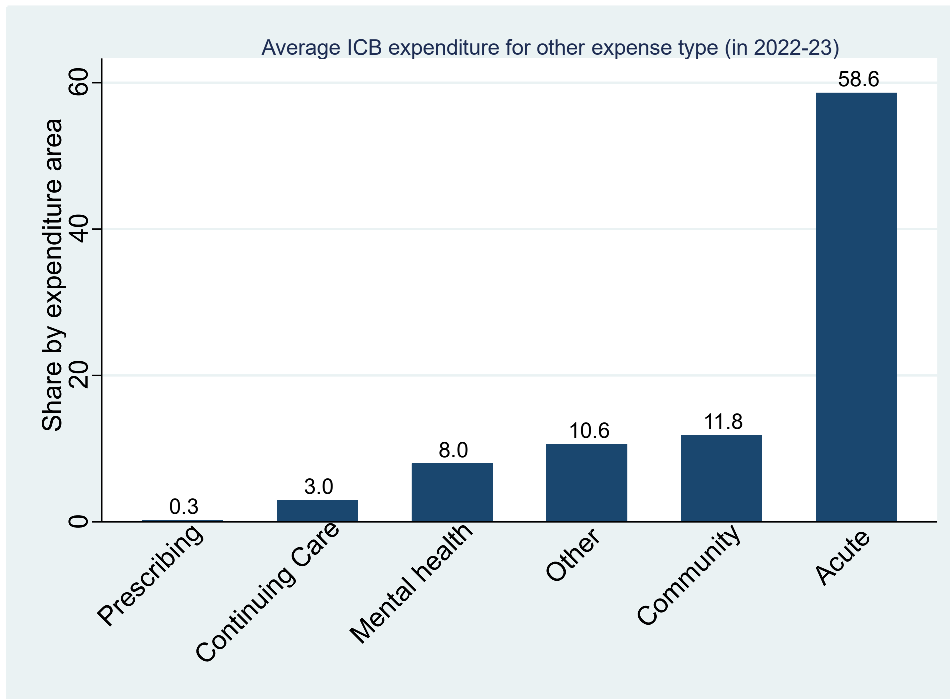


Figure 4: Expenditure categories for Other Type of Purchase

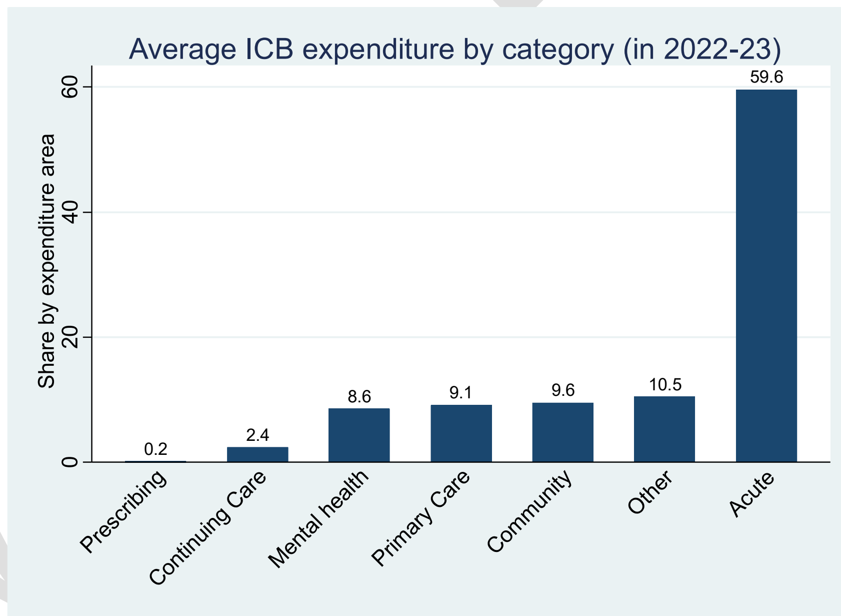


Figure 5: Average ICB expenditure by category (in 2022-23)

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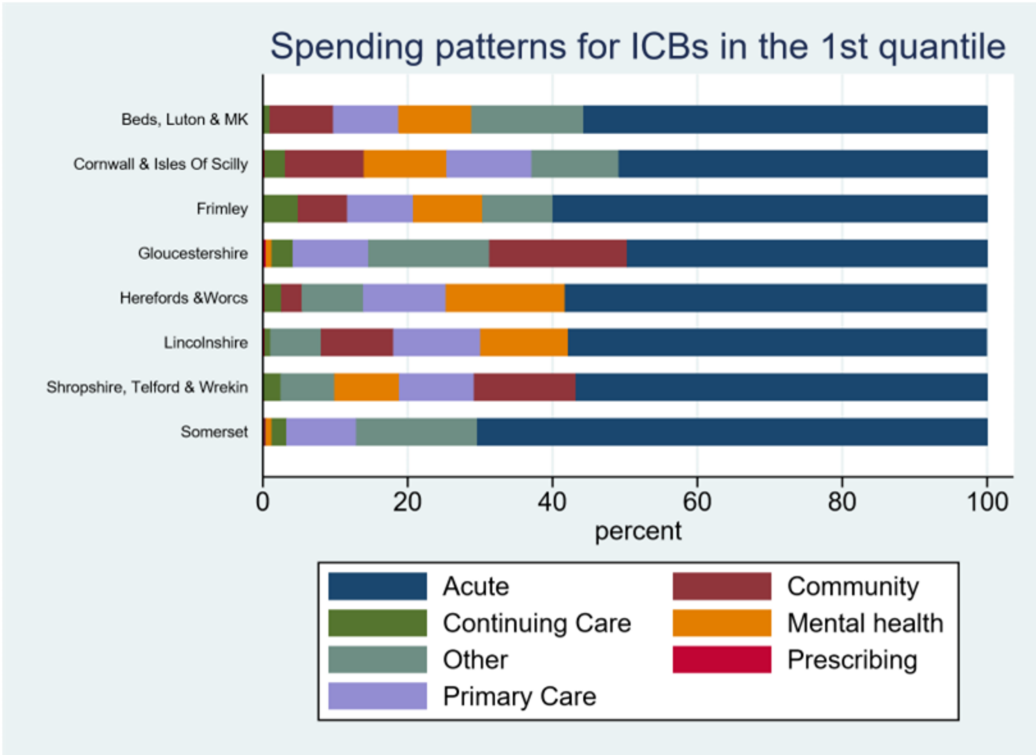


Figure 6: First Quantile ICBs

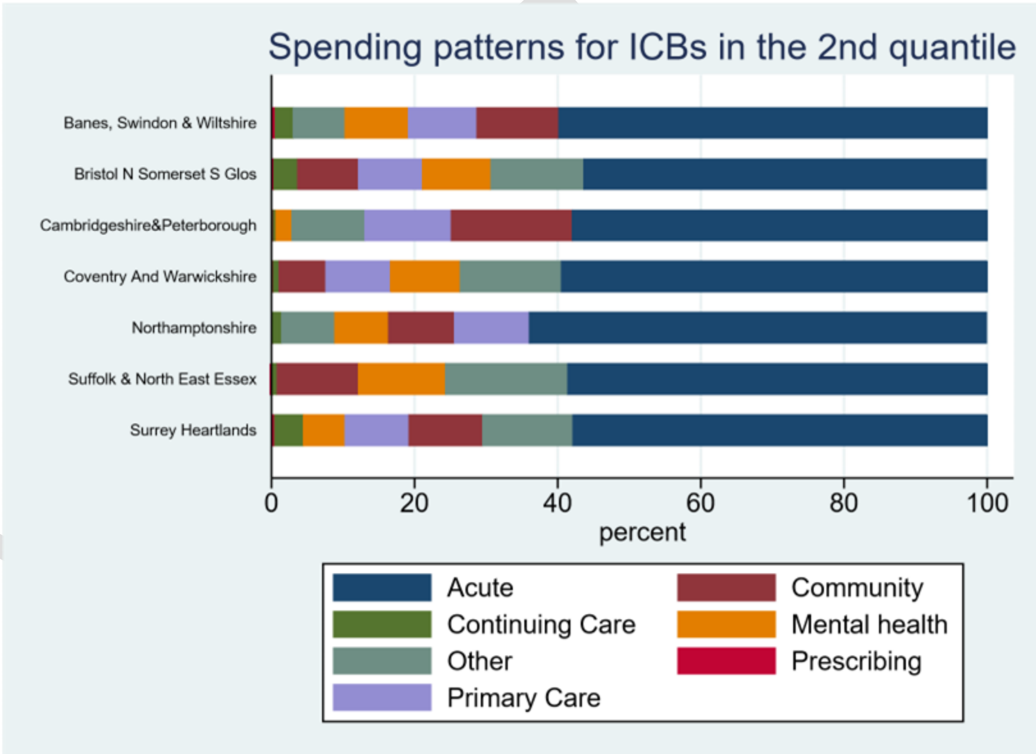


Figure 7: Second Quantile ICBs

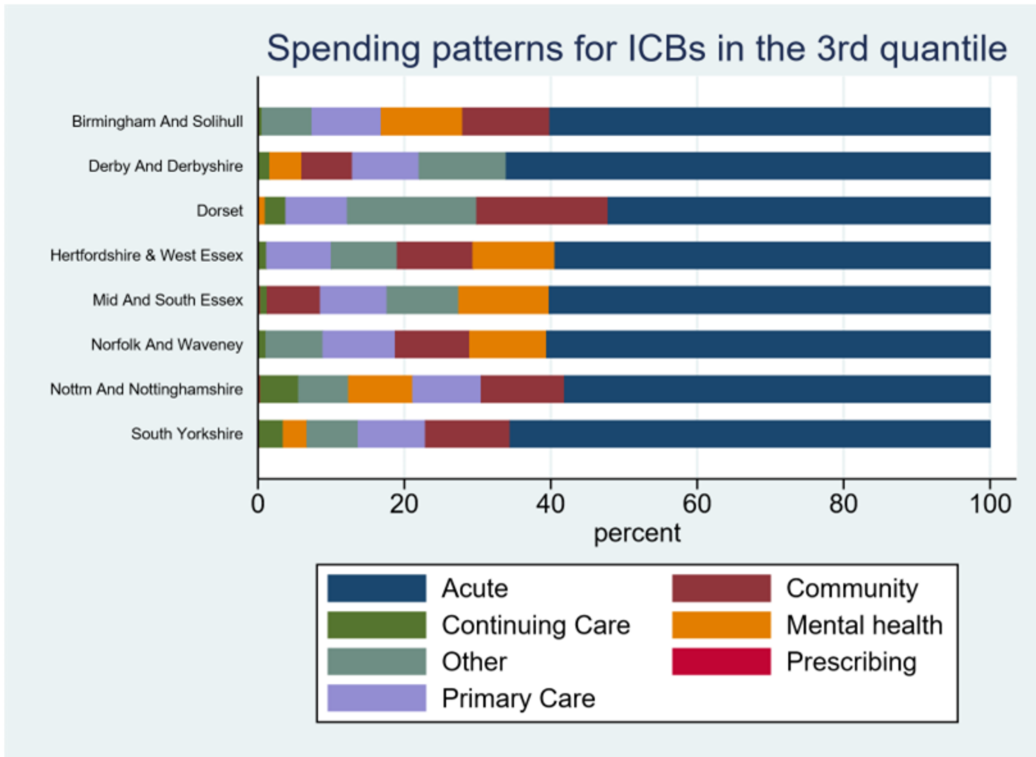


Figure 8: Third Quantile ICBs

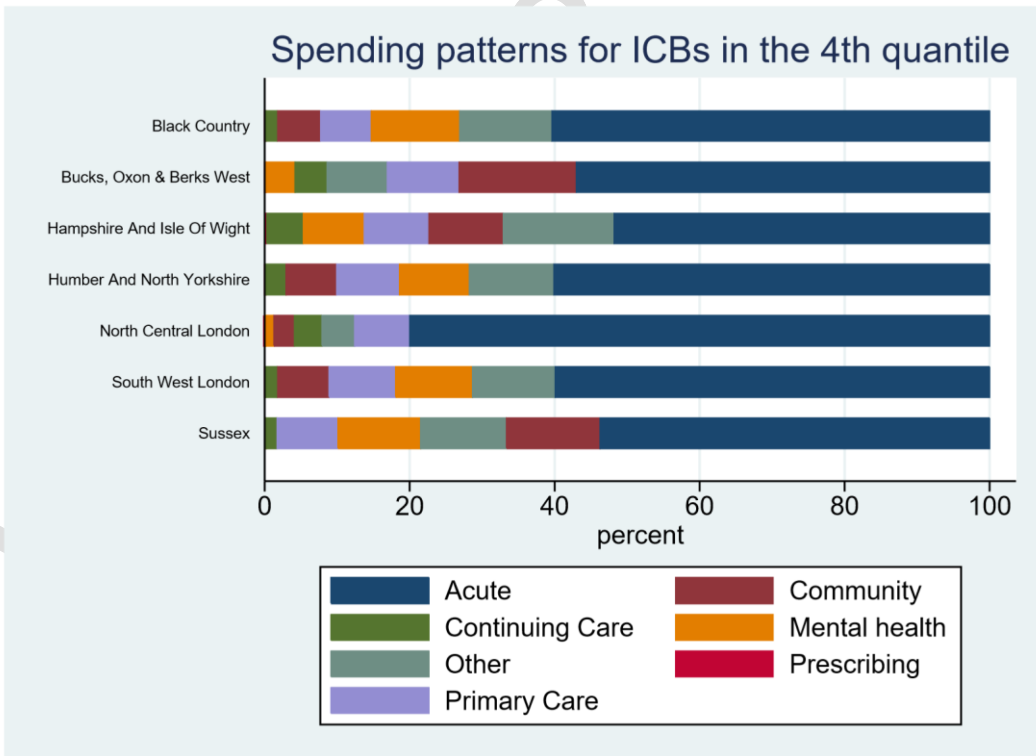


Figure 9: Fourth Quantile ICBs

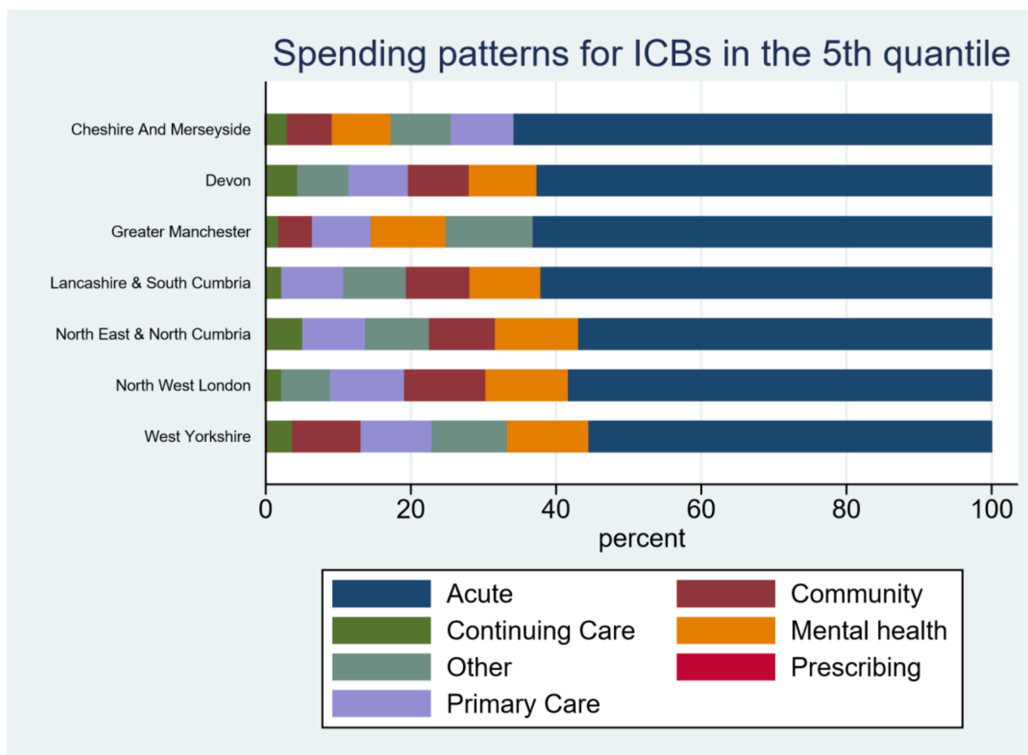


Figure 10: Fifth Quantile ICBs

### 6.3.4. Limitations

There may be variation in how each ICB captures expense areas and this possibly affects the expense distribution at ICB level. For example, acute services include acute mental health services as well, which may be classed under mental health category instead. Also, children's services have been captured in continuing care, though some ICBs have included these in community care.[3] Prescribing might only include cost of medicines prescribed in primary care.

Subsequently, we will examine the changes in spending over the later periods with reference to their baseline positions. Given the focus of the HCA 2022 on enhancing primary prevention and delivery of community-based care while reducing pressures on acute services, we will show on whether ICBs are able shift their resources in order to do so. We will specifically focus on identifying any outliers through this analysis and show the changes relevant to their case. We will also compare trends in ICB allocation (including those from pooled budgets such as the Better Care Fund) and whether ICBs are able to have achieve a financial balance over time.

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[1] Some ICBs do not have a separate category for continuing care (See Lancashire and South Cumbria for an example see: https://www.healthierlsc.co.uk/application/files/6716/9029/4640/LSCICB_webversion.pdf) or a separate category called central budgets and reserves (Example, Cambridgeshire and Peterborough https://www.cpics.org.uk/download/017-icb-annual-report-and-accounts-202223-final.pdf?ver= 7432)

[2] In the case of North Central London, we note that just about 50% of these purchases from NHS trusts local to the ICB, while the remaining reflect purchases from other NHS Trusts.

[3] North Central London ICB is an example, see https://nclhealthandcare.org.uk/ wp-content/uploads/2023/07/QMJ_ICB_Annual_Report_2022-23_FINAL.pdf

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# 7. Discussion

## 7.1. Introduction

In this section we consider and reflect on the Phase 1 findings overall. In section 7.2 we summarise the findings from WP1 and WP2 in relation to the Phase 1 research questions. In Section 7.3 we the supplement realist-informed national policy document analysis (established in Section 4) in the light of the Phase 1 research data and analysis. In section 7.4 we reflect on the Phase 1 findings in the light of the current policy and legislative context and the research of others. In Section 7.5 we discuss the strengths and limitations of the Phase 1 research. In Section 7.6, we outline brief recommendations. Finally, in Section 7.7, we outline our plans for engagement and outputs relating to Phase 1 findings.

## 7.2. Summary of research findings

This section summarises our research findings across all Phase 1 work packages in relation to the Phase 1 research questions.

### 7.2.1. RQ1a: How are governance structures and leadership arrangements developing to facilitate co-ordination?

The permissive nature of the HCA 2022 and related policy is reflected in the mixed national picture regarding the development of governance structures and leadership arrangements in ICSs. In relation to ICBs, we found that many are adopting a centralised approach by retaining control of resources and decision making at ICB scale for the vast majority of their budget. Commissioning decisions were commonly reserved for the ICB itself or ICB committees with a focus on a particular function, such as finance, performance or quality.

In Phase 1 of our research (WP1.3 and 1.4), we considered the role of PBPs and provider collaboratives, and where commissioning responsibilities were being located by ICBs. In relation to PBPs we found the majority of ICBs designate an informal or advisory remit to PBPs and provider collaboratives and are not delegating formal commissioning functions them (see RQ1e below). Our analysis of Governance Handbooks found that 11 ICBs had formed ICB committees or sub-committees at place scale and one ICB had provider collaborative committees or sub-committees. In terms of leadership of PBPs, we found that the appointment of ICB Executives as place leads was a mechanism through which some ICBs were delegating limited budgetary responsibilities to places. Governance arrangements for PBPs in some ICBs were complex, with a 'layering' of multiple mechanisms, such as combining ICB Committee status with delegation to an individual director, who was also part of the ICB, and an ICB Non-Executive member of each place. In some cases, ICB directors considered

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establishing formal place-based governance structures to be difficult, creating overly complex structures, and a distraction from making progress with transformation objectives. In terms of the leadership of provider collaboratives, most appear to be led by provider members, and are considered as 'bottom-up' developments in terms of their form and function.

Some ICB directors found collaborative forums within systems potentially duplicative and suggest that greater clarity is required, particularly in relation to the relative roles of places and provider collaboratives. Some perceived the role of ICBs to be shifting towards performance management, including of individual providers (see below), leading to potential duplication of role between NHSE and ICBs. Consequently, the roles of ICB and NHSE regarding performance management, were also in need of greater clarity. This was echoed by Healthwatch leads (WP1.2), who identified the lack of additional resource to support an expanded governance infrastructure as a key barrier to representing patient voice at all levels. The 'bottom-up' development of provider collaborative arrangements and consequent variation in form or function caused some concern that this high degree of variation might lead to duplication and lack of clarity about relative roles, and therefore be detrimental to effective system working.

The interviews with policy stakeholders (WP1.1) and ICB directors (WP 1.4) suggest that ICPs are thought to have considerable potential to drive forward the longer-term objectives of ICSs, such as the prevention agenda. However, it was suggested the latent power of ICPs is not currently being realised, due in part to ICPs perceived lack of ability to hold ICBs to account.

### 7.2.2. RQ1b: How are accountability relationships developing within systems (including between diverse statutory, independent, and community-based organisations and bodies), and with regulators, to facilitate the achievement of system aims?

The issue of accountability relationships and their development, both within systems and between system organisations and centralised bodies, was an important concern for both policy stakeholders (WP1.1) and the ICB directors interviewed (WP1.4). Policy stakeholders suggested consideration during the development of the Bill was given to a potential accountability framework for ICBs that would more closely integrate health and social care functions across NHS organisations and local government. This aspiration was abandoned part way through the policy development process, reportedly because it was seen as too challenging to reconcile local government systems, processes and accountabilities (which are fundamentally integrated into the democratic system) with those relevant to NHSE via this legislative route.

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Clarity regarding accountabilities and who was responsible for what within systems was perceived as lacking, which contributed to inefficient governance processes that took time and energy away from delivery-focused activity. This related both to the roles of collaborative forums in systems (see RQ1a above) and also to the accountabilities of individual providers. Policy stakeholders (WP1.1) suggested system-level accountabilities were 'on top' of organisational accountabilities, which contributed to a lack of clarity around responsibility for ensuring system success (or indeed for certain system issues or failures).

The holding to account of ICBs by NHSE was a key issue identified by both policy stakeholders (WP1.1) and the group of ICB directors (WP1.4). Specifically, there was concern regarding the strong emphasis on assessing ICBs on the basis of financial position, including deficit reduction, as well as metrics including urgent and emergency care recovery, elective activity levels, and A&E wait times. Some ICB directors (WP1.4) described an unwelcome shift in the role of the ICB towards performance management of its partner members, with an expectation by NHSE that the ICB leaders would hold providers to account for performance. ICBs were thought by some to be transforming into 'mini regulators', and policy stakeholders noted the variation in identities and roles adopted by ICBs, ranging from 'performance managers' to 'conveners'. Both policy stakeholders (WP1.1) and ICB directors (WP1.4) indicated that the risk of focussing so heavily on such measures is that, while they are measurable and provide central assurance, this does not support the development of strong collaborative dynamics or effective integration within Systems themselves and may in fact disrupt this. Furthermore, policy stakeholders (WP1.1) suggested that an ICB's accountability for financial performance, ultimately vested in the CEO, and the expectation from the centre that ICBs should demonstrate 'grip' regarding spending and activity, was seen as part of the reason that ICBs have seemingly been reluctant to delegate budgets and power to places in keeping with principles of subsidiarity (see also RQ1e).

There were various opinions regarding ICPs expressed in the policy stakeholder interviews (WP1.1). Whilst some felt that ICPs had significant potential power and influence due to their role in shaping the strategic direction of their system, others felt that in practice ICPs 'lacked teeth' with regard to holding the ICB to account and consequently this risked ICPs being a discussion forum lacking in ability to affect change. In terms of system-level oversight and assessment, concerns were expressed regarding the proposed CQC evaluation framework and there was a suggestion that this function might more usefully concentrate on considering the extent to which ICSs are meeting the individual strategies and objectives that they have set in order to address their specific population needs and contextual conditions.

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### 7.2.3. RQ1e: How are ICBs exercising the flexibilities of the HCA 2022 regarding delegation? What is the manner and degree of delegation from ICBs?

ICBs are making limited use of the flexibilities of the HCA 2022 at this time. Our examination of governance arrangements (WP1.3) did not reveal any examples of ICBs delegating functions to other relevant bodies, using the powers of section 65Z5 of the Act. We found a small number of instances where ICBs were jointly exercising functions with other bodies under section 65Z5 of the Act. In the main this related to joint commissioning arrangements with other ICBs.

In terms of 'internal' delegation (where the ICB delegates functions to its own committees/sub-committees/staff), our analysis of ICB Governance Handbooks (WP1.3) and the interviews with ICB directors (WP1.4) indicate that delegation of ICB commissioning functions to PBPs occurs in only a small number of ICBs. We found delegation of commissioning decision making functions occurs in only a small cohort of ICBs, with a very small subset of these delegating 'full' commissioning responsibility for NHS services for local populations to place-based ICB committees or sub-committees, together with budgetary responsibility. In terms of provider collaboratives, only one ICB had established a provider collaborative as an ICB committee or sub-committee (with delegated functions relating to planning, engagement, governance, and assurance). This committee was also a joint committee of the ICB and NHS provider members. These limited internal delegation arrangements were also reflected in the understanding of national level policy stakeholder interviewees (WP1.1) regarding the extent and nature of delegation arrangements across the country.

A more common arrangement was limited delegation to place through delegation to ICB Executive Directors, Delegating to ICB Executive Directors appears to be a commonly used option to allow financial decisions to be made in PBPs. This arrangement appeared to be used in the main to facilitate decision making in relation to budgets (for example making decisions about spending money on a specific project) rather than commissioning of services.

The important role played by local context in shaping local governance arrangements emerged strongly in interviews with ICB directors (WP 1.4) and policy stakeholders (WP 1.1). Policy stakeholders saw local flexibility to determine place-based commissioning arrangements as an important principle, and diversity of local contexts, particularly regarding local authority/system/place configuration, was seen as part of the justification for arrangements to be shaped 'bottom-up.' Some places were said by ICB directors to have optimal conditions (for example coterminosity of place and local authorities, alignment with

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provider landscape and cohesion with scope of wider partners) to support the development of shared aims and unity of purpose among place partners, which were considered a prerequisite for ICBs to delegate commissioning decision making functions. Conversely, other local contexts were said to render delegation unrealistic or unnecessary, such as where all parties are involved in decision-making at system scale, or where budgets were difficult to separate. It should be remembered that ICSs chose their place configurations themselves. However, it may be that these were configured with other factors than delegation in mind. In some instances, such as where boundaries make budgets difficult to separate, ICBs could also consider altering boundaries to enable this.

Putting local context aside, other less fixed factors were identified by ICB directors as steering decisions regarding delegation of ICB functions. Firstly, maturity of relationships: where ICB leaders considered relationships between place partners were such that they should not be entrusted with collective decision-making regarding resource allocation. Secondly, concerns around financial risk and a loss of control: some ICB leaders had concerns about losing control of financial decision making, particularly where the ICB had financial difficulties. Thirdly, the belief that putting place complex governance arrangements would be ‘a distraction from the real job’: that the administrative burden of governance arrangements to enact delegation outweighed the benefits of delegation. Fourthly, in relation to the delegation of procurement and contracting responsibilities, some ICB directors were concerned about conflicts of interest within PBPs. This begs the question as to how ICBs, which also have significant provider representation, are seen as not being susceptible to these problems. Importantly, as highlighted in RQ1b, it appears that accountability and oversight pressures for ICBs are a factor militating against the delegation of functions and control to more local levels within systems.

In place of formal delegation of functions to place-based ICB committees, some ICBs highlighted other routes to subsidiarity, such as including representatives of place on the ICB commissioning committees, and the establishment of advisory working groups. Some directors held the view that PBPs needed enough freedom to make spending decisions, but did not require the delegation of formal commissioning decision making.

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### 7.2.4. RQ1f: What functions, responsibilities and roles are evolving in place-based partnerships and Provider Collaboratives, and are different types of commissioning functions evolving at different system levels?

There was a sharp contrast between the limited delegation of formal commissioning decision making and budgetary responsibilities to PBPs and provider collaboratives, and the significant roles which ICB directors assigned to place committees, and provider collaboratives, in practice (WP1.4).

Place-based partnerships were considered fundamental to system working. They were described by ICB directors as leading health and care strategy and planning at place, service planning, and service delivery and transformation, and acting as a convenor of place partners. Less frequently, responsibilities in relation to population health management and the general promotion of health and wellbeing were identified as core responsibilities. Policy stakeholder interviewees (WP1.1) recognised place as the level where effective integration between diverse partner organisations should be happening to meet the specific needs of local populations. They noted, however, that place-based leads were primarily focussed on relationship management attempts to shape and highlight and identify of the place within the system rather than orchestrating budgetary spending.

Provider collaboratives were proliferating in number and variation of membership. Some were considered too embryonic to contribute to system objectives. The most common responsibilities of more established collaboratives were working to reduce variations in outcomes and improve access to services, collaborating to achieve greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures, collaborating to improve efficiency and improve economies of scale. Provider collaboratives were commonly thought of as bottom-up developments, and this was reflected in the great degree of variation in form and function. For some, this variation was concerning, raising questions regarding whether it would be more beneficial to have greater consistency, including within systems, regarding the role of provider collaboratives. It was suggested there were a need for increased clarity about what the 'ask' of provider collaboratives was, particularly in the light of possible duplication or lack of definition regarding the remits of places and provider collaboratives.

There was an expectation among some ICB directors (WP1.4) that commissioning should be substantively different in ICBs from CCGs. Some suggested commissioning was an activity taking place wherever there were conversations regarding service planning. Arrangements in ICBs were evolving to establish the optimum scope and scale of commissioning activities for

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particular services. Some services, such as ambulance services, were being commissioned jointly at a pan-ICB scale. For other services, some ICBs had established service specific commissioning committees. Where PBPs and provider collaboratives were not delegated formal decision-making responsibilities, ICS leaders told us that their places had important advisory roles relating to the planning and provision of services to their local population, such as providing leadership and acting as the focal point for shaping priorities, aligning priorities and gathering intelligence, which would feed into an ICB committee. There appeared to be a trend towards locating the procurement and contracting function centrally with the ICB due to perceived economies of scale and value. Some concerns were raised by ICB directors regarding conflicts of interest, which were perceived to be too great in PBPs to allow formal commissioning decisions to be taken. This raises questions as to why similar problems are not perceived at ICB level.

### 7.2.5. RQ2a: Are systems making use of joined-up/pooled budgets? How are they doing this and under which circumstances?

Overall, our interviews with ICB directors (WP1.4) suggested that usage of joined up/pooled budgets had not changed greatly in the period since the establishment of ICBs, and this was also the impression from a national level interviewee (WP1.1). The majority of the 17 ICB directors interviewed indicated either that the use of joined-up/pooled budgets had not altered, or they were not sure. ICB leaders indicated that they were concerned with ensuring such funds were used effectively, and were engaged in trying to understand how such funds were being used in order to target them more effectively.

### 7.2.6. RQ2d: What metrics are most suitable for monitoring outcomes and impact of multi-level system change?

To identify metrics suitable for future impact evaluation of HCA 2022 (WP2), we used WHO Health System Performance Assessment framework to guide selection of indicators under various health functions and outcomes. We did this considering a broad set of indicators derived from existing national frameworks and previous literature. Subsequently, we narrowed these to relevant and measurable indicators, while also identifying data availability for the included indicators. In all we identified 97 indicators with complete data that may reflect system change related with the HCA 2022.

National level stakeholder interviewees in WP1.1 were also asked to identify relevant metrics and indicators for assessing the outcomes and impact of multi-level system change. Responses were broad and varied and included evidence of the agreement and coherence of a vision for local outcomes between system partners, as well as demonstrable establishment of

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locally relevant (aligned with the locally agreed objectives) integrated teams (e.g. neighbourhood teams, discharge teams), or collaborative services (e.g. elective hubs). The key point was that these progress indicators should be tailored to reflect local context and priorities. Further suggestions included undefined measures to assess: an increase in proactive care activity, the prominence and influence of primary and social care providers in setting system priorities and shaping activity, and improvements in patient experience across services. The four core purposes of ICSs were highlighted as a framework for identifying and selecting relevant indicators by some WP1.1 interviewees, and these included measures of quality of life and years of healthy life lived, but also socio-economic factors such as the proportion of the working age population in employment. Assessing the extent to which ICSs were addressing health inequalities was considered important, but there was recognition that measuring and attributing ICS activities to improvement in population health outcomes and addressing health inequalities was challenging because of the extended time period involved and the issue of disentangling contributory factors.

### 7.2.7. RQ3a: How are ICSs incorporating patient and public perspectives into their development and operation?

WP1.2 was developed to gain initial insight into how ICSs are working with patients and the public, engaging with Healthwatch leaders nationally as a proxy for patient and public involvement. This enabled us to develop a national picture of how patient and public perspectives were being incorporated into ICS structures and strategic priorities.

As with the other WPs, the data collected from the survey of Healthwatch demonstrated variation in the organisation and approach taken by ICSs. This was largely influenced by the diverse and still evolving governance structures of individual ICSs and places (see WP1.3 findings in Section 5.2) and as a result Healthwatch engagement in these and their subsequent influence. Often this influence was dependent on fostering relationships with individuals, rather than a more formalised, systematic approach to patient and public engagement across the whole ICS, and nationally. Some respondents felt their input was tokenistic, and ICB decisions foregone conclusions, often driven by financial challenges.

These practical challenges suggested an overall feeling of disillusionment with ICSs, and scepticism as to their longevity and relevance to patients and the public. A minority of respondents could identify small-scale service changes they had influenced, but the majority expressed an overall lack of engagement from the ICS, feelings of being undervalued, and a wish to focus limited resources at place level, where Healthwatch appear to have a strong presence, and patients are more engaged with local service provision. The direct experiences

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of patients and the public will be examined in depth during the Phase 2 WP3 case study work, which will involve engagement with not only Healthwatch but also other community and patient groups.

### 7.2.8. RQ3b: What groups are most likely to benefit from improved collaboration?

National level policy stakeholder interviewees were asked in WP1.1 to identify patient and population groups most likely to benefit from increased collaboration and service integration. One broad suggestion was that any patient groups that generally experienced poor access or outcomes would be likely beneficiaries. As were those that frequently used services, or combinations of services, spanning multiple providers, particularly when these crossed community, primary, secondary and specialist 'boundaries.' More specifically, patient and population groups highlighted included: people with long-term conditions, frail older people, people with learning disabilities, and rough sleepers. It was also emphasised that local demographics and contextual factors within systems would shape priorities, integrated service activity, and prospective beneficiary groups. There were expectations that ICSs should improve the experience of care for those living in deprived areas and reduce inequalities, although this was recognised a longer-term project that might be challenging to understand from the perspective of the influence of ICS-related activities. This correlates with initial findings from the tracer groups document analysis that our selected groups of older people with frailty and children and young people with complex needs would like benefit from more joined up service provision potentially within the scope of ICSs, such as early identification, multidisciplinary working, and community-based care.

### 7.2.9. RQ4a: How is the duty to tackle health inequalities embedded within the ICB governance structure, and how are broader wellbeing inequalities being addressed by ICBs and ICPs?

The Governance Handbook analysis shows that 37 ICBs have established committees focused on improving population health and reducing disparities in healthcare access. While some ICBs have dedicated health inequality committees, others integrate this responsibility into broader committees such as commissioning or place-based committees. Phase 2 will focus in detail on how health and wellbeing inequalities are being addressed by ICBs and ICPs.

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### 7.3. Revisiting programme theories underlying the Health and Care Act 2022 and the introduction of Integrated Care Systems: further Realist evaluation

In Section 4, the national policy document analysis conducted as part of WP1.3 was presented in the form of four context, mechanism, outcome (CMO) configurations (Tables 2-5) reflecting programme theories associated with the HCA 2022 and associated policy. The first (Table 2, presents an overarching CMO configuration for the HCA 2022 and ICSs; Tables 3-5 focus on the programme theories associated with the three key themes of the HCA 2022: working together and supporting integration; reducing bureaucracy; ensuring accountability and enhancing public confidence. Although the mechanisms within the Act relate, in some cases, to the objectives of multiple themes, the CMO configurations were developed to reflect the emphasis placed on mechanisms and associated outcomes from the range of policy documents collected and analysed.

In this Section, we consider how the data and analysis from WP1.1-1.4 may shed light further on, or highlight tensions, between the policy programme theories associated with the HCA 2022 and ICSs, in particular. The purpose here is to begin to develop an understanding of the potential gap between policy as 'espoused' and policy as 'realised', whilst recognising that (a) this is the start of an ongoing process that will continue to develop and be refined through the Phase 2 work, particularly WP3 and the qualitative, in-depth ICS case studies, and (b) that the data from interviewees and respondents from WP1.1, 1.2 and 1.4 represents a diverse range of perspectives, each of which reflects their own role, context, and experiences. The extent to which these opinions reflect what is happening locally will be followed up in Phase 2. As such, this further analysis of the programme theories is intended to support understanding, particularly, of the connections between mechanisms and outcomes and what factors might support or inhibit the achievement of those specific outcomes via the mechanisms associated with them in the HCA 2022 and related policy.

In what follows, we highlight a number of mechanisms and outcomes that can reasonably be assumed to be associated (the explicit logic of the link of how the former will realise the latter is not always clear in policy documents) from Tables 3-5, beginning with Table 3: 'Working together and supporting integration CMO configuration.'

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| Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
| --- | --- |
| Principle of subsidiarity: that decisions should be taken closest to whom they affect. Stakeholders within systems will collaborate at sub-System levels (Places and Neighbourhoods) to meet the distinct needs of local populations | Decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes |

Both WP1.1 and WP1.4 interviews highlighted that the principle of subsidiarity is not being broadly adhered to in practice. The accountability and oversight regime, and resource constraints, that ICBs are subject to were presented as factors in creating resistance from ICBs to delegate and divest power and control to places in a meaningful way. Decisions are thus typically taken at system level where there is often a lack of contextual understanding of the specific needs of diverse places. Thus, any ability to make judgements regarding the extent to which more local decisions might lead to better outcomes is undermined by the centralisation of decision-making power and control at system level.

| Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
| --- | --- |
| Prescribed ICP membership makes health and social care equal partners, and Local Authorities will have a role in nominating members to the ICB | Prescribed membership of ICP and ICB makes health and social care equal partners<br><br>Local Authority participation will drive integration through pooled budgets and joint working arrangements |

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Emerging evidence of the partnership relationship between local authorities and NHS organisations across ICBs and ICPs is mixed from WP1.4 and WP1.1 findings. Although there was recognition that the HCA 2022 creates the conditions and structures for closer collaboration this was often lacking in practice within systems (WP1.4), and the pressures on ICBs to focus on delivering against NHS targets around, for example, GP access and elective recovery, were highlighted. Although there was positivity and optimism from some interviewees about the potential of ICPs to set a strategic direction, shaped by relevant collaborations across the health and care stakeholders in a given system (WP1.1; WP1.4), there were also concerns that ICPs were struggling to establish a purpose and identity or exercise influence. Intentions to more formally integrate local authority stakeholders into ICBs

were relinquished during the development of the Bill due to perceived insurmountable complexities around integrating governance and accountability requirements of local government and the NHS. There was little reported evidence of any increase in budget pooling or significant joint working arrangements from WP1.1 interviewees at that time. Although the picture and dynamics between NHS and local authority partners is likely to be mixed and variable between systems, this is likely an area that requires further attention in order to fulfil the objectives above.

Next, we address a mechanism and outcome pair from Table 4: ‘Reducing bureaucracy CMO configuration.

| Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
|---|---|
| Shift from competitive retendering to collaborative delivery models as part of an overall increased emphasis on collaboration and de-emphasis of competition | Reduced bureaucratic fragmentation leading to more efficient resource use and more joined up provision |

De-emphasising the need for competitive service retendering and shifting to a greater emphasis on collaboration via the introduction of the PSR is suggested as a mechanism that will help to realise more efficient resource use and reduced bureaucratic fragmentation within systems. Policy stakeholder interviews (WP1.1) highlighted concerns that many systems are dealing with ambiguities around accountabilities and governance arrangements. It is important to note that this is likely to create inefficiencies regarding the orchestration of provision, specifically due to duplication of decision-making, which needs to be considered as potentially offsetting efficiencies generated by avoiding the need to work around competitive tendering processes.

Finally, we consider mechanisms and outcomes from Table 5: 'Ensuring accountability and enhancing public confidence CMO configuration.’

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| Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
|---|---|
| Care Quality Commission reviews of ICSs | CQC reports will provide an independent assessment of how well areas are performing providing decision-makers and the public with information about the quality of care and joint working within each area |

The CQC's assessments of ICSs are currently on pause following the results of reviews led by Dr Penny Dash and Dr Mike Richards, which highlighted various issues including problems with the single assessment framework. This is a live and evolving issue, but the current situation is clearly not providing meaningful information to decision-makers and the public about the quality of care and joint working in systems and enhancing public confidence in ICSs. Whatever processes are developed and implemented, as the WP1.1 data highlights, it may be helpful to assess systems according to the locally specific objectives that they have identified as important to address, doing so however raises challenges of comparing systems and finding ways to allow for considerable variation that stems from the flexibility associated with ICSs' establishment and approaches.

| Mechanisms (changes that will enable desired results) | Outcomes (desired results) |
|---|---|
| Establish ICBs and ICPs in legislation | Embed accountability for system performance and delivery into the accountability arrangements of the NHS to Government and Parliament |

Challenges and complexities regarding ICB accountabilities to NHSE, in particular, were a central finding of the Phase 1 work overall. A focus on NHS-centric metrics and financial position were highlighted as potentially reassuring for the Centre but undermining the capacity of systems to make progress against the four core aims, particularly broader socio-economic and population health goals. As such, the metrics around system performance and delivery for which ICBs are being held to account for is rather narrow and disconnected from the more holistic goals set out for them to deliver against, and this may undermine the broader objectives around effective multi-level collaboration and integration (WP1.1). This is related to a broader question of who in the system is ultimately responsible for ensuring

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system success and accountable for things going wrong. Furthermore, accountability dynamic between ICBs and local providers within systems are also somewhat confused, i.e. whether the ICB's role should be one of performance management (for which it is underpowered) or more of a collaborative convener. Addressing all these ambiguities will be important for ensuring that accountability arrangements around performance and delivery are robust (WP1.1; WP1.4).

## 7.4. Analysis of Phase 1 findings

This interim report concerns the findings from Phase 1, and the first 12 months, of the Health and Care Act 2022 Post-Implementation Review. It represents the first step towards addressing the overarching aims to build and strengthen the evidence base concerning the development and governance of collaboration in ICSs, and identify appropriate metrics for assessing the impact and outcomes of this collaboration. This section of the Discussion analyses and considers the implications of the Phase 1 findings.

**Clarity of roles and responsibilities**

Our findings suggest, as ICB governance arrangements develop under the HCA 2022, an emerging concern is the general lack of clarity in relation to who is responsible for what. In terms of the internal system landscape our findings point to the potentially duplicative roles of places and provider collaboratives. In particular, there appears to be wide variation in form and function of provider collaboratives, which in some systems may have been 'bottom-up' developments without any oversight regarding their formation. Our findings in this regard are drawn from partial perspectives due to the practical limits of the research activities which could be undertaken within the Phase 1 period. In particular, our interviews with local ICSs focused on ICBs and not ICPs, and we spoke to ICB directors but not LA leaders, provider organisation leaders or place based or provider collaborative leaders. However, our finding of a lack of clarity in relation to the distribution of roles and functions within systems and duplication of remits has been noted in other research concerning system working since the HCA 2022 (Sanderson et al. 2024).

The HCA 2022 is 'silent' regarding governance arrangements in ICSs beyond statutory ICBs and ICPs. The roles and responsibilities of PBPs and provider collaboratives are a matter for local design. Many appreciate this local freedom, and the opportunity to shape arrangements that best suit local contexts. Conversely, however, it appears that some systems wish to establish greater clarity regarding responsibilities, whether that occurs within each system or through more national guidance. As has been noted previously (see Sanderson et al. 2024),

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while not all systems would appreciate more central direction regarding governance arrangements, in practice finding local solutions is a time-consuming process of trial and error. Additional guidance could share learning and solutions between systems or provide scaffolding which can be locally amended to reflect local circumstances and preferences.

There is also a lack of clarity in relation to the role of the ICB itself, and the relationship between ICBs and NHSE. There had been an unwelcome shift for some in the role of the ICB towards performance management, with an expectation from NHSE regions that ICBs should hold providers to account for performance. ICBs were in danger of becoming 'mini regulators', with the originally anticipated goals (i.e. improving outcomes in population health and healthcare, tackling inequalities, enhancing productivity and value for money; and helping the NHS support broader social and economic development) effectively 'crowded out'. This can be understood as a shift from horizontal accountability relationships between partners in ICSs, to a vertical accountability relationship through which ICBs hold the rest of the system (including individual providers) to account. As interviewees noted, this shifting relationship has the potential to disrupt the partnership working between peers on which ICSs were based by placing ICBs in a hierarchical relationship with the rest of the NHS system partners. It appears at this time that the additional measures introduced by HCA 2022 to strengthen mutual accountability, such as the duty to collaborate, are in danger for some systems of being outweighed by vertical accountability relationships.

The accountability of NHS providers was not altered by the HCA 2022 and they remain independent statutory organisations accountable to NHSE. It is not clear therefore how ICBs can hold providers to account (Petsoulas and Allen, 2021). ICBs were positioned as convening collective accountability between partner organisations for whole-system delivery and performance (NHS England, 2024b).

In addition to the lack of clarity in relation to provider accountability, the apparently shifting role of ICBs was perceived to duplicate the role of NHSE regions. This risks providers feeling over-regulated, with the introduction of additional vertical accountability arrangements which can be duplicative and additional bureaucracy in a system that is already heavily regulated (Ham, 2023). Our findings in this regard echo the findings of other recent research that the HCA 2022 has not clarified accountabilities for NHS providers, and provider leaders are frustrated by increased regulatory scrutiny, and a perceived imbalance in staff resources between regulators and the regulated (Sanderson et al. 2024), and that accountabilities were not well defined between ICBs and NHS England's national team (Bliss et al. 2024). The recent Darzi report also found differing understandings across ICBs of their performance

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management responsibilities in relation to providers, and a perception of 'too many people holding people to account rather than doing the job' (DHSC, 2024).

**The Principle of Subsidiarity**

The principle of subsidiarity, that decisions should be taken closest to whom they affect, underlies system working. The Good Governance Institute give subsidiarity a wider description:

> "Subsidiarity dictates that local groups should have the power to organise their own work, make their own decisions and create their own structures, rather than just being assigned power by employers" (The Good Governance Institute, 2021)

What subsidiarity means in practice in relation to the distributions of roles and responsibilities across systems is not straightforward. NHSE guidance suggests that the principle of subsidiarity is expected to be embedded in governance arrangements, with responsibility for the planning and delivery of integrated services delegated to geographical places (NHSE 2019). The White Paper 'Integration and Innovation: working together to improve health and social care for all' indicates that 'significant' delegation to both place level and provider collaboratives from ICSs is expected.

It is worth noting that the debate about the best scale for decisions to be taken is part of a long history in the NHS of reorganisation across spatial scales, with no consensus among policy makers or commentators over where functions and responsibilities should be located (Lorne et al. 2019). Before ICSs, previous intermediate tiers delivered planning functions across wide geographic areas, as well as having capacity for dispute resolution and managing finances. Furthermore, the recognition of the necessity for detailed oversight of the delivery of local services across a territory with a meaningful identity among those involved, including staff and the public, has also been consistently recognised (ibid). Many current place-based partnerships are based on the footprints of the previous CCGs, and under this previous regime it was in fact easier to make decisions at this scale due to the existence of CCGs as statutory bodies.

Our research found a lack of delegation of decision-making commissioning functions and commensurate financial decision making to places (i.e. resource allocation, procurement and contracting). Local explanations for this included a local geographical context which was not conducive to delegation, attitudes to financial risk, perceptions of strength of collaborative relationships, and attitudes to formal governance structures and associated administrative burdens. It is important to interrogate these explanations. In relation to the issue of the

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administrative burden, this suggests something of a catch-22 developing around the idea of delegation to places: delegation to places is not possible because of a lack of formal statutory arrangements, but formal statutory arrangements would themselves impede delegation and decision-making by increasing bureaucracy. Furthermore, ICBs may be able to remove some of the barriers in the local context preventing delegation by altering the boundaries of their places. CCGs, many of which were constituted over similar footprints to current places, had statutory responsibility for all aspects of commissioning until 2022. It is also the case that barriers in relation to the 'maturity' of place relationships are arguably somewhat curious, given that partners have been working together at system and place scale for some time now. It is possible, as will be discussed in relation to organisational sovereignty below, that arguments regarding maturity reflect the difficulty for partners to reach agreement between themselves in relation to contentious issues using consensus approaches. There is a risk that the consensus model of decision-making, which requires place partners to agree decisions amongst themselves, has created a barrier to achieving subsidiarity. It is likely that the lack of delegation is largely driven by the need to maintain a strong financial grip, and that ICBs do not yet believe that the putative benefits of delegation outweigh the perceived financial risks. All of these issues will be followed up in Phase 2 of our research.

Despite the lack of formal delegation, ICS leaders told us that they see PBPs as fulfilling a fundamental and crucial role in system working. Some ICB directors suggested that informal decision-making responsibilities had provided sufficient scope for meaningful action at place scale. Recent research suggests that commissioning is seen as an activity diffused throughout the system rather than being located in a single place, wherever there were conversations regarding service planning (Sanderson et al. 2024). If we understand commissioning to refer to a wide-ranging set of activities including objective setting and decision making, management of partnerships, supporting patient choice, information collection, service design and resource allocation and procurement and contracting (Wade et al. 2006, Checkland et al. 2024), then a number of these responsibilities were reported to be enacted in place-based partnerships that were not in receipt of any formal delegation. Whether such arrangements which allow PBPs input into the commissioning process, without having ultimate responsibility for decision making, satisfy the principle of subsidiarity is not clear, and our Phase 2 work will follow up these findings to explore whether the claims made about the important role of places are reflected in the actual work being done. There is evidence from previous evaluations that locally based services such as primary care require local commissioning, and recent review of the literature on integration highlights (Checkland et al. 2024) the key commissioning tasks

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which require local (place-level) action to manage relationships and support collaborative service provision.

It is noteworthy that concerns regarding conflict of interest were raised regarding situating procurement and contracting at place scale. Previous research has indicated that ICS leaders have tended not to see conflicts of interest as an issue (Sanderson et al. 2024). However, there appears to be emerging concerns now, that taking procurement and contracting decisions at place may involve 'too many' conflicts of interest. This raises questions regarding why conflicts are seen as an issue at place level but not within the ICB itself, and suggests there should be a re-evaluation of the potential for conflicts of interest at all levels in systems.

**Permissiveness and control**

Permissiveness, and flexibility, are central to the HCA 2022 and associated policy, as illustrated by its prominence in policy stakeholder reflections on the Act and its impact thus far (WP1.1). Indeed, the notion that permissiveness and flexibility will facilitate innovative home-grown transformation can be traced back to the permissive approach of the Vanguard programme (Checkland et al. 2019). The permissive approach of ICS policy guidance in allowing great flexibility for the design of system governance arrangements and implementation of delegation to system partnerships, and organisations, means that there will be wide variation in the form, degree and maturity of system partnership working. This variation should be considered to reflect the process of developing locally appropriate arrangements. However, it is clear that the freedom given to ICSs to decide their own governance arrangements beyond the statutory ICB and ICP has been something of a double–edged sword. While a cohort of ICBs are using this flexibility to put in place complex governance arrangements which deliver decision-making arrangements which make sense to all partners, other ICBs are finding the lack of a 'blueprint' is leading to unclear and duplicative responsibilities. In this respect it could be argued that, for some, the governance arrangements are too permissive and flexible. Some of the ICB directors interviewed for WP1.4 were concerned that governance arrangements could become 'an industry in itself'.

Conversely, it can be argued that alongside what some regard as too little control over how systems enact their responsibilities, there is too much control regarding what systems can do. Policy stakeholders (WP1.1) and ICB directors (WP1.4) feared that national must dos, performance management and short-termism are 'crowding out' local planning and local solutions. Some suggested national control regarding what should be done is preventing collaboration and proving an obstacle to the realisation of locally agreed objectives. It is also

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the case that the enforced focus on NHS concerns in ICBs is at the expense of health and wellbeing objectives, which are influenced by more than health services alone. Our finding in this regard has been observed previously in relation to the crowding out of local action on health inequalities by Alderwick et al. (2024), disruption of transformation efforts (Bliss et al. 2024) and its detrimental effect on collaboration (Sanderson et al. 2024). Alternatively, policy stakeholder interviewees (WP1.1) suggested that significant variation in the way that ICSs organise and orchestrate services may lead to variations in patient and population outcomes. Over time, this may result in consequences that may shape the overarching attitude towards the permissiveness of the policy landscape.

One way to address this imbalance may be for ICPs to have greater influence over the work of the ICB. Our findings suggest that the potential for the ICP to carry out this function is recognised but interviewees generally felt that ICPs were not exercising this power currently due to a perceived lack of levers available to them. This mirrors the findings of evaluations of the role of Health and Wellbeing Boards, which were also felt to lack levers to make change happen and to hold system partners to account. This in turn suggests that considerations as to how best to embed and develop the role of ICPs could usefully start with lessons learned by Health and Wellbeing Boards (Hunter et al. 2018).

Overall, we suggest that, if ICSs to realise their longer-term goals, it may be necessary to consider the balance between flexibility regarding how things should be done, and control regarding what needs to be done.

**Organisational sovereignty and consensus decision making**

The HCA 2022 did not make any fundamental changes to the nature of co-ordination in ICSs. Collaboration is a voluntary, consensual, non-binding model of coordination, and providers, including NHS organisations, remain separate organisations with their own organisational interests and accountabilities, and freedom to dissent.

The Act contained several mechanisms aimed at encouraging collaborative behaviour and the precedence of system, rather than direct organisational, interests. However, it is apparent that some ICB leaders still fear that partners may not adhere to decisions which are perceived to be against organisational interests. Interviewees highlighted the financial pressures facing system partners and fears that this may destabilise collaborative relationships. Such tensions may be particularly pronounced in a highly resource constrained environment, such as systems facing considerable financial deficits. This presents a knotty problem for such systems, which are faced with particularly hard decisions to address, which can only be

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resolved through reaching consensus. In some cases, relationships between partners are not considered sufficiently 'mature' to allow these decisions to be taken, particularly away from the ICB itself. However, relationships between partners have been under development since the establishment of STPs in 2017, and arguably it is no longer early days for collaboration. This raises questions about the sufficiency of the consensus-based approach to drive through hard decisions in difficult contexts. It is not particularly clear at the moment if systems can drive through decisions which may involve winners and losers. Indeed, the conventional approach for particularly low performing systems is to revert to centralisation and command/control style of decision making.

**Patients, population and metrics**

Phase 1 has begun initial consideration of potential patient group beneficiaries of, as well as prospective metrics for assessing, integration and collaborative activity via ICSs in a variety of ways through WP1 and WP2. Although this is an ongoing endeavour through the research as a whole, what WP1.1, in particular, suggests is that stakeholders consider a broad spectrum for potential beneficiaries and metrics to be plausible. While this may be argued to be a reflection of the broad health and socio-economic aims of ICSs, it does suggest that a degree of caution is required in terms of the scope of what ICSs and system-based collaboration might realistically be hoped to affect and achieve, and the logic underlying how actions might realise the intended benefits through implementation.

As noted at the start of this section, our findings at this point are interim and represent the first step towards addressing the overarching aims to build and strengthen the evidence base concerning the development and governance of collaboration in ICSs under the HCA 2022. However, at this interim point there is a contrast between the intent of the Act, which was to remove the impediments to collaboration, and the consequent changes to the landscape which appear to have been triggered by making ICSs 'weight bearing'.

## 7.5. Strengths and limitations

A key strength of Phase 1 of this research has been the multi-dimensional and multi-method approach taken across the various WP1 sub-WPs and WP2. Although this has been practically challenging in terms of research orchestration, particularly in the context of a general election that necessitated pausing certain data collection activities for several weeks, it has provided a basis to address the various RQs from different perspectives, at different scales, and using methods with different advantages. Phase 1 thus establishes a strong foundation upon which to build and iterate on in Phase 2.

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There are also a number of limitations that are important to recognise. Although we used prior knowledge and snowballing to identify policy stakeholders in WP1.1 to approach regarding participation in the study, it was not our intent to be comprehensive in these interviews. Therefore, it is possible we have not captured the full range of relevant reflections regarding the aims of HCA 2022, and its effects to date.

In relation to the survey of local Healthwatch (WP1.2) and the ICB directors telephone interviews (WP1.4), there is the possibility of response bias. In particular it is possible that people agreed to participate in the research because they held strong views about ICS/Healthwatch interactions, and ICB structures respectively. While WP1.4 allowed us to develop an insightful picture across systems nationally, there is a need to gain the perspectives from other stakeholders in systems beyond ICB directors, particularly those working primarily at place level and in LAs as well as patients. It is also important to remember that the interviews reflect the views of the interviewees. The in-depth qualitative case studies of two ICSs in WP3 will allow us to explore in more detail how places are enacting their role and how governance and other mechanisms are working in practice.

### 7.6. Implications of Phase 1 for policy and practice / Recommendations

As this is an interim report, the recommendations which can be made at this stage are necessarily limited. The main implications of the Phase 1 research are:

- Consideration should be given to increasing guidance regarding roles and responsibilities to obviate individual ICSs spending too much time on discussing universal common issues, in particular the roles of ICBs, PBPs and provider collaboratives are lacking clarity and could usefully be specified more fully.
- ICB leaders suggested to us that the principle of subsidiarity is being realised in ways that may not be captured by ICB Governance Handbooks. Therefore, ICB leaders should explain more clearly in their published documents how subsidiarity is being enacted locally.
- There is a potential mismatch between the evidence as to the value of delegation, the associated policy aspiration to subsidiarity and the enactment on the ground of a more centralised model of commissioning. How the majority of places are enacting the important role of supporting and enabling local collaborative service delivery in the absence of delegated decision-making and budgetary responsibilities remains an important question. This requires further study and is being addressed by a linked

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project carried out by the Policy Research Unit in Health and Social Care Systems and Commissioning (https://prucomm.ac.uk/).

- Our research suggests that some ICBs are not delegating commissioning decisions to place-based partnerships due to concerns regarding conflicts of interest. Current guidance regarding the management of conflicts of interest should be reconsidered, including considering whether and how far the issues that our interviewees identified as affecting places are also relevant at the level of the ICB.
- There is a need for further research regarding the role of provider collaboratives. The role of provider collaboratives is clearly of significance but is currently unclear, and there is a need to better understand what they are for and how they contribute to system working. A linked project, which focuses specifically on provider collaboratives, is currently underway as part of the Policy Research Unit in Health and Social Care Systems and Commissioning (https://prucomm.ac.uk/). The findings from the study will be used to inform and support Phase 2 of this research project, which will include consideration of provider collaboratives in the case study ICSs in WP3.
- The role of ICPs remains unclear, and many of the issues raised in our interviews reflect earlier issues highlighted in evaluations of Health and Wellbeing Boards. Further work is required to maximise the value associated with ICPs, and there is a potential to learn lessons from the experiences of Health and Wellbeing Boards.

It is sometimes said that it remains 'early days' and that ICSs could not be expected to be meeting their potential yet. However, a contrary view might be that partnership working across geographical footprints currently established as ICSs has been going on since 2016. It might therefore be expected that more progress would have been made. Our study suggests that lack of clarity around who is responsible for what may be relevant here, with some evidence pointing towards the need for more guidance as to **how** the different structures within ICSs should relate to each other (the how of ICS functioning), particularly in relation to decision making, with less control over **what** ICSs are doing in order to allow them to pursue their strategic priorities more effectively.

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## 7.7. Engagement and outputs: Phase 1

During Phase 1, we:

- Met regularly with research advisory group (including DHSC and NHSE colleagues, national thought leaders, and PPIE members) to discuss and refine research activities.
- Attended two structured meetings for policy makers in our Research Update Group in order to share early findings and discuss policy developments, and in the second meeting to discuss plans for Phase 2.
- Informally engaged with DHSC and NHSE policymakers and analysts throughout to ensure use of best data and metrics, add-value and avoid duplication of in-house work.
- Proactively connected with researchers on related projects. We have been holding monthly meetings with the research team for the PRU HSSC project - 'Delivering integrated Neighbourhood services: understanding commissioning and service design within Places" - because the interest of both projects overlaps we are exploring ways to ensure that each can enhance the value of the other and duplication can be avoided.

Once this interim report is reviewed and complete, we will produce short research briefings for ICS members and partner organisations, and a plain English summary of the Phase 1 findings for distribution through PPIE members and the Healthwatch network. We will also provide a feedback session for Healthwatch to present the results of the Healthwatch survey in WP1.2 to stakeholders.

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# 8. References

ALDERWICK, H., HUTCHINGS, A. & MAYS, N. 2024. Solving poverty or tackling healthcare inequalities? Qualitative study exploring local interpretations of national policy on health inequalities under new NHS reforms in England. *BMJ Open*, 14:e081954.

ALLEN, P. 2002. A socio-legal and economic analysis of contracting in the NHS internal market using a case study of contracting for district nursing. *Social Science & Medicine*, 54, 255-266.

ALLEN, P., OSIPOVIC, D., SHEPHERD, E., COLEMAN, A., PERKINS, N. & GARNETT, E. 2015. Commissioning through Competition and Cooperation. Final Report to the Department of Health. London: PRUComm.

ALONSO, J. M. & ANDREWS, R. 2022. Does vertical integration of health and social care organizations work? Evidence from Scotland. *Social Science & Medicine*, 307, 115188.

BAXTER, S., JOHNSON, M., CHAMBERS, D., SUTTON, A., GOYDER, E. & BOOTH, A. 2018. The effects of integrated care: a systematic review of UK and international evidence. *BMC Health Services Research*, 18, 1-13.

BEARD, J. R. 2024. Beyond integrated care for older adults. *Nature Aging*, 4, 1-4.

BENNETT, C. & FERLIE, E. 1996. Contracting in Theory and in Practice: some evidence from the NHS. *Public Administration*, 74, 49-66.

BINKS, V. & CUNNET, J. 2023. Exploring and understanding the VCSE sector in Provider Collaboratives. NHS Confederation.

BLISS, A., WILLIAMSON, S. & ALAYO, L. 2024. The state of Integrated Care Systems: tackling today while building for tomorrow. NHS Confederation.

BOLDEN, R., KARS-UNLUOGLU, S., JARVIS, C. & SHEFFIELD, R. 2023. Paradoxes of Multi-Level Leadership: Insights from an Integrated Care System. *Journal of Change Management*, 23, 337-357.

BRAITHWAITE, J., HIBBERT, P., BLAKELY, B., PLUMB, J., HANNAFORD, N., LONG, J. C. & MARKS, D. 2017. Health system frameworks and performance indicators in eight countries: a comparative international analysis. *SAGE Open Medicine*.

CARE ENGLAND. 2024. From Inception to Implementation: A Year of Integrated Care Systems.

CHECKLAND, K., BRAMWELL, D., HAMMOND, J., BAILEY, S., WARWICK-GILES, L., ALLEN, P. & SANDERSON, M. 2024. Effective commissioning for integrated service delivery at Place: what functions and structures does the literature suggest are required?

CHECKLAND, K., COLEMAN, A., BILLINGS, J., MACINNES, J., MIKELYTE, R., LAVERTY, L. & ALLEN, P. 2019. National evaluation of the Vanguard new care models programme: Interim report: understanding the national support programme.

CHECKLAND, K., HAMMOND, J., SUTTON, M., COLEMAN, A., ALLEN, P., MAYS, N., MASON, T., WILDING, A., WARWICK-GILES, L. & HALL, A. 2018. Understanding the new commissioning system in England: contexts, mechanisms and outcomes. Final report. NIHR Policy Research Programme.

CHECKLAND, K., WARWICK-GILES, L., BRANWELL, D., HAMMOND, J., BAILEY, S., ANSELMI, L. & SUTTON, M. forthcoming. Tackling health inequalities: the role and potential impact of Integrated Care Systems. Policy Research Unit in Health and Social Care Systems and Commissioning.

DEN EXTER, A. P. & GUY, M. 2014. Market competition in Health Care Markets in the Netherlands: some lessons for England? *Medical Law Review*, 22, 255-273.

DHSC 2021. Integration and innovation: working together to improve health and social care for all.

DHSC 2022a. Health and Care Act 2022: core measures impact assessment.

Working Paper

DHSC. 2022b. Health and social care act 2022 core measures impact assessment. Technical report. Available: https://assets. publishing.service.gov.uk/media/6363dc43e90e0705b204cb5f/ Health-and-Care-Act-2022--Core_Measures-Impact-Assessment. pdf. [Accessed 9 September 2024 ].
DHSC 2022c. Health and social care integration: joining up care for people, places and populations.
DHSC. 2023. Review of Section 75 arrangements: supporting document Available: https://www.gov.uk/government/calls-for-evidence/improving-integrated-commissioning-in-health-and-social-care/review-of-section-75-arrangements-supporting-document [Accessed 30 October 2024].
DHSC 2024. Independent investigation of the NHS in England. Lord Darzi's report on the state of the National Health Service in England.
DUNN, P., FRASER, C., WILLIAMSON, S. & ALDERWICK, H. 2022. Integrated care systems: what do they look like. *Health Foundation*.
DWICAKSONO, A. & FOX, A. M. 2018. Does decentralization improve health system performance and outcomes in low-and middle-income countries? A systematic review of evidence from quantitative studies. *The Milbank Quarterly*, *96***,** 323-368.
EUROSTAT & WORLD HEALTH ORGANISATION 2017. *A System of Health Accounts 2011 Revised edition: Revised edition*, OECD publishing.
FATIMAH, A., BRITTEON, P., TURNER, A. J., ANSELMI, L., GILLIBRAND, S., WILSON, P., SUTTON, M. & LAU, Y.-S. 2023. Evaluating whole system reforms: a structured approach for selecting multiple outcomes. *Health Policy*, 138**,** 104933.
FERNANDEZ, J.-L., MCGUIRE, A. & RAIKOU, M. 2018. Hospital coordination and integration with social care in England: the effect on post-operative length of stay. *Journal of Health Eeconomics*, 61**,** 233-243.
FROSINI, F., DIXON, A. & ROBERTSON, R. 2012. Competition in the NHS: a provider perspective. *Journal of Health Services Research and Policy*, 17**,** 16-22.
HAM, C. 2023. Accountability and autonomy in the NHS in England: priorities for the Hewitt review, NHS Confederation.
HAM, C., RALEIGH, V. S., FOOT, C., ROBERTSON, R. & ALDERWICK, H. 2015. *Measuring the performance of local health systems: a review for the Department of Health*, King's Fund.
HEALTHWATCH ENGLAND. 2021. Our strategy 2021-2026. Available: https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20210512%20-%20Our%20strategy%20explained.pdf [Accessed Accessed 24th October 2024 ].
HEALTHWATCH ENGLAND. 2022. Introduction to Healthwatch. Available: https://network.healthwatch.co.uk/sites/network.healthwatch.co.uk/files/20220907%20Introduction%20to%20Healthwatch%20final%20updated%20tone%20of%20voice.pdf [Accessed Accessed 24th October 2024].
HOUSE OF COMMONS. 2018. Integrated care: Organisations, parternships and systems. Seventh Report of Session 2017–19, House of Commons Health and Social Care Committee. Available: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf (accessed February 2024). [Accessed February 2024].
HOUSE OF COMMONS 2021. Explanatory notes to the Health and Care Bill 2021.
HOUSE OF COMMONS 2023. Introducing Integrated Care Systems, Thirty-Fifth Report of Session 2022–23.
HUNTER, D. J., PERKINS, N., VISRAM, S., ADAMS, L., FINN, R., FORREST, A., & GOSLING, J. (2018). Evaluating the leadership role of health and wellbeing boards as drivers of health improvement and integrated care across England. Available: http://eprints.whiterose.ac.uk/151457/ [Accessed 31 Oct. 2024]
IMPOWER/COUNTY COUNCIL NETWORK 2022. The evolving role of county authorities in Integrated Care Systems.

Working Paper

KELLY, L., HARLOCK, J., PETERS, M., FITZPATRICK, R. & CROCKER, H. 2020. Measures for the integration of health and social care services for long-term health conditions: a systematic review of reviews. *BMC Health Services Research,* 20**,** 1-11.
LEWIS, R., CHECKLAND, K., DURAND, M. A., LING, T., MAYS, N., ROLAND, M. & SMITH, J. 2021. Integrated care in England - What can we learn fro a decade of national pilot programmes? *International Journal of Integrated Care,* 21.
LILJAS, A. E. M., BRATTSTRÖM, F., BURSTRÖM, B., SCHÖN, P. & AGERHOLM, J. 2019. Impact of integrated care on patient-related outcomes among older people–a systematic review. *International Journal of Integrated Care,* 19.
LOCAL GOVERNMENT ASSOCIATION. 2012. Establishing local Healthwatch: introduction and the local authority role. Available: https://www.local.gov.uk/sites/default/files/documents/establishing-local-health-337.pdf [Accessed October 2024].
LORNE, C., ALLEN, P., CHECKLAND, K., OSPIOVIC, D., SANDERSON, M., HAMMOND, J., PECKHAM, S . 2019. Integrated Care Systems: What can current reforms learn from past research on regional co-ordination of health and care in England? PRUComm. Available: https://prucomm.ac.uk/assets/uploads/PRUComm_-_Integrated_Care_Systems_-_Literature_Review.pdf [Accessed October 2024]
MCNALL, M. & FOSTER-FISHMAN, P. 2007. Methods of rapid evaluation, assessment, and appraisal. *American Journal of Evaluation.* June 1**,** 151-68.
MORCIANO, M., CHECKLAND, K., BILLINGS, J., COLEMAN, A., STOKES, J., TALLACK, C. & SUTTON, M. 2020. New integrated care models in England associated with small reduction in hospital admissions in longer-term: a difference-in-differences analysis. *Health Policy,* 124**,** 826-833.
MORCIANO, M., CHECKLAND, K., DURAND, M. A., SUTTON, M. & MAYS, N. 2021. Comparison of the impact of two national health and social care integration programmes on emergency hospital admissions. *BMC Health Services Research,* 21**,** 1-10.
MOSS, C., ANSELMI, L., MORCIANO, M., MUNFORD, L., STOKES, J. & SUTTON, M. 2023. Analysing changes to the flow of public funding within local health and care systems: An adaptation of the System of Health Accounts framework to a local health system in England. *Health Policy,* 137**,** 104904.
NATIONAL AUDIT OFFICE 2022. Introducing Integrated Care Systems: joining up local services to improve health outcomes. Department of Health and Social Care (DHSC).
NATIONAL AUDIT OFFICE 2024. NHS Financial Management and Sustainability.
NHS ENGLAND 2014. Five Year Forward View. London: NHS England.
NHS ENGLAND 2017. Next Steps on the NHS Five Year Forward View. . London: NHS England.
NHS ENGLAND 2022a. List of Statutory Functions to be considered for delegation and joint working arrangements. NHS Futures.
NHS ENGLAND 2022b. NHS Oversight Framework - technical report.
NHS ENGLAND 2022c. NHS oversight metrics for 2022/23. NHS England.
NHS ENGLAND 2022d. Statutory Guidance: Arrangements for delegation and joint exercise of statutory functions. Guidance for integrated care boards, NHS trusts and foundation trusts. .
NHS ENGLAND 2023. *Delivery plan for recovering urgent and emergency care services*, NHS England.
NHS ENGLAND. 2024a. Arrangements for delegation and joint exercise of statutory functions. Available: https://www.england.nhs.uk/long-read/arrangements-for-delegation-and-joint-exercise-of-statutory-functions/ [Accessed 9 Oct. 2024]). .
NHS ENGLAND 2024b. Guidance on integrated care board constitutions and governance.
NHS ENGLAND 2021. ICBs Guide to developing a Scheme of Reservation and Delegation

Working Paper

NHS ENGLAND AND NHS IMPROVEMENT 2018. Refreshing NHS Plans for 2018/19.
NHS ENGLAND AND NHS IMPROVEMENT 2019. Designing Integrated Care Systems in England.
NHS ENGLAND AND NHS IMPROVEMENT 2021. Working together at scale: guidance on Provider Collaboratives.
NHS ENGLAND AND NHS IMPROVEMENT AND LOCAL GOVERNMENT ASSOCIATION 2021. Thriving places - Guidance on the development of place-based partnerships as oart of statutory integrated care systems.
PAPANICOLAS, I., RAJAN, D., KARANIKOLOS, M., SOUCAT, A. & MARIMONT, J. F. 2022. Health system performance assessment: a framework for policy analysis, World Health Organization.
PAWSON, R. & TILLEY, N. 1997. *Realistic evaluation.* , London, SAGE.
PETSOULAS, C. & ALLEN, P. 2021. Summary and commentary on the issue of accountability in the Health and Care Bill 2021. London: PRUComm. Available: prucomm-note-on-accountability-issues-in-bill-nov-2021.pdf [Accessed 31 Oct. 2024]
PORTER, A., MAYS, N., SHAW, S., ROSEN, R. & SMITH, J. 2013. Commissioning healthcare for people with long-term conditions: the persistence of relational contracting in England's NHS quasi-market. *BMC Health Services Research,* 13 (Suppl 1).
SANDERSON, M., OSIPOVIC, D., PETSOULAS, C., ALLEN, P., SUTTON, M. & LAU, Y. 2024. The Architecture of System Management (2022-2023). Policy Research Unit in Health and Social Care Systems and Commissioning.
THE ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH 2024. Integrated Care Systems Survey Report.
THE GOOD GOVERNANCE INSTITUTE 2021. Place in integrated care: the noble aim of subsidiarity. Avaiable at: https://www.good-governance.org.uk/publications/insights/place-in-integrated-care-the-noble-aim-of-subsidiarity [Accessed October 2024]
TIRATELLI, L. & NAYLOR, C. 2024. Driving better health outcomes through integrated care systems: The role of district councils. . London: The Kings Fund.
TSIACHRISTAS, A., STEIN, K. V., EVERS, S. & RUTTEN-VAN MÖLKEN, M. 2016. Performing economic evaluation of integrated care: highway to hell or stairway to heaven? *International Journal of Integrated Care,* 16.
WADE, E., SMITH, J., PECK, E. & FREEMAN, T. 2006. Commissioning in the reformed NHS: policy into practice. . Health Services Management Centre/NHS Alliance.
WATTAL, V., CHECKLAND, K., SUTTON, M. & MORCIANO, M. 2024. What remains after the money ends? Evidence on whether admission reductions continued following the largest health and social care integration programme in England. *The European Journal of Health Economics***,** 1-20.

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# 9. Appendix

## Appendix A: Feedback from research team and PPIE members on the value of PPIE in Phase 1

[TABLE REDACTED IN V1.2]

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## Appendix B: Health and Care Act 2022 and Integrated Care System related policy documents and sources analysed

| Source name | Month, Year of publication or update | Available from |
|---|---|---|
| NHS Long Term Plan | 08/2019 | https://www.longtermplan.nhs.uk/ |
| Long Term Plan Implementation Framework | 06/2019 | https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf |
| Integration and Innovation: Working Together to Improve Health and Social Care for All (White Paper) | 02/2021 | https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version |
| Health and Care Act 2022 | 04/2022 | https://www.legislation.gov.uk/ukpga/2022/31/contents |
| Integrating care: Next steps to building strong and effective integrated care systems across England | 01/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf |
| Health and Care Act 2022: core measures impact assessment | 07/2022 | https://assets.publishing.service.gov.uk/media/6363dc43e90e0705b204cb5f/Health-and-Care-Act-2022--Core_Measures-Impact-Assessment.pdf |

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| Source name | Month, Year of publication or update | Available from |
|---|---|---|
| Health and Care Act 2022: Impact assessments summary document and analysis of additional measures | 11/2022 | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1115453/health-and-care-act-2022-summary-and-additional-measures-impact-assessment.pdf |
| NHS England Integrated Care webpage (including 'What is an ICS?' video) | n.d. | https://www.england.nhs.uk/integratedcare/ |
| The Hewitt Review: an independent review of integrated care systems | 04/2023 | https://assets.publishing.service.gov.uk/media/642b07d87de82b00123134fa/the-hewitt-review.pdf |
| Hewitt Review and Health and Social Care Select Committee report on integrated care system autonomy and accountability | 06/2023 | https://www.england.nhs.uk/long-read/hewitt-review-and-health-and-social-care-select-committee-report-on-integrated-care-system-autonomy-and-accountability/ |
| Guidance on the preparation of integrated care strategies | 02/2024 | https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies |

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| Source name | Month, Year of publication or update | Available from |
|---|---|---|
| Expected ways of working between integrated care partnerships and adult social care providers | 07/2022 | https://www.gov.uk/government/publications/adult-social-care-principles-for-integrated-care-partnerships/expected-ways-of-working-between-integrated-care-providers-and-adult-social-care-providers |
| Guidance to integrated care boards on applying to NHS England to amend their constitution | 07/2022 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B1650-guidance-to-integrated-care-boards-on-constitutional-change.pdf |
| Guidance on integrated care board constitutions and governance | 07/2024 | https://www.england.nhs.uk/long-read/guidance-on-integrated-care-board-constitutions-and-governance/ |
| Appendix A to integrated care board guidance: executive lead roles on integrated care boards | 07/2024 | https://www.england.nhs.uk/long-read/executive-lead-roles-on-integrated-care-boards/ |
| Annex to Guidance on integrated care board constitutions and governance: model constitution | 07/2022 | https://www.england.nhs.uk/wp-content/uploads/2021/06/PRN00831iii-annex-icb-model-constitution-template-july-2024.docx |

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| Source name | Month, Year of publication or update | Available from |
|---|---|---|
| Integrated care partnerships: engagement summary | 03/2022 | https://www.gov.uk/government/publications/integrated-care-partnerships-engagement-findings/integrated-care-partnership-icp-engagement-summary |
| Integrated care partnership engagement document: Integrated care system implementation | 09/2021 | https://www.gov.uk/government/publications/integrated-care-partnership-icp-engagement-document/integrated-care-partnership-icp-engagement-document-integrated-care-system-ics-implementation |
| Frequently asked questions (FAQs) on the integrated care partnership engagement document | 09/2021 | https://www.gov.uk/government/publications/integrated-care-partnership-icp-engagement-document/frequently-asked-questions-faqs-on-the-integrated-care-partnership-engagement-document |
| Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems | 09/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf |
| Integrated care system implementation guidance on working with people and communities | 09/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0661-ics-working-with-people-and-communities.pdf |

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| Source name | Month, Year of publication or update | Available from |
| --- | --- | --- |
| Integrated care system implementation guidance on effective clinical and care professional leadership | 09/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf |
| Integrated care system implementation guidance on partnerships with the voluntary, community and social enterprise sector | 09/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf |
| Human resources framework for developing integrated care boards | 03/2022 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B1427-Human-resources-framework-for-developing-integrated-care-boards-version-2-March-2022.pdf |
| Building strong integrated care systems everywhere: guidance on the integrated care system people function | 08/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf |
| Working together at scale: guidance on Provider Collaboratives | 08/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf |

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| Source name | Month, Year of publication or update | Available from |
| --- | --- | --- |
| Integrated care systems: design framework | 06/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf |
| Guidance on the employment commitment: supporting the development and transition towards statutory integrated care systems | 06/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/06/B0724-employment-commitment-guidance-supporting-ics-v1.pdf |
| Legislating for integrated care systems: Five recommendations to Government and Parliament | 10/2022 | https://www.england.nhs.uk/long-read/legislating-for-integrated-care-systems-five-recommendations-to-government-and-parliament/ |
| Integrating care: Next steps to building strong and effective integrated care systems across England | 01/2021 | https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf |

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## Appendix C: Potential metrics for ICSs

| Indicator | Source | Data Source |
|---|---|---|
| **Final goals** | | |
| Healthy life expectancy at birth | PHOF | ONS |
| Healthy life expectancy at 65 | PHOF | ONS |
| Life expectancy at birth | PHOF | ONS |
| Life expectancy at 65 | PHOF | ONS |
| Disability-free life expectancy at birth | PHOF | ONS |
| Disability-free life expectancy at 65 | PHOF | ONS |
| Life expectancy at 75 | NHS Outcomes Framework | NHSoF *(I)* |
| **Workforce and Resource** | | |
| Available virtual ward capacity per 100k head of population | NHS Outcomes Framework | NHS England*(I)* |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Leaver rate | NHS Outcomes Framework | NHS workforce statistics (NHS Digital) |
| Sickness absence rate | NHS Outcomes Framework | NHS Digital |
| FTE doctors in General Practice per 10,000 weighted patients | NHS Outcomes Framework | GP workforce (NHS Digital) |
| Direct patient care staff in GP practices and PCNs per 10,000 weighted patients | NHS Outcomes Framework | GP workforce (NHS Digital) |
| **Access** | | |
| Total patients waiting more than 52, 78 and 104 weeks to start consultant-led treatment | NHS Oversight Framework | RTT waiting times |
| Total elective activity undertaken compared with 2019/20 baseline | NHS Oversight Framework | RTT waiting times |
| Total diagnostic activity undertaken compared with 2019/20 baseline | NHS Oversight Framework | Monthly Diagnostic Waiting Times and Activity |
| Total patients waiting over 62 days to begin cancer treatment compared with baseline | NHS Oversight Framework | Cancer Waiting times |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Proportion of patients meeting the faster cancer diagnosis standard | NHS Oversight Framework | Cancer Waiting times |
| Total patients treated for cancer compared with the same point in 2019/20 | NHS Oversight Framework | Cancer Waiting times |
| Outpatient follow-up activity levels compared with 2019/20 baseline | NHS Oversight Framework | Hospital Episode Statistics |
| Proportion of ambulance arrivals delayed over 30 minutes | NHS Oversight Framework | Urgent and Emergency Care Daily Situation Reports |
| Ambulance average response times by category | NHS Oversight Framework | Ambulance Quality Indicators |
| Proportion of patients spending more than 12 hours in an emergency department | NHS Oversight Framework | A&E Attendances and Emergency Admissions |
| Proportion of Urgent Community Response referrals reached within two hours | NHS Oversight Framework | 2-hour Urgent Community Response (I) |
| Number of general practice appointments per 10,000 weighted patients | NHS Oversight Framework | Appointments in General Practice (Sub-ICB level) |

Working Paper

| Indicator | Source | Data Source |
| --- | --- | --- |
| Number of Completed Referrals to Community Pharmacist Consultation Service (CPCS) from a. general practice and b. NHS111 per 100,000 population | NHS Oversight Framework | NHS England (NA) |
| Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted | NHS Oversight Framework | NHS Digital and NHS Business Services Authority (BSA) |
| Number of children and young people accessing mental health services as a % of trajectory | NHS Oversight Framework | Mental Health Services Monthly Statistics |
| Number of people with severe mental illness receiving a full annual physical health check and follow-up interventions as a % of trajectory | NHS Oversight Framework | Mental health: physical health checks for people with severe mental illness |
| Number of people accessing IAPT services as a % of trajectory | NHS Oversight Framework | IAPT reports and NHS Talking Therapies Monthly Statistics |
| Number of adults and older adults with severe mental illness accessing community mental health services as a % of trajectory | NHS Oversight Framework | Mental Health Services Monthly Statistics |
| Access to GP services | NHS Outcomes Framework | GP Patient Survey |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Access to NHS dental services | NHS Outcomes Framework | NHS Digital and NHS Business Services Authority (BSA) |
| Waiting > 90 days for IAPT: % of referrals (in month) waiting > 90 days for first treatment | PHE, NHSE | IAPT reports and NHS Talking Therapies Monthly Statistics |
| No. able to get routine appointments evenings and weekends | DH | GP Patient Survey |
| % able to get same-day appts (who wanted one) | DHSC, NHSE | GP Patient Survey |
| Delayed transfers of care (delayed days) from hospital per 100,000 population | DD, ASCOF, PHE, BCF, QP, NHSE | Discharge delays (Acute) |
| IAPT waiting times against 6 and 18-week standards | MHEWG, NHSE | IAPT reports and NHS Talking Therapies Monthly Statistics |
| Access to GP < 48 hrs | DHSC | GP Patient survey |
| **Quality: effectiveness** | | |
| Successful completion of drug treatment - opiate users | PHOF | Office of Health Improvement and parities (OHID) |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Successful completion of drug treatment - non-opiate users | PHOF | Successful completion of alcohol treatment |
| Successful completion of alcohol treatment | PHOF | Successful completion of alcohol treatment |
| Estimated diabetes diagnosis rate | PHOF | NHSE |
| Mortality rate from causes considered preventable | PHOF | ONS |
| Under 75 mortality rate from cardiovascular diseases considered preventable | PHOF | *NA* |
| Under 75 mortality rate from cancer considered preventable | PHOF | *NA* |
| Under 75 mortality rate from liver disease considered preventable | PHOF | *NA* |
| Under 75 mortality rate from respiratory disease considered preventable | PHOF | *NA* |
| Emergency readmissions within 30 days of discharge from hospital | PHOF | NHS Digital |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Preventable sight loss - age related macular degeneration (AMD) | PHOF | Moorfields Eye Hospital |
| Preventable sight loss -– glaucoma | PHOF | Moorfields Eye Hospital |
| Preventable sight loss - diabetic eye disease | PHOF | Moorfields Eye Hospital |
| Preventable sight loss - sight loss certifications | PHOF | Moorfields Eye Hospital |
| Estimated dementia diagnosis rate (aged 65 and over) | PHOF | Primary care dementia data |
| Proportion of patients discharged from hospital to their usual place of residence | NHS Oversight Framework | Acute Discharge situation report |
| Inappropriate adult acute mental health placement out-of-area placement bed days | NHS Oversight Framework | Out of area placements in Mental Health Services |
| Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check | NHS Oversight Framework | Learning disabilities health check scheme |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Inpatients with a learning disability and/or autism per million head of population | NHS Oversight Framework | Learning Disability services monthly stats |
| Rate of personalised care interventions | HS Oversight Framework | *NA* |
| Summary Hospital-level Mortality Indicator | HS Oversight Framework | NHS Digital |
| Health-related quality of life for people with long-term conditions | NHS Outcomes Framework | NA |
| Proportion of people feeling supported to manage their condition | NHS Outcomes Framework | GP Patient Survey |
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions | NHS Outcomes Framework | Hospital Episodes Statistics |
| Health-related quality of life for carers | NHS Outcomes Framework | NA |
| Health-related quality of life for people with three or more long-term conditions | NHS Outcomes Framework | NA |
| Emergency readmissions within 30 days of discharge from hospital | NHS Outcomes Framework | NHS Digital |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services | NHS Outcomes Framework | Adult Social Care Outcomes Framework (ASCOF) |
| Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital | NHS Outcomes Framework | ASCOF |
| Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital | NHS Outcomes Framework | NA |
| Admission of full-term babies to neonatal care | NHS Outcomes Framework | National Neonatal Research Database |
| Cardiac rehabilitation completion | COIS, NHSE | National Auditof Cardiac Rehabilitation (NACR)* |
| Myocardial infarction, stroke and end stage kidney disease in people with diabetes | NICE | NA |
| Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation | COIS, NICE | NA |

Working Paper

| Indicator | Source | Data Source |
| --- | --- | --- |
| People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital | COIS | Sentinel Stroke National Audit Programme (SSNAP) |
| People who have had a stroke who receive a follow up assessment between 4 and 8 months after initial admission | COIS, NICE | SSNAP |
| Alcohol: re-admissions | COIS, NICE | HES |
| **Quality: safety** | | |
| Adjusted antibiotic prescribing in primary care by the NHS | PHOF | ePACT2 (I) |
| Neonatal deaths per 1,000 total live births | NHS Outcomes Framework | ONS (up to 2022) |
| Stillbirths per 1,000 total births | NHS Outcomes Framework | ONS |
| National Patient Safety Alerts not completed by deadline | NHS Outcomes Framework | Central Alerting System (I) |
| Potential under-reporting of patient safety incidents | NHS Outcomes Framework | NA |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Overall CQC rating | NHS Outcomes Framework | CQC |
| Acting to improve safety - safety culture theme in the NHS staff survey | NHS Outcomes Framework | NHS Staff survey |
| Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate | NHS Outcomes Framework | UKHSA |
| Clostridium difficile infection rate | NHS Outcomes Framework | UKHSA |
| E. coli bloodstream infection rate | NHS Outcomes Framework | UKHSA |
| Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care | NHS Outcomes Framework | Future NHS (AMR programme workspace) |
| Patient safety incidents reported - England level data | NHS Outcomes Framework | National Reporting and Learning System |
| Patient safety incidents reported - Provider level data | NHS Outcomes Framework | National Reporting and Learning System (I) |
| **Quality: experience** | | |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Percentage of patients describing their overall experience of making a GP appointment as good | NHS Oversight framework | GP Patient Survey |
| Patient experience of GP services | NHS Outcomes Framework | GP Patient Survey |
| Patient experience of GP out of hours services | NHS Outcomes Framework | NA |
| Patient experience of NHS dental services | NHS Outcomes Framework | NA |
| Patient experience of hospital care | NHS Outcomes Framework | Adult inpatient Survey (CQC) |
| Patient experience of outpatient services | NHS Outcomes Framework | NA |
| Responsiveness to inpatients' personal needs | NHS Outcomes Framework | NA |
| Patient experience of A&E services | NHS Outcomes Framework | Urgentand Emergency Care Survey (CQC) |
| Women's experience of maternity services | NHS Outcomes Framework | Maternity Survey (CQC) |
| Patient experience of community mental health services | NHS Outcomes Framework | Community Mental Health Survey (CQC) |
| Patient reported outcome measures (PROM) | Previous literature | NHS Digital |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| **Prevention** | | |
| Diabetic eye screening - uptake | PHOF | NHSE |
| Infectious Diseases in Pregnancy Screening - HIV Coverage/Syphilis/Hepatitis B | PHOF | Maternity service and screening laboratories |
| Chlamydia detection rate per 100,000 aged 15 to 24 | PHOF | UKHSA |
| New STI diagnoses (exc chlamydia aged <25) / 100,000 | PHOF | UKHSA |
| Population vaccination coverage - BCG - areas offering universal BCG only | PHOF | NA |
| Population vaccination coverage: Dtap IPV<br><br>Hib HepB (1 and 2 year old) | PHOF | NHSE |
| Population vaccination coverage - MenB (1 and 2 years) | PHOF | NHSE |
| Population vaccination coverage - Rotavirus<br><br>(Rota) (1 year) | PHOF | NHSE |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Population vaccination coverage -PCV | PHOF | NHSE |
| Population vaccination coverage - DTaP/IPV booster (5 years) | PHOF | NHSE |
| Population vaccination coverage: Flu (primary school aged children) | PHOF | NA |
| Population vaccination coverage - Flu (at risk individuals) | PHOF | NHSE |
| Population vaccination coverage - PPV | PHOF | UKHSA |
| Population vaccination coverage - Shingles vaccination coverage (71 years old) | PHOF | UKHSA |
| Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months | PHOF | UKHSA (I) |
| Number of people receiving mechanical thrombectomy as a % of all stroke patients | NHS Oversight Framework | SSNAP |
| Proportion of people with CVD treated for cardiac high-risk conditions | NHS Oversight Framework | Cardiovascular Disease Prevention Audit |

Working Paper

| Indicator | Source | Data Source |
|---|---|---|
| Proportion of diabetes patients that have received all eight diabetes care processes | NHS Oversight Framework | National Diabetes Audit (NA) |
| Number of people supported through the NHS diabetes prevention programme as a proportion of patients profiled | NHS Oversight Framework | National Diabetes Audit (NA) |
| Number of referrals to NHS digital weight management services per 100k head of population | NHS Oversight Framework | NHS Digital Weight Management Programme |
| Proportion of acute or maternity inpatient settings offering smoking cessation services | NHS Oversight Framework | NHS Digital |
| Proportion of patients who have a first consultation in a post-covid service within six weeks of referral | NHS Oversight Framework | NHSE*(I)* |
| Bowel screening coverage - % patients aged 60 - 74 screened in the last 30 months | NHS Oversight Framework | NHSE |
| Breast screening coverage - % females aged 53 - 70 screened in the last 36 months | NHS Oversight Framework | NHS Digital |

Working Paper

| Indicator | Source | Data Source |
| --- | --- | --- |
| Cervical screening coverage - % females aged 25 - 64 attending screening within the target period | NHS Oversight Framework | NHS Digital |
| Proportion of people over 65 receiving a seasonal flu vaccination | NHS Oversight Framework | UKHSA |
| Population vaccination coverage – MMR for two doses (5 year olds) | NHS Oversight Framework | UKHSA |
| Serious mental illness: smoking rates | COIS, NICE, QP | *NA* |
| Alcohol: admissions | COIS, NICE | Hospital Episodes Statistics |
| Smoking cessation advice for smokers with selected conditions: percentage, 15+ years, annual | NHSE | Quality and Outcomes Framework (QOF), NHSE |

Working Paper