NHS Confederation

A new operating model for health and care

May 2025

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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Key points

- To quickly address operational and financial challenges, adapt to major reorganisation and deliver the ambitious reforms anticipated in the ten-year health plan, the health and care system requires a simple and effective system operating model where every part of the system is clear on its purpose, what it is accountable for, and to whom.

- Based on engagement with senior leaders across the health and care system, this paper describes, for the first time, how bodies operating at the health and care system's five geographical scales – national, regional, systems, place and neighbourhood – could work together to achieve a more integrated and devolved healthcare model that delivers the government's three shifts. This must always start with communities, empowering them to be active agents in their own health and wellbeing and to be partners in the design of public services.

- Change should be guided by three key principles:

    1. **Devolution and subsidiarity** – A system as large, complex and diverse as the NHS cannot be commanded and controlled effectively from the centre. The operating model should devolve decision-making to local leaders to drive change, while holding them accountable for outcomes. To deliver neighbourhood health and shift towards prevention, the NHS must become a more effective partner within the system and with local communities. This requires alignment between two of the largest reforms and reorganisations ever seen in both the NHS and local government.

    2. **Change-led improvement** – The health and care system needs a change model which empowers the public with greater choice and local leaders with greater autonomy over how the changes are delivered. The system's drivers of change must be rebalanced, with greater focus on lateral peer learning to drive improvement and bottom-up accountability to patients and the public, alongside top-down policy incentives.

3. **Clarity and accountability** – The core objective of the health and care system is to shift to a more preventative, cost-effective and empowering model of care. To achieve this, the system must both reduce acute demand and redistribute resources out of hospital. There should be clear accountability in each area for who is responsible for delivering the shift, although the decision about which organisation leads change should vary according to local context and be agreed locally. Clear metrics, financial and regulatory mechanisms are needed, including a metric to shift a greater proportion of the NHS budget towards primary and community care by the end of this parliament.

- Commissioning and delivery models should emphasise a person-centered and outcome-focused approach. Local leaders should be empowered to elevate the things best delivered at scale and be held accountable for outcomes.

- The ten-year health plan must provide a consistent and aligned set of policies that incentivise and enable the three shifts, including: proportionate oversight, payment mechanisms which incentivise improved outcomes, multi-year funding and planning cycles, and improved pooled budget arrangements to deliver neighbourhood health.

- The NHS Confederation looks forward to supporting members and partners in the centre and wider health and care system, to embed a new system operating model. This will involve more detailed work on delivery models for the left shift and for neighbourhood health.

Introduction

The NHS is embarking on significant structural reorganisation. It is doing so while simultaneously grappling with significant operational and financial challenges and delivering the government's ten-year health plan reforms. The system's ability to deliver these changes depends heavily on having the right operational and governance structures.

There is currently no clear system operating model. Instead, historic structures are layered on top of one another like a coral reef. While the government has begun to develop a new operating model, more work is needed to simplify complex governance arrangements in the centre and within the system.

This paper describes how the system and the centre could work together to deliver a more integrated and devolved healthcare model that can achieve the government's three shifts. It maps how different functions within the health and care system could operate to deliver the model of change.

Based on engagement with senior leaders across the health and care system, the paper:

- summarises the current state of play and learnings from the past
- presents a more devolved model of change
- outlines the method for delivering this model, driven by the system's core objective
- describes how delivery of this objective is shared across three core functions
- outlines how delivery could be distributed nationally, regionally and locally
- describes how change can be delivered locally, through a flexible approach to who leads change, and driven by a clear set of principles and policies.

Defining geographical scales

National: This encompasses central government and its national bodies. In the context of this paper, this largely refers to the Department of Health and Social Care (DHSC). However, to address the wider determinants of health, a significant amount of joint working is needed across government departments, in particular with the Ministry of Housing, Communities and Local Government (MHCLG) and the Department for Work and Pensions (DWP). National bodies are established by government to oversee, regulate and support specific sectors or functions. The main national body referred to in this report is NHS England, which is being absorbed into DHSC – its sponsor department. NHS England is currently responsible for setting the overall strategy and outcomes that systems will be accountable for delivering.

Regional teams: Since the NHS was founded there has been a regional tier within the health and care system's governance structure. From regional hospital boards to regional health authorities, strategic health authorities, and now NHS England regional teams, each iteration has aimed to improve the management and delivery of health services at the regional level. With the announcement that NHSE will be absorbed into DHSC and likely changing integrated care board (ICB) footprints, the regional tier is again being reformed.

Integrated care system: An integrated care system (ICS) brings together the health and care organisations in a particular local area to deliver joined-up health and care services. Each ICS is made up of an integrated care board (ICB) and an integrated care partnership (ICP), along with NHS and social care providers and other partners, which will work in tandem to meet their four purposes. ICBs are the statutory NHS organisations with responsibility for planning health and care services for the area it covers. While there are currently 42 ICBs across England covering a population of around 1 to 3 million people, multiple mergers are anticipated following the 50 per cent cuts to ICB running and programme costs. In the future NHS operating model, an ICB will be expected to work with its local populations and local authority commissioners (increasingly mayoral footprints) to strategically commission joined-up health and care services and meet their

four purposes. ICPs are collectively responsible for setting the integrated care strategy and bringing together NHS, local authority, voluntary, community and social enterprise (VCSE) and wider sector partners.

Providers: Providers refer to a wide range of players, from those working at a larger population level (typically acute, mental health and specialist providers) to those working more locally (typically community, primary care and social care providers). They are responsible for delivering high-quality (safe, effective and positive patient experience) and efficient care. Increasingly, providers operating at place level work as the engine rooms for the integration of care services by bringing together all of the above at a local level.

Place: Defining 'place' is complex, as it varies in meaning across the health and social care sector. In this paper we largely refer to place in relation to its 'health' functions delivered through place-based partnerships, as defined in the Thriving Places[1] guidance. Places should align with local service boundaries to streamline operations for providers and partners. Most places correspond to local authority footprints, often serving 250,000-500,000, though some can cover up to 1.2 million people. These partnerships are collectively viewed by health and care leaders as the engine rooms for integration, where a lot of the delivery for integrating care services happens. The future of place-based-partnerships may be impacted in some systems by cuts to ICBs budgets and at the time of writing it is unclear whether 'place' will exist as a geographical scale distinct from neighbourhoods.

Neighbourhood working: A more proactive, personalised and holistic model of care will be delivered at neighbourhood level. While we recognise the government language of a 'neighbourhood health service', this paper uses 'integrated neighbourhood working' as language that more closely reflects what is happening and different sector roles in the future of healthier neighbourhoods. Neighbourhoods vary in size, from a few houses to areas with 50,000+ people. People define their neighbourhoods based on local geography and history, while public services may use larger boundaries, based on statutory or service boundaries including primary care networks (PCNs) or district councils. While scale is helpful for enhancing resilience and sustainability for neighbourhood working, conscious effort must be made to work in and empower neighbourhoods that make sense to citizens.

A complex operating context

The government is running an intensive process to develop a ten-year health plan.[2] This will deliver the government's reform agenda: to shift from "hospital to community", from "analogue to digital" and from "treatment to prevention".[3] However, the government announced a significant NHS reorganisation programme, while nearing the end of this process.[4]

The aim of the reorganisation is twofold: decentralise power within the NHS and reduce bureaucracy and duplication. The government will abolish NHS England, integrating its functions into the Department of Health and Social Care (DHSC) and cutting its combined workforce by 50 per cent. This is happening at the same time as 50 per cent cuts to integrated care boards' (ICBs') running and programme costs and NHS providers' corporate cost growth.

NHS England has confirmed that the ten-year health plan will detail these changes as part of a new operating model that is "rules-based, provides earned autonomy and incentivises good financial and operational performance".[5] The changes will then be formalised through primary legislation.[6]

We expect the ten-year health plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems and the centre of the NHS. At the time of writing, though, it is unclear how functions will change, especially those held by neighbourhood teams, place-based partnerships, primary care at scale, trusts and integrated care partnerships (ICPs). Work is underway, led by NHS England regional directors and Richard Barker in his new national role,[7] to define a 'model region', which will also shape the future role of DHSC nationally.

With a view to laying the foundations for delivery of the ten-year health plan, NHS England's new chair, Dr Penny Dash, undertook some rapid work with a group of ICB chairs and chief executives to define the future focus, role and functions of ICBs. The first iteration of the Model ICB Blueprint is an important

first step towards greater clarity.[8] It reiterates the system leadership role ICBs have as strategic commissioners, working to improve population health, reduce inequalities and improve access to more consistently high-quality care. It also introduces new 'neighbourhood health providers', which will sit between ICBs and neighbourhoods in driving delivery of a neighbourhood health service.

ICBs should be pioneers of reform through strategic commissioning

Strategic commissioning must serve as a turning point in the relationship between commissioners and providers – a relationship that has historically been difficult to get right. Traditionally, the relationship has been transactional, with individual providers contracted for specific episodes of care, and assurance based on activity rather than patient experience or outcomes.

If ICBs are to be the 'pioneers of reform', strategic commissioning must embody a new approach within the future operating model. Rather than organisation-based deals, the unique convening role of ICBs must be leveraged to harness the collective power and expertise across the system to contract for specific health outcomes across entire pathways.

Crucial to this transformation is the capability of ICBs to understand their population's health needs, co-produce a system strategy, and manage contracts with providers to deliver the outcomes they have been commissioned to achieve and maximise the value of available resources. The latter must be done while empowering providers, including neighbourhood care leaders, to make the tactical decisions about how to achieve those outcomes.

The future of place-based-partnerships has been thrown into question by cuts to ICBs' budgets and, at the time of writing, it is unclear whether it will exist as a distinct geographical layer or become synonymous with neighbourhoods. Given that systems are likely to take different approaches to integrated working at place and neighbourhood level, a flexible approach should be taken to support the models that works best locally.

In the framework that emerges, system partnerships and collaboration must be front and centre, especially between the NHS and local government (including mayoral strategic authorities). If it is to successfully deliver the government's three shifts and a neighbourhood health service, the NHS needs to become a better partner and move beyond a purely medical model.

The operating context has become incredibly complex. Healthcare leaders urgently need more clarity about how they are being expected to – and will be empowered to – deliver recovery and reform. The consequences of this lack of clarity have been highlighted in several government reviews, including by Dame Patricia Hewitt and Lord Darzi.[9,10] These reviews also highlighted the burden of a top-down 'command and control' system in which the centre (including regulators) micromanage delivery, distracting healthcare leaders from delivering recovery and transformation.

The Secretary of State for Health and Social Care has described his ambition "to lead an NHS where power is moved from the centre to the local and from the local to the citizen. Morrison meets Bevan."[11] This means making the healthcare service more accountable outwards to the communities it serves, not just upwards to Whitehall. Better integration with local government services is crucial to driving this change (as well as with community safety partners and the voluntary, community and social enterprise – VCSE – sector). Historically, local government has been overlooked in the NHS operating model – partly as it has sat outside of NHS England's remit. However, the reabsorption of NHS England in DHSC's wider remit offers an opportunity to remedy this. And with local government embarking on its own significant reorganisation and devolution programme, alignment is more important than ever.[12]

Learning from the past

Recent history suggests that it can be difficult to translate a new operating model into practice – particularly in the context of extreme operational and financial pressures and the time-consuming and disruptive structural reorganisation that often follows.

For example, NHS England's operating framework – published in October 2022 – sought to translate changes introduced in the Health and Care Act 2022 into practice, by empowering and supporting local systems to deliver on their responsibilities.[13] The framework acknowledged that:

> "This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context."

The centre and healthcare leaders broadly accept that this operating framework has not been embedded. The reasons for this are threefold. Firstly, between July 2022 and May 2024, NHS England underwent an extensive reorganisation,[14] including cutting 36 per cent of staff, devolving functions and merging five arm's-length bodies.[i] Secondly, there was a large-scale reorganisation of, and cuts to, local commissioning over the same time period, which hugely impacted the pace of frontline change, integration and efficacy of partnerships. Thirdly, providers and systems faced significant operational and financial challenges. These included increased demand in primary, mental health and urgent and emergency care and a large elective backlog, which were exacerbated by inflation, industrial action and a 30 per cent reduction in ICBs' running costs in 2023/24.[15] These combined factors led to retrenchment into the status quo command and control structure.[16]

With the merger of NHS England and DHSC and cuts to ICBs, questions arise about the future of numerous functions currently held by NHSE and ICBs. Many of these functions require highly specialist technical expertise (such as training, implementation and safety, and security management for digital and data functions, including artificial intelligence) and which have significant implications for quality and safety (for example, formal regulation and oversight of trusts and ICBs). It therefore seems likely that the reshaping of NHS national bodies has only just started.

[i]Including NHS England, NHS Improvement, NHS Digital, NHS X and Health Education England.

To succeed where previous attempts have failed, the new operating model must do two things:

- Provide a high-level articulation of the overall function of bodies operating at each of the health and social care system's geographical footprints– not just NHS bodies.

- Leave sufficient scope for local determination about exactly how services are delivered and by whom.

A model of change

The government's 2025 mandate to NHS England made clear that a new operating model is needed to support its reforms and to improve performance.[17] The mandate describes a future end state for the health and care system in which:

> "The top-down centralised model of control will, over time, need to give way to a more devolved system where ICBs and trusts have greater freedom and flexibility and where patients have more choice and control."

The government's change model for the health and care system must therefore aim for an end state in which functions are devolved locally, supported by greater autonomy of local systems, organisations and patients – akin to the Hewitt review's description of "self-improving systems".[18] Implicit in this description is an increasingly hands-off, ultimately smaller role for the centre.

This approach can be described as rebalancing the drivers of change in the system. The Human Learning Systems model of public service reform acknowledges that achieving positive outcomes, personalisation of services and best use of resources requires a shift from a focus on control to a focus on fostering collaboration, learning and adaptation as the core drivers of change.[19] This ultimately allows public services to respond to the complex realities of people's lives in a more flexible and 'human' way – offering both a better service to users and better value for taxpayers' money.

In the context of the health and care system, top-down policy needs to be coordinated to effect change in complex systems. Those systems need to sustain learning and mutual support through lateral working with peers. And services need to be co-created with, and accountable bottom-up to local citizens who use them to become human-centred.

Model 1: Rebalancing drivers of change in the health and care system

1. Top-down policy incentives	Alignment of national policy and incentives including oversight, regulation, financial incentives and targets.
2. Lateral improvement	A self-directed improvement model and learning system.
3. Bottom-up accountability	Strengthened local accountability and scrutiny and meaningful public involvement in system, place, provider and neighbourhood working.

The role of the centre changes in the context of a health and care system which is driven more by bottom-up and lateral drivers of change. DHSC, NHS England and other national and regional bodies will need to increasingly shift from central priority-setting and delivery towards supporting and enabling local organisations and systems to deliver change and to create the conditions that enable them to do so. For example, most activity relevant to 'transformation' should be delegated to ICBs and providers. It will also need to focus on functions benefiting from aggregation, such as digital infrastructure and models of procurement.

Some changes will be needed to ensure the health and care system is set up to deliver this new model. But first, it is important to consider what objectives the health and care system has been set up to achieve.

Objectives of the health and care system

ICSs' four purposes

Aneurin Bevan founded the NHS in 1948 based on the principles of providing comprehensive, universal, high-quality, patient-centred, collaborative, efficient and accountable healthcare, free at the point of use. Notably, this extended to improving physical and mental health as well as preventing ill health.[20] The NHS's raison d'etre remains broadly the same today.[21] Arguably the main change the new NHS Constitution must reflect is the move towards a social model of care delivered at a neighbourhood level.

But over subsequent decades the NHS has undergone various reforms and evolutions – with its most recent now underway. There is now a much greater acknowledgement of the inequalities that exist in society, and it has become eminently clear that the NHS is just one player in a complex ecosystem of public services that influence citizens' health and prosperity.

The Health and Care Act 2022 introduced integrated care systems (ICSs) – through both integrated care boards (ICBs) and integrated care partnerships (ICPs) – which bring together health, care and other key organisations in a local area to plan and deliver joined-up health and care services.[22] The 2022 Act formalised the 'triple aim' as a guiding principle for ICS partners and a statutory duty on NHS bodies within ICSs, encouraging them to work collaboratively to deliver more joined-up and effective care, while also ensuring that resources are used efficiently.[23]

In subsequent guidance, NHS England offered a more contemporary description of the objectives of the health and care system by asking ICSs to fulfil four core purposes:[24]

1. Improve healthcare and population health outcomes
2. Reduce inequalities in outcomes, experience, and access
3. Increase productivity and value for money
4. Support social and economic development

This fourth purpose seeks to maximise the NHS's already significant contribution to economic growth while recognising the importance of socio-economic factors in the wider determinants of health, thus helping deliver the government's Health and Growth Missions.[25]

As constituent parts of ICSs, statutory NHS and VCSE providers and local government responsible for delivery. How each purpose is delivered should largely be left to local discretion. This is important, as local areas vary in terms of their power structures, quality of relationships and operational capabilities.

Shifting to a more preventative and empowering model of care

In the context of the government's current priorities, there is one core, cross-cutting objective from which to hang a new system operating model.

The government has set out three clear priorities or 'shifts'. But in the context of the operating model these can be boiled down to one: the left shift. The analogue to digital shift is a fundamental enabling function and therefore a vehicle for the wider reforms. Meanwhile, simply treating unwell patients in a community setting rather than a hospital building is unlikely to dramatically improve efficiency or outcomes – those services must be preventative in nature.

The core challenge is therefore **shifting to a more preventative and empowering model of care, particularly in relation to higher intensity users, which is delivered closer to people's homes**. This is sometimes referred to as the 'left shift'. Keeping people well will require different skills to those held exclusively within the NHS.

To deliver this objective, the system must:

1. **Move the money**: A smaller proportion of NHS spending must go into acute hospital-based activity. This cannot be achieved by demand-side measures alone because there is little or no evidence that these can enable a reduction in acute capacity – much less generating cashable savings. Change therefore must start from an explicit commitment to reducing acute capacity – something which must come nationally and also within systems.

2. **Boost out-of-hospital capacity**: Simultaneously, capacity needs to be built in out of hospital services – primary, community and mental health settings – so they are able to reduce demand and offer better alternative provision. This also means reengineering a hospital-focused workforce to support care in the community.

As strategic commissioners, responsibility for 1 and 2 will primarily sit with ICBs. They can achieve this by managing contracts with providers in a way that maximises the value of the available resources and improves population health. Payment reform is needed to enable ICBs invest in earlier, more cost-effective interventions.

The operating model is key to enabling the gain/loss share to align financial incentives. By focusing the entire health and care system on this single challenge, the new operating model can reduce complexity and cost. If the above actions are committed to, the decision about which organisation leads the shift should be left to local discretion, according to organisational maturity. A range of delivery models is therefore needed. This is explored further (from page 23).

Functions to deliver these objectives

These objectives are delivered through three core functions, which are iterative and interactive in nature:

Strategy	Delivery	Oversight and improvement
Setting overall strategy and direction	Delivering against agreed pathways and outcomes	Overseeing the system based on quality, finance and operational performance
Defining outcomes and some common specifications	Redesigning, innovating and transforming pathways to deliver improved outcomes and reduced cost, in a way that is data-driven and responds to local population needs	Driving improvement within organisations and systems
Allocating resources to achieve the four purposes	Aligning enablers (data, analytics, digital infrastructure and tools, workforce deployment, financial flows/incentives for improvement) to support delivery	
Managing the market and contracting for services by setting out a range of payment mechanisms and incentives available to strategic commissioners	Delivering against agreed pathways and specifications	

Strategy

National and regional teams play a role here by setting the overall strategy, direction and outcomes that the system must deliver. ICBs, as strategic commissioners, also play a role in strategy by allocating resources and contracting for services, using a range of payment mechanisms and incentives to deliver their four purposes.

Delivery

Providers are primarily responsible for delivery of care at place and neighbourhood level and will work closely with ICBs as strategic commissioners to transform care pathways.

Oversight and improvement

National and regional teams are primarily responsible for overseeing the system based on quality, finance and operational performance and will support organisations and systems to drive improvement. Organisations will, however, have responsibility for first-line oversight through their boards. As strategic commissioners, ICBs will have some contractual oversight. All organisations will play a role in driving improvement.

Roles and responsibilities
System governance and core functions

This section presents a high-level articulation of the roles and responsibilities of bodies operating at the health and care system's five main geographical scales: national, regional, systems, place and neighbourhood. More detail is provided in the annex.

Communities

System governance should start with communities, which have agency to make decisions about their own care and are active partners in the design of public services

Delivery

Neighbourhood

- Delivery of a more proactive, personalised and holistic model of care.
- Engagement and empowerment of individuals and communities, driven by a biopsychosocial approach.
- Empowering the frontline with autonomy and risk in the right places, with infrastructure to allow them to deliver effectively

Typically serving around **30,000 to 50,000 people**

Place

- The engine rooms of integrated care – integrating provision of different public services around people ('total place').
- Acting as the support and strategy lead for neighbourhoods, providing the supporting infrastructure for budget and workforce pooling, and in some cases holding the governance function.
- Translating the strategic goals of ICSs into local delivery for the benefit of local populations.
- Convening local partners to collectively respond to the challenge of improving population health and quality of life with a 'community first' approach.

Typically serving around **250,000-500,000 people**

Strategy and oversight/improvement

System

- Develop a system-wide strategy to deliver the four purposes.
- Deliver structural transformation of health services by integrating services and delivering the three shifts.

Typically serving around **1 million to 3 million people**

Systems include:

- integrated care boards
- integrated care partnerships
- local authorities, including mayoral strategic authorities
- statutory and non-statutory providers
- places
- neighbourhoods.

Regional

- Working closely with organisations to co-develop national policy and strategy to bridge the gap between national policy and local implementation.
- Oversight of the quality, financial, and operational performance of providers and ICBs within their region and supporting them to develop capabilities.

National

- National leadership of the NHS through setting strategy and the outcomes systems will be accountable for delivering.
- Develop policy and commission services that are best done once nationally.
- Create an enabling environment for change and improvement.

Delivering the system's core objective: the left shift

Moving the money to earlier, more cost-effective interventions should improve allocative efficiency, boosting productivity to help address the NHS financial challenges (alongside ongoing efforts to improve technical efficiency). This will require "hardwiring of financial flows" through three levers:

1. **Payment mechanisms:** A payment mechanism – adopted in the NHS Payment Scheme from April 2026 – which incentivises earlier, proactive intervention. This is likely either an outcome-based contract or capitated contract, where providers keep any savings from allocative efficiency.

2. **Gain/loss share mechanism:** All providers along a care pathway must have an aligned financial incentive to deliver care earlier and avoid downstream admissions, ensuring acute providers are not financially penalised for doing so. This will likely be through a lead/integrated care provider or partnership, which sub-contracts services.

3. **Measurement:** If the objective is to move money into primary and community-based care, we must know whether it is being achieved. This will require a metric which is monitored locally and nationally and enables intervention when necessary.

Rather than promoting one delivery model, the centre should create strong incentives for systems and providers to develop a credible collaboration and accountability model that suits their local legacy and assets. The centre should require business plans and medium-term financial plans backed up by clinical plans defining care transformation (in particular around elective care). Monitoring progress in delivering the left shift will allow the efficacy of different models to be assessed and, if necessary, adapted.

Different delivery models

Integration and transformation are being delivered differently across systems. As each ICS is different, enforcement of a uniform approach to delivering the left shift would not work and risks creating unnecessary expense, significant disruption and delaying delivery. To deliver reform, practical, responsive and inclusive governance arrangements are needed to solidify partnership working as the expected standard at the heart of commissioning and delivering quality care.

Clinical leadership will be key to delivering transformation, as will building consensus between clinical and managerial staff. Appropriate local arrangements should evolve from a robust understanding of system context and commitment to shared principles, generating a partnership structure that is greater than the sum of its parts and maximises the strengths of each unique organisation or contributor. There is a precedent for different approaches to this, as outlined below.

The focus of any delivery model should be on delivering a person-centered and outcome-focused approach. Local leaders should be empowered to elevate where things are best delivered at scale and held accountable for the outcomes they achieve – not for developing a particular structure.

Within every model, partnership at place level – at a population size of around 250,000-500,000 – will be critical to moving towards more integrated, person-centred care and optimising the use of collective resources. Since the integration white paper and Thriving Places guidance, place partnerships have been the expected delivery model in England.[26,27] Systems such as Cambridgeshire and Peterborough have a vertical model in which the ICB contracts with each place, potentially delegating commissioning responsibilities and/or financial allocations and a provider or provider collaborative is usually the designated 'lead' for integrating care. Leeds is another example of a place-based approach, where budgets are pooled across NHS bodies and local authorities. At this more local geography, commissioning can be integrated with co-terminous local authorities and proactive care can be planned around populations.

In other systems, particularly smaller systems such as Gloucestershire, where there are just two providers, there is a distributed model of leadership. This model may become less common with ICSs becoming larger and fewer in number.[28]

In other systems, the budget is delegated to a lead provider which then sub-commissions services to be delivered at place or neighbourhood level. For example, in Birmingham and Northumbria, a provider is designated to lead the commissioning of services, with delivery devolved to local neighbourhoods. In other systems, like Hertfordshire and West Essex ICS, the primary care at-scale provider is the lead provider of an integrated urgent treatment centre, which they deliver as part of a collaborative with other community, acute and out-of-hospital providers.

These provider collaborative or lead provider models may form the basis of an accountable care organisation (ACO) type approach – a provider with delegated responsibility for improving the health of a particular population cohort and planning the most cost-effective care interventions to that end. Through sub-contracting services, this approach ensures multiple providers across a care pathway have aligned incentives, sharing financial benefit from better managing demand and preventing more costly downstream interventions.

ACOs have precedence in other countries, including Spain, Germany and the USA, and despite proposing the idea in 2014, the Health and Care Act 2022 effectively moved England towards accountable care systems in the form of ICBs.[29]

However, the current approach does not align incentives across providers. The latest NHS operational planning guidance signaled a move towards lead providers being given responsibility for planning and transformation of local services for a defined population cohort, stepping in the ACO direction.[30] This would require devolving knowledge and skills to provider organisations. NHS England indicated that this may extend to delivering strategic commissioning directly (through delegation arrangements and provider collaboratives), but that an accountable care model would only be explored in the most mature systems.[31] It is therefore a delivery model that is unlikely to take precedence for at least a decade.

The below model illustrates three emerging 'delivery models' for achieving the left shift through place-based collaboration. These are archetypes which are presented to offer clarity. They and not mutually exclusive (for example, place could effectively be a lead provider) and are not intended as a definitive description of the future direction of travel.

Delivery models

To achieve the left shift from hospital to home

Place partnerships

An existing model

- **The commissioning function is held by ICBs**.
- **There is significant delegation to place**, including budgets, convening local partners and responsibility for strategic commissioning for locally determined provision – starting with enhanced and transformational resource, not core service funding.
- **Governance structure based on collective accountability and delegation of certain decisions** from individual organisations to partnership in line with the scope of the 'joint venture'.
- **The integrator function could be held by the ICB or shared with providers at place level/at scale**.
- **One option would be an alliance approach**, whereby health and social care teams are brought together with an agreed management structure and the ability to hold contracts.
- **This approach will require close working with local government and joint commissioning** through Section 75 agreements.
- **Increased integration** of NHS provider and local council teams.

Lead care provider/partnership

An emerging model

- **The commissioning function is held by ICBs**.
- **The integrator function sits within the lead care provider/partnership** (this could be providers or provider collaboratives of any kind).
- **The provider/partnership holds a risk-based capitated budget focused on improving outcomes for a defined population cohort**. The provider/partnership sub-contracts to other providers (including VCSE) at place and neighbourhood.
- **Combined delivery of acute, community-based, mental health and GP services** – with a focus on the latter three service types.
- **The provider/partnership takes on the GMS contracts** (where there is GP support for this) **or sub-contracts providers to deliver care**. Most GPs are salaried employees of the provider/partnership.
- **Close working with local government as integrated teams that work on the wider determinants of health**, enabled by Section 75 agreements.

Case study: Birmingham and Solihull Integrated Care System's Community Care Collaborative (example of a community trust lead provider model)

The Community Care Collaborative is a partnership between primary (predominantly general practice), acute, community, mental health, social care and ambulance services, as well as the voluntary sector. It aims to provide better joined-up health and care services in local neighbourhoods across Birmingham and Solihull, making it easier for people to access the care they need closer to home and reduce pressure on local acute hospitals.

Its East Birmingham Locality Hub was the first launched in December 2023 and has been the trailblazer of this new and innovative approach to creating a neighbourhood health service at a locality level. Their approach integrates social prescribing, community care and key interventions, such as healthy lifestyle support, befriending and family and carer support, all coordinated by the multidisciplinary team. The hub, which also benefits from a co-located urgent treatment centre and community diagnostic centre, is particularly focused on improving care for people with high intensity use of emergency departments (locally known as frequent service users), by offering personalised support at the neighbourhood level.

In their first year the Community Care Collaborative have achieved:

- GP attendances – down 31 per cent
- A&E attendances – down 20 per cent
- Inpatient spells – down 21 per cent
- Outpatient spells – down 25 per cent
- Community contacts – down 15 per cent
- Social care packages – down 77 per cent

Case study: ChenMed model of risk-capitation funding in the USA (example of a primary care lead provider model)

ChenMed operates under the MediCare Advantage model in the US and aims to create financial incentives to keep people well and out of hospital.

MediCare (the commissioner) gives ChenMed, a primary care and wellbeing provider (the lead provider), the budget to cover the cost of healthcare for a particular population cohort (people over 65 with complex health needs and/or high levels of deprivation). ChenMed have an incentive to keep people healthy (and make a profit on savings) through their services, but will sub-commission acute and other services when required.

Despite similar complex health needs among their patients, ChenMed averages 1,324 inpatient hospital days per 1,000 patients over 65 compared to an average of 2,220 across Miami and 2,236 in England. Read more about this model in Unlocking reform and financial sustainability.

Primary care at scale

For primary care to operate as a lead provider, it is imperative that primary care is supported to operate in an integrated way, carry risk and work at scale. Primary care leaders must be empowered to drive change as opposed to being 'done to'. The government should therefore strongly incentivise the development of primary care provider collaboratives to bring together primary care providers at place/system level to have a collective voice and with the ability to become legal entities that can hold contracts and act as a strategic provider partner to the ICB and the rest of the system.

Primary care provider collaboratives are now developing across the country – many supported by the ICB to establish as a collaborative and become a legal entity that can hold contracts or be hosted by an existing legal entity. In areas where there are strong and mature federations, such as Herefordshire, the collaborative has been built around the federation infrastructure.

In other places such as Sutton, it is through an alliance of PCNs and others, such as in Birmingham and Solihull, the collaborative (which brings together primary, community, mental health and social care) is hosted by the community trust. Collaboratives should embrace wider primary care – pharmacy particularly – given the opportunities to use their capacity and infrastructure, as well as optometry, dentistry and audiology.

To support integrated working, the workforce should be developed around multi-disciplinary teams that include GPs, nurses, social workers and mental health professionals. All health and care professionals working in these neighbourhood hubs should also have access to digitally enabled and integrated shared care records which would help improve the continuity of care and ensure services are patient-centred and responsive.

Principles to guide change

1. Devolution and the principle of subsidiarity

The health and care system's road to recovery and reform is complex, with no quick or easy fix. The resolution must be a joint endeavour involving all ICS partners, supported by the government and NHS England. By embedding a non-hierarchical collaborative governance structure, local systems would have the autonomy they need to lead, while ensuring they align with national health priorities.

As part of this, the principle of subsidiarity should apply, with greater resource and decision-making devolved locally and a centre less focused on performance managing process, and more focused on health outcomes and the things that are best done once for the whole NHS. Local organisations and systems should be given the tools and levers to improve quality, productivity and access and drive change based on what works best locally.

Progress towards a more devolved model must be accelerated, including bolstering the role of ICBs as strategic commissioners. The resources saved by

reductions to ICBs' corporate costs should be used to support the development of mature collaborative structures on the provider side. NHS England's work on the model region should take into account the devolved model articulated in the government's mandate and avoid the tendency to 'scale'.

2. A system approach to change

The centre should provide space for genuine co-design of the most appropriate delivery mechanisms for local populations, with staff and local communities, by not over-prescribing models of care or service delivery models but providing a consistent and stable direction of travel under which places can work together.

National and regional teams should organise packages of support around shared goals and co-developed strategies, reducing adversarial dynamics.

With a rapidly evolving healthcare landscape, financial challenges across health and social care and the wider public sector, and a widening disparity in health outcomes, the imperative to bolster and support leadership that helps drive through systemic change and continuous improvement has never been more pressing. Improvement is more than an add on or nice to have: it is the enabler of the wide-scale change and transformation the health and care system needs.

To create sustainable change, the sector needs to move into a model that emphasises horizontal, peer-to-peer learning, providing support and empowerment to local leaders so they can deliver it. Leaders should be supported and empowered through the sharing of learning and good practice around how to develop and agree local outcome metrics and how effective cross-organisational teams are built, based on areas which have successfully implemented new models. Organisations such as the NHS Confederation can support the development of a culture of continuous learning, sharing and scaling.

As part of this, the development of leadership and management capacity at all levels must be supported, including by investing in leadership training programmes for ICB, trust and primary care leaders, fostering capabilities for self-assessment.

3. Clarity and accountability

ICSs need clarity about the outcomes they are expected to deliver. They also need appropriate governance and accountability arrangements to enable them to embed a delivery model of their choosing.

Effective transformation at neighbourhood, place and system level will require support to build capability and capacity. At the same time, stronger accountable central systems and direction are needed in key policy areas such as data, digital and innovation. There are certain things which benefit from national or regional standardisation such as procurement frameworks, data integration, clear information standards and medicines formularies.

There is a clear role for centralised procurement of essential digital platforms and tools to minimise cost and maximise benefits to the system and also in areas such as governance and regulation of fast-changing digital services (particularly in relation to AI tools) and data adherence and security.

Other major areas, from resource allocation to oversight, will require the centre to provide clarity and alignment on national policies. There should, for example, be a shift from process compliance to a small number of high-impact and measurable health indicators that are linked to population health. There are questions about the suitability of DHSC as the host for some of these functions previously held by NHS England or whether they will be hosted in existing or additional arm's-length bodies.

Policies to enable change

The ten-year health plan must deliver the following policy changes as part of the new system operating model:

1. Payment mechanisms which incentivise improved outcomes

To achieve long-term sustainability, the allocation of resources should be aligned with population health outcomes, such as reduced hospital admissions,

improved access to primary care and enhanced patient satisfaction. This would help ensure resources are directed towards the highest value interventions, rather than being spread across low-impact services. Outcomes-based payment mechanisms should incentivise improvements in care quality, safety and experience; improvements in population health and health outcomes; and reductions in inequalities in health outcomes. This approach would incentivise preventive care and encourage more efficient use of resources.

2. Multi-year funding and planning cycles

HM Treasury confirmed that multi-year budgets would be allowed for the NHS. DHSC/NHS England should translate this into the system by providing the NHS with multi-year funding and planning cycles that are focused on delivering outcomes and aligned with local government. A longer-term approach is crucial to providing greater consistency and certainty, allowing local leaders to focus more on what matters to residents.

3. An enabling centre

Strategy is the alignment of policy and incentives to achieve change, but too often the NHS interprets 'strategy' as an extensive to-do list without a coordinated approach to deliver it. There is a need to move towards a smaller set of national priorities that everyone is held to account for (via the NHS Constitution), with more local flexibility depending on the health and care needs of different local communities. The centre can help drive the strategic direction by offering clear outcome metrics and bolster systems to deliver by offering a 'menu' of options for them to choose from.

Moreover, national policy and incentives, including supportive oversight, regulation, financial incentives and targets, need to be better aligned to deliver the three shifts. The centre should focus on defining things which support delivery of national priorities, including the three shifts.

Developing a metric for the left shift

To start shifting the proportion of the NHS budget towards primary and community care by the end of this parliament, there is a need to develop a metric that incentivises organisations and systems to reduce hospital-based activity and increase provision of preventative community and primary care. This should be regularly reported to the Secretary of State to support monitoring of progress.

There are at least three different metrics that could be used, including:

1. **Prevention metric** (as per the Hewitt review) – a new accounting definition of primary and secondary preventative services (across health and local government services). The last government accepted this recommendation, although rejected the proposal to shift 1 per cent of all health spending towards prevention over five years. DHSC civil servants say they are still awaiting ministerial sign off to begin work on this definition.

2. **Primary/community-based care investment standard**. A target to shift spending from acute to primary/community-based care providers, from a current baseline. This would differ from the Mental Health Investment Standard, (which requires a yearly increase linked to the system's overall budget growth), and would require systems to increase spending on primary/community-based care through, for example, transferring services into the provision of primary/community-based care providers, or by uplifting the contracts from primary/community-based care at a faster rate than secondary care contracts. While this is easier to measure, it is harder to account for spending on integrated care providers. While it may instigate change in the short term, considerations will need to be given regarding risks to reinforce the barriers between providers, rather than encouraging them to work together and pool resources.

3. **Patient bed days**. The most common metric used by local systems to measure a reduction of time spent in hospital. Investment in preventative and out-of-hospital services, such as the establishment of more rehabilitation centres, should reduce acute patient bed days.

4. Procure digital services at scale

Implementing large-scale digital health services has consistently been a challenge for the NHS. Procuring digital services and delivering at scale requires continuously evolving and robust infrastructure which handles frequent, seamless updates. Health services can be both personalised and democratised with modern digital and data infrastructure with central, responsive and adaptive central authority, acting as a service provider and commissioner. Clarity on the governance regime for centralised procurement of digital services is urgently needed, and consideration must be given to capabilities for delivering specialist digital and data functions.

In the longer term, every citizen can expect to have full access to their health data via the NHS App, linked to a digital health or single patient record. They will be empowered to access, monitor, communicate and manage their own health records, seek accessible advice, tools and clinical information, manage medication and have overall control over how they interact with the NHS and its services, including participation in research. This will be crucial for the successful integration and operation of digital health services across the country. Several obstacles must be addressed, including data security and privacy, ease of use, scalability, interoperability, equity and access, and trust and acceptance.

5. Improve data sharing to support population health management

Several changes are needed to support the integration of data to support population health management and the development of a single patient record to enable self-management.

The government should require suppliers to separate patient data in electronic patient records (EPRs) from clinical use data. This will ensure suppliers adhere to a standardised data framework established by the government, which includes implementable interoperability criteria. Consequently, standardised patient data can be shared seamlessly using Fast Healthcare Interoperability Resources (FHIR) between NHS organisations, eliminating barriers to data interoperability.

To support improved data sharing and population health management and encourage a robust data-sharing environment, the Data (Use and Access) Bill must strengthen interoperability criteria between systems and organisations to enable seamless data exchange. Mandating standardised data frameworks will ensure consistent and reliable data sharing across various platforms and between vendors and providers. In addition, the centre must deliver robust data security and privacy measures.

6. Proportionate oversight and self-directed improvement

There needs to be an effective success/failure regime to support the shift towards an integrated, devolved system that is set up to deliver the three shifts. The focus should be on supporting self-directed improvement, with punitive levers being used as a last resort. This is a significant departure from the traditional NHS approach to performance management which incentivised organisational decision-making based on satisfying regulatory interests, not those of the wider system or populations.

NHS England's draft Performance Assessment Framework confirms that ICBs will no longer play a role in provider oversight alongside NHS England and moves from a system oversight to an individual organisational approach.[32] As this framework is tested and iterated, it is essential that commissioners have the right levers to support collaboration to deliver the left shift.

ICSs need holistic leadership and improvement support from the centre, including regions, to ensure they have the capabilities to effectively discharge their functions, particularly in the context of cost reduction programmes. For ICBs this should focus on strategic commissioning skills, including robust analytics, contracting and resource allocation capabilities. Providers should be given additional support as they move towards lead provider or ACO-type models, and with certain ICB functions likely to be delegated to providers in the upcoming health bill.

Peer review has been an effective driver of improvement in local government for many years. Greater use of peer review in and alongside formal oversight processes can support quality improvement while also helping to identify and

spread best practice; all parts of the centre and the system should foster a learning culture.

Oversight should be proportionate, flexible and consolidated, seeking to reduce the burden on providers and ICBs and enable local systems to take ownership of delivery. A core metric for ICS performance should be preventive and empowered model of care, including effective delivery of neighbourhood models. ICBs will continue to have oversight of how providers deliver care against the health outcomes they have commissioned them to achieve for their population, with a focus on population health improvements, patient satisfaction and access to care. NHS England should define a clear pathway for providers to proactively share intel and/or request support from the ICB and/or NHS England to prevent issues from escalating and requiring formal intervention. This should be informed by a dynamic monitoring system which NHS England, ICBs and providers can access to inform decisions and oversight of quality and productivity.

7. Improve pooled budgets arrangements

DHSC and the Ministry of Housing, Communities and Local Government should review the Better Care Fund and Section 75 arrangements as part of a plan to make it easier to pool budgets across the NHS (including primary care) and local government and provide recurrent delegated budgets for place-based partnerships.

Greater use of these arrangements would help make progress towards better sustainability of the public pound. The government could facilitate this by simplifying and broadening these arrangements, reducing reporting and governance requirements. One crucial part of this is allowing primary care organisations to pool budgets. They are currently unable to enter such arrangements, which is prohibitive to greater integration.

8. Reset the relationship with citizens

Moving to a truly devolved model will require resetting the system's relationship with citizens. The expectations of both 'parties' will change as part of a reciprocal relationship or 'compact':

- The system will give citizens greater ownership and choice over the care they receive and equip them with knowledge to improve their health and wellbeing.

- In return there is greater responsibility placed on citizens. This means the greatest support will need to be given to those who need it most.

A deeper connection with citizens will ensure that services are built on a strong understanding of population health, promoting good health and wellbeing.

Within the current operating model, those who most need this approach are least likely to receive it.

While the majority of citizens won't recognise a new operating model, they will notice its consequences. The public expects to see improved outcomes (such as improved access, joined-up systems, clarity on their health, responsiveness). A clear operating model will be essential to achieving this.

This model should be anchored to citizens through optimising the trusted organisations and familiar expertise that are already rooted in communities. In health, this often means general practice or community pharmacies – visible and accessible services embedded in the daily life of many neighbourhoods. Yet for many people, especially those most marginalised, trust also lies in local voluntary and community sector organisations, peer groups and informal networks. To improve and simplify local access, we must strengthen these trusted entry points and ensure they are connected through local infrastructure and digital tools that make services easier to find and navigate.

The review of the NHS Constitution, which is currently underway and being aligned with the ten-year health plan public engagement, provides an opportunity to codify this new relationship.

9. Support the move to a neighbourhood health service

Neighbourhood working represents a transformative opportunity to address systemic pressures in health and care, declining levels of public satisfaction with the NHS and most importantly, declining healthy life expectancy and growing health inequalities. This model is based on the recognition that the most effective health creation occurs within communities and that long-term sustainability will depend on enabling more local, biopsychosocial models of delivery.

Across the country, promising neighbourhood work is already underway – led by primary care, mental health and community trusts, alongside VCSE organisations, local authorities and communities themselves.[ii] This work should not be about restarting, restructuring or rebranding, but about building momentum, recognising where we need to go further faster and creating shared commitment to neighbourhood working, even amid significant system pressures. Some delivery models for neighbourhood health are led by a place-based collaborative, others by a lead provider (including primary-care at scale, community and mental health trusts or local authorities). Each model has its own merits and drawbacks.

The form these models take should be based on optimising existing assets, expertise and capacity to provide the infrastructure for those working at neighbourhood level, giving them the autonomy and resources to work proactively and collaboratively. The approach should be driven by investing in place-based infrastructure (place-based collaboratives, lead provider models and/or provider collaboratives) to act as a sustainable driver for neighbourhood working. These partners would be expected to deliver against core outcomes for the neighbourhood health service, but with flexibility to respond to wider community and local needs, informed by neighbourhood teams, community insight and population health data.

[ii] See for example Bethnal Green's Neighbourhood Mental Health Team

Conclusion

Effective governance structures and a clear operating model are needed if the health and care system is to deliver recovery, reorganisation and reform.

The overnment has provided a clear vision for the health and care system through its three shifts (the 'what'). A new system operating model is needed to provide clarity on the functions (the 'how') that are needed to shift towards a more preventative and empowering model of care and roles and responsibilities for delivery (the 'who'). The model must leave sufficient room for local discretion in determining which organisations lead the shift towards a more preventative and empowering model of care, building on what is already working and avoiding delay and distraction from undoing existing effective models. Rather than privileging one model, the centre should create strong incentives for systems and providers to develop a credible collaboration and accountability model that suits their local legacy and assets.

This transformation should be guided by the principles of devolution and subsidiarity, a system approach to change, and clarity and accountability. The ten-year health plan must align policies to incentivise these shifts, ensuring a more effective, efficient and citizen-centred healthcare system.

The NHS Confederation will be doing some more detailed work on delivery models for the left shift and neighbourhood health. Please get in touch with Annie Bliss to find out more: **annie.bliss@nhsconfed.org**

Annex

This annex presents a more detailed breakdown of the roles and responsibilities of bodies operating at the health and care system's five main geographical scales: national, regional, systems, place and neighbourhood. It describes how each layer could deliver its core functions and summarises the challenges that each is experiencing.

Roles and responsibilities

National

Core functions –strategy and oversight/improvement:

- Define the overall strategy and outcomes systems will be accountable for delivering
- Develop policy and commission services that are best done once nationally
- Create an enabling environment for change and improvement

Current challenges:

- Overcoming culture of excessive regulatory complexity and micromanagement of delivery
- Pull from politicians towards national political priorities
- Lack of proximity to the system

How functions could be delivered:

- Provide necessary resources for systems to deliver a set of defined outcomes
- Focusing just on the things which should be done nationally and doing them once, well

- Commission things that need to be done nationally, such as specific digital and highly-specialised services
- Define the direction and outcomes that systems need to deliver while leaving sufficient room for local discretion to determine how to achieve them
- Accountability arrangements based on trust and developing systems to develop capabilities, with some limited but effective mechanisms for intervening when things go wrong, for example where there are misalignments or governance issues, ensuring that priorities like prevention, health equity, and digital transformation are consistently pursued across the system
- Foster and support cross-sector collaborations with the aim of fostering healthier, thriving communities

Regional

Core functions – strategy and oversight/improvement:

- Working closely with organisations to co-develop national policy and strategy to bridge the gap between national policy and local implementation
- Delivering functions best done regionally, such as high-level strategic workforce planning
- Oversight of the quality, financial, and operational performance of providers and ICBs within their region and supporting them to develop capabilities

Risks:

- Duplication with national tier and ICBs

How functions could be delivered:

- Adopt a 'team of teams' approach, as in North East and Yorkshire
- Assure delivery of NHS England strategy at the regional level
- Agree an operating model with ICSs

- Oversight of NHS organisations focused on assuring delivery against integrated care strategies, intervening where needed and avoiding duplication
- Identifying best practice, using this to support and enable improvement
- Support organisations and systems to develop their capabilities for strategic commissioning, improvement and operational and clinical management
- High-level strategic workforce planning, development, education and training

System

Population footprint of around 1 million to 3 million people

Core functions – strategy and oversight/improvement:

- Develop a system-wide strategy to deliver the four purposes
- Deliver structural transformation of health services by integrating services and delivering the three shifts

Current challenges:

- Investment in the health service is not aligned with population health outcomes

How functions could be delivered:

- Work as an equal partnership with local authorities to transform public services
- Creating the right environment to enable local decision-making at place
- Delivery against a set of locally-defined outcomes, including through contract oversight
- Support mutual accountability arrangements through peer support, peer review and improvement
- Over time, make a decisive shift from contracting individual providers for activity (or services), towards contracting that drives collaboration to improve people's health (or outcomes)

- To support their estate management responsibilities, take on enhanced estate management capabilities and functions currently held by NHS Property Services, supporting co-location to transform services
- Commission and develop neighbourhood health
- Support medicines optimisation

Integrated care boards

Core functions:

- Set a system strategy based on an understanding of their population's health needs, including the identification of underserved communities.
- Effectively and strategically commission and contract services to improve population health, reduce inequalities and increase allocative efficiency through payer functions and resource allocations
- Convene the system with a view to transforming services, including shifting towards prevention and care closer to home
- Evaluating impact to ensure optimal, value-based resource use and improved outcomes

Current challenges:

- Duplication of oversight role with NHS England's
- Struggling to meet competing demands
- Budget constraints

How functions could be delivered:

- Lead strategic commissioning and strategically invest in health outcomes
- Evaluate population needs with a focus on underserved communities, set population health outcomes, allocate resources, and monitor impact based on population data, forecasting and modelling.
- Convene system partners to, over time, make a decisive shift from contracting individual providers for activity (or services) to contracting that drives collaboration to improve people's health (or outcomes)
- Use greater ability to coordinate and support co-location to transform services

- Day-to-day contract management role to ensure delivery of outcomes that providers have been commissioned to achieve for their population, including more seamless, joined-up care for patients
- Increasingly devolving more recurrent delegated budgets to place-based partnerships, giving them increased autonomy to take risks

Integrated care partnerships

Core functions:

- ICP partners collectively set and drive strategic direction of the ICS through delivery of the integrated care strategy
- Act as a bridge between local NHS and wider political, economic and social development

Current challenges:

- They are tasked with delivering the longer-term strategic areas which require more advanced levels of partnership working, such as improving population health outcomes, reducing health inequalities and accelerating the scale and pace of change towards prevention and social and economic development, but lack levers to enact change
- Lack of capacity and profile

How functions could be delivered:

- Convene public sector and wider partners to drive mission delivery
- Promote a shared culture based on trust, mutual respect and transparency within a system, through inspiring leadership and professional humility, which recognises and values all partners' contributions
- Enable participation and co-production with the voluntary, community, and social enterprise (VCSE) sector, the public and patients as well as partners such as academia, local business and emergency services

Strategic authorities including directly elected mayors

Core functions (specifically relating the health):

- Align economic and social policies with health objectives
- As part of ICSs, collaborate with NHS partners to address the wider determinants of health and shift from sickness to prevention

Current challenges:

- Focus on establishment and new structures
- Lack of clarity on what their statutory health duty entails
- Socio-economic context of local area driving focus
- Lack of awareness of NHS leaders of their role

How functions could be delivered:

- Align economic and social policies with health objectives both locally (such as in local growth plans and local industrial strategies) and across regional statutory strategies
- Support public service reform and prevention within places
- Use the Statutory Health Duty to hold the system to account in delivering health improvement and health inequalities, focusing on how they can work with broader partners on the wider determinants of health
- Becoming statutory partners of the ICB
- Some mayors (or a delegate) will be appointed to one or more relevant ICPs, with an expectation that they (or a delegate) be considered for the position of chair or co-chair
- Work closely with ICBs to set priorities and develop plans, with a focus on fostering partnership working to address the wider determinants of health

Local authorities

Core functions (specifically relating to health):

- Pursue inclusive growth with health at its centre

- Commission services that impact health and wellbeing, including housing, social care and public health

Current challenges:

- Budget constraints
- Navigating structural reform

How functions could be delivered:

- Local accountability arrangements will change in the coming years as a result of the government's devolution white paper.[iii] The move towards a standardized sub-regional model of leadership – including restructuring two-tier areas (county and district councils) into single-tier unitary authorities (covering populations of ~0.5 million) – provides an opportunity to align more closely with NHS bodies
- Use local democratic accountability to enhance accountability to local communities
- Support public service reform and prevention within places
- Development of the Joint Strategic Needs Assessment and consideration of wider evidence to inform system level decision through health and wellbeing boards (HWBs)
- Monitoring and driving place level integration through HWBs
- Support place board models by delegating functions and budgets to 'place leads'

Providers

Core function – delivery:

- Delivering high-quality and efficient care
- Delivering some strategic commissioning directly through delegation arrangements and provider collaboratives
- Develop clear anchor strategies
- Act as sector 'voice' and leader in system and place-based planning

Current challenges:

- Recovering operational performance
- Shifting resources from the acute sector into the community and primary care

[iii] English Devolution White Paper

How functions could be delivered:

- Increasingly shifting funding away from acute, towards community and primary care services
- Ensuring provider resilience and appropriate infrastructure to drive this shift through provider collaboratives and/or at-scale primary care
- Greater cross-system transparency of service pressures beyond the acute sector
- Input into system-wide strategy and translate this into local strategies and plans
- Deliver high quality and efficient services
- Trust boards to provide first line defence in ensuring high quality care within organisations
- Pathway to maturity with the possibility of moving to accountable care organisation models

Place

Population footprint of around 250,000 to 500,000 people

Core functions (in terms of their relationship with health functions) – delivery:

- The engine rooms of integrated care – integrating provision of different public services around people ('total place')
- Acting as the support and strategy lead for neighbourhoods, providing the supporting infrastructure for budget and workforce pooling, and in some cases holding the governance function

- Translating the strategic goals of ICSs into local delivery for the benefit of local populations
- Convening local partners to collectively respond to the challenge of improving population health and quality of life with a 'community first' approach

Current challenges:

- Finances challenging relationships
- Streamlining the complex and overlapping nature of local accountability
- Lack of central support or commitment to place-based working

How functions could be delivered:

- Help facilitate, streamline and improve decision-making at system level, supporting greater progress towards distributed leadership models at system level
- Enabling participation and co-production in service delivery with the VCSE sector, the public and patients as well as partners such as academia, local business and emergency services
- NHS (including primary care) and local authority bodies within partnerships take on increasing responsibility over budgets delegated by ICBs, ensuring budgets are effectively pooled across NHS and local government via Section 75 agreements and the Better Care Fund
- Aligning greater autonomy for revenue and capital expenditure with holistic investment in addressing inequalities, including where appropriate through Strategic Authorities
- Maintain a sustainable governance structure and workforce at place

Neighbourhoods

Population footprint of around 30,000 to 50,000 people

Core function – delivery:

- Delivery of a more proactive, personalised and holistic model of care
- Engagement and empowerment of individuals and communities, driven by a biopsychosocial approach
- Empowering the frontline with autonomy and risk in the right places, with infrastructure to allow them to deliver effectively

Current challenges:

- NHS performance management which focuses on a bio-medical model, distorts incentives to undermine trust, discourage frontline autonomy, and encourage short-term focus on acute needs

How functions could be delivered:

- Transformation of service model, particularly to those with highest level of need, linked to other areas of public service reform
- The right expertise and cross-system triage systems (managed through economies of scale) at the local footprint
- Strong integration at place to unlock the provider infrastructure: pooled budgets, population health data, workforce planning and digital infrastructure – leaning on the expertise of local government
- Leverage community insight to design and deliver care, empowering citizens to manage their health and fostering community resilience
- Harness the expertise and intrinsic motivation of frontline staff across the NHS (not just primary and community care), local government, and VCSE to create matrix teams
- Delegate funding and decision-making to integrator function – place-based, or involve the PCN, provider collaboratives, or the VCSE sector.

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