



Integrated Care
Systems Network
NHS Confederation

The state of integrated care systems 2024/25

Delivering through change

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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.

For more information, visit: www.nhsconfed.org

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Integrated Care Systems (ICS) Network

The Integrated Care Systems Network is part of the NHS Confederation. As the only national network bringing together the leaders of health and care systems, we support ICS leaders to exchange ideas, share experiences and challenges, and influence the national agenda.

For more information, visit: www.nhsconfed.org/ics

Find out more about our [leadership](#) and [strategic commissioning](#) support and our member forums.

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Key points

- Our annual report on the state of integrated care systems (ICSs), based on a survey of ICS leaders, examines systems' progress, how they are responding to the changing policy landscape and their role in implementing the 10 Year Health Plan.
- Nearly four in five ICS leaders are confident their system can fulfil each of their four core purposes and over half say they made progress towards the government's three shifts over the past 12 months.
- ICS leaders fully support the 10 Year Health Plan. More than three in five think shifting health spending into the community by 2035 will make the most difference to their local communities and are confident they can build on the work they have already done to deliver a neighbourhood health service.
- However, ICS leaders think NHS reorganisation has created a significant distraction and barrier to systems' progress. Ninety-five per cent of integrated care board (ICB) respondents are very or fairly concerned about the impact of the required cost reductions on their ability to deliver against national and system priorities.
- ICB leaders understand the need to reduce duplication, but the lack of direction from national leadership has left them in a difficult position. Delays to key national decisions about timelines, appointments and funding for redundancy costs have left ICB leaders unable to make progress with organisational change. ICB leaders urgently need clarity on national funding so they can proceed with the required restructures.

- Despite these challenges, ICB leaders are committed to their role as strategic commissioners. They are most confident in their ability to understand their local context and develop a population health strategy but recognise organisational development and upskilling are required to fulfil their payer, market-shaping and impact-evaluation functions.
- ICBs are being asked to focus their remaining resources on strategic commissioning while retaining accountability for other important statutory functions, which would require primary legislation to change. ICBs are most concerned about the future of All Age Continuing Care (AACC), safeguarding and medicines optimisation responsibilities.
- A quarter of ICS leaders are likely to keep integrated care partnerships (ICPs) following the intent to remove the statutory requirement for them in the 10 Year Health Plan, while about two in five plan to integrate ICP functions into health and wellbeing boards and work in partnership with strategic authorities. Regardless of structures, ICS leaders are determined to continue the legacy of ICPs in bringing together partners to address the wider determinants of health. Around two in five believe strategic authorities will advance the government's health agenda, but there is local variation and uncertainty about the future.

Recommendations

On behalf of ICS leaders, we make the following recommendations to the Department of Health and Social Care (DHSC) and NHS England:

- **Work with HM Treasury to clarify national funding and timeline for ICB redundancies.** This is to either allow ICBs to implement their restructures in 2025/26 or to allow what can be afforded to be delivered this year, with the remainder delivered in 2026/27.
- **Deliver clear and regular communication with ICB leaders about timelines, process and expectations for the ICB change programme, equipping them to implement changes effectively and safely.** This should include additional support for ICBs making greater reductions, clustering or merging.

- **Support and resource the development of ICBs' strategic commissioning skills and capabilities.** Particular attention should be given to their functions as healthcare payers.
- **Appoint a senior commissioning lead in the future DHSC national structure,** reporting into the director general for system development, with commissioning expertise to support ICBs.
- **Model collaboration with other government departments** to promote integration between the NHS, local government and wider partners by aligning policy, guidance, legislation and the health and economic growth missions.
- **Embed a more devolved and enabling operating model by:**
 - **providing ICBs with the levers, autonomy and aircover they need** to make difficult commissioning decisions to support new service models and shift resources from hospitals to communities
 - **working with ICBs to co-produce the tools they need** to effectively discharge their functions
 - **adopting an approach** that is **locally led with national principles to policy development, building on existing work and partnerships,** in particular **in relation to neighbourhood health.**

Introduction

ICSs have experienced an undeniably challenging year, marked by constrained public finances and significant structural changes across the public sector. These challenges have remained and, in some cases, are greater than when this research was conducted. Yet, as this report shows, ICS leaders remain committed to delivering the government's vision for change and continue to drive meaningful improvements in health and care outcomes for their populations.

In March 2025, the government announced a range of measures to reduce duplication and provide better value for money across the NHS. This includes a 50 per cent cut in the running and programme costs of ICBs, the return of NHS England to the DHSC and reducing providers' corporate cost growth. To deliver cost reductions, ICBs have established clustering arrangements and a proportion of ICBs are set to merge into bigger footprints in April 2026. However, the original deadline of end of September for delivering cost reductions quickly proved to be too ambitious.

There are also many instances where ICBs have struggled to get the clarity they need from DHSC and NHS England to progress their change programmes. Currently, the lack of decision on whether there will be national funding to meet redundancy costs is putting ICBs in the very challenging position of being unable to begin the finance and HR processes needed to implement their restructures effectively and in a way that minimises impact on staff.

These announcements preceded the publication of the government's 10 Year Health Plan in July 2025. The plan sets out measures to improve our health and care system, many of which NHS leaders have been calling for. New legislation is expected to be laid before parliament in 2026 to implement several of these changes.

Local government is also undergoing major change, with two-tier areas and smaller or failing unitary authorities reorganising and the government intending for strategic mayoral authorities to cover the whole of England by the end of this parliament.

The State of Integrated Care Systems is the ICS Network's flagship annual report. It sets out the views of ICS leaders on progress, how they will deliver the 10 Year Health Plan and how they are adapting to the rapidly changing political and policy landscape.

Methodology

This report is based on data collected through secondary research and quantitative and qualitative methods.

Through a national survey, we invited leaders of the 42 ICSs in England to share their views on ICS development, the 10 Year Health Plan and NHS and local government reform. It was open to ICB chief executives and chairs and ICP chairs from 21 July to 20 August 2025. We received 53 responses, representing over 80 per cent of systems (34 out of 42). The survey was undertaken before the appointment of chairs and chief executives to the new ICB clusters.

Responses were split across 20 ICB chairs, 21 ICB chief executives, 10 ICP chairs and two joint ICB/ICP chairs. All respondents were asked the same questions except for an additional set of questions on the future of ICBs for ICB respondents only. At times we have compared responses to last year's survey, but comparison is limited by different wording of questions and by different individuals completing the survey. Qualitative responses were analysed using inductive thematic analysis to identify emerging themes. We also undertook individual interviews with 12 leaders from different roles across ICBs and ICPs, including survey respondents, place leaders, ICB directors of strategy and chief financial officers, to discuss the findings and the wider context in greater depth.

Since this data was collected, the operating context has become even more challenging. Various changes and disruptions, in particular a lack of decision around national funding to meet redundancy costs, have impacted ICBs' ability to deliver their change programmes within the very contracted timescales.

1. ICSs are already progressing the government's priorities

1.1 Confidence in the four core purposes of ICSs remains high

Overall, most ICS leaders feel confident that their system is currently able to fulfil each of their four purposes:

- improving population health and healthcare outcomes
- tackling inequalities in outcomes and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

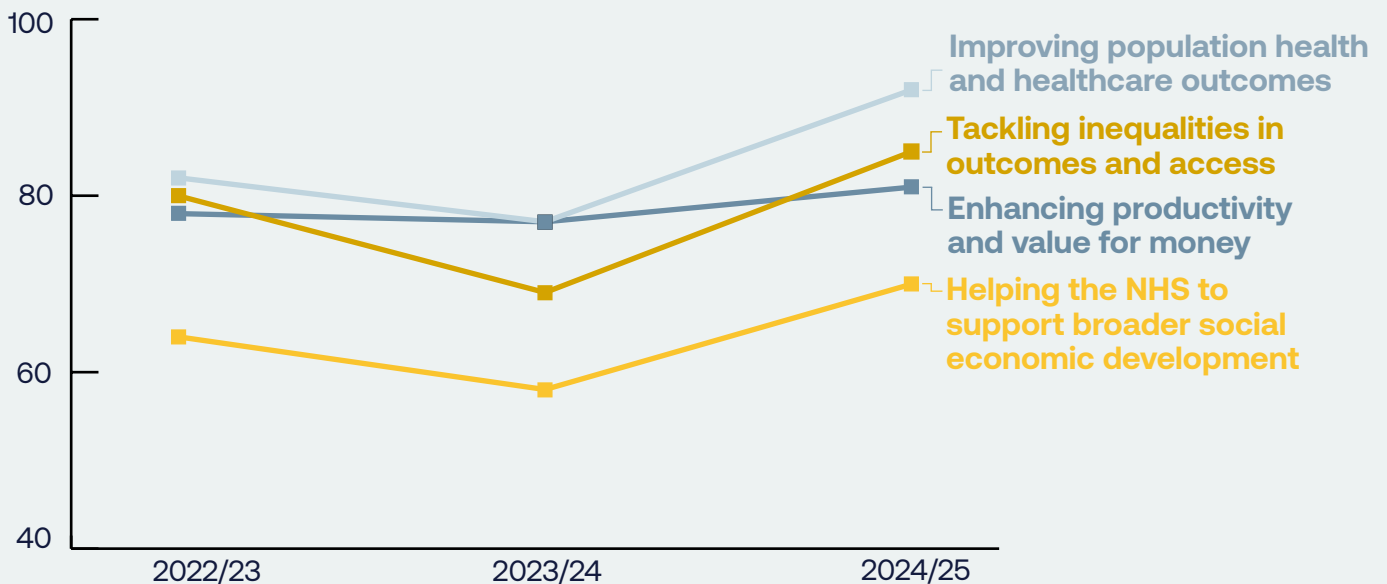
Looking back to survey responses in 2023 and 2024, this confidence is at its highest level since ICSs were put on a statutory footing in 2022 (figure 1 on page 11). A larger proportion of leaders report feeling 'very confident' or 'fairly confident' across all four purposes, while the percentage of respondents who feel 'not very confident' or 'not confident at all' is at its lowest.

ICS leaders are clearly starting to see the results of the work they have been doing with their teams to drive transformation over the last three years. This ranges from supporting providers, to improving productivity and efficiency and targeted work on prevention.

Figure 1: Time series: confidence across the four purposes of an ICS

“How confident are you that your system is currently able to fulfil each of the four purposes of an ICS?”

% confident



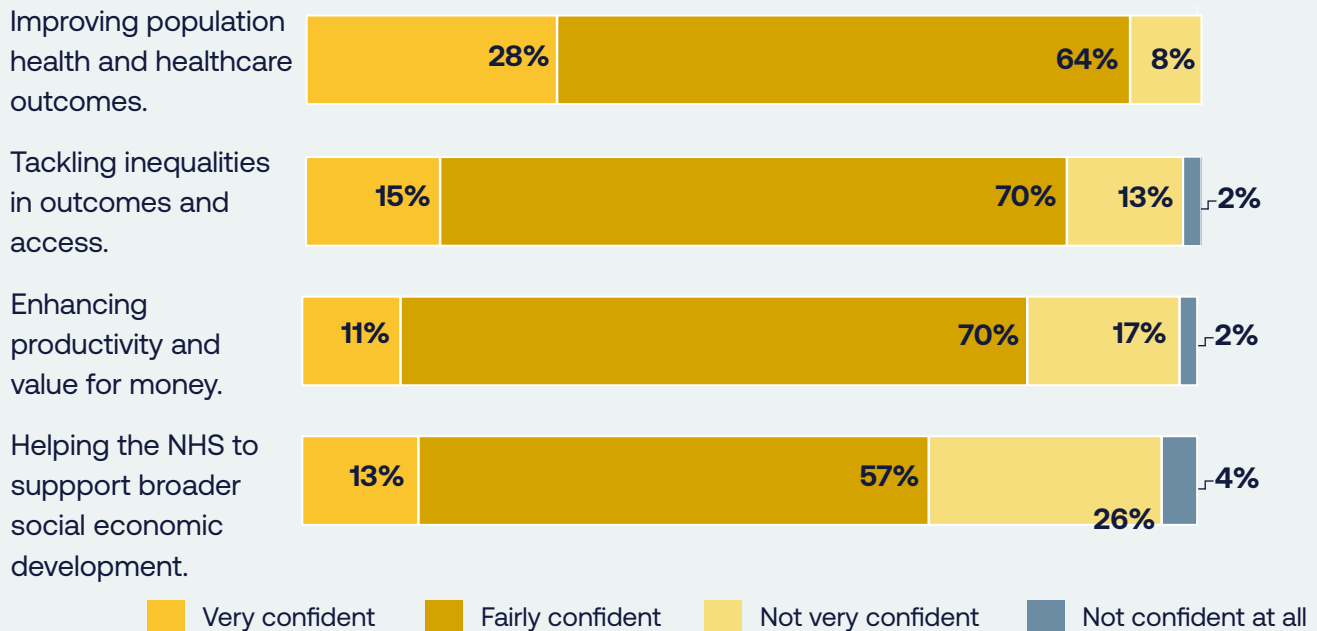
% confident = % 'very confident' + % 'fairly confident'

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation;
2022/23: n=45; 2023/24: n=62; 2024/25: n=53

Figure 2 (page 12) shows survey results that respondents feel most confident about improving population health and healthcare outcomes (92 per cent), followed by tackling inequalities (85 per cent) and enhancing productivity and value for money (81 per cent). Confidence is lowest in supporting the NHS to support broader social and economic development with over a quarter (26 per cent) not very confident in their ability to deliver this purpose, which is consistent with findings from previous year's survey.

Figure 2: Confidence across the four purposes

“How confident are you that your system is currently able to fulfil each of the four purposes of an ICS?”



‘I don’t know’ was an option which received no responses.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n=53

The NHS has a key role to play in contributing to economic growth and has increasingly been active in supporting those currently economically inactive due to long-term sickness. But there is still more progress to be made to harness the opportunities of partnership working between the NHS and other local partners.

For one ICP chair: “Economic development isn’t a core purpose [of the NHS]. How does the NHS press into the economic development leadership that local and upper tier local authorities bring and have as a responsibility?”

The 10 Year Health Plan indicated potential changes to local government representation on ICB boards, from local authorities to mayors, which will have implications for delivering this aim.

While the first three purposes are reflected in the Model ICB Blueprint, the fourth has received significantly less attention. At the same time, ICSs have received funding to deliver programmes on the fourth purpose and particularly around work, health and skills, including WorkWell and health and growth accelerators. Many are already working closely with their mayoral strategic

authorities in this area and strategic commissioning provides an avenue to harness NHS funding to contribute to economic growth. If the lack of clarity surrounding the fourth purpose is not addressed by the government, it may erode confidence among ICS leaders and their partners in the NHS's ability to support broader social and economic development, potentially leading to partners disengaging or ICBs having to deprioritise this crucial work.

ICS leaders are committed to delivering on their four core purposes and focusing on making a difference to the health and wellbeing of their communities.

As one ICB chief executive described: “We have skills, governance and structures focusing on these areas. There is still much more to do but we are having an impact on these aims.”

ICB leaders highlight the risks of undoing or slowing some of this progress due to the distraction linked to structural changes in ICBs and local government (see section 3).

1.2 ICSs are making progress towards the three shifts

Three shifts were outlined for the NHS in the government's election manifesto and subsequent 10 Year Health Plan:

- moving care from hospitals to the community
- making better use of technology
- prioritising prevention over treatment.

These ambitions have been widely welcomed by ICS leaders (see figure 3 on page 14). ICS leaders believe each shift is essential to improving population health, easing pressure on hospitals and NHS staff, reducing waiting times and delivering high-quality care more sustainably and equitably. However, ICS leaders told us that delivering these shifts will be incredibly challenging. We asked them whether their system had made progress on the three shifts over the past 12 months. There was broad agreement across all three areas, although most selected ‘agree’ rather than ‘strongly agree’, indicating a sense of cautious optimism.

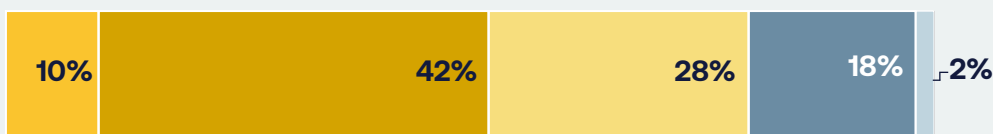
Figure 3: Progress on the three shifts

“The current government has been in place for about 12 months. It has committed to delivering three shifts to improve health and care services for the future. To what extent do you agree with the following statements:

Over the past 12 months, our system has made progress towards shifting care from hospital to community.



Over the past 12 months, our system has made progress towards shifting care from analogue to digital.



Over the past 12 months, our system has made progress towards shifting care from treatment to prevention.



‘I don’t know’ was an option which received no responses.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n=50



ICS leaders feel they have made the most progress towards shifting from treatment to prevention with six in ten (60 per cent) respondents agreeing or strongly agreeing and only around one in ten (14 per cent) disagreeing. ICS leaders highlighted a range of preventive initiatives (see case study 3) spanning hypertension, vaccination programmes, A&E admissions avoidance, oral health, frailty and children and young people. Further work on prevention will be conducted through the prevention accelerators and demonstrators outlined in the 10 Year Health Plan, incorporating a system approach across multisector partnerships.

A similar percentage of respondents (58 per cent) report progress in moving care from hospitals into the community. Most ICSs have made a strategic commitment to shifting care closer to home, but the challenges in making this a reality are longstanding, with the NHS experiencing a ‘right drift’, not a left shift, as outlined in the Darzi report. The NHS Confederation has already set out principles for making the left shift a reality, including a strong role for systems and measuring the movement of resources. ICS leaders highlight other key enablers such as linked financial incentives and strengthened community,

mental health and primary sectors. Over the past 12 months, ICSs have continued to lay the foundations for community-based care, including through the creation of integrated neighbourhood teams.

ICS leaders think they have made the least progress on harnessing digital technology, with just over half of respondents (52 per cent) agreeing that they have made progress and one fifth of respondents (20 per cent) disagreeing.

One ICB chief executive explained that “progress has been made on analogue to digital but slower and much less within our control – as NHSE control the funding streams and much [of the] funding has disappeared over the last two years.”

Although digitisation is a crucial enabler to shifting from treatment to prevention and providing more care closer to home, the NHS still lags behind other health systems in this area.

Despite these challenges, there have been positive developments.

An ICB chair cited “significant growth in use of the NHS app” and “implementing an EPR in their acute trusts” as examples of progress (see ‘ICSs in action’ in box below).

ICS leaders have also been developing and implementing their digital strategies to ensure high levels of digital maturity (see case study 2), while also addressing the risks of digital exclusion.

ICSs in action: advancing the three shifts of the 10 Year Health Plan

From hospital to community

- **Bath and North East Somerset, Swindon and Wiltshire (BSW) ICS** implemented an outcomes-based provider-led community service contract to measure service outcomes. The contract addresses the three shifts and will enable the system to deliver the 10 Year Health Plan.

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- **A partnership initiative in Cambridgeshire and Peterborough** supports those accessing A&E most frequently while their integrated neighbourhood teams proactively identify people at increased risk. Collectively, over 6,000 personalised care plans were developed in the first year, resulting in reduced trips to A&E, 20 per cent reductions in non-elective admission costs, and improved patient outcomes.
- The **Pharmacy First service in Kent and Medway** delivered 94,000 patient consultations for minor injuries and illnesses between January and August 2024. Nine in ten pharmacies in Kent and Medway offer an enhanced service, whereby pharmacists can assess, treat and, when appropriate, provide prescription medicine for seven common conditions including earache, sore throat and urinary tract infections (UTIs).

From treatment to prevention

- **Nottingham and Nottinghamshire ICS** introduced 'Best Years Hubs' as a new volunteer-led pilot ageing well service for residents of Newark, Sherwood and Ashfield. The service addresses frailty, social isolation, self-care advice and wider digital inclusion, housing and financial advice in a community setting (which offers transport and a befriending phone line) to ensure that healthcare is more accessible, person-centred and preventative.
- **Shropshire and Telford and Wrekin ICS** increased mobile tuberculosis screening uptake from 0 per cent to 33 per cent among migrant communities, improving early detection and reducing risk.
- **North West London ICS** developed the community engagement on hypertension toolkit. This resource provides guidance, strategies and tools essential for effective community engagement in preventing, detecting and controlling hypertension.

From analogue to digital

- **Bedfordshire, Luton and Milton Keynes (BLMK) ICS** improved access to GP services and enhanced GP access hours through digital consultation tools, online triage and video appointments.

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- **Hertfordshire and West Essex ICS** invested in a new data platform that brings together patient level coded data across primary, secondary, community and non-NHS sources (social care, hospices) to identify and pursue opportunities for improvement. The platform allows the ICB to take data driven decisions by measuring population health outcomes in real time, identifying opportunities to improve care and reduce inequalities, and highlight people who are at greatest risk of adverse events. For example, insights have demonstrated opportunities to improve care for people with frailty and in their last year of life, resulting in the development of bundles of care across general practice and community services. Insights from the platform are showing the impact of this work, with a 57 per cent reduction in emergency admissions for people with frailty.
- **Cheshire and Merseyside ICS** made significant improvements to community services, with more than 10,600 admissions to virtual wards in-year, which would otherwise have been inpatient stays.

1.3 Longstanding challenges to systems' progress persist

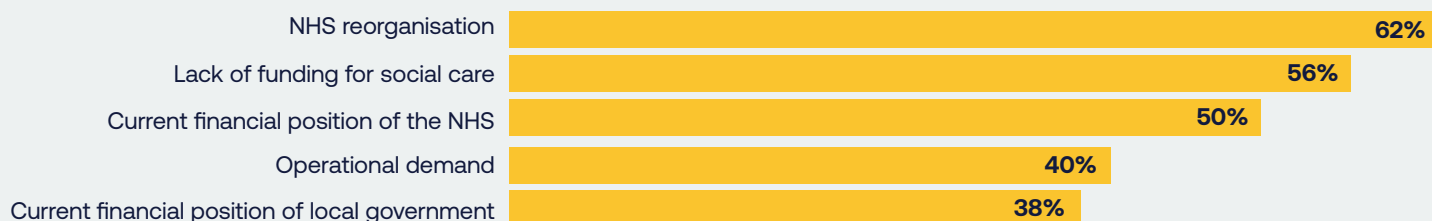
In recent decades, NHS commissioners have seen successive waves of reorganisations and ICBs are no exception. The government's requirement for ICBs to reduce their running and programme costs by 50 per cent has initiated the establishment of clusters and the approval of the first mergers of ICBs to take place on 1 April 2026. While these cost reductions aim to balance the books and streamline the role of ICBs to focus on strategic commissioning, over half of ICS leaders see NHS reorganisation as the number one barrier to their system's progress over the next two years.

They described several risks associated with this level of upheaval, including distraction from delivery of the 10 Year Health Plan, more limited headspace for senior leadership and impact on staff morale.

An ICB chair highlighted that "all attention has been on the process of reorganisation itself", impacting their ability to focus on the three shifts while an ICB chief financial officer explained that changes in leadership can impact on organisational memory and delay decision-making.

Figure 4: Barriers to progress

“What do you think will be the biggest barriers to your system’s progress against the four purposes over the coming 24 months? Select up to five.”



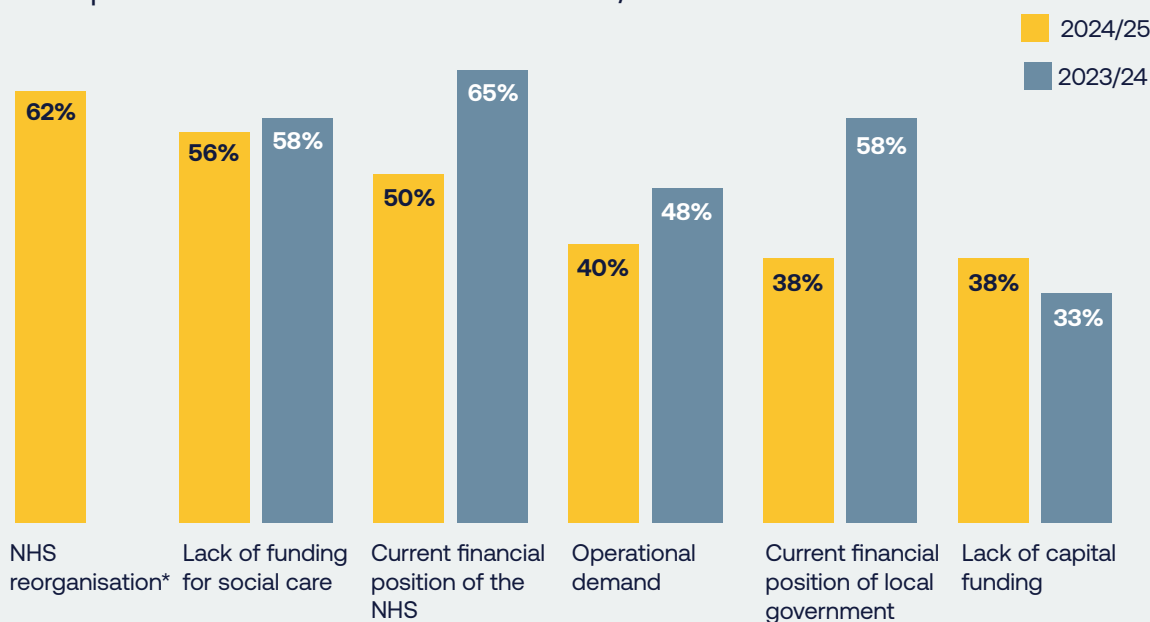
Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; up to five options permitted from choice of 19; n=50

Lack of funding for social care is also a major concern, with over half of respondents selecting it as one of the biggest barriers to their system’s progress against the four core purposes. This remains consistent with findings from the State of ICSs survey for the past two years (see figure 5 below).

Figure 5: Timeseries of barriers to progress

“What do you think will be the biggest barriers to your system’s progress against the four purposes over the coming 24 months?”

The six most commonly selected barriers in 2024/25 compared with the percentage of respondents that selected them in 2023/24



*not provided as an option in 2023/24.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; 2024/25 n=50, 2023/24 n=52

Rising demand and cost in adult and children's social care continues to put pressure on local government financial sustainability. Addressing the long-term challenges facing the social care sector through the Casey Commission will be essential to delivering the ambitions of the 10 Year Health Plan. But in the short term, the government should tackle urgent capacity and interface challenges in the sector, including its limited scope to focus on transformation due to demand pressure.

One ICB chair explained: "As we speak, there are between 300 and 400 people in our hospital beds who shouldn't be there. Not all of them are waiting for social care but a good proportion of those people are waiting to be transferred into nursing homes or back to their own home or residential care. We're relying on our local authority colleagues who are even more strapped for cash than we are."

The interface between the NHS and adult social care can also be improved. In partnership with the Association for Directors of Adult Social Services, the NHS Confederation will be setting out how the NHS and adult social care can tackle some of these challenges in the short term.

Case study 1: Shifting care closer to home in North Central London

Overview

North Central London (NCL) ICS is a leading example of how care can be shifted from hospitals to communities, despite significant system pressures. Central to its success has been its neighbourhood health approach. Like many systems, NCL has a hospital-centric model, spending just over half its budget on acute services, despite 90 per cent of patient contacts occurring in primary care.

Vision and approach

As a system convenor, NCL ICB has embedded a data-driven population health approach and neighbourhood working at the heart of its shared vision. Through engagement with residents and partners, NCL has set a

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clear direction, mapped people's needs and created the conditions for co-design of integrated care pathways.

Collaborative culture and strong cross-sector partnerships

NCL's strong tradition of cross-sector partnership working has enabled transformation beyond the capacity of any single organisation. Progress has depended on a shared belief in system-wide benefits, strong clinical leadership and trust between partners.

The NCL Health Alliance exemplifies this culture. The 'all in' multi-sector collaborative has worked with the ICB to support high-risk patients with comorbidities, who represent a large share of healthcare demand and cost. In 2023, NCL introduced a system-wide general practice model for planned and proactive care through its Long Term Conditions Locally Commissioned Service. This provides holistic, person-centred care to a risk-stratified group, with outcome-based payments at the primary care network level.

Aligning commissioning priorities

NCL has made progress aligning commissioning priorities across organisations, partnerships and collaboratives. It has secured ringfenced funding for inequalities and committed 5 per cent of its capital budget to the local care estate. Its medium-term strategy prioritises targeting inequities, population-focused commissioning, aligning services around cohorts and using a shared outcomes framework. Technical work is underway to shift resources toward planned and preventative care with provider leadership and the introduction of neighbourhood 'integrators'.

Delivering the shift: key interventions

A standout initiative is the multi-agency care and coordination team (MACCT), led by Haringey GP Federation and Whittington Community Health operating in Haringey. It brings together GPs, social workers, therapists, mental health practitioners and voluntary, community and social enterprise (VCSE) sector staff to provide integrated care to higher-risk adults living with frailty and long-term conditions.

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In October 2024, Camden launched its first integrated neighbourhood team (INT) in east Camden, co-locating staff from general practice, community services and Camden Council. The INT aims to strengthen frontline collaboration, streamline processes and test innovative models of care.

These examples build on 'core offers' for community and mental health services, underpinned by two foundational reviews in 2021, which provided the evidence base to standardise and integrate previously inconsistent services across boroughs.

Measuring success

- The MACCT has supported over 2,500 patients, predominantly over 65s living in areas of high deprivation, reducing A&E attendance and hospital admissions by 30 per cent and enabling more people to live independently for longer.
- In Camden, early evaluation shows that stronger relationships and smoother day-to-day working are fostering more joined-up support and pathways, with local people receiving more coherent and holistic care in one place.
- The core offers for community and mental health services have helped secure £55 million of additional funding for community health services over five years, reduced adult waiting lists by 5,500 patients since early 2024, and are projected to save 66,000 occupied bed days by the end of 2024/25.

Next steps

As NCL ICB merges with North West London ICB to become the largest in the country, development of the neighbourhood health model and local partnerships will remain a central priority and vehicle for person-centred health and care.

2. Managing the transition to strategic commissioning

2.1 Barriers to delivering ICB cost reductions

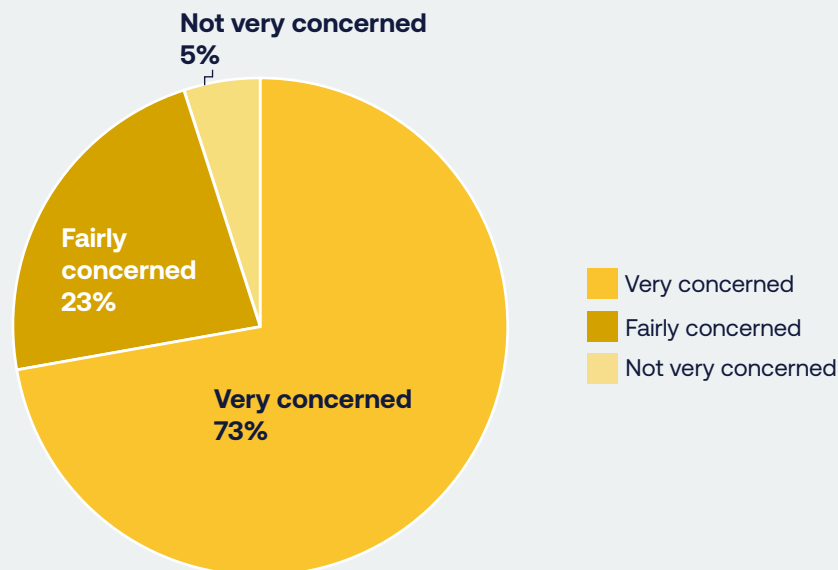
ICB leaders are committed to reducing duplication and providing better value for money. They worked collaboratively with national leaders to develop the Model ICB Blueprint and have risen to the challenge of meeting the required 50 per cent reduction in running and programme costs, with plans underway to restructure their organisations. Most ICBs have agreed clustering arrangements with neighbouring ICBs, while a small number will be merging on 1 April 2026.

This is the second time ICBs have been asked to make considerable cuts and builds on the 30 per cent cuts from 2023-2025. The latest round of cuts is based on all ICBs achieving running and programme costs equalling £19 per head of population. Each ICB had a different baseline spend per head of population which means that the reduction each is expected to make varies, with a range from 27 to 63 per cent. As such, the process has had a differential impact on ICBs across the country.

Ninety-five per cent of ICB survey respondents are very or fairly concerned that the cost reductions will impede their ICS's ability to deliver against national and system priorities (see figure 6 on page 23). They raised concerns about the process of restructure and communication from national partners, and highlighted the lack of a clear plan following the initial announcement. Significant delays in confirming the extent to which national funding would be made available to fund staff redundancies, alongside delays to leadership appointments, have made this process challenging.

One ICB chief executive shared that “the issue has been the lack of clarity on timescales and milestones for appointments, and funding.”

Figure 6: “How concerned are you, if at all, that the ICB cost reductions will impede your ICS’s ability to deliver against national and system priorities?”



‘Not concerned at all’ and ‘I don’t know’ were options which received no responses.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; ICB respondents only; n=40

These barriers have made it difficult to efficiently implement the cost reductions requested and have exacerbated the impact of this NHS reorganisation. At the time of the survey, most ICBs indicated the absence of national funding would force them to delay redundancies across all staff to 2026/27. These ICBs could not fund the costs of the redundancies without putting their financial plans at risk and breaching their cost controls. Until this issue is resolved, ICBs remain in limbo – unable to release the necessary savings, provide certainty to staff and effectively plan for the future.

The scale of disruption and impact on staff morale and wellbeing cannot be underestimated. The energy and focus of senior leaders and their teams has been absorbed by delivering these efficiencies and turnover of ICB leadership has been substantial, adding to this destabilisation.

One ICB chief executive described “distraction and lack of focus at a time of uncertainty” as a “significant delivery risk for the second half of 2025/26”.

In the long term, questions remain whether the reduced allocation will be sufficient for ICBs to effectively deliver their strategic commissioning role and implement the 10 Year Health Plan.

One ICB chair explained: “The 10 Year Health Plan sees the expectation of ICBs evolving but the cost reductions will leave them without the resource to deliver.”

Recommendations to DHSC and NHS England

Work with HM Treasury to clarify national funding and timeline for ICB redundancies to either allow ICBs to implement their restructures in 2025/26 or to allow what can be afforded to be delivering this year, with the remainder delivered in 2026/27.

Deliver clear and regular communication with ICB leaders about **timelines, process** and **expectations** for the **ICB change programme, equipping them to implement changes effectively** and **safely**. This should include additional support for ICBs that are making greater reductions, clustering or merging.

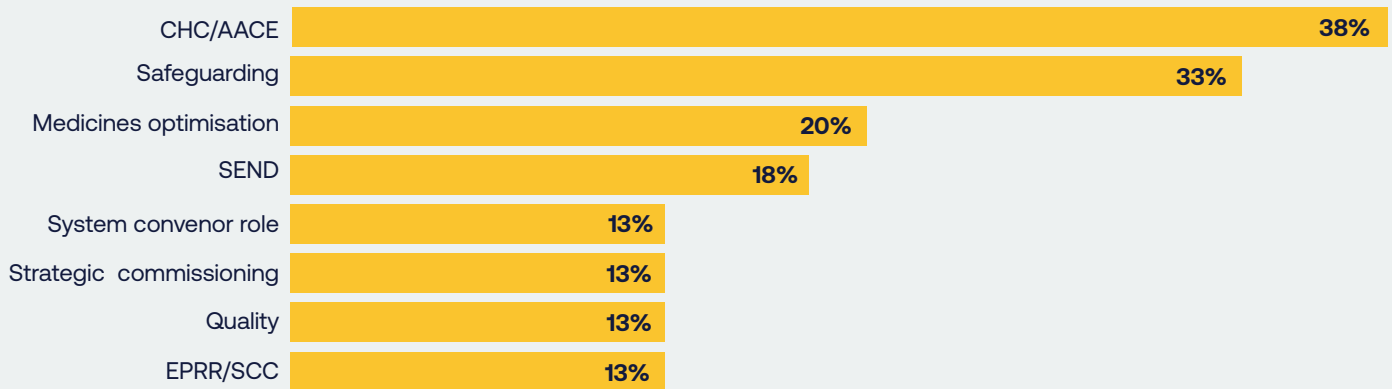
2.2 Uncertainty about ICBs’ future functions

To meet the cost reductions and focus on their role as strategic commissioners, ICBs are planning to reduce, deliver differently or stop some of their existing functions. The Model ICB Blueprint, released in May 2025, provided guidance on which functions ICBs should review, with suggestions about where these functions could be transferred to, such as NHS providers, NHS England regional teams or local authorities.

ICB respondents are most concerned about the impact of the cost reductions on the delivery of All Age Continuing Healthcare (AACE), safeguarding and medicines optimisation (see figure 7 on page 25).

Figure 7: ICB functions

“In order to meet the cost reductions by December 2025 and focus on their role as strategic commissioners, ICBs are planning to reduce, deliver differently or stop some of their functions. What functions, if any of these, are you most concerned about? Please list up to three.”



Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; ICB respondents only; additional responses represented 10% or less of the overall responses; n=40

This concern reflects the fact that ICBs hold statutory responsibilities around AACE, safeguarding and SEND, and that these functions serve some of their most vulnerable populations. The Model ICB Blueprint identified these as functions to be considered for transfer out of ICBs, but this will require the passing of primary legislation. In the meantime, ICBs still need to deliver them within the target of £19 per head of population.

At the time of the survey, ICB leaders were reviewing how they could deliver these functions at this lower cost, but with no confirmation of the timeline, process or receiver for a potential transfer of functions. Since the survey, NHS England has published best practice guidance on NHS continuing healthcare (CHC), safeguarding and SEND which recommends that all three functions remain within ICBs, with guidance on how they can be delivered more efficiently. This position may change in the government’s forthcoming NHS reform bill given the wording in the Model ICB Blueprint on devolving these functions over time and the emphasis in the 10 Year Health Plan on provider integration.

ICBs are committed to addressing the unwarranted variation in spend on CHC, with complex factors to consider when deciding how it should be delivered. The clinical and financial risk and complexity linked to CHC, means not all local areas will have organisations willing to take on delivery.

One ICB director of strategy explained: “Whatever we do in the future, that’s either going to be a huge proportion of our workforce and our budget or we outsource it but we’re still accountable.”

Medicines are the most common healthcare intervention, cause of avoidable harm to patients and the second highest area of NHS spending after staffing. Medicines optimisation seeks to ensure the best outcome for patients and best value for the taxpayer. ICBs have been responsible for driving forward and overseeing medicines optimisation across the system, working closely with all partners and particularly general practice. Medicines optimisation contributes to each of the four purposes and is an opportunity to drive transformation.

An ICB chair described it as “an important budget management mechanism for ICBs.”

The Model ICB Blueprint indicates that delivery should be transferred to providers over time, with ICBs retaining strategic overview as part of their commissioning responsibilities. Since the survey, NHS England has published best practice guidance which recommends that each ICB should retain senior medicines leadership to fulfil its requirements in relation to strategic commissioning of medicines and leadership of innovation uptake.

ICB leaders are concerned because it is an “important budget management mechanism for ICBs” and a key part of their ambitious cost improvement programmes.

While not a statutory function, ICBs have an important role as a system convenor to bring together partners across their ICS to manage challenges, solve problems and harness the power of collaboration. Mentions of this role has been minimal in recent government publications such as the Model ICB Blueprint and 10 Year Health Plan, causing uncertainty about their role as convenors going forward. Many ICB leaders feel it is important to retain this function as ICBs can bridge the gap between NHS organisations and wider partners.

One ICB chief executive explained: “The system convenor role is about having the authority to convene but it’s non-hierarchical authority. I don’t convene provider CEOs because I’m more important or powerful but because I’m not one of them. I can convene as a neutral space that supports them to navigate some of the things they need to navigate. [...] If you take away the convening role, you will just have institution, institution, institution – and the things in the middle are lost.”

ICBs can take a step back and reflect a wider view, rather than the interests of individual organisations or sectors.

As one ICB director of strategy described: “I think ICBs will continue with a role around convening. It won’t be for everything and I don’t think it should be and it never was. [...] It’s about how we set out our vision and take a leadership role in some of it. You can lift yourself up and have a helicopter view on behalf of the population. We have to look at the total needs of the population, not just those who use a service, because we don’t want people to be patients, we want to do what we can to keep people out of the system.”

ICB leaders are working closely with national partners to review and adapt how they deliver their responsibilities. Going forward – and ahead of legislative changes – financial and clinical risks associated with changing delivery of CHC, safeguarding and SEND should be planned for and mitigated as much as possible. ICBs must be given the resources they need to deliver these functions. This also applies to providers if functions are delegated to them in future. If these changes are not managed carefully, patient outcomes will suffer and ICBs could potentially be subject to judicial review for not meeting statutory responsibilities they have not been resourced to deliver.

ICBs’ legacy as a system convenor should be taken forward in their role as strategic commissioners and supported with permissive and flexible guidance. Moving towards new delivery models will require buy-in from all system partners – as the budget and contract holder, ICBs are best placed to do this.

2.3 Supporting ICBs to thrive as strategic commissioners

Alongside the Model ICB Blueprint, the 10 Year Health Plan has given ICBs a clear mandate to become strategic commissioners and NHS England's strategic commissioning framework will provide further detail on what this entails. It aligns with the vision we set out previously on behalf of members and represents a substantial shift in expectations which will take time to embed.

ICB leaders are clear the next few months will be crucial in developing and implementing new ways of working between all parts of the system, adapting to their local contexts. For example, one ICB chief executive raised the need to do further work on the interface between ICBs' role in contract management and the role of regional teams in provider oversight and performance management.

ICB leaders are optimistic about the potential for strategic commissioning to improve the health of patients and residents and want to see a fundamental shift away from more 'tactical' commissioning.

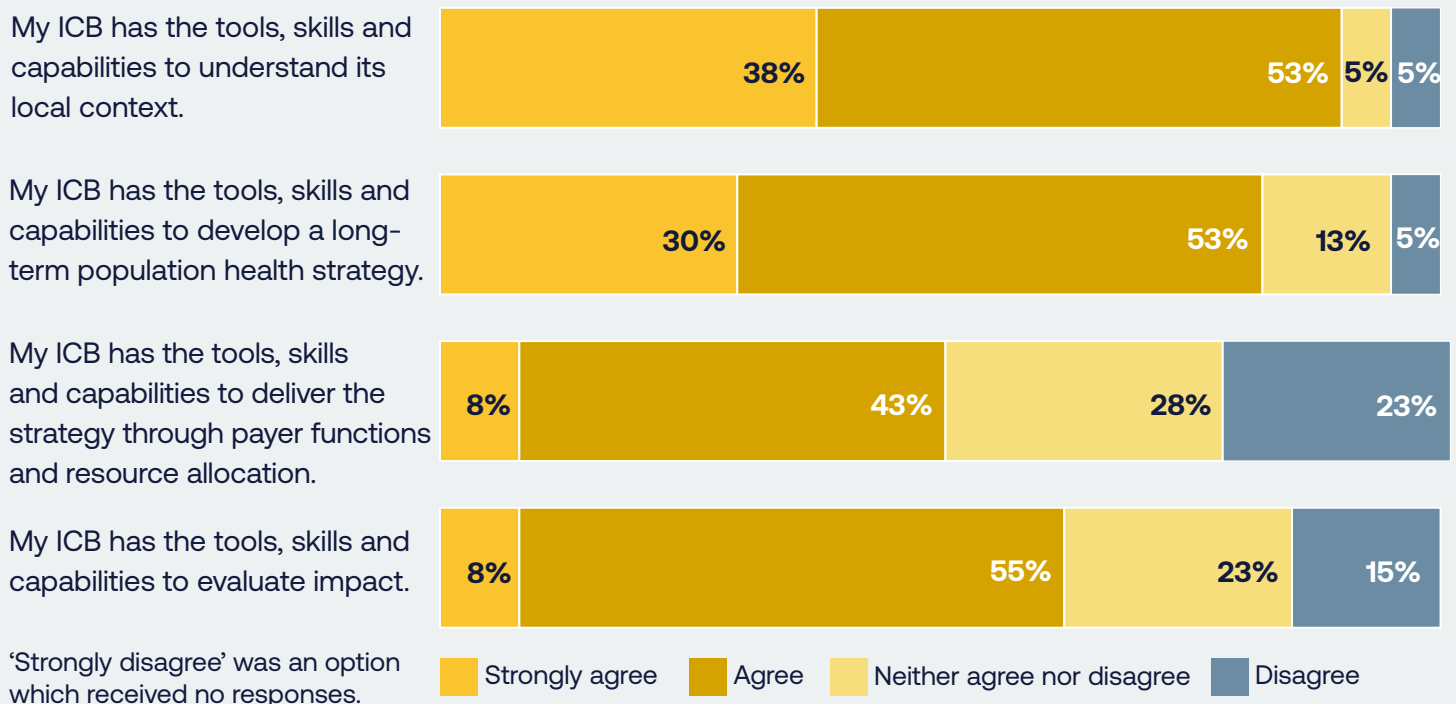
An ICB chair shared that they wanted to continue in their role because of the emphasis on strategic commissioning: "If we use our strategic commissioning powers, we can still get a lot done and make change happen. One of the biggest challenges as an ICB is how you move the money round. If we are to really make sense of strategic commissioning that gives us a focus on that challenge."

In the context of the continued uncertainty on the future of many statutory functions, ICB leaders are concerned about investing in and building strategic commissioning capability while maintaining the capacity and capability needed to meet their core statutory obligations. An ICB chief financial officer explained that with potentially limited scope to reduce statutory functions, there is likely to be scarce resource to invest in strategic commissioning, such as the intelligent payer functions. This is likely to result in a slower path for ICBs building their strategic commissioning capabilities and skills to deliver the governments' three shifts.

The Model ICB Blueprint set out four core functions of an ICB that underpin its role as a strategic commissioner. There is variation in how confident ICB respondents feel in the tools, skills and capabilities to deliver these different elements (see figure 8 below). Over four in five ICB leaders agree or strongly agree that their ICB has the tools, skills and capabilities to understand its local context (91 per cent) and develop a long-term population health strategy (83 per cent). This reflects the work they have been doing since 2022 to develop strategies with their partners and understand the needs of their populations, which built on the legacy of clinical commissioning groups (CCGs).

Figure 8: Strategic commissioning

“The Model ICB Blueprint has set out four core functions of an ICB in order to deliver its role as a strategic commissioner, which was reinforced in the 10 Year Health Plan. To what extent do you agree or disagree with the following statements:



Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; ICB respondents only; n=40

However, over one in five ICB respondents (23 per cent) disagree that their ICB has the tools, skills and capabilities to deliver the strategy through payer functions and resource allocation.¹ This may reflect concerns about the impact of cost reductions on capacity and capability for intelligent payer and

1. This is defined in the Model ICB Blueprint as “oversight and assurance of what is purchased and whether it delivers outcomes required.”

contracting, or a lack of common understanding about what the payer function means. ICB leaders are also slightly less confident that they have the tools, skills and capabilities they require to evaluate impact, with 15 per cent of respondents feeling they do not currently have sufficient skill and capability in this domain.

There is broad agreement that some commissioning skills and capabilities were lost during the COVID-19 pandemic and during the shift in emphasis towards collaboration and partnership when ICSs were established. The ongoing cost reductions will also lead to more skilled and experienced staff leaving. During the transition period, national and regional partners should support ICBs to retain the right skills and capabilities to deliver their strategic commissioning role and other statutory responsibilities.

ICB leaders are clear on which areas they need to focus on to rebuild their capabilities and upskill their staff. This includes leadership and organisational development to shift culture and ways of working, including support around strategic thinking. More sophisticated data analysis and drawing from health economics and actuarial science will also be important.

One ICB chief executive described the need to “strengthen our econometric, analytical and statistical capacity and capability.”

ICBs are moving at pace to become strategic commissioners. National guidance, rules and policies should support – not hinder ICBs – in this role and keep up with changes delivered at a local level. ICB leaders want national teams to develop new contracts and payment incentives and to support better performance measurement in mental health and community care. This will require coproduction and collaboration between ICBs and their partners and national and regional teams. At the same time as ICBs are improving their commissioning knowledge and upskilling their staff, national partners should embed expert commissioning expertise in decision-making at senior levels. The NHS Confederation will be working closely with national partners to support the strategic commissioning development programme in 2026/27 as well as ICBs directly through its [Strategic Commissioning Forum](#).

Achieving the three shifts will require difficult decisions, and ICB leaders need the confidence and backing of the centre to make the kind of strategic decisions that tackle immediate challenges and deliver long-term, transformational change. Ensuring ICBs can deliver the required cost reductions as efficiently as possible in 2025/26 and 2026/27 is crucial to allow them to effectively deliver their strategic commissioning function.

Recommendations to DHSC and NHS England

Support and resource the development of ICBs' strategic commissioning skills and capabilities. Particular attention should be given to their functions as healthcare payers.

Appoint a senior commissioning lead in the future DHSC national structure, reporting into the director general for system development, with commissioning expertise to best support ICBs in the future.

Case study 2: Digitising health and care in Devon

Overview

In 2022, Devon ICS (One Devon) launched a five-year digital strategy to modernise its health and care services. At the time, many services still relied on paper records, and electronic systems were fragmented. Patients had limited digital access to their health information, and Devon's rural and coastal geography, ageing population and infrastructure gaps added further challenges.

Vision and approach

Digital transformation is seen as a key enabler across One Devon's strategic goals: urgent and emergency care, planned care, diagnostics, children, young people and maternity, and digital innovation. With a parallel focus on maximising the value of existing digital investments, it also supports the system's financial recovery through joint procurement, infrastructure consolidation and standardisation.

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Delivering the shift: key interventions

Devon has made major progress, especially in building a shared digital infrastructure. The EPIC Electronic Patient Record (EPR) system – first used in Royal Devon University Healthcare NHS Foundation Trust (FT) – is now being rolled out in Torbay and South Devon FT and University Hospitals Plymouth NHS Trust.

Meanwhile, the Devon and Cornwall Care Record (DCCR) provides a single summary of patient data for 321 organisations and 45,000 users across Devon, Cornwall and the Isles of Scilly. It enables real-time data sharing across a range of providers, supporting patients to receive the right care without having to repeat their story.

In adult social care, Devon's Digitisation of Social Care (DiSC) programme – delivered by NHS Devon, local councils and care-sector bodies – has supported 182 providers in moving from paper to interoperable digital records that will enable better data sharing with the wider health and care system.

Finally, Devon has created the award-winning GP in the Cloud (GPITC) service, developed with local partners. The service allows GPs, nurses and other staff to access core GP systems remotely, meaning they can consult from anywhere in the UK.

Measuring success

EPIC EPR replaces paper records and enables patients to access test results, appointments and care teams via the MY CARE app. With all acute trusts in Devon soon to be using EPIC, it means that by the end of 2026 MY CARE will be available to everyone in Devon.

Devon and Cornwall were the first to implement the National Record Locator within the DCCR, which now holds around 35,000 electronic Patient Escalation Plans (eTEPs). An added benefit of the DCCR is that paramedics can access records and eTEPs via mobile devices, helping them honour patients' end-of-life wishes.

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By March 2025, 93 per cent of CQC-registered care homes had adopted DSCRs, exceeding the national target of 80 per cent.

GPITC has supported flexible working, rapid cross-site cover and business continuity for practices and PCNs. It has also contributed to faster, more reliable access to records and online consultation platforms, underpinning 'digital first' contact and improving the experience of patients and staff.

The DiSC programme achieved high uptake in a complex provider landscape, leaving a strong foundation for future improvements.

The One Devon Dataset (ODD) supports population health management and more strategic commissioning. This pseudonymised, linked dataset helps NHS organisations and councils in Devon to segment patients and profile risk.

Next steps

One Devon's digital strategy offers a practical blueprint for ICSs shifting from analogue to digital. Devon will continue its formula for achieving progress by prioritising areas of momentum and a focus on inclusion, sustainability and collaboration. It will also continue development of the ODD to use more data from other health and care services, plus the introduction of new risk stratification models to identify patients who would benefit from earlier intervention.

3. A new era for partnership working between local government and the NHS

3.1 Taking forward the legacy of integrated care partnerships (ICPs)

In the 10 Year Health Plan, the government announced its intention to remove the statutory requirement for ICPs. These statutory committees are responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population. Since 2022, ICPs have been formed between the ICB and all upper-tier local authorities within the system geography, with membership of other partner organisations determined locally.

The Health and Care Act 2022 allowed flexibility in how ICPs should operate. ICPs have taken different forms across the country, varying widely based on local arrangements with place partnerships, health and wellbeing boards and broader system structures. ICS leaders highlighted the important role of the ICP in bringing partners together and broadening the focus of the ICB outside of the NHS to work collaboratively with partners to address the social determinants of health. Although changes in national policy mean that the relationship between local government and the NHS is changing, ICS leaders reflected what the legacy of partnership working through the ICP should be built on.

An ICB chair commented: “ICPs have provided a great multi-sectoral and statutory arrangement to collaborate and agree a joint five-year system-wide strategy and annual delivery plan. The local engagement, alignment and commitment achieved must be retained.”

When asked how they would maintain joint working between the NHS, local government and wider partners, almost half of all respondents (46 per cent) said they would incorporate ICP functions into health and wellbeing boards. There is local variation in existing relationships between the ICP and health and wellbeing boards, with some smaller systems effectively merging both. While some ICS leaders acknowledge some level of duplication between both, others emphasised the risk that health and wellbeing boards are too driven by the political nature of councils.

For one ICP chair “the ICP was a middle ground that wasn’t dominated by anyone” and it was key to focusing on local issues.

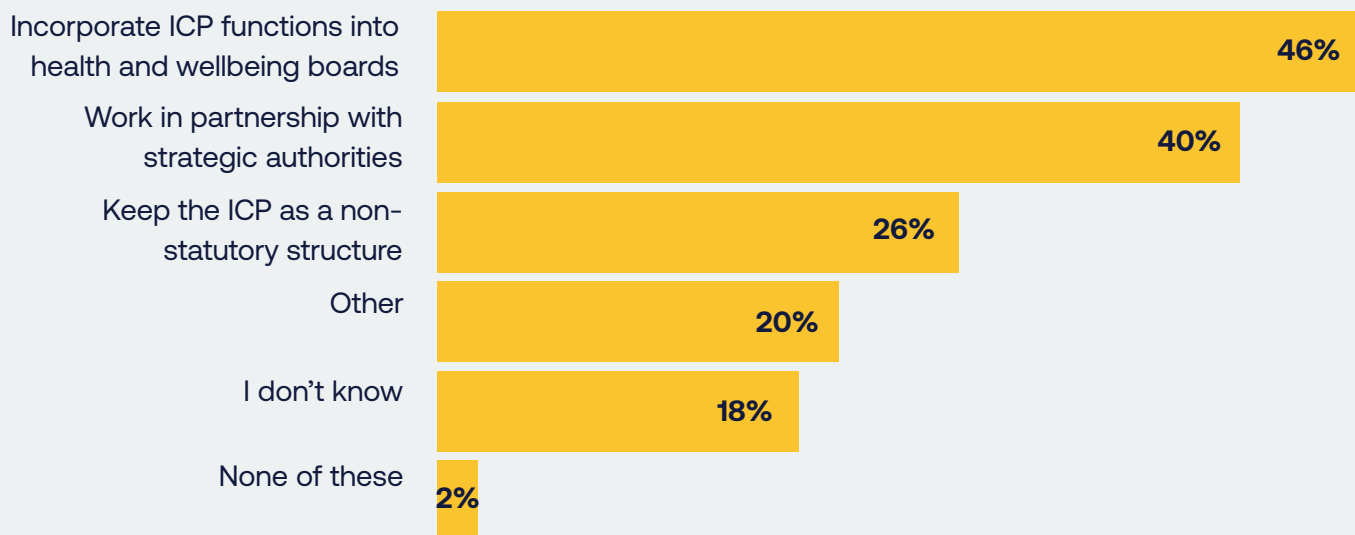
The difference in scale between health and wellbeing boards and the larger footprints of ICBs will also need to be addressed in governance arrangements.

An ICB chair commented: “Fundamentally those ICPs were a very good forum for bringing together all of the system partners, and if they don’t exist in the same form as they do now, the NHS has got to come up with some other proposal or structure that means they will actively engage with those other partners and it may be the health and well-being boards.”

Alongside this, two out of five respondents (40 per cent) indicate that they will maintain joint working through partnership with strategic authorities (see section 3.3) and around a quarter (26 per cent) will retain the ICP as a non-statutory structure (see figure 9 on page 36). At the time of the survey, there was still uncertainty about what the future of the ICP might look like and many ICS leaders were waiting for structural changes to be embedded before making any further decisions.

Figure 9: Integrated care partnerships

“In the Ten-Year Health Plan, the government announced its intention to remove the statutory requirement for integrated care partnerships (ICPs). What ways (if any) are you planning to maintain joint working between the NHS, local government and wider partners? Select all that apply.”



Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n= 50

Regardless of what form the partnership takes, collaborative working between the NHS, local government, the public and the VCSE sector is critical to address complex health and social care needs in the community.

An ICP chair reflected: “Unless we truly integrate health and social care and bring together all statutory partners, we will never deliver prevention which is key to the long-term future of the NHS and local government to reduce demand and of course address falling healthy life expectancy.”

Originally proposed in the [Hewitt Review](#), ICS leaders previously supported setting up a national ICP forum to enable engagement with key government departments such as the DHSC and Ministry of Housing, Communities and Local Government (MHCLG). One ICP chair explained that although the context has changed, the need for cross-government working at a national level is still essential. As strategic mayoral authorities (see section 3.3) expand across the country and are encouraged to take on a stronger leadership role in health, ICS leaders will be exploring different avenues to strengthen relationships between local government and the NHS at all levels of the system – from local to regional.

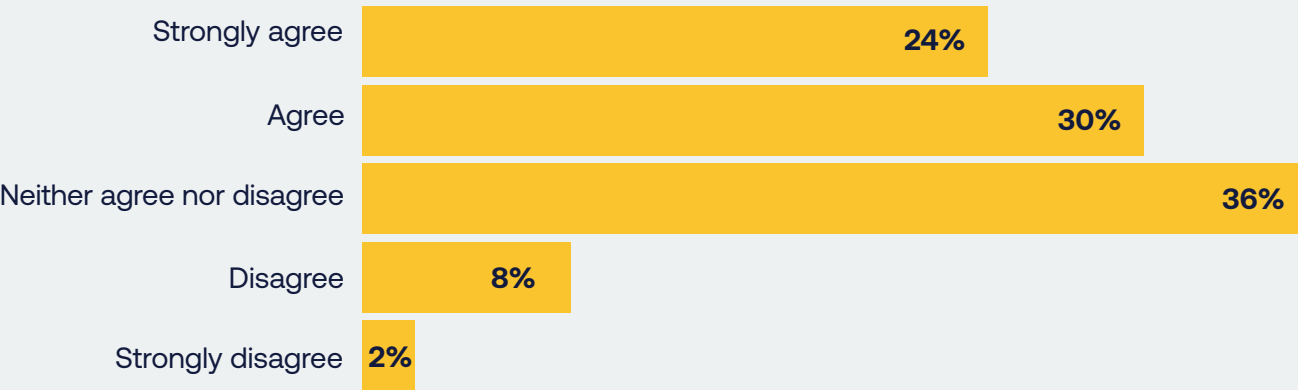
3.2 The impact of local government reorganisation

Through the English devolution and community empowerment bill, introduced in parliament in July 2025, the government intends to replace all two-tier county and district councils with single tier unitary authorities. This presents an opportunity for more standardised and improved system integration.

We asked leaders if the reorganisation of local government, the largest in over 50 years, may present opportunities for more integrated working. ICS leaders expressed a mixed view, with many feeling that it is too early to speculate and will depend on how the changes are delivered. Over half (54 per cent) of respondents agree or strongly agree that local government reorganisation will improve integration and cross-sector working in the long term, while over a quarter (36 per cent) neither agree nor disagree (see figure 10 below).

Figure 10: Local government reorganisation

“To what extent do you agree with the following statement: Local government reorganisation will improve integration and cross-sector working in the long-term (5+ years).”



‘Don’t know/no opinion’ was an option which received no responses.

Source: NHS Confederation | State of Integrated Care Systems Survey 2024/25; n=50

ICS leaders identified some key enablers to integration and cross-sector working: alignment of boundaries where possible, buy-in of local government to health, and the strength of relationships. They also highlighted the risks of organisational redesign, and its potentially detrimental impact to existing relationships and partnership working, particularly as the NHS goes through its own reorganisation.

On the other hand, an ICP chair noted that moving to unitary authorities where housing, social care and public health are managed within one organisation, presents an opportunity for stronger engagement and integrated working on key priorities including prevention. It may still be too early to tell what the long-term impact of these changes will be. However, the scale of change in both the NHS and local government in some areas of the country will likely reduce headspace and capacity for partnership working.

3.3 The expansion of strategic authorities

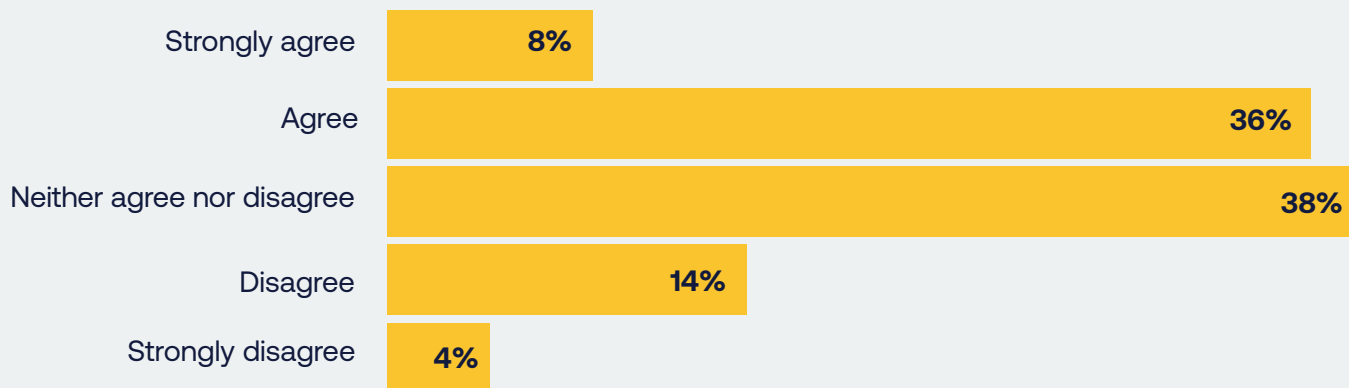
The government announced through the [English devolution white paper](#) its intention to establish strategic authorities across England by the end of this parliament. The English devolution bill further states: ‘Strategic authorities should play an active role in ensuring positive health outcomes in their areas.’ This will include a new health duty for strategic authorities to give ‘regard’ to improving population health and addressing health inequalities when undertaking their role. This, while welcome, is fairly limited in its scope.

The government built on strategic authorities’ role in health in the 10 Year Health Plan. This included alignment between strategic authority and ICB boundaries where possible, mayors sitting on ICBs boards instead of local authority representatives and the development of prevention demonstrators (see case study 3). ICS leaders can see some of the opportunities of devolution. Over two in five (44 per cent) respondents agree or strongly agree that the establishment of strategic authorities will advance the government’s broader health agenda (see figure 11 on page 39).

But there are still many unknowns. Nearly two in five respondents (38 per cent) neither agree nor disagree, suggesting that a large proportion of respondents are still unclear about how strategic authorities will contribute to health. This may reflect local variation with most ICSs not yet having a directly elected mayor in their patch. This raises questions about who sits on an ICB board in areas with no directly elected mayor.

Figure 11: Strategic authorities

“To what extent do you agree with the following statement: The establishment of strategic authorities will advance the government’s broader health agenda.”



‘Don’t know/no opinion’ was an option which received no responses.

Source: NHS Confederation | State of Integrated Care Systems Survey 2024/25; n=50

Some ICS leaders expressed concerns about the onus on individual mayors and the variation in capability, capacity and interest among them to take on this role among their many other responsibilities.

One ICB chair shared that “strategic authorities could be a major opportunity to accelerate integration of health, social care and public health services ... but there is a risk that individual mayors may not prioritise this as much as others.”

Further, mayors do not have direct levers on health and social care services, though their forthcoming new health duty will increase their influence over population health and health inequalities across their footprints. As they increasingly hold levers to influence health, including as members of ICB boards, mayors may benefit from targeted health leadership training and support.

ICS leaders have identified that these further developments should enable improved integration and partnership working by creating an authorising environment to engage with new partners and extend into areas that impact the health and wellbeing of populations. There is an opportunity to align national and local priorities, co-develop strategy that is health-orientated across government, and leverage economies of scale to promote economic, physical and social wellbeing and resilience.

Despite alignment between the 10 Year Health Plan and the English devolution bill, the absence of any reference to ICSs' fourth purpose which connects health and prosperity is notable. As described in section 1, there is a lack of clarity about where this will sit in the new way of working and lower confidence among ICS leaders in their systems' ability to fulfil this purpose, which is consistent with the two previous iterations of this report.

Recommendations to DHSC and NHS England

Model collaboration with other government departments to promote integration between the NHS, local government and wider partners by aligning policy, guidance, legislation and the health and economic growth missions.

Case study 3: Scaling prevention: lessons from Greater Manchester (GM) prevention demonstrator

Overview

Cardiovascular disease (CVD) is the leading cause of premature death and health inequalities across Greater Manchester (GM) with heart and circulatory diseases killing more than one in four people and costing an estimated £2.53 billion annually. GM's stroke admission rate is the highest in the region, with stroke the leading cause of disability, accounting for a significant portion of social care spend and an estimated societal cost of £36 billion per year. Now, GM is positioning itself as a national 'prevention demonstrator', backed by the 10 Year Health and Plan. The community and the health care system are benefiting from a sustained and concerted effort to shift from a sickness to prevention model.

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Vision and approach

The prevention demonstrator is based on the recognition that people need support to address ill health, crime and anti-social behaviour and prevent escalation of social issues, poor educational outcomes or economic inactivity. A cross-sectoral, integrated team provides a local, person-centred, preventative system of care and support in a neighbourhood, joining up health with the full range of local support.

GM has long been leading the way on prevention, having leveraged opportunities arising through devolution, establishing a strong governance structure, the GM population health strategy and a sophisticated, integrated data system.

Delivering the shift: key interventions

GM's CVD need tool, just one of several successful prevention initiatives, demonstrated in year savings of up to £6.2 million and prevented nearly 700 strokes, by identifying unmet clinical need (defined as gaps in good care) using routinely collected GP data. The tool analyses data sets to identify high-risk cohorts needing support, recognising the link between CVD and health inequalities.

Measuring success

Feedback from clinicians has been overwhelmingly positive with one GP commenting that “the ability to highlight patients at greatest prioritisation through the tool has fundamentally changed our approach to call and recall. We would previously try to contact patients twice and then move on, but the demonstration of their unmet need has changed our approach – discussing with patients the benefit of undertaking their reviews and leading to increased engagement.”

While it is widely recognised that prevention is better than cure, through this initiative, GM has been able to address a long-held challenge by quantifying the impact of prevention initiatives.

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Next steps

GM will continue to build its case as a prevention demonstrator, engaging with leaders and chief executives on long-term plans for growth and prevention, including associated outcomes working towards ten-year prevention plans. This includes expanding the CV need tool to address frailty, followed by people with multiple long-term chronic conditions.

4. Delivering the 10 Year Health Plan: rising to the challenge

4.1 ICS leaders are committed to delivering the 10 Year Health Plan

ICS leaders are committed to the vision of a neighbourhood health service set out in the 10 Year Health Plan and are already progressing on delivering the three shifts (see section 1.2). Improving population health, reducing health inequalities and supporting people to stay well out of hospital is at the heart of the ICS mission.

One ICB chair told us that “what I really like about the 10 Year Plan is the fact it started by talking to the public, and so it’s really grounded in what the public want.”

Working closely with their local partners, ICBs are uniquely placed to bring all the different parts of the health and care system together and focus on the purpose of the plan.

For one ICB chief executive, the ICB needs to put residents first: “keep the vision of population health and wellbeing alive” and “create an environment where people can succeed.”

Drawing on their commissioning skills and expertise and building on the partnerships and structures established so far, including at place, ICBs also have an important role in supporting the changes to provider delivery models envisaged in the 10 Year Health Plan. This includes the development of integrated health organisations (IHOs) which can hold capitated contracts and new single- and multi-neighbourhood provider contracts. ICBs will play a key role in commissioning these new contracts from providers.

While ICS leaders support the plan's overall vision, which builds on their own strategies, they highlight the lack of clarity on how it will be delivered, and the need for its proposals to align effectively. Greater join up is needed between different policy areas, from financial flows and accountability to data and digital.

An ICP chair described “clear tensions in the plan in a number of areas, for example whether neighbourhood health management is primarily about changing how we work in neighbourhoods or is more about structures and buildings.”

Around a quarter of survey respondents (26 per cent) think developing IHOs holding outcomes-based contracts will make a big difference to their local communities (see figure 12 on page 46). Some respondents, however, felt that the rebirth of foundation trusts (FTs) may be a “step backwards”, particularly as the 10 Year Health plan sets out that FT status is a prerequisite for becoming an IHO. The characteristics needed to be an effective FT may not be the same as those needed to be a successful IHO which financially binds together partners to jointly deliver acute, community-based, mental health and primary care services and drive population health. ICS leaders would therefore like to see a strong focus on collaboration in the inclusion criteria for the new FTs and IHOs. Closer working with primary care will be particularly important to empower neighbourhood working.

As we await further details on what this new regime will look like, ICBs will need the right levers and support from regulators to drive these changes as well as the freedom to pursue other delivery models such as alliance or lead provider approaches. The development of IHOs will also take time. IHOs are therefore unlikely to provide a solution to some of the NHS's immediate operational and financial changes. The NHS Confederation will shortly be publishing a report on IHOs.

4.2 Enabling care closer to home

Over three in five respondents (64 per cent) think ‘shifting a proportion of health spending into the community by 2035’ is one of three changes introduced by the 10 Year Health Plan that will make the biggest difference to their local

communities (see figure 12 on page 46). Thirty-eight per cent of respondents chose it as their number one change when asked to prioritise among their choices (see figure 13 on page 47). This is consistent with findings from last year's survey which found that the majority of systems had made a strategic commitment to shift resource to allow more people to be treated in their local community.

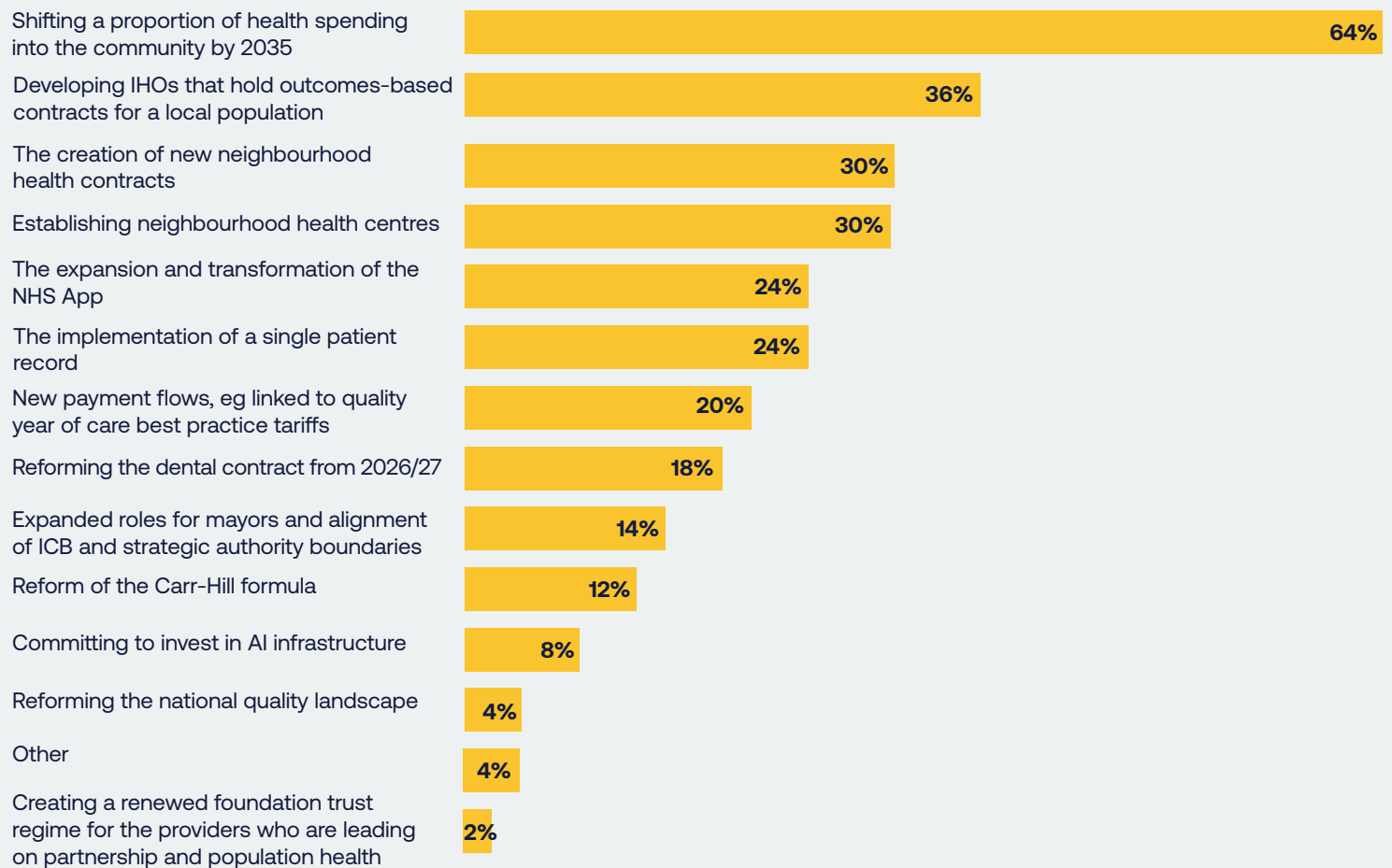
ICS leaders are clear that shifting health spending into the community represents a consequential change for all parts of the health and care system. It is, however, an essential tool to implement a truly preventative approach to healthcare and make the NHS financially sustainable.

An ICB chief financial officer shared that in some cases delivering care closer to home will not always be cheaper but might be “the right thing to do.”

For one ICP chair, it is not just about shifting health spending into community health services but “enabling and empowering communities to be healthy so that they can support each other.”

Figure 12: 10 Year Health Plan

“What three changes set out in the 10 Year Health Plan do you think will make the biggest difference to your local communities?”



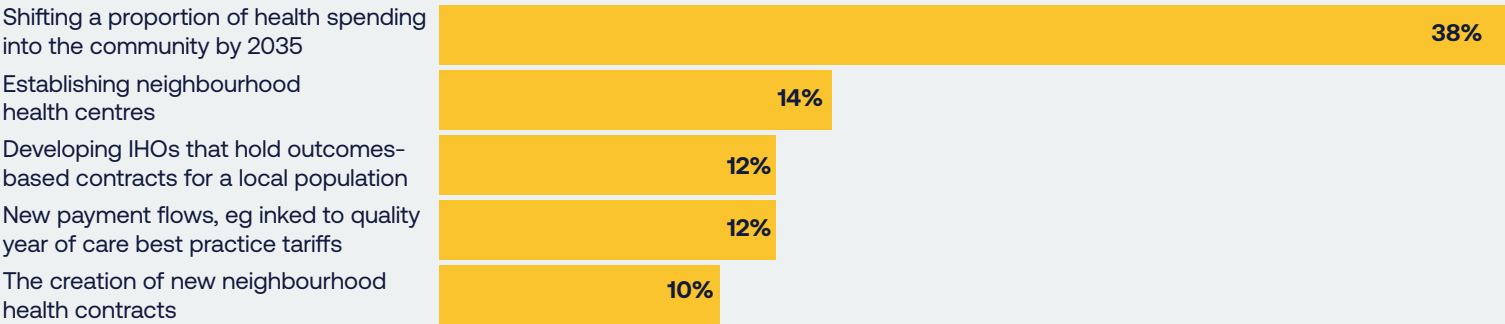
‘None of these’ was an option which received no response.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n=50

ICS leaders are also supportive of the focus on the plan on neighbourhood health, which is underpinned by a shift of health spending into the community. Over one in five respondents (30 per cent) chose establishing neighbourhood health centres and the creation of new neighbourhood health contracts as some of the top changes that will make a difference to their local communities.

Figure 13: 10 Year Health Plan

“Of your top three, what one change set out in the 10 Year Health Plan will make the biggest difference to your local community?”



Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n=50

For one ICB chief executive, delivering through neighbourhoods is one way of implementing a social model of healthcare. It should enable people, through a physical space and/or a team of professionals to receive wraparound, personalised care and be delivered in partnership with local authorities and the VCSE sector. ICBs will be commissioning these new single- and multi-neighbourhood contracts and will play a key role in shaping the establishment of neighbourhood health centres, building on what already exists.

The 10 Year Health Plan’s vision for a neighbourhood health service aligns with how systems are already approaching neighbourhood health.

For one ICB chief executive, these announcements helpfully build on the work they are already doing, giving it “more prominence and a bit more structure around it.”

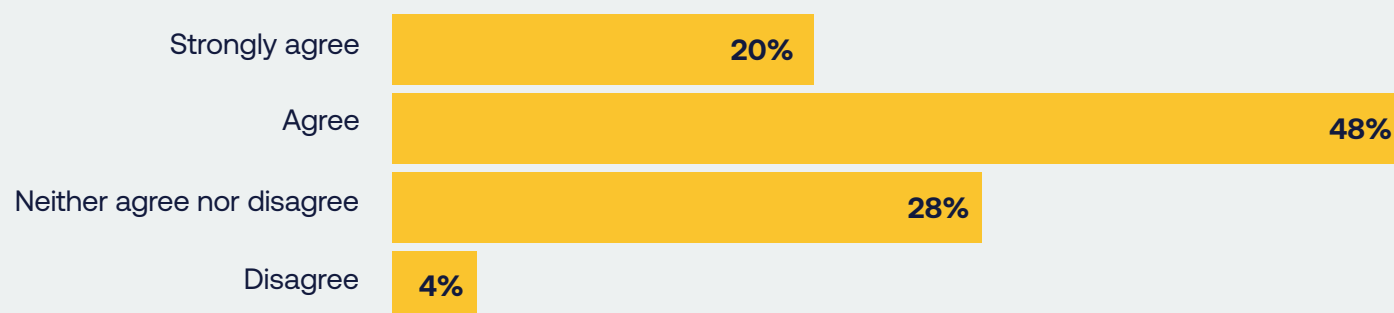
At the same time, one ICB chair warned that “we should avoid having a national model [for neighbourhoods] imposed on every community in the country. They have to be built from the bottom up and avoid destroying the partnerships already established.”

Over half of respondents (68 per cent) agree or strongly agree that their system has a clear plan for supporting the shift to a neighbourhood health service (see figure 14 on page 48). Across ICSs, different neighbourhood models have developed, and ICBs and their partners are focused on how to scale good

practice and implement the plans they have developed. Our previous work has demonstrated a diverse range of approaches, including system-wide approaches, reflecting the important role of primary care and general practice, with communities at the heart of change.

Figure 14: Neighbourhood health service

“To what extent do you agree or disagree with the following statement: My system has a clear plan for supporting the shift to a neighbourhood health service.”



‘Strongly disagree’ and ‘Don’t know/no opinion’ were options which received no responses.

Source: State of Integrated Care Systems Survey 2024/25 | NHS Confederation; n=50

London, for example, drawing on its unique governance arrangements, has developed a target operating model for neighbourhood health, using place-based partnerships to provide local leadership and nominate an integrator organisation which will enable integration at neighbourhood level. In the south west, Cornwall and the Isles of Scilly ICS has invested £6 million a year to develop integrated neighbourhood teams covering approximately 191,000 people and separated across three places. Each place is led by a leader based in the community and mental health trust.

For one place leader, the biggest challenge for neighbourhood development is demonstrating savings in the acute sector to maintain investment: “It’s the right thing to do but, at the same time, everyone’s asking for evidence that no one can really get because it’s so difficult to measure.”

In a financially constrained environment and without the opportunity to double-run, we need to change financial flows to support neighbourhood health and ensure the money follows the patient.

One ICB chair emphasised the need to “unpick all of the block contracts so we can start to properly contract these integrated community-based services.”

All eyes are now on implementation. From September 2025, the DHSC will support 43 places through the National Neighbourhood Health Implementation Programme (NNHIP), to accelerate the work that is planned or already happening in many areas of the country, through learning together, sharing solutions, tackling challenges and delivering improvement. The NNHIP will also be joined up with parallel national 10 Year Health Plan delivery work led by NHS England.

4.3 A new operating model

The government has set out a new operating model for the NHS that aims to devolve power and to simplify the historically complex governance arrangements in the centre and within the system, including a blueprint for the regions. The absorption of NHS England into DHSC, expected to be completed in April 2027, is an opportunity to reimagine the national team and its relationship to ICS leaders. This operating model will be further iterated and supported by legislative change in forthcoming primary legislation.

When asked during interviews what behaviours and ways of working they expect from national and regional teams within the more devolved operating model described in the 10 Year Health Plan, most ICB respondents sought greater autonomy and trust in ICBs and providers to deliver their local plans. ICB leaders also supported the government’s overarching objective to reduce bureaucracy and provide clarity on roles and responsibilities.

ICB leaders want to see improved cultures and ways of working to ensure “clarity, challenge and support” as well as “confidence and commitment to ICBs.”

Implementing the new operating model will take time but a change in the role of ICBs should be accompanied by a change in how they are supported by and work with the government and national and regional bodies.

For one ICB chief executive, there should be “a clear articulation of what the strategic commissioner role will be” and regulators working in “lockstep” with ICBs to make decisions and drive transformation.

Recommendations to DHSC and NHS England

Embed a more devolved, enabling operating model by:

- Providing ICBs with the levers, autonomy and aircover they need to make difficult commissioning decisions to support new service models and shift resources from hospitals to communities.
- Working with ICBs to co-produce the tools they need to effectively discharge their functions.
- Taking a ‘locally-led with national principles’ model to policy development, building on existing work and partnerships, in particular around neighbourhood health.

Conclusion and summary of recommendations

ICSs are going through an unprecedented period of change and the next few months will be crucial to their success. ICS leaders are ready to seize the opportunity for change outlined in the 10 Year Health Plan to improve population health, reduce health inequalities and ensure effective and sustainable health and care services for the future.

Moving away from a hospital-centric health system and towards a preventative approach to health will continue to require strong partnership working between ICBs, NHS providers, primary care, local government and the VCSE sector. The progress made so far should be built on, not lost, during this transition. ICS leaders took on their roles because they believe in the four core purposes and many have recommitted to leading their organisations, inspired by the opportunity of strategic commissioning.

ICBs commission nearly £164 billion of public money (19 per cent of public sector spending in England). To ensure ICBs can deliver on their strategic commissioning role, the government and NHS England need to provide a clear roadmap to delivering the required running cost reductions and ensure they have the capacity and capabilities to succeed.

Close collaboration and communication between ICB leaders and national and regional teams will be crucial to releasing the savings needed and provide much-needed certainty to ICB staff. Regardless of what structures are developed, from retaining ICPs to working in partnership with health and wellbeing boards and strategic authorities, close collaboration between the NHS, local government and wider partners is at the heart of the mission of ICSs.

On behalf of ICS leaders, we make the following recommendations to the DHSC and NHS England:

- 1. Work with HM Treasury to clarify national funding and timeline for ICB redundancies** to either allow ICBs to implement their restructures in 2025/26 or to allow what can be afforded to be delivering this year, with the remainder delivered in 2026/27.
- 2. Deliver clear and regular communication with ICB leaders about timelines, process and expectations for the ICB change programme, equipping them to implement changes effectively and safely.** This should include additional support for ICBs making greater reductions, clustering or merging.
- 3. Support and resource the development of ICBs' strategic commissioning skills and capabilities,** particular attention should be given to their functions as healthcare payers.
- 4. Appoint a senior commissioning lead in the future DHSC national structure, reporting into the director general for system development,** with commissioning expertise to best support ICBs in the future.
- 5. Model collaboration with other government departments** to promote integration between the NHS, local government and wider partners by aligning policy, guidance, legislation and the health and economic growth missions.
- 6. Embed a more devolved, enabling operating model by:**
 - a. Providing ICBs with the levers, autonomy and aircover they need** to make difficult commissioning decisions to support new service models and shift resources from hospitals to communities.
 - b. Working with ICBs to co-produce the tools they need** to effectively discharge their functions.
 - c. Taking a 'locally-led with national principles' model to policy development, building on existing work and partnerships,** in particular around neighbourhood health.

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