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Enabling Integrated Care Systems to work better

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Introduction

Thirty years ago, Alan Langlands, the then chief executive of the NHS, told health service managers that they "should not read all the paper that comes out of the Department of Health". He promised to try to reduce it, adding that "when you have more than 50 priorities, the truth is that you have no priorities at all".

Half a dozen years later a health secretary, Alan Milburn, warned that the "top-down" model of the NHS "cannot deliver for the twenty-first century". The centre of gravity needed to move "from Whitehall to the NHS front line".

Then in 2005 David Nicholson, as NHS chief executive, urged managers to "look out, not up". And in 2010 another health secretary in Andrew Lansley promised that his mighty reorganisation would end the "political micro-management" of the NHS with its "day-to-day political interference".

And as recently as the summer of 2023, Steve Barclay, widely seen as one of the more interventionist of recent health secretaries,* spoke of the need to reduce "top-down national targets, missives and directives".

As these quotes illustrate, the tension between centralism and localism has been one of the recurring themes of NHS history.

The health service's tax-funded nature has made it highly political and that, combined with the availability of ever more data on performance, ever closer to real time, has provided the opposite of a centrifugal force. Not just policy decisions, but monitoring and management, get pulled into the centre, even when almost all former health secretaries, whatever they did in office, agree that there is a limit as to how far the service should be run or managed by ministers or from Whitehall.[1] Indeed, since the mid-1980s there has, in one form or another, been an NHS executive aimed at separating, at least to a degree, the management of the service from the setting of strategy and priorities by ministers.

NHS England, as a statutory board, is the latest and nominally most independent of these arrangements. One of its prime roles is to enable Integrated Care Systems (ICSs), through which the money for most NHS services now flows, to fulfil their multiple duties (see Box 1). Yet talk to chairs and chief executives of Integrated Care Boards, and to the chairs of Integrated Care Partnerships, and the complaints about various forms of micro-management are almost as loud as ever. This short paper, based on interviews with those involved in ICSs, looks at how the new arrangements can be made to work better.

* One of our interviewees said that the NHS joke was that while some health secretaries have wanted to be the NHS chief executive, Steve Barclay was the only one who wanted to be its chief operating officer.

Box 1 **What are Integrated Care Systems?**

There are 42 Integrated Care Systems (ICSs) covering all of England, which vary in size, geography and demography. They are at various stages of development. Almost all work with more than one local authority. ICSs started out as essentially voluntary arrangements but took on a new, statutory form on the passing of the Health and Care Act 2022. And when they did, they were born into a storm as NHS waiting lists, the cost of living crisis, inflation and public sector strikes (including in the NHS) all exploded on to the political agenda.

ICSs are not the simplest of arrangements to explain. They are arguably more of a concept than an organisation and consist of two statutory parts: an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The former is the organisation through which the money for most NHS services now flows, while the latter brings together the NHS, local government, social care, and the voluntary, community and social enterprise sectors to set a 'health and care strategy' for each area covered by an ICB.

The duties of ICSs include improving productivity and ensuring value for money, with ICBs accountable to NHS England for the NHS cash. But their wider aim is to improve population health, reduce health inequalities and improve health outcomes – while better integrating both health and social care (a goal increasingly shared by health systems around the world).

Not all measures to improve population health and prevention are done within ICSs. Some clearly lie with central government – such as housing, welfare and education policy, or the regulation of alcohol, tobacco and unhealthy foods. But much of integrated health and social care, plus more specific issues around housing, schools, green spaces and the like have to be done locally. These simply cannot be done by command and control from the centre, which is where ICSs come in.

The vast majority of ICSs' duties need to be done locally

The introduction of ICSs has not been entirely smooth. Their formal launch in July 2022 saw them born into a storm. NHS waiting lists were rising. Inflation was starting to take off, eating into budgets and creating a cost of living crisis that was likely worsen the health inequalities ICSs are meant to tackle. Repeated industrial action by nurses, consultants and junior doctors was soon to follow. On top of that they faced some pretty arbitrary headcount reductions, while this year they are struggling with one of the toughest financial settlements ever.

The promise to shift control from the centre has not materialised. Chairs and chief executives in ICSs complain of all too familiar frustrations: too many targets; over-reporting back to the centre; money coming out in ring-fenced sums – often in "penny packets" – for specific programmes and which in turn come with extensive accountability and reporting requirements.

Indeed, to the outside eye, it seems remarkable that the NHS regularly gets lumps of ear-marked cash to cope with "winter pressures" when winter, unsurprisingly, comes around every year. Added to that are complaints about Treasury and Cabinet Office controls over expenditure so slow and cumbersome that they create delays and add cost. These are overlaid by a strong perception that something has gone wrong in the relationship between NHS England and a Department of Health and Social Care (DHSC) seen to be taking a greater interest in seeking itself to manage the NHS.

The previous government acknowledged that there is a problem

Four months after the creation of ICSs, the Sunak government commissioned the former Labour health secretary Patricia Hewitt to conduct a rapid review of the new bodies' governance and oversight. Its terms of reference called for recommendations to "empower local leaders... giving them greater control while making them more accountable for performance and spending".

The report called for "greater autonomy for ICSs – including in particular a radical reduction in central targets and top-down performance management together with an increase in financial autonomy and flexibility". The use of "small in-year funding pots with extensive reporting requirements" should end, as far as possible. The Treasury, Cabinet Office, DHSC, and NHS England should seek to produce a simpler, less restrictive approval process for capital, with a move to multi-year revenue budgets.* All that, it argued, would "enable ICS leaders to deliver both short-term performance and longer term improvements in population health".

The report received a somewhat lukewarm response from DHSC. A year on, there has been some formal reduction in national targets and the department says that NHS England has significantly reduced both the number of separate allocations for service development and the level of reporting on them.[2]

But it seems to feel little different on the ground. The local authority chair of one ICP said:

> **"NHS England hasn't really changed. The Hewitt review's plea to government was to stop all this top-down stuff. But I haven't seen, or we haven't experienced, any real change in attitude or culture."**

* A position shared with the Institute for Government. See: *Capital Spending in Public Services: Fixing how the government invests in the NHS, schools and prisons*, 2024, www.instituteforgovernment.org.uk/publication/capital-spending-public-services

The chair of an ICB said the issue is less the number of targets – "there have always been quite a lot of targets" – but more the way it is done:

> **"Everything – but everything – seems to require filling in detailed templates to produce project plans to a specification set by someone at the national level.**
>
> **"Everything seems to involve half a dozen people from the Treasury, half a dozen people from the Cabinet Office, and half a dozen from the department and from NHS England, and you end up having to do things in a way that pleases all these different parties who may all have slightly different objectives and slightly different ways of doing things.**
>
> **"There is just so much governance and assurance, and it just squeezes stuff out. If I signed off, with my board, everything we are meant to sign off, with the proper discussion, we would meet three times a week for 24 hours a day. There seems to be a real fear of delegation.**
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> **"We have created a system that needs trust to work but we probably have less trust than we've ever had in my time working in the NHS. The Treasury relationship has changed markedly. It is much more micro, it is much less trusting and it is a lot more interventionist."**

Or as another interviewee put it: "What the Treasury mistakes for financial control is spending money in small packets." The result "is that the Department of Health is obsessed with holding to account NHS England but that then forces NHS England to hold the NHS to account in a similar and quite unintelligent way."

Wes Streeting, at the time the shadow health secretary, appears to have picked up on this. He said that the NHS appears to have "lots of people holding other people to account".[3] The system is over-administered centrally, even while it is under-managed locally.[4]

When it comes to devolving the money, one interviewee said:

> **"NHS England keeps saying it has plans to do that, but it never actually does because it says ICBs are immature or not quite ready yet. Well, they never will be. It is a self-fulfilling prophecy. Because if you do not give them the power and the resources to do stuff, they won't be able to, and therefore they will fail. I am sure that is not the intention. It is the worry."**

Furthermore, the relationship between NHS England and the department does seem to have changed since the 2022 Act – which, along with making ICBs and ICPs statutory, also gave ministers, through the department, greater powers of direction over NHS England.

Back in 2010, before the creation of NHS England, the core Department of Health, including what was then the NHS executive, had around 2,600 civil servants. The creation of NHS England undoubtedly hollowed the department out, in both good and bad ways.

The managers in the NHS executive left the department for NHS England, as did some senior civil servants, not least because that looked to be where the action was. By 2017, core departmental numbers were down to just under 1,370, including those helping ministers hold NHS England to account. The numbers unsurprisingly rocketed during Covid, but in 2022/3, the latest year for which they are available, the total stood at almost 3,200, more than double the 2017 low.

The numbers are not easy to interpret given other changes in the 2022 Act, which included the abolition of Public Health England. That brought perhaps 900 of its former employees into the department in the shape of the Office for Health Improvement and Disparities.

But the NHS policy and performance group within DHSC employed well over 600 civil servants last year and the department's recent advertisement to re-appoint a director of urgent and emergency care describes the job in a way that sounds much more like an operational delivery role than an oversight one – when NHS England already has such a post. The charge against the centre is that the degree of 'man marking' and second guessing of NHS England by the department has risen, while departmental requests to trusts and ICBs for data on performance issues leads to duplication of effort and wasted time and resource.

One senior NHS figure said: "Does the department have an operational delivery role? The answer is it doesn't. But it thinks it does. Increasingly it thinks it does." Indeed, the former health secretary Steve Barclay installed a screen in the secretary of state's office that runs SHREWD, a near real-time data app that shows the pressure on urgent and emergency care, including, for example, waiting times for A&E and where ambulances are queuing outside hospitals. This is the type of data used locally to manage the system but about which a minister can do nothing on a day-to-day basis.

All this implies that the inevitable pendulum between central control and local initiative and freedom has once again swung too far towards the former. What that produces, we were told, is duplication along with delays to service changes and developments as multiple business cases have to be made. Ministers now personally sign-off new small – 40 to 50-bed – units. Mobile dentistry vans, based on the experience of the use of one in Cornwall, have been pressed on more rural ICSs – even where the ICB, which knows its local area, thinks it could get better value in other ways for the small sums of money involved. Women's health hubs are being established as a ministerial initiative. One for each ICS at a cost of £25 million over two years – which sounds impressive until one realises that it translates to just under £300,000 a year per ICS, but with no guarantee of funding after that.

Plans for community diagnostic centres, aimed at cutting waiting times, have had to be scrapped and resubmitted where they did not meet a national specification that at times changed. Meanwhile, the much-vaunted promise from 2019 of 40 'new' hospitals – for which nothing like full capital has been committed – has been so bogged down in business cases and revisions that there is serious doubt whether any at all will be completed by the original 2030 target.

A dose of hard-headed realism is needed – both ways

Nobody much likes being managed. Complaints about what comes down from the centre, whether in the private or public sectors, are far from restricted to the NHS. There can be an element of indulgence here: "I could do my job better if only they would leave me alone," with blaming up being a substitute for action and responsibility.

The brute truth, however, is that the NHS is a tax-funded service and ministers are accountable for its performance. They are subject to complaints and pressure from MPs and patient groups and they need to respond to the media. They are bound to have priorities.

Furthermore, aside from any current issues, it is the politicians who, for good or ill and from time to time, reshape the way the service works – sometimes significantly: whether by introducing market-like mechanisms, rowing them back or reintroducing them; cutting or expanding the intermediate layers; accompanying a big increase in spending with rigidly managed performance targets; or, by reshaping the entire structure in an attempt to end the 'political micro-management' of the NHS.

Nothing quite so pure as that vision was ever going to happen. Furthermore, it is inevitable, given the state of NHS waiting times and waiting lists, that ministers will take a direct interest in the mechanisms for getting them down – an interest in new ideas as well as old, proven ones, which, aside from lots more money, included in the 2000s a large dose of performance management.

Any incoming secretary of state will, for a good time to come, want to pull all levers available to tackle that issue. Indeed, some of those we spoke to pointed to the deteriorating performance on waiting times prior to the pandemic as the start of the period when the relationship between NHSE, DHSC and the Treasury began to decline and centralism reasserted itself. It is far easier to 'let go' and allow local initiatives when things are going well than when they are not.

But the hard truth the other way is that the NHS cannot be run effectively by command and control from the centre. Waiting times cannot be cut sustainably merely by focusing on what goes on in hospitals. They are affected by what is happening in primary, community and social care and by what is being done to reduce the need for hospital treatment in the first place. The better integration of health and social care, the improvements in population health and the reduction of health inequalities cannot be achieved by fiat. They require what ICSs were set up to do and includes their partnership working with local government, other agencies and the voluntary and community sectors. In other words, ICSs need to be enabled to do their job.

So what might be done?

An incoming government has the chance to recast a whole set of relationships. Between the Treasury, the Cabinet Office and DHSC; between the department and NHS England; and thus between NHS England and ICSs.

This involves not a change in structures, but a change in behaviour. This will require the whole-hearted commitment not just of the new health secretary but the chancellor and the prime minister too. The case for the Treasury reducing its micro-management of spending, delegating more to departments applies across government, not just in health and social care, as was argued in a recent Institute for Government report.[5]

With that, the relationship between NHS England and the department, and thus between NHS England and ICSs, looks in need if a revamp. Essentially, an incoming secretary of state, amid the obvious priority of seeing waiting times fall, needs to ask themselves – and the senior figures in both the department and in NHS England – week in week out: "What are we doing, this week, to enable ICSs to function better and what could we stop doing that is getting in the way of that?" There will not, of course, be weekly progress. But the aim will be to ensure that the centre progressively does less, thus freeing up the ICSs to innovate more.

In putting this proposition to those we interviewed, the response was that this was not an entirely daft idea. We were told: "It would require quite a sophisticated secretary of state". Another interviewee said: "I don't think it is naïve but it would be highly aspirational. It would need to be done at the start of a government. This sort of behaviour is hard to change, and it does require that sort of persistence."

Labour, at the start of a new government, has quite rightly made it clear that it is not interested in structural change to the NHS. But if Integrated Care Systems are to fulfil their potential, what is needed is a change in behaviour, and a mechanism to achieve that – plus the changes in the relationship between the Treasury and DHSC outlined above.

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