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People, partnerships and place: How can ICSs turn the rhetoric into reality?

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When the NHS was established almost 75 years ago, it was a service focused very much on episodic treatment. Changes in demographics, patterns of disease, treatments and technologies have created a need to establish a more joined up, co-ordinated and collaborative health and care system. The quest to establish such a system has been a near constant over the past three decades. And while efforts have been made, progress has been slow.

Integrated care reforms have tended to centre on creating new structures and governance arrangements across health and social care in the hope that more collaborative service delivery would naturally follow. For too long the rhetoric has focused on improving people's lives through better co-ordination of services and care closer to home, while the reality has remained as a fragmented system dominated by the acute sector, with patients and service users stranded in the gaps.

While reforms have explored different approaches, they have so far been insufficient in substantially addressing the culture, norms, systems and processes needed to support integrated ways of working and fundamentally change the way services operate.[1]

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Since the introduction of the internal market in the early 1990s they have also operated alongside policies relating to competition and choice, and although it can be argued that collaboration and competition are not mutually exclusive, in practice the tension between the two has been real.

A new era of integrated care arrived in England in July 2022, when 42 integrated care systems (ICSs) went live as statutory entities responsible for integrating NHS, local authority and other services and for improving population health and wellbeing. While ICSs, and their predecessors in shadow form, have existed informally since 2016, it is only now that they have been legally enshrined and taken responsibility for the majority of the NHS's operational budget. Beneath these 42 ICSs, the practical design and delivery of integrated care in most systems will be driven at place level, largely in line with health and wellbeing board geographies.

But given the longstanding history of this policy area, it is perhaps not a surprise that many practitioners are sceptical about how and why efforts to improve integration this time will be any different. Structures and organisational charts are evolving, but it is unclear yet what and whether real change will follow. And while the latest legal reforms may remove some of the financial and legal hurdles that persistently get in the way of partnership working, integration will only improve if people who deliver services do something different as part of their day jobs. Good practice exists in many pockets across the country, but it is yet to be mainstreamed and sustained. More work and focus are needed to tackle the deep-rooted challenges that make more collaborative ways of working difficult.

This project aimed to understand the perceptions and experiences of people working and leading health and care services on the risks to the current integrated care reforms. Sense-checks like this can help establish the common ground on integration at the place level (even if it is only the things which are difficult), as well as help send clear signals to system and place leaders and policy makers on where more attention might be needed to achieve the potential for integration.

To understand these perspectives, we hosted a series of roundtable workshops with over 50 stakeholders representing different perspectives, asking them to think about what integration at the place level could look like and what might need to change to realise that vision. The workshops took place in the

months leading up to the Health and Care Act 2022 legislation and when ICSs became statutory entities in July 2022. While progress will have been made in developing place-based partnerships since then, our ongoing conversations with individuals suggest that the same risks and challenges still apply. Stakeholders included:

- general practitioners (GPs) and the wider primary care team
- acute hospital consultants
- community health care providers
- social care providers
- voluntary, community and social enterprises (VCSEs)
- patients and service users
- system and place-based leaders
- regulators
- academics.

In this briefing, we start by discussing what we mean by integration and place, and how the ambiguity inherent to these concepts contribute to the challenges in making them a reality. We then draw on the learning from the roundtables to describe five main risks to integration that appear to remain unresolved by current reforms. These risks are:

- embedded culture and behaviours and inter-organisational power dynamics
- organisational complexity, duplication and overlapping focus
- resource constraints
- difficulties in defining, measuring and evaluating integration
- integration fatigue.

We conclude by offering some suggested approaches to mitigating the risks, which should be the focus of system leaders as partnerships take hold. These include:

- ways of building integration into the day job
- bringing clarity to the complexity of governance structures
- better use of performance management, metrics and data
- fostering culture change through greater mutual understanding
- rebalancing capacity, including management capacity.

Definitions and context

What do we mean by integration?

Before we discuss the current impediments to integrated working, it is helpful to first discuss what is meant by the term 'integration' and what desirable outcomes of an integrated system might be. Many of the challenges we discuss and that have been raised by roundtable participants stem from integration being a nebulous concept that has different meanings in different contexts.

Integration is not so much a service intervention that can easily be lifted from one place and applied to another. It is rather a web of systems, processes and behaviours that influence how different teams, professions and organisations work together, the outcome of which is a coordinated service delivered to meet the needs of patients and service users. It refers to both how the NHS works with broader services – like social care, housing and the VSCE sector – as well as how the NHS works within itself (e.g., between primary and secondary care services).

Although there is no one definition for what integration looks like (indeed, recent guidance has been careful not to be prescriptive in how local partnerships establish integrated ways of working), there is more consensus on what the vision is for integration in the NHS since 2013 onwards.[2] This has been articulated in the Health and Social Care White Paper and builds on the goals for integration set in the NHS Five Year Forward View, the NHS Long Term Plan and the 'I Statements'*. Table 1 on the next page summarises these key visions for integration in English health policy that form the basis of the latest reforms.

* The "I Statements" originally developed by National Voices and TLAP provide a narrative for what good quality integrated care looks like, from the point of view of anyone who needs access to multiple services over time. They were adopted as a national definition for integrated care by all the system leading bodies in England, including the Department of Health in a national 'shared commitment' document.

Table 1. Key visions for integration from previous decade

Policy and year	Vision
Integrated care and support – Our shared commitment and narrative for integrated care 2013	Set out shared vision by Department of Health and 12 partner organisations to make integrated care the norm by 2018. National Voices and Think Local Act Personal (TLAP) co-developed a narrative for integrated care and support would look like from an individual's perspective: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."
The Five Year Forward View 2014	Set vision for new model of care delivery and commissioning that would reduce inequalities and shift more services out of hospital and into the community. Led to the establishment of Sustainability and Transformation Partnerships intended to close three widening gaps: • Health and well-being • Care and quality • Funding and efficiency.
The NHS Long-Term Plan 2019	Set vision that integration and place-based care would be central to how the NHS would accelerate progress in improving health in early childhood years, early diagnosis and prevention of major health problems, and support for people to age well. Accelerated development of ICSs to bring together local organisations to redesign care and improve population health, creating shared leadership and action.
Integration and innovation: Working together to improve health and social care 2021	Establish ICSs as legal entities, intended to: improve health and care outcomes • tackle inequalities in outcomes, experience and access • boost productivity and value for money; and • support broader social and economic development.

The terminology relating to ICSs can be confusing. The Health & Care Act 2022 established integrated care boards (ICBs) and integrated care partnerships (ICPs). The ICB will take on responsibilities previously held by clinical commissioning groups. They bring together local NHS commissioners and providers and local authorities with responsibility for social care with a core statutory function of arranging health services for its population. The ICP is expected to have a wider membership including public health, local Healthwatch, the VCSE and others, and is responsible for developing an 'integrated care

strategy' to which the ICB and local authorities must have due regard when developing their service delivery plans. The intention is that ICSs will promote equal partnership between the NHS and local partners – a consistent challenge in previous integrated partnerships in England. In this report the term 'integrated care system' is intended to encompass the roles of both ICB and ICP.

What do we mean by 'place'?

Another complicating factor is the different levels of the system in which integration takes place (see Box 1 below). ICSs are hugely heterogeneous, with populations varying from roughly 500,000 to 3 million and geographic footprints relating to varying numbers of local authorities and provider organisations. While ICSs are expected to oversee the development of services within their patches and to directly implement strategic change at a large population area, the expectation is that much of the heavy lifting on integration and bringing together of actual services will happen at a more local level, so our roundtable discussion largely focused on the challenges and opportunities of delivering integrated care at 'place' level.

Box 1. Planning levels for integration

The different planning levels within ICSs have been set out in the White Paper 'Joining Up Care for People, Places and Populations', which includes the following definitions.

- Individuals: for people wanting to live lives which are as healthy and independent as possible, their communities, for carers and families
- Neighbourhood and communities: areas covered by, for example, primary care networks and their community partners
- Place: a geographic area that is defined locally, but often covers around 250–500,000 people, for example at borough or county level
- System: usually larger geographies of about one million people which often (but not always) cover multiple places
- National: in this case, the whole of England

Source: Department of Health and Social Care (2022), Health and social care integration: joining up care for people, places, and populations

Defining 'place' is not straightforward, and indeed guidance published by NHS England and the Local Government Association states that 'there is no single approach' for how and at what scale partners should come together to work in an ICS.[3] In general, a place would be expected to have a geographic footprint which is meaningful to local people, not necessarily defined by NHS administrative boundaries – although pre-existing relationships between NHS services may be considered. The critical point is that the local definition of 'place' is agreed by local partners. In many cases place will be defined using the existing health and wellbeing board footprint.

Partners in a typical place are likely to include:

- NHS trusts (hospitals, community services, mental health services)
- Primary care networks (PCNs)
- Local authorities (both first and second tier)
- Social care providers
- VCSE organisations
- Wider public service providers (e.g housing, education, etc).

Each place is expected to establish clear governance arrangements and lines of accountability to support effective delivery of shared outcomes and make clear the relationships with the ICS and relevant council(s).[4]

The risks and challenges for integration at place level

Five key risks stood out during roundtable workshops as common across all or almost all stakeholder groups. Place leaders will need to consider these risks and approaches to their mitigation as they develop their plans. These are as follows.

1 Embedded **culture and behaviours** and **inter-organisational power dynamics** act against the development of place-based approaches that are genuinely owned by all relevant partners. This relates to both relationships and ways of working between the system and place (e.g. NHS England and place-based leads), as well as across teams and organisations within a place (e.g. acute and primary care organisations or NHS and social care).

2 **Organisational complexity, duplication and overlapping focus** – including the simultaneous development of multiple partnership structures and the existence of large providers spanning multiple ICSs – which can lead to uncertain goals and misaligned incentives.

3 **Resource constraints** – whether revenue, capital or capacity (including but not limited to workforce capacity) – limit the ability of the place to implement change and in particular to develop multi-disciplinary working, i.e. the design might be right but the ability to act is missing.

4 **Difficulties in defining, measuring and evaluating integration**, and limitations of existing data constrain our ability to describe and measure the impact of change and ensure appropriate incentives.

5 Staff, fatigued by the Covid-19 pandemic and by inexorable operational pressures, are also suffering from '**integration fatigue**'.

These risks overlap with each other. For example, poor use of performance metrics is likely to exacerbate issues relating to resource use and loss of power. Consequently, there is also overlap in the potential mitigations. In this section we describe each of the risks, and then propose some actions which ICS and place leaders may take to address those risks collectively.

1. Culture and behaviours

The need for more collaborative culture has long been understood as key to integration – with many frameworks and principles established over time on what this should look like in practice, at both organisational and practitioner level. Although many places are making good progress on this, several factors are still at play that may undermine the ability for local partnerships to function well at place level.

Power and scale imbalances across and within sectors

While ICSs and place-based partnerships are intended to promote equal partnership between the NHS and its wider partners, there is a risk that new structures continue to focus inwardly on NHS aims and objectives set at the organisation level at the expense of collaborative working. While new health and social care partnerships at the ICS level have a statutory basis, they are still composed of independent organisations from the NHS, local authorities and VCSE sector partners that each have different priorities and must work within broader system objectives and accountability structures.

Stakeholders reflected how historical efforts to integrate working have suffered when the NHS has set the terms for transformation and strategy, with partners from local authorities and voluntary sector organisations expected to "fit in" rather than be given equal representation in decision-making. This can lead to over-medicalised solutions – for example, if discharge processes focus more on medical management than supporting people with daily living and accessing their community. It also leaves out the rich expertise of local government, social care and voluntary sector organisations who often have deeper roots into communities, with longer histories of tackling inequalities and organising services around an individual. A number of roundtable participants expressed fears that within the current system architecture, NHS-led ICBs will be afforded greater influence and precedence than ICPs, which could sideline local government and other system partners while undermining efforts at the place level to reduce inequalities and improve population health.

"Councils invest a lot in communities and already have an infrastructure and an architecture for place-based working and community involvement in place. There's a risk that integration leads to re-invention in the NHS rather than leaning into the potential that's already there."
(Place-based lead)

"There's a risk we drift back into a medical model for social care. Our job [as voluntary sector organisations] is to turn upside down the conversation that's going on in ICSs at the moment, which is very system, hospital-based and not a conversation based on a real appreciation of outcomes. That's what sat behind its conception but not happening yet."
(Engagement lead, charity organisation)

Integration therefore requires a mutual appreciation for who does what best in the system – and which services are best placed where, which may require redistributing power and responsibilities previously held in one organisation to another. Without broader culture change and incentives, power and ownership over place-based decisions and strategy will likely remain with the NHS at the expense of developing more collaborative working. There are positive examples of trusts working to co-create more collaborative cultures

at place level and deliberately stepping back to allow other partners to lead partnership arrangements.[5] However, the relative power of acute hospitals in a place is often a virtue of both their relative size – being often the largest organisation in terms of both budget and management resource – and the relative priority given to the performance targets which are measured in the acute sector.

While supporting a more permissive membership structure for place-based partnerships was unanimously welcome, few participants from the primary care, local authority and voluntary sectors felt that on its own it would be sufficient to correct these power imbalances and avoid decisions being dominated by the organisational needs of acute hospitals.

> "Not-for-profit providers feel locked out of strategic planning in many systems…In the areas where there is joining up of services or involving social care in planning, integration will work. But there are many areas where this isn't happening […] this won't change unless social care providers are given a mandated voice in the new systems. [It] currently feels very NHS-acute health dominated, and a lot of social care providers still feel very dictated to and that's the culture that needs to change."
> **(Chief executive, social care provider)**

Stakeholders reflected how difficult it can be to achieve this power shift in the face of funding pressures that leave organisational leaders protective of limited resource (see section on financial imbalances below). There are some parallels between the challenges experienced by the VCSE sector and by primary care organisations. In both cases multiple small organisations have limited management resources compared to large acute providers, and can be vying for available funding – which also impedes progress against collaborative working and requires a longer-term cultural shift:

> "We are used to a culture of competitiveness in the VCSE [sector] and holding onto to whatever limited funding we have – so culture change towards collaboration within the sector will also take time."
> **(Policy manager, charity organisation)**

VCSE participants remarked on the tendency of statutory bodies, particularly within the NHS, to view the VCSE sector as 'one', and not account well for differing priorities and pressures that affect each organisation differently. This is not a new challenge and has been well-documented for years.[6] But as places and ICSs develop, it will be important that they are mindful of these dynamics and work more intentionally with VCSE sector partners and ensure that resources are better aligned with overall needs of local populations and communities.

The ability to form relationships, establish trust and counter power imbalances is also challenged by overlapping geographical boundaries and the fact that trusts, local authorities, VCSE and community providers are often working across multiple places. Some local authority roundtable participants commented that this can create added complexity for councils in forming partnerships and working out how best to organise limited resources and workforce. But there is hope that as places develop, the voices of local communities and partners will be strengthened:

> "Local authorities often have to interact with multiple ICSs that are built around hospital acute systems, but not around communities. This brings all sorts of complexity in terms of how we develop relationships… but the solution is local working and subsidiarity– this is the level where we all come together. Right now, so much of the conversation isn't on the right thing still – the voices of care workers, residents, families aren't in the ICS discussion, but there is a chance to bring it into the place-discussion – and that's where our focus should be." **(Council lead)**

The same also applies for trusts working across several places and/or systems, which limits leadership bandwidth and makes it difficult to align strategic priorities.

Balance between central and local control

Ensuring that place-based partnerships are rooted in local needs will also require new relationships between the centre and local systems, and roundtable participants noted this as another key cultural barrier that may hold back the delivery of place-based partnerships.

Participants noted the consistent tendency – particularly when resources are pressured – for NHS England to default to a performance management approach, often targeted at individual organisations and leaders, to drive outcomes and change. This creates a dynamic where NHS organisations and leaders often feel more accountable upwards than outwards to their communities. Some stakeholders reflected on the way assurance requirements and performance management from NHS England have undermined the ability for local partnership relationships to develop, with the need to reassure upwards often blocking genuine innovation and cutting into limited bandwidth to make changes at the local level.

> "There's a real question as to whether we'll get to a culture where we're moving away from national dictation of what should happen at the local level to one of subsidiarity."
> **(Place lead)**

Stakeholders feared that if these cultural tendencies stay the same, places would be reluctant to be open and transparent about what they perceive as internal shortcomings and challenges – lest it invites greater external scrutiny of partnership working.

This makes getting subsidiarity and striking the right balance between flexible autonomy and standardisation one of the biggest risks – and opportunities – of the new reforms. There is a recurring tension over which decisions are best made at which part of the system within the NHS, and long history of rhetoric for devolution that has not been followed up. Stakeholders remarked on the need for greater clarity about what will be done nationally versus at the ICS level, and by ICSs or places. This does not mean relinquishing all decisions to local place – there are some things that should be done at greater scale. At the same time, participants agreed that for place-based partnerships to flourish, subsidiarity needs to be embraced from the centre with less control of what integration should look like and how it should work locally.

For its part, NHS England has acknowledged these tensions and committed to reforms from within that better support local systems. The legal enshrining of ICSs coincided with the announcement that NHS England will establish a new operating model and reduce the number of its staff by 30–40% in order to take on a more focused role in the system.[7] This transition is now underway, but many questions remain about what NHS England is going to be and how it will delegate its functions.

A key motivation for the changes is to free up more space for ICSs to lead at a local level and assume greater responsibility (and accountability) for decision-making in their communities. But even as ICSs take hold, participants voiced concerns that some decisions – such as around capital spend – are still being micromanaged by NHS England, and risk perpetuating command and control dynamics while diminishing the ability for place-based partnerships to deliver change.

There is also a risk that as ICSs mature, they become the new 'centre' that fails to devolve leadership effectively to place and the front line teams at the centre of integrated care delivery. In November 2022 the government initiated an independent review into the oversight of ICBs (led by former Health Secretary Patricia Hewitt) to advise on how these newly established bodies can best function with autonomy and accountability.[8] Regardless of the outcomes of the Review, it will be imperative that ICSs have the skills and capacity to build relationships and trust at the place level and manage performance challenges in ways that do not recreate the behaviours and culture that came before them.

2. Organisational complexity, duplication and overlapping focus

Alongside the development of ICSs, other partnership and delivery structures that sit within or alongside these bodies are also forming and evolving. These include (but are not limited to) the development of PCNs, provider collaboratives, clinical networks and the ICS itself.

The picture which emerges is one of overlapping structures and partnerships that are not fully aligned. This is consuming the scarce time of clinicians and managers who are already fully engaged with doing their day job. The narrative for each structure is often poorly developed and understood differently by different participants, and accountabilities remain unclear. Participants highlighted provider collaboratives and PCNs as two areas where the ambiguity of how these partnerships fit within broader integrated structures may hinder progress. That said, it remains important to reach clarity at a local level – given the variation between systems, the risk is that a single nationally defined approach would simply add more complexity.

Provider collaboratives and other forms of provider networks

Provider collaboratives have been developing organically over time, with trusts opting to coordinate activity and work together to address common challenges, for example through joint procurement, delivering shared clinical support services (e.g. pathology), or consolidating clinical services.[9] In recent years, NHS

England has set out expectations that all NHS providers should be engaged in formal collaborative arrangements across a wider geography, and these expectations go well beyond the sharing of back-office functions. This, as with the creation of ICSs, is reflective of the shift in national policy direction away from competition as the main driver of improvement enshrined in the Health and Social Care Act of 2012. National guidance has set minimum expectations for these collaboratives but these have supported flexibility in how trusts agree scope and priorities. The development of provider collaboratives, in parallel with the development of ICSs, has resulted in wide variation in the way that provider collaboratives define their aims and the function they have across the acute, mental health and community sectors. It is not clear at a national level that the two policies are fully aligned, and this has contributed to the complexity to be tackled by local leaders.

Box 2. Minimum requirements for provider collaboratives

Provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience by, for example, providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, cancer alliances and clinical support service networks. Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems."

Source: NHS England (2021), Working Together at Scale

This openness from NHS England on how provider collaboratives are implemented locally has been welcomed, but the downside for system leaders is how to navigate the complexity of working across a range of different partnership arrangements. Many trusts are already part of pre-existing collaborations like cancer alliances, while also forging new partnerships with wider stakeholders like primary care, each with their own governance structures.

Participation in too many partnerships risks spreading both clinical and managerial resource thinly, and potentially creating tensions where the goals of different types of partnership are not fully aligned – a concern echoed by NHS provider organisations that could constrain the benefits of these collaborative arrangements.[10] A particularly important tension is that between a provider collaborative and place. This goes beyond the issue of spreading limited capacity too thinly to become a question of unclear accountability. If places are to lead health planning and delivery locally, then their relationship with provider collaboratives requires much clearer delineation by local leaders.

To some extent, the distinction lies in that between vertical and horizontal collaboration. Provider collaboratives (and PCNs, which are discussed further below) are largely examples of 'horizontal' collaboration between similar types of organisation, whereas place-based partnerships are intended to deliver 'vertical' collaboration between organisations operating at different points in the system.

In addition to the establishment of provider collaboratives, there are many existing providers who operate across much larger geographies than place, or even ICS footprints. These include not only providers of very specialist services, but also organisations such as ambulance trusts, whose services are integral to local pathways of care. For these organisations, there is a real tension between the need to deliver services which are responsive to local needs, and the need for an appropriate degree of organisational consistency in order to deliver economies of scale.

Primary care networks

The complexity of existing arrangements also relates to PCNs and how they collaborate effectively within place-based partnerships. PCNs are primary care service-delivery organisations intended to enable primary care services to work more effectively and improve their ability to recruit staff, manage facilities and finances. PCNs are also intended to work with community, social and VCSE services to realise the potential of the full primary care team. There

have been previous attempts to enhance capacity and scale within primary care, such as the development of GP federations, but the establishment of PCNs is the first time a consistent approach has been mandated across England.

NHS England recently commissioned the Fuller Review to assess how ICSs and primary care would work together to improve care for patients, leading to a comprehensive set of principles for the development of primary care at a neighbourhood level.[11] However, getting the relationship right between primary and acute services will be essential for places to function well. Currently there is broad variation in how well PCNs operate within themselves, and especially in how they engage with local acute providers and other local partners. Some general practice participants expressed concerns that primary care providers are not seen as trustworthy because they are private entities and lack scale, which has been a roadblock to effective collaboration in some areas. And where greater scale has been achieved, participants questioned whether it had also resulted in greater efficiencies and leverage – and felt that more thought was needed about where and how PCNs add value alongside other partnership arrangements:

> "We keep hearing that at scale is the answer – but with PCNs scale is generating further bureaucracy. There is no blanket answer and will depend on the service." **(GP)**

Some of the challenge for PCNs connects to conflicting views and expectations of their purpose and role within a place. General practice leads spoke to the challenge of balancing demands at the system level that PCNs will deliver population health management and drive integration locally with member expectations that the core role of PCNs is to improve the sustainability of general practice and deliver greater economies of scale. It requires significant headspace and resources for PCN clinical directors to navigate these competing roles and engage practices to support better business management while also forming productive alliances with broader community partners and system leaders. This can involve balancing responsibilities as far-ranging as introducing new roles like social prescribers while developing local strategies for tackling health inequalities and reaching overlooked and disadvantaged communities. These dual objectives have meant that some PCNs feel they are under-delivering on both fronts.

Each place will have PCNs that look different, but fundamentally there are risks that unless places think carefully about how best to support PCNs with organisational development, population health management and workforce development, on top of the resources needed to do the daily job of seeing patients, very little will be achieved in terms of meaningful local service integration.

3. Resources, funding and capacity constraints

Integrated care reforms have consistently been constrained in the UK and elsewhere by the broader context in which they take place. For example, in England historically, the Payment by Results incentives have inhibited the creation of services that span the primary/secondary boundary. Below we discuss new emerging financial and practical challenges that may limit place-based partnerships and their ability to drive change.

Deficit environment and ever-growing demand

ICSs and place-based partnerships have been developing at a time when the NHS is confronting real-terms cuts to deal with inflation while being expected to deliver savings of over £5.5 billion (around 5% of total system allocation) – many multiples above the 1.1% productivity growth target set in the Long Term Plan.[12] The recent Autumn Statement[13] increased funding by £3.3 billion a year from April 2023 over the next two years to help services cope with inflation, but this is only about half of what is likely to be needed, and does not make up for the £2.5 billion worth of inflation and unexpected cost pressures the NHS has already endured this financial year.

This means that services will have to deal with ongoing pressures from Covid-19, rising levels demand for care and rising A&E attendances, all with substantially less money. Add to this extreme staffing pressures, with vacancies reaching an all-time high and numbers of staff leaving the health and care workforce on the rise. All of this will make investing in public health and prevention very difficult, and it is likely that the NHS organisations will have to make staff and service reductions just to break even.

> "We're in a deficit environment and will be for some time." **(Acute consultant)**

These pressures are if anything worse for local authorities, where real-terms budget cuts have undermined aspirations to facilitate development of innovative models of care and support more collaborative service delivery. Over a decade of austerity has seen government funding to councils reduced by over 60% and that has had a knock-on effect on spending on services related to social care and public health. Social care spending (despite some lessening of austerity) in the year prior to Covid-19 still had not returned to 2011/12 levels in real terms.[14]

Financial pressures have left the social care provider market in a fragile state, with frequent and sudden exits of providers who struggle to remain financially viable.[15] Severe workforce shortages also contribute to the fragility of the provider market – which is characterised by low pay, poor conditions, low status and insecure contracts alongside competition from other industries. These challenges have exacerbated delayed discharges from hospital and undermined a genuine shift to more proactive services and community-based alternatives of care.

This challenging climate may create a 'burning platform' from which to drive change and an incentive for all parts of the system to work better together to make the best use of limited resources. However, implementing integrated care takes resources, infrastructure, staff and, importantly, headspace – all of which are hard to come by in periods of financial difficulty. Stakeholders worried that there is a big risk that these financial circumstances undermine integrated service delivery at the place level, as places will need ICSs to financially back the changes they propose once holding system wide budgets.

"ICSs won't come with a great deal of resources, those are already committed within organisations... So we need to trust enough to think about resource differently. We don't listen to the people that are recipients enough, we don't listen to providers enough and the system doesn't allow that...Our job [as system leaders] is to turn upside the conversation that's going on in ICSs at the moment, which is very hospital focused and not a conversation based on a real appreciation of outcomes. That's what's sat behind the conception of integration but is not happening yet."
(Place lead)

One of the most consistent findings of previous evaluations of integration is the need for upfront resources and enough budget for new integrated service models and ways of working to double-run alongside existing systems.[16,17] Integrated approaches need time to mature and find their footing before other ones are switched off. There is a risk that under current plans, places will be expected to redesign services "in flight", which is unlikely to give teams the best chance at adapting and developing new ways of working that can be sustained.

Financial pressures can also perpetuate cultural challenges and make it exceedingly difficult to redirect or reallocate control over very scarce resources. Indeed, since 2015, trust spending plans have almost consistently been overspent by the region of £2 billion each year – revealing the pressures acute providers have been in and the difficulty in shifting more resources into the community as desired.[18]

"We're really good in the NHS at creating adverse incentives. The whole conversation in integration is about taking away from hospitals – and I can tell if you, if you're a hospital finance director, you can have all your consultants lined up to deliver integrated care, but if I'm then told that will attack my cost base, and I'm going to be beaten up for not hitting financial targets and delivering on elective backlog, then all of the disincentives are there for me work in a way that doesn't allow care to be moved out of hospital."
(Chief operating officer, hospital trust)

This financial context plays out in front-line service delivery and hinders more proactive management of patients in primary care and the community. Historically, spending on NHS community and primary care services has been squeezed relative to spending in the acute sector. Local councils are legally obliged to balance their books each and every year. With these services already overstretched themselves and with demand increasing, participants reflected that it is difficult to see how more capacity will be absorbed out of hospital:

"GPs can see upwards of 50 patients a day and see each one for less than 10 minutes, while hospital-based doctors often have 20–30 minutes to make an assessment. This

has implications for risk holding, which will need to be accounted for in integrated systems if general practice is expected to take on more." **(GP)**

The pandemic has only made these pressures more extreme, with large backlogs in each part of the system. Stakeholders felt that there is a risk that providers will be absorbed in bringing down waiting lists and responding to very real pressures in urgent and emergency care, making it more difficult to balance resources with the capacity needed to support better population health management and more proactive service models. Participants acknowledged that these aims should not be at odds with one another; approaches like population health management help to better match clinical resources with need and identify if there are alternative approaches that could better serve patients who are waiting. However, in practice, the short and long-term goals compete for limited energy:

"The pressures are arguably greater now because of the backlog which will dominate specialist job plans and the language coming down from ICSs… At the same time primary care pressures are going to divert energy away from developing PCNs and keep energy in individual practices… pressures are creating a storm that we need to do it differently, but will be enormously difficult, though good examples are out there." **(Academic)**

There is a risk that without deliberate plans in place to support action on both fronts, the most immediate issues will continue to take precedence. To ensure that the goals of elective recovery and population health improvement complement rather than compete for space, the elective recovery strategy and targets will need to evolve away from a narrow focus on acute capacity and take a whole-system view on the challenge.

Practical barriers that limit multi-disciplinary working

A hallmark of integration is multi-disciplinary team working – but here participants highlighted several risks that limit the ability for place-based partnerships to deliver joined-up services.

Some of these barriers relate to practical issues, like differences in how pay and benefits are organised across different sectors. Even within the NHS, we heard examples of Agenda for Change being inconsistently applied between primary and community care services, making it difficult to blur boundaries and form blended teams between out-of-hospital services and coordinate this capacity as effectively as possible.

Joint-management and multi-disciplinary working also requires sophisticated data and information sharing, which participants remarked is lacking in some places. There are specific challenges in general practice, community and social care services, where data collection and sharing to understand and manage system flows is less well established. This results in insufficient information to understand whole system performance and capacity – which can distort incentives and priorities within integrated partnerships (see the section on metrics below).

"Even with a dedicated data team we are struggling to get information that can clearly show our demand and capacity [in general practice]. [Data] is so powerful, but all practices have different ways of how they record appointments. This is data at its simplest… let alone being able to measure the complexity of what we are seeing." **(GP)**

Nor are the systems and infrastructure in place so that data and information are shared seamlessly across multi-disciplinary team members to support joined-up decision-making. Participants revealed concerns that shared care plans and records are still limited in some areas, which feeds disjointed care and can lead to patients needing multiple conversations across a care team which should be far better coordinated.

"We need to organise the system around a care plan that follows the patient everywhere, but that requires a shared record and data. Right now, we're not even sharing prescribing information which is a lost opportunity." **(Acute specialist)**

The capacity constraints described above have also challenged multi-disciplinary working and integrated service delivery in some areas. Primary care and social care colleagues noted that integration has often felt like "glorified task shifting", with administrative responsibilities being shifted under the guise of integrated working, but without mutual support or greater resources to support meaningful shared ownership of patient management.

> "Little bits of extra work often end up creeping into primary care that other providers don't know about…we need integrated care amongst providers to be able to give integrated care to patients. Primary care aren't victims and don't need to be 'upskilled'. Rather than [acute partners] taking contracts over, it would be interesting to see if hospitals could give us staff." **(GP)**

As one example, some general practice participants reflected on how they have needed to hire entire dedicated resource to handle filing and coding hospital letters on electronic patient records – a task that could potentially be done automatically within acute care. Primary care doctors also commented on how capacity constraints in acute care have cut against some of the aims of integration, as consultants have limited capacity to support more proactive co-management between primary and acute services:

> "We're working hard to be doing more proactive co-management of patients, but services are so busy we can't even get through to consultants to ask simple questions about patients – this cuts against the aims of Advice and Guidance and keeping more patients out of hospital… Good integration would see consultants supporting GPs in decision making on who specialists should be seeing, rather than the GPs having to make decisions on their own who to refer." **(GP and PCN clinical director)**

There are also cultural differences that cannot be understated and pose real challenges to making multi-disciplinary teams work. Integration can be perceived as blurring lines between professional and organisational boundaries, which historically has had an impact on the identity and

responsibilities of registered professionals.[19] Considerable organisational development is needed to help bring disparate roles and skills purposefully together, in a context where there is little time and managerial capacity. Teamwork as imagined is very different from teamwork as done – and participants cautioned that this can often be underestimated when establishing new ways of working.

Unrealistic expectations

The significant limitations on capacity (as described above) suggest that the expectations of what new place-base arrangements can achieve must be proportionate, realistic and fair given the current climate. The complex behavioural, cultural and practical changes required will take time to deliver and must be accounted for when setting expectations about what integration can achieve and by when. There is a tendency to be overly optimistic about the impact of integration – both in terms of the scale of effects and the time it takes to deliver them.[20] Stakeholders noted how detrimental it can be to engage in partnership working when improvements are expected too soon or are unreasonably ambitious or mismatched with the scope of the changes being delivered.

For example, integrating service delivery and developing more proactive care models are unlikely to result in cost savings if they help lead to service delivery changes that identify unmet need and increase activity as a result. Nor is integration likely to shift more services out of hospital if there are insufficient numbers of social care or community care staff to support new models of care and ways of working. Wider population health trends also need to be considered. It is possible that integrated care is happening, may be working and might have a measurable effect – but other factors are having an increasingly negative effect, leading to little change overall.

There is a risk that if the early goals and objectives of ICSs and place-based partnerships are not set appropriately, reasonable approaches and strategies will be disrupted too early if they are seen to have little impact. This is the common thread of integrated care reform in England, where nearly every structural reform and new system architecture has been replaced before it has had a chance to prove itself.[21]

Participants also had concerns that the objectives for integration might not sufficiently account for the local context in which they take place, which could lead to unreasonable expectations for areas to transform at the same rate. For

example, rates of potentially avoidable hospital admissions vary widely across and within ICSs, and will be linked to different levels of deprivation, access to primary and community care services, and continuity of care across areas. The complexity of each place and local history needs to be accounted for when determining how rapidly changes can be made, and how performance will be measured differently as a result.

4. Metrics, measurement and incentives

Integration is difficult to define, measure and evaluate. The intention is that integration will improve processes so that services work better together, which will translate into improved health and system efficiency over time. However, it is far easier to observe and measure process than long-term outcomes, and exceedingly difficult to draw a causal link between the two and understand if integration is progressing in such a way that long-term objectives can be realised. This limits our understanding of its impact, and what difference subsequent reforms have ultimately made to service users and patients. Even if leaders are clear on vision for integrated care, this does not always translate into clear objectives that place-based leads are setting out to achieve with integrated care, and why, as they agree interventions.

Part of the challenge stems from disjointed incentives and difficulty in understanding the effects of integration, which have undermined a common sense of purpose of what integration is intended to achieve and how. Without resolving these issues, there is a risk that we end up in a similar place to where we are now, with different parts of the system working with competing understandings and priorities.

Poor use of metrics and measurement

Participants pointed to the poor use of metrics to encourage joint working between organisations or teams, and the acute focus of current targets.

While the vision for integration is broad, much of the national discourse relating to integration tends to focus on the relationship between hospital care and other parts of the system, in particular social care, with the aim of reducing hospital bed use. This is apparent in the disproportionate number of targets and quality of data related to acute care activity relative to other parts of the system. And when these targets are set, they tend to be directed at individual NHS organisations and incentivise organisational activity at the expense of shared goals.

"Part of the problem is that what gets measured tends to get prioritised, and in the NHS, there is a much clearer view of capacity constraints in hospitals than in primary, community, social care or voluntary services given where system targets are currently set and the latest elective recovery goals are focused. The overreliance on hospital-based measures has inhibited change within community and social care services." **(GP)**

Participants recognised that if we intend to create meaningful change for service users by integrating health and social care, then more attention needs to be paid to these services and the experiences of those who use them.

"In other spheres of life, we are all asked for feedback straight away – for example, I buy something from Amazon and I'm asked how the driver did; I book an Airbnb apartment and I am asked to review the host, and the host is asked to review me. We are squeamish about this in health and care. Do we need to be? The success of integration should not purely be measured by the impact on hospital admissions." **(Chief medical officer, consultancy)**

Lack of focus on the perspective of those using services

The limited and poor use of data to support collective goals is compounded by a lack of patient and service user perspective, which runs the risk that place-based partnerships will lose sight of their ultimate purpose of improving outcomes and experiences for people. While new measures of people's experiences of care are being developed, there is much more to be done across the UK to effectively understand the challenges that patients, service users and carers face in negotiating the maze of services, organisations and funding entitlements, and use this knowledge to deliver better care.

The data being collected tends to focus narrowly on activity and service utilisation but leaves out rich, qualitative insights on patient and service user experience that are core to knowing whether integration is meeting its objectives.

"The picture we're developing isn't much clearer than we've already got, because we're not collecting the type of data we need. Conversation tends to stop at performance data, but that is not where we'll tell whether integration is working. We need far richer insights on user and patient experience – but there is no provision at the moment for how we share qualitative insights across ICSs and change the landscape for listening and learning so we're actually making services better for people."
(Head of public affairs, charity organisation)

Collecting this type of information requires infrastructure and resources to embed meaningful patient and service user engagement, which some participants cautioned continues to fall short. This is particularly true when it comes to the involvement of the most vulnerable who have the worst experiences with care and are often the ones least engaged with, pointing to insufficient attempts at meaningful co-production and shared ownership of population health strategies with local communities:

"We need to think about the purpose [of integration] and need far better and meaningful co-design and co-production with people in communities who are most likely to be excluded. What are we all aiming for, what does a good life look like? Groups like this which are not particularly diverse will not have that range of insight."
(Chief executive, charity organisation)

"If the focus of integration is improving people's lives the organisations will follow. The biggest thing is having a sense if the system cares about having a good outcome. As someone with a learning disability, I might need reasonable adjustments in the health settings, but might not be good at articulating what good support looks like. It needs to matter. I'm frustrated about the situation; we just seem to go around a loop, but I will remain hopeful." **(Patient advocate)**

Participants also cautioned against the tokenistic efforts if data are not then acted on, and not backed up with strong leadership and infrastructure to embed user data into strategic thinking and decision-making. Measurement and collection of data cannot be an end itself but must be used intentionally to actually improve people's experience, satisfaction and engagement with services.

Funding flows and regulation

As with measurement, there is a gap between the system narrative and what's actually happening to support more joined up and collaborative working within places. While the importance of prevention and better managing care out of hospital has been a clear objective of integration over time, participants expressed concern that the incentives are still not in place to encourage this reality.

For one, siloed working is reinforced in the way in which services are financed. The Payment by Results regime proved a significant barrier to integration. The increasing financial difficulties prior to the pandemic meant that in many areas Payment by Results was effectively suspended, and that was enacted formally during the pandemic. NHS England's operational planning guidance now requires ICBs and partner trusts to deliver a financially balanced system (namely a duty on breakeven) and gives commissioners and trusts local ownership to set payment values on "simplified terms".[22] While this is intended to align organisational and system priorities, some participants still feared there is a lack of clarity on how new funding mechanisms will work in practice, and if all the unintended consequences have been sufficiently thought through:

> "Unhelpful payment systems are disappearing, but there is every danger that we'll end up with a new payment system that aims low and introduces perverse outcomes that will be quite complex and requires a lot of work." **(Academic)**

Similarly, the way services are regulated has tended to cut against whole-system working and integration. It is true that Care Quality Commission (CQC) regulatory processes are certainly adapting to better account for system performance, and the CQC will be using the 'I statements' as part of their assessment framework. But even with these shifts, stakeholders feared that they have been insufficient to make up for the cultural barriers and nurture a shared sense of accountability across different system partners:

"Within [the CQC's work], how do we ensure that the ICSs have a role in supporting the local authorities as well? We need to be thinking if local authorities are failing, what does that mean for the ICS? Adult social care is always the poor relation, often referred to in the meetings but focus stays on acute." **(Regulator)**

5. Fatigue, burnout and 'integration overload'

Even without the challenge of developing new ways of working in ICSs and place-based partnerships, leaders at all levels face a substantial challenge in keeping staff motivated after two-and-a-half years of working in a pandemic and 10 years of austerity. Deteriorating performance statistics are not simply numbers, they represent the worsening experience of real people. As patients and services users receive less timely, and perhaps poorer quality care, likewise staff are experiencing real moral injury and burnout. While this context can make the aims of integration even more pressing and worthwhile, developing the systems and processes needed to make integration work in practice may take second position to addressing more extreme issues facing the service.

Part of this stems from the current focus of integration efforts still feeling abstract and removed from the day job of front-line staff. The creation of new boards, strategy documents and changing organisational charts does not automatically lead to integration at the front line and all this is some distance away from actual joined-up and coordinated service delivery. In our workshops stakeholders remarked that, despite longstanding policy objectives to improve integration, reforms have felt distant to the problem at hand for many practitioners and detached from clinical practice – perhaps because of the consistent focus on structure changes. Some specialist consultants remarked, for instance, how they did not understand what integration meant for them, and what they should be doing differently to support its delivery:

"If you ask most front-line clinicians what 'place-based' is, they have no clue. They have seen so many structural changes and the NHS continues to expect structural change to create functional change. But what will be different this time?" **(Acute specialist)**

This speaks to the opportunity costs that have come with successive and overlapping reforms, which in some cases have contributed to a fatigue and wariness of integration as teams consistently grapple with structural ambiguity as organisational boundaries blur and governance processes adapt. Available reports support the argument that full-scale reorganisation in governance can be poorly thought-out or evidenced, and frequently brings about a long period of disruption and adaptation, which can outweigh the intended benefits of reform.[23]

At the same time, participants reflected on how unlike previous efforts, there is a greater appreciation now for population health and health inequalities and the role local systems have in tackling them, and that the vision for ICSs and place-based systems are more consistent with the efforts that came before it. A challenge will be navigating political uncertainty and avoiding any temptation to restructure partnerships again before they are given adequate time to mature and a common sense of purpose to evolve.

A call to action – addressing the risks and maximising the benefits

This report has captured some of the lingering risks and challenges for integration as the dust settles around the recent legislative reforms and formation of new partnership structures. Many of the risks identified above are long-standing, but they are not inevitable. Below we discuss five priority areas of focus for place-based leads and regional and national teams to address some of these challenges and give places and ICSs their best chance at success.

Building integration into the day job

To make integration feel less like an abstract goal, day-to-day clinical and managerial practice must change in some way. ICS and place-based leaders should be holding at the forefront of their minds the question 'what will be different on a Monday morning?' as a result of their deliberations. First and foremost, how will the experiences of people who use services be different and better? What different conversations will chief executives be having, with whom, and what will happen as a result? How will the way in which GPs and consultants interact with each other change? What will be different for the district nurse or for the domiciliary care worker? How will

success be measured? And how will these changes be achieved within the resources available?

Integration is not the objective for its own sake – it is an approach to streamline services for people accessing them and to improve outcomes and help keep people healthy and well. Integration only happens if people do something different as part of their day jobs – structural shifts and changes to organisational diagrams alone will never drive change. While many of the challenges and risks that we focus on in this report connect back to culture change, 'culture' is not some nebulous external factor; it is intrinsic to organisations and systems. If culture is 'the way we do things around here', then the only way we will change the culture is through the daily actions and work of teams on the ground.

This means adopting an 'integration-in-all-policies' mindset and ensuring that implications for coordination and how the whole system works together are part of all strategic decisions. This will be supported by making integration more visible and tangible for front-line teams, and a daily part of the way they work and think about their role. This can be facilitated, for example, by ensuring that the tools which support population health management and integrated care are on the desktop or mobile device of clinicians in a seamless way and linked to treatment pathways, reminders and prompts. This in turn requires a strong back office and change management resource of a type that is still often lacking, particularly in primary care settings.

Ultimately, integration may be advanced through a series of small improvements to ways of working rather than through the creation of a 'perfect system'. But the selection of the 'right' incremental steps will require the devolution of resources, the power to make change happen to places and, within them, to integrated clinical teams. This local agency was evident in the response to the Covid-19 pandemic and needs to be reignited in the face of the current challenges facing health and care.[24]

Bringing clarity to complexity

Maximising capacity in the system depends on simplifying and streamlining decision-making and governance arrangements. At a time when services are facing such extreme pressure, place-based leaders will need to devote as much headspace as possible to front-line care and delivery, rather than navigating complex, bureaucratic structures of accountability.

More needs to be done to simplify governance and planning arrangements within ICSs and make clear which decisions can be made where in the system. This includes clarifying lines of accountability, reducing duplication wherever possible, and making explicit the remit of different partnerships (e.g., what is owned by place versus neighbourhood versus provider collaboratives working at the system level). Otherwise, ICSs run the risk, for example, of delegating budgets to places without sufficient freedoms to make appropriate changes.

While more clarity and simplification are needed from the centre, the fact that ICSs are heterogeneous mean that there is no single best approach which can be applied at all local levels. This underlines the importance of efforts to decentralise decision-making and control, giving more autonomy to ICSs to define for themselves how these arrangements should work in practice. This means that governance and planning arrangements will better reflect the distinctive history and culture that informs decision-making in each place as well as in provider collaboratives and other partnership structures.

Reducing complexity also depends on consistency. Perhaps the most powerful action that the new government could make would be to resist the temptation to impose yet more reform before the current system has had the chance to prove itself. Evidence of previous reforms designed to integrate care demonstrates that a limiting factor in their success is a change to their operating context.[25] This may require patience that extends over several years as the fruits of integration are not available quickly.

Better use of performance management, metrics and data

Many of the risks to integration relate to expectations around outcomes, and how to measure, define and incentivise them, while ensuring the right flows of information are in place to meet objectives.

Integrated care reform has suffered from short-termism, as energy and focus often gravitate towards the immediate challenges at the expense of long-term goals and objectives. Performance frameworks, where they have existed, have tended to focus on organisational targets, which incentivise organisational activity and leave out considerations for how well services work together and can lead to ill-defined goals across partners. The NHS Oversight Framework for 2022/23 clearly shows where performance will be measured at the ICB level and at trust level. In addition, it is positive that the government has

committed to working with local systems to develop a single set of health and social care outcomes at place level to which ICSs (and all partners within) will be accountable.

But it will be important that these frameworks are used by ICBs in a way that genuinely encourages integration rather than apportioning blame. Current performance frameworks tend to focus on metrics measurable in the short term. Ideally ICBs should establish a mix of long and intermediate-term goals alongside short-term targets. They also need to relate to activities and outcomes that are experienced by patients and clinicians, as was identified by roundtable participants. These might include patient and staff reported experience of coordination of care, collaboration and decision making.

National performance targets have a role in addressing key goals – and in a highly politicised public system such as the NHS feel inescapable. However, these should be kept to a minimum as every additional national goal risks displacing local focus on something potentially more valuable. Sufficient appreciation of the local context for each ICS should be considered to avoid unrealistic expectations, and flexibility given to place-based partnerships to develop their own objectives and goals aligned with local priorities.

Significant work has been done already to develop integration scorecards that provide a clear logic model for how the different enablers and components of integrated care interact and contribute to different outcomes.[26] These should be developed further, with more data developed so that performance is better understood in community and social care sectors, and how patients and service users experience these services. This would help avoid a culture driven by achieving national targets at the expense of meeting local need.

ICSs and places are, rightly, being asked to consider the wider costs and benefits of the investments they make. For example, they should consider 'social value', i.e., the impact of their investments on wider measures such as employment, wider wellbeing and strengthened communities. But this more holistic approach goes beyond the standard analysis that generally underpins a 'business case' used within the NHS, which focuses on the costs to and savings for health care providers following any particular investment. Health and care leaders will need to become adept at new approaches to the valuation of their investments. This is a particular challenge where investment by one partner is needed to generate a financial benefit for a different partner.

Foster culture change through greater mutual understanding and joint working

Given that so many of the risks to integration are rooted in cultural differences, more needs to be done to foster greater mutual understanding between the NHS, social care, community care and other local partners. Perhaps surprisingly, given the length of time integration has been an objective, misunderstandings of role and difference in language persist.

But beyond shared understanding, there is scope to give more priority to joint appointments where appropriate and the development of integrated teams. This requires 'passporting' schemes so that local staff can work flexibly across organisations. Too often, formal bureaucratic requirements act as stumbling blocks to simple and effective schemes for integrated working.

Before agreeing joint governance arrangements, a deep understanding is needed of how individual governance structures work and function – for example, decisions should not be delegated to local authorities that they are not able to make.

With mutual understanding comes greater trust, which is essential for integration to work. To build trust across the system, real autonomy, resources and control must be delegated and shared across partners. This applies both at the delivery level (e.g. between the acute sector and primary care or voluntary care organisations) as well as the planning level (e.g. between the centre and local and regional partners). It is not enough, for example, for the NHS to contract with the voluntary sector to deliver a service but not offer any control or responsibility in how that service is designed and shaped to meet local needs. Likewise, the relationship between the centre and place-based partnership bodies must adapt in the same way.

Rebalance capacity

Integrated care reforms have consistently been constrained in the UK by broader system pressures. Without significant changes to the way resources are allocated in the system, there is a risk that the latest reforms will have limited impact. General practice, social care and community services are each overloaded, which limits the ability to relieve bottlenecks in hospitals and treat more patients and service users closer to home. It is perhaps a sad indictment of funding policy that, despite goals to increase funding for primary care, that sector has received a decreasing share of NHS funding since 2010.[27]

More resources and capacity need to be shifted into care settings outside hospitals – which may require double running services for a time. This will require a rethinking about financial flows to meet system objectives – and a willingness to close down services after a time once new community service models are established to shift fixed costs from one part of the system to another. Otherwise, there is a risk that demand will continue to expand to fill the capacity available.

In thinking about the distribution of capacity, ICBs and places should consider not only service capacity but also management capacity. In some ways those parts of the system expected to undergo the greatest transformation – primary care and community services – are those least equipped with the leadership and change management capacity (as distinct from capability) to do so.

There may be opportunities to free up capacity by streamlining the way different parts of the service work together. For example, legacy demand management activity like consultant-to-consultant referrals having to go back through to GPs is putting unnecessary pressure on primary care. A first step for ICBs can be to think about how to redistribute operational capacity and resource across the system to build up more out of hospital management resources to improve system flow. This may help take some of the pressure off PCNs, which are feeling overloaded in navigating competing goals.

Operational capacity and support also need to be distributed to voluntary sector and other local community partners. A missed opportunity in supporting more prevention and helping to keep local people well and out of hospital has been a lack of resilient broader local services. Part of this has stemmed from the NHS failing to pay for core costs, not just project costs, in its partnerships with VCSEs, and also having long pay periods that make it difficult for smaller organisations to partner with the NHS.

Conclusion

While limited progress has been made in realising the aims of integration so far, there are genuine differences in where we are now compared to where we have been in the way places are set up and work together. The competitive mindsets established in the 1990s and 2000s are largely in the past; NHS England has stated an ambition to take a scaled-back role in local systems; and local relationships have accelerated, not least through crisis planning and pandemic response.

But at the same time, places are establishing while coping with long-standing financial and operational pressures that have been made several degrees worse by the pandemic and financial crisis.

Participants in our roundtables were largely optimistic about the opportunities presented by this latest round of reforms, despite the risks and challenges discussed in this paper, and there was a great deal of consistency across professional boundaries. Ensuring that places can thrive will be key to making the aims of integration a reality, and in the next phase of embedding these reforms, leaders at every level must shift their focus from organisational and structural change to addressing the behaviours, incentives, skills and resources needed to integrate services at the front line.

Otherwise, we risk repeating the cycle of successive reorganisations that change how services are planned and coordinated – and come with a significant opportunity cost and disruption – but fail to address the fundamental and deep-rooted changes needed to deliver integration that is really felt by both staff and patients.

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