This submission is made by Dr Lisa Knight in a personal capacity as an academic researcher.

1 This submission draws on research on leadership in Integrated Care Systems.[1] The fieldwork took place during the first full year of Integrated Care Boards (ICBs) as statutory bodies. This submission addresses the three areas in the Committee's call for evidence and draws recommendations from them. The findings set out here describe the conditions on which ICB performance and capability depended before the changes announced in 2025 and are considered in relation to those changes.

## Key points

- The financial deficit was associated with partner organisations turning inwards, as finance, workforce and population health were addressed separately and joint working diminished as budgets tightened.
- Decision-making was concentrated within the central ICB team. Place leaders reported having limited authority to act and anticipated that this concentration would increase as resources fell; they also regarded the ICB as distant from neighbourhood delivery.
- Leaders reported that national performance management focused on finance and waiting times, while inequalities and wider outcomes were not examined. Prevention, they considered, did not receive the priority given to elective recovery.
- Leaders reported difficulty reconciling immediate operational pressures with long-term strategy. They also found that the system lacked the financial slack and stability required to innovate or invest in prevention.
- Differences between the NHS and local government financial regimes, and the relatively low investment in social care, undermined partnership between the ICB and local authorities.

## The impact of the oncoming changes on ICBs' performance and capability to deliver on their responsibilities

### *Relationships between partners*

2 Leaders were consistent that partnership working rested on relationships built over long periods, and that collaboration was most effective where relationships between individuals and organisations had endured over many years. The ICBs created through the mergers taking effect from April 2026 and April 2027 bring together leadership teams and partner organisations from previously separate systems.[2] The research found that the relationships on which partnership working depended were the product of time and continuity.

### *Centralisation and the distance from place*

3 Leaders reported a gap between the ICB and the communities it served. Decisions about service models were perceived to be made centrally, without sufficient knowledge of local populations, and leaders regarded the separation between the ICB and neighbourhood delivery as the central governance difficulty. Place leaders experienced their relationship with the central ICB team as directive and anticipated that this would increase as resources fell, since, in their experience, financial scarcity drew decisions towards the centre. Central ICB leaders, by contrast, regarded holding budgets at system level as a means of limiting the financial risk associated with delegation. Place leaders reported that this left them with limited scope to respond to their communities' needs. The findings indicate that concentrating decisions within the ICB reduced local flexibility and constrained the tailoring of services to communities, and that this concentration increased under financial pressure. The mergers create larger ICB footprints at the same time as the 10 Year Health Plan places neighbourhood health at the centre of reform;[3] the research suggests that the relationship between the ICB and

place is the aspect of governance most in need of attention in the design of merged ICBs.

***Financial pressure and siloed working***

4 Under financial deficit, partner organisations turned inwards to protect their own positions, rather than working jointly towards system balance. Finance, workforce and population health were considered separately, and leaders identified withdrawal into individual organisations as the characteristic response to tightening budgets. Leaders were also unclear about the extent of the ICB's authority over partner organisations, including whether it could take decisions that bound providers and what would follow if a system-level decision lacked agreement from organisations retaining their own statutory responsibilities. The research found that convening partners towards a shared purpose under financial pressure was the work of ICB leaders rather than of any particular function. Merged ICBs will convene a larger number of partners with reduced running costs, and the findings indicate that this convening role depended on the capacity of ICB leaders.

***Clinical and care professional leadership and partnership with local government***

5 Leaders identified investment in clinical and care professional leadership as a priority, with clinical leads at place provided with protected time and resources. Clinical leadership arrangements were reported to have strengthened, while care professional leadership was acknowledged to lag behind. The partnership with local government was weakened by the different financial rules governing the two sectors. The NHS could plan for and run a deficit, whereas local authorities were required to balance a fixed budget; NHS leaders acknowledged that local government would not regard them as equal partners until NHS finances were managed on the same basis. Leaders also regarded social care as underfunded relative to health and described funding arrangements as favouring acute services over prevention. The findings indicate that these leadership arrangements depended on dedicated time and resources, a consideration relevant to how the running cost reductions are applied.

***Innovation and prevention***

6 Operational pressures increased leaders' perception of risk and reduced their support for innovation and improvement. Leaders considered that the system lacked the stability needed to test new approaches and extend them across the system, and that innovation at scale depended on financial slack that was unavailable. Investment in prevention was regarded as unaffordable in light of current demand for treatment, given that returns would take several years to materialise. Innovation and investment in prevention therefore depended on financial slack and organisational stability, both of which are affected by the re-organisation.

## Management of staff reductions

7 Two findings from the research bear on the management of staff reductions: the link between leadership visibility and workforce morale, and the tension leaders experienced between operational and strategic demands.

8 The wider workforce was found to be under pressure from efficiency requirements, changes to staffing, unfilled posts and rising demand. Where ICB leaders engaged the workforce through communication, direct contact and specific initiatives to support wellbeing, staff were reported to feel included and valued and morale improved; where leaders did not, morale was perceived to decline. Leadership visibility was therefore linked to workforce morale. As ICBs reduce their headcount, the findings indicate that the visibility of leaders to remaining staff is relevant to sustaining morale.

9 Leaders regarded balancing pressing operational demands against longer-term strategy as the main challenge of their roles. Many reported that recurring crises absorbed their time, leaving little capacity for strategic planning, while operational responsibilities repeatedly took precedence over longer-term work. ICBs are expected to focus on their role as strategic commissioners;[4] the findings indicate that strategic work was the work most readily displaced by operational demand.

## Government oversight of whether the restructure is increasing efficiency

10 Leaders reported that national performance management concentrated on financial position and waiting lists, without addressing the wider purposes of the ICS. They regarded this emphasis as failing to reflect the aims of improving population health and reducing inequalities. According to leaders, performance was assessed on finance and hospital waiting times alone, while their contribution to social value and to reducing inequalities was not examined. Board plans were described as centred on emergency department and waiting time targets, with little or no space for discussion of health inequalities, prevention or the wider determinants of health. Leaders considered that prevention had not received the organisational priority and resources given to elective recovery.

11 The findings above indicate that the performance management ICB leaders already experienced was narrow, and that this narrowness itself hindered the pursuit of the statutory purposes. The Committee may wish to consider whether the oversight of the re-organisation will assess ICBs' capability in respect of those purposes, in particular integration, health inequalities and prevention, alongside cost.

## Recommendations

12 **Decision-making structures at place.** The research found that centralisation within the ICB limited local flexibility and increased under financial pressure. The design of merged ICBs should set out what decision-making authority and resource sit at place level and how the distance between the ICB and its neighbourhoods is to be addressed.

13 **Clinical and care professional leadership.** The research found that protected time for clinical leads supported clinical leadership at place, and that care professional leadership was less developed. Investment in both should be maintained through the running cost reductions.

14 **Relationships and visible leadership.** The research found that partnership working rested on relationships built over long periods and that leadership visibility was linked to workforce morale. Management of mergers and staff reductions should take account of both.

15 **Performance reporting.** The research found that national performance management focused on finance and waiting lists. Oversight of merged ICBs should require regular reporting on prevention and health inequalities alongside financial and access measures.

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[1] L. Knight, R. Neiva Ganga and M. Tucker, 'Integrated care system leadership: a rapid realist review', *Leadership in Health Services*, 37(3), 2024, pp. 327-341, https://doi.org/10.1108/LHS-12-2023-0092; L. Knight, R. Neiva Ganga, M. Tucker, A. P. Shore and S. Nolan, 'Contexts and complexities: a realist evaluation of integrated care system leadership', *Leadership in Health Services*, 38(1), 2025, pp. 153-169, https://doi.org/10.1108/LHS-06-2024-0051; L. Knight, 'Emerging challenges in integrated care system leadership: a qualitative case study', *British Journal of Healthcare Management*, 2025, https://doi.org/10.12968/bjhc.2025.0015.

[2] Department of Health and Social Care, *Reductions to the running costs of integrated care boards and progress towards aligning the boundaries of integrated care boards and strategic authorities*, Written Ministerial Statement HCWS915, 9 September 2025.

[3] Department of Health and Social Care, *Fit for the future: 10 Year Health Plan for England*, July 2025.

[4] Department of Health and Social Care, HCWS915 (2025), as above.