The King's Fund

Ideas that change health and care

Realising the potential of integrated care systems

Developing system-wide solutions to workforce challenges

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Contents

Key messages

- Integrated care systems (ICSs) were given statutory powers and new legal responsibilities for the first time in July 2022. These changes were intended to increase collaboration in the health and social care sector and to enable the NHS, local authorities and other partners to take collective responsibility for improving health outcomes, reducing inequalities, delivering better value for money, and driving local social and economic development.
- This research examines the development of ICSs by assessing their efforts to develop system-wide approaches to the recruitment, training and retention of staff. Workforce issues such as these are currently some of the biggest challenges facing the health and care sector, and require a co-ordinated response from multiple organisations of the kind that ICSs were designed to enable.
- Leading system-wide transformation is slow and the work is hard, but there are clear signs that progress is being made. We found evidence of ICSs beginning to build a more 'whole-system' approach to workforce. Our research identified six distinctive ways in which ICSs are adding value:
  - organising around a shared purpose
  - building system leadership
  - encouraging system-focused behaviours
  - scaling and spreading success
  - using resources more effectively
  - managing complexity.
- Although we found evidence in our case study sites of ICSs performing all six of these functions, the degree to which this is happening varies across systems. We invite ICS leaders to challenge themselves on the extent to which they are performing these six functions in their local system.
- Despite signs of progress, there is a clear risk of ICSs going 'off track' as a result of pressures on services, intense political scrutiny, and extremely difficult economic circumstances – and the effect these conditions are having on the behaviours of leaders locally, regionally and nationally. There is widespread concern that ICSs may not achieve their full potential unless more is done to create an environment conducive to their success.

- Our research suggests that success relies primarily on supporting people to think, plan and act in 'system-focused' ways. If this is to happen, different behaviours are needed at all levels of the system. National bodies need to create a more enabling environment and ensure that accountability and funding mechanisms support system working. Local leaders need to model system working in their relationships with partners across the system. We outline four enabling actions for leaders at all levels:
  - maintain a clear focus on long-term transformation
  - practise system collaboration and invite challenge
  - grip tight on outcomes but loose on means
  - value the views of local people, patients and staff.
- There is considerable interest in how ICSs are performing and there is a danger that attention focuses on the things that are easier to measure. Our research suggests that the less visible work of supporting people to work together differently is critical for success and must not be undervalued. The ability to do this well is one of the key factors that will determine whether ICSs succeed in delivering better population health and more joined-up care for people using services.

1 Introduction

Born into a storm

Integrated care systems (ICSs) have not had an auspicious start since becoming statutory organisations in July 2022. Previous research has described how they were 'born into a storm' – a toxic mix of intense service pressures, an exhausted workforce, and economic instability (**Timmins *et al* 2022**). Nine months after the creation of integrated care boards (ICBs) – one of the key bodies at the heart of ICSs (*see* box on page 6) – they were required to reduce their running costs by 30%, leading to a large and protracted redundancy programme and significant uncertainty for staff. Waves of industrial action over the course of 2023 and 2024 and ongoing operational challenges have only added to these pressures.

Given these unprecedented challenges, asking whether ICSs have been a success is not a helpful or illuminating question. Moreover, each ICS is on a unique trajectory, with some having up to five years' head start over others. However, it is important to understand how ICSs are developing so far and what might help them to achieve their full potential. In this report, we look at ICSs through the lens of one of the biggest challenges facing the health and care system – workforce. We chose to focus on workforce both because it is currently one of the main barriers to meeting the goals of ICSs and because it is exactly the kind of complex, multi-faceted, whole-system challenge that ICSs were created to address.

The workforce crisis facing the NHS and social care services has been acknowledged for some time (**Warren 2022**), leading to the publication in 2023 of the first national NHS workforce strategy in over 15 years (**NHS England 2023**). On one level, this is a crisis caused by a mismatch between demand and supply, with population needs rising rapidly and workforce numbers unable to keep pace. Difficulties with recruitment and retention both contribute to this; recent increases in people entering nursing and other professions have not been sufficient to outweigh the effects of large numbers leaving the workforce, and have only been seen in some services rather than across the whole system (**Holmes 2022**). On another level, there is much more to the issue than numbers; it is also about culture, leadership, morale, experiences of racism and discrimination, productivity, and skill

mix (Warren 2022). The NHS Long Term Workforce Plan represents a welcome but incomplete response to this complex set of challenges and does not address the equally concerning workforce gaps in social care (Holden 2023).

Resolving some of these issues requires national action. However, by bringing together organisations from across the wider health and care system, ICSs have the potential to play an important role in transforming the workforce to meet the needs of local populations, and developing new workforce solutions that straddle organisational and professional boundaries.

What are integrated care systems?

Integrated care systems (ICSs) are partnerships designed to bring together the various NHS organisations operating in an area with local government, voluntary sector organisations and other partners. By working together, the intention is that these organisations develop a common understanding of the needs of the local population and use their collective resources to better meet those needs – for example, by co-ordinating services more closely or by shifting resources towards prevention and early intervention.

Some ICSs have existed since 2017 but it was the 2022 Health and Care Act that gave ICSs legal responsibilities and budgets for the first time. This legislation required that each ICS includes an integrated care board (ICB) responsible for NHS resources and an integrated care partnership (ICP) responsible for setting the strategic vision for the system. The Act also introduced a number of other changes intended to increase collaboration in the health and care sector and to move away from a reliance on competition as being the primary driver of improvement.

NHS England identifies four 'fundamental purposes' for ICSs (NHS England and NHS Improvement 2020):

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

For more details, *see* Charles (2022).

A whole-system approach

ICSs were created out of a recognition that many of the issues experienced by people using health and care services cannot be isolated to failures or under-performance in individual organisations. Rather, there are system-wide challenges that require a system-wide response (Charles and Murray 2022). Workforce is a prime example of such a challenge, with multiple interdependencies linking workforce issues in the NHS with those in social care services and in the voluntary and community sector, as well as in the wider 'workforce' of people with unpaid caring responsibilities. As set out by NHS Employers in a guide to *Integrated workforce thinking across systems*, these challenges cannot be solved by any one organisation or sector working alone (NHS Employers 2022).

In recognition of the complexity of challenges like this, ICSs were created with the goal of bringing about a shift to 'system working' that would be fundamentally different from anything previously seen in the NHS (*see* box below). Achieving such a transformation would be ambitious at the best of times, and even more so in the current context.

What is 'system working'?

Collaboration in the health and social care sector is not new. There are countless examples stretching back many years of organisations working together for the benefit of local people – for example, the vanguard sites involved in NHS England's new care models programme between 2015 and 2018 (Naylor and Charles 2018). However, the 'system working' that ICSs were created to bring about is intended to be distinctive in two senses. First, the geographical scale goes beyond previous examples of collaboration, with ICSs covering populations of up to 3 million people. This in itself makes it a more complex task, with a larger number of organisations to involve.

Second, system working also has a more transformative set of goals. It is not simply about working in partnership to co-ordinate services, but about effecting a fundamental shift through which the NHS and its partners take collective responsibility for improving population health, reducing inequalities, increasing productivity, and driving local social and economic development. This requires working with a broader set of partners beyond health and social care, such as the education and housing sectors.

In relation to workforce, the concept of system working includes creating a sense of there being 'one workforce' across the whole system working towards a common set of goals.

About this report

This report is for anyone wanting to understand how ICSs are developing so far, and how they can be given the best possible chance of succeeding despite the adverse circumstances described earlier. To shed light on these broad questions, we focus on one specific area of ICSs' work – exploring what they are doing to support whole-system approaches to workforce and the challenges they are encountering in doing so. As described in subsequent sections, many of the insights into what ICSs are doing around workforce also have much broader implications in terms of the role of ICSs more generally.

The report is based on qualitative research in four case study sites:

- Humber and North Yorkshire
- Herefordshire and Worcestershire
- North Central London
- Greater Manchester.

We selected these sites in order to give a range of population and system characteristics, not because we regarded them as having the 'best' or most developed ICSs. Elsewhere in the report, we acknowledge that ICSs in many other areas are also doing innovative work on workforce.

In each of these sites we conducted in-depth interviews with ICB leaders involved in workforce roles (including chief people officers and their teams), senior leaders in people/human resources (HR)/workforce roles in NHS trusts, people with responsibility for the adult social care workforce, voluntary sector leaders, Healthwatch representatives and others. This allowed us to understand the development of ICSs through the eyes of a different cross-section of people from previous research, which has tended to focus on the views of chief executives and chairs.

We interviewed 24 people in total. Further details on our research methodology are provided in annex A.

The report is structured as follows. Section 2 examines what ICSs are doing to support whole-system approaches to workforce, describing six functions they are attempting to perform, how they are attempting to add value through doing so, and the challenges they are encountering. In section 3, we focus on the role of national leaders – particularly government and NHS England – in creating an environment that would enable ICSs to have more impact, through their work on workforce and more broadly. In section 4, we take stock of progress made by ICSs so far and discuss some of the issues and implications arising from our research. Section 5 concludes with proposals for a way forward that would help ICSs achieve their full potential, highlighting the need for leaders in national bodies and local systems to act together.

2 How ICSs are supporting whole-system approaches to workforce

Our research identified six critical functions that integrated care systems (ICSs) in our case study sites are performing to support whole-system approaches to addressing workforce challenges. These roles capture how ICSs can add value and offer something distinctive to the contribution made by individual organisations. The functions are:

- organising around a shared purpose
- building system leadership
- encouraging system-focused behaviours
- scaling and spreading success
- using resources more effectively
- managing complexity.

In this section we use workforce examples to illustrate how ICSs can perform these functions in practice. We focus on the behaviours needed from local leaders rather than attempting to provide a comprehensive account of the specific actions needed to develop whole-system approaches to workforce. We also examine some of the challenges leaders are encountering in doing this work.

Although we found evidence of all six functions being performed in our case study sites, the degree to which this is happening varies across systems. We therefore invite ICS leaders to challenge themselves on the extent to which they are performing these six functions in their local system.

Organising around a shared purpose

Shared ambitions are the foundation of system working and can be a powerful vehicle for unifying diverse views and enabling people to make decisions across a complex system (Walsh and de Sarandy 2023). For this reason, the ability of an ICS to cultivate a sense of shared purpose around workforce matters; it lies at the heart of being able to harness people's energy and motivation to work together.

We highlight below three ways in which the ICSs in our case study sites were organising around system-wide workforce plans to support healthier people and places. System leaders were working together to create:

- a sustainable pipeline of people who can deliver health and care
- a workforce that addresses health inequalities
- a workforce designed around individuals and communities rather than organisational and professional boundaries.

A shared ambition to create a sustainable pipeline of people who can deliver health and care

At a time when workforce is in short supply, it is perhaps unsurprising that ICSs found it relatively easy to build support for work to create a sustainable pipeline of people entering the workforce. Some ICSs are doing so by investing heavily in a 'grow your own' workforce strategy. They hope that attracting local residents into the health and care workforce, and keeping them in it, will provide a sustainable solution to meeting demand. To do so, they have been building closer strategic partnerships with local higher education institutions and others to ensure that they are involved in system working.

Herefordshire and Worcestershire ICS, for example, knows that their rural location and distance from an international airport make it harder to recruit and retain staff. Their 'grow your own' local talent strategy is proving successful in uniting partners around a shared agenda. They are thinking about how, as a system, they can challenge preconceptions about who accesses a career path in health and care, including medicine. This work relies on close partnerships across sectors, particularly with education and the voluntary, community and social enterprise (VCSE) sector – targeting schools, offering pre-employment support as well as

opportunities to progress once in the system. For example, the ICS has developed a clear career pathway that shows how a support worker can progress to senior clinical roles.

A shared ambition to create a workforce that addresses health inequalities

The 'grow your own' approach to workforce also creates significant opportunities to address health inequalities among the local population. Some systems are placing considerable emphasis on this, seeing it as a way of drawing on the different strengths of the partner organisations involved in the ICS and improving population health at the same time as tackling workforce issues:

> *Our single biggest contribution we could make, around health inequalities in Hull, is about people finding meaningful jobs that are paid above minimum wage, that aren't zero-hours contracts.*
>
> VCSE leader, Humber and North Yorkshire

An example of this approach is the work done in North Central London to support young people leaving care to enter the health and care sector, described in the box below.

Creating opportunities for young people leaving care in North Central London

North Central London ICS identified that 2,000 young people a year were leaving the care sector across its boroughs. It now has a system-wide programme, developed as part of NHS England's Universal Family Programme, which supports young people who have experienced care to move into meaningful employment and training in the health and care sector. The programme includes varied inputs from organisations across the system, such as mentoring support and the opportunity to participate in simulations that help young people experience what it is like to work in health care. Previously, individual boroughs had done work on this, but the involvement of the ICS was seen as having enabled people to come together and take up new opportunities.

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Creating opportunities for young people leaving care in North Central London *continued*

These new partnerships and collaborations opened doors to wider funding (for example, the Mayor's Fund for London). The work was jointly sponsored by senior leaders from the NHS and from local government Economic Regeneration teams, and is a clear example of how working together as a system with leadership and resource to make things happen can have an impact. As one interviewee explained, 'It was happening before, but it wasn't going anywhere, it was just ending up as a PowerPoint presentation.'

A shared ambition to create a workforce designed around individuals and communities rather than organisational and professional boundaries

By bringing together different partners, we saw signs that ICSs have changed the conversations people have about the workforce – for example, by broadening the focus to encompass the wider workforce beyond the NHS, including unpaid carers and volunteers. ICSs have had to support people to think differently about what care (and the workforce that delivers it) could look like in the future. Humber and North Yorkshire ICS's Breakthrough programme is one example of how a structured programme can be used to engage people in these conversations effectively. It also illustrates how good engagement enables transformation to happen at pace (*see* box on page 14). Interviewees clearly valued the structured process of engagement, supplemented by organisational development support, to make sure that people felt heard – perhaps for the first time – by other partners:

> *I think it's been a really good, structured approach, really taking it in bite-size pieces… The level of involvement has been remarkable really… taking people on that journey as well, if we want this to be a system change, making sure there are people across the whole system and at all different levels involved in it.*
>
> VCSE leader

Humber and North Yorkshire's Breakthrough programme

The Breakthrough programme aims to transform the health and care workforce in Humber and North Yorkshire and to reduce health inequalities by doing so. The programme takes a whole-system approach and has attempted to harness the power of dispersed leadership – in 2023/24, more than 340 people from all parts of the local system were actively involved through task and finish groups covering 11 workstreams. Interviewees across this ICS spoke enthusiastically about having a structured and highly inclusive approach to workforce transformation.

The first workforce summit in the system took place in September 2022. As a way of building shared purpose, partners were asked to think through how the care and support offered to a fictitious woman, named Rani, could be improved. Rani's story, and the workforce transformation required to better support her in her own home, became a shorthand for people to think about how a system (including the VCSE, volunteers and unpaid carers) could work in different ways.

Following the summit, the integrated care board (ICB) launched 180 Days of Action on Workforce. During this period, system partners undertook a series of activities to agree what a whole-system approach to workforce would look like in eight areas, including care at home and ethical international recruitment. The ICS used powerful story-telling and high-quality communications (including a 180 Days digital storybook and film) to share the outputs from this process, and to demonstrate why change is needed and what the new approach will involve.

The 180 Days programme fed into the Breakthrough programme, which provides the vehicle for taking forward the priority actions identified. One of the notable aspects about the Breakthrough programme, which was mentioned by everyone we interviewed, was the way in which all partners – from the ambulance service to the VCSE – were made to feel they had an equal voice in the room. This 'levelling up the room' did not happen simply by putting people together; leaders recognised the skill and expertise needed to enable participants to have conversations that could be challenging and sometimes deeply uncomfortable. This programme appears to have created an environment in which partners continue to see the value of doing system work, and are committed to working together in this way.

Building system leadership

Working as a system calls for new forms of leadership, and ICSs have an important role to play in growing and cultivating these new forms. System leadership requires specific skills and capabilities, such as the ability to bring together people from different sectors and organisations, to make sense of the whole system, to hold on to an overall vision for it, and to maintain constancy of purpose collectively over time (Walsh and de Sarandy 2023; Timmins 2015).

ICSs have created spaces that bring together leaders from across the health and care system and more widely to discuss workforce challenges and to develop solutions. All the case study sites have a workforce or people board responsible for overseeing the system's work on workforce. There are also groups leading workstreams focusing on specific workforce issues and service areas. Interviewees shared how they were working to make these boards and groups representative of the whole system in terms of their membership.

However, interviewees noted that it was not enough to have people 'around the table'. Creating genuine whole-system leadership involves supporting people to act effectively in these collaborative spaces and tackle the power imbalances that can sometimes get in the way. We found several examples of integrated care boards (ICBs) addressing these issues and attempting to support the development of system-leadership skills.

Providing training and development in system-leadership skills

System working can challenge established ways of working and leadership styles. Even experienced leaders acknowledged that this is a significant shift that many may need support with:

> *It's a very different skillset for us as chief execs, to be able to work in partnership and to develop those partnership relationships, as opposed to a traditional skillset that a chief exec had, where you were just in charge of your own organisation. You have to cede your authority in the sense you have to facilitate joint leadership across the system and in place. And that's a very difficult skillset. And for some, it's easier to do than others.*
>
> Chief executive of an acute trust

All four sites were investing in development programmes designed to strengthen system-leadership skills. Some have identified specific parts of the system where training and development is needed. For example, Herefordshire and Worcestershire ICS has developed leadership training for primary care clinicians to help support their participation in system work. The work was overseen by an ICB lead who had fostered a relationship with primary care over a period of time.

System leadership is not just for people in positions of authority. North Central London is an example of an ICS working to support frontline staff to do system work, with a programme for nurses and midwives that aims to help them develop system-leadership skills.

Creating a more diverse leadership community and addressing power imbalances

We found widespread tensions in ICSs between focusing on NHS priorities versus wider system agendas, with several interviewees describing a tendency for ICS work to be NHS-centric. To address this risk, some ICSs have purposefully reduced the number of representatives from traditionally powerful parts of the system (such as acute trusts), in favour of greater representation from other parts of the system (such as the VCSE sector). Some interviewees felt that considerable progress had been made in this regard:

> *Now it's pretty standard that we have equal voices in the room. When we run our summits or we come together to review how we've been doing, it's accepted that actually you're going to have an equal number of voices in the room. So voluntary sector has the same number of voices as the acute. So it hasn't been without its teething problems, but we were very purposeful about it, and we've got a different model.*
>
> ICB Chief People Officer

One example of this is the 180 Days and subsequent Breakthrough workforce programmes in Humber and North Yorkshire ICS, described on pages 13–14. Humber and North Yorkshire also appointed a leader from the voluntary sector to chair the workforce board for the system (*see* box on page 17). Other ICSs have made similar decisions to appoint leaders from outside the NHS to senior roles as a way of bringing a different dynamic and perspective into system conversations.

Recruiting a VCSE chair for the workforce board in Humber and North Yorkshire

Humber and North Yorkshire ICS diversified its workforce board by deliberately recruiting a chief executive from the VCSE sector to be chair and responsible officer for the workforce transformation programme – a person from a sector that some participants argued is often marginalised and not always influential in workforce planning. In this role, the chair has helped to challenge NHS-centricity by having more partners from non-health organisations at the table and amplifying the voices of smaller and marginal organisations. This has led to a more inclusive multi-sector approach that involves more diverse voices.

Other examples involved ICSs seeking to diversify their system-leadership community by creating opportunities for staff from marginalised groups to become involved in system work. In North Central London, the Future Leaders programme, aimed at staff from Black, Asian and ethnic minority communities, is an example of a leadership initiative whose purpose is to support people from minority communities to take up leadership roles that may not otherwise be available to them (*see* box on page 25).

Another issue in relation to building a diverse leadership community was the challenge of engaging primary care in workforce development at the system level. This has been an important issue in many ICSs because of the need for practices to provide backfill when GPs take time out of clinical work to contribute to work at the system level. ICSs were working in various ways to better engage with primary care, including having funded primary care representatives on the people and workforce boards, engaging with GP federations, and using individuals with a specific primary care role within the ICS to facilitate engagement.

Strengthening relationships

Effective system leadership depends on trust and relationships. ICS leaders described the importance of protecting time to build relationships with other sectors and organisations. For example, ICB chief people officers told us they prioritised meeting regularly with their counterparts in NHS trusts and other partner organisations, having protected time with them to conduct deep dives

on specific workforce issues, and taking part in joint development activities. These relationships help engender a more collaborative leadership approach – work that may not be easily measurable but which is fundamental to the success of the system's work on workforce and other matters. We also heard that it can be challenging to give this relational work the priority it deserves:

> *And there's some good relationships that we can hang off, but they take time to build and people sometimes have struggled, I think, to allow themselves the time. In a world that's massively pressured and everything's about targets, allowing yourself the time to just build the relationships, because that's going to be the currency against which you work, is really difficult.*
>
> ICB Chief People Officer

Encouraging system-focused behaviours

Since the creation of the internal market in the NHS in 1990, NHS trusts have functioned as sovereign organisations, often in competition with each other, including for staff. One of the expectations when ICSs were introduced was that they should adopt a 'one-workforce' approach (**NHS England and NHS Improvement 2021**), optimising staff resourcing across the system. The benefits were expected to include more flexible deployment of staff to meet the needs of local populations, and delivery of integrated, multidisciplinary, person-centred care.

The attempt to move towards 'one workforce' across all health and social care partners in ICSs relies on organisations adopting a system-focused approach, rather than one where each partner focuses exclusively on its own recruitment and retention activities in isolation. Especially given current workforce shortages, an 'organisation-first' approach reinforces zero-sum competition between providers for a limited supply of staff.

We saw some evidence of system-focused behaviours taking root. For example, in response to workforce shortages, a provider collaborative in Greater Manchester agreed a rate for additional hours to avoid trusts competing for staff, and tackled problems in ambulance handover and surgery waiting times by shifting workforce capacity around the system. And in Humber and North Yorkshire, large acute trusts have provided guidance and training to support smaller trusts and social care providers with the complex process of international recruitment.

Persistence of organisation-first behaviours

The general sense from across the case study sites is that system-focused behaviours are becoming more widespread. However, a number of interviewees identified resistance to this shift and provided evidence of organisation-first behaviour persisting in both NHS providers and ICBs. This included: defensive behaviour in system meetings and activities; superficial agreement on system activity without commitment to implementing the necessary practices; protectionism around budgets; and ongoing competition for staff.

In some instances, organisational processes and interests stood in the way of system-focused activity. We heard about attempts to use mutual aid arrangements to help fill gaps in corporate services teams that failed because each organisation still has its own policies, procedures and systems rather than a cross-system approach. Similarly, an agreement among provider boards to achieve greater alignment on locums was resisted by finance teams that all had different approaches to the problem. Some interviewees were concerned that at times, partners are collaborating primarily to solve problems in their own organisations, with some suggesting that it takes a crisis – such as the Covid-19 pandemic – for organisations to act in a genuinely system-focused way.

However, there was also recognition of the context that trusts are working in. They are still accountable for ensuring that they have a workforce that can deliver care that is safe and appropriate, so there are some aspects of workforce strategy that are legitimately owned by them rather than by the system. Furthermore, we heard several reports about how trusts need to stay competitive around workforce because of competition from other neighbouring ICSs. This context means that the tension between competition and collaboration is unlikely to go away; rather, it will be an ongoing tension that ICS leaders will need to continue to manage.

How ICBs are supporting system-focused behaviour

Our research found that ICBs are attempting to support system-first behaviours in a number of ways.

First, they are delivering programmes that instil these values and behaviours across the workforce. For example, Herefordshire and Worcestershire ICB operates an ‘academy’ model that brings together providers from across the system to provide

training that is available to all staff working in health and care, including staff from VCSE organisations and independent social care providers. By creating flexible career paths and development opportunities that support workforce retention, the academy model represents a system-wide response to the system's needs, but it also models a 'whole-system' perspective designed to encourage system-focused behaviours among staff (*see* box below).

Herefordshire and Worcestershire ICS Academy

Herefordshire and Worcestershire has established an academy to deliver training and development, comprising a 'one-stop shop' – an integrated suite of training, learning and workforce development resources available to the health and social care workforce across the system.

The model is led by the ICB but relies on collaboration and co-design from organisations across the system, whose representatives work within seven faculties based around professional groupings – medical, pharmacy, health care science, nursing and midwifery, allied health professionals, social care, and the voluntary sector. Some functions sit across faculties, including (for example) an advanced clinical practitioner working group, a system-wide apprenticeship participation hub, a leadership and culture programme, and a management development framework.

The model includes training and development programmes that are hosted on the ICS Academy Exchange, a shared learning management system that allows all partner organisations to access e-learning and book on to face-to-face training sessions. Some of the system-wide programmes implemented to date include training on hate crime, developing potential, LGBTQI+, health literacy, personal care decision-making, health inequalities capability building, and the Oliver McGowan Mandatory Training on Learning Disability and Autism programme. At a time when financial and capacity challenges make it harder for individual organisations to address the workforce development needs required to deliver integrated care, the Academy Exchange has created the opportunity to increase learning and development across the health and care workforce.

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Herefordshire and Worcestershire ICS Academy *continued*

The Academy also provides the framework for cross-system workforce planning. Through working groups facilitated by the ICB, representatives from each faculty work together to establish their workforce development needs – and the extent to which these are unmet – in relation to supply, upskilling, new roles, new ways of working, leadership and talent management, and to support system-wide solutions to the challenges identified. This approach enables a focus on the areas that most need targeting (such as the social care and voluntary sector workforces) while also encouraging interdependent working on key workforce objectives. It also fosters a common approach to key issues that sit across professional groupings, such as hospital discharge.

Although organisations have been used to considerable autonomy in relation to workforce planning, they have discovered that they share common challenges and needs, and now report appreciating the benefits of collaboration rather than competition.

ICBs are also encouraging system-focused behaviours through relationship-building and organisational development. Practical examples include creating cross-system committees to oversee collective approaches to specific issues (for example, ethical international recruitment), and working with motivated individuals in partner organisations who can see how patients stand to benefit from collaboration. One interviewee noted that acute trusts in their system are now giving greater recognition to the need to involve partners across the breadth of health and care in workforce planning; another observed that as systems start to actively reward system-focused projects, individuals are starting to offer up time to participate in them because they see the associated career opportunities.

Another way that ICBs are supporting system-focused behaviours is by providing the infrastructure to scale up examples of good practice. One interviewee described a partnership, currently in development, which will see an acute trust seconding nurses to a hospice when staffing falls to insufficient levels to keep its beds open, thus alleviating pressure on the wider system. The partnership is being worked out at place level, but will be shared across the ICS if successful. The following subsection provides further examples of how ICSs are supporting successful initiatives to be spread or scaled up.

Scaling and spreading success

The introduction of ICSs enables health and social care partners to work together across a larger geography. Although care must be taken to avoid 'lift and shift' approaches that ignore local context, there are opportunities to have impact at a greater scale and to avoid duplication of effort by spreading and scaling successful innovations across the wider system (**Horton *et al* 2018**). We found examples of system-wide workforce initiatives that had been led by ICBs as well as provider-led initiatives that had then been scaled up to system level. Whether ICB- or provider-led, practices adopted and developed at system level are often passed back to organisations or places for locally specific implementation.

ICB-led programmes

We heard several examples of ICBs leading programmes that are being implemented system-wide. For example, Greater Manchester has developed a Wellbeing Toolkit designed to encourage self-care among the workforce, available to all staff across the system. Other examples of ICB-led activities across our case study sites include:

- a system that allows local providers to recruit international staff ethically through the ICB
- provision of a training programme on autism and learning disability for all health and social care staff
- developing workforce strategies, induction packages and human resources (HR) documentation such as job descriptions that can be used by providers across the ICS
- joint recruitment, training and placements across the system
- funding link workers to test new methods of care delivery for specific communities.

Together, these examples illustrate the breadth of system-wide workforce programmes being led by ICBs. The exact role played by the ICBs in these examples varied. In some, the ICB acted as a vehicle for overseeing the implementation of a nationally mandated programme, not dissimilar to the role played by previous bodies such as strategic health authorities. However, generally, the ICB role tended to be a more facilitatory one – for example, supporting the piloting of workforce initiatives or encouraging organisations in the system to consider new opportunities.

Provider-led programmes

Our sites shared several examples of workforce initiatives that had been led by local providers and scaled up across the system. For example, local authorities and social care providers in Greater Manchester have collaborated with NHS community services to deliver a programme that has created blended roles based in neighbourhoods, equipping social care staff with the skills to deliver some health care tasks (*see* box below).

Blended health and care roles in Greater Manchester

The Blended Roles programme in Greater Manchester was established to address challenges across neighbourhood-based roles supporting people within their own homes. It focused on independent sector home care services, and district nursing teams. The challenges identified were as follows:

- People were reporting a disjointed experience of care and support and a lack of person-centred conversations.
- There were reports of poor communication between health and care professionals.
- There were issues with recruitment, retention and caseloads for home care and district nursing teams.

A pilot in the Tameside locality brought teams closer together, through joint working and jointly developed care planning, with home care staff trained and competency assessed to undertake some tasks previously performed by district nurses.

The impacts of the pilot were as follows:

- More than 9 in 10 (92%) of staff members surveyed reported improved job satisfaction.
- Staff and patients reported better joined-up care, with reduced risk associated with poor communication across organisational boundaries.
- There was a reduction in the number of people waiting for interventions.
- There was a significant impact on the number of visits needed by district nurses, which has increased the amount of time available to spend with people with more complex nursing needs.

The programme continues to gain momentum and develop across Greater Manchester. In 2021, a dedicated Blended Roles Coordinator was appointed to expand the programme across the ICS and, following the same model, an insulin administration training programme has been piloted in Tameside.

The role of ICBs in supporting and scaling up provider-led programmes

ICBs have a role to play in supporting both the development and the scaling up of provider-led programmes, ensuring that the benefits can be felt system-wide. As one ICB Chief People Officer told us, 'When you find out what people are doing in isolation and you bring it all together, you can actually achieve far more'.

For example, the work on blended roles in Greater Manchester started in one locality but was rolled out across the system with resource from the ICS. Notably, although the ICB's involvement 'provided the traction' to scale up the programme, it was handed back to places and organisations for locally specific implementation, indicating that there needs to be a balance between 'doing things once' and tailoring programmes to meet local need.

Similarly, North Central London's Future Leaders programme, designed to progress more Black, Asian and ethnic minority staff into senior roles, was started by one provider and was then developed into a system-wide programme. The ICB played an important role in scaling up the programme to system level (*see* box on page 25).

In some instances, in addition to providing support to scale up provider-led initiatives, ICBs have delivered complementary activity that has added value to the work already going on in organisations and places within the system. In Humber and North Yorkshire, the ICB established an Inclusion Assembly to connect and scale up existing staff networks (such as those for people from Black and ethnic minority backgrounds, people with disabilities, and LGBTQI+ staff). By bringing the networks together, the ICB created possibilities for wider impact beyond the work of the individual networks.

Future Leaders programme in North Central London

In response to the under-representation of Black, Asian and ethnic minority staff in leadership roles, North Central London ICS established the Future Leaders programme, designed to help people progress to more senior roles.

The programme follows an asset-based approach to enable leaders currently under-represented at board level to move into board positions. Each organisation nominates participants interested in an executive leadership role, and these individuals then receive mentorship and support. The programme has created a network of aspiring leaders across the ICS who support each other.

The programme objectives are to:

- increase the number of executive directors from under-represented ethnic backgrounds across the ICS
- appoint a minimum of three individuals across health, primary and social care by April 2024
- demonstrate what works in accelerating members of under-represented groups into leadership roles.

The ICB played a co-ordination role, helping to bring the funding together from participating organisations, and assigned a senior responsible officer for the programme.

Although the process of getting agreement across multiple organisations and levels of governance was reported to be a challenge, the ICS has been instrumental in extending collaboration from a few organisations that already had a high degree of partnership working to a system-wide programme. Building relationships has been key in implementing the programme in terms of convincing organisation leaders to commit resource to programmes without certainty of the impact within their organisation.

Participant feedback on the programme has been positive and so far, three (21%) of the first cohort have secured new roles at an executive director level.

Ongoing challenges in scaling and spreading success

Although we heard a number of examples of ICSs supporting workforce solutions at scale, we also heard that this work can still be challenging. For example, one interviewee explained how it can be highly time-consuming and labour-intensive when agreement and sign-off needs to be achieved across multiple partners.

We also heard of some examples where local partners were concerned that a system-wide offer (for example, on staff health and wellbeing) might duplicate existing offers within individual organisations. The ICB addressed these concerns by reviewing existing provision, engaging carefully with providers to understand how a system-wide offer could add value, and piloting the new service before rolling it out fully.

Using resources more effectively

Part of the rationale for establishing ICSs was to enable organisations to make better use of their collective resources to improve population health and care outcomes. We found some examples of ICSs sharing funding and other resources to support workforce development across the system. However, we also heard that pressure on budgets was making this harder to do, and in general our assessment is that ICSs are still some way from fully embracing their potential role as stewards of collective resources.

ICB leaders talked about how they are using funding in different ways to support workforce initiatives across the system. For example, in Humber and North Yorkshire, the ICB has combined money from several sources to create a fund that task and finish groups can bid for to do work related to the 11 workstreams developed through the Breakthrough programme (*see* box on page 14). The fund is managed by a Workforce Investment Committee that involves partners from across the system who make investment decisions jointly. This illustrates the kind of difference that ICSs could make; in principle, having a statutory budget-holding body with a broader remit than previous NHS commissioning bodies should make it easier for funding to be used flexibly in this way.

Moving resources upstream

To meet the rising demand for health and care services, there is a broad consensus that more emphasis needs to be placed on improving population health, helping people to stay well, and preventing avoidable illness (**Hewitt 2023**). Achieving this means strengthening the community-based workforce, including in primary care, social care and the VCSE sector (**Baird *et al* 2024**). In recognition of this, some ICSs are attempting to use their resources to invest in this 'upstream' part of the

workforce. For example, in one site, underspends in parts of the mental health workforce budget were being used to fund local voluntary sector services to support people while they waited to see a professional.

ICBs were also seeking to support community-based services by providing non-financial support. For example, one chief people officer discussed wanting to use the ICB's workforce and HR expertise to support workforce development in VCSE, primary and social care organisations. However, the need to focus on providing internal HR support to ICB employees during the major restructuring and redundancy processes of the previous year (*see* section 3) has so far meant that the teams have lacked capacity to do much of this system-facing work:

> *Our people services team are largely concerned with the organisational change* [in the ICB] *at the moment… But longer term, the ambition is that there is potential for our HR advisory service to offer a service to primary care, to social care, to the VCSE sector.*
>
> ICB Chief People Officer

Although support such as this was welcomed, some interviewees from outside the NHS believed that ICSs need to be much bolder in using funding differently – for example, by investing more significantly in the community-based or preventive workforce.

Creative use of apprenticeship funding

All of the case study sites were trying to make best use of the apprenticeship levy to grow their workforce across the system (*see* box on page 28). Apprenticeships can be used to help people into work and also for existing health and care staff to further develop their skills, while still working. Apprenticeships can also help diversify the workforce by recruiting and training people who may not have previously had the opportunity to work in health and social care.

Maximising use of apprenticeship funding

The apprenticeship levy is money paid by employers that is then stored in an apprenticeship fund and used to help organisations pay for apprenticeship training. The levy applies to all employers with a payroll of more than £3 million. Where there is an underspend, the money is typically returned to central government.

All the sites talked about how they were using apprenticeship funding to maximise the health and economic benefits for local people. Often, this included looking at how underspends in one part of the system could be used elsewhere.

Through its Academy model (*see* box on pages 20–21), Herefordshire and Worcestershire ICS is developing an apprenticeship-wide participation hub at system level to help support cross-sector, multidisciplinary thinking on apprenticeships. The ICS is also enabling existing health and care staff to undertake apprenticeships by using workforce development funding to backfill their posts, which was described as a 'big investment but we see it as critical to grow the future workforce'.

In Greater Manchester, there is an aspiration to develop jointly delivered health and social care apprenticeships, allowing trainees to gain experience in different areas including acute, primary care and social care, with an opportunity to specialise afterwards.

In North Central London, the ICS is working with voluntary sector partners to widen access to apprenticeships to all parts of the local population.

Managing complexity

System working is complex and messy. Patients and the public need ICSs to manage the complexity of modern health and care if they are to experience care that feels seamless and joined up. The ability of ICSs to do so is arguably one of the key factors that will determine their success. Our research explored how ICS leaders are attempting to embrace this complexity and to enable others to view it with enthusiasm and potential, rather than feeling overwhelmed by it.

The concept of 'living systems' that are dynamic, constantly changing, and dependent on interconnecting networks offers a helpful metaphor for system work (Rogers 2021). Viewed as living systems, the task of managing complexity becomes one of understanding relationships, making connections, adaptation

and collective action rather than following clear plans and strategies. These are all roles that ICSs are well-placed to play, as illustrated by the examples described in previous subsections.

Making decisions in the context of complexity

Good governance and shared ambitions are key to supporting people to make high-quality decisions amid uncertainty and ambiguity. Much effort goes into trying to articulate decision-making structures (often with complex organograms). The ICSs in our case study sites had experienced mixed success in terms of arriving at a clear and effective set of arrangements. Pre-existing arrangements across the health and care system make this work somewhat challenging. For example, elected local authority representatives need to remain accountable to a specific geographical population, and this can make them feel less able to take decisions on behalf of a wider system.

The structures created by the 2022 health and care reforms are undoubtedly highly complex, involving a large number of partner organisations and multiple decision-making bodies and levels (including integrated care partnerships (ICPs), ICBs, and various other boards and committees at place and system levels). Despite this, some of the leaders we interviewed said they felt empowered to make decisions within a clear framework and shared priorities. Others were less certain that the new structures would drive change and support good governance. For example, we encountered frustration from some interviewees at having to 'wade through layers' of meetings in order to get a decision. There was some debate about whether this is an inherent feature of the current arrangements or something that will improve over time as processes become clarified and simplified.

Supporting people to understand the complexity of system work

Making good decisions requires more than a framework or clear governance structures; it requires people to behave in ways that build understanding and trust. Interviewees spoke repeatedly of the importance of both taking this time and working critically to ensure that people in all parts of the system felt heard and understood:

> *Every month, we have a deep dive into a strategic priority with all the chief executives. So we do make the space for it, because you have to. If you don't carve*

> *out the time… so that's kind of one of our philosophies – if you don't carve out the time, you'll go backwards because you can't stand still.*
> ICB Chief People Officer

We heard, for example, how helpful it is to take time to craft a shared language – and work through basic concepts such as 'is the front door at the hospital, or in someone's home?'

In our case study sites, support to help people make sense of the complexity of the system was sometimes provided in the form of independent coaching and facilitation, as well as practical programme management. Funding for this kind of resource was easily overlooked and was often hard-fought for, and yet leaders placed a high value on having the challenge, climate and space to think and behave differently, and to practise having honest and often uncomfortable conversations.

The ability to manage complexity and to plan and deliver improvements depends a great deal on what we describe as a 'hidden infrastructure'. It is this work – of strengthening relationships and making connections, organising around a collective purpose and building the capacity to think about the future – that enables 'living systems' to learn, adapt and improve. Recent resources provide more detailed descriptions of what this work looks like in practice, including research on the practice of collaborative leadership (**Walsh and de Sarandy 2023**), practical guidance on creating a culture of integration (**NHS Employers 2023**), and a benchmarking tool for assessing progress (**NHS Employers 2024**).

3 Creating an environment in which ICSs can flourish

In this section we examine the role of national bodies in creating an environment in which integrated care systems (ICSs) can flourish. Our analysis highlighted three themes that were seen to be particularly important in our case study sites:

- realistic expectations
- an enabling approach to accountability and regulation
- flexible funding.

Realistic expectations

As described in the introduction, the two years since ICSs were given statutory status have been among the most challenging the NHS has ever faced. It became clear in our research that these challenges have significantly impeded ICSs' efforts to develop innovative workforce solutions across their local system.

The practicalities of abolishing clinical commissioning groups (CCGs) and setting up integrated care boards (ICBs) have been more complex and time-consuming than expected in some of our case study sites – particularly where CCGs had not already merged prior to the creation of the ICB. In addition to the intrinsic challenges that come with any restructuring, we heard that managing the redundancy processes triggered by the national requirement to reduce management costs by 30% has consumed a significant amount of time for human resources (HR) and workforce teams in ICBs, while industrial action in 2023 and 2024 has meant that their counterparts in NHS trusts have often been focused on maintaining safe staffing levels.

Dealing with these immediate pressures has meant that staff in HR and workforce teams who otherwise could have been implementing strategic ambitions to redesign and transform the workforce across the local system have instead often

been diverted to crisis management. This has inevitably meant that their focus has been on more transactional processes at the expense of transformational thinking and actions:

> *We've probably never really experienced it as bad as this, as it is right now in terms of recruitment and retaining staff. And then trying to make the biggest transformational change in our history… When your back's up against the wall, you need to do what needs to be done here and now and sometimes that longer-term vision and aim does get lost.*
>
> Voluntary, community and social enterprise (VCSE) leader

> *I feel like we've slowed down a little bit on progress* [since becoming a statutory body] *because the organisation is trying to form itself… I think we've probably lost some of that impetus that we had as a partnership. It's not been a fantastic 12 months in terms of being able to push forward on some of the transformational stuff.*
>
> Social care leader

In this context, policy-makers and national bodies need to be realistic about how fast ICSs can be expected to demonstrate progress on workforce and other objectives. Excessive pressure to deliver quickly can be counterproductive. For example, we heard of systems having to take sub-optimal action mid-year (such as not filling vacancies, adding to pressures on staff) because they had been required to submit unrealistic financial plans at the start of the year. We also heard that the pressure to meet unrealistic expectations was in some cases having an extremely negative impact on individuals' welfare:

> *What* [national bodies] *are asking for is not deliverable. Trying to keep kicking people to get something that you can't get is just cruel. And I see it in the faces of colleagues busting a gut, trying to face in two different directions at the same time. Really, really good, able people. It's brutal and it's shameful and it's destroying people – good people that have worked for decades.*
>
> VCSE leader

In some sites we saw ICS leaders pushing back on some national demands and trying to protect their staff from the adverse impact these can have, but this took

confidence and was seen as being easier for more established leaders or in sites with better performance and finances. Many interviewees argued that they would need more time and a period of stability before they would be able to fully realise the potential of ICSs to deliver innovative solutions to workforce challenges.

An enabling approach to accountability and regulation

There was recognition among the system leaders we interviewed that ICSs need to be held to account by national bodies for delivering improvements for local people. There was also recognition that national bodies are themselves changing and that their approaches to working with local systems are evolving over time. For example, NHS England is working to implement a new operating framework designed to reshape its interactions with local systems (NHS England 2022), but these changes take time to embed. Despite these efforts, a clear and consistent message from our research was that the mechanisms currently used by NHS England and other national bodies to hold ICSs to account, as well as the style and manner with which these mechanisms are sometimes deployed, often have several unintended negative consequences.

One of the concerns commonly raised was that the volume of reporting requirements to national bodies consumes a significant amount of time, which reduces capacity in workforce teams to deliver strategically important work with local system partners. It was felt that the data returns and assurance required by some national programmes was disproportionate to the scale of the programme or to its importance relative to other local priorities:

> *I'll give you an example, it's really frustrating because the Health Education England contract, you're required to fill in a 40-page online self-assessment against that. They were asking for examples of best practice, et cetera. The time that that takes to go through that and then you never get anything back, it seems to go into a dark hole.*
>
> Acute trust HR Director

Highly directive performance management by national bodies can also have a knock-on effect on local relationships within systems. Some ICB chief people officers described becoming pulled into assurance conversations between NHS England and HR directors in provider trusts. Several talked about the difficulty they encountered

in playing a dual role, acting as an enabler of collaboration across the system at the same time as being expected to play an enforcement role on behalf of national and regional teams (for example, in relation to the amount providers spend on agency staff). A common view was that existing forms of accountability make it harder to balance these two roles successfully:

> *We're almost becoming the region and taking over all of those assurance elements. And that wasn't the purpose of ICB… 70% of those meetings* [between the ICB Chief People Officer and HR directors in trusts] *will be eaten up in managing the pressure that's coming in through that national and regional session rather than purely being around the transformation.*
>
> ICB Chief People Officer

> *I have found that really hard to get my head around. Am I there to tell the providers off or am I there to build relationships with them?… And that constant shifting between the type of relationship you're holding is very difficult… So, I think some clarity around where does the reporting and the management happen, the performance management of the system, and where does the collaboration happen, would probably be the biggest thing actually – and not muddling those.*
>
> ICB Chief People Officer

A fundamental challenge identified by several interviewees is that there is a mismatch in scope between NHS England and ICSs. NHS England is only held accountable by ministers for the performance of the NHS, whereas ICSs have a whole-system remit and include bodies such as integrated care partnerships (ICPs) and local authorities, which have no equivalent national body holding them to account. This mismatch in scope can have a material impact on the kinds of workforce issues ICSs give priority to, driving the NHS-centricity discussed in section 2. For example, we heard that workforce plans submitted to NHS England on an annual basis do not cover some of the more innovative work that systems are doing to create new ways of working and blended roles across health and social care:

> *We came into this role full of enthusiasm for the opportunities it brought to truly look at cross-system workforce development and the fourth purpose of ICSs. And actually, it feels like you're being stuffed into an NHSE* [NHS England] *performance box.*
>
> ICB Chief People Officer

There was also a widespread view that despite efforts to develop systems-based regulation and accountability, the continuing role of the Care Quality Commission (CQC) and NHS England in holding individual NHS providers to account reinforces organisation-first behaviours and can make it harder to change ways of working in the ICS. Some of the leaders we interviewed from NHS trusts were candid about how this can encourage behaviours such as competing for staff, as described in section 2:

> *People say they hold the system to account. Well, they don't hold the system to account, they're holding us to account, as individuals. So, at the end of the day, that promotes certain behaviours doesn't it? So, people will look after themselves, and do what they need to do, because we are not being held to account as a system.*
>
> Acute trust Chief Executive Officer

Reflecting on what a more enabling approach to accountability would look like in practice, a common theme from interviewees was that it would include a bigger emphasis on supporting peer-to-peer challenge and learning within and between ICSs. As proposed by the Hewitt Review (**Hewitt 2023**), this could draw on well-established peer review processes used by local government. Strengthening local accountability arrangements in this way could complement accountability to national bodies and allow the latter to adapt their approach accordingly.

Flexible funding

One of the principal opportunities created by ICSs is the ability to direct resources to the parts of the system where they will have greatest impact. Interviewees in our case study sites wanted to invest in building workforce capabilities across the full breadth of the system in order to deliver their strategy to shift towards a more community-based model of care. However, they argued that their ability to make the most of opportunities like these will require greater flexibility in how national funding can be used.

A major concern was that it has become increasingly difficult to use national funding to support workforce transformation, training and development outside of the NHS. Several interviewees connected this to the merger of Health Education England (HEE) with NHS England and the consequent changes to workforce development funding previously available through HEE, as well as recent changes

to workforce development funding for adult social care. ICB leaders said they now had less flexibility in terms of how funding could be used. In some sites, interviewees representing social care and other parts of the wider workforce said they were starting to see a reduction in budgets for training and education:

> *We used to have HEE* [Health Education England] *funds every year which we used to support whole-system workforce development, those have now gone… NHSE* [NHS England] *money needs to be spent in the NHS, can only be transferred to NHS partners. We obviously try to push the boundaries… We have included colleagues from primary care and social care… But the assurance and their concern is only about the NHS.*
>
> ICB Chief People Officer

> *The funding to enable career pathway development* [for social care staff], *to enable access to education and training, to release people from the front line to enable them to progress and to match it with pay progression, is simply not there.*
>
> Social care leader

As touched on in the previous subsection, on accountability, a common criticism was that funding for workforce initiatives often comes in the form of relatively small and time-limited funding pots designed for specific purposes and with multiple conditions attached. We heard that this can limit ICSs' room for manoeuvre and make it harder to plan ahead. For example, some of the ICB workforce teams interviewed said they were unable to use underspends in one training budget to support the development of a different staff group that they had identified as being a higher priority locally. We also heard that this approach to funding can lead to lots of staff (particularly those in innovative new roles) being employed on fixed-term contracts, making it harder to attract the right candidates in sufficient numbers and to retain and develop them over time. And because different funding pots often come from different national or regional teams, interviewees felt that they were not always well aligned in terms of their objectives:

> *I think what we have is lots and lots of tiny pots of money that don't aggregate to a big impact. What I want to see is a smaller number of big programmes, that are longer term, that have a real impact on people.*
>
> ICB Chief People Officer

> *Half the time, nurses can't even go on the training because they're short-staffed. And then we can't spend the training money more innovatively on the things that we could spend it on. Give us more autonomy on the training and development that meets those localised needs.*
>
> ICB workforce lead

In relation to workforce and more generally, giving local systems greater discretion to use funds in ways that best serve their local needs and priorities is likely to deliver greater impact from the resources available. It would also help to strengthen the local partnership working on which the success of ICSs depends.

4 Taking stock of progress

As stated in the introduction, the two years since integrated care systems (ICSs) took on statutory powers and responsibilities have been extremely difficult. However, looking across our interviews, our overall view is that progress is being made. It has not always been linear, it has certainly not come easily, and it remains at times elusive to define. Nonetheless, in our case study sites, we saw signs that ICSs are beginning to build a more 'whole-system' approach to workforce despite the challenges described. Several interviewees surmised that something 'feels different' under the new arrangements:

> *I can't measure the difference, I can't show you the evidence for that, I just know it feels different.*
>
> Voluntary, community and social enterprise (VCSE) leader

As shown in section 2, there are examples of systems doing innovative work on workforce that takes advantage of the system-wide perspective that ICSs offer. Our concern is that some of these examples may prove to be standalone projects dependent on highly motivated individuals, rather than being the product of a more comprehensive transformation in the way organisations are approaching workforce challenges.

In general, the 2022 reforms, which gave ICSs statutory powers for the first time, were seen as having helped to consolidate an existing direction of travel. Some interviewees argued that they would not have been able to take their system work as far or as fast without the clear legal mandate given to them by the Health and Care Act:

> *I think it cuts off nine months of partnership work, having an ICS… because the mandate to work at scale and think about it as a system is there.*
>
> Public health consultant

However, this was not a universally held view. In one of the sites, there was a widespread feeling that the upheaval associated with the 2022 reforms had

set them back, at least temporarily, and that some of their more transformative plans on workforce had been delayed as a result. These differences between sites illustrate the uniqueness of each ICS and the impact of local circumstances and histories.

There were also different views on the role of integrated care boards (ICBs) and the value they are adding to partnership work. Many felt that ICBs are still 'finding their feet'. Some of the provider trust leaders we interviewed suggested that there is a risk of ICBs becoming an 'extra layer' in the NHS performance management hierarchy rather than a nexus for the local system. ICB interviewees often acknowledged this risk and said that they were trying to ensure that their teams focus their efforts on activities that add most value to the wider system. This included speaking to partners to understand what they would find helpful from the ICB.

Although we saw signs of progress, our research also found that there is a clear risk of ICSs going 'off track' as a result of the extremely difficult circumstances in which they have been created and the policy responses to those circumstances. Several sites reported that the need to focus on national imperatives such as elective recovery meant that some of their partnership work on workforce transformation was proceeding at a slower pace, and ICB leaders frequently found themselves being pulled into a performance management role at the expense of focusing on the six functions described in section 2. The concern must be that ICSs will not achieve their full potential unless more is done to create an environment conducive to their success (*see* section 3).

Visible and invisible changes

Part of the challenge in assessing the progress made by ICSs is that some of the most important work conducted over the past two years is intangible and hard to measure. There have been visible changes – for example, partner organisations adopting a shared approach to recruitment, developing new roles or extending training opportunities to staff outside the NHS. But changes of this kind have been underpinned by the largely invisible efforts of local leaders to strengthen relationships, change mindsets, and encourage different behaviours within their system. This unseen work is vital because without it, the shift to system working will not be sustainable.

With any transformation programme there is a risk of disillusionment if changes do not deliver visible improvements quickly. This raises the question of how ICSs can bring more visibility to some of the underpinning work done within their system. Internal communications across the ICS are an important part of this – partner organisations need to be telling a clear and consistent story about the changes they are trying to bring about, and repeating this story whenever possible so that staff and the wider public are brought into the journey.

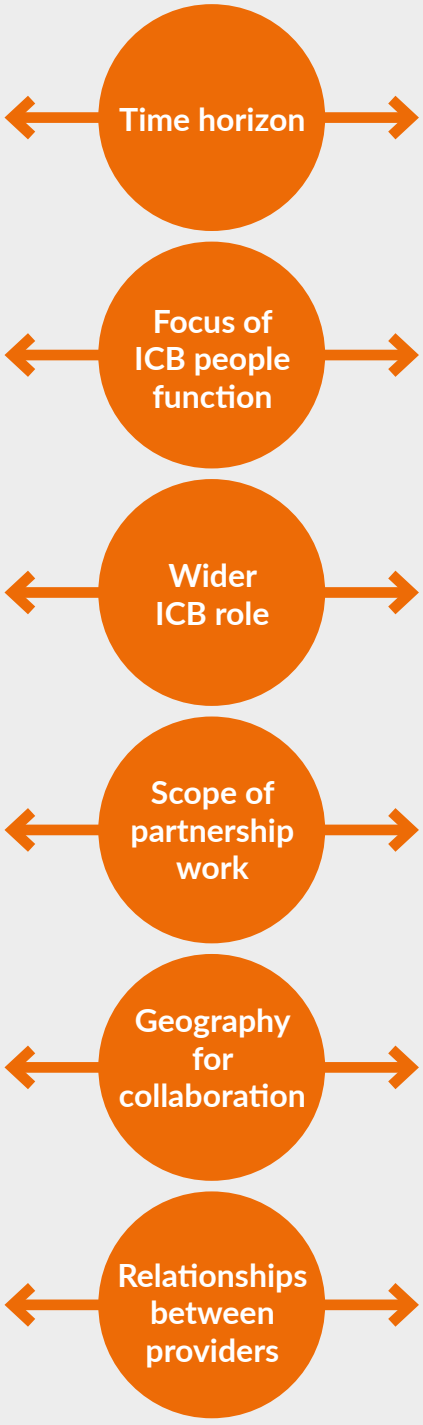
The importance of the less visible, relational work conducted by ICSs also raises questions about how success is measured. The approach taken in future by NHS England and the Care Quality Commission (CQC) to overseeing and regulating ICBs and ICSs will be crucial here. Both organisations will need to give sufficient weight to assessments of the quality of relationships and leadership behaviours across the system.

Navigating tensions

During our research, we were struck by the complexity of the leadership challenge facing people working on the workforce agenda in ICSs, particularly ICB chief people officers and their teams. Performing these roles successfully involves navigating a series of tensions, which often cannot be wholly resolved one way or the other, but which need to be skillfully managed and balanced (*see* Barry Johnson's work on 'polarity management') (Johnson 2014).

The tensions or polarities commonly discussed in our interviews are illustrated in Figure 1 on page 41. Some of these are a direct result of the design of ICSs. As ICSs mature and ways of working become more embedded, these tensions may become easier to navigate, but they are unlikely to be resolved entirely. This again highlights why so much time and effort has been needed over the past two years in terms of relationship-building, organisational development and leadership development, and why work on these invisible success factors will need to continue.

Figure 1 Tensions that system leaders are having to navigate in relation to workforce



A partnership between national bodies and local systems

Many of the messages from interviewees regarding the role of national bodies discussed in section 3 echoed the recommendations of the independent review of ICSs led by Patricia Hewitt (Hewitt 2023). In short, they called for a more enabling approach to accountability in which national bodies would set the overall goals and priorities but give greater discretion to local systems about how best to meet those goals. None of the interviewees challenged the basic premise that ICSs need to be held to account, but they felt that the current approach often proves counterproductive.

To move this relationship forward, care is needed to avoid framing it in terms of 'us' and 'them'. National bodies and ICSs are themselves part of a shared system, and the same principles that make for successful system work within ICSs also apply to the relationships between national and local leaders. Drawing on principles identified by previous research on system leadership and collaborative leadership (Walsh and de Sarandy 2023; Hulks *et al* 2017), we would suggest that national, regional and local leaders need to work together to pursue the actions described in the box below.

Six principles for an effective partnership between national bodies and ICSs

- Build a stronger sense of shared purpose across all levels in the system.
- Create a climate of trust in which everyone can be candid about the challenges.
- Strengthen relationships, including through frequent personal contact.
- Actively manage power dynamics and hierarchies.
- Surface and manage conflict quickly and fairly.
- Develop practices and processes that support joint decision-making.

Adapted from Walsh and de Sarandy (2023).

Attending to these six principles will help all involved to rebuild trust and to ensure that the new ways of working that local leaders are attempting to build in ICSs are also mirrored at other levels. This concurs with the findings of a review (published by the NHS Confederation) of how the health and care system in England is governed, which argued that there is an 'urgent need to value trust and restore respect between leaders at all levels' (Ham 2022).

Unresolved issues

Our research touched on questions that are beyond the scope of this work to answer. Chief among these is the continued status of NHS foundation trusts as independent sovereign entities. Some of our interviewees felt that the 2022 Health and Care Act was in effect an incomplete set of reforms – having transformed the NHS commissioning landscape but leaving NHS providers largely untouched. On this argument, achieving a full shift to system working will not be possible while trust boards continue to be legally accountable for the performance of their organisation, and their organisation alone. Other interviewees cautioned against further legislative reform and argued that a lot more could still be achieved within the existing legal framework. This is a complex debate with strong arguments on both sides, but it is one that the government will need to give careful consideration to.

The other major unresolved issue is the lack of a national strategy for the social care workforce. The NHS Long Term Workforce Plan gives a trajectory for growing and changing the health care workforce over the coming years, but the lack of an equivalent national plan for social care remains a huge omission. Barriers relating to social care funding and pay will also require action from government. Some of our interviewees argued that the goal of creating 'one workforce' across health and care cannot be fully achieved when pay rates in adult social care continue to be significantly lower than in the NHS, and while the national funding arrangements for the two systems remain as different as they are now. In some parts of the country, ICSs have taken steps to bring the two workforces closer together (for example, by harmonising terms and conditions), but there is a limit to how much can be achieved through these local initiatives without more fundamental changes from national government.

5 What next?

In this report, we have used workforce as a lens for looking at how integrated care systems (ICSs) are functioning in their efforts to address system-wide challenges. Are they taking steps that could lead to better and more joined-up care for people using services – for example, by working across boundaries, sharing resources between sectors, or revising their ideas about what solutions could look like or who needs to be involved in decisions?

Working differently – as one system – is hard. It is hard to think and plan across organisational, professional and geographical boundaries. It is hard agreeing to share your scarce resources. But it can also be hugely motivating. Across the four case studies, we found leaders committed to working as a system, pioneering new ways of working together, and clear about the opportunities this could bring. But we also found them exhausted by the challenges involved.

We have suggested that it is too early to give a verdict on the success of ICSs – especially given the difficult context of the last two years. But we do not think it is too early to suggest actions that will enable people to be effective leaders in their system.

Enabling actions

Throughout this report we have highlighted the visible and less visible elements that support system change. We want to follow that through in our recommendations – but that brings with it a note of caution.

There is a danger that national and local attention gets focused on the visible things that are easier to name, describe and measure, such as the number of new nurses recruited across an area. The less visible qualities – such as being able to surface and manage power dynamics, or being able to really understand a problem by seeing it from lots of different perspectives – are harder to articulate and count. Attention needs to be paid to both, but we would argue that there is value in

paying greater attention to this less visible work precisely because it does not get discussed formally or collectively in the same way.

In practice, this means that people wanting to do 'system work' need to be given the right conditions to flourish. Much of what we heard from local leaders was in line with the recommendations of the Hewitt Review (**Hewitt 2023**) and we would encourage government to return to those recommendations. Here, we focus on four actions that national and local leaders can adopt that would give ICSs the best chance of achieving their full potential.

1. Maintain a clear focus on long-term transformation

ICS leaders are impatient for change – they know that transformation is needed if they are to deliver on their ambitions. At the same time, they want greater time and freedom to test and implement change. They want national bodies such as NHS England to have realistic expectations about what can be achieved in the current context, and to hold them to account for longer-term goals as well as short-term priorities.

However, we suggest that ICSs also need to challenge themselves on their ability to focus on this transformative work. We spoke to some remarkable individuals across the case study sites who were pioneering system work that framed solutions in new ways. This work requires a different dialogue, different skills, and an ability to retain a focus on the future. In some cases though, this more transformative work felt fragile – dependent on a few individuals rather than firmly embedded across partners with a sense of collective responsibility. To put this work on a more sustainable footing, ICS leaders need to strengthen the infrastructure and skills needed to drive improvement and change across their local system.

2. Practise system collaboration and invite challenge

It is not sufficient to bring people together; ICSs also need to focus relentlessly on their shared purpose and to use that to align and challenge how people behave.

We have wanted to avoid positioning ICSs and national bodies such as NHS England as being in opposition to each other. They share an ambition of better integrated care, and yet it is clear from our interviews with local leaders that this

can, at times, get lost. Local, regional and national leaders all need to be able to model system collaboration for others to see. This includes:

- being prepared to be challenged and to challenge behaviours that are not in line with shared ambitions and the principles of system working
- paying attention to power dynamics, making sure all parts of the system have a voice (including people and communities), and being prepared to do things differently in ways that those with most power might not like
- regularly questioning the dominance of the NHS in whole-system approaches and designing mechanisms to counterbalance this.

3. Grip tight on outcomes, loose on means

Leaders (at all levels) are sometimes accused of holding too tight a grip on the system. Although this is understandable given the intense political pressure and urgent imperative for improvements in care quality and health outcomes, it can create a context in which innovation and adaptive change is stifled. Hunter and Bengoa (2023) argue that integrated care requires leaders to be 'tight on [the] outcomes being sought but loose over the means to achieve these'. In line with this, we suggest that national, regional and local leaders:

- agree what an enabling approach to accountability and regulation looks and feels like and ensure that behaviours at all levels are in line with this
- ensure that performance measures reflect the efforts of the whole system, not just the NHS
- consider how national funding can be used more flexibly to support system working
- support partnership working at place level and empower place leaders to deliver broader system objectives in a way that adapts to the local context.

It is particularly important that the Oversight and Assessment Framework currently being developed by NHS England is designed in a way that reinforces system working, including by holding integrated care boards (ICBs) to account for population health outcomes that can only be achieved through working in partnership, in addition to metrics within the direct control of the NHS.

4. Value the views of local people, patients and staff

We suggest that the most powerful way to gain insight into whether integrated care is making a difference is to understand what it feels like working in or being cared for by the system. As part of this, ICSs need to work more closely with people and communities to understand their experiences and priorities. A resource by Thorstensen-Woll *et al* (2021) provides guidance and examples of how to do this in practice. Systems also need to be able to measure their progress from the perspective of people who use services. It is to be hoped that the Integrated Care Experience survey initially signalled in 2019 and currently being piloted in a selection of systems will help with this in future.

Finally, we learnt a great deal by talking to people involved in leading change locally, and our findings have been shaped by listening to their views. We encourage others (again at local, regional and national levels) to find out what it feels like to be a leader of change in the health and care system and to use those insights to understand what is needed to support people to work and behave in a way that is 'system-focused'.

It is early days, and there is clearly room for improvement. Few would argue for another restructure – and no one we spoke to proposed an alternative to ICSs. Indeed, we found ambition and optimism that services could be improved if ICSs are given the time and conditions to deliver the changes their leaders know are needed. It is time to focus on how people at all levels can be supported to work differently to allow ICSs to achieve their full potential.

Annex A: Methodology

Research questions

- What progress are integrated care systems (ICSs) making on creating a workforce that can meet the needs of their local population now and in the future?
- What does this tell us about how ICSs are developing more broadly and the ways in which they can have most impact?

Research approach

Phase 1: Scoping and site selection (May–Aug 2023)

We carried out scoping interviews with ICS leaders recruited through our existing networks. The purpose of these was to help us refine the focus of our research and identify potential case study sites. We also engaged with ICS leaders through the Chief People Officers network convened by NHS Employers.

We developed a shortlist of potential case study sites drawing on intelligence gathered through scoping activities. Our objective was to choose a sample of sites that maximised diversity in terms of the following criteria, all of which produce different sets of issues in terms of workforce supply and demand:

- Geographical and population characteristics – including a mixture of urban and rural sites.
- NHS provider landscape – including sites containing multiple large teaching hospitals as well as sites served by a smaller number of trusts.
- Local government arrangements – variation in terms of the structure of local government (unitary versus two tier) and the degree of co-terminosity with ICS boundaries.
- Level of ICS maturity – as measured by NHS England's system oversight framework.

Once the shortlist was determined, meetings were arranged with some of the sites to get further information before we selected four sites to invite. Some of the sites initially selected did not respond to the invitation to participate and were therefore excluded from the project. Details on the final four sites included in the study are provided below.

Phase 2: Case study interviews (Sep–Oct 2023)

We conducted semi-structured interviews with six participants in each case study site. In order to understand progress from a range of perspectives, we interviewed people in the following roles in each site:

- Integrated care board (ICB) chief people officer
- NHS trust human resources (HR) director or chief executive
- Social care workforce lead
- Healthwatch lead
- Voluntary sector leader
- One other local leader with workforce expertise, as suggested by our main contacts in each site.

Information sheets and consent forms were shared with participants, and they had a chance to ask questions before they gave consent. We conducted the interviews on Microsoft Teams, and each lasted one hour. The interviews were recorded and transcribed.

Phase 3: Analysis and stakeholder workshops (Nov 2023–Feb 2024)

A coding frame agreed by the team was used to analyse the data. This was tested on several interview transcripts by all members of the research team and refined until a final coding frame was agreed. Excerpts under each code were analysed thematically and summarised. A quality assurance process was followed throughout the project.

Emerging findings were tested through online workshops and calls with a range of groups and individuals, including ICB chief people officers, voluntary sector leaders, and national bodies.

Case study site details

Humber and North Yorkshire

Humber and North Yorkshire ICS serves a population of 1.7 million across a very large geographical area. It contains a mixture of urban and rural areas, including cities, market towns, and rural and coastal communities.

North and Central London

North Central London ICS serves a population of about 1.4 million residents. The population is highly mobile and the ICS has distinct workforce challenges and opportunities associated with the atypical demographics of the London population and high living costs. It has a high concentration of health and care providers within a relatively small area, including several large trusts providing highly specialised services, and education and research institutions.

Greater Manchester

Greater Manchester ICS serves a population of 2.8 million people. The area has a history of working together long before the ICS was established because of a series of devolution deals agreed with national government. The ICS brought together 10 former clinical commissioning groups (CCGs) along with local authorities and other partners.

Herefordshire and Worcestershire

Herefordshire and Worcestershire ICS serves a population of around 800,000. The area is largely rural and has a complex local government landscape with unitary local government in Herefordshire and two-tier arrangements (with a county council and six district councils) in Worcestershire. Challenges include a relatively low-wage economy, low social mobility, and a population that is older than the regional or national average.

Interview questions

The interview topic guide covered the following areas:

- ICS development so far – experiences and views on how the ICS has developed since becoming a statutory organisation.
- Current workforce issues – including any issues that were specific to their system.
- Current responses – examples of local partner organisations tackling workforce challenges collaboratively as a system, and the role played by the ICSs in this.
- Barriers and facilitators – to progressing collaborative work on workforce.
- Impact – on staff, patients, population health and inequalities.
- Future opportunities – further opportunities for collaborative working on workforce issues and the role of the national bodies in supporting ICS development.

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