RCSLT

ICB Briefing

22 July 2025






Purpose of today's session

- The role and structure of ICBS
- Their impact on SLT
- History
- Key elements
- How they work
- Changes in commissioning models – the Model Blueprint
- Opportunities for SLTs
- Q&A

The story so far...

- The 2012 Health & Care Act: from the NHS Commissioning Board to CCGs – alphabet soup
- Sustainability & Transformation Partnerships (STPs) in 2016 and the ICS shadow years
- ICBs, ICPs and ICSs – the 2022 edit – the Health & Care Act 2022

Integrated Care Systems: what are they?

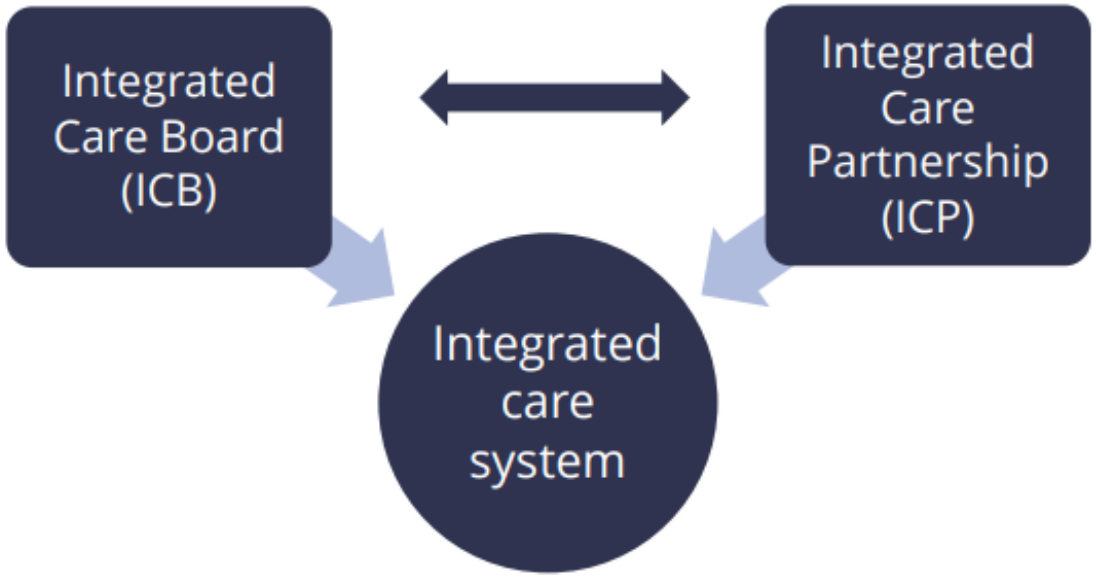
- Partnerships of organisations that work collectively to plan and deliver joined up health and care services in their area.

- From July 2022, 42 ICSs established across England on a statutory basis. Each ICS includes an integrated care partnership (ICP) and an integrated care board (ICB).

- ICSs aim to improve healthcare outcomes, tackle inequalities, enhance productivity and value for money, and support broader social and economic development.

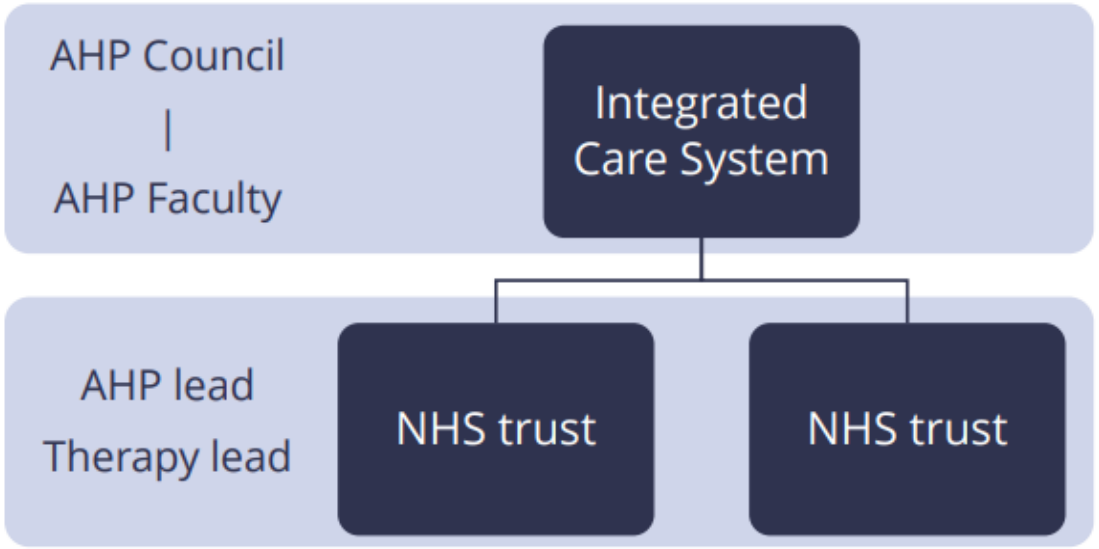
Integrated Care Systems: what are they?

- Each ICS is made up of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).
- The ICB is responsible for planning and commissioning.
- The ICP is a partnership between the NHS and local authorities in the ICS area. It looks at how the wider health and care needs of the population will be met.



How are AHPs represented?

- An **AHP Council** of chief AHPs from local providers to ensure a system-wide integrated approach.
- An **AHP Faculty** which looks at workforce supply, education and training across the ICS.
- An **AHP Lead**.
- Some systems also have a **Chief AHP**.



Our ICS wish list

- The primary legislative requirement on children and young people
- How rehab and community are being done beyond adult acute
- Taking account of the whole health and care economy, not just NHS
- Joint commissioning and pooled budgets with education
- Inclusion of non-NHS providers in the ICP and strategy preparation
- Commissioning across the ICS for low incidence high need conditions (hearing loss, selective mutism, complex stammer)
- Specialist commissioning coming down to the ICS from NHSE (cleft and gender identity services)

2025: the model blueprint

- More questions than answers
- Darzi and strategic commissioning
- What goes where?

https://www.digitalhealth.net/wp-content/uploads/2025/05/Model-Integrated-Care-Board-%E2%80%93-Blueprint-v1.0.pdf

The model blueprint – things to welcome

- The focus on population health and prevention - shifting focus from institutions to population outcomes
- Reducing health inequalities and on inclusion
- User involvement and co-design
- Developing and agreeing best practice pathways
- Future investment decisions ‘guided not just by precedent’
- Co-design with local government.

The model blueprint – areas of concern

- Workforce reduction may affect AHPs in positions of leadership, or opportunities for AHP leadership. Upheaval from ICB mergers will destabilize existing leadership structures.
- How realistic the resource reductions and the pace of them are.
- Transfer of activities away from ICBs: the potential transfer of SEND and safeguarding functions – statutory roles and responsibilities. Other transfers include sustainability, digital, infection control.
- Decentralisation of workforce planning: moving education and training responsibilities away from ICBs risks fragmenting professional development.
- Transition disruption: the impact on staff morale and continuity of care, and the availability of adequate resource for transition planning.
- The sustainability of merged ICBs with respect to the amount of resource per head, and overall population size.

Model blueprint – reassurance needed

- All remaining NHSE direct specialised commissioning is to be reviewed.
- ‘directing resources where they will have the greatest impact’. This cannot just be a numbers game of which conditions are most common.
- ‘forecasting and modelling demand and pressures’: include unmet need as well as demand for services already commissioned.
- Outcome-based contracts: this should actually mean outcomes, not outputs or activity in disguise.
- Clinical leadership with AHPs represented in strategic planning.
- A dedicated rehab lead in each ICB.

2025: the model blueprint

To be discussed...

- Encouraging new providers, for example in frailty.
- Transferring high level strategic workforce planning to regions or to national level. There are potential risks around disjointed efforts and local disparities.
- Transferring local workforce development including recruitment and retention to individual providers.
- Transferring responsibility for data to national level.

The 10 year plan

The three shifts and the SLT role

- Sickness to prevention
- Hospital to community
- Analogue to digital

Economic benefit

Neighbourhood health services

Workforce plan to follow

What should SLTs do next?

1. Keep across discussions about the future of your ICB – which others is it merging with?
2. How are SLT and AHPs involved in these conversations and what is my route to influence?
3. What services and pathways do I need to ensure are protected through the changes?
4. What new opportunities are presented and how will I advocate for them?
5. Can the team at RCSLT help me? If so, get in touch!

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Questions?

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