

Financial planning and partnership in integrated care systems (ICSs)

September 2023

It's now over a year since the passing of the Health and Care Act 2022, which made integrated care boards (ICBs) accountable to NHS England and responsible for the overall finance and performance of all the NHS partner organisations (including provider trusts) within their integrated care system (ICS). The intention of this is a move away from competition towards a more collaborative, whole systems approach.

Over the last two years, the NHS financial planning round has been far from straightforward. The 2022/23 process was substantially delayed, with some ICB plans not agreed until June 2022, some three months after the start of the financial year. At this point, five ICBs still had planned deficits totalling around £100m. By March 2023, 16 ICBs were forecasting an overspend against plans agreed with NHS England. Similar issues have arisen in the 2023/24 financial planning round, with a third of ICBs forecasting a combined deficit of £650m and many of those that have agreed financial plans admitting they will be challenging to deliver.

This briefing builds on a roundtable hosted by CIPFA and NEP, which brought together finance professionals from across the NHS and local government to explore how financial planning and partnership in ICSs are working in practice and to share some of the current challenges involved and lessons that could be learned.

What are the responsibilities of ICB directors of finance and to whom are they accountable?

Throughout the establishment of ICBs as statutory bodies, there was much debate around financial accountability and how it operates in practice. More recently, the [Hewitt review](#) set out that robust financial accountability, both to local residents and to Parliament via NHS England, is non-negotiable and needs to sit within a wider framework of local accountability for ICSs.

So what are the accountabilities of an ICB finance director? Our discussion highlighted that there appears to be some ambiguity, suggesting accountability is open to interpretation. As one participant in the discussion suggested: in the move away from the purchaser-provider model towards a more collaborative, whole system approach, ICB finance directors are effectively “unlearning how to operate.”

The discussion identified three levels of accountability:

- The ICB has a statutory responsibility to remain within its set spending limits and is accountable to NHS England for doing so. An ICB finance director has a professional accountability to a regional director in NHS England for the financial performance of the ICB as the statutory organisation.

- The ICB is also responsible for overall financial performance across the wider system¹, so the ICB finance director has a ‘softer’ accountability for influencing the financial performance of NHS provider trusts within their ICS.
- More broadly, there is the responsibility for closer working with local government and wider partners across the system. Finance directors are accountable for providing collaborative leadership to ensure good public financial management to improve outcomes, reduce inequalities and support measures that benefit the whole health and care system in their local area.

These multiple accountabilities are further complicated by the backdrop of the wider financial environment, which is challenging across the entire public sector. All finance directors are having difficult conversations about how to achieve a balanced financial plan, not only in the NHS but also across local government, as is apparent from the increasing number of Section 114 notices being issued.

As for the accountability of ICB finance directors to NHS England for the financial performance of the system, participants highlighted that perhaps their biggest issue was with their relationship with NHS England at national level. Participants suggested that it doesn’t always feel like an “adult-to-adult” conversation when trying to understand the resources available.

From April 2022, NHS England has set funding allocations for ICBs that comprise the majority of NHS spending. However, NHS England continues to control significant funding streams in what could be seen as a partial return to the financial incentives seen under the previous ‘payment by results’ regime. Examples of such centrally held pots include primary care, public health and specialist drugs, as well as those related to specific priorities (for example, for elective services recovery and addressing health inequalities).

This lack of transparency over what sums may actually come to ICBs presents a real challenge for finance directors, particularly around the Elective Recovery Fund (ERF), as they may have little certainty on available funding and what their actual position at year-end may be. It was also suggested that this lack of clarity may even have an impact in terms of their professional code, as it affects their ability to provide a ‘true and fair view’ of the position of the ICB.

The discussion around the complexities of centrally held funding highlighted a difficulty in relation to the wider accountability for closer working across the NHS and local government. Local government colleagues struggle to understand the intricacies of the NHS system and vice versa. This makes it difficult for respective finance directors to have conversations on an equal footing, given the fundamental difference in the roles and the regimes in which they operate.

For example, in local government the finance director (or section 151 officer)² has a statutory responsibility to balance the books each year. In the NHS, the secretary of state and departmental

¹ ICBs must work collaboratively with the other NHS organisations in their system to agree financial and operational plans on behalf of the whole ICS. NHS provider trusts still submit their own plans to NHS England, but these must agree with ICB plans.

² [Section 151 of the Local Government Act 1972](#) requires local authorities to make arrangements for the proper administration of their financial affairs and appoint a section 151 officer, also known as a chief financial officer (CFO), to have responsibility for those arrangements.

accountable officer are accountable to Parliament for the money voted to the Department of Health and Social Care (DHSC) and for delivering against the control total. In local government, the finance director may not be directly responsible for social care budgets – a senior finance business partner or director of adult services may hold responsibility for that budget. There is a definite need to foster a shared understanding, not only of the different regimes but of the players involved and their roles and responsibilities.

The lack of flexibility was also identified as a barrier to closer working. The annual focus and uncertainty around centrally held funding in the NHS means ICBs have to “land a jumbo jet on a postage stamp” and lack the flexibility available to local government, such as the ability to hold and use reserves. This lack of a clear view of the financial position across the medium term makes it extremely challenging to begin to plan with local government colleagues how to best address long-term issues such as reducing inequalities. As one finance director commented:

We have to try to be as creative as our professional boundaries will allow in terms of the delivery of in-year financial performance, given the lack of an ability to carry funds forward through reserves, as is possible in the local government sector.

Financial planning is also made more complicated by the pressure of trying to balance local priorities against national targets on which funding depends. These national targets, or political priorities, exist not only at the NHS end of the relationship. For example, local government has been feeling the twin pressures of increasing demand for services and the delayed proposals for social care charging reform. However, what these pressures mean is that despite the best intentions at local level, some shared priorities such as moving towards greater prevention can be ‘crowded out.’

In terms of progress towards integration, in the current year there has perhaps been a bit of a ‘backwards step’ in engagement due to wider considerations such as the new statutory arrangements, governance and accountability mechanisms, and the huge challenges of the financial and economic backdrop. In contrast, during the COVID-19 pandemic, there were clear benefits of closer collaboration, pressure to work more closely together and perhaps more flexibility in budgets to consider wider arrangements, so greater progress was made in some areas. Moving forward, a restatement of what integration is trying to achieve and what successful joint working looks like would be helpful.

All this ambiguity around accountabilities and priorities, together with the different cultures and regimes across the NHS and local government, make the quest to improve joint working extremely challenging.

Can lessons be learned from the local government regime in relation to Section 25 statements?

In local government, when a council is agreeing its annual budget and precept for council tax, the CFO must, under Section 25 of the Local Government Act 2003, report to the council on the robustness of the estimates made in setting the budget and the adequacy of the available reserves.³ As highlighted above, the NHS financial planning round over the last two years has suffered substantial delays due to a number of ICBs struggling to agree a financial plan with NHS England, with a number of finance directors admitting that the plans agreed will be challenging to deliver. So is there any value in ICB finance directors going 'on record' with their professional view of the financial plan?

The initial discussion centred around the fact that in local government, the intent of a Section 25 statement is positive, with the CFO providing assurance that the estimates are robust and the reserves adequate. Should there be a risk that either of these elements are in doubt (ie a negative Section 25 statement), then action would be needed ahead of the budget being set.

Given the ambiguities discussed above around the financial accountability in ICBs and the lack of clear mechanisms in place to take such action ahead of agreeing the financial plan, there was a question around the value in raising such a flag, other than making it public knowledge that the ICB's budget may be insufficient to meet its published plan and aspirations. While this could be considered helpful in terms of greater transparency, managing expectations and providing an early warning of difficult decisions ahead, in the absence of any available actions to mitigate, it may also risk unintended consequences.

The one clear course of action open to an ICB finance director is to not agree a balanced plan with NHS England and proceed with a planned deficit. However, the reality of this may make it even more difficult to take any action, as this comes with additional control and regulatory oversight, a point highlighted by the [National Audit Office](#) in relation to NHS providers:

Trusts in deficits have stricter financial conditions placed upon them, which limits the extent to which their deficit can increase, but also gives them less flexibility to take action to address the reasons for their deficit.

Participants highlighted that in the process of agreeing financial plans, many finance directors are already having difficult conversations – both with NHS England and their ICB – in which they are clearly setting out their professional view of the local assessment of the challenges involved in delivering the plan. They are highlighting concerns around the ability to balance the activity needed to meet national targets and local priorities against delivering the level of savings required to bridge the financial gap in the face of uncertainties presented by assumptions around inflation and industrial action.

However, participants highlighted that these conversations could be perceived as being “slightly odd” and not conducted on an equal footing, given the lack of transparency around the

³ Further information on Section 25 reports can be found in CIPFA's [Building financial resilience: managing financial stress in local authorities](#).

assumptions made at national level, what resources may be available in-year from centrally held funds, and the lack of any flexibility to deviate from the national settlement at local level.

Participants felt that it would be helpful to have a greater understanding of the relationships involved at national level, driving these conversations and the underlying assumptions set out in national guidance – for example, between NHS England, DHSC and HM Treasury.

The ability of the ICB finance director to ‘see the whole picture’ or take action to mitigate risks of non-delivery against the plan is often unclear. Thus, in effect, they are setting out their professional opinion in a manner similar to that required in a Section 25 statement, although perhaps in a less obvious manner.

Effective financial planning and partnership across NHS and local government partners in ICSs

In December 2022, CIPFA published [Integrating care: policy, principles and practice for places](#), which identified a number of actions for both local and national level to improve partnership working across the NHS and local government. A number of these were reflected and expanded upon by participants, including the following:

- The need for partners to embrace the opportunity to truly work differently and take a more strategic, long-term and place-based approach encompassing the social determinants of health, reducing inequalities and with greater emphasis on prevention to achieve the core purposes of ICSs and ensure that services remain sustainable.
- The need for a whole-systems, outcomes-based approach with priorities, outcomes and the associated metrics determined in the context of a national framework based on evidence of local circumstances and need. Linking resource allocation to outcomes would enable evidence-based decisions on resource allocation and the ability to track and evaluate progress.
- The need to foster a shared understanding of the different systems in which they operate and the pressures they face, so partners can build the relationships and trust crucial for success.
- At place level, the delegation of functions and resources should be underpinned by a principles-based, combined framework incorporating robust governance, accountability and finance arrangements. This should be adaptable over time to identify where they are on their journey and chart a course for future evolution.
- The critical role of CFOs in the NHS and local government in providing collaborative financial leadership, both in shaping local arrangements to ensure good public financial management and in supporting the finance function as key enablers of closer integration.

Across the finance profession in the NHS and local government, there is broad acceptance and understanding of the need for closer integration and joint working, and there is already a lot of good work happening. Most ICSs are already grappling with issues such as how do we think more

broadly around how to make best use of available funding across places, to truly shift resources upstream and enable a greater emphasis on encompassing the social determinants of health.

However, the reality is extremely challenging in a climate of ever-tightening resources, and as one participant stated, “the incumbent costs of provision are high.” It is almost impossible to start to consider a twin-track approach of investing in more upstream activity and focus on local priorities, while also meeting the NHS mandate and national targets on which funding is often dependent. As highlighted above, local government colleagues are also struggling to meet the challenges of the wider climate.

Indeed, even conversations among NHS and local government finance professionals can be challenging. Not only are the funding and finance regimes and cultures vastly different, there is a question around the equality of footing for these conversations. On the local government side, there is an arguably more ‘adult’ and transparent approach with the regime of reserves – the ability to modify service provision for non-statutory services to “live within our means.” On the NHS end of the conversation, there are the ambiguities outlined above. Section 151 responsibility sits at national level, with the rigidity of single-year plans and a lack of transparency around the resources available, even mid-way through the financial year, necessitating more of a ‘best estimates’ approach. Thus, the levers available to pull are very different. Where ‘sensible conversations’ do occur in areas where they may be beneficial – for example, around shifting resources towards social care to ease pressures on hospital discharge – all these constraints make actually achieving this and still meeting the national targets and financial plan almost impossible.

Even getting the right people involved in these conversations can be complex. The broader aims of improving population health, reducing inequalities and having a greater emphasis on prevention go beyond just the narrow focus on health and social care. Almost all local government services, in all tiers of councils, potentially impact on the social determinants of health and wellbeing, and the responsibility for these budgets sits with the respective service director. Even within the narrower view of health and social care, there is the challenge of involving private and third sector service providers and VCSE organisations in such conversations.

At the moment, in the run-up to an election, the focus on national priorities is understandable. The emphasis on immediate measures such as waiting times, GP access and time to assessment in social care are important to manage and evaluate the here and now. However, to tackle the health and wellbeing of local populations, a different set of metrics is required to inform evidence-based decisions to shift activity and resources over the long term. There is a need to track and monitor spending in a different manner, to identify activity that improves the health and wellbeing of populations at local levels – which will vary in different areas – rather than a set of nationally prescribed metrics focusing attention and resources. As one participant suggested, “if it’s not being measured, it’s not being managed.”

While some of this work may be beginning in integrated care partnerships (ICPs) and reflected in some of the published strategies, there is a real tension in that these wider, long-term ambitions are not reflected in the current national targets on what needs to be delivered.

How could financial planning be approached differently?

Given the experience of the last two years, discussion turned to what lessons can be learned and how planning might be approached differently in the future. While it was felt that there are many issues that are unlikely to be solved for 2024/25, given there will likely be “less scope for innovation

in an election year”, there are definitely areas for improvement that would be beneficial in the longer term.

Clarity on funding and assumptions in financial planning

Local government is used to setting medium-term financial plans, whereas in the NHS the focus has been very much on a one-year cycle and the annual plan. The two-year settlement means that ICBs already have an idea of their allocations for 2024/25, and the move towards more medium-term financial planning should be helpful. However, the operational and planning guidance, including details of centrally held funding, often comes quite late. Although it is issued in December, often much of the detail follows later, meaning that lots of assumptions have to be made on what the actual financial position may be, often right up until the start of the financial year.

Earlier provision of the guidance and improved transparency, with both national and local ends being absolutely transparent on the assumptions made (for example, use of consistent data sets around demographics, inflation, etc), would enable a more informed and clearer planning process, with NHS England and ICBs working more effectively together.

A different type of planning process

There was agreement that in the longer term, there needs to be more of a joint planning space, with longer-term, multi-agency involvement rather than the NHS/medical centric view. In some areas, generally where there is some co-terminosity between partners, there has been some work towards this. However, there is huge variation across the country in terms of the geography, relationships, demographic and financial positions. The current ‘one size fits all’ national planning process in the NHS and the focus on nationally described priorities creates a tension, making any consideration for local determination of difference from that national policy framework almost impossible.

Place-based view of finance

Rather than the focus on organisational finances in isolation, identifying the resources available at local level and how they could be targeted differently would enable a broader view. This could enable consideration of how the dial could be shifted towards a focus on broader population health and reducing inequalities, with a focus on prevention, to provide better outcomes for the local area. The discussion drew on CIPFA’s earlier work on [aligning local public services](#), which focused on identifying total public spending in place from all public agencies.

The focus on forming place-based partnerships in the 2022 restructuring was helpful, and in some areas lots of work and progress has been made. However, it was felt that this year, other pressures have distracted from this somewhat, and perhaps there is a need to go back to basics. A restating of the purpose and intention to ensure that those conversations are happening with the right people around the table would be helpful. It was felt that place is the critical level where all partners can be drawn into a different view of the entire place-based picture, the pathways and pressures involved and where there may be possibilities for genuine partnership.

As one participant stated:

It feels like place is the special sauce in the planning round... that's where the action really is, and if we are not developing and cultivating those, then we're missing a trick.

As highlighted in [Integrating care](#), robust governance, accountability and finance mechanisms at the level of place-based partnerships are crucial. Central to these relationships, and those at the wider system level, is fostering a greater understanding of the different regimes, cultures and pressures across the partners.

Longer-term planning horizon

More progressive local authorities are already looking beyond the medium term, looking five or ten years ahead to project and predict the resource base and cost pressures over the longer term and expose the likely key challenges. Some are also managing their capital investment programme and balance sheets over the longer term, taking a more community asset-based approach to planning. Taking such longer-term approaches on a multi-agency basis across an entire place enables wider scenario planning to expose the headroom available for shifting the dial towards improving population health, prevention and reducing inequalities.

A number of other areas for improvements were also covered in the discussion, including the following:

- Appropriate and consistent measures and metrics that track improvements in the health and wellbeing of populations rather than those focused on the treatment of illness and care needs and allow for local variations.
- Simplification of reporting to enable those at both central and local level to track outcomes back to the resources that delivered them. This would not only improve transparency and evidence-based decision making, but it would also improve engagement, particularly at the local level.
- Improving the sharing of information across organisations, both within and beyond the NHS. Breaking down the silos of different approaches, activities and recording could help in providing one version of the truth.

Much of the discussion at this event built on issues and recommendations in CIPFA's 2022 [Integrating care](#) report. What this discussion clearly demonstrated is the critical role of the finance profession in closer integration. Bringing together services to improve population health and reduce inequalities needs to be supported by long-term planning and stripping away the barriers preventing closer alignment of services.

This is made challenging by the vastly different financial, governance and legislative frameworks, but this further highlights the importance of the role and the need for strong, collaborative leadership to ensure good public financial management, supporting what is of benefit to the whole health and care system in the local area. While ICBs and wider ICSs are becoming accustomed to the new statutory structures, there is substantial variation in the approaches and arrangements being adopted, which will need to evolve over time as new ways of working are tried and tested.



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