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Integrated Care Systems and Strategic Authorities: Coming together to tackle health inequalities and the wider determinants of health

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About this essay

This is the fourth in a series of essays that will answer key questions about the effectiveness of devolution in addressing health inequalities. It is part of our joint programme of work supported by The Health Foundation.

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1. Introduction

The King's Fund and the Centre for Local Economic Strategies have been exploring the role that strategic authorities can play in reducing health inequalities[1]. This has involved interviewing key decision-makers including mayors and NHS leaders, convening roundtables with wider stakeholders, exploring existing evidence, and tracking and responding to the government's emerging policy on health and devolution over time.

In all these activities, one relationship has loomed large at every turn: that between strategic authorities (SAs) and integrated care systems (ICSs). SAs hold significant levers in policy areas that have the power to impact the wider determinants of health. ICSs hold responsibility within their areas for planning services, improving population health, and tackling health inequalities.

Making progress on health inequalities requires these organisations and partnerships to work effectively together.

However, two major policy developments over the last 12 months stand to alter the dynamics of this relationship in fundamental ways. The implementation of the English devolution white paper[2], the English Devolution and Community Empowermnet Bill[3] and the 10 year health plan[4] along with other associated changes[5] will alter both ICSs in terms of their composition and responsibilities, and therefore in how SAs and ICSs relate to one another.

How will things play out going forward and what needs to happen to make the most of the relationship for health inequalities? In this essay we explore this question. We draw on research, conducted prior to the announcement of the 10 year health plan, in which we spoke to strategic authorities, mayors and ICSs from around the country about how they saw their relationship with the health system. We also draw on observations of developments since then.

This essay begins by setting out the recent policy changes introduced through the 10 year health plan and their implications for ICSs and SAs. We then explore how these changes will shape the interaction between mayors, strategic authorities, and integrated care boards (ICBs), outlining different models of engagement that may emerge. Following this, we examine how ICBs themselves might respond and the risks posed by mismatched levels of engagement. We go onto consider structural challenges, including geographical alignment and timing of reforms,

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[1] TL Goodwin (2024). *Combined Recipe for Healthy Communities*. CLES. Read.

[2] The English Devolution White Paper lays out a blueprint to spread and deepen devolution in England, primarily through the vehicle of strategic authorities. See: D Buck (2025). *The English Devolution White Paper: a long read but will it be good for your health?* King's Fund. Read.

[3] Read.

[4] The Ten Year Plan for Health (2025) sets out how the government intends to create a health service 'fit for the future' through three shifts: from hospitals to communities, from treatment to prevention and from analogue to digital. For more information see: S Arnold et al (2025). *Truly Fit for the future? The 10 Yeear Health Plan explained*. King's Fund. Read.

[5] This includes a new focus of integrated care boards and NHS regions, set out in respective 'blueprints' and more changes to come. See NHS Confederation (Here) and (Here).

before turning to issues of financial integration, accountability, and leadership signals. Finally, we summarise the key insights and set out recommendations for government to maximise the potential of these partnerships in tackling health inequalities.

2. The 10 year health plan and changes to integrated care systems

The government's plans to rapidly roll-out and expand SAs and elected mayors across England has great potential to improve health and health inequalities, including through their relationship with ICSs[6].

ICSs were formally established in 2022 by the previous government to improve coordination between health and social care services. This was achieved through ICBs, which focus on integrating health and care delivery, and integrated care partnerships (ICPs), which bring together local partners to make more joined-up decisions on wider factors affecting population health[7].

Although early days, there were some signs that this was leading to more emphasis by the health and care system on the wider determinants of heath and health inequalities and in some existing SAs[8], mayors have been active, for example in co-chairing their local ICP[9].

The 10 year health plan and related changes to the role and nature of ICSs will change the relationship between SAs and ICSs, deepening it and changing its nature.

First, the plan removes the statutory requirement for ICPs, which have previously provided a forum for mayors to help shape the strategic direction of local health systems. Instead, strategic authority mayors, or their representatives, will be expected to join ICBs. This change will alter the voices and balance of decision making within ICBs, as local government and NHS providers are removed and replaced by mayors and strategic authorities. The inclusion of mayors, with their own public mandates and legal responsibilities - including forthcoming health duties[10] - will introduce new dynamics to commissioning and other key decisions.

Second, ICBs will also be different. The ICB blueprint[11] and strategic commissioning framework that followed[12], emphasises commissioning for population health and a

[6] See our earlier evidence review, and essays on the proposed health duties of mayors, their role in employment and heath, in more affordable housing and transport for health set out our views in these areas. These are available from the CLES website.
[7] A Charles (2022). *Integrated Care Systems Explained.* The King's Fund. Read.
[8] D Buck (2024) *Are integrated care systems making progress on tackling health inequalities?* The King's Fund. Read.
[9] For example in Greater Manchester.
[10] For a discussion of their responsibilities and duties in the health see: D Buck et al (2025) *A new health duty for mayors and strategic authorities: getting it right*. Cles. Read.
[11] (2025). *Model Integrated Care Board – Blueprint v1.0*. Read.
[12] This framework sets out in detail the detailed expectations of ICBs in their new role as population health commissioners, Read.

stronger strategic role for ICBs. This is accompanied by the the NHS region blueprint suggests a stronger role for the seven regional teams in NHS performance and overseeing 'medium-term regional strategic plans to deliver the 10 year health plan[13]. Taken together this signals that ICBs will increasingly be expected to shape the future of local health and care systems though understanding the local context, long-term population health planning, commissioning and resource allocation - all underscored by a strong evaluative culture.

Finally, the geography of ICBs is also changing, on the one hand to create efficiencies and on the other to better match the geography of the emerging SA landscape. This means fewer and larger ICBs in many cases, and in theory they will be better mapped to (sub) regional economies.

These upcoming changes will bring significant disruption, particularly at a time when health and care systems, wider public services, and local economies are already under pressure. They also present opportunities, alongside varied approaches and partnerships at different stages of maturity. The way mayors and SAs engage with ICBs will be critical to the success of efforts to tackle health inequalities collaboratively.

3. How will mayors and strategic authorities interact with ICBs?

Our research revealed differing views among mayors regarding their membership of ICBs. Some mayors wanted to be on ICBs because from their perspective the ICB is the key decision-making body, whereas the ICP was further away. To influence key decisions, the ICB is where they feel they need to be. In addition to this practical point, our research revealed a more philosophical one: the absence from the ICB is symptomatic of what one mayor referred to as a "democratic gap in health services and the way they are delivered".

However, others felt that the world of NHS commissioning was too vast and complex, and that taking on responsibilities in this area might risk consuming excessive bandwidth within strategic authorities, leaving them less resourced for their other work. Those who held this view tended to see the ICP, where they had previously been sitting, as the right place to remain - giving them influence when needed, but without onerous responsibility

Given this, we foresee several possible models that may emerge in terms of the ICB-SA relationship, each with different implications for the support that will be needed from central government. Mayors could be fully engaged, partially engaged, or less engaged depending on how they interpret their new health duties and whether they see the ICB as a key vehicle for the delivery of their health agendas. Below we sketch out what this variation may look like in practice:

[13] This sets out the role of the NHS region management tier, which will have three core roles: to oversee regional health system performance (they will take on this role from ICBs); playing an "integrator" role between the centre and systems; and coordinate transformation aligned with national priorities, including in the 10 year health plan. E Jones & J Kiely (2025). *The model region blueprint: what you need to know. NHS Confederation*. Read.

Full engagement: This scenario involves a mayor and strategic authority that view improving population health and reducing health inequalities as a core objective, and as essential to building a stronger regional economy. They see the Integrated Care Board (ICB) as a key delivery mechanism and invest time and effort in understanding and working with it, while also seeking to influence and drive a coherent long-term strategy that includes the health and care system but extends far beyond it. In such a situation, we would expect the SA to hold the ICB to account for its actions in areas such as contributing to wider strategies (e.g. environment, economic growth, planning, transport, housing); encouraging health institutions, particularly provider trusts, to act as anchor institutions[14]; meeting existing legal duties on health inequalities; co-resourcing joint prevention initiatives; and ensuring transparent reporting of impacts on population health outcomes. Initially, this level of engagement is most likely among established strategic authorities with a history of connection through the ICP to the wider workings of their system.

- Partial engagement: A mayor and SA that sees the health of the population and narrowing health inequalities as an important goal that may relate to building a stronger regional economy. They see the ICB as a mechanism for delivery, but not necessarily a key one. They are more wary of engaging with the health and care system, and are less familiar with its structures. They are serious about the health duty that they have and seek to do more over time. They are likely to choose one or two key areas, that are already closely aligned with their existing competencies and activity and seek to strengthen the ICB's connectivity and contribution in these areas. They are, initially at least, likely to be in learning mode before strengthening their position in terms of accountability and joint resourcing. This situation could arise in established strategic authorities, or in new strategic authorities seeking to get ahead of the game.

- Low engagement: A mayor and SA that limits engagement on health to membership of the ICB, and is not an active driver of its strategy. They may be active in some limited areas where there is a specific fit or where connections already exist – for example in the care of those likely to be discharged from hospital without settled accommodation, where the SA may support a coordinated approach with the rest of local government. Initially, at least, this situation is likely in newer strategic authorities with lesser experience of connecting health to wider policy and sectors.

4. How will ICBs engage with mayors and strategic authorities?

[14] See CLES & The Democracy Collaborative (2019). Health institutions as anchors: establishing proof of concept in the NHS. CLES. Read; and TL Goodwin (2023). Healthy places: Buiding inclusiove economies through integrated care systems. CLES. Read.

On the other side of the table will be the ICBs, which will be in differing positions in terms of their understanding of and commitment to improving the wider determinants of health and health inequalities[15]. In some systems, the connection has been hard-wired for a long time, most notably in Greater Manchester where a focus on population health has gone hand-in-hand with devolution and economic goals[16], but this is the exception rather than the rule. As with strategic authorities, we foresee difference across the country, ranging between:

- Full engagement: An ICB that fully understands the range of organisations involved in the wider determinants of health as drivers of health inequalities, and actively seeks to partner to maximise joint impact. Its constituent health institutions act as anchor institutions and it recognises the health and care system's role in economic growth, productivity and a healthy workforce as well as other wider determinants such as good quality housing. It is therefore fully engaged with the wider SA plans - seeing itself as the long-term steward of its population's health. In its population health commissioning it expects that the health and care system will work jointly with other parts of the public sector, the VCSE sector, and others to provide holistic responses to people's current and future health needs, and shifts resources to that effect. Finally, it elevates and applies the expertise in public health to these goals[17], coordinating with public health expertise both in SAs and local authority public health teams.

- Partial engagement: An ICB that is aspirational in its intentions and has some experience of working around the wider determinants of health itself, its constituent health institutions act as anchors to some degree, but this is variable among them. It may have aspirations to go further, but finds it hard to find space for this agenda among competing priorities.

- Low engagement: An ICB that is strongly focussed on financial break-even and supporting the health provider sector to meet targets around waiting times, quality and financial balance. Its constituent health institutions are not active as anchors. It doesn't prioritise prevention activity that extends beyond the role of the NHS and defined care pathways. It perceives its commissioning function narrowly, including on population health where its focus is on segmenting, risk stratifying and treating patients as opposed to wider joint-commissioning with partners. Its health inequalities work is restricted to a focus on healthcare, such as core20plus5 approaches[18].

[15] H Elliot et al (2025). *From Policy to action: A document content analysis reviewing the adoption of the healthcare inequality programme in local health system plans in England.* BMJ Open. Read.
[16] J Jabbal & D Buck (2024). *Population health in Greater Manchester: The journey so far.* King's Fund. Read.
[17] See Smith (2025). *Same cycle – different bike.* King's Fund. Read.
[18] Core20plus5 has been NHS England's conceptual approach to reducing health inequalities through the provision of health care, for adults see NHS England: here. For Children, see NHS England: here.

5. Mitigating risks of low and mismatched engagement

If we consider this picture of varying levels of interest and engagement between different ICSs and SAs, the question of how they will match up becomes critical. In some cases, both sides will fully appreciate the value of partnership and be strongly aligned; in others, engagement will vary between the two; and in some, one or both partners may have low involvement (see Figure 1 and description below). This variability creates significant risks for the success of partnerships between ICBs and mayors or SAs in tackling health inequalities. The Department of Health and Social Care (DHSC) and the Department for Housing, Communities and Local Government (MHCLG) need to recognise these risks and take steps to mitigate them. We set these out in the figure below and the activity and support associated with different 'engagement pairs' below the figure.

Figure 1: Engaged, or not? ICSs and mayoral strategic authorities

		ICBs		
		High engagement	Partial engagement	Low engagement
Mayors/SAs	High engagement	Strong connection, alignment and high likelihood of success, between health and growth and health inequalities goals	Good connection, and good progress possible, but may be limited initially	Frustration, resolves into an accountability/ transactional relationship only
	Partial engagement	Good connection, and good progress possible, but may be limited initially	Some progress in limited, agreed areas. A developmental approach over time	Disappointment, and sense of opportunity missed, possibility but fragile
	Low engagement	Frustration, resolves into an accountability/ transactional relationship only	Disappointment, and sense of opportunity missed, possibility but fragile	Poor connection and information exchange only, little change or sense of purpose, and no curiosity about why this matters

<u>Engagement 'pairs' and types of action and support required:</u>

- Green: Ambassadors, likely with trailblazer programmes. Encouraged to show-case and share their learning with the other groups.

- Amber: Development of an emerging leaders group, a group of areas and systems that could be supported to learn from each other, with coordinated offers from the centre to enable them to do so. This could also learn from and connect existing networks such as The Health Foundation's mayoral regions programme, the NHS Confederation's ICS network; and the Health Anchors Learning Network[19].

- Pink: A voluntary in-depth support and development offer, designed with particular emphasis on the side of the partnership that is less engaged.

- Red: Core learning offer with an emphasis on setting out the case for engagement on both sides, and demonstrating why this is important.

We recommend that that policy and support in this space is developed based on dynamic mapping and assessment of where SAs and ICBs sit on the matrix above. This should be done by DHSC, and the MHCLG in concert with NHS England and the Local Government Association. This could then be followed by targeted support and development programmes, with the goal of moving from bottom right to top left over time. It is clear, and right, that both ICBs and strategic authorities are intended to be strategic leaders in future, shaping their partnership for the good of their local population's health and wider wellbeing. We stress that this should not be interpreted or delivered as a form of performance management, but as support and expertise.

6. Geographical alignment and mismatched timetables for change

Geographical alignment also matters[20], overlapping boundaries between services or sectors creates confusion, coordination and accountability problems, and ultimately a poor sense of ownership and stewardship for a given population's health and wider outcomes. The 10 year plan recognises this in setting out that its *"aim is that ICBs should be coterminous with strategic authorities wherever feasibly possible"*[21], and the government will "*encourage*" ICBs to shift their boundaries to make this happen, where they are not already well aligned. A set of ICB mergers already announced is being undertaken with this explicitly in mind[22].

In principle this is welcome. During our research we heard frequently from systems and SAs around the country that geographical incongruity could be a major barrier to effective partnership working on population health initiatives

[19] See respectively: Health Foundation, NHS Confederation, and Health Anchors Learning Network.
[20] See: DHSC (2021). *Integrated care systems boundaries review: decision summary*. GOV.UK. Read. Additionally, see: P Dunn (2022). *Integrated care systems: what do they look like?* Health Foundation. Read.
[21] UK Government (2025). *Fit for the future: 10 year health plan for England*. Read.
[22] See: here.

between organisations. It also seems that in many systems, people view the chance for ICSs to merge with others (and in so doing pool resources) as a potentially helpful moment of reset that will allow them to live up to the original aspirations of integration in terms of breaking down barriers between organisations and joining up services[23].

While the overall aim is positive, undoubtedly there will be disruption in the transition. Some of the SAs we spoke to during our research were clear that they saw restructures and reorganisations, whatever positive effects they may have in theory, as a barrier to partnership working in practice. Some places experienced the initial creation of ICSs as something that disrupted well-functioning local arrangements, and reported that they've had to work hard since "*to get that alignment back in [the] system*" ever since. In these places, further changes simply feel like "*another bombshell*"[24] which will require working through before any progress can be made.

For many we have spoken to, the secret to good partnership working on health or anything else is building relationships and locally specialised ways of working. Reorganisations shift these relationships and mean that this work has to be done afresh – and some in more mature systems were concerned that changes to geography would mean undoing what was already established and well-functioning.

Accordingly, as the government embarks on this programme of bringing about coterminosity between ICSs and SAs, it will be important to allow things to develop differently in different places, and at different speeds so that areas with pre-existing and effective arrangements, even if they appear messy from the outside, are not forced to rebuild their relationships and models from scratch at too fast a pace.

This challenge is compounded by misaligned timetables for boundary changes and alignment between ICBs and SAs[25]. While ICS mergers and budget adjustments are expected within the next 12 months, the creation of new SAs in some areas may not occur until the end of the current parliament – the government has already unexpectedly delayed the elections for four regional mayors from 2026 to 2028[26]. This mismatch risks putting the cart before the horse - and runs counter to the spirit of the 10 year health plan - by potentially locking ICB structures in place before many SAs are operational.

This dynamic will be particularly acute in areas that are affected by the second other major challenge: that in some places there is a mismatch between NHS

[23] S Arnold et al (2025). *Integrated care board cuts – what does it all mean*. King's Fund. Read.
[24] The King's Fund has heard similar strands of opinion to this before, as described in this report on Population health in Greater Manchester. See J Jabbal & D Buck (2024). *Population health in Greater Manchester*. King's Fund. Read.
[25] S Williamson & V Tether (2025). *ICB clusters and mergers: what you need to know*. NHS Confederation. Read.
[26] Paun, A et al (2025). *The government's decision to delay mayoral elections cannot be justified on democratic or fairness grounds*. Institute for Government. Read.

patient flows and the local government geographies that will form the basis for new SAs[27]. In such areas, it will once again be important to allow some flexibility for ICBs, and accept that while better geographical alignment is a noble aim, it may not be possible in all circumstances.

This is a complex challenge, and perfect geographical alignment across the country is unlikely. However, the government must act to prevent the biggest risk we foresee: that ICB reorganisation by DHSC and NHSE - driven by efficiency savings and a desire to lock down NHS structures - takes precedence over the creation of SAs. This would undermine the government's stated intention in the 10 year health plan that ICBs should align with SAs, not the other way around.

To avoid this, we need stronger guidance from DHSC, NHSE, and MHCLG, as well as a clearer - and in some cases slower for ICBs and faster for SAs - path to alignment than currently planned. While this may involve short-term political and operational costs, these are worth incurring to secure better health outcomes for the population over the long term.

7. Alignment of finances, accountability and leadership signals

The government is clearly serious about increasing the financial power and flexibility of SAs, which is welcome. It has set out its plans for how this will happen over time, as SAs become more mature and established they will receive an integrated settlement which covers wide areas of funding on the wider determinants of health[28]. As the most established and mature, Greater Manchester, and the West Midlands were in receipt of over £900mn in 2025-26, and the North East, South Yorkshire, West Yorkshire, and Liverpool City Region Combined Authorities and the Greater London Authority will also receive this kind of funding in 2026-27[29].

In our research, we found that the lack of actual or perceived flexibility around NHS funding streams created 'massive barriers' to collaboration with SAs. The creation of ICSs was partly based on their role in tackling health inequalities and supporting wider social and economic goals that influence health. Early assessments showed some promising plans, with all ICB and ICP strategies and joint forward plans including commitments to address wider determinants of health such as housing, education, poverty, and green spaces[30].

However, in practice, a clear tension emerged: whether to focus on NHS core business or to take a broader role in addressing the social and economic conditions that drive health inequalities. In-depth work by The Health Foundation highlighted that objectives on tackling health inequalities were often crowded out

[27] D West (2025). *Which ICBs are heading for a merger*. HSJ. Read.
[28] The integrated settlements cover economic development and regeneration; transport and local infrastructure; adult skills; employment support; housing and strategic planning; environment and climate change; and health, wellbeing and public service reform. For more on the details and qualifying conditions to receive an integrated settlement, see here.
[29] (2024) *Integrated Settlements for Mayoral Authorities,*. Gov.uk Read.
[30] D Buck (2024). *Are integrated care systems making progress on tackling health inequalities*. King's Fund. Read.

by priorities such as hospital waiting times and financial pressures[31]. There was also tension between health inequalities work defined in NHS care delivery terms, such as Core20PLUS5, and the wider contributions ICSs could make to improving population health.

This has been underpinned by a general lack of prioritisation and funding for prevention, especially that which is not directly clinical. The last government rejected the Hewitt Review's[32] proposals to increase prevention spend by ICSs by 1 per cent (amounting to around £1bn per year). This government has taken some welcome steps to support more joint work between combined authorities, local government and ICSs, especially in the field of preventing people falling out of work due to illness, through the health and growth accelerators[33].

One of the core three shifts in the 10 year health plan is prevention, while there were some welcome specific proposals, most commentators judged the commitments on the prevention shift to be the weakest[34]. This includes the financial wiring and incentives to underpin the shift and to work more closely with SAs as they mature and gain more responsibilities and greater control of funding through the health duty and integrated settlements. Despite a chapter devoted to rewiring the finances, the 10 year health plan said very little about the financial wiring and accountability changes needed to incentivise and shift ICBs to work more cohesively with others including SAs.

The government needs to provide much greater clarity on what it considers the appropriate level of prevention spending and how this will be achieved. As part of this, it should send strong signals that ICBs are expected to commission more prevention initiatives and address wider determinants of health in partnership with local government and SAs, supporting the shift toward ICBs acting as population health commissioners.

Finally, accountability differs between ICBs and SAs: ICBs are accountable to NHS England (while it exists) and DHSC, whereas SAs are accountable through local democratic structures. Navigating this could create tensions. To mitigate these, the development and use of shared accountability tools, such as jointly held outcomes frameworks, and clear expectations about minimum engagement and commitment on both sides should be encouraged. These mechanisms can help foster joint responsibility and strengthen collaboration[35].

8. Summary of recommendations

In summary, the evolving relationship between SAs and ICSs represents a significant opportunity to address health inequalities and improve population health. However, this

[31] H Alderwick et al. (2024). *Solving Poverty or tackling healthcare inequalities?* BMJ Open. Read.
[32] P Hewitt (2023). *The Hewitt Review: An independent review of integrated care systems*. GOV.UK. Read.
[33] See here.
[34] S Arnold et al. (2025). *Truly fit for the future? The 10 yearh health plan explained.* The King's Fund. Read.
[35] As we have proposed in our essay on the mayoral strategic authority health duties, see D Buck et al (2025). *Getting it right: The new health duty on strategic authorities*. CLES. Read.

potential will only be realised if both sides are supported to navigate new responsibilities, align their priorities, and overcome structural and financial barriers. Engagement will vary across the country, and without targeted support, there is a risk of fragmented approaches and missed opportunities. Ensuring coherent leadership, geographical alignment, and clear financial and accountability frameworks will be critical to creating partnerships that deliver on the ambitions of the 10 year health plan. We therefore make the following recommendations to government in these areas

- **Dynamic engagement mapping:** Given that SAs and ICBs will have varying levels of engagement, government should dynamically map the current state of engagement and design targeted support and development programmes. The goal should be to move all SA–ICB partnerships toward high engagement over time.
- **Prevent misaligned geographies:** There is a clear risk that ICB geographies will be locked down before those of SAs, which contradicts government policy objectives. Stronger guidance is needed, and in some cases, a slower path to ICB mergers and alignment than currently planned. While this may involve short-term political and operational costs, these are worth incurring for long-term population health benefits.
- **Clarify prevention spending:** Government must define what it considers the appropriate level of prevention spending and how to achieve it. As part of this process, it should send strong signals that ICBs are expected to commission more prevention initiatives and address wider determinants of health in partnership with local government and SAs, supporting the shift toward ICBs as population health commissioners.
- **Shared accountability mechanisms:** The development and use of shared accountability tools such as jointly held outcomes frameworks should be encouraged to foster joint responsibility and strengthen collaboration between ICBs and SAs.