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National Audit Office

REPORT

Restructuring of Integrated Care Boards

Department of Health & Social Care

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National Audit Office

Restructuring of Integrated Care Boards

Department of Health & Social Care

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

27 October 2026

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Contents

Key facts 4

Summary 5

Part One
The government's plans to reform Integrated Care Boards 14

Part Two
Progress in preparing reformed Integrated Care Boards to be strategic commissioners of local health services 25

Part Three
Progress in transitioning to an affordable operating model and managing associated risks 37

Appendix One
Our audit approach 50

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Key facts

Nov 2024

date when the government announced that Integrated Care Boards (ICBs) would focus on strategic commissioning and neighbourhood health services to improve population health and reduce inequalities

£18.76

the target ICB running cost per head of population in 2025-26 compared with a baseline of £32.98, an average reduction in running costs of 43%

£908mn

the annual reduction in ICB running costs that NHS England (NHSE) estimates could be achieved by meeting the target running cost per head

£171 billion	the total expenditure ICBs were responsible for in 2025-26
£2.2 billion	ICB total running costs in 2025-26 excluding redundancy payments; NHSE projects ICB running costs of around £1.4 billion in 2026-27
25	the number of ICBs or ICB clusters in April 2026, compared with 42 in April 2025
Around 8,000	NHSE's estimate of the reduction in full-time equivalent ICB staff required to achieve the target running cost per head
£582 million	NHSE's estimate of total ICB expenditure on voluntary and compulsory redundancy payments in 2025-26
15	the number of respondents to our survey (out of 19 ICBs or ICB clusters) who said they wanted more guidance on their future roles and responsibilities from NHSE

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Summary

1 Integrated Care Boards (ICBs) are responsible for planning and funding health services in England to improve population health and reduce health inequalities in their area. ICBs receive funding from NHS England (NHSE) for commissioning NHS services in their area and are accountable for delivering value for money from their NHS budget. They work in partnership with NHS trusts, primary care providers (such as GPs) and local authorities to address the wider determinants of health and decide what local healthcare services should be provided to meet the health needs of the population they cover. Working through NHSE, the Department of Health & Social Care (DHSC) has overall responsibility for oversight and strategic direction of ICBs.

2 The 2024 Darzi review of the NHS concluded that the role of ICBs needed to be clearer and that there were opportunities to reduce duplication with other bodies.[1] In response, DHSC and NHSE announced plans to restructure ICBs so they could focus more on commissioning services. The restructuring also aimed to reduce ICB running costs by half by eliminating duplication and achieving economies of scale.

3 At the beginning of 2025-26, there were 42 ICBs across England, responsible for total expenditure of £171 billion. They spent £2.2 billion on their running costs in 2025-26 and the remainder on commissioning health services for their local populations. NHSE estimates that reducing running costs will require ICBs to cut staff numbers by around a third, equivalent to around 8,000 posts in total. To help them achieve the running cost reduction, some ICBs have merged or formed clusters. By September 2026, there were 25 ICBs or clusters of ICBs. Current ICB boundaries do not always match local or strategic authority boundaries. In July 2026, the government announced further devolution plans, including a commitment to align ICB and strategic authority boundaries by the end of the current Parliament.[2]

4 This report examines the reforms to ICBs, including progress in changing their size, role and functions, the progress and impact of ICB consolidation and staff reductions, and DHSC's oversight of whether the objectives of the ICB reforms are being met. The report covers:

- DHSC's objectives for the reforms to ICBs (Part One);
- progress in preparing reformed ICBs to be strategic commissioners of local NHS services (Part Two); and
- progress in establishing new operating models, making savings, and managing associated risks (Part Three).

1 Department of Health & Social Care, *Independent investigation of the NHS in England*, September 2024.
2 Cabinet Office, *Rewiring the State*, July 2026.

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5 Alongside the reforms to ICBs, the government is also proceeding with wider plans to merge NHSE into DHSC by March 2027 and plans for further devolution. These wider changes are not the subject of this report. We do not audit ICBs, so have not evaluated their individual plans or the relative progress they have made. We have examined the direction DHSC and NHSE have provided to ICBs and the assurance they have sought about action ICBs have taken. Further details of our scope and approach are at Appendix One.

Key findings

The objectives of the ICB reforms

6 DHSC has accepted independent recommendations for clearer and more consistent ICB roles and responsibilities. Overall, the 2024 Darzi review concluded that the management structure involving ICBs was fit for purpose but that DHSC needed to address differences across ICBs in how they understand their role, including how far they are responsible for the performance management of providers. The review also raised concerns about duplication of functions between ICBs and providers, including infection prevention and control (paragraph 1.5).

7 DHSC expects ICBs to have a stronger focus on strategic commissioning to help improve the health of their populations. In November 2024, DHSC announced that ICBs would focus on their role as strategic commissioners. Strategic commissioning is defined as an evidence-based process for planning, purchasing, monitoring and evaluating services over the longer term, with the aim of improving population health and reducing health inequalities. Previously, ICBs had mixed views about where they should focus their efforts, including how they should tackle population health. NHSE stated that rebuilding strategic commissioning capabilities will provide greater clarity and consistency on the role of ICBs. It instructed ICBs to consider stopping activities where there is duplication, such as regulatory or assurance functions carried out by providers or NHSE regional teams. To support ICBs, NHSE set out its expectations of the revised role in a strategic commissioning framework in November 2026 and launched a strategic commissioning development programme to help ICBs build this capability (paragraphs 1.6, 2.3, 2.4, and 3.3).

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8 NHSE instructed ICBs to reduce their running costs by around half. In March 2025, NHSE estimated baseline ICB running costs for 2025-26 of £2.1 billion, or approximately £32.98 per head of population.[3] To achieve estimated savings of £908 million a year, NHSE instructed ICBs to reduce their running cost expenditure to £18.76 per head of population (weighted according to levels of deprivation in the population and local costs), an average reduction of 43%. However, some ICBs needed to reduce their expenditure by much more than others to achieve the £18.76 target. For example, Surrey Heartlands ICB needed to reduce its running costs by 63%, while North East and North Cumbria ICB faced a 27% reduction (paragraphs 1.6 and 1.13 to 1.17).

Progress in preparing reformed ICBs to be strategic commissioners of local health services

9 It has been challenging for ICBs to identify the skills and capabilities they need while their future functions have been evolving. NHSE has moved quickly to reform ICBs, while other elements of NHS reform have progressed more slowly. This meant ICB restructuring began before related decisions had been settled, including the future role of regional teams within NHSE pending its own planned merger with DHSC. From April 2027, pending legislative changes in the Health Bill, responsibility for commissioning many services will move from NHSE to ICBs.[4] These services include vaccinations, child health information, screening, sexual assault and abuse services, primary care, and some specialised services.[5] NHSE recognised that, if ICBs are to focus on commissioning, other bodies such as trusts may be better placed to undertake activities that are not considered core to strategic commissioning. However, ICBs faced uncertainty during 2025 while NHSE considered the readiness of DHSC, its regional teams, and trusts to receive and discharge these functions. In September 2025, NHSE provided guidance on the more complex functions, and in January 2026 it issued further guidance confirming which of the remaining functions ICBs should plan to retain and which to transfer. ICB activities such as oversight of provider performance and workforce planning were to be stopped because they duplicated NHSE and provider activity. Functions fulfilling ICB statutory duties, such as taking decisions on Continuing Healthcare packages for individuals with significant health needs, and making special educational needs and disabilities assessments, would remain with ICBs (paragraphs 2.5 to 2.9, and Figures 6 and 7).

3 Baseline running costs for 2025-26 are NHSE's estimate of what running costs would have been in 2025-26 prior to the April 2025 announcement to restructure ICBs.
4 *Health Bill*, 2026-27, HC, Bill no. 131.
5 Primary care is currently commissioned by ICBs under a delegation agreement with NHS England.

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10 ICBs have clustered or merged so they can cover larger populations and achieve savings. NHSE told us that it had concluded that operating efficiently below a population of 1.5 million may be difficult. NHSE therefore asked ICBs to consider clustering arrangements and explore formal mergers as part of wider cost reductions and organisational restructuring. Before the restructuring, there were 42 ICBs, with weighted populations ranging from 0.6 million to 3.6 million and an average of 1.5 million. By April 2026, several ICBs had either formally merged or clustered with others, resulting in 25 ICBs or clustered ICB groupings. ICBs responding to our questionnaire of ICB Chief Finance Officers identified several benefits, including reducing costs and duplication through changes to senior management, sharing good practice across a wider footprint and working at greater scale to streamline contracts and better understand and address variation (paragraphs 2.11 to 2.15).

11 Closer alignment between ICBs and strategic and local authority partners creates opportunities but may also bring short-term challenges while aligning boundaries and forming new relationships. The 10 Year Health Plan committed to aligning ICB boundaries with strategic authorities wherever feasible.[6] Strategic authorities are devolved local government bodies that bring together powers, responsibilities and funding at a regional level to support economic growth and improve local public services. There are currently 20 operational strategic authorities in England. There may be further announcements on strategic authorities as the government's devolution plans evolve. In July 2026, the government committed to ensuring all areas of England have a strategic authority by 2028, with ICB boundaries aligned to strategic authorities by the end of the current Parliament (expected by 2029).[7] This alignment offers opportunities to better integrate health and social care services and coordinate action to prevent ill-health. However, uncertainty about future strategic authority boundaries makes current decisions on ICB configuration difficult. In October 2026, NHSE confirmed that further ICB mergers expected in 2027 will be delayed to at least 2028 to allow time for the national picture to become clearer. Changes to ICB structures through mergers and clustering will also affect existing strategic and working relationships with local authorities, alongside potential changes from the Health Bill and local government reform (paragraphs 2.16 to 2.20).[8]

6 UK Government, *Fit for the Future: The 10 Year Health Plan for England,* CP1350, July 2025.
7 The July 2026 announcement said that, where there are strong reasons for larger ICBs, they may align to boundaries of multiple strategic authorities.
8 *Health Bill,* 2026-27, HC, Bill no. 131; Ministry of Housing, Communities & Local Government, *Local government reorganisation: Policy and programme updates,* February 2025.

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12 DHSC and NHSE have set out the initial outcomes they expect ICBs to achieve as strategic commissioners, but the performance measures need further development to reflect the new ICB operating model and ensure there is a consistent baseline for tracking performance over time. NHSE currently assesses ICBs annually. The 2026-27 NHS oversight framework provides an initial basis for comparing performance between ICBs on core functions such as population health and inequalities, effectiveness and experience of care, patient safety, finance, productivity, and innovation. NHSE also published a commissioning capability self-assessment in June 2026 to help ICBs understand strengths, weaknesses and where they may need additional support. However, NHSE is still developing how it will assess ICBs' performance as strategic commissioners and on their neighbourhood health strategies. NHSE plans to refine the metrics in the oversight framework for 2027-28 to ensure they are aligned with the strategic commissioning framework and ICBs' new operating model. NHSE will need comparable measures over time to assess whether ICBs are improving population health and reducing health inequalities during the transition (paragraphs 2.22 to 2.24).

13 Some ICBs have made early progress in implementing strategic commissioning plans. ICBs are at different stages in implementing five-year commissioning plans that focus on neighbourhood health priorities. For example, NHSE has told us that Essex ICB has established neighbourhood teams and plans to assess population health inequalities, and Kent and Medway ICB is using GP-led neighbourhood teams, a single contractual approach and an outcomes-based incentive with the aim of shifting investment from hospital to community care. NHS Alliance, an independent membership organisation representing the health and care system in England, has also interviewed leaders from the first six merged ICBs.[9] It identified lessons on leadership, staff engagement and the technical elements of a merger. For example, ICB leaders emphasised the importance of the merged ICBs learning from and sharing the best elements of each legacy organisation (paragraphs 2.25 and 3.13, and Figure 10).

9 NHS Alliance, *ICB mergers: lessons for future success*, July 2026.

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Progress in transitioning to an affordable operating model and managing associated risks

14 Most ICBs have developed new operating models to reduce running costs. In April 2025, NHSE set each ICB a target for running costs per head of population and asked them to produce affordable operating plans. NHSE instructed ICBs to remove duplication with the functions of providers and NHSE (such as overlapping performance management of providers), while recognising the need to invest in strategic commissioning skills. ICBs expect to spend less on administering most functions and have identified savings by focusing more clearly on their strategic commissioner role, streamlining corporate services, and making greater use of technology. By June 2026, 13 of the 19 respondents to our questionnaire had developed a new operating model, and six had partly developed their operating model. The ICBs that were taking longer were mainly those that were clustering or merging, so were facing additional challenges (paragraphs 3.2 to 3.6, Figure 11 and Figure 12).

15 ICBs need to manage a significant programme of redundancies to achieve the required savings. To save an estimated £908 million a year in running costs, ICBs need to cut total staff numbers by around 8,000 (full time equivalent), around a third of total ICB staff. This requires making many staff redundant. In March 2026, ICBs reported that they expected to make a total of 5,856 voluntary redundancies. ICBs also expect to reduce staff numbers through compulsory redundancy, recruitment freezes and removal of vacant posts. In practice, NHSE's most recent data show that, between November 2025 and June 2026, around 3,700 staff left ICBs through redundancy. NHSE estimated that, in 2025-26, ICBs spent a total of £582 million on redundancy payments. NHSE funded around £400 million of this, with ICBs funding the remainder. NHSE does not collect data on ICBs' future projected redundancy numbers or payments projections (paragraphs 3.7, 3.8 and 3.20).

16 The redundancy programmes have taken longer than expected. Originally, NHSE instructed ICBs to complete restructuring by December 2025. However, the voluntary redundancy scheme and available funding was not confirmed until November 2025. By September 2026, eight ICBs or clusters informed NHSE that they had given notice to all staff at risk of redundancy, seven said they still had work to do, and the remainder did not confirm. NHSE told us that problems accessing pensions statements and disputes over partial retirement had contributed to the delays. Slower progress with redundancies has impacted on how quickly ICBs have reduced their running costs towards the target. Although in-year data indicate they are closing the gap, NHSE estimates that by March 2027 ICB running costs for 2026-27 will be around £1.4 billion, £200 million above the £1.2 billion target. NHSE and DHSC have an important role to play in ensuring that savings do not erode over time through staff numbers rising again. NHSE has issued guidance to ensure that they recover redundancy payments from staff who go on to work for other parts of the NHS within a set time (paragraphs 3.9 to 3.11 and 3.20 to 3.23).

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17 ICBs have tried to prevent the restructuring from disrupting front-line services, but the transition has had some negative impacts on relationships with local partners. Our 2025 guide *Government exits and redundancies* set out the challenges presented by changing an organisation's operating model. Our survey evidence and research by others indicates that the ICB reforms have had an inevitable impact on staff morale and engagement. Clustering and merging ICBs must also restructure teams and merge data and systems, and all ICBs need to manage the loss of corporate expertise and memory. ICBs have sought to manage these transitional challenges by involving staff in the design of the new organisation, keeping stakeholders informed and engaged on the changes, and sharing learning with other ICBs. However, there are early signs of issues for some services. For example, the Public Service Ombudsman has reported that challenges providing services for patients with ADHD and autism are made worse by organisational changes within ICBs.[10] Local authorities also told us that workforce instability and the loss of experienced ICB staff had affected programme delivery and weakened joint commissioning arrangements. Local authorities were concerned that ICB cuts may leave them with gaps to fill and place greater onus on health and social care providers to manage frictions. Several local authorities stressed the importance of maintaining links with senior ICB leaders during the transition, and the need for joined-up system thinking in the context of wider reforms to local government (paragraphs 3.12, 3.13 and 3.18 to 3.19, and Figure 15).

18 DHSC, NHSE and ICBs must manage risks to capability and capacity if ICBs are to deliver long-term improvements in population health. Clarity about an ICB's new role, and the capabilities it needs, should drive decisions on workforce requirements and redundancies. ICBs will need specific expertise to be effective strategic commissioners and analytical skills to assess local population health needs. NHSE has provided guidance to support ICBs in developing the skills they will need as they focus on their strategic commissioner role, and it has asked for assurance from ICBs that they can deliver their objectives within their reduced funding. ICBs confirmed that they had developed or made progress towards developing the structures they need to perform their role and meet the running cost target, although some reported risks that their running cost budget may not meet the full costs of their activities. Some ICBs responding to our questionnaire expected to spend less on digital transformation, developing neighbourhood health services, and prevention activities, which are objectives of the 10 Year Health Plan. Local authorities we interviewed have concerns about how the changes will impact on local health services (paragraphs 3.16 to 3.17 and 3.24 to 3.25, Figure 11, and Figure 15).

10 Public Service Ombudsman, *Improving ADHD and autism services; commissioning with confidence*, Autumn 2026.

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Conclusion

19 ICBs are implementing significant restructures, with the dual objectives of strengthening their role as strategic commissioners and reducing running costs by 43% from previous levels of around £2 billion. To support the changes, NHSE has provided guidance and support on strategic commissioning, organisational restructuring, and redundancy arrangements, and ICBs have responded at pace. Most ICBs have developed new operating models and have substantial workforce reductions underway. Many ICBs have clustered or merged to achieve efficiencies, and some newly formed ICBs are already making progress with plans to improve health in their neighbourhoods.

20 The reforms have progressed faster than some of the arrangements that are needed to support them. Key aspects of ICBs' future role, and their relationships with NHSE regional teams and local government, have continued to evolve during implementation. While DHSC and NHSE have closely monitored progress towards reducing running costs, they have less assurance about whether ICBs will retain the skills and capacity needed to deliver effective strategic commissioning. Arrangements for assessing the performance of the reformed ICBs are still developing, which may make it difficult to track how the reforms influence population health outcomes. Closer alignment with local government could bring significant benefits in terms of operational efficiency, prevention services and care in the community. Getting there will be challenging and will require proactive management at all levels of the health service, particularly in the context of wider government reforms. DHSC and NHSE now need to provide greater clarity on the future model for ICBs, strengthen assurance over capability and workforce risks, and establish clear measures of success if they are to demonstrate that reforms deliver sustainable improvements and value for money.

Recommendations

21 These recommendations are aimed at NHSE pending its planned merger with DHSC.

a NHSE and DHSC should publish a clear statement of ICB roles, functions and accountabilities, including how ICBs will share responsibilities with NHSE regional teams, providers and other parties. This statement should build on the guidance NHSE has shared to date and include a timetable for any remaining decisions or planned future changes, clarifying any dependencies with other ongoing changes, such as the planned merger of NHSE into DHSC, devolution, and developments in local government.

b NHSE and DHSC should develop and publish a benefits realisation framework for the ICB reforms, setting out the intended savings, service improvements and population health outcomes. The framework should set out how the success of the reforms will be measured, including by drawing on data NHSE will collect through its annual performance and capability assessments of ICBs.

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c NHSE and DHSC should ensure there are robust arrangements, supported by clear and comparable performance information, for scrutinising how effectively ICBs operate as strategic commissioners, maintain the capacity and capability they need to discharge their statutory functions, and contribute to improved outcomes. These arrangements should support accountability nationally and locally, including to local partners and communities.

d NHSE and DHSC should ensure that savings are sustained and not eroded through growth in staffing by requiring ICBs to make an informed assessment of the impact of the reductions on capacity and productivity, staffing and consultancy costs, achievement of running cost targets and delivery of expected net savings.

e DHSC and NHSE should ensure proportionate controls across all NHS organisations for recovering redundancy or Mutually Agreed Resignation Scheme payments from staff who go on to work elsewhere in the NHS. DHSC should work with NHS Business Services Authority to implement this through its management of the NHS Jobs contract.

f NHSE and DHSC should support ICBs in learning from one another. This could include a systematic evaluation of the outcomes of ICB clustering and merging (building on reporting by NHS Alliance), disseminating good practice from the best strategic commissioners, and identifying and promoting proven shared-services approaches with details of the savings that ICBs have achieved.

g DHSC and NHSE should work with ICBs to ensure there is sustained focus during the transition to new ICB arrangements on:

- maintaining effective networks and senior-level relationships with local partners, particularly during redundancy programmes;
- engaging with other bodies undergoing reforms, including local government, police and education partners, so that changes are informed by joined-up system thinking, and areas of joint accountability and governance are specified.

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Part One

The government's plans to reform Integrated Care Boards

1.1 This part of the report sets out the rationale for the Department of Health & Social Care's (DHSC's) proposed reforms to Integrated Care Boards (ICBs), and what the government is aiming to achieve from the reforms.

The establishment of ICBs

1.2 Integrated Care Systems (ICSs) were set up to improve health outcomes and efficiency by joining up health, social care and other services. They have existed in various forms since 2016 but were placed on a statutory footing through the 2022 Health and Care Act. We reported previously on the establishment of ICSs in our 2022 report *Introducing Integrated Care Systems*.[11] ICSs brought together NHS, local government and other partner organisations, and comprised an ICB and an Integrated Care Partnership (a committee jointly formed by the ICB and local authorities in each local area).

1.3 ICBs are responsible for planning and funding health services in England to meet the healthcare needs of the population and address health inequalities. ICBs receive funding from NHS England (NHSE) for commissioning NHS services in their area and are accountable for delivering value for money from their NHS budget. They work in partnership with NHS trusts, primary care providers (such as GPs) and local authorities to address the wider determinants of health and decide what local healthcare services should be provided. At the time they were established in 2022, there were 42 ICBs across England. In 2025-26 they were responsible for a total expenditure of £171 billion.[12] Working through NHSE, DHSC has overall responsibility for oversight and strategic direction of ICBs (**Figure 1**).

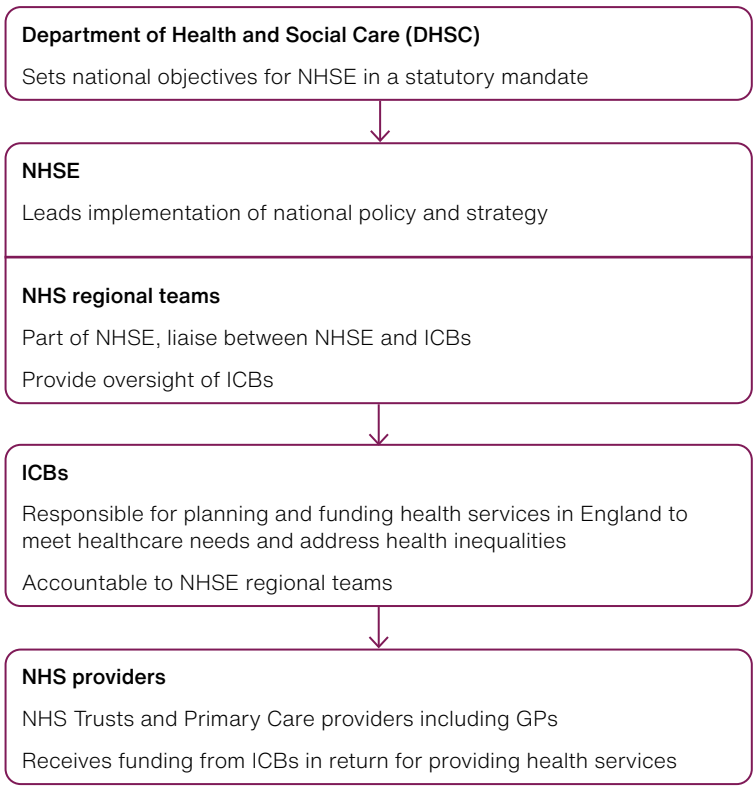
11 Comptroller and Auditor General, *Introducing Integrated Care Systems: joining up local services to improve health outcomes*, Session 2022-23, HC 655, National Audit Office, October 2022.
12 NHS England, Annual Report and Accounts 2025/26, page 43.

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Figure 1

The role of integrated care boards (ICBs) within the health service in England, 2025-26

ICBs receive funding from NHS England (NHSE) for planning and funding health services to improve population health and reduce health inequalities in their area



Note

1 This is a simplified representation of the healthcare system in England.

Source: National Audit Office Analysis of Department of Health & Social Care and NHS England documents

1.4 ICBs were expected to work closely with local partners to ensure the ICS met its objectives to:

- improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;
- enhance productivity and value for money; and
- help the NHS support broader social and economic development.

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Proposed reforms to ICBs

1.5 In September 2024, DHSC published the independent Darzi review of the NHS in England (**Figure 2**).[13] It found that the management structure involving ICBs was fit for purpose, but ICBs understood their roles differently, such as the extent to which they were responsible for the performance management of providers and how they should tackle population health. The review concluded that there was a need to clarify roles and accountabilities and to ensure the right balance of management resources across the NHS.

1.6 Following the review, DHSC announced plans to reform ICBs. Although DHSC did not explicitly publish its objectives for the ICB reforms, public announcements and communications to ICBs make clear what it wants ICBs to achieve in broad terms.

- In November 2024, DHSC announced that ICBs would focus on their role as strategic commissioners and on the development of new neighbourhood health services. Strategic commissioning is defined as an evidence-based process for planning, purchasing, monitoring and evaluating services over the longer term, with the aim of improving population health and reducing health inequalities. Previously, ICBs had mixed views about where they should focus their efforts, including how they should tackle population health. NHSE stated that rebuilding strategic commissioning capabilities will provide greater clarity and consistency on the role of ICBs.
- In April 2025, NHSE wrote to all ICBs announcing plans for ICBs to reduce their costs by around half, to a cost per head of weighted population of £18.76 by the end of 2025.

1.7 The reforms to ICBs are proceeding in parallel with wider health reforms. The Health Bill was introduced to the House of Commons in May 2026. The proposed reforms include the abolition of NHSE, pulling functions directly into DHSC by March 2027, and changes to statutory data functions and the single patient record.[14] DHSC expects to reduce administrative posts by around 18,000 across DHSC, NHSE and ICBs, saving more than £1 billion a year by the end of the Parliament.

1.8 In respect of ICBs, the Health Bill also proposes to:

- abolish Integrated Care Partnerships;
- remove the duty for ICBs to have providers of medical services and NHS trusts on their boards; boards are to include representatives from any mayoral authorities in their areas;
- remove the duty for ICBs to work together with NHS trusts in their local area to deliver financial balance (instead, NHS trust spending objectives would be set by the Secretary of State); and
- transfer most NHSE commissioning functions to ICBs.

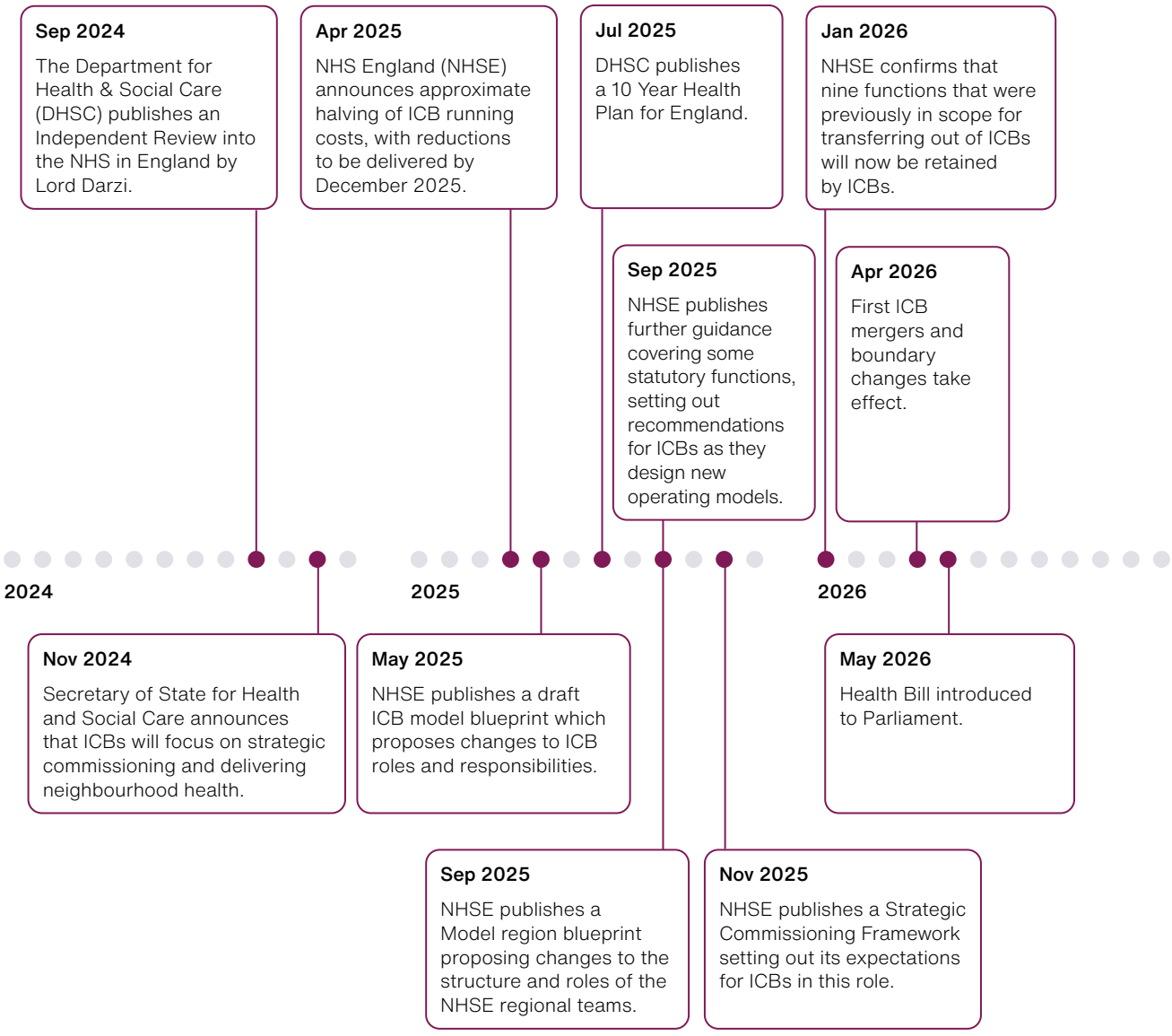
13 Department of Health & Social Care, *Independent investigation of the NHS in England*, September 2024.
14 As at 27 October 2026 the Health Bill was proceeding through Parliament and was subject to amendments.

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Figure 2

Timeline of key policy and other announcements on Integrated Care Boards (ICBs), September 2024 to May 2026

Since 2024, the government has announced changes to ICBs' role, structure and running costs



Note

1 An ICB is a statutory NHS organisation in England responsible for planning and coordinating health and care services across a specific geographical area, aiming to improve population health and reduce health inequalities.

Source: National Audit Office analysis of Department of Health & Social Care and NHS England documents

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Reducing ICB running costs

1.9 The majority of ICB funding is used for the delivery of services. In 2024-25, around 49% of estimated ICB expenditure went to acute care, 20% to primary care, 10% to mental health, 9% to community health services, and 5% to Continuing Healthcare.[15,16]

Trends in ICB running costs

1.10 ICBs also incur their own running costs. These running costs break down as follows.

- **Administration costs for corporate costs (and services 'hosted' by ICBs):** NHSE sets each ICB a running cost allowance which they should not exceed.
- **ICB staff costs associated with health programme spending (programme pay):** Expenditure on staff directly employed by the ICB to facilitate the delivery of services.
- **Commissioning Support Unit (CSU) costs:** CSUs have provided some, but not all, ICBs with support in their role as commissioners, for example support in business intelligence, clinical procurement, or informatics services. DHSC's 2025 10 Year Health Plan announced the closure of Commissioning Support Units.[17]

1.11 Total running costs (excluding redundancy payments) fell slightly in real terms between 2023-24 and 2025-26 (**Figure 3**).[18] In 2025-26 prices, ICBs spent an estimated total of £2.3 billion on running costs in 2023-24, dropping to £2.2 billion in 2025-26.

1.12 There has been considerable variation in running costs across ICBs (**Figure 4** on page 20). Baseline 2025-26 running costs ranged from £50.77 per head of population at Surrey Heartlands ICB to £25.60 at North East and North Cumbria ICB.[19]

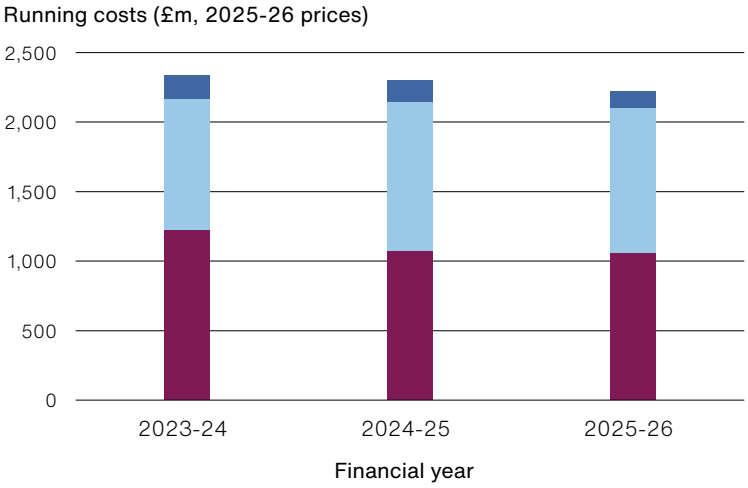
15 'Continuing Healthcare' refers to health and social care arranged and funded solely by the NHS for some people with long-term complex health needs.
16 These percentage estimates are indicative. They are based on NHSE data on all ICB expenditure for the period of April 2024 to December 2024, scaled up for a 12-month period.
17 UK Government, *Fit for the Future: The 10 Year Health Plan for England,* CP1350, July 2025.
18 Financial data are presented in 2025-26 prices using GDP deflators at market prices published by HM Treasury in June 2026.
19 Baseline running costs for 2025-26 are NHSE's estimate of what running costs would have been in 2025-26 prior to the April 2025 announcement to restructure ICBs.

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Figure 3

Integrated Care Board (ICB) running costs, 2023-24 to 2025-26, in 2025-26 prices

Total running costs have fallen by five percent in real terms between 2023-24 and 2025-26



	2023-24	2024-25	2025-26
Administration costs	1,228	1,075	1,064
Programme pay costs	938	1,071	1,039
Commissioning Support Unit (CSU) costs	171	153	122
Total running costs	**2,338**	**2,298**	**2,225**

Notes

1 Administration costs are the corporate costs of running an ICB and include both pay costs and non-pay costs.

2 Programme pay costs are expenditure on staff directly employed by an ICB to support the delivery of services. Non-pay programme costs would include all healthcare services commissioned by ICBs and are not part of ICB running costs.

3 CSUs supported some, but not all, ICBs in their role as commissioners, including through business intelligence, clinical procurement and informatics services. CSU costs refer to programme spend directed through CSUs.

4 All costs have been adjusted for inflation and presented at 2025-26 prices using GDP deflators at market prices published by HM Treasury in June 2026.

5 Totals may not sum up due to rounding.

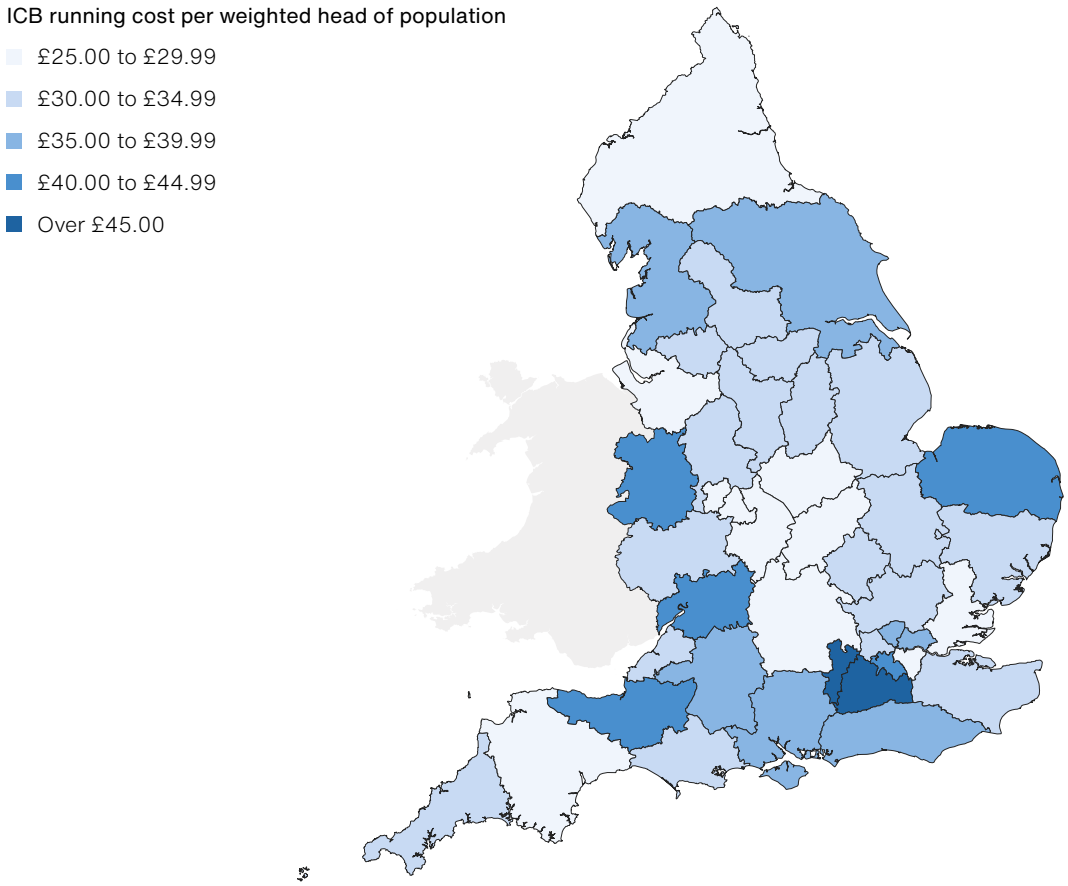
Source: National Audit Office analysis of NHS England data

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Figure 4

Estimated baseline Integrated Care Board (ICB) running costs per weighted head of population in England, 2025-26

Estimated baseline ICB running costs per weighted head of population ranged from £25.60 to £50.77



Notes

1 The baseline running costs in 2025-26 are an estimate of what running costs would have been in 2025-26 prior to the April 2025 announcement to restructure ICBs.

2 The population in each ICB is the 'core services weighted population'. This is a population that is weighted by needs, demographics, inequality and unavoidable costs (due to, for example, remoteness). Populations with higher levels of need or cost will have a higher weighting.

3 Total running costs in each ICB consist of three elements: administration costs; programme costs; and Commissioning Support Unit (CSU) costs.

4 Administration costs are the corporate costs of running an ICB.

5 Programme costs are expenditure on staff directly employed by the ICB to support the delivery of services.

6 CSUs provided some, but not all, ICBs with support in their role as commissioners, for example, support in business intelligence, clinical procurement, or informatics services. CSU costs refer to programme spend directed via CSUs.

7 ICB baseline administration costs are the total of running cost allowance published in January 2025 before the approximate halving in running costs was announced in April 2025 and separate allocated funding for delegated commissioning of pharmacy, ophthalmology and dentistry services.

8 ICB baseline programme pay and CSU spend is based on outturn data from between April 2024 and December 2024 projected over a 12-month period and inflated by 2.9% in line with the expected pay award for 2025-26.

Source: National Audit Office analysis of NHS England and Office for National Statistics data. Office for National Statistics licensed under the Open Government Licence v.3.0. Contains OS data © Crown copyright and database right 2026

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Running cost reduction target

1.13 One of the objectives of the ICB reforms announced in April 2025 was to reduce ICB running costs by around half in 2025-26 from a baseline of £2.1 billion.[20] To address inconsistencies in the level of running costs across ICBs, NHSE instructed each ICB to achieve a target running cost per head of population (weighted according to local population needs and costs) of £18.76, which needed to include all ICB administration costs and programme pay.

1.14 To calculate the target running cost, NHSE carried out a top-down analysis. It:

- applied a 50% reduction to the 2025-26 running cost allowance (excluding delegated pharmacy, ophthalmology and dentistry (POD) commissioning) which had been published in January 2025;
- applied a 50% reduction to the projected programme pay and CSU spend for 2025-26 (excluding programme pay for Continuing Healthcare and Primary Care);[21]
- applied a 25% reduction to the projected programme pay and CSU spend for 2025-26 on Continuing Healthcare and Primary Care;
- included but did not apply a reduction to the allowance for delegated POD commissioning for 2025-26 which had been published in January 2025; and
- divided the total of the above elements by the total number of registered patients in England of 64 million.

1.15 NHSE's analysis resulted in the running cost per head of population of £18.76 for each ICB (weighted according to levels of deprivation in the population and local costs), compared with a baseline national average of £32.98. NHSE asked ICBs to develop bottom-up operating plans that were affordable within this reduced running cost. Some ICBs needed to reduce their running costs by much more than others to achieve the running cost target (**Figure 5** on pages 22 and 23). For example, Surrey Heartlands ICB needed to reduce its running costs by 63%, while North East and North Cumbria ICB faced a 27% reduction.

1.16 NHSE noted that some variation in costs between ICBs would be warranted where some ICBs host services for other ICBs. However, NHSE expected the target cost per head of population to be delivered at the regional level. By 2026-27, the target cost per head of population had risen to £19.60 to reflect pay settlements in the intervening period.

20 Baseline running costs for 2025-26 are NHSE's estimate of what running costs would have been in 2025-26 prior to the April 2025 announcement to restructure ICBs.

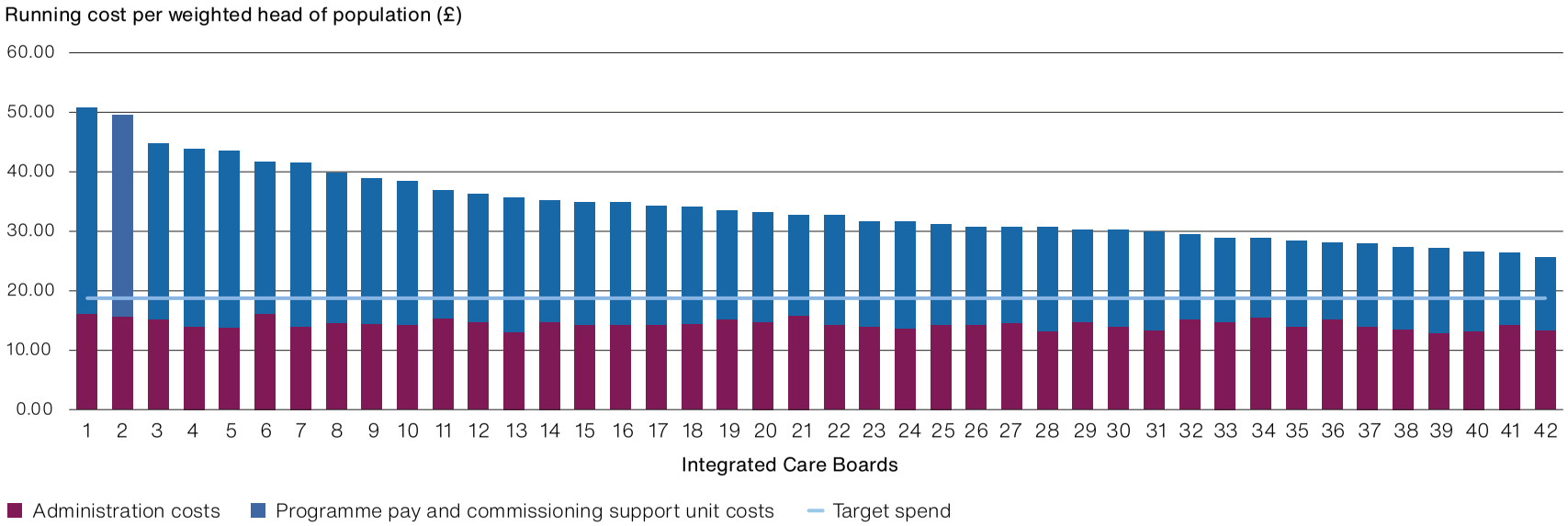
21 To estimate the projected programme pay and projected CSU spend for 2025-26, NHSE used data covering the period April 2024 to December 2024, extended to cover a 12-month period and inflated by 2.9%, in line with expected pay settlements for 2025-26.

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Figure 5

Estimated Integrated Care Board (ICB) baseline running cost per weighted head of population compared to target running cost in England, 2025-26

The running cost reductions ICBs were required to make to achieve a common target of £18.76 per head varied from 27% to 63%



1 = Surrey Heartlands; 2= Frimley; 3 = Gloucestershire; 4 = Norfolk and Waveney; 5 = Somerset; 6 = South West London; 7 = Shropshire, Telford and Wrekin; 8 = Sussex; 9 = North Central London; 10 = North East London ICB; 11 = Bath and North East Somerset, Swindon and Wiltshire; 12 = Hampshire and Isle Of Wight; 13 = Lancashire and South Cumbria ICB; 14 = Humber and North Yorkshire; 15 = Lincolnshire; 16 = Derby and Derbyshire; 17 = South Yorkshire; 18 = Suffolk and North East Essex; 19 = Cambridgeshire and Peterborough; 20 = Herefordshire and Worcestershire; 21 = Hertfordshire and West Essex; 22 = Dorset; 23 = Nottingham and Nottinghamshire; 24 = North West London; 25 = West Yorkshire; 26 = Staffordshire and Stoke-on-Trent; 27 = Kent and Medway; 28 = Greater Manchester; 29 = Bedfordshire, Luton and Milton Keynes; 30 = Bristol, North Somerset and South Gloucestershire; 31 = Cornwall and the Isles Of Scilly; 32 = Mid and South Essex; 33 = South East London; 34 = Buckinghamshire, Oxfordshire and Berkshire West; 35 Coventry and Warwickshire; 36 = Leicester, Leicestershire and Rutland ICB; 37 = Devon; 38 = Black Country; 39 = Cheshire and Merseyside; 40 = Birmingham and Solihull; 41 = Northamptonshire; 42 = North East and North Cumbria

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Figure 5 *continued*
Estimated Integrated Care Board (ICB) baseline running cost per weighted head of population compared with target running cost in England, 2025-26

Notes

1 The baseline running costs in 2025-26 (administration costs, programme staff costs and commissioning support unit costs) are NHS England's estimates of what it expected ICB running costs to have been in 2025-26 prior to the April 2025 announcement to restructure ICBs.

2 The population in each ICB is the 'core services weighted population'. This is a population that is weighted by needs, demographics, inequality and unavoidable costs (due to, for example, remoteness). Populations with higher levels of need or cost will have a higher weighting.

3 Total running costs in each ICB consist of three elements: administration costs; programme costs; and Commissioning Support Unit (CSU) costs.

4 Administration costs are the corporate costs of running an ICB.

5 Programme costs are expenditure on staff directly employed by the ICB to support the delivery of services.

6 CSUs provided some, but not all, ICBs with support in their role as commissioners, for example, support in business intelligence, clinical procurement, or informatics services. CSU costs refer to programme spend directed via CSUs.

7 ICB baseline administration costs are the total of running cost allowance published in January 2025 before the approximate halving in running costs was announced in April 2025 and separate allocated funding for delegated commissioning of pharmacy, ophthalmology and dentistry services.

8 ICB baseline programme pay and CSU spend is based on outturn data from between April 2024 and December 2024 projected over a 12-month period and inflated by 2.9% in line with the expected pay award for 2025-26.

9 The target running cost (including both administration costs and programme costs) per weighted head of population in 2025-26 was £18.76. The lowest running cost per head was £25.60 requiring a £6.84 (27%) reduction to meet the target. The highest running cost was £50.77 per head requiring a £32.01 (63%) reduction to meet the target.

Source: National Audit Office analysis of NHS England data

Securing savings

1.17 DHSC is aiming to secure savings of around £1 billion a year from the reforms. A running cost of £18.76 per head of population for each ICB equates to total ICB annual running cost expenditure of £1.2 billion, a total estimated reduction of £908 million (43%) on the baseline running costs for 2025-26. In December 2025, DHSC told the Public Accounts Committee that it expected to abolish 18,000 posts across DHSC, NHSE and ICBs, saving over £1 billion per year by the end of the Parliament, with savings directed to front-line care. DHSC had brought forward around £400 million funding from later years to help meet ICBs' redundancy costs in 2025-26. DHSC informed the Committee that savings made from staff reductions would more than cover the cost of the redundancies, although it did not confirm the point at which the savings would exceed the costs.

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Objectives of the reforms

1.18 As set out above, DHSC had two main aims for its reforms. In Parts Two and Three, we will evaluate progress with each of these objectives.

- Part Two will examine progress in ensuring that reformed ICBs are ready to deliver intended outcomes. It will examine how ICBs' new role as strategic commissioners has been defined and how DHSC will assess whether the ICBs are improving public health and reducing health inequalities across the populations they cover.
- Part Three will examine how DHSC and NHSE are managing risks as ICBs develop and transition to a new operating model, and how they are ensuring that this new model delivers savings and value for money.

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Part Two

Progress in preparing reformed Integrated Care Boards to be strategic commissioners of local health services

2.1 This part of the report examines proposed changes to Integrated Care Boards' (ICBs') role, functions and coverage, and how the Department of Health & Social Care (DHSC) and NHS England (NHSE) plan to ensure reformed ICBs can operate effectively as commissioners of NHS services and help improve health outcomes across their populations.

ICBs' new role as strategic commissioners

2.2 As part of the ICB reforms (see Part One), DHSC has instructed ICBs to refocus as strategic commissioners. From December 2024 to April 2025, NHSE defined strategic commissioning and the role ICBs will play, including exploring scope to transfer elements of ICBs' functions to other parties. NHSE defines strategic commissioning as an ongoing evidence-led process to plan, purchase, monitor and evaluate healthcare services over the long term, with the aim of improving population health and reducing health inequalities.

2.3 NHSE has provided information on how it expects ICBs to perform as strategic commissioners. In November 2025, it published a Strategic Commissioning Framework, which set out its expectations for ICBs to:

- improve population health, reduce health inequalities and improve equitable access to high-quality healthcare;
- be accountable for delivering value for money from their NHS budget; and
- work in partnership with government, local government, providers and other stakeholders to address the wider determinants of health, such as employment, to support wider socioeconomic development.

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2.4 NHSE provides ICBs with additional support in their role as strategic commissioners. This includes the following.

- The strategic commissioning development programme, which launched in June 2026. This programme aims to provide practical support to help ICBs build capability and a consistent approach to strategic commissioning.
- Offices for pan-ICB commissioning (OPICs). The seven OPICs, hosted by one ICB in each NHS region, will support commissioning at scale from April 2027. NHSE plans for all ICBs across a region to have equal access to expert commissioning knowledge and will facilitate regional collaboration.

Specific changes to ICB roles and responsibilities

2.5 ICBs are due to take on new commissioning responsibilities from April 2027, pending legislative changes. These include vaccinations as well as child health information, screening, health and justice, sexual assault and abuse, primary care and specified specialised services. NHSE currently holds statutory responsibility for these services but had already delegated responsibility to ICBs for primary care services and specified specialised services. The Health Bill proposes that statutory responsibility for all these functions will pass to ICBs.

2.6 NHSE recognises that, if ICBs are to focus on their role as strategic commissioners, they will have to stop, delegate to trusts or do less of some of their current functions, particularly those duplicated within the healthcare system. Functions that are not core to strategic commissioning include managing the performance of providers, and assurance and regulatory functions such as safeguarding and infection control. ICBs cannot choose to stop fulfilling their statutory duties but they may delegate responsibility for doing so to another statutory body along with an agreed level of funding to perform the function.

2.7 In May 2025, NHSE published a draft 'ICB model blueprint' to set out a "shared vision" for ICBs in the future. It outlined:

- **ICBs' purpose and role** to improve their population's health and ensure access to consistently high-quality services.
- **ICBs' core functions** to understand local context, develop a long-term population health strategy, allocate resources in contracting and procuring services, and evaluate the impact of commissioned services; and
- **the functional changes** to ICB responsibilities; NHSE proposed exploring the scope to transfer some functions, not central to the strategic commissioning role, from ICBs to providers, NHSE regional teams and DHSC; NHSE recognised that some of these changes would require legislation to implement.

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2.8 NHSE's assessment of its readiness or the readiness of trusts to receive specific ICB functions evolved between May 2025 and January 2026. In September 2025, NHSE provided further guidance to ICBs through a series of good practice guides on some of the statutory functions that it had previously suggested may transfer to other statutory bodies. These guides set out initial recommendations for ICBs to consider as they designed new operating models as well as to improve their effectiveness in the short term.

2.9 ICBs are now expected to retain more responsibilities than proposed in May 2025. NHSE published the most recent update on ICB functions in January 2026 (**Figure 6** overleaf). Four functions will transfer in full to DHSC, NHSE, regional teams or providers. These functions are: oversight of provider performance; local workforce development and training; estates and infrastructure; and data collection, management and processing. A further four functions will be retained in part by ICBs with some elements transferring to other parties. A further nine functions that were in scope for transferring out of ICBs in May 2025 will be retained by ICBs through 2026-27 and possibly beyond (**Figure 7** on page 29). For some of these functions, there is potential for efficiencies or for transferring elements of the functions to other parties, in line with September 2025 NHSE guidance.

2.10 ICBs have raised concerns about the timeliness of information provided by NHSE about changes to their role. ICBs have also identified risks to how they will operate and deliver services in future. We cover how ICBs are managing these risks in Part Three.

Changes to the size, coverage and geographical boundaries of ICBs

2.11 As part of the cost reduction and organisational restructuring plans, NHSE suggested that ICBs consider clustering arrangements and explore mergers. Before these changes, ICB weighted population sizes varied significantly. The average was 1.5 million, but they ranged from 0.6 million in Shropshire, Telford and Wrekin ICB to 3.6 million in North East and North Cumbria ICB. NHSE told us that it had concluded that a population of at least 1.5 million was needed to deliver economies of scale and maintain the specialist skills required to operate effectively.

2.12 ICBs had the option of clustering or merging to cover larger populations.

- **Clustering ICBs** may realise economies of scale by reducing duplication through joint senior appointments, combined teams and shared committees. ICBs that form a cluster remain separate legal entities and must each continue to fulfil their statutory functions and manage their own financial position. It is expected that clustering ICBs will subsequently merge to provide greater stability and to remove any remaining duplication in activities.
- An **ICB merger** involves NHSE closing down the existing ICBs and establishing a new successor ICB. Staff, assets and liabilities transfer to the new organisation through an NHSE transfer scheme, and a new ICB board is appointed.

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Figure 6

Proposed changes to Integrated Care Board (ICB) functions and responsibilities, January 2026

ICBs will retain many of their functions and responsibilities, with some transferring to the Department of Health & Social Care (DHSC), NHS England (NHSE), or NHSE regional teams or providers

ICB functions **Retained**	• Emergency preparedness, resilience and response • General Practice IT • Green plan and sustainability • Primary care operations and transformation (with the option to onward delegate)
ICB functions **Retained** (with a focus on sharing best practice)	• Medicines optimisation • NHS Continuing Healthcare • Infection prevention and control • Safeguarding • Special educational needs and disabilities (SEND), pending national review
ICB functions **Transferred** to the **Centre**	• Data collection, management and processing
ICB functions **Transferred** to **Regional teams**	• Oversight of provider performance • High level strategic workforce planning, development, education and training (with some exceptions to be retained by ICBs) • Research development and innovation (majority of elements to be transferred)
ICB functions **Transferred** to **Providers**	• Local workforce development and training including recruitment and retention (from April 2026 onwards) • Pathway and service development (to be increasingly undertaken by providers) • Digital technology leadership and transformation (ICBs to provide strategic oversight and providers to take forward local delivery)
ICB functions **Transferred** to a mix of **Centre**, **Regional teams**, and **Providers**	• Estates and infrastructure
ICB functions whose future status is **Not yet confirmed**	• Development of neighbourhood and place-based partnerships

Notes

1 ICB functions included in this table are those that NHSE scoped for transfer in the ICB model blueprint, May 2025. Following review, NHSE clarified that functions identified in the ICB model blueprint as "review for transfer" should either be transferred "moving into 2026-27" or retained "through 2026-27 and possibly beyond".

2 Transfer of ICB functions is not clearcut in all cases. Some elements within a function are to be retained by ICBs and other elements are to be transferred to other parties.

3 'Centre' refers to NHSE and DHSC, which are planned to merge by March 2027.

Source: National Audit Office review of NHS England documents

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Figure 7

Changes in NHS England's (NHSE's) guidance on Integrated Care Board (ICB) functions, May 2025 to January 2026

NHSE's plans for retaining or transferring some functions evolved between May 2025 and January 2026

ICB function	ICB model blueprint (May 2025)	NHSE good practice guidance (September 2025)	NHSE update on ICB 'review for transfer' functions (January 2026)[1]
Continuing Healthcare	Explore transfer	Recommended functions retained within ICBs (with efficiencies)	Retain with focus in line with good practice guidance
Infection prevention and control	Explore transfer	Recommended elements to retain (with efficiencies) and elements that could be transferred to other parties following detailed local discussions	Retain with focus in line with good practice guidance
Safeguarding	Explore transfer	Recommended elements to retain (with efficiencies), elements to transfer to trusts, and elements where further work is needed	Retain with focus in line with good practice guidance
Special educational needs and disabilities (SEND)	Explore transfer	ICBs should continue to hold strategic commissioning responsibilities for SEND at the current time	Retain pending national review
Medicines optimisation (MO)	Transfer to providers	Recommended core strategic MO functions and options for transferring out some elements in the short and medium term to reduce running costs	Retain with focus in line with good practice guidance
Emergency preparedness, resilience and response	Transfer to NHSE regional teams	No additional guidance published	Retain
General Practice IT	Explore transfer	No additional guidance published	Retain
Green plan and sustainability	Transfer to NHS providers	No additional guidance published	Retain
Primary care operations and transformations	Transfer to NHS providers	No additional guidance published	Retain

Notes

1 Following review, NHSE clarified that functions identified in the ICB model blueprint as "review for transfer" should either be transferred "moving into 2026-27" or retained "through 2026-27 and possibly beyond". For simplicity, the latter category is presented here as 'retain'. The exception is Emergency preparedness, resilience and response, as NHSE considers it highly unlikely that a case would be made for ICBs to delegate this function.

2 ICB functions included in this table are those where, between May 2025 and January 2026, NHSE-led reviews of the readiness to transfer the functions concluded they should not be transferred by ICBs before April 2027 at the earliest. NHSE confirmed that a further four functions will be retained in part by ICBs, with some elements transferring to other parties. These included: research, development and innovation; high level strategic workforce planning, development, education and training; pathway and service development programmes; and digital technology leadership and transformation.

Source: National Audit Office review of NHS England documents

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2.13 Nineteen out of a total of 25 ICBs or ICB clusters responded to our questionnaire. Respondents that had clustered or merged identified several benefits from clustering or merging. These included opportunities to reduce costs and duplication through changes to board, executive and management arrangements; support for sharing good practice; and the ability to work at greater scale, creating opportunities to streamline contracts and better understand and address variation.

Progress to date in clustering and merging

2.14 NHSE established a 'light touch' national programme and issued guidance to support ICBs in making decisions on clustering and merging. This guidance advises ICBs to consider emerging strategic local authority boundaries, including mayoral and combined authority arrangements, as well as unitary and metropolitan borough footprints. NHSE regional teams also worked with ICBs to support decision making. Seven out of 13 merged or clustered ICBs that responded to our questionnaire reported that they had received somewhat or very sufficient support from NHSE and DHSC on clustering and merging.

2.15 Prior to the restructuring, there were 42 ICBs. By April 2026, multiple ICBs had merged with or clustered alongside other ICBs, resulting in 25 ICBs or clusters of ICBs (**Figure 8** on pages 32 and 33).

- The first mergers and boundary changes took effect on 1 April 2026. **Seven new ICBs** were created. Twelve original ICBs merged to form six new organisations. In addition, Hampshire and Isle of Wight ICB absorbed parts of Frimley ICB following a boundary change accompanied by a substantial increase in size and operational expansion.
- Twenty original ICBs formed **nine new clusters**. These were initially expected to merge formally by April 2027. However, due to ongoing strategic authority reforms, further mergers will be delayed until at least 2028 (see below).
- **Nine** of the original 42 ICBs remain **unchanged**.

Aligning with local government boundaries

2.16 In July 2026, the government set out its ambition for every area in England to have a strategic authority in place by the end of 2028. Strategic authorities are devolved local government bodies that bring together powers, responsibilities and funding at a regional level to drive economic growth and improve public services in their area. As at 27 October 2026 there were 20 operational strategic authorities in England. There are two types.

- **Foundation strategic authorities,** including all non-mayoral combined authorities and combined county authorities, along with any local authority designated as a strategic authority without a mayor.

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- **Mayoral strategic authorities** (MSAs), including mayoral combined authorities and mayoral combined county authorities. Those that meet eligibility criteria may be designated as 'established' MSAs. Established MSAs have further devolved powers and receive central government funding through a single 'integrated settlement'.

2.17 The 10 Year Health Plan outlined aims for ICB boundaries to align with strategic authorities wherever feasible.[22] The government plans to align these boundaries by the end of the current Parliament (expected by 2029). Where there are strong reasons for larger ICBs, they may align to boundaries of multiple strategic authorities. NHSE advised ICBs to take account of local government boundaries, including emerging strategic authority boundaries, when considering opportunities to cluster or merge. Most ICBs currently align with the boundaries of upper-tier authorities, which enables and supports effective co-commissioning between NHS and local authorities. There are some areas of the country which are not fully aligned, such as Cumbria, North Yorkshire, and Thames Valley.

2.18 Achieving alignment between ICBs and strategic authorities is more challenging. Some areas of the country do not yet have a strategic authority, while there are other areas where strategic authority and ICB boundaries are not yet aligned. As at 27 October 2026, only six out of the 25 ICB areas were aligned (**Figure 9** on page 34). Areas of the country where there was not full alignment included the West Midlands and Dorset.

2.19 Aligning ICBs with strategic authorities offers opportunities to better integrate health and social care services and coordinate action to prevent ill-health because decision-makers are focused on the same populations. NHSE originally expected clustered ICBs to merge from April 2027 to support further efficiencies and a stronger focus on strategic commissioning. However, some clusters span current or expected strategic authority boundaries, and uncertainty over future strategic authority boundaries has complicated ICBs' decisions on configuration and the timing of mergers. In October 2026, NHSE confirmed that further ICB mergers initially expected in 2027 will be delayed to at least 2028 to allow time for the national picture to become clearer.

ICB relationships with local government bodies

2.20 Changes to ICB structures, local government reforms and potential changes arising from the 2026 Health Bill may affect existing strategic and working relationships between ICBs and local authorities. If the Health Bill receives Royal Assent, ICB boards must include representatives from any MSAs. The Health Bill impact assessment expects MSA representation to help ICBs influence wider determinants of health, including housing, transport and economic development.

22 UK Government, *Fit for the Future: The 10 Year Health Plan for England,* CP1350, July 2025.

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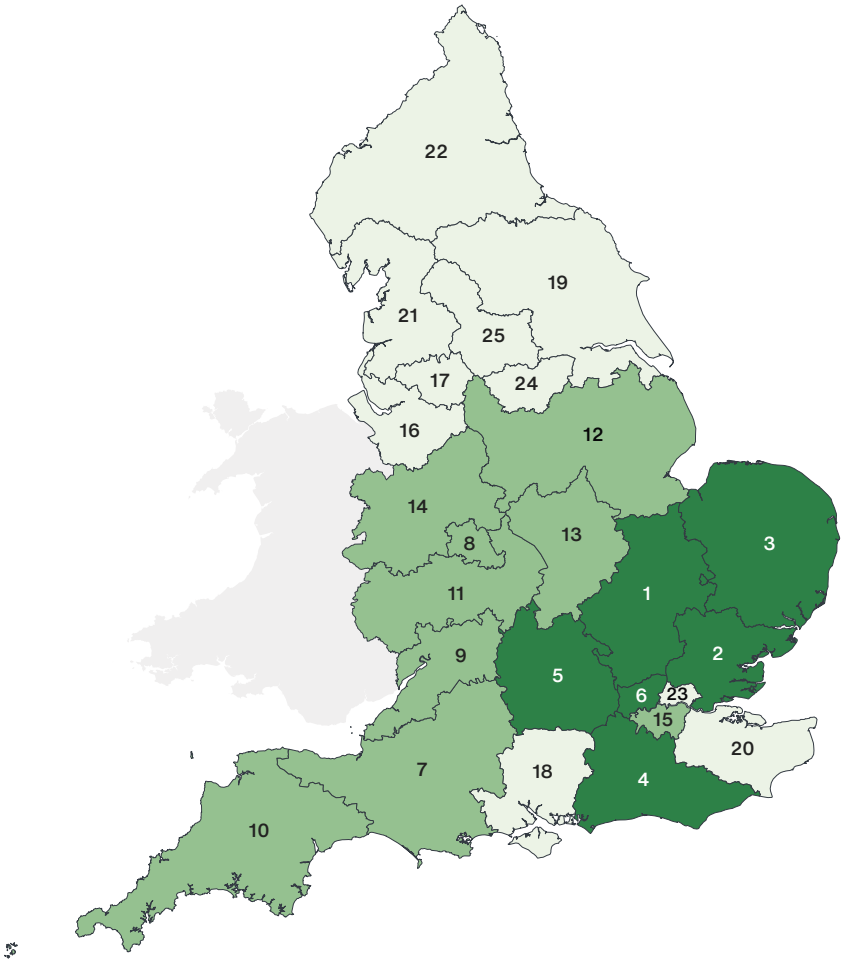
Figure 8

Integrated Care Board (ICB) and strategic authority (SA) boundaries in England, as at 27 October 2026

As at 27 October 2026, the majority of ICBs or cluster boundaries did not align with current SA boundaries, many of which were not yet final

ICB and cluster boundaries as at 27 October 2026

- Merged
- Clustered
- Neither merged nor clustered



Merged

1 NHS Central East ICB
2 NHS Essex ICB
3 NHS Norfolk and Suffolk ICB
4 NHS Surrey and Sussex ICB
5 NHS Thames Valley ICB
6 NHS West and North London ICB

Clustered

7 NHS Bath and North East Somerset, Swindon and Wiltshire ICB with NHS Dorset ICB and with NHS Somerset ICB Cluster
8 NHS Birmingham and Solihull ICB with NHS Black Country ICB Cluster
9 NHS Bristol, North Somerset and South Gloucestershire ICB with NHS Gloucestershire ICB Cluster
10 NHS Cornwall and the Isles of Scilly ICB with NHS Devon ICB Cluster
11 NHS Coventry and Warwickshire ICB with NHS Herefordshire and Worcestershire ICB Cluster
12 NHS Derby and Derbyshire ICB with NHS Lincolnshire ICB and with NHS Nottingham and Nottinghamshire ICB Cluster
13 NHS Leicester, Leicestershire and Rutland ICB with NHS Northamptonshire ICB Cluster
14 NHS Shropshire, Telford and Wrekin ICB with NHS Staffordshire and Stoke-on-Trent ICB Cluster
15 NHS South East London ICB with NHS South West London ICB Cluster

Neither merged nor clustered

16 NHS Cheshire and Merseyside ICB
17 NHS Greater Manchester ICB
18 NHS Hampshire and Isle of Wight ICB (boundary change)
19 NHS Humber and North Yorkshire ICB
20 NHS Kent and Medway ICB
21 NHS Lancashire and South Cumbria ICB
22 NHS North East and North Cumbria ICB
23 NHS North East London ICB
24 NHS South Yorkshire ICB
25 NHS West Yorkshire ICB

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Figure 8 *continued*

Integrated Care Board (ICB) and strategic authority (SA) boundaries in England, as at 27 October 2026

Strategic authority boundaries as at 27 October 2026

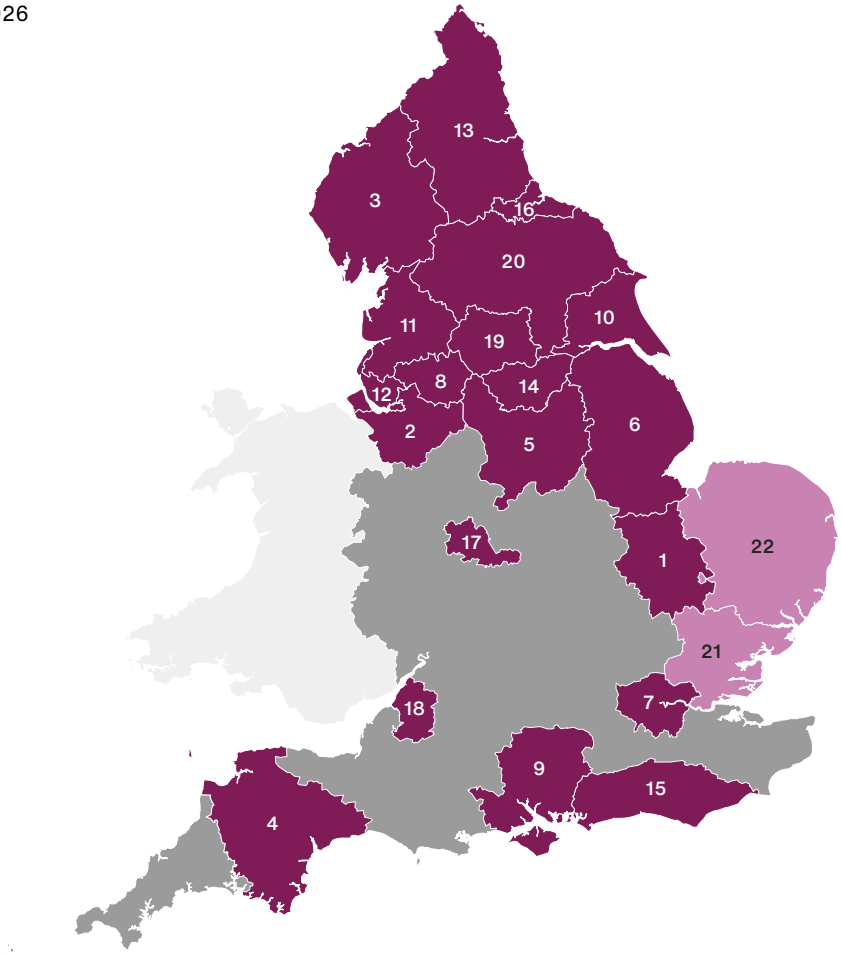
- Existing
- Planned
- Not yet established

Existing strategic authorities

1 Cambridgeshire and Peterborough
2 Cheshire and Warrington
3 Cumbria
4 Devon and Torbay
5 East Midlands
6 Greater Lincolnshire
7 Greater London
8 Greater Manchester
9 Hampshire and the Solent
10 Hull and East Yorkshire
11 Lancashire
12 Liverpool City Region
13 North East
14 South Yorkshire
15 Sussex and Brighton
16 Tees Valley
17 West Midlands
18 West of England
19 West Yorkshire
20 York and North Yorkshire

Planned strategic authorities

21 Greater Essex
22 Norfolk and Suffolk



Notes

1 This figure reflects the position on ICB and strategic authority boundaries as at 27 October 2026. There may be further announcements on strategic authorities as the government's devolution plans evolve up to 2028.

2 A strategic authority is a regional governance body that sits above individual local councils and is designed to take responsibility for certain powers and funding devolved from central government. 'Existing' strategic authorities are those which are operational, including both foundation strategic authorities and mayoral strategic authorities. 'Planned' strategic authorities are areas announced by the government as part of the devolution priority programme where the strategic authority is confirmed but not yet operational. 'Not yet established' areas of the country are areas where strategic authority boundaries are not yet formally confirmed by the government (there is variation within this, some areas are agreed and going through the formal process, and other areas are yet to be confirmed).

3 An ICB cluster is a grouping of two or more ICBs that work together under shared leadership and combined teams, while remaining separate legal organisations.

4 An ICB merger is when separate ICBs are abolished and replaced by a single new ICB. Following the merger, there is only one legal organisation, one board and one set of statutory responsibilities for the merged area.

5 Hampshire and Isle of Wight ICB remained the same legal organisation but underwent a boundary change, having absorbed part of Frimley ICB. This change was accompanied by a substantial increase in size and operational expansion.

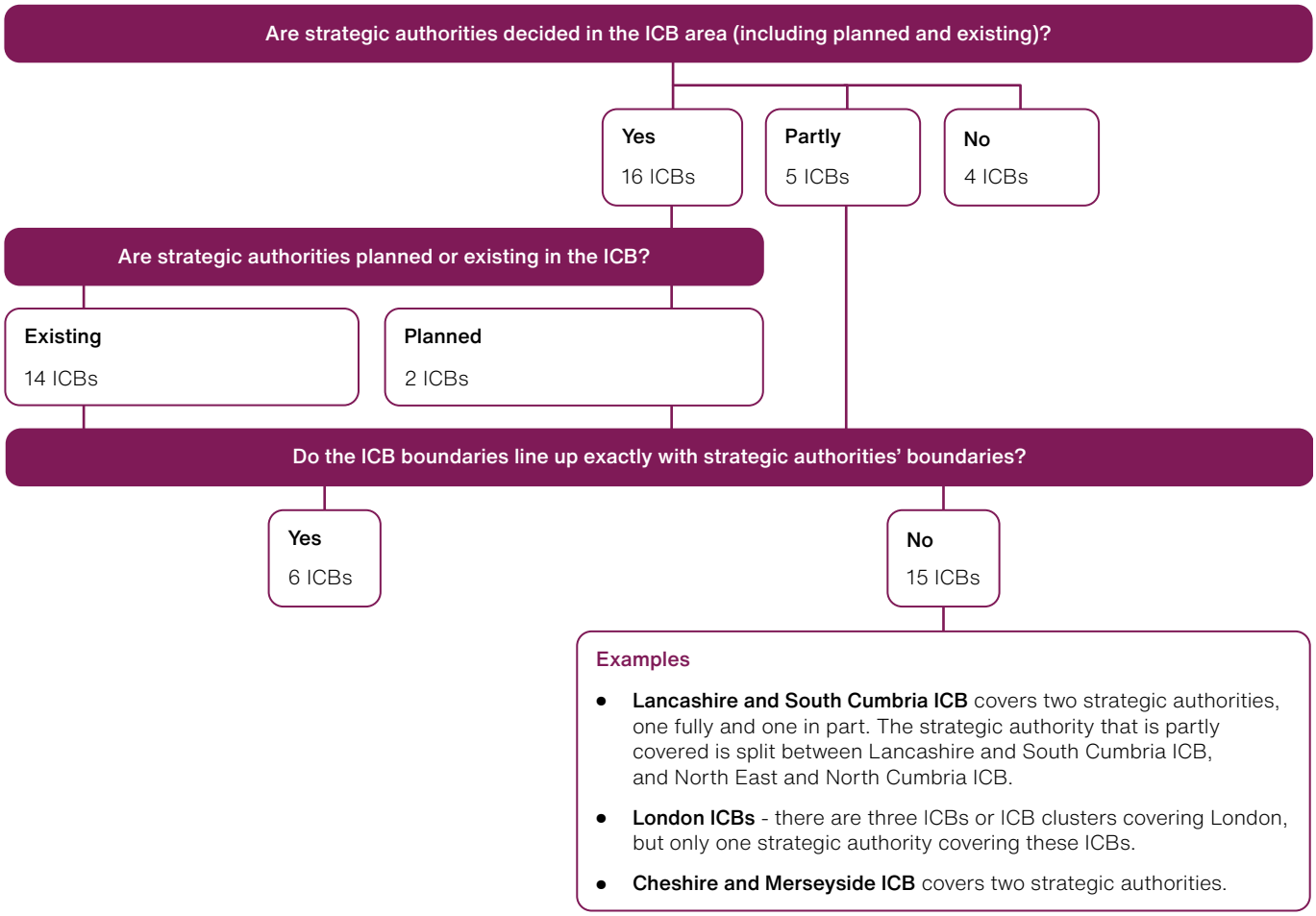
Source: National Audit Office analysis of NHS England, Ministry of Housing, Communities & Local Government and Office for National Statistics data. Office for National Statistics licensed under the Open Government Licence v.3.0. Contains OS data © Crown copyright and database right 2026

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Figure 9

Extent of alignment between Integrated Care Board (ICB) and strategic authority boundaries

As at 27 October 2026, six out of 25 ICB or ICB cluster boundaries aligned with an existing or planned strategic authority boundary



Notes

1 This figure reflects the position on ICB and strategic authority boundaries as at 27 October 2026. There may be further announcements on strategic authorities as the government's devolution plans evolve up to 2028.

2 A strategic authority is a regional governance body that sits above individual local councils and is designed to take responsibility for certain powers and funding devolved from central government. 'Existing' strategic authorities are those which are operational, including both foundation strategic authorities and mayoral strategic authorities. 'Planned' strategic authorities are areas announced by the government as part of the devolution priority programme where the strategic authority is confirmed but not yet operational.

3 The four ICBs which do not have a strategic authority established in the ICB area are in areas where strategic authority boundaries are not yet formally confirmed by the government (there is variation within this, some areas are agreed and going through the formal process, and other areas are yet to be confirmed).

4 The analysis covers 25 ICBs or ICB clusters in England, as at 27 October 2026. An ICB cluster comprises two or more ICBs operating under shared leadership and combined teams while remaining separate legal organisations.

5 'Partly' decided means that within an ICB there are some areas which are covered by an existing or planned strategic authority, and some which are not.

6 Of the 25 ICB or ICB cluster areas, 21 had an existing or planned strategic authority covering all or part of their area. The boundary-alignment assessment relates to these 21 areas.

7 The six ICBs whose boundaries align with strategic authorities' boundaries are: Essex, Greater Manchester, Hampshire and the Isle of Wight, Norfolk and Suffolk, South Yorkshire, and West Yorkshire.

Source: National Audit Office analysis of NHS England, Ministry of Housing, Communities & Local Government and Office for National Statistics data

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2.21 The strategic commissioning framework also emphasises the importance of ICBs working collaboratively with local partners to tailor services to community needs. In practical terms, merged ICBs will cover wider areas than local authorities. Many will cover at least three or four local authorities, and the West and North London ICB covers 13 local authorities. This will require ICBs to work closely with multiple health and wellbeing boards to align population health improvement plans and neighbourhood health plans.[23]

DHSC's plans for assessing whether the reformed ICBs are performing their new role effectively and delivering the intended outcomes

2.22 NHSE publishes an annual assessment of each ICB every financial year. The assessment considers how well the ICB has discharged its functions during the year.

2.23 NHSE published the updated NHS oversight framework for 2026-27 in June 2026. It describes this framework as "intentionally evolutionary", retaining the oversight approach from the 2025-26 framework but updating it to reflect changes, including the role of NHSE regional teams in overseeing performance. ICBs will be subject to the following.

- **Performance assessments:** NHSE will segment ICBs based on performance metrics covering population health and inequalities; allocating resources; effectiveness and experience of care; patient safety; finance, productivity and innovation; and people and culture. From 2026-27, NHSE will present the data in league tables to allow organisations and the public to understand how ICBs perform relative to their peers.
- **Capability assessments:** NHSE will provide a view on how well an ICB has met its statutory functions, performed its strategic commissioning role, worked with partners and commissioned services.

2.24 It is not yet clear how NHSE will assess whether the reforms are leading to improved strategic commissioning performance. The 2025 strategic commissioning framework sets out ICBs' roles as strategic commissioners. While the framework emphasises the value of comparing performance across ICBs, it does not include national strategic commissioning standards. In June 2026, NHSE published a commissioning capability self-assessment to help ICBs understand strengths, weaknesses and the development support they need. Over 2026-27, NHSE plans to develop ICB capability assessments for measuring how ICBs are performing in their strategic commissioner role and on neighbourhood health strategy. NHSE intends to implement the new model in 2027-28 to assess ICB performance in 2026-27. In the meantime, NHSE intends the 2025-26 annual assessment to provide a qualitative view of ICB leadership, governance and strategic commissioning readiness.

23 Health and wellbeing boards are statutory committees that bring together the NHS, local government and other local partners to set the strategic direction for local health and care services.

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2.25 ICBs are at different stages of implementation of their five-year commissioning plans for neighbourhood health priorities. Some ICBs have made early progress on how they will work with other parties to improve health outcomes in their local area (**Figure 10**).

Figure 10

Examples of Integrated Care Boards (ICBs) implementing new strategies to improve health outcomes in their areas, as at October 2026

Some ICBs have made early progress with developing strategic commissioning plans; NHS England (NHSE) has shared two examples of this

NHS Essex ICB

NHS Essex ICB was formed on 1 April 2026 by merging Mid and South Essex ICB with the Essex-based areas previously covered by Suffolk and North East Essex ICB and Hertfordshire and West Essex ICB.

NHS Essex ICB has developed a three-level model to define and differentiate roles across the system (Essex-wide, multi-neighbourhood, and single neighbourhood), helping to avoid duplication of work.

The ICB has also developed a strategic commissioning model and has set out plans for the development of integrated neighbourhood teams across Essex. Neighbourhood teams are already established, and the plans include an assessment of population inequalities within each neighbourhood, supported by a neighbourhood health prioritisation framework.

Kent and Medway ICB

As part of its strategic commissioning plan, Kent and Medway ICB plans to bring together a single £13.5 million neighbourhood investment fund, targeted at around 92,000 people with the highest needs. The model uses GP-led neighbourhood teams, a single contractual approach and an outcomes-based incentive. It aims to reduce A&E use and shift investment from hospital to community care.

Note

1 These examples are based on material provided to the National Audit Office by NHS England and are intended to illustrate approaches taken by selected ICBs. The examples are illustrative and do not necessarily reflect the experience of all ICBs.

Source: National Audit Office review of NHS England documents

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Part Three

Progress in transitioning to an affordable operating model and managing associated risks

3.1 This part of the report examines the Department of Health & Social Care's (DHSC's) and NHS England's (NHSE's) oversight of progress by Integrated Care Boards (ICBs) in transitioning to an affordable operating model, making savings through reducing ICB staff numbers and running costs, and managing risks such as retention of the skills and capabilities that are needed to ensure that the new model delivers value for money.

Identifying an affordable operating model

3.2 In April 2025, NHSE announced plans for ICBs to reduce their running costs by around half. After setting a target running cost per head of population, NHSE asked ICBs to create plans affordable within their reduced running costs that could be implemented by December 2025. In some cases, ICBs merged or clustered with other ICBs to help them meet the running cost target (see Part Two).

3.3 To help them determine their future operating model and staff requirements, NHSE instructed ICBs to do the following.

- **Identify functions where there was duplication:** These included assurance and regulatory functions that were already undertaken by providers or NHSE regional teams, and performance management of NHS providers.
- **Recognise the need to maintain and invest in some functions:** These included finance and contracting functions, strategic commissioning functions and neighbourhood health functions.

3.4 Respondents to our questionnaire for ICB chief financial officers identified a range of opportunities to reduce running costs. These opportunities included the following.

- **Refocusing ICB role:** Spending less time on performance oversight of providers which would instead be carried out by NHSE.
- **Corporate services:** Making savings through streamlining and combining finance, human resources, communications and governance teams within merged or clustered ICBs.

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- **Joint procurement:** Using joint procurement frameworks within merged or clustered ICBs to enable negotiations at scale and deliver savings from aligning supplier contracts.
- **Digital and automation:** Using automation, artificial intelligence and other tools for data analysis and administrative tasks.

3.5 We asked ICBs whether they would spend more, less or the same in specific areas (**Figure 11**). The main areas where respondents expected to spend less were corporate support functions, performance management and contract oversight, and statutory functions. ICBs also told us that they expected significant staffing reductions in corporate and administrative roles, including organisational development and performance management roles. They also reported reductions in programme, place-based roles and transformation managers, including clinical leads and teams. Some ICBs expected to spend less on digital transformation activities, developing neighbourhood health services, and prevention activities which are objectives of the 10 Year Health Plan. Other ICBs expect to spend more in these areas.[24]

Progress in moving to the new operating model and managing the transition risks

3.6 ICBs began developing their new operating models from April 2025. Responses to our questionnaire indicated that, by around June 2026, 13 out of 19 respondents had developed a new operating model for how their ICB would work in future (**Figure 12** on page 40). The remainder had partly developed their new operating models.

3.7 To move to a new operating model with lower running costs, NHSE expected ICBs to cut staff numbers by around a third from a March 2025 baseline of around 23,000 ICB staff (full time equivalent (FTE)). This required making staff redundant through voluntary and compulsory redundancy schemes. In November 2025, DHSC confirmed:

- HM Treasury had approved a voluntary redundancy scheme, which was designed to be quick to implement and to minimise the need for compulsory redundancies;
- the level of funding it would provide to each ICB to support with redundancy costs. In 2025-26, NHSE allocated £401.5 million to ICBs for redundancy payments. ICBs would need to cover the cost of any redundancy payments above their allocation; and
- that ICBs were expected to meet their new running cost targets from April 2026 and no further funding would be available to them for restructuring from 2027-28.

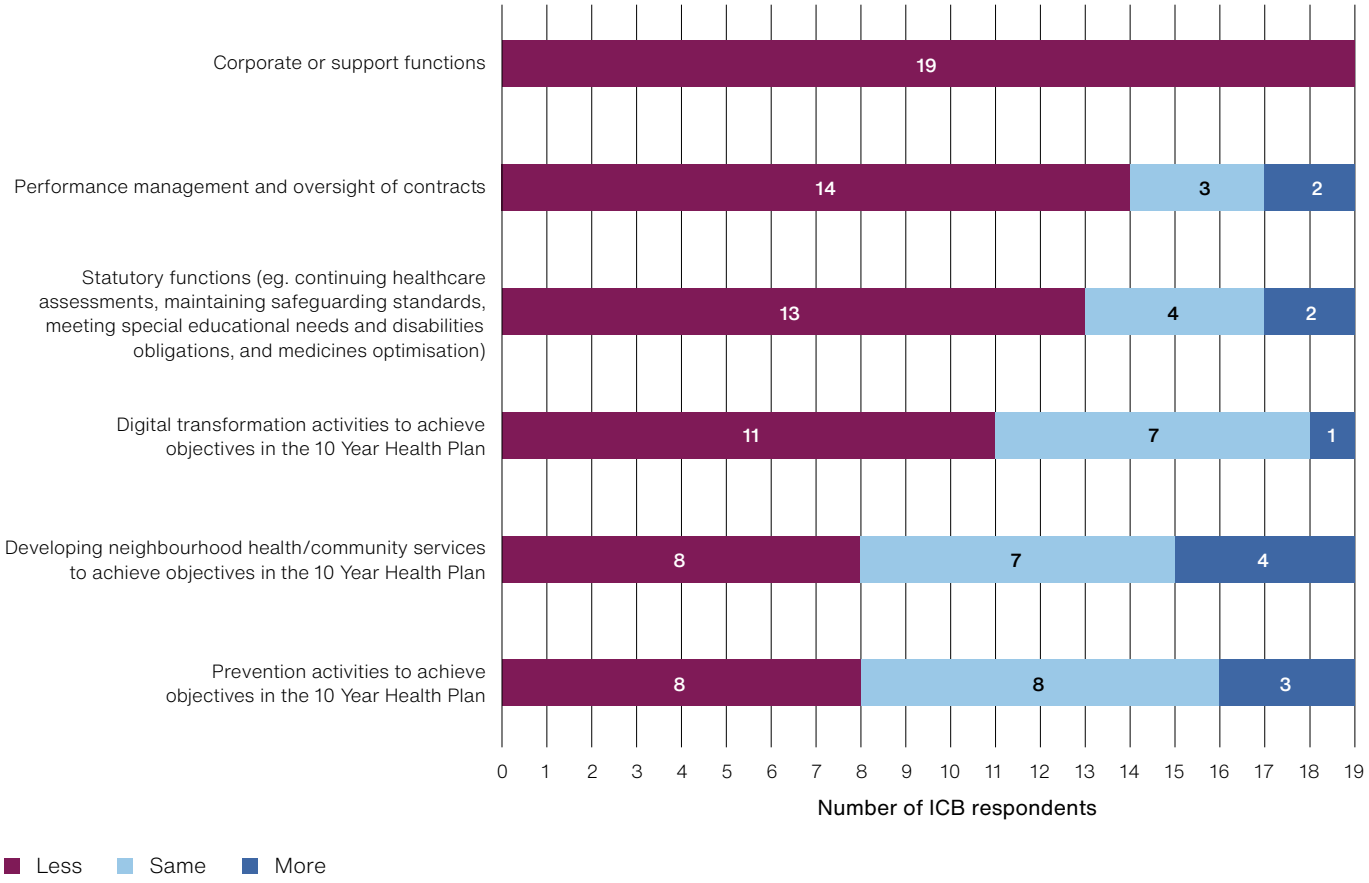
24 UK Government, *Fit for the Future: The 10 Year Health Plan for England*, CP1350, July 2025.

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Figure 11

Areas where Integrated Care Boards (ICBs) expected to spend more, less or about the same amount (per head of population) following reductions in running costs

Most respondents to our questionnaire expected to spend less on their support functions, performance management and oversight, statutory functions and digital transformation activities



Notes

1 The question asked of ICB chief financial officers was: "For the activities and services listed below, does your ICB plan to spend more, less, or about the same (per head of population) following the reduction in running costs?" The survey was open for a six-week period over May and June 2026.

2 An ICB cluster is a grouping of two or more ICBs that work together under shared leadership and combined teams, while remaining separate legal organisations.

3 Responses were received from 19 of 25 ICBs or ICB clusters. The views of respondents may not be representative of all ICBs or ICB clusters.

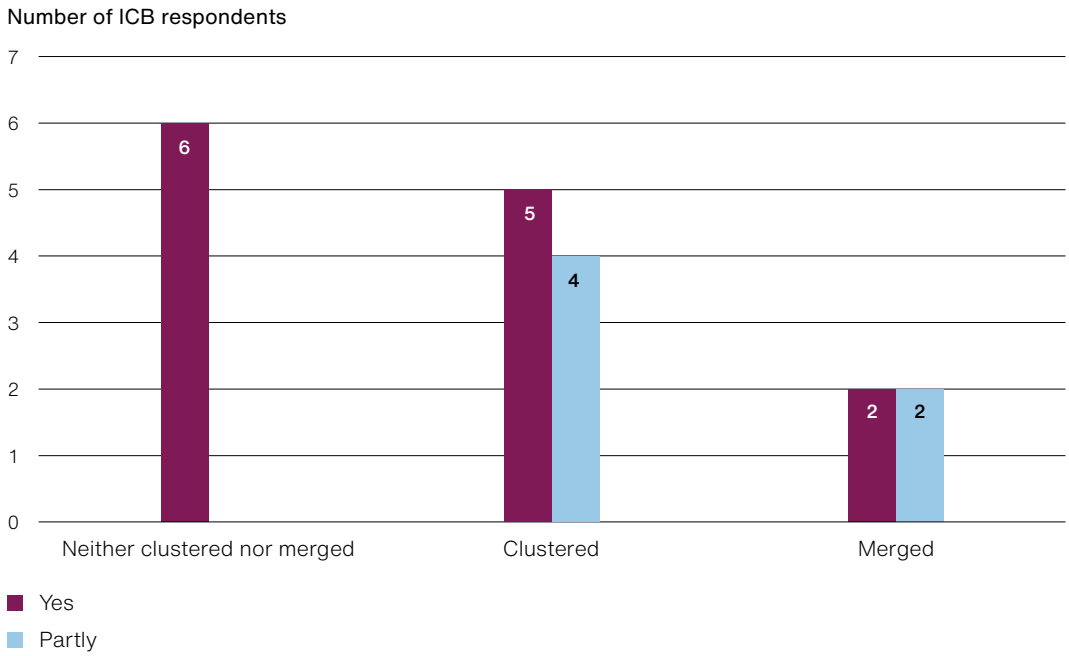
Source: National Audit Office survey of Integrated Care Board chief financial officers May to June 2026

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Figure 12

Integrated Care Board (ICB) progress in developing a new operating model as of June 2026

ICBs responding to our questionnaire that had not merged or clustered were more likely to report completing a new operating model than ICBs that had merged or clustered by April 2026



Notes

1 The question asked of ICB chief financial officers was: "Have you developed a new operating model for how your ICB will work in the future?". Three potential responses were provided: "Yes. We have finalised a new operating model for our ICB"; "Partly. We have made progress in developing a new operating model for our ICB"; and "No. We have not yet started developing a new operating model for our ICB." No ICBs responded that they had not yet started developing a new operating model. The survey was open for six weeks over May and June 2026.

2 An ICB is a statutory NHS organisation in England responsible for planning and coordinating health and care services across a specific geographical area, aiming to improve population health and reduce health inequalities. An ICB cluster is a grouping of two or more ICBs that work together under shared leadership and combined teams, while remaining separate legal organisations.

3 Responses were received from 19 of 25 ICBs or ICB clusters. This included six of 10 ICBs that neither merged nor clustered, all nine ICB clusters, and four of six merged ICBs. The views of respondents may not be representative of all ICBs or ICB clusters.

Source: National Audit Office survey of Integrated Care Board chief financial officers, May to June 2026

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3.8 NHSE estimated that achieving the target running cost reduction would require ICBs to reduce total staff numbers by 8,209 (FTE). In March 2026, ICBs reported that they expected to make a total of 5,856 voluntary redundancies, 71% of the total reduction required. Of 19 ICBs responding to our questionnaire, 15 also expected to reduce staff numbers through compulsory redundancies, and 13 through attrition (recruitment freezes or removal of vacant posts). NHSE's most recent data show that around 3,700 staff left ICBs between November 2025 and June 2026 through redundancy, mostly voluntary (**Figure 13** overleaf). NHSE does not collect data on ICBs' future projections of redundancies as ICBs are responsible for funding and delivering further staff reductions to remain within their budgets.

3.9 The redundancy programmes have taken longer than originally planned. Originally NHSE instructed ICBs to implement new operating models by December 2025. However, the voluntary redundancy scheme and funding were not confirmed until November 2025. By September 2026, eight ICBs or clusters confirmed to NHSE that they had given notice to all staff at risk of redundancy, seven said they still had work to do, and the remainder did not confirm. NHSE told us that problems accessing pensions statements and disputes over partial retirement had contributed to the delays.

3.10 Slower-than-planned progress on developing new operating models has had an impact on how quickly ICBs have reduced their running costs to the £1.2 billion target (**Figure 14** on page 43). In 2025-26, ICB running costs totalled £2.2 billion. NHSE's data indicate that ICBs are making progress in closing the gap. NHSE has extrapolated in-year expenditure data to project full year ICB running costs for 2026-27. As at July 2026, NHSE projected full-year running costs of £1.7 billion, around £500 million above the target running cost. It estimates that, by year end, total ICB running costs for 2026-27 will be around £1.4 billion, £200 million above the target. This estimate is based on NHSE's understanding of ICBs' ongoing progress in reducing costs.

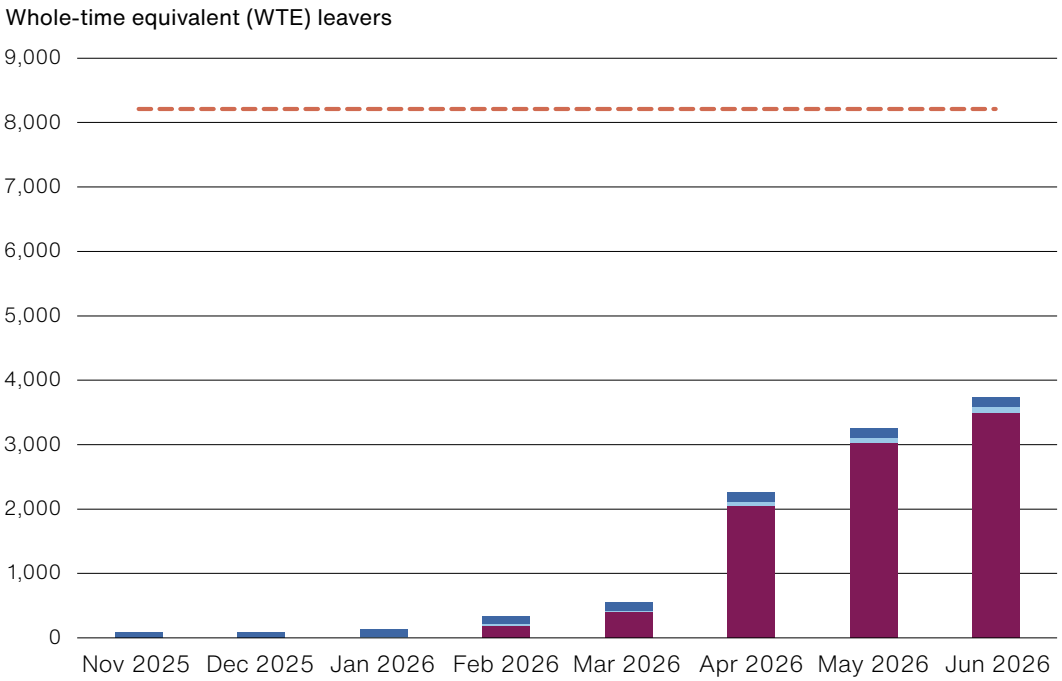
3.11 ICBs that could not reduce their running costs to the target by April 2026 did not receive any additional funding from NHSE. NHSE told us that ICBs were responsible for budgeting for their expected expenditure and must bear the consequences of any shortfall. Some ICBs typically hold some contingency that they may be able to draw on, or may be able to make further savings by sharing services with other ICBs. To remain within their budget, some ICBs may have had less funding available for investment in other areas, which could include commissioning services for patients.

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Figure 13

Cumulative numbers of staff leaving Integrated Care Boards (ICBs) through voluntary redundancy, compulsory redundancy and mutually agreed resignation, November 2025 to June 2026

Around 3,700 staff left ICBs through redundancy and mutually agreed resignation between November 2025 and June 2026; NHS England (NHSE) estimated that ICBs will need to reduce staff numbers by 8,209 to achieve the required reduction in running costs



	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Voluntary redundancy	0	0	5	193	405	2,055	3,032	3,492
Compulsory redundancy	6	8	17	22	26	63	81	103
Mutually agreed resignation scheme	80	89	115	119	124	143	146	146
Estimated required reduction	8,209	8,209	8,209	8,209	8,209	8,209	8,209	8,209

Notes

1 The ICB voluntary redundancy programme was announced in November 2025. June 2026 is the latest date for which NHSE held ICB leaver data.

2 A mutually agreed resignation scheme is a form of voluntary severance where employees leave by agreement with their employer in return for a severance payment. The scheme is intended to create vacancies that can be filled through redeployment and reduce the need for redundancies during organisational change.

3 Whole-time equivalent (WTE) is calculated in the NHS by dividing the number of required hours for the role by 37.5 hours. WTE is broadly equivalent to Full Time Equivalent (FTE) measures of staff numbers.

4 The staff reductions shown in this figure do not include reductions achieved through recruitment freezes or removal of vacant posts. ICBs responding to our questionnaire reported that they expected to also use these approaches. The estimated required WTE reduction of 8,209 could be achieved through all methods including recruitment freezes and the removal of vacant posts.

5 An ICB is a statutory NHS organisation in England responsible for planning and coordinating health and care services across a specific geographical area, aiming to improve population health and reduce health inequalities.

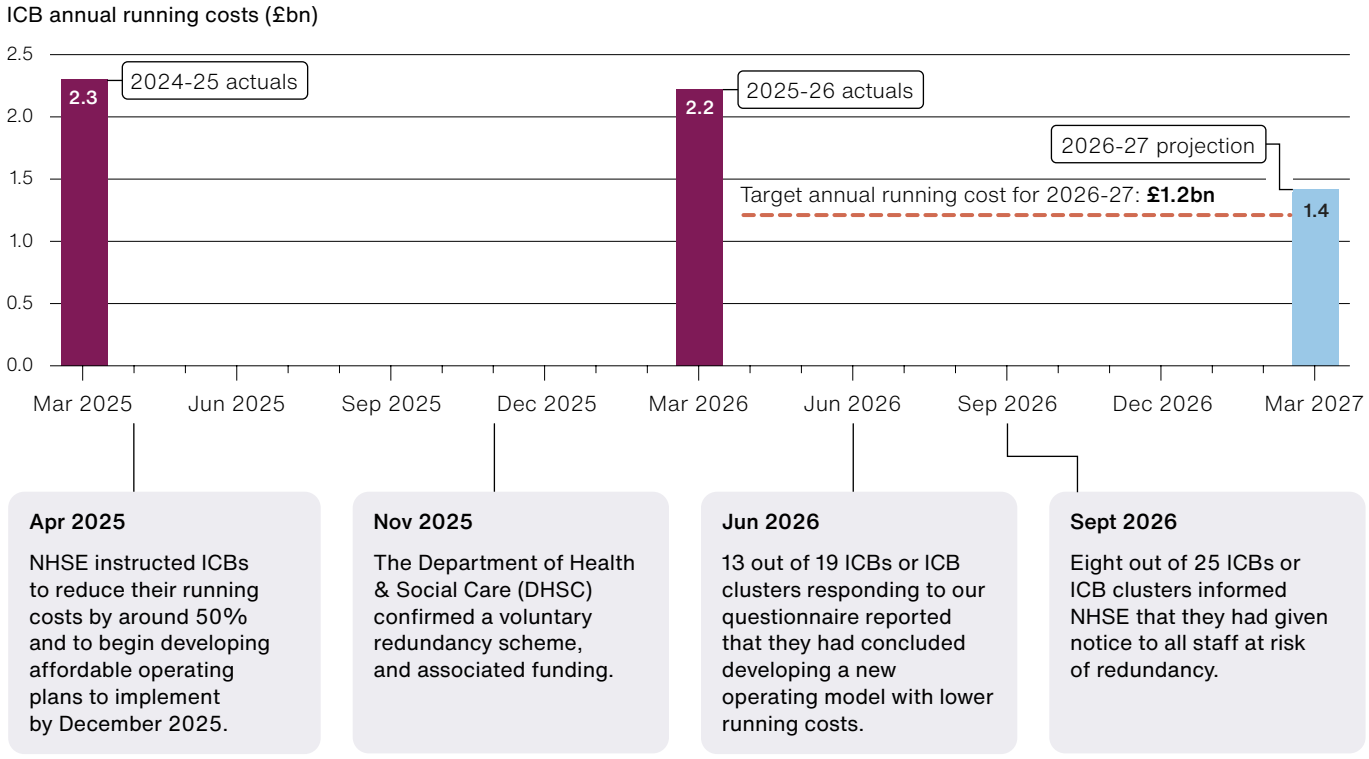
Source: National Audit Office analysis of NHS England data

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Figure 14

Actual and projected total Integrated Care Board (ICB) annual running costs compared with NHS England's (NHSE's) target, April 2025 to March 2027, in 2025-26 prices

ICBs have reduced their running costs more slowly than originally planned. NHSE expects ICB annual running costs to be £1.4 billion in 2026-27, £200 million above its £1.2 billion target



Notes

1 The 2026-27 running cost in this chart has been projected by NHSE. We have not audited this projection. NHSE based its projection for 2026-27 (£1.4 billion) on its understanding of restructuring progress across individual ICBs to make an estimate of their likely end of year running costs. The projection was made in September 2026.

2 NHSE has also extrapolated in-year expenditure data to project full-year ICB running costs for 2026-27. As at July 2026, NHSE projected full-year running costs of £1.7 billion, just under £500 million above the target running cost.

3 The £1.2 billion target running cost is NHSE's allocation for ICB running costs for 2026-27. ICBs that overspend against this target do not receive any additional funding from NHSE and must bear the consequences of any shortfall by, for example, reducing investment in other areas.

4 NHSE instructed ICBs to reduce their running costs by around 50% in April 2025. It subsequently set the target running cost at £1.2 billion, 43% of the baseline running cost. The target will be adjusted over time to reflect inflation.

5 Running costs have been adjusted for inflation and presented at 2025-26 prices using GDP deflators at market prices published by HM Treasury in June 2026.

Source: National Audit Office presentation of NHS England data and analysis

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3.12 Changing an organisation's operating model can present significant challenges.[25] In the short term, organisations must ensure they can carry out core activities effectively with fewer staff, re-assess existing processes, and manage the impact of the redundancy programme on morale and productivity. Our questionnaire asked ICBs to identify the top three transitional challenges they had to manage. Their responses included the following.

- **Impact on staff morale:** Of the 12 out of 13 clustering or merging ICBs that responded to our questionnaire, all 12 reported that maintaining morale and culture had been in their top three challenges. Research by NHS Alliance and the Health Foundation during 2026 also indicated low morale within ICBs. ICBs told us they were managing these challenges through staff engagement and consultation, and by providing support for teams and trying to be as open with staff as possible.
- **Organisational changes:** 10 out of 12 clustering or merging ICBs reported challenges restructuring teams, while nine out of 12 experienced challenges merging data and systems. Mitigations included establishing governance and transition management arrangements, and organisational design processes, and working with partner ICBs, local authorities and providers to develop shared delivery arrangements.
- **Maintaining corporate memory and leadership capacity:** ICBs are using various strategies to manage the risk of loss of expertise, including workforce planning, handovers and knowledge retention, and matrix working.

3.13 Some ICBs reported that they had managed risks and challenges through collaborating and sharing learning with other ICBs. For example, one ICB responding to our questionnaire had conducted a benchmarking exercise by function, to explore differences in delivery models. NHS Alliance interviewed leaders from the first six merged ICBs and reported what they learned from their experience to inform future mergers.[26] They identified enablers that support a successful transition covering leadership and support, communication and engagement with staff, and managing complexity to deliver the technical elements of the transition. For example, ICB leaders emphasised the importance of learning and sharing best practice from each legacy organisation involved in a merger.

25 National Audit Office, *Good practice guide: Government exits and redundancies,* September 2025.
26 NHS Alliance, *ICB mergers: lessons for future success*, July 2026.

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3.14 Our questionnaire asked ICBs about the support they received from DHSC and NHSE to help manage transition risks. ICBs described the support as "somewhat or very sufficient" in areas including: managing exits and redundancies (13 out of 19 respondents); clustering and merging (seven out of 13);[27] and calculating the required running costs (nine out of 18).[28] There were other areas where ICBs considered they had received "somewhat insufficient" or no support, including information on their future role (15 out of 19) and on the rationale and objectives of the restructuring (10 out of 19).

How DHSC and NHSE are managing longer-term risks to outcomes and value for money

3.15 Government departments should manage risks to longer-term outcomes and value for money when designing and implementing redundancy schemes. Challenges include retaining people with critical skills so that the organisation can maintain performance and achieve desired outcomes, and minimising the cost of redundancies to reduce the payback period in which savings are secured.

Risks to performance and health outcomes

3.16 Clarity about an organisation's new role, and the capabilities it needs, should drive decision-making on workforce requirements and redundancies. In this case, ICBs will need specific expertise to achieve the intended outcomes set out in Part Two, such as strategic commissioning and analytical skills to assess local population health needs.

3.17 As explained in Part Two, NHSE has sought to reform ICBs at pace, but other elements of NHS reforms have progressed more slowly. In particular, due to the complexity of merging NHSE into DHSC, ICB restructuring has proceeded ahead of the restructuring of NHSE regional teams, pending NHSE's own planned merger with DHSC. The respective roles of ICBs and NHSE and how they will work together in future have been refined iteratively. Responses to our questionnaire suggest that some ICBs found developing new operating models within this process challenging.

- Fifteen out of 19 respondents said that the information NHSE had provided on their future role was somewhat insufficient. As set out in Part Two, NHSE provided guidance in the draft ICB model blueprint, good practice guides and further updates, supplemented by the strategic commissioning framework and development programme. NHSE told us that, while some ICBs asked for more guidance, other ICBs asked for less prescription on their future operating model and that it had sought to strike a balance in how much direction it provided to support decision-making on staffing.

27 Thirteen respondents gave views on the support for ICBs merging or clustering.
28 Only 18 out of 19 ICBs which participated in our survey responded to the question on running costs.

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- Respondents also identified a range of areas where there may be gaps or risks to how they would operate and deliver services in the future. These areas included lack of clarity about ICB and NHSE responsibilities, changes from the May 2025 ICB model blueprint, loss of capacity and expertise in medicines management and Continuing Healthcare, concerns about building strategic commissioning capacity, and risks to services as Commissioning Support Units are closed.

3.18 Other stakeholders were also concerned about future delivery of services by ICBs. The Public Service Ombudsman has reported that challenges providing services for patients with ADHD and autism are made worse by financial pressures and organisational changes within ICBs.[29] The Royal College of GPs told us it had concerns about the loss of clinical leadership within ICBs. Clinical leads contribute to work on health inequalities, safeguarding and commissioning, and they have important local relationships and knowledge. As noted above, some ICBs plan to spend less on neighbourhood health and prevention activities.

3.19 Although the restructuring has not involved wholesale transfer of functions from ICBs to local authorities, local authorities were concerned that ICB cuts may leave them with gaps to fill and place a greater onus on health and social care providers to manage frictions. NHSE has reflected this concern in its risk register, which rates the Model ICB risk as 'Amber-Red', noting "significant concern from local authorities and the Ministry of Housing, Communities & Local Government". Local authorities told us that workforce instability and the loss of experienced ICB staff had affected programme delivery and weakened joint commissioning arrangements (**Figure 15**). Several local authorities stressed the importance of maintaining links with senior ICB leaders during the transition and the need for joined-up system thinking given the wider reforms to local government.

Risks to savings

3.20 NHSE estimates that ICBs will save £908 million a year, a 43% reduction in their baseline running costs for 2025-26 (Part One). ICBs spent a total of £582 million on redundancy payments in 2025-26 (including £401.5 million allocated to them by NHSE).[30] NHSE does not have an estimate of what ICBs will spend in 2026-27 as ICBs are responsible for any further payments. NHSE told us that it expects the cost of exit payments for departing staff to be overtaken by savings in salaries and other staff costs by around March 2027.

3.21 Our guide on exits and redundancies emphasises that organisations should make efforts to keep staff numbers from creeping up again once immediate pressures to pare back costs have been lifted. If ICBs do not have the skills they need to deliver, they may re-fill roles that have previously been made redundant.

29 Public Service Ombudsman, *Improving ADHD and autism services; commissioning with confidence*, September 2026.
30 The £582 million represents the amount ICBs recognised as expenditure in 2025-26. This includes redundancy costs that had been incurred but had not yet been paid at year end.

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Figure 15

Risks raised by local government representatives about reductions in Integrated Care Board (ICB) capacity, June to September 2026

Local authorities are concerned that cuts to ICBs could impact on capacity, capability and service delivery

Risk	What stakeholders reported	Potential impact
Weaker engagement between ICBs and local authorities	Local ICB teams, contacts and leadership roles have been reduced or removed making it difficult to identify decision makers and weakening joint commissioning arrangements.	Less collaboration, slower decision-making, and weaker local coordination of health, social care and community services.
Disputes over funding	Reduced health funding contributions and funding disputes. Some reported ICBs' inconsistent application of the frameworks for NHS Continuing Healthcare.	Increased financial pressure on local government.
Lack of clarity on future roles	Uncertainty about what strategic commissioning means in practice, what activities ICBs should stop doing, and how future arrangements will operate.	Inconsistent implementation, delayed decision-making, and difficulty planning services and workforce requirements.
Workforce instability and loss of ICB expertise	Significant turnover, redundancies and leadership churn. Concerns that experienced staff with local understanding, finance specialists and analysts are leaving.	Loss of organisational capability and institutional knowledge, and weaker delivery of transformation programmes.
Multiple concurrent reforms	ICB restructuring is occurring alongside local government reorganisation, local government funding reform, devolution, special educational needs and disabilities (SEND) reform and children's social care reform.	Reduced capacity to manage change effectively.
Larger ICB footprints leading to less local responsiveness	Concerns that larger ICBs are becoming more remote from local communities, with standardised approaches potentially overlooking local needs and priorities. This is shown in the following examples. • One local authority reported that its ICB had reduced clinical officer cover from one officer per local authority to one across three. These officers sign off Education, Health and Care plans which children with special educational needs require to access support. • Additional concerns have been raised on statutory safeguarding responsibilities. Local authority Chief Executives, ICB Chief Executives and other local partners are required to meet every six months on safeguarding. Given ICBs are covering larger footprints and multiple local authorities, there is a concern about how they will continue to fulfil these responsibilities.	Less tailoring of services to local populations, poorer neighbourhood delivery, and risk of a 'one-size-fits-all' approach.

Notes

1 An ICB is a statutory NHS organisation in England responsible for planning and coordinating health and care services across a specific geographical area, aiming to improve population health and reduce health inequalities.

2 Strategic commissioning is defined as an evidence-based process for planning, monitoring and evaluating services over the longer term, with the aim of improving population health and reducing health inequalities.

Source: National Audit Office analysis of Department of Health & Social Care documents, NHS England documents, and stakeholder interviews with local government representatives

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3.22 Organisations should implement safeguards against staff who have left through exit or redundancy schemes being re-employed within the NHS again in a relatively short space of time. Our 2013 report *Managing the transition to the reformed health system* covered earlier reforms to the health service. We reported that, of 10,000 staff (FTE) made redundant, 2,200 were subsequently re-employed by the NHS.[31] The current voluntary redundancy scheme includes clawback rules to protect the public purse. Employees who leave an ICB on voluntary redundancy and are re-employed with an NHS employer, DHSC or any of its arms-length bodies will be required to repay some or all of their voluntary redundancy payment within six to 12 months depending on the size of the payment, seniority of the employee and terms and conditions.[32]

3.23 There are controls in place to support compliance with clawback arrangements. NHSE has issued guidance to ICBs to ensure that clawback provisions are explicitly included in local redundancy agreements. The obligation is on the individual to declare and repay where required. In addition, the NHS standard contract requires providers to have processes that identify individuals who have received a redundancy or exit payment. In responding to our questionnaire two ICBs provided specific examples of their controls.

- Including a standard question in its recruitment processes asking applicants if they have received a voluntary redundancy payment within the last 12 months.
- Obliging staff being made compulsory redundant to confirm that they had not started employment with another NHS employer within four weeks of exiting the ICB. The redundancy payment would not be processed without this written confirmation.

Assurance that ICBs can perform their revised role

3.24 NHSE does not track centrally the types of roles ICBs are abolishing or the calibre of people leaving, and it was concerned that it had limited visibility of whether the new strategic commissioning functions would be adequately resourced. To gain assurance, in January 2026, NHSE asked ICBs to provide statements confirming that they: had considered and understood the functions for which they are accountable; were confident they could discharge these functions within the £19 per head running cost allowance; had assessed the risks of the running cost reduction; and had identified mitigations for any changes to how the ICB's functions will be delivered.

31 Comptroller and Auditor General, *Managing the transition to the reformed health system*, Session 2013-14, HC 537, National Audit Office, July 2013.

32 Voluntary redundancy clawback rules depend on whether the employee's terms and conditions are Agenda for Change (the NHS national grading and pay system), medical or very/executive senior manager. The policy for voluntary redundancy differs from compulsory redundancy. Under Agenda for Change, if an employee is made compulsory redundant and takes up a new role with an NHS employer with the new employment starting within four weeks of their termination date, they will not be entitled to a redundancy payment. Agenda for Change terms and conditions do not apply to consultants or NHS very/executive senior managers. Contractual clawback requirements will be stated in the employment contract and settlement agreement.

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3.25 NHSE received written responses from all 25 ICBs and ICB clusters between January and March 2026.

- All but one ICB provided the assurance that they would have the structure in place to perform their role efficiently and effectively. The remaining ICB confirmed that it was making progress towards developing the structure needed to fulfil its role. ICBs noted that their success will depend on finalisation of structures and operating models and managing the transfer of functions successfully.
- Twenty out of 25 ICBs or clusters provided assurance that they could meet the running cost reduction target, with the remaining five making progress towards this. However, some ICBs providing assurance to NHSE, or responding to our questionnaire, reported risks that their running cost budgets may not meet the full cost of their activities (such as the cost of meeting statutory responsibilities or covering services previously provided by Commissioning Support Units) or transition costs (such as the full cost of redundancies).

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Appendix One

Our audit approach

Our scope

1 Our independent conclusions on the restructuring of Integrated Care Boards (ICBs) were reached by analysing and synthesising evidence collected through fieldwork between April 2026 and October 2026.

2 Fieldwork was structured around the planned reforms to ICBs including the changes to their size, role and functions, the progress and impact of ICB consolidation and staff reductions, and the Department of Health & Social Care's (DHSC's) and NHS England's (NHSE's) oversight of whether the objectives of the ICB reforms are being met.

3 Our analytical framework comprised three evaluative criteria which covered the following: DHSC's objectives for the reforms to ICBs; progress in preparing reformed ICBs to deliver improved local population health as successful commissioners of NHS services; and progress in establishing new operating models, making savings through reducing ICB staff numbers, and managing associated risks.

Our evidence base

4 The report is based upon an evidence base which includes interviews with officials and stakeholders, a questionnaire to chief financial officers of ICBs, review of departmental documents, and quantitative analysis of financial and workforce data.

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Interviews

5 We conducted interviews with a range of organisations and stakeholder groups during fieldwork to inform our audit, including:

- government bodies, including officials from NHSE and DHSC, and the Ministry of Housing, Communities & Local Government, to understand the government's views of key issues, risks, and future plans;
- sector bodies, including NHS Alliance, the Healthcare Financial Management Association (HFMA) and the Royal College of GPs; and
- health think tanks, including the Health Foundation and The King's Fund.

We also interviewed representatives from local authorities and representative groups to understand the interdependencies and impact of ICB restructuring on local government.

- Representative bodies we spoke to included the Local Government Association, the County Councils Network, the Local Councils Network, the London Councils Network, the Association of Directors of Adult Social Services, the Association of Directors of Children's Services, and a Local Government Reference Panel chaired by the National Audit Office.
- Local authorities we spoke to included Dorset Council, Kirklees Council, Liverpool City Council, Nottingham City Council, Southampton City Council, Winchester City Council, and Worcester County Council.

Questionnaire

6 To develop our understanding of the challenges and opportunities faced by ICBs as they restructured, we sent an online questionnaire to ICB chief financial officers. We requested contact details from NHSE to target our questionnaire and engaged with HFMA on the wording of the questions and the questionnaire design. We also liaised with internal National Audit Office survey experts to quality assure our approach. We sent the questionnaire to ICBs in May 2026, after the first wave of ICB mergers on 1 April 2026. We emailed a questionnaire link to all chief financial officers of ICBs. For ICBs that had formed an ICB cluster, we asked for a single response. The questionnaire ran from 19 May to 30 June 2026.

7 We had 22 questions covering areas such as ICB role and function, running costs, mergers and clusters, workforce changes, and the role of NHSE and DHSC. We received responses from 19 out of 25 ICBs or ICB clusters. We note the risk that chief financial officers who did respond to our questionnaire may not have been representative of those who did not respond.

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Document review

8 We reviewed both publicly available documents and departmental documents provided in response to our evidence requests, to understand the rationale for the planned changes to ICBs, changes to ICB roles, DHSC expectations for ICB consolidation and staff reductions, and oversight arrangements for ICB restructuring.

9 Documents we reviewed included:

- board meeting minutes;
- impact assessments;
- risk registers;
- assurance statements;
- programme performance monitoring reports; and
- good practice guides.

We reviewed each document against our overarching audit questions. We also used the review to refine the scope of the study, including defining our more detailed audit questions and methods.

Quantitative analysis of financial and workforce data

10 We analysed financial and workforce data provided by NHSE to understand trends over time in ICB running costs and workforce composition. The latest available data held by NHSE were for June 2026. Financial data are adjusted for inflation and presented in 2025-26 prices using GDP deflators at market prices published by HM Treasury in June 2026. The data included:

- ICB workforce whole-time equivalent (WTE) and headcount data, by ICB and occupation code for the period April 2024 to June 2026, to identify changes in the aggregate workforce and its composition over time. WTE is calculated in the NHS by dividing the number of required hours for the role by 37.5 hours. WTE is broadly equivalent to full-time equivalent (FTE) measures of staff numbers;
- ICB leavers by ICB, occupation code and reason for leaving over the period April 2024 to June 2026, to identify changes in the ICB workforce due to redundancy, transfers and attrition over time;
- redundancy funding allocated and expensed by ICBs in 2025-26;
- aggregate ICB running cost data broken down by administration costs, programme pay costs, and commissioning support unit programme costs for the period 2023-24 to 2025-26; and
- NHSE's projected running costs for 2026-27.

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