National Audit Office

REPORT

Restructuring of Integrated Care Boards

Department of Health & Social Care

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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

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.

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).

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.

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.

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.

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).

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.

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.

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.