Integrated Care Systems and tobacco control: improving outcomes in population health and healthcare

Findings from a survey of Integrated Care Boards and a content analysis of Integrated Care Strategies

ash. action on smoking and health

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Contents

Summary of key findings

- Tobacco control was perceived by survey respondents to be an above average or high priority in 14 of the 29 surveyed Integrated Care Boards (ICBs)
- 31% of survey respondents were not confident that tobacco dependence treatment services would be fully implemented in acute and mental health hospitals in their Integrated Care System (ICS) area by March 2024.
- The implementation of tobacco dependence treatment services has been enabled by dedicated funding, strong partnerships, ICB and clinical leadership, local government leadership and support, regional support, leads within NHS trusts, and dedicated managers.
- The implementation of tobacco dependence treatment services has been inhibited by funding limitations and long-term financial uncertainty, competing priorities and lack of capacity, problems recruiting staff, IT and reporting differences across the system, and COVID-19.
- Of the 32 publicly available integrated care strategies assessed in March 2023, 15 included goals or ambitions specifically focused on smoking, of which 4 also had defined outcome targets.
- Inequalities were being addressed by surveyed ICBs in a variety of ways: nine ICBs had specific inequalities strategies while others had included inequalities in their integrated care strategy, or other corporate documents or mechanisms.
- The commitment of ICBs to wider tobacco control and the prevention of smoking is diverse. Some ICBs have detailed plans and mechanisms in place while others remain focused on the implementation of tobacco dependence treatment services.

Introduction

Integrated Care Boards were legally established on 1 July 2022, replacing clinical commissioning groups and taking on their functions as well as absorbing some planning roles from NHS England. There are 42 ICBs in England.

ICBs are the executive function of Integrated Care Systems, which have been in development since 2016. The purpose of integrated care systems is to bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development[1].

The other key component of each ICS is an Integrated Care Partnership (ICP), a broad alliance of organisations including the NHS, local authorities and the voluntary, community, faith and social enterprise sector. A core statutory role of ICPs is to produce a strategy setting out the priorities for the integrated care system. These

[1] NHS England 2023: What are integrated care systems?

strategies will inform the forward plans of each ICS. A majority of ICPs had published their first integrated care strategy by March 2023.

One of the tasks handed to ICBs is the roll-out of tobacco dependence treatment services, as set out in the NHS Long Term Plan[2]. These are major new services for smokers within NHS settings including hospitals, mental health units and maternity services. Given the impact of smoking on population health and health inequalities, there is considerable scope for integrated care systems to take on a broader strategic role in smoking prevention and tobacco control.

This short survey of ICBs was undertaken to gain an initial picture of how important smoking is to their work and priorities. It provides a baseline for a longer-term investigation into the efforts of ICSs to deliver population health and healthcare outcomes through tackling the harms of smoking.

Methods

The findings in this report are drawn from an online survey of integrated care boards and a content analysis of ICP's published integrated care strategies.

The short online survey was conducted using Survey Monkey and was live from January to early March 2023. Key contacts in integrated care boards were asked to complete the survey or to pass it to the lead officer for tobacco control to complete. Non-responding ICBs were followed up by telephone. Twenty-nine valid, complete surveys were received from the 42 ICBs in England, a response rate of 69%.

The content analysis of integrated care strategies was undertaken at the end of March 2023. Nine survey respondents had provided links to their strategies and a further 23 strategies were downloaded from ICB websites. Of these 32 strategies, 11 were in final form, 17 were described as draft, initial, interim or transitional, and 4 were summaries for the public. The summaries were included in the analysis as they all cited the strategies' goals, ambitions and targets.

Respondents to the survey

Eighteen of the 29 survey respondents (62%) were employed by their ICB. The other 11 respondents had roles in their ICB but were employed elsewhere: four were employed by local authorities, four were employed by the NHS, two were joint local authority and NHS appointments, and one was a consultant.

The amount of time respondents spent on tobacco control is described in Table 1. A third of respondents (n=9) spent more than half of their time on tobacco control. Most respondents had broader briefs for prevention, population health and/or inequalities.

[2] NHS Long Term Plan, 2019

Table 1. Survey respondents' time spent on tobacco control (n=28)

All	3 (11%)
Most	3 (11%)
Over half	3 (11%)
About half	4 (14%)
Less than half	9 (32%)
Very little	6 (21%)

Governance and the priority given to tobacco control

Survey respondents were asked who provided leadership and oversight for the ICB's work on smoking and tobacco and to name any committee that was involved. Of the 29 respondents:

- 24 (83%) described at least one committee
- 13 (45%) named a committee with specific responsibility for tobacco
- 15 (52%) named a committee with a broader remit for population health, prevention and/or inequalities, of which 5 also identified a committee with specific responsibility for tobacco

This was a free-text question which some respondents answered more fully than others. These results may therefore under-represent the full extent of local governance arrangements for tobacco control work. Nonetheless, the range of governance arrangements is apparent: some ICBs have yet to establish any formal governance for tobacco control work, whereas others have a process of management and oversight in place, as in the following examples:

> *Whilst I lead on the day to day management of the Project, there is a strong governance structure in the form of a long-standing monthly Tobacco Dependency Steering Group, with the addition of monthly Tobacco Dependency Implementation/Delivery Groups. The Steering Group feeds up to the Health Inequalities Programme Board and our SRO chairs both meetings.*
>
> *The SROs for Prevention are the two Directors of Public Health. Oversight is via the ICS Prevention Workstream which feeds into the Inequalities, Prevention and Population Health Committee of the ICB. There is strong leadership from the DsPH for this work across the ICS and through the comprehensive programmes within Public Health Teams as well. There is also a multidisciplinary, collaborative approach through the steering group for the Tobacco Dependence Treatment Services Programme.*
>
> *The inpatient work in our ICB is the QUIT programme, which is overseen by the QUIT Oversight Board. Broader smoking/tobacco work is reported through Place-based governance.*

Survey respondents were asked how they perceived the priority given to tobacco control by their ICB. Of the 28 who answered, half felt that tobacco control had a high

or above average priority. Of the remaining 14, 12 felt that tobacco control had an average priority. Only two said that it was a low priority (Table 2).

Table 2. Perceived priority of tobacco control in ICBs (n=28)

Level of priority	*No. of ICBs*
High priority	8 (29%)
Above average priority	6 (21%)
Average priority	12 (43%)
Below average priority	0
Low priority	2 (7%)

Implementation of the NHS Long Term Plan

The NHS Long Term Plan requires that, by the end of 2023/24, people will be offered NHS-funded tobacco treatment services who are:

1. Admitted to hospital and who smoke (acute and mental health)
2. Pregnant women and their partners
3. High-risk mental health outpatients

Respondents to the survey were asked how confident they were that all trusts in their area would implement these services by March 2024. Table 3 illustrates the result for each service type. Confidence in full implementation was highest for maternity services (76% including services already implemented) and lowest for high-risk mental health outpatients (31%).

The survey was conducted before the 2023/24 funding for tobacco dependence treatment services was confirmed. The funding package is less than had been expected by ICBs.

Table 3. Survey respondents' confidence of service implementation in all trusts by March 2024 (n=29)

	Already implemented	*Confident of full implementation*	*Not confident of full implementation*	*Don't know*
hospitals (acute and mental health)	3 (10%)	15 (52%)	9 (31%)	2 (7%)
maternity services	9 (31%)	13 (45%)	6 (21%)	1 (3%)
high-risk mental health outpatients	0	9 (31%)	15 (52%)	5 (17%)

Respondents were asked to describe in their own words what factors had enabled and inhibited the implementation of tobacco dependence treatment services.

Factors that had enabled implementation included:

- the dedicated funding
- strong partnerships
- ICB and clinical leadership
- local government leadership and support
- regional support
- leads within NHS trusts
- a dedicated manager
- a process of review and learning
- the NHS mandate to deliver
- good governance arrangements

Factors that had inhibited implementation included:

- funding limitations and long-term financial uncertainty
- competing priorities and lack of capacity
- problems recruiting staff
- IT and reporting differences across the system
- COVID-19 and its impact on NHS trusts
- an over-ambitious timetable
- lack of leadership (ICB, clinical)
- lack of engagement from staff in trusts and resistance to change
- lack of community stop smoking services in some areas
- blocks within trusts to NRT provision by advisers

All survey respondents identified both positive and negative factors and many described them in some detail. Overall, the implementation of tobacco dependence treatment services has been a complex and challenging task, beset with many obstacles. The services are new to NHS trusts and their staff, who are already under pressure from elsewhere. They come with no long-term financial guarantee so they risk remaining a marginal 'add-on' concern. COVID-19 disrupted the timetable and piled more pressure on NHS trusts. Recruiting staff has been difficult in some areas and the lack of interoperability between IT systems has undermined core monitoring and communication tasks. Even the provision of NRT by Tobacco Dependency Advisers (TDAs) has been prevented in some trusts due to conflicts with pharmacy regulations.

The following quotes capture something of this complexity:

> *Recruitment and retention of Tobacco Dependency Advisors has been difficult partly through delays in local HR processes, banding of staff and fixed term contracts in certain trusts. These roles are new and staff need time to gain experience to provide the necessary level of support. Complexities of updating data systems and lack of appropriate data infrastructure in NHS to capture smoking status on admission or smoking status post 28 days discharge. Changing staff culture can take longer than timeframe of NHS Long Term Plan – we need to be hearing more often nationally of the expectation that this is THE future for the NHS and not a temporary 'project'.*

> *Short term funding has impacted upon recruitment/retention of TDAs and tobacco dependence treatment programme leads, which is essential to the*

progress of the services. Funding may not cover true costs, plus there are cost pressures to rest of the system e.g. community. Varying oversight/input from trust leadership to support the progress of smokefree commitments e.g. NHS Pledge. Trusts have reported complications with TDAs and pharmacy regulations re NRT administration which has resulted in delay in some treatment provision and establishing services.

The COVID pandemic significantly impacted the implementation of our pathways; restrictions on wards meant our teams weren't able to easily deliver VBA training; system pressures overall meant capacity for culture change work was not available; different operating systems across trusts has made data collection across our area a challenge; access to varenicline; each trust has an exec sponsor but their ability to support is not consistent due to system pressures.

There is still a sense that this is seen as an 'add on' to the more important work of acute hospitals. I'm unsure whether culture change among frontline professionals has happened, and that they see this as part and parcel of their role. Money was slow to be released in previous years to support work in trusts due to financial pressures.

The scale of these challenges has demanded a commensurate response from the many stakeholders involved in delivering tobacco dependence treatment services. Other than the dedicated funding, the enablers described by survey respondents were overwhelmingly human resources: strong cross-sector partnerships; commitment and leadership from the ICB, clinicians and local authorities; support from regions; and specific personnel in ICBs, trusts and local authorities sorting out the problems and getting services in place.

The following quotes reflect the positive view that many respondents had of achievements to date despite the obstacles:

The willingness of all system partners to really take this project forward within their organisations, and working together as a collaborative approach, has really enhanced this project implementation, including sharing lessons learned and communication materials, pathways, and staffing on each site.

Coordinated approach between ICS and trusts through tobacco dependence steering groups. Examples of senior leadership input within trust-owned steering groups to ensure high level focus of such services. Currently we are developing a tighter practice network between the ICS and the trust tobacco dependence leads which is supporting trusts in progressing tobacco dependence work. We want to keep continued focus on this for shared learning, peer support and to encourage and engage with senior leadership within the trusts.

Support from local authority stop smoking teams; ICB leadership; full support from regional tobacco control teams; excellent stakeholder engagement.

Our ICS is committed to striving for 5% by 2030 and the Chair and Chief Executive are committed and there is brilliant support from ADPHNE and OHID. We will work to ensure we can provide the right level of support so these

services are retained long term. We need to get this 100% committed by every single trust Chief Executive, Director of Finance and Medical Director.

The uncertainty about the long-term funding of tobacco dependence treatment services after 2023/24 was one of the inhibiting factors identified by respondents in response to these open questions. They were subsequently asked a specific question about the likelihood of tobacco dependence treatment services being retained following the end of the transformation period in March 2024. Half (n=14) said they did not know and half (n=15) said that this was likely or very likely. No respondents felt that retention of services was unlikely. Hence the issue for respondents was principally one of uncertainty.

Integrated Care Strategies

ICPs' integrated care strategies will inform the forward plans of each ICS. The content analysis of the 32 publicly available integrated care strategies sought to describe the extent to which smoking and tobacco control were addressed within each document. After an initial review of the documents, the following exclusive categories were used to differentiate the strategies:

- There is no direct mention of smoking in the strategy
- Smoking is mentioned in the strategy but is not referenced in any goal, ambition, priority or target
- Smoking is cited as an example within a broad goal, ambition or priority
- Smoking is the specific focus of a goal, ambition or priority but no targets are defined
- A specific target for smoking is defined

Table 4 describes the number of strategies within each category and illustrates each category with examples that typify the diversity overall. Although there is an order to the categories, the differences between them may reflect stylistic or technical choices about how content is communicated, as much as real differences in the priority given to smoking. Nonetheless, this analysis reveals wide variation across integrated care partnerships in how smoking should be prioritised within their long-term strategies. Overall, smoking was included in a goal, ambition or priority in 75% of the strategies assessed.

Table 4. Presence of 'smoking' and 'tobacco' in integrated care strategies (n=32)

Content category	*No. of strategies*	*ICS example*	*Selected text from strategy*
There is no direct mention of smoking in the strategy	2 (6%)	NHS Devon	Improving outcomes in population health and healthcare: • Population heath and prevention will be everybody's responsibility and inform all we do. We will focus on the top five risk

			factors for early death early and disability • By 2028 we will have: decreased the gap in healthy life expectancy by 25% and decreased by 25% the under 75 mortality rate from causes considered preventable
Smoking is mentioned in the strategy but is not directly referenced in any goal, ambition, priority or target	6 (19%)	NHS Cornwall and the Isles of Scilly	We recognise the importance of tobacco and alcohol control, and will work more closely across our different teams to better develop what support we can offer to our people across all of our organisations.
		NHS Norfolk and Waveney	Both Norfolk and Waveney have higher prevalence of smoking at time of delivery compared to the rest of England. / Inequalities exist from birth to older age (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyle, unemployment)
Smoking is cited as an example within a broad goal, ambition or priority	9 (28%)	NHS Suffolk and North East Essex	Our Collective Ambition is to enable the 'Best Health and Wellbeing' to be a genuine reality for everyone living in Suffolk and North East Essex. We will do this by: • minimising the risk factors that drive the most death and disability in our population e.g. smoking, alcohol use • taking action in our ICS at every opportunity on smoking cessation, early cancer diagnosis, high blood pressure, supporting those with chronic respiratory disease and severe mental illness and improving maternity care
		NHS South West London	Priority 2: • Preventing ill-health, promoting self-care and supporting people to manage their long-term conditions, including a focus on healthy eating, physical activity, smoking and alcohol misuse and mental wellbeing and link

			up with offers in the community. Supporting people to manage long-term conditions for example diabetes, COPD, MSK, ischaemic heart disease
Smoking is the focus of a goal, ambition or priority but no specific targets are defined	11 (34%)	NHS Buckinghamshire, Oxfordshire and Berkshire West	What we want to achieve: • A reduction in the overall number of smokers in Buckinghamshire, Oxfordshire and Berkshire West, especially in our most deprived areas • Fewer young people will take up smoking • More people will stop smoking, especially in deprived areas • A reduction in conditions made worse by smoking, including fewer people developing cancer and lung disease

		NHS Gloucestershire	Unifying Theme 2: Smoking
			• Smoking is the single biggest cause of inequality in premature death rates and the leading cause of preventable disease and disability.
			• 50% of long-term smokers will die prematurely, many more live with debilitating illnesses
			• Higher smoking prevalence is associated with almost every indicator of deprivation or marginalisation. In Gloucestershire:
			  ○ Smoking prevalence in adults – 11.6%
			  ○ Routine and manual workers – 26%
			  ○ Smoking prevalence in adults with a serious mental illness – 38%
			  ○ Smoking status at time of delivery - 11%
			Ambition: Identify greater numbers of smokers and signpost to appropriate smoking cessation

		NHS Greater Manchester	Reducing harms from tobacco, alcohol and drugs: reducing smoking prevalence as part of our Make Smoking History Programme; reducing alcohol and tobacco harms especially during pregnancy; and changing lives with those experiencing multiple disadvantage and struggling with the complexities of drug, alcohol, mental health and associated problems.
A specific target for smoking is defined	4 (13%)	NHS Cheshire and Merseyside	Aim to reduce smoking prevalence rates from 12.5% to 5% by 2030
		NHS North East and North Cumbria	We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030
		NHS Nottingham and Nottinghamshire	Our ambitions: • A smoke free generation by 2040 ensuring that we take an equitable approach to working with our most vulnerable groups • Reduction in smoking prevalence in adults (aged 18+) to 5% by 2035.
		NHS South Yorkshire and Bassetlaw	Smoking in pregnancy: Reduce the percentage of women in South Yorkshire and Bassetlaw who are smoking at time of delivery to 6% by March 2024 Smoking in adults: Reduce percentage of adults in South Yorkshire and Bassetlaw who smoke to below 10% by March 2024, with a reduction in the gap between the proportion of the general population who smoke and people with routine and manual occupations and severe mental illness

Inequalities and other ICB plans

As smoking is the leading cause of health inequalities, survey respondents were asked if their ICB had an inequalities strategy. Of the 23 respondents who knew the answer

to this question, 9 said that the ICB did have a strategy. Ten of the remaining respondents reported that a strategy was in development (n=3), or that inequalities were addressed either in the Integrated Care Strategy (n=3) or in other corporate documents or mechanisms (n=4). Three respondents referenced the Core20PLUS5 framework.

The following comments illustrate this diversity of approaches:

> *At the heart of the Integrated Care Strategy is our common endeavor of reducing inequalities. Smoking cessation is recognised as a cross cutting priority particularly because of the impact it has across the five health conditions within Core20PLUS5 framework.*
>
> *Health inequalities are heavily and explicitly integrated into the ICP strategy, rather than having its own strategy as it cuts across and should be embedded within everything we do.*
>
> *There is a strategy for the Improving Population Health Programme and each year an annual report. We also collate all the inequalities work through our reporting for Core20PLUS5 and the operational guidance. We have a health Inequalities Network and a Health Inequalities Academy. Inequalities are front and centre of the ICB Strategy and two of the 10 big ambitions directly relate to reducing inequalities.*
>
> *We have a series of Health Inequalities priorities which were agreed by our ICB at board level.*

As all ICBs have received ring-fenced funding to tackle inequalities, survey respondents were asked if their ICB had allocated any of this funding to tobacco control. Only 17 of the 29 respondents knew the answer to this question. Of these, 13 said that some of the funds were being spent on tobacco control and four reported that they were not.

The purposes to which inequalities funding was allocated included:

- the delivery of tobacco dependence treatment services and NRT
- place-based prevention projects
- targeted work with marginalised communities
- targeted work with vulnerable patients
- support for a regional tobacco control function

Survey respondents were asked if their ICB had any other plans to address smoking and tobacco. In their free-text answers, 17 respondents (59%) described plans or commitments to a wider tobacco control or prevention agenda. The following examples highlight the importance of partnerships, community engagement and a population health perspective:

> *The tobacco dependence treatment programme forms an element of a wider Tobacco Control Programme of work, which incorporates multiple partners from across the ICS including public health, NHS, police, fire service, prison, probation, community and VCSE sector.*

Tobacco dependency steering group beginning to take on wider tobacco remit (beyond LTP delivery). Currently in scoping phase. Development of community led projects to tackle dependency in communities facing highest inequalities. Smoking is one of the 3 'unifying themes' in the ICP strategy with plans to follow.

Addressing smoking and tobacco dependency is a key part of our Prevention programme which reports into our Population Health Improvement Board (PHIB) that has been recently been established. The intention is that partners across the system will focus on how collectively we can utilise resources to support our population to adopt healthy lifestyle behaviours. The PHIB will be adopting a logic model approach that identifies those key outcomes and with a supporting delivery plan by Q1 2023/24.

Smoking is one of the key priority areas within our ICB strategy and our Directors of Public Health are supportive of a regional approach to comms and engagement, these discussions are still in the early stages of discussion.

We have a wider ambition through are LTP Strategic Group and the Prevention Network to support a whole system approach to address smoking an tobacco working in partnership with our 5 places, embedding into other programmes of work to address the route causes of smoking and how we support people not to start to smoke in the first place, but also to work with them on the wider physical and emotional challenges as to why they feel they cant stop.

Discussion

The findings reported here are drawn from a survey of ICBs with a 69% response rate, and a content analysis of ICP's integrated care strategies from 76% of ICBs (all that were publicly available at the end of March 2023). This report offers an early, provisional snapshot of the engagement of integrated care systems with tobacco control.

The first two of the four purposes of ICSs are to improve outcomes in population health and healthcare and to tackle inequalities in outcomes, experience and access. These purposes balance the traditional priorities of the NHS to deliver good healthcare outcomes with the longer-term priorities of the whole public health system to improve population health. This is commonly a source of tension in health policy; recently the parliamentary Health and Social Care Committee has urged the DHSC and NHSE to ensure that ICSs have the capacity to focus on public health and prevention given the demands of short-term, operational challenges[3]. In her major review, Patricia Hewitt draws attention to the same problem and notes its perennial nature[4]:

> *'There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. … Unless we make the change, the*

[3] House of Commons Health and Social Care Committee, *Integrated Care Systems: autonomy and accountability*, HC 587, March 2023
[4] Rt Hon Patricia Hewitt, *The Hewitt Review, An independent review of integrated care systems*, April 2023

continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large of efficient enough to cope.'

Smoking illuminates this problem: it is a condition that requires treatment, for which extensive new services in acute hospitals and other NHS settings are being rolled-out, yet wider action is needed to bring down the population prevalence of smoking and so reduce the number of people who end up in hospital with smoking-related conditions.

ICBs have had much to do, with their partners in NHS trusts and local authorities, to implement tobacco dependence treatment services, as set out in the NHS Long Term Plan. It has not been easy, given resource constraints, competing priorities, recruitment problems, and the lack of interoperability of IT systems and related monitoring difficulties. At the time of the survey, in early 2023, only 10% of surveyed ICBs had fully implemented tobacco dependence treatment services in acute and mental health hospitals, and 31% were not confident of full implementation by the March 2024 deadline. Findings were better for maternity services and worse for high-risk mental health outpatients. Since the survey closed, the funding package for tobacco dependence treatment services in 2023/24 has been confirmed and is less than ICBs were expecting.

The requirements of the NHS Plan have, however, kick-started the tobacco control work of ICSs. Most surveyed ICBs had governance arrangements in place to oversee tobacco control including 45% that had a specific committee with responsibility for tobacco. Partnerships, which are so central to the ethos of ICSs, have been embraced and developed to enable the roll-out of tobacco dependence treatment services. Clinical leadership in NHS trusts and public health expertise in local authorities have both been important.

Tobacco dependence treatment services may have paved the way for tobacco control in ICSs but their future is not secure. The long-term financial uncertainty hanging over tobacco dependence treatment services was identified by respondents as one of the factors inhibiting their roll-out and half of respondents said they not know how likely it was that these services would be retained after the 2024 deadline. Even if the services are retained, respondents expressed concern that they would not be fully integrated into NHS provision but perceived as an 'add-on', vulnerable to future cost-cutting. These are reasonable concerns, given the size of the current financial pressures on these new organisations[5].

As for the long term: it will be some time before a fair assessment can be made of ICSs' achievements in addressing population health outcomes and inequalities. Their intentions, however, are promising, judging from the commitments expressed in ICP's integrated care strategies. Although only four of the 32 strategies assessed had specific targets for smoking, 24 strategies (75%) included smoking within a goal, ambition or priority.

Turning these ambitions into programmes and investment will take time and resources, which ICBs will soon have less of thanks to the NHSE's announcement of a

[5] Health Service Journal, *ICSs' £3bn deficit plans rebuffed by NHSE*, HSJ 12th April 2023

30% cut to ICBs' Baseline Running Cost Allowance by 2025/26[6]. Even before this cut, the National Audit Office found that while 77% of surveyed ICS staff reported that their ICS intended to invest in prevention, only 31% felt they currently had the capacity to do so[7].

Yet ICS leaders are committed to reducing inequalities[8] and ICPs bring together the people and institutions with the necessary expertise to deliver population health outcomes. This may not be the perfect time to 'shift the dial' towards prevention and population health, but in most areas a framework for change is emerging. Having created these new opportunities, the government would be wise to support ICSs to realise the goals that all partners round the integrated care table want to achieve.

[6] NHS England, *Correspondence to ICB chief executives*, 2nd March 2023
[7] National Audit Office, *Introducing Integrated Care Systems: joining up local services to improve health outcomes*, October 2022
[8] NHS Confederation, *Prevention in health and social care*, February 2023