Written evidence | Integrated Care Boards: re-organisation

1. This evidence is submitted on behalf of the Mobilising Community Assets to Tackle Health Inequalities (MCA) programme, in partnership with the National Centre for Creative Health (NCCH).

2. Our evidence focuses on one risk that runs through all three of the Committee's questions: the reorganisation removes relationships and local knowledge that strategic commissioning depends on, and the voluntary, community, faith and social enterprise (VCFSE) sector – which carries much of that knowledge – is least able to absorb the disruption. We set out why this threatens capability, and what is required to protect delivery and secure value for money.

1: Will restructured ICBs have the capacity and capability to effectively fulfil their responsibilities?

3. Strategic commissioning depends on knowledge, not only structures. To commission for a population, an ICB needs to understand the assets in that population – including community, voluntary and creative health[1] provision that sits outside formal NHS services but shapes demand on them. That understanding is held by people and sustained through relationships built over years.

4. The reorganisation removes many of those people and severs relationships at the point when the strategic-commissioning model asks ICBs to know their populations better. This is a capability gap, not only a reduction in capacity. There has been a loss of NHS knowledge of the locale, a loss of connection with knowledge held by community partners, and a loss of trusted relationships that cannot quickly be rebuilt.

5. The VCFSE sector is disproportionately affected. It is typically funded on short-term, insecure arrangements and lacks the reserves or infrastructure to weather a prolonged period of system churn. As commissioning teams merge and contacts change, the informal channels through which small organisations connected into the system are lost, and the institutional memory of what those organisations provide and for whom goes with them. The parts of the system most able to reach underserved communities become least visible to the commissioners now responsible for them.

6. Research from the MCA programme finds that effective collaborative governance for creative health rests first on trust-based relationships between community and VCFSE providers and senior figures in the health and care system — relationships built slowly, and the foundation for everything that follows (Dayson et al., 2026). In an MCA evaluation of a 'Creative Health Connector' role in Doncaster, researchers show how even a single VCFSE post built and sustained working relationships with the ICB, GPs and NHS commissioners that had not existed before, and unlocked concrete results. Collaborations between the voluntary sector and NHS and other partners led to employment outcomes and to funding for provision targeting specific health conditions (Holding and Lockley, 2026). Findings from this work show that in the absence of that connecting role momentum stalls and, on the return of that role, relationships have to be rebuilt from the ground up.

7. The ICB reorganisation threatens this at scale — as commissioning teams merge and posts are lost, the relationships and knowledge that connect the system to its communities leave with the people who held them, and there is no mechanism to transfer them.

2: Are DHSC and NHS England managing the reorganisation in a way that protects delivery?

[1] Creative health describes the use of creative activities and approaches to support health and wellbeing outcomes. This can include provisions such as dancing for falls prevention and singing for lung health, or engagement methods such as creative coproduction with patients and the public.

8. Our evidence speaks mainly to capability and VCFSE impact rather than to the programme management of the transition, but on the evidence we hold, we suggest the pace of change is a threat to continuity of provision.

9. In particular, the sequencing of the reorganisation creates a risk to delivery. Relationships and local knowledge are being dismantled on a running-cost-reduction timetable, ahead of the structures meant to replace them. Where VCFSE provision is lost during this gap, the communities it reaches lose support before the new arrangements are in place to pick it up.

10. We see no clear mechanism in the reorganisation for preserving VCFSE institutional knowledge and relationships through the transition. Protecting delivery requires a deliberate handover of local knowledge as teams merge, rather than leaving continuity to chance; and this continuity needs to extend past NHS services alone, to protect the value of integrated care systems.

11. This risk is not confined to less developed systems. Gloucestershire has one of the most mature creative health systems in England, built over two decades, with sustained NHS investment and creative health embedded in ICB structures; even there, the ICB merger has prompted renewed uncertainty (Hearst et al., 2025).

3: What is required to ensure the reorganisation delivers genuine improvements and value for money for taxpayers?

12. The reorganisation can deliver improvement and value for taxpayers only if strategic commissioning is built to see, value and sustain the community and VCFSE provision that reduces demand on NHS services.

Structural safeguards

13. It is important that the VCFSE voice is secured in the new arrangements. With integrated care partnerships being abolished through the Health Bill (Clause 24 of the Bill as currently before the House of Lords), the VCFSE representation that ICPs carried is not automatically replaced. Health and Wellbeing Boards are becoming the focal point for cross-system partnership and neighbourhood planning, but their membership is being settled locally and does not guarantee a VCFSE seat. The programme's research finds that creative health governance works best when it is accountable to local contexts and builds on the strength of local creative assets (Dayson et al., 2026) — which requires the sector to be present where decisions are made. We recommend that VCFSE representation on Health and Wellbeing Boards is secured rather than left to local discretion, so that the sector's knowledge is present where priorities are now set.

14. The Health Bill's neighbourhood health plan provision (Clause 25 of the Bill as currently before the Lords) replaces the duty to prepare a joint local health and wellbeing strategy with a duty, on the responsible local authority and its partner ICBs, to prepare a neighbourhood health plan. In doing so it removes explicit mention of ‘wellbeing’ from the plan's remit. It also limits the duty to involve others to ‘the people who live or work in the area’ — it does not require the responsible local authority and its partner ICBs to involve specific types of VCFSE and community partners in preparing the plan. We recommend that this involvement duty is widened to better include VCFSE and community partners, and that wellbeing is retained in the plan's remit, so that the mechanism now central to the reorganisation is built around the wider determinants of health and the partners who address them.

Operational mechanisms

15. Our research has identified a number of implementation mechanisms that enable VCFSE and creative health provision/ partnerships with NHS. We outline a selection of them here:

16. Strategic commissioning works only if commissioners can see the assets in their area and the outcomes they produce. In the Doncaster evaluation, a recurring barrier was that cultural assets' offers were not clear or visible to the system (Holding and Lockley, 2026); a mapping exercise across Staffordshire and Stoke-on-Trent similarly identified over 100 creative health assets that were prevalent but under-recognised and underused (Marsden, 2026). Two things can address this: systematic asset mapping, and the use of trusted community leaders as a route to local knowledge that formal data does not capture.

17. Alongside this, a data layer would let commissioners weigh VCFSE provision properly. For example, our Coastal Community project has created data dashboards combining area-level health data with community asset maps for commissioners. Within our work with Gloucestershire ICB (Hearst et al., 2025), we have recorded how data dashboards have served a vital function. There the dashboard aligns attendance at creative provision with NHS metrics and has repeatedly shown strong outcomes at a fraction of the cost of clinical alternatives, supported by a minimum dataset that routinely integrates NHS numbers.

18. Similarly, our work into the economic case for creative health (McNeill, E., et al. 2026) has highlighted how current economic appraisal methods can disadvantage the VCFSE sub-sector of creative health, despite services offering high value on returns. Through our proposed National Minimum Dataset, we seek to create measurement and health-equity systems designed around access to VCFSE provision, not only access to primary care – work which we believe should sit more centrally within healthcare reform, making use of opportunities such as the movement toward digital and use of the NHS app as an enabler of this transformative NHS number-linked data collection.

19. Finally, we encourage Government to consider how they might best protect the VCFSE supply chain, so that there is provision left to commission. A model built around fewer, larger contracts can squeeze out the small and individual providers who do much of the work closest to communities. The Doncaster evaluation shows both the promise and the fragility here. A connector model linking VCFSE providers, GPs and wider support can open real opportunities, but roles and provision funded on short, insecure terms face a cliff-edge when the funding ends (Holding and Lockley, 2026). Sustained resourcing is, in the programme's research, a precondition for the sector to develop and sustain provision (Dayson et al., 2026).

20. Consortium models – in which smaller providers collaborate, bid together, share back-office and governance capacity, upskill, and hold institutional knowledge collectively – are a practical way to keep that provision viable and to give commissioners a route to it. Such models already work in different forms: a lead-provider consortium in Gloucestershire secured a multi-year NHS contract and simplified commissioning by reducing the number of small contracts the system had to manage (Hearst et al., 2025), while a hub-and-spoke model in West Yorkshire has strengthened the collective case for long-term investment (Bailey et al., 2026). Supporting such models would directly mitigate the risk, set out above, that the reorganisation erodes the VCFSE base.

Recommendations

- Secure VCFSE representation in the new arrangements, rather than leaving it to local discretion.
- Widen the neighbourhood health plan involvement duty (Health Bill, Clause 25) to include VCFSE and community partners, and retain wellbeing in the plan's remit.
- Build commissioner intelligence on community and VCFSE assets — through asset mapping, trusted community leaders, and dashboards linking community engagement with NHS service use — with information-governance, consent and digital-exclusion safeguards in place.
- Support VCFSE consortium models so that smaller providers can collaborate, bid and sustain provision through and beyond the transition.

Supporting evidence

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