The King's Fund

Integrated care systems explained: making sense of systems, places and neighbourhoods

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6 comments

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What are integrated care systems?

Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based

services, physical and mental health, and health and social care. All parts of England are now covered by one of 42 ICSs (*see* Map 1).

ICSs are intended to bring about major changes in how health and care services are planned, paid for and delivered, and are a key part of the future direction for the NHS as set out in the NHS Long Term Plan (/topics/nhs-long-term-plan) . It is hoped that they will be a vehicle (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) for achieving greater integration of health and care services; improving population health and reducing inequalities; supporting productivity and sustainability of services; and helping the NHS to support social and economic development.

ICSs are part of a fundamental shift in the way the health and care system is organised. Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement. They have grown out of sustainability and transformation partnerships (/publications/stps-in-the-nhs) (STPs) – local partnerships formed in 2016 to develop long-term plans for the future of health and care services in their area.

Despite being effectively mandated by NHS England and NHS Improvement, ICSs (and before them STPs) have no basis in legislation and no formal powers or accountabilities. However, this looks set to change in the near future, with plans to put ICSs onto a statutory footing from 2022 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf) .

Map 1: The 42 integrated care systems in England

This map shows the location and boundaries of the 42 integrated care systems (ICSs) in England.

Why are ICSs needed?

The NHS was set up primarily to provide episodic treatment for acute illness, but it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions. As a result, the NHS and its partners need to work differently by providing more care in people's homes and the community and breaking down barriers between services. ICSs are the latest in a long line of initiatives aiming to address this by integrating care across local areas.

ICSs also have the potential to drive improvements in population health (/publications/vision-population-health) and tackle health inequalities by reaching beyond the NHS to work alongside local authorities and other partners to address social and economic determinants of health. Evidence consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live – that exert the greatest impact on health and wellbeing.

The case for collaborative working in the health and care system has been strengthened by the experience of the Covid-19 pandemic, as the response has rested on different parts of the system working together to address the public health emergency, enable continued provision of essential services and to support people to remain well in their communities. Many health and care leaders

emerged from the initial stages of the pandemic with renewed conviction about the benefits of collaboration and a determination to keep hold of and build on the progress made.

How are ICSs operating?

The development of ICSs

Since April 2021, all parts of England have been covered by one of 42 ICSs (*see* Map 1). Some systems have already been working as ICSs for a number of years, while others have evolved from STPs more recently. In all cases, the ways of working and governance structures underpinning ICSs remain a work in progress.

Over recent years, the work of ICSs and STPs has focused on a number of areas, including:

- reaching a shared view between system partners of local needs and the resources available for health and care
- agreeing a strategic direction for local health and care services based on those needs and resources
- driving service changes that are needed to deliver agreed priorities
- taking a strategic approach to key system enablers, for example by developing strategies around digital technologies and estates
- establishing infrastructure and ways of working to support collaborative working, for example by putting in place new governance arrangements to enable joint decision making and agreeing system-wide leadership arrangements
- strengthening collaborative relationships and trust between partner organisations and their leaders.

There is no blueprint for developing an ICS. In contrast to many previous attempts at NHS reform, national NHS bodies have so far adopted a relatively permissive approach, allowing the design and implementation of ICSs to be locally led within a broad national framework. As a result, there are significant differences in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working across systems. This approach leaves some uncertainty around what the end state of the changes will be, and variation across the country can make these reforms more difficult to understand. However, the advantage is that it enables systems to create arrangements that are suited to their local context and build on the strengths of their existing relationships and local leadership.

There is currently no statutory basis for ICSs. They are voluntary partnerships that rest on the willingness and commitment of organisations and leaders to work collaboratively. Progress has sometimes been achieved through workarounds to the current legislative framework; these workarounds can be complex and lead to duplication and protracted decision-making processes. Proposals have now been put forward to address this, and to improve transparency and accountability, by establishing ICSs as statutory bodies (*see* below (https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#legislative-change)).

Systems, places, neighbourhoods

A key premise of ICS policy, and a core feature of many of the systems that have been working as ICSs the longest, is that much of the activity to integrate care and improve population health will be driven by commissioners and providers collaborating over smaller geographies within ICSs (often referred to as ‘places’) and through teams delivering services working together on even smaller footprints (usually referred to as ‘neighbourhoods’). This is important as ICSs tend to cover large

geographical areas (typically a population of more than 1 million) so aren't well suited to designing or delivering changes in services to meet the distinctive needs and characteristics of local populations.

A three-tiered model of systems, places and neighbourhoods has been proposed by NHS England and NHS Improvement in their guidance on ICSs (https://www.england.nhs.uk/publication/designing-integrated-care-systems-icss-in-england/) (*see* box). While this model is an over-simplification of the diverse set of arrangements and contexts seen in reality, the terminology is now in widespread use within the NHS.

Guidance from NHS England and NHS Improvement on systems, places and neighbourhoods

Neighbourhoods (populations of around 30,000 to 50,000 people*): served by groups of GP practices working with NHS community services, social care and other providers to deliver more co-ordinated and proactive services, including through primary care networks (PCNs).

Places (populations of around 250,000 to 500,000 people*): served by a set of health and care providers in a town or district, connecting PCNs to broader services, including those provided by local councils, community hospitals or voluntary organisations.

Systems (populations of around 1 million to 3 million people*): in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

* Population sizes are variable – numbers vary from area to area, and may be larger or smaller than those presented here. Systems are adapting this model to suit their local contexts, for example some larger systems are operating an additional intermediate tier between place and system.

Map 2 An example of the places and neighbourhoods within an ICS


Map showing an example of places and neighbourhoods within an ICS. The map of the UK has one area highlighted in yellow, showing South Yorkshire and Bassetlaw ICS. A magnifying glass shows the five places that make up this ICS; Barnsely, Doncaster, Rotherham, Sheffield, and Bassetlaw. There are 36 local neighbourhoods within these places.

Examples of the sorts of activities that might sit at these different levels include:

- neighbourhoods – formation of PCNs; bolstering primary care services; developing multidisciplinary teams; delivering preventive interventions for people with complex care needs
- places – redesigning local services; joining up care pathways across NHS, local government and VCS services; supporting the development of PCNs; building relationships with communities
- systems – setting strategy; managing overall resources and performance; planning specialist services across larger footprints; strategic improvements to key system enablers such as digital infrastructure, estates and workforce planning

There is no simple answer for which activities should sit at which level due to wide variation in the scale and characteristics of local systems and places. In its recent guidance on ICSs (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) , NHS England and NHS Improvement did not define the exact division of roles and responsibilities between ICSs and their constituent places. Instead, it left freedom for this to be determined locally, indicating that decisions should be based on the principle of subsidiarity[1] (#footnote1_z3bergx) with systems taking responsibility only for things where there is a need to work at scale. ICSs are taking different approaches to guide these decisions, for example in West Yorkshire and Harrogate, three 'subsidiarity tests' have been agreed to determine whether something should be led by the wider system or by the local places within it.

The relationship between systems, places and neighbourhoods is explored in greater detail in our report *Developing place-based partnerships: the foundation of effective integrated care systems* (/publications/place-based-partnerships-integrated-care-systems) .

1. (#footnote1_z3bergx) The principle of subsidiarity is the idea that decisions should be made as close as possible to local communities.

The development of places and neighbourhoods

In many parts of the country, partnerships at place level have been forming over a number of years. For most areas, places will be based on local authority boundaries, but there may be some cases where other geographical footprints are deemed to provide a better basis for collaborative working. Place-based partnerships bring together a broad range of partners – including local government, NHS providers, voluntary and community sector organisations, social care providers and others – to join up the planning and delivery of services through a multi-agency approach and to address the social, economic, and wider health needs of their population. Experience suggests that much of the work involved in integrating care and improving population health will be driven through these more local partnerships. ICSs will be expected to delegate significant responsibilities and budgets to this level.

In many areas, partnerships at place level are referred to as integrated care partnerships (ICPs), however there are variations on this terminology, for example, in South East London ICS they are referred to as 'local care partnerships' (LCPs) and in Greater Manchester as 'local care organisations' (LCOs). These different acronyms reflect local preferences rather than differences in the work being done by the partnerships. Some are informal partnerships, while others have more formal arrangements underpinned by contractual mechanisms and/or pooled budgets.

At the neighbourhood level, all but a handful of GP practices in England have come together in around 1,300 geographical primary care networks (PCNs) (/publications/primary-care-networks-explained) covering populations of approximately 30–50,000 patients. This was encouraged by a new GP contract (/publications/202021-update-gp-contract-explained) that channels money for new staff directly to general practice via the newly formed PCNs. In their initial stages, most PCNs have been focused first

and foremost on building relationships between GP practices within their network and shoring up primary care provision. There are high expectations of what these new networks will do over time; they will be required to deliver a set of seven national service specifications, provide a wider range of services in primary care, use the skills of a greater range of professionals and work closely with other services in the community through multidisciplinary teams.

What does the future hold for ICSs?

It is intended that ICSs will become increasingly important over the coming months and years, with significant responsibilities for planning services and managing NHS resources, and providing the basis for collaboration across health and care organisations. In its recent document, *Integrating care: next steps to building strong and effective integrated care systems across England* (https://www.england.nhs.uk/integratedcare/integrated-care-systems/), NHS England and NHS Improvement set out its vision for the future landscape of the health and care system (/publications/next-steps-towards-integrated-care), outlining four interlocking elements: ICSs, places, provider collaboratives (*see* below) and the national and regional NHS bodies.

Legislative change

On 11 February 2021, the Department of Health and Social Care published the White Paper *Integration and innovation: working together to improve health and social care for all (https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version)*, which sets out legislative proposals for a health and care bill. For a full overview of the White Paper proposals, read our explainer *The health and social care White Paper explained* (/publications/health-social-care-white-paper-explained).

The proposals include a range of measures intended to support integration and collaboration. At the heart of the changes is a proposal to establish ICSs as statutory bodies in all parts of England. Under the proposals, a statutory ICS would be led by two related entities operating at system level – an 'ICS NHS body' and an 'ICS health and care partnership' – together, these will be referred to as the ICS.

- **The ICS NHS body** will be responsible for NHS strategic planning and allocation decisions, and accountable to NHS England for NHS spending and performance within its boundaries. Key responsibilities of the ICS NHS body will include:
    - securing the provision of health services to meet the needs of the population by taking on the commissioning functions that currently reside with clinical commissioning groups (CCGs) alongside some of those that currently reside with NHS England
    - developing a plan to meet the health needs of the population
    - setting out the strategic direction for the system
    - developing a capital plan for NHS providers within the geography.

It will be governed by a unitary board which will be directly accountable for NHS spend and performance. At a minimum, the board will include a chair, chief executive, representatives of NHS trusts, general practice and local authorities, and others to be determined locally. The chief executive will be the accountable officer for the NHS money allocated to the NHS ICS body.

- **The ICS health and care partnership** will be responsible for bringing together a wider set of system partners to promote partnership arrangements and develop a plan to address the broader health, public health and social care needs of the population (the ICS NHS body and local authorities will be required to 'have regard to' this plan when making decisions). Membership will be determined locally but alongside local government and NHS organisations is likely to include representatives of local VCS organisations, social care providers, housing providers, independent sector providers, and local Healthwatch organisations.

This dual structure is a new development. It attempts to overcome concerns that ICSs would struggle to act both as bodies responsible for NHS money and performance at the same time as acting as a wider system partnership. There are major questions about how this will work in practice, particularly how the two bodies will relate to one another and what dynamic will emerge between them.

The White Paper sets an expectation that place-based partnerships should form a central part of ICSs. However, arrangements at place level will not be given a legislative basis and local systems will be free to develop their own arrangements, building on existing partnerships where these are working well.

Overall, while the proposals set some core expectations regarding the form and functions of ICSs, providing some greater clarity over accountability and governance, they also deliberately avoid a prescriptive approach, leaving significant flexibility for areas to determine the best system arrangements for them. This means that much remains to be seen in terms of how the reforms are implemented locally.

Subject to the successful passage of a health and care bill through parliament, it is intended that these proposals will be implemented in April 2022.

What does this mean for commissioners?

The legislative proposals entail significant structural change for NHS commissioning. CCGs will be abolished, with their functions and most of their staff transferring into the ICS NHS body. It is also intended that ICSs will take on some of the commissioning responsibilities of NHS England within their boundaries (NHS England is currently responsible for directly commissioning some specialised services, such as neonatal services and treatments for rare cancers) giving local systems a greater say in how specialised commissioning budgets are spent in their area.

These shifts build on changes to commissioning (https://www.kingsfund.org.uk/publications/what-commissioning-and-how-it-changing) that have been underway for several years. Many CCGs have been working more closely together at a system level for some time through joint management structures or formal mergers, in line with the expectation set in the NHS Long Term Plan that there should 'typically' be a single CCG for each ICS. The number of CCGs has therefore fallen significantly in recent years.

At the same time, many CCGs have been working more closely with local councils at 'place' level to align and integrate commissioning for NHS and local authority services. There is a risk that the trend towards consolidation of NHS commissioning structures could undermine these arrangements. To counter this, some larger CCGs are already organising some of their functions across a system-wide footprint and other functions around place footprints, and it is likely that more systems will adopt similar approaches to facilitate joined-up service planning and resource management at place.

Over time, it is hoped that commissioning will become more strategic, focusing on the planning and funding of new models of integrated care rather than being based on annual contracting rounds.

What does this mean for providers?

Providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes for the communities they serve. While the functions and duties of NHS trusts and foundation trusts will remain largely unchanged under the proposed legislative reforms, they will also be expected to participate in multiple collaborative forums, including membership of the ICS NHS body and forming collaboratives with other providers at system and at place (*see* box). They will be bound by a new duty to collaborate with local partners and a shared duty to promote the triple aim of better health, better care and lower cost. The changes also erode some aspects of foundation trust autonomy; each ICS will be expected to develop a capital plan for the NHS providers within its footprint and the government will be given a new 'reserve' power to impose capital spending limits on individual, named foundation trusts that are not working to prioritise capital spending within their ICS.

Provider collaboratives are set to become a key part of the emerging arrangements in the NHS over the next few years.

These may take different forms and will vary in their scale and scope: some will be 'vertical' collaboratives involving primary, community, local acute, mental health and social care providers coming together to join up their services; others will be 'horizontal' collaboratives involving providers working together across a wide geography with other similar organisations to transform services and/or improve quality and efficiency. All NHS providers will need to join a provider collaborative, and individual providers may be involved in more than one.

Further guidance on the form and functions of provider collaboratives is expected later in 2021.

Providers are already playing a critical role in the changes underway in many systems, contributing to and/or leading work at ICS level to plan and transform services and improve system performance, and collaborating with other local providers (including those from outside the NHS) at place and neighbourhood levels to redesign care pathways and deliver more integrated services for local people. Payment models are also changing (/publications/payments-contracting-integrated-care), with many examples of providers and commissioners agreeing to move away from activity-based payments for acute services in favour of block or aligned-incentive contracts (https://www.hfma.org.uk/online-learning/bitesize-courses/detail/an-introduction-to-aligned-incentive-contracts).

Increasingly, commissioners and providers are working hand in hand to plan care for their populations. While distinct commissioning and provision responsibilities will technically remain in separate organisations under the proposed legislative changes, in practice the division will be blurred as providers will be represented on the ICS NHS body board.

What does this mean for local government?

The involvement of local government is essential for ICSs to be able to drive meaningful improvements in health and wellbeing. It can bring three key benefits. The first is the opportunity to join up health and social care at all levels in the system, creating better outcomes and a less fragmented experience for patients and users. The second is the potential to improve population health and wellbeing through the leadership of public health teams as well as NHS and local government acting together to address wider determinants of health such as housing, local planning and education. Finally, the involvement of local government can enhance transparency and accountability through supporting engagement with local communities and providing local democratic oversight.

Collaborating across the NHS and local government is not easy, and requires local leaders (including

NHS leaders as well as officers and elected members in local government) to better understand each other's challenges, to recognise and respect differences in governance, accountabilities, funding and performance regimes, and to find ways to manage these differences.

While the extent of engagement still varies widely, there is evidence that local government is playing a stronger role in ICSs than it did in the early days of STPs. In most cases, local authorities are part of the ICS board and/or other parts of the governance arrangements (this will become a requirement under the proposed legislative changes), and within some ICSs local government representatives are leading programmes and/or offering wider leadership as the ICS lead or independent chair. Health and wellbeing boards are often playing a key role in ICS governance (/publications/articles/health-wellbeing-boards-integrated-care-systems) , and there is a growing role for overview and scrutiny committees in some systems. As ICSs are established as statutory bodies, it will be important to ensure that their new responsibilities for NHS resources and performance don't crowd out wider system priorities and weaken the sense of equal partnership across the NHS and local government that many ICSs have worked hard to nurture.

Importantly, partnerships between local government and NHS organisations are also developing at the level of 'place', which is usually coterminous with local authority boundaries. It is often at this more local level that planning and services can be joined up most effectively, and it will therefore be essential to continue to foster and support place-based partnerships as ICSs develop.

What does this mean for oversight and regulation?

Despite the focus on collaboration and system-working in recent years, the primary focus of NHS regulators has continued to be on managing the performance of individual organisations. The interventions and behaviours of the regulators have sometimes made it more difficult for organisations to collaborate. To address this, the Care Quality Commission (CQC) has begun to test approaches to regulating systems, and NHS England and NHS Improvement has created seven joint regional teams bringing together the regulation of commissioners and providers. Over time, national and regional NHS bodies will be expected to shift their focus to regulating and overseeing systems of care (alongside their existing responsibilities in relation to individual organisations) increasingly working alongside local systems to support them to change and improve services. The recent White Paper includes proposals to create a 'system oversight framework (https://www.engage.england.nhs.uk/consultation/system-oversight-framework-2021-22/) ' and an 'integration index (/blog/2019/07/meaningful-measures-integration) ' to measure system performance, and suggests a formal merger between NHS England and NHS Improvement.

Why have some of these changes been controversial?

A number of concerns have been raised in relation to these developments. STPs received widespread criticism in their early stages for developing plans behind closed doors, failing to engage the public and key partners, and proposing unrealistic financial savings. The work of systems has moved on significantly since these early stages; there has been a focus on broadening communication and engagement in the work of STPs and ICSs, and many of the more controversial proposals contained in the 2016 plans (for example proposals to make financial savings and reduce hospital bed numbers) have been dropped (/publications/sustainability-transformation-partnerships-london) in recognition that some of their initial assumptions were unrealistic.

Concerns have also been raised in relation to the accountability and transparency of ICSs. As they are not currently statutory bodies, there have been no formal requirements around the governance of ICSs, and their role in local decision-making has not always been clear. Some systems have taken steps to address this by developing their governance structures, building in local democratic

oversight, meeting in public and publishing papers and information, however this remains highly variable and there is still some way to go. Placing ICSs on a statutory footing should lead to greater transparency and accountability.

Some controversy has arisen around whether these developments could open the door to privatisation of the NHS (/publications/articles/big-election-questions-nhs-privatised). Concerns were most prominent around the development of the integrated care provider contract (https://www.england.nhs.uk/integrated-care-provider-contract/) (a new contractual form allowing commissioners to award a long-term contract to a single organisation to provide a wide range of health and care services to a defined population), with campaigners arguing that this could lead to health and care services coming under the control of private companies. Two judicial reviews were brought against NHS England in relation to the contract, but both were dismissed. The NHS Long Term Plan subsequently set an expectation that integrated care provider contracts would be held by public statutory providers. In terms of the overall direction of these reforms, the emergence of stronger public sector partnerships and the erosion of market-based reforms are unlikely to lead to a larger role for private companies in delivering NHS services.

Where next?

The next year will be a critical period for the development of ICSs. To undertake the roles and responsibilities expected of them under the proposed changes to legislation, a concerted effort will be required to develop system-working, both in terms of formal structures and governance, and the capabilities and relationships required to support them to function effectively.

The King's Fund has worked over many years to understand and support the development of integrated care and place-based working, both through our research and policy work and the leadership and development support we offer to local health and care systems. This work points to a number of key areas that local and national leaders involved in the development of ICSs now need to focus on:

- ensuring the changes support genuine multiagency partnerships that span the NHS, local government, voluntary, community and social enterprise (VCSE) organisations and other partners, and that ICSs' new responsibilities for NHS resources and performance don't lead them to focus narrowly on the NHS in isolation
- finding ways to work more closely with and alongside local communities as key partners in shaping services and improving population health and wellbeing
- prioritising the reduction of health inequalities as a central focus of the ICS agenda, drawing on the widest possible range of levers to support these efforts
- establishing how the proposed new structures will work in practice, and how they will relate to one another, for example:
    - the relationship between the ICS NHS body board and the ICS health and care partnership board, including what each will focus on and the balance of power and influence between them
    - the development of provider collaboratives, and how they will work with ICSs and place-based partnerships
    - the relationship between ICSs and their constituent places, including how ambitions to delegate resources and decision-making to place can be realised
- focusing on strengthening the development of place-based partnerships and PCNs, with ICSs building up from these more local partnerships rather than becoming overly distracted by national asks
- developing clear lines of accountability and transparency around how and where decisions are made, while continuing to allow flexibility for locally led change
- continuing to align oversight and regulation more closely behind the work of systems, prioritising the cultural and behavioural changes needed to support this.

A key challenge for those involved in ICSs will be to drive these changes while also dealing with the challenge of restoring and recovering services in the wake of Covid-19. ICSs and the place-based partnerships within them could play a critical role in these efforts, particularly in tackling the deep health inequalities exposed and exacerbated by the pandemic.

The proposed legislative changes will need to be implemented carefully to avoid the disruption of a top-down reorganisation, with an approach that supports incremental, locally led change. It will also be important to recognise the limitations of what legislative change can achieve; while it may help to remove some barriers to collaboration, it will not deliver the changes in behaviour that are needed to fully harness the potential benefits of system-working. The focus should continue to be on developing new collaborative ways of working between leaders and teams at all levels of the health and care system.

Finally, evidence from previous attempts to integrate care indicates that these changes will take time to deliver results. This means that local and national leaders need to make a long-term commitment to the development of ICSs and avoid the past mistake of moving swiftly to the next reorganisation if desired outcomes are not rapidly achieved.

Related content

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By Anna Charles et al - 20 April 2021
(/publications/place-based-partnerships-integrated-care-systems)

The next steps towards integrated care

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By Richard Murray et al - 9 December 2020 11-minute read
(/publications/next-steps-towards-integrated-care)

The health and social care White Paper explained

In February 2021, the Department of Health and Social Care published a White Paper setting out legislative proposals for a health and care Bill. Here, we consider the proposals and what they might mean for the health and care system in England.
By Helen McKenna - 9 March 2021 21-minute read
(/publications/health-social-care-white-paper-explained)

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By Richard Murray - 9 December 2020 6-minute read
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Integrated care systems in London: Challenges and opportunities ahead

Commissioned by the Greater London Authority, this report looks at how the five integrated care systems in London were developing before Covid-19 and how this has changed as a result of the response to the pandemic.
By Anna Charles et al - 22 February 2021
(/publications/integrated-care-systems-london)

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