The King's Fund

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

19 August 2022
12 comments

Authors

Anna Charles

This explainer was originally published on 9 April 2020. It was updated on 19 August 2022.

Contents

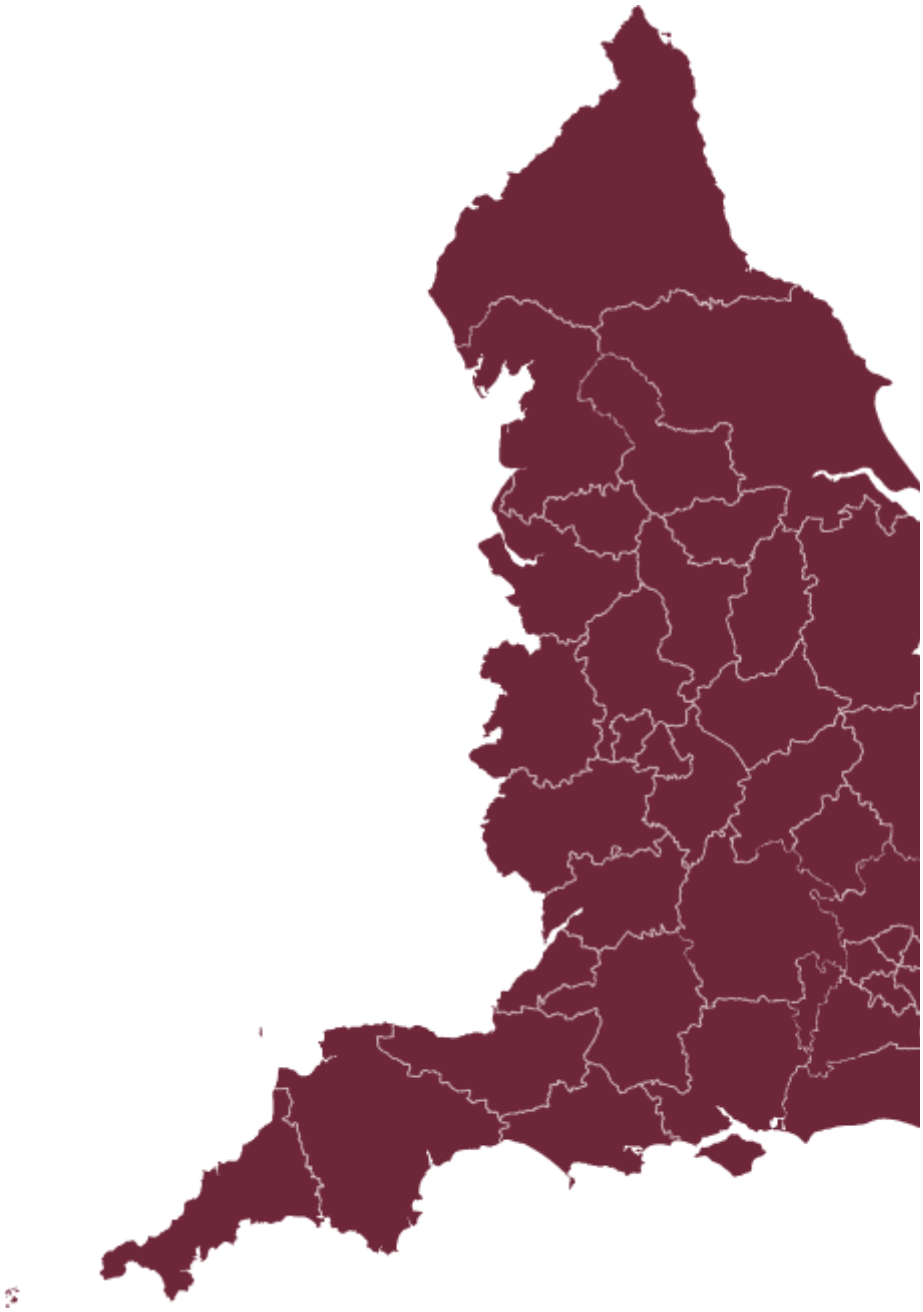
What are integrated care systems?

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.

There are 42 ICSs across England, covering populations of around 500,000 to 3 million people.

Map 1: The 42 integrated care systems in England

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



Source: © Crown copyright and database right 2020 • Created with Datawrapper

ICSs have existed in one form or another since 2016, but for most of this time have operated as informal partnerships using soft power and influence to achieve their objectives. Following the passage of the 2022 Health and Care Act, ICSs were formalised as legal entities with statutory powers and responsibilities. Statutory ICSs comprise two key components:

- **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area
- **integrated care partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

Working through their ICB and ICP, ICSs have four key aims (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) :

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

ICSs are the centrepiece of the reforms introduced through the 2022 Health and Care Act and are part of a fundamental shift in the way the English 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.

Why are ICSs needed?

When the NHS was set up it was primarily focused on treating single conditions or illnesses, but since then the health and care needs of the population have changed. People are living longer with multiple, complex, long-term conditions and increasingly require long-term support from many different services and professionals. As a consequence, people too often receive fragmented care from services that are not effectively co-ordinated around their needs. This can negatively impact (https://www.gov.uk/government/publications/integrated-care) their experiences, lead to poorer outcomes and create duplication and inefficiency. To deliver joined-up support that better meets the needs of the population, different parts of the NHS (including hospitals, primary care and community and mental health services) and health and social care need to work in a much more joined-up way. ICSs are the latest in a long line of initiatives (https://www.nao.org.uk/report/health-and-social-care-integration/) aiming to integrate care.

As argued in The King's Fund's vision for population health (/publications/vision-population-health) , an integrated health and care system is just one of the four pillars of a population health system (https://www.kingsfund.org.uk/publications/vision-

population-health#what-is-population-health) . Evidence (https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on) 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 have the greatest impact on health and wellbeing. Health inequalities (/publications/what-are-health-inequalities) are wide and growing but they are not inevitable, as evidence shows (/blog/2017/08/reducing-inequalities-health-towards-brave-old-world) that a concerted approach, combining the NHS and wider policies to address the social and economic causes of poor health, can make a difference. ICSs therefore also have a critical role to play in driving forward efforts to improve population health and tackle inequalities in their local areas. These goals are clearly set out in the four functions of ICSs (see above), and the new Triple Aim for NHS bodies (which was amended to specifically include consideration of inequalities).

The triple aim is a legal duty on NHS bodies which requires them to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities in that health and wellbeing)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both themselves and other relevant bodies.

To meet these objectives, ICSs need to reach beyond the NHS to bring together local authorities, VCSE organisations and other local partners.

These are complex reforms, and it is vital that they are underpinned by a clear narrative describing how they will benefit patients, service users and communities. Working alongside National Voices, Age UK and the Richmond Group of charities, The King's Fund has developed a joint vision (https://www.nationalvoices.org.uk/sites/default/files/public/publications/reform_for_people_-_a_joint_vision_for_integrating_care_0.pdf) that sets out what integrated care and partnership working could mean for people and communities. It will be important for ICSs to not lose sight of these core objectives, and to find ways to hear from local communities (/publications/understanding-integration-listen-people-communities) and involve them (/projects/lessons-wigan-deal) directly in their work.

Where did ICSs come from?

ICSs have been developing for several years. They evolved from sustainability and transformation plans/partnerships (STPs) (/topics/integrated-care/sustainability-transformation-plans-explained) – geographical groupings of health and care organisations formed in 2016 to develop 'place-based plans' for the future of health and care services in their areas. Since then, local systems have been strengthening these partnerships (/publications/year-integrated-care-systems) and working through them to plan and improve health and care.

Over recent years, the work of ICSs (and before them 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 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, workforce 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.

Until July 2022, there was no statutory basis for these arrangements. STPs and ICSs were voluntary partnerships that rested on the willingness and commitment of organisations and leaders to work collaboratively. This meant that progress sometimes had to be made through workarounds to the legislative framework, creating complex and protracted decision-making processes and leading to concerns around transparency and accountability. This has all changed with the 2022 Health and Care Act and the establishment of ICSs as legal entities. However, it is also important to recognise the limitations of what this legislation can realistically achieve. It is not possible to legislate for collaboration and co-ordination of local services; this requires changes to behaviours, attitudes and relationships among staff and leaders right across the system.

In contrast to previous attempts at NHS reform, national NHS bodies have 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 (https://www.health.org.uk/publications/long-reads/integrated-

care-systems-what-do-they-look-like) in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working. The statutory requirements for ICSs have created greater consistency in their governance arrangements and responsibilities, but still leave significant flexibility for systems to determine their own arrangements. This means that much remains to be seen in terms of how the reforms are implemented locally.

Variation in how ICSs have developed means they can be complex and difficult to understand. But systems of care and the health needs of local populations are themselves complex in ways that don't lend themselves to simplicity and standardisation. The flexibility ICSs have been given has the advantage of enabling them to develop arrangements to suit their local contexts, respond to population needs and build on their existing strengths, and could help to engender a greater sense of local ownership of and commitment to the changes than in previous NHS restructures.

What do ICSs look like?

How ICSs are structured

As set out above, statutory ICSs include two key parts: an ICB and an ICP. This section sets out further detail on each of these structures and the interface between them.

Integrated care boards (ICBs)

The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by clinical commissioning groups (CCGs) and some of the direct commissioning functions of NHS England. The ICB is directly accountable (/publications/understanding-accountabilities-structures-health-care) to NHS England for NHS spend and performance within the system. ICBs may choose to exercise their functions through delegating them to place-based committees (see below) but the ICB remains formally accountable.

Each ICB must prepare a five-year system plan setting out how they will meet the health needs of their population. In developing this plan and carrying out their work, the ICB must have regard to their partner ICP's integrated care strategy and be informed by the joint health and wellbeing strategies published by the health and wellbeing boards in their area (https://www.gov.uk/government/publications/joint-strategic-needs-assessment-and-joint-health-and-wellbeing-strategies-explained) . In addition, the ICB and its partner NHS trusts and foundation trusts must develop a joint plan for capital spending

(spending on buildings, infrastructure and equipment) for providers within the geography.

The ICB operates as a unitary board, with membership including (at a minimum); a chair, chief executive officer, and at least three other members drawn from NHS trusts and foundation trusts, general practice and local authorities in the area. In addition, at least one member must have knowledge and expertise in mental health services. ICBs have discretion to decide on additional members locally. Each ICB must also ensure that patients and communities are involved in the planning and commissioning of services.

ICBs must not appoint any individuals to their board whose membership could reasonably be regarded as undermining the independence of the health service. This requirement is intended to ensure that private sector organisations do not exert undue influence and that their participation is to the benefit of the system, reflecting sensitivities around private sector involvement in the NHS.

Integrated care partnerships (ICPs)

The ICP is a statutory joint committee of the ICB and local authorities in the area. It brings together a broad set of system partners to support partnership working and develop an 'integrated care strategy', a plan to address the wider health care, public health and social care needs of the population. This strategy must build on local joint strategic needs assessments and health and wellbeing strategies and must be developed with the involvement of local communities and Healthwatch. The ICB is required to have regard to this plan when making decisions.

There is significant flexibility for ICPs to determine their own arrangements, including their membership and ways of working. Membership must include one member appointed by the ICB, one member appointed by each of the relevant local authorities, and others to be determined locally. This may include social care providers, public health, Healthwatch, VCSE organisations and others such as local housing or education providers.

Take a look at our diagram (/node/94444) illustrating the structure of integrated care systems and other key local planning and partnership bodies.

This dual structure was designed to support ICSs to act both as bodies responsible for NHS money and performance at the same time as acting as a wider system partnership. It remains to be seen how this will work in practice,

including how the two bodies will relate to one another and what dynamic will emerge between them. For example, it may be difficult for ICPs to have real clout in the system and drive the agenda of their ICS when much of the resource and formal accountabilities sit with the ICB.

Some systems are further ahead (https://www.wypartnership.co.uk/application/files/9916/5729/3814/West_Yorkshire_functions_ar in embedding these arrangements than others, and in many cases the formation of the ICP lagged behind (https://www.hsj.co.uk/policy-and-regulation/boards-responsible-for-integration-strategy-unlikely-to-be-fully-operational-before-autumn-2022/7030956.article) the initial establishment of the ICB (which was held to tighter deadlines due to the legislative timetable).

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, improve population health and tackle inequalities 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 people) so aren't well suited to designing or delivering changes in services to meet the distinctive needs and characteristics of local populations.

This three-tiered model of neighbourhoods, places and systems is an over-simplification of the diverse set of arrangements seen in reality, but the terminology is now in widespread use within the health and care system. National policy (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) and guidance (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/) has made it clear that ICSs will be expected to work through these smaller geographies within their footprints.

An overview of neighbourhoods, places and systems

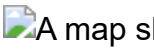
Neighbourhoods (covering populations of around 30,000 to 50,000 people*): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (/node/93397) (PCNs) and multi-agency neighbourhood teams.

Places (covering populations of around 250,000 to 500,000 people*): where partnerships of health and care organisations in a town or district – including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.

Systems (covering populations of around 500,000 to 3 million people*): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.

* 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 have an additional intermediate tier between place and system.

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

 A map showing South Yorkshire and Bassetlaw ICS, with five places, and 36 nieghbourhoods.

There is no simple answer for which activities should sit at which level due to wide variation in the scale and characteristics of local areas. As a consequence, the exact division of roles and responsibilities between ICSs and their constituent places and neighbourhoods has not been laid out in legislation or guidance. Instead, there is freedom for this to be determined locally with an expectation that decisions should be based on the principle of subsidiarity , meaning ICSs will take responsibility only for things where there is a need to work at scale. Local systems are taking different approaches to applying this principle, for example West Yorkshire ICS has agreed three ‘subsidiarity tests (https://www.wypartnership.co.uk/application/files/6716/5703/3676/NHS_West_Yorkshire_ICB_C ’ to determine whether something should be led by the wider system or by the local places within it.

ICSs will be expected to delegate significant responsibilities and budgets to place-based partnerships, as stressed by the government’s integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) and the guidance document *Thriving places* (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf) . The 2022 Health and Care Act

made provision for the formation of place-based committees (which can be established as subcommittees of the ICB) but left flexibility for local areas to determine how these should be formed and how they will operate. Outside of the legislation, the recent integration White Paper set out a greater degree of formality and national oversight of these arrangements, and outlined plans to introduce minimum expectations around place-level governance, leadership arrangements and a new shared outcomes framework from April 2023.

For more detail on the formation of place-based partnerships, and the relationship between place and system, see our report, *Developing place-based partnerships (/publications/place-based-partnerships-integrated-care-systems)*.

What does this mean for commissioning?

The 2022 Health and Care Act entailed significant structural change for NHS commissioning. CCGs were abolished, with their functions and many of their staff transferred into ICBs. ICBs have also taken on some commissioning responsibilities from NHS England (https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-letter-roadmap-for-all-direct-commissioning-functions-may-2022.pdf), including the commissioning of primary care and some specialised services (with a plan (https://www.england.nhs.uk/publication/nhs-england-commissioning-functions-for-delegation-to-integrated-care-systems/) for further delegation over time), giving local systems a greater say in how budgets for these services are spent in their area.

These shifts build on changes to commissioning (/publications/what-commissioning-and-how-it-changing) that have been underway for several years. Before their abolition, many CCGs had been working more closely together at a system level through joint management structures or formal mergers and the number of CCGs had fallen significantly. At the same time, many CCGs were working more closely with local councils at 'place' level to align and integrate commissioning for NHS and local authority services, and some larger CCGs were organising some of their functions across a system-wide footprint and other functions around place footprints.

The legislation has also changed procurement and competition requirements, removing the requirement for mandatory competitive retendering (supported by a new provider selection regime, due to be implemented by December 2022).

This is all part of a shift towards strategic commissioning (/publications/thinking-differently-commissioning) and a more collaborative approach to planning and improving services. This means that, instead of focusing on procurement and

contract management, the role of commissioners is to work closely with key partners across the system (including with providers) to understand population needs, determine key priorities and design, plan and resource services to meet those needs.

What does this mean for NHS providers?

NHS providers are increasingly being expected to look beyond their organisational priorities to focus on system-wide objectives and improving outcomes and reducing inequalities for the communities they serve. While the legal functions and duties of NHS trusts and foundation trusts remain largely unchanged under the recent reforms, they are also expected to participate in multiple collaborative forums, including membership of the ICB and forming collaboratives with other providers (/publications/provider-collaboratives) . NHS trusts and foundation trusts are also now bound by a new duty to collaborate with local partners and a shared duty to promote the triple aim (see above).

NHS 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.

The policy intention is that commissioners and providers should increasingly be working hand in hand to plan care for their populations. While distinct commissioning and provision responsibilities still formally sit in separate organisations, in practice the division is becoming increasingly blurred (for example, as providers are represented on the ICB). Fundamentally, a key principle in the reforms is that providers are part of the ICS – just as much as the ICB and ICP are – and as such they are being asked to take on wider responsibilities for the performance of the whole system.

What does this mean for local government?

Since ICSs first began developing in 2016, the involvement of local government has varied widely (/publications/articles/health-wellbeing-boards-integrated-care-systems) . The King's Fund has argued (/publications/year-integrated-care-systems) that, for ICSs to succeed, they will need to function as equal partnerships with local government not just involved but jointly driving the agenda alongside the NHS and other key partners. Importantly, partnerships between local government

and NHS organisations are also developing at the level of 'place', which is usually coterminous with local authority boundaries.

The involvement of local government in ICSs and place-based partnerships 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 and tackle inequalities 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.

Within the new statutory ICS structures, the involvement of local government has been formalised through the ICP and through the direct representation of local authorities on the ICB. In addition, ICSs must draw on the joint health and wellbeing strategies of their local health and wellbeing boards in producing their integrated care strategies and five-year system plans.

However, now that ICBs have significant NHS budgets and responsibilities, there is a risk of their focus on NHS resources and performance crowding out wider system priorities and undermining the sense of equal partnership many systems have worked hard to nurture. This is already causing tensions between the NHS and local government (https://www.hsj.co.uk/integrated-care/icss-are-an-nhs-steamroller-says-disrespected-council-leader/7032734.article) in some areas.

What does this mean for VCSE organisations?

VCSE organisations play a critical role within local health and care systems both as service providers and as vehicles for community engagement and voice. They are therefore important strategic partners for ICSs in terms of delivering improvements in health and wellbeing and reducing inequalities – which often involves working more closely with communities.

The involvement of VCSE organisations within formal ICS structures is open to local determination, but national guidance (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf) has set clear expectations that they should be involved both within the governance structures (for example, through membership of the ICP) and in delivering key workstreams.

Resource constraints and the diversity of the sector can both act as barriers to the participation of VCSE organisations, and their involvement in shaping priorities, plans and decisions at system level remains limited in many cases. In some systems, VCSE alliances or infrastructure organisations are playing an important role in bridging this gap, while other ICSs have identified funding for a dedicated post or function. Importantly, VCSE organisations also have an important role at place and neighbourhood levels.

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. 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.

In line with this ambition, NHS England is developing a new operating model. This will build on changes that have already been made to the work of its national and regional teams (including bringing together the regulation of commissioners and providers through the merger of NHS England and NHS Improvement). A new integration index (/blog/2019/07/meaningful-measures-integration) is also under development to better measure the success of efforts to integrate care from the perspective of patients, carers and the public.

At the same time, the CQC is adapting its approach to monitoring and inspection to better reflect system working. The 2022 Health and Care Act introduced a duty on the CQC to review health care and adult social care in each ICB, including looking at how partners in the ICS are working together.

How will we know if ICSs are working?

ICSs will be accountable nationally to NHS England, via their ICB, for NHS spending and performance. They will be expected to achieve financial balance and to meet national requirements and performance targets.

In addition to these national accountabilities, ICSs also have the potential to nurture different forms of oversight to drive local improvements in care. This is

because ICSs are partnerships in which local organisations exercise collective leadership and work towards developing a sense of mutual accountability for resource use and outcomes. This may take the form of peer challenge and support from partners within an ICS, drawing on local data on performance and outcomes.

Importantly, to really understand whether their work is making a difference, ICSs will need to use insights from local people including patients, service users and families. As we have argued in previous work (/publications/understanding-integration-listen-people-communities) , the best way to understand whether integration is delivering results is through the eyes of people using services.

Where next?

The coming months will be a critical period for the development of ICSs as they begin operating as statutory bodies. Ultimately, whether or not these reforms succeed will come down to how they are implemented locally, and whether the right national conditions can be created to support their work.

It won't be easy to find the bandwidth to do the hard work of changing ways of working (/blog/2022/03/integrated-care-systems-need-to-be-different) at a time when health and care services are under such pressure, and there is a risk (/blog/2022/07/are-ics-getting-right-start) that established ways of working will be recreated within the new structures. To avoid this, ICSs will need to keep sight of their core objectives and the ethos of system working behind their development.

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

How does the NHS in England work and how is it changing?

Watch our animation to discover the key organisations that make up the NHS and how they can collaborate with partners in the health and care system to deliver joined-up care.
Duration - 5 mins
(/audio-video/how-does-nhs-in-england-work)

Integrated care systems: how will they work under the Health and Care Act?

We've developed a diagram to show how integrated care systems will work under the Health and Care Act.
(/audio-video/integrated-care-systems-health-and-care-act)

Building collaborative leadership across health and care organisations

Develop the skills and behaviours required to work with local leaders to redesign health and care systems.
Start date: 6-7 December 2022
Duration: Four modules
(/courses/building-collaborative-leadership)

Integrated care in practice: realising the potential of integrated care systems

7 - 10 November 2022 - Virtual conference
(/events/integrated-care-practice)

Developing place-based partnerships: The foundation of effective integrated care systems

This report considers the potential of place-based partnerships to improve population health and support truly integrated care, and highlights principles to guide their development and the support they might need from national and regional leaders.
By Anna Charles et al - 20 April 2021
(/publications/place-based-partnerships-integrated-care-systems)

Integrated care: our position

()

Joined-up care: Sam's story

Why does integrated care matter? And what does it mean for patients? This short animation brings integrated care to life.
Duration - 3 mins
(/audio-video/joined-care-sams-story)

The Health and Care Act 2022: the challenges and opportunities that lie ahead

Now the Health and Care Act has been passed, Richard Murray reflects on the negotiations that went down to the wire, what didn't make it and what's needed to ensure the reforms are successful.

By Richard Murray - 3 May 2022 4-minute read

(/blog/2022/05/health-and-care-act-2022-challenges-and-opportunities)