

# Integrated care systems: what do they look like?

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# Contents

Key points	3
1. Introduction	4
2. Our approach	6
3. Integrated care system structure and context	7
4. Implications for policy	18
Supporting information	20

## Key points

- Integrated care systems (ICSs) are the centrepiece of the biggest legislative overhaul of the NHS in a decade. From July 2022, England will be formally divided into 42 area-based ICSs, covering populations of around 500,000 to 3 million people.
- ICSs face a mammoth task. Staffing shortages in the NHS are chronic, health and care services are under extreme strain, and health inequalities are wide and growing. This long read presents analysis of publicly available data on some of the characteristics of ICSs and policy context in each area. We outline some of the challenges facing ICSs and reflect on the implications for national policy.
- The task facing ICSs is not equal. Pressures on services and the health of the population vary widely between ICSs – as do the resources available to address them. ICSs also look very different in their size, complexity and other characteristics that will shape how they function and their ability to collaborate to improve services.
- National policy on ICSs must acknowledge this variation and be realistic about what different areas can achieve. Differences in local context should be reflected in how ICS performance is assessed and reported. Policymakers must target support for ICSs with different needs, and some areas will likely require additional resources to help deliver national policy objectives.

# 1. Introduction

The NHS in England is about to be reorganised. In April 2022, government passed the Health and Care Act 2022 – the biggest legislative overhaul of the NHS in a decade. The Act is based on the idea that collaboration – between hospitals, GPs, social care, and others – is needed to improve local services and make the best use of public money. The legislation undoes many of the changes made by the Coalition government in the last round of major NHS reforms in 2012.

The centrepiece of the legislation are integrated care systems (ICSs) – area-based agencies responsible for planning local services to improve health and reduce inequalities (Box 1). From July 2022, England will be formally divided into 42 ICSs, covering populations of around 500,000 to 3 million people. ICSs have existed informally since 2016, but – until now – lacked formal powers.

ICSs face a mammoth task. Staffing shortages in the NHS are chronic,<sup>1</sup> record numbers of people are waiting for routine hospital treatment,<sup>2</sup> and health inequalities in England are wide and growing.<sup>3</sup> But these challenges are not evenly distributed between ICSs – and some systems are better equipped to deal with them than others. Policymakers have allowed some flexibility in how local systems have been developed and organised, which means they vary widely in size, structure, and other characteristics.

In this long read we analyse publicly available data on some of the characteristics of ICSs and context in each area – including the organisational and policy context, health challenges, and capacity within the health care system to address them. We compare areas and discuss implications for policy.

## Box 1: Structure of the new health system in England

From July 2022, integrated care systems (ICSs) will become the new intermediate tier of the health system in England. ICSs have been given four broad aims by national policymakers, including to:

- improve outcomes in population health and health care
- tackle inequalities in outcomes, experience and access to services
- enhance productivity and value for money
- help the NHS support broader social and economic development.<sup>4</sup>

Each ICS will be made up of two new bodies. Integrated care boards (ICBs) will be responsible for controlling most NHS resources and planning health care services in their area, taking on the functions previously held by clinical commissioning groups (which will be scrapped under the changes). Each board will be joined by an integrated care partnership (ICP): a looser collaboration of NHS, local government, and other agencies, responsible for developing an ‘integrated care strategy’ to guide local decisions.<sup>5</sup> ICBs have been asked to produce 5-year strategic plans by March 2023, with each ICP due to publish an interim integrated care strategy in December 2022 ‘if it wishes to influence’ the ICB’s plan.<sup>6</sup>

Within each ICS, NHS organisations will work with local authorities and others to plan and deliver services at ‘place’ level.<sup>7</sup> ‘Places’ have no firm boundaries and will be defined according to ‘what is meaningful to local people’ – often based around existing local authority areas. There is an expectation that some budgets and decision making will be delegated to agencies at this ‘place’ level.

Alongside these partnerships, NHS providers will also need to work together in provider collaboratives.<sup>8</sup> These may be ‘vertical’ collaboratives – for instance, including primary, community, mental health, and acute hospital services in a particular area – or ‘horizontal’ – which might include multiple hospitals providing specialist services across larger geographical areas.

## 2. Our approach

We use publicly available data to describe the basic characteristics of ICSs and key health challenges in each area. We describe data in five domains: ICS organisational and policy context, population health and inequalities, integrating services, elective care, and workforce. The objectives of ICSs are broad and we only cover a small number of indicators related to the new systems. As a result, we do not provide a comprehensive picture of the context for ICSs in England and the challenges they face.

We selected relevant indicators in each domain and used the most recent data available to illustrate how the context for ICSs vary as close as possible to their time of launch. Our analysis is based on the ICS boundaries that will take effect from July 2022. The indicators we chose were limited to those available at the ICS-level or that could be aggregated to ICS level (for instance, through aggregating data from clinical commissioning groups or lower layer super output areas (LSOAs) – small areas covering around 1,500 people). This meant we could not include some indicators, such as healthy life expectancy or workforce vacancies. See appendix 2 for more detail on these data and rationale for indicator selection.

### 3. Integrated care system structure and context

#### ICSs vary widely in structure and complexity

The average population covered by an ICS is around 1.5 million people. But the range is large: the smallest covers a population of just over 500,000, while the largest covers more than 3 million people (Figure 1). New ICBs will be responsible for managing most health care resources in each area. But many other organisations – local authorities, NHS trusts, general practices, and others – often with powerful interests, will be involved in local planning and decision making.

Bigger ICSs tend to involve more health and care organisations. For example, some systems cover more than 10 upper-tier local authorities – responsible for social care, public health, and other services – while others cover just one. Bigger ICSs are also likely to involve more ‘places’, which will involve additional governance and infrastructure (such as more local committees).

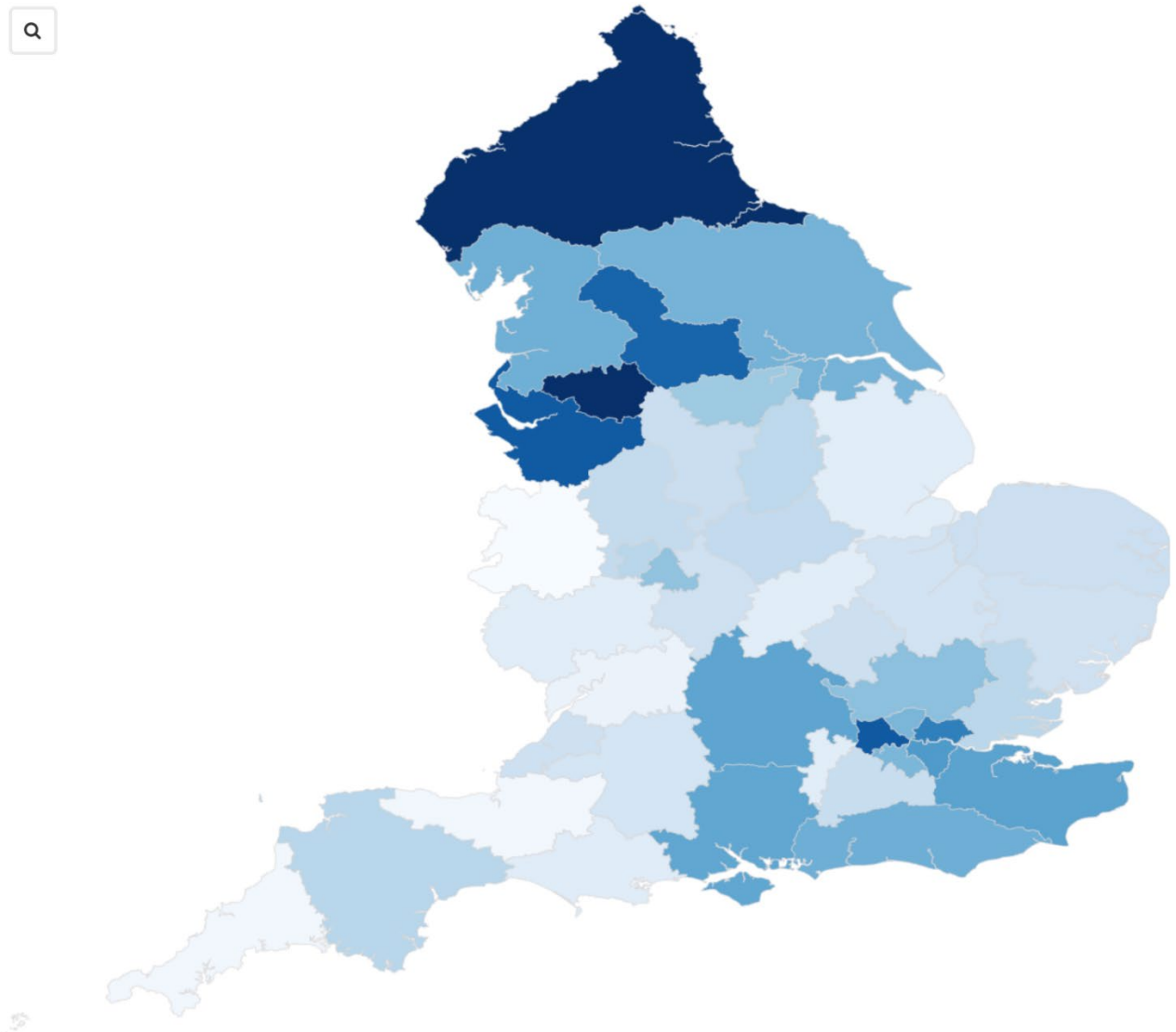
The complexity of the organisational landscape within each ICS is likely to affect how the system functions – for example, by making it easier or harder to make decisions and implement service changes. Differences in governance and decision making between organisations – for instance, between the NHS and local government – can hold back partnership working.<sup>9</sup> And evidence from past integrated care initiatives in England suggests that having fewer participating organisations – ideally with similar geographical boundaries – can help facilitate faster progress.<sup>10</sup>

The historical context in each ICS will also have a strong influence on how local agencies work together.<sup>99</sup> For example, the existing relationships between hospitals, GPs, and other agencies – good or bad – will shape how ICSs develop. Some parts of the country may have a head start through their involvement in previous policy initiatives on integrated care (see appendix 1). West Yorkshire and Harrogate, for example, has a relatively high concentration of areas involved in recent policy initiatives on integrated care – including new care model ‘vanguards’ and integrated care ‘pioneers’. The experience of working together in previous versions of ICSs will also make a difference – and national NHS bodies established ICSs in waves depending on their perceived ‘maturity’.

**Figure 1**

The size of the population that each ICS covers varies, ranging from 520,000 to 3.1 million  
Projected populations for each ICS in 2022/23

521,391  3,146,943



**Source:** NHS England, Allocation of resources 2022/23



## Some ICSs have a high concentration of deprivation

National policymakers are emphasising the need to prioritise action on reducing inequalities. ICSs have been tasked with leading efforts to identify and reduce health inequalities in their area, alongside broad objectives to improve population health and contribute to social and economic development.<sup>11</sup>

To help guide action, NHS England has developed an approach – known as ‘Core20PLUS5’ – that focuses on reducing inequalities by targeting efforts at people living in the 20% most deprived areas (defined using the Index of Multiple Deprivation).<sup>12</sup> Mapping how this target population is distributed between ICSs paints a stark picture (Figure 2). Less than 1% of neighbourhoods in Surrey Heartlands are in the most deprived fifth of the neighbourhoods nationally, compared with nearly 50% in Birmingham and Solihull. Wide inequalities in health outcomes between ICSs are also clear: rates of cancer mortality among those younger than 75 vary from 60 to 146 per 100,000 of the population.

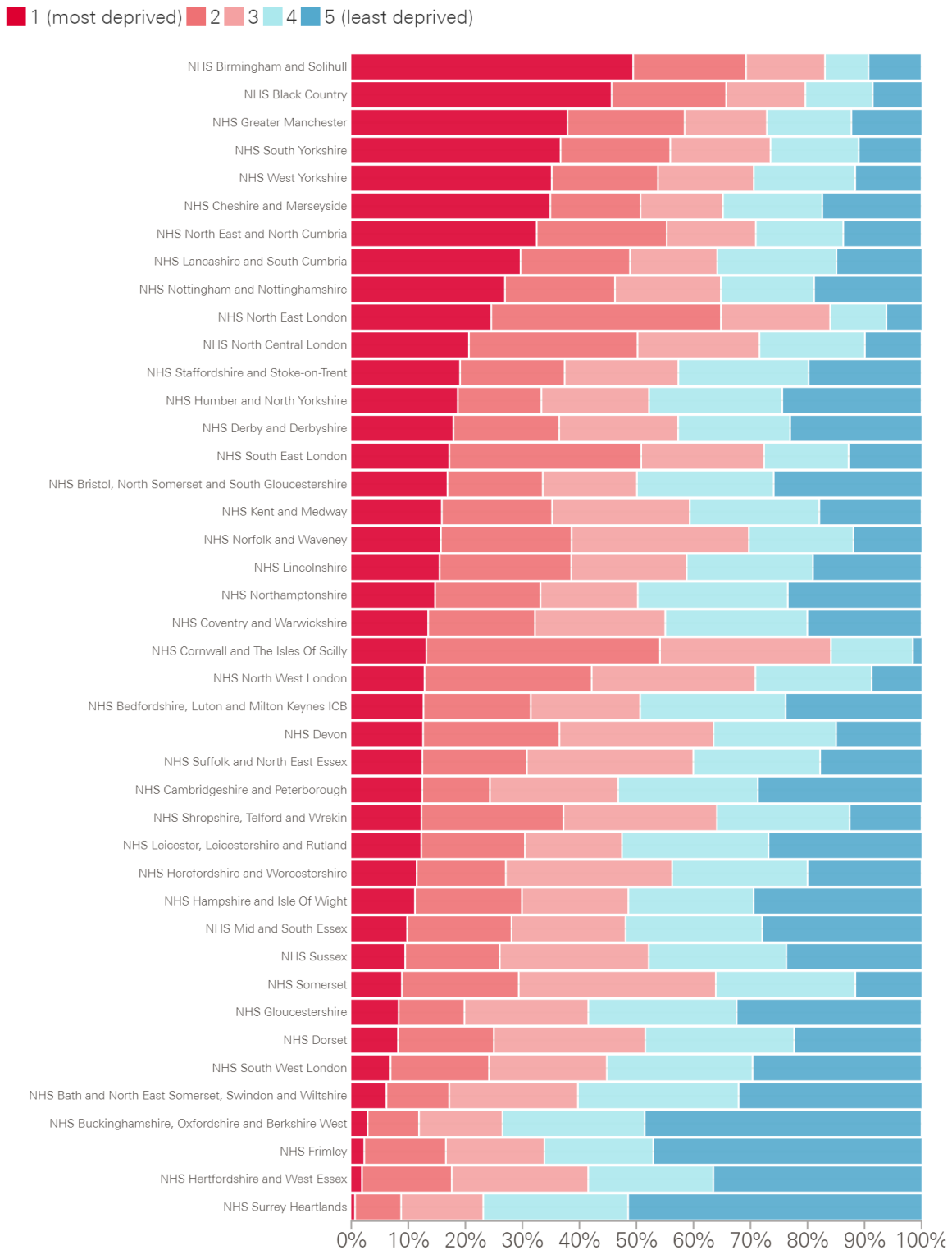
Systems with similar patterns of deprivation may pursue common approaches (see Figure 2). This includes areas with a relatively high concentration of more deprived neighbourhoods (eg Greater Manchester or South Yorkshire), and those with relatively few neighbourhoods in the most deprived group (eg Hertfordshire and West Essex, or Frimley). Other areas – such as Staffordshire and Stoke-on-Trent, or Bristol, North Somerset and South Gloucestershire – have a more even spread across deprivation levels. And some have a higher proportion of neighbourhoods close to average levels of deprivation – including Somerset, and North West London. Variation within areas is also significant.<sup>13</sup>

Previous versions of ICSs were often dominated by NHS agencies and limited in their approaches to reducing inequalities.<sup>14,15</sup> The NHS has an important role to play in ensuring equitable access to health care services. But ICBs and other NHS agencies will need to work closely with local government and other partners to address wider factors that shape health and health inequalities, such as employment, housing, and education. Making partnerships work is challenging and depends on a mix of factors, such as governance and leadership, resources and capabilities, cultures and relationships, and more.<sup>9</sup>

**Figure 2**

## ICSs cover areas with varying levels of deprivation

The percentage of neighbourhoods (LSOAs) in each deprivation quintile in each ICS



**Source:** Ministry of Housing, Communities & Local Government, English indices of deprivation 2019

## Potentially avoidable hospital admissions vary between and within systems

Closer integration of health and social care services is a longstanding policy objective in England. A series of policy initiatives have been developed that aim to strengthen services in the community and increase focus on disease prevention – for instance, by encouraging GPs, social care, mental health services and others to provide more coordinated care outside hospitals. ICSs will now be responsible for leading integration of services for people living in their area – and local agencies will work together to develop an ‘integrated care strategy’ to guide decision making.

Integrated care is hard to define and measure – and ambitions for what it could achieve are often broad and vague. But policymakers in the NHS have typically hoped that integrating services may reduce potentially avoidable admissions to hospital. Rates of unplanned hospital admissions for people with ambulatory care sensitive conditions – such as asthma, where effective management in the community can help prevent hospital admission – vary widely between ICSs (Figure 3). So do rates of emergency admissions for people with acute conditions who would not usually require a hospital admission, as well as readmissions to hospital within 30 days of being discharged.

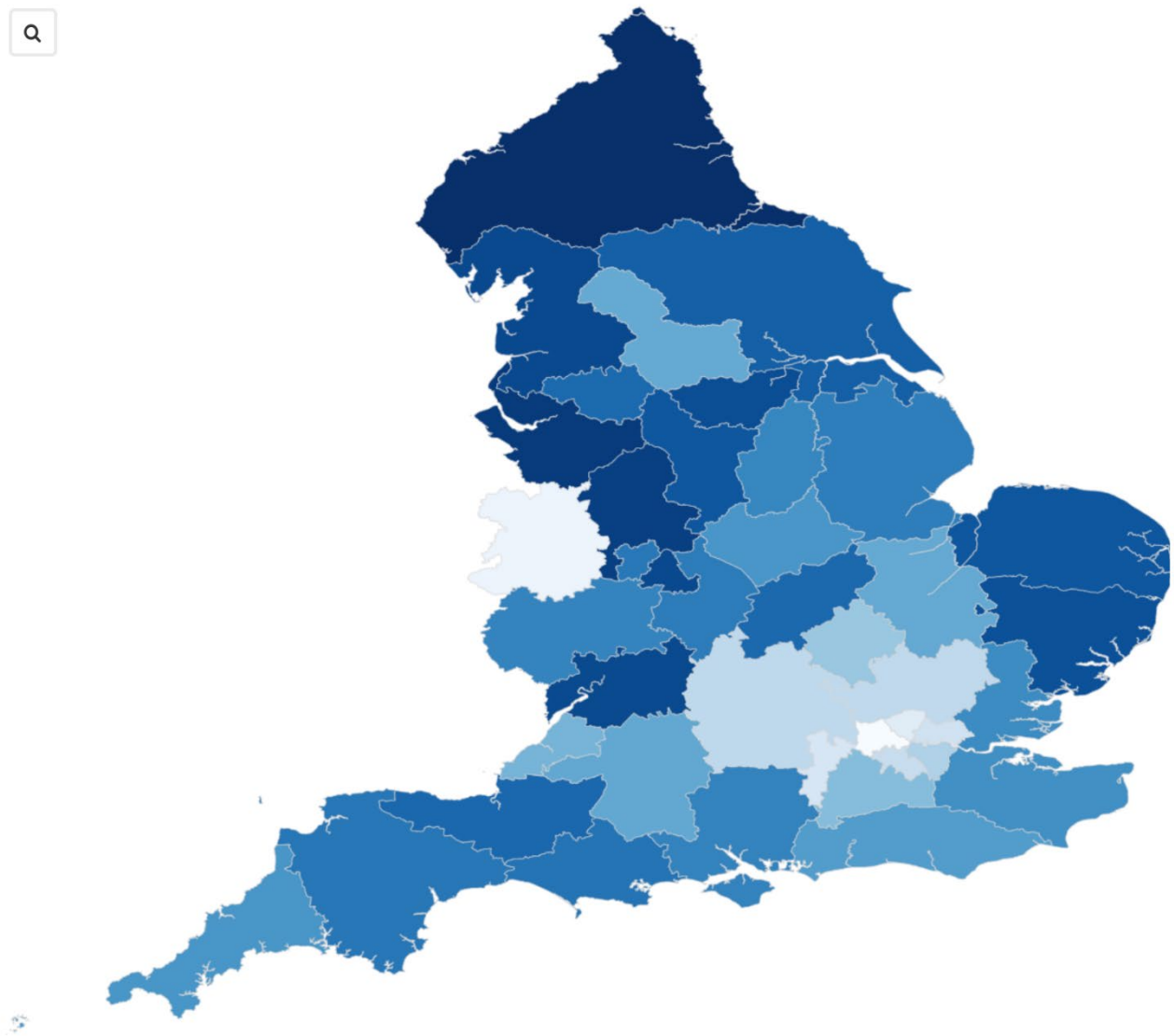
A mix of factors are linked to rates of potentially avoidable hospital admissions – including deprivation and other patient characteristics, access to primary and community services, continuity of care, and more.<sup>16,17,18,19</sup> Looking at admissions across large areas like ICSs is potentially misleading and masks significant variation within areas.<sup>20,21</sup> ICS leaders will need to understand how rates vary between much smaller areas to design and target appropriate interventions. National policymakers have identified ‘places’ as the organisational level where agencies will work together to develop new models of integrated care in the community.<sup>22</sup> But it is not always clear what these ‘places’ look like and there are a mix of options for their development.<sup>7</sup>

**Figure 3**

## Indicators of potentially avoidable hospital use are far higher in some ICSs than others

Unplanned hospitalisations for ambulatory care sensitive conditions (ACSCs) per 100,000 population , 2020/21

314.9  887.85



**Source:** NHS Digital, NHS Outcome Framework: 2.3.i, March 2022

## Some systems face a bigger challenge in getting services back on track

Health and care services in England are under extreme strain. Appointments in general practice are higher than before the pandemic, but the number of permanent, fully qualified GPs has fallen since 2016.<sup>23</sup> Urgent and emergency care is under severe stress. And the waiting list for routine hospital care has reached a record high of more than 6 million – with around 300,000 people waiting over a year.<sup>Error! Bookmark not defined.</sup>

Recovery of elective care services is a government priority<sup>24</sup> and – having taken on greater responsibility for managing waiting lists during the pandemic<sup>25</sup> – ICSs will now play a leading role in addressing the backlog of elective care in an ‘inclusive’ way. National policymakers have set an ambition for systems to deliver over 10% more elective activity than before the pandemic over the course of this year, with additional funding contingent on systems meeting agreed activity targets.<sup>26</sup>

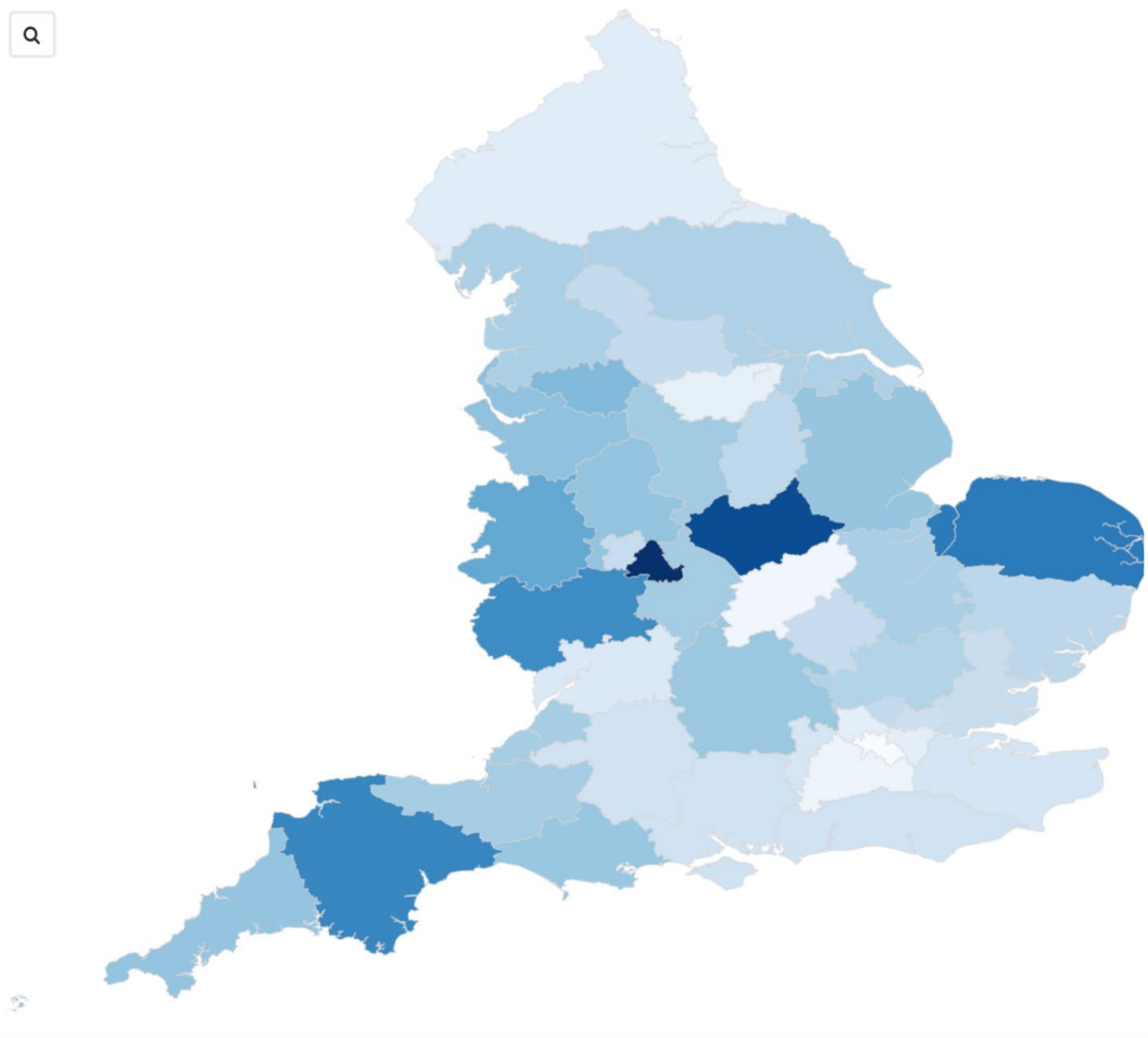
ICSs are seeking to do this from very different starting points – affected by local health needs, waiting times going into the pandemic, the unequal impact of COVID-19, and more. Estimating the true scale of the backlog in different areas is complex. For example, the number of ‘missing patients’ returning for treatment is unknown and new demand will continue to appear. But data from March 2022 show the percentage of people on waiting lists who have been waiting for routine hospital treatment for more than 1 year varies from 1% to 13% (Figure 4). Meeting national timelines for eliminating long waits is a significant ask for some areas, with just over half of those waiting more than 2 years concentrated in seven ICSs (excluding waits for specialised services attributed to NHS England).

**Figure 4**

## The size of elective care backlog and length of waiting times is far greater in some ICSs than others

The percentage of patients on the waiting list who have been waiting more than a year in March 2022

0.82  13.24



**Source:** NHS England, *Consultant-led Referral to Treatment Waiting Times, March 2022*

Resources available to meet this challenge differ. Staff shortages are likely to be the main limiting factor and workforce capacity varies between systems (see next section). Access to independent sector providers is unequal, with access higher in more affluent areas.<sup>27</sup> And some areas are at greater risk of missing their targets and losing out on much-needed additional funding<sup>26</sup> – such as those in more deprived areas where activity has been more disrupted by the pandemic and slower to recover.<sup>28,29</sup>

Other factors – including the geography of the ICS and the complexity of the provider landscape within it – will also affect the ability to recover services.<sup>30</sup> ICSs with a history of NHS providers working together to plan and deliver care – for example, through piloting acute care collaborations as part of the new care models programme<sup>31</sup> – may have a head start in working through some of the logistical challenges involved (sharing information and aligning clinical protocols, for example).

## Resources differ between ICSs

Workforce shortages in health and social care are chronic and will be a major constraint on the ability of ICSs to achieve their aims.<sup>32</sup> Tackling the growing backlog of unmet need and long waiting lists, for instance, depends on having enough staff to increase elective activity and support patients while waiting for treatment. ICSs will take on responsibilities for workforce planning: they are expected to play a ‘critical’ role in ‘growing, developing, retaining and supporting the entire local health and care workforce’<sup>35</sup>, and must develop a local workforce plan to ensure adequate staffing in their system.<sup>33</sup>

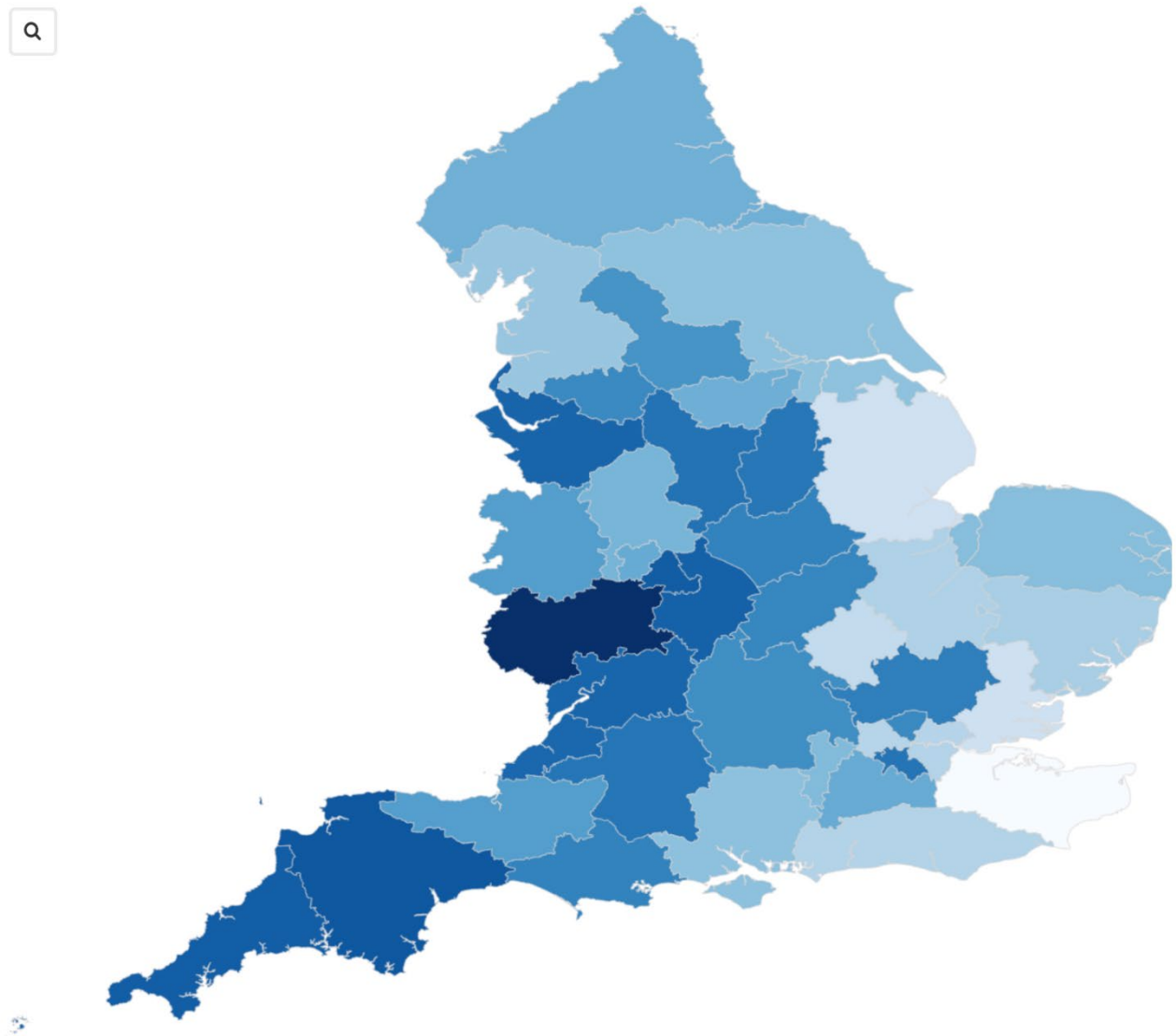
Workforce capacity varies between ICSs. For example, the number of GPs per 100,000 weighted patients and clinicians per 100,000 people in each ICS ranges widely (Figure 5) – as does the number of hospital staff. Addressing the shortage of GPs will be critical, particularly given the growing number of people living with more complex needs, including multiple long-term conditions. But shortages in general practice are not evenly distributed, and previous analysis shows there are fewer GPs per head in more deprived areas.<sup>34</sup> Some ICSs will also face distinct workforce supply issues, with evidence suggesting that rural areas often struggle to retain and recruit new staff.<sup>35</sup>

**Figure 5**

## The GP workforce varies by ICS

The number of full time equivalent (FTE) GPs per 100,000 weighted patients in March 2022

47.03  68.95



**Source:** NHS Digital, General Practice Workforce, March 2022



With clinical commissioning groups abolished under the new reforms, ICSs will be responsible for controlling most NHS resources, including some budgets for specialised services previously held by NHS England.<sup>36</sup> The impact of rising inflation will be felt across the NHS, even after an additional £1.5bn was allocated to systems in May to cover higher costs.<sup>37</sup> As a conservative estimate, government would need to top up spending by at least £2.4bn by 2024/25 to match the plans set out in the spending review in 2021.<sup>38</sup> But the scale of the financial challenge will likely differ between systems, leaving some ICSs with a much bigger task ahead of them in delivering net financial balance in 2022/23.<sup>39,40</sup> Systems experiencing particularly severe staff shortages, for example, may incur additional workforce costs to ensure services have the staff they need to run safely.

## 4. Implications for policy

The latest reorganisation of the NHS in England comes at a time of intense pressure on the system. The backlog of unmet need is growing and NHS staffing gaps currently stand at more than 100,000.<sup>41</sup> Public satisfaction with the NHS has fallen to a 25-year low.<sup>42</sup> Ongoing underinvestment in adult social care means that many people are going without the care they need. These challenges are compounded by a gloomy economic outlook and rising inflation that will eat up a share of planned health and care budgets.<sup>38</sup> ICSs face a daunting task when they inherit responsibility for managing NHS services in July 2022.

But the task facing ICSs is not equal. Pressures on services and the health of the population vary widely between ICSs – as do the resources available to address them. ICSs also look very different in their size, complexity, and other characteristics. Variations within the NHS are nothing new. But these differences will shape how ICSs function and their ability to collaborate to improve services. For instance, more complex systems with little history of working together may find it harder to make decisions and agree service changes. Less complex ICSs in more affluent areas may face an easier task.

What does this mean for policy on ICSs? First, national policymakers must acknowledge the wide variation between local systems and be realistic about what different areas can achieve. ICSs have already been set a long list of objectives and national priorities – including improving the responsiveness of urgent and emergency care services, increasing access to primary care, returning the NHS to pre-pandemic levels of productivity, and more.<sup>11</sup> NHS England is in the process of updating the NHS's guiding strategy, the *NHS Long Term Plan*. This presents an opportunity to define realistic expectations for the performance of ICSs. But it should also acknowledge that progress will differ between systems, given their varied contexts and starting points.

Second, these differences should be reflected in how ICS performance is assessed and reported. The approach to doing this is currently unclear. A mix of policies are under development: a revised system oversight framework from NHS England,<sup>5</sup> a new approach to assessing ICSs from the Care Quality Commission,<sup>43</sup> and an outcomes framework for the 'place' level of the system<sup>22</sup> have all been promised by national policymakers. Measures to assess previous versions of ICSs were narrowly focused and imbalanced towards hospitals – and used to construct overall ratings for local areas.<sup>44</sup>

The right approach to measuring local health system performance depends on policy objectives – for example, whether policymakers want to judge ICS performance or support local systems to improve services.<sup>45</sup> Any future approach to measuring ICS performance should reflect the broad range of objectives for local systems and avoid overly simplistic comparisons between areas. Publicly reported data should also link ICS performance to the underlying resources and context in each area – for

example, to allow comparisons on relevant indicators between ICSs with similar levels of deprivation.

Finally, policymakers must provide targeted support and resources for ICSs with different needs. For example, national NHS bodies are seeking to reduce health inequalities by targeting interventions at people living in the 20% most deprived areas of the country. But the most deprived areas are not evenly distributed between ICSs (Figure 2). Cuts to local government spending have also been greater in more deprived areas.<sup>46</sup> As a result, ICSs in some areas will likely require additional resources to help deliver national policy objectives. The same is true within ICSs, where variations in health and use of services exist between ‘places’ and neighbourhoods within them – for example, in the provision of high-quality GP services between richer and poorer neighbourhoods in England.<sup>34,47</sup> National NHS bodies must also focus their support for ICSs on the broader range of factors needed for local partnerships to operate effectively – including culture, management, use of data, and more.<sup>9</sup>

# Supporting information

## Acknowledgements

The authors would like to thank Stephen Rocks, Charles Tallack, Tim Gardner, Sean Agass and Jennifer Dixon from the Health Foundation for their contributions and comments on earlier drafts of the long read. Some of the analysis forms part of a larger research project on the role of integrated care systems in reducing inequalities. We would like to thank Nicholas Mays and Andrew Hutchings from The London School of Hygiene and Tropical Medicine for their involvement in this part of the work. Errors or omissions remain the responsibility of the authors alone.

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This long read was published originally on 15 June 2022 at the following address:

[www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like](http://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like)

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### Please note:

- (1) On 6 July 2022 we updated this analysis (and appendices) with 2020/21 data for the following three indicators:
  - Unplanned admissions for chronic ambulatory care sensitive conditions (ACSC).
  - Emergency readmissions within 30 days of discharge.
  - Emergency admissions for conditions that do not usually require hospital.
- (2) On 14 July we corrected an error and updated the indicator 'The number on the waiting list per 1,000 population' as it was previously a duplicate of the indicator 'The number of complete pathways per 1,000 population'. We also removed a column from appendix 1 (the data table) – 'The number on the waiting list per 100,000 population' – as the data was incorrect.

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