NHS Reform: Integrated Care Systems

March, 2022

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1. Introduction

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ICSs (integrated care systems) are the future of health and care integration in England. There are now 42 ICSs covering all of England. This report will define ICSs, their accompanying systems, legislation, what they mean for providers, and case studies demonstrating the benefits we are already seeing from the reform.

An ICS brings NHS providers, Clinical Commissioning Groups (CCGs), local authorities and voluntary sector partners together to collaboratively plan and organise how health and care services are delivered in their area.

ICSs take on responsibility for the resources and health of an area or 'system'. Their aim is to deliver better, more integrated care for patients.

2. Historic Overview

On the 5th of November 2018 the Secretary of State for Health and Social Care published a policy paper describing the UK Government's vision for prevention titled "Prevention is better than cure". This stated that the "NHS and local authorities need to put prevention at the heart of everything they do" [2].

This was followed in January 2019 with the publication of the NHS Long Term Plan. This was a blueprint for how the Government will spend additional funding over the coming years [3].

These publications argued that little will be gained in disease prevention without closer working between NHS and non-NHS organisations.

NHS England suggested that one route to improved health and disease prevention is through developing 'place-based' health and care systems across England.

The NHS was set up primarily to provide episodic treatment for acute illness, but there have long been calls 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 the community, while 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.

2.2 Sustainability and Transformation Plans (STPs)

Sustainability and Transformation Plans were first introduced in 2016 by NHS Providers, commissioners and local authorities, working within 44 new geographical 'footprints' across England [4]. The plans set out a vision for the future of health and care service delivery in their areas. By 2018 these had evolved into partnerships, many of which had established joint working arrangements. The most well-developed STPs were termed ICSs. As of 19 March 2021, all are ICSs.

2.3 Integrated Care Provider Contracts (ICPs)

Alongside ICSs, areas in England can also choose to use the ICP (integrated care provider) contract, a more intensive model of integration [4].

They are population-based models of care that integrate primary, secondary, community and other health and care services under one single contract provider.

ICPs are different from ICSs, which focus on achieving integration without contractual change.

An ICP brings together several providers to take responsibility for the provision and quality of care for a defined population within an agreed budget.

The key feature of an ICP is that there will be a single contract with a single organisation for most of the health and care services in the area. The ICP contract holder would be

responsible for the provision of services but may not necessarily deliver all the services itself. It could instead hold sub-contracts with other providers.

2.4 Health and Wellbeing Boards

Health and wellbeing boards are a formal committee in a local authority, charged with promoting greater integration and partnership between public bodies [5]. They have a statutory duty to work with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

The boards have very limited formal powers. They are constituted as a partnership forum rather than an executive decision-making body.

In most cases, health and wellbeing boards are chaired by a senior local authority elected member. The board must include a representative of each relevant CCG, local Healthwatch representatives, as well as local authority representatives. The local authority has considerable discretion in appointing additional board members.

3. Legislation

3.1 The NHS Long Term Plan

In 2018, the government announced £20.5bn of additional funding for the NHS in England by 2023/24 [6]. Launched in January 2019, the NHS Long Term Plan set out priorities for how this money would be spent over the following ten years to improve and reform the NHS.

The NHS long term plan sets out the pathway for a new service model. The aim is for patients to receive more options, better support, and properly joined-up care at the right time in the optimal care setting.

The plan focused on building an NHS fit for the future by:

- Enabling everyone to get the best start in life
- Helping communities to live well
- Helping people to age well

The plan also included measures to:

- Improve out-of-hospital care, supporting primary medical and community health services
- Ensure that all children get the best start in life by continuing to improve maternity safety. This included halving the number of stillbirths, maternal and neonatal deaths, and serious brain injury by 2025
- Support older people through more personalised care and stronger community and primary care services
- Make digital health services a mainstream part of the NHS, so that in 5 years, patients in England will be able to access a digital GP offer

ICSs are central to the delivery of the Long-Term Plan. On the 11th of 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*, which set out legislative proposals for the health and care bill [7]. Many of the proposals build on the recommendations in the Long-Term Plan.

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The paper states:

"Instead of working independently, every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met." [7]

The White Paper groups the proposals under the following themes: working together and supporting integration; stripping out needless bureaucracy; enhancing public confidence and accountability; and additional proposals to support public health, social care, and quality and safety.

The Local Government Association commented on the white paper:

"We are pleased that the DHSC has heard and acted on local government's calls for a wider health and care partnership to promote collaboration and equal partnership beyond the NHS. We strongly welcome the commitment to flexibility for systems to develop their own Heath and Care Partnerships that are built on existing partnerships, and which reflect each system's unique combination of experience, assets, and challenges [7]."

4. Why are they needed?

The current focus on integrated care is reflective of a long-standing concern in the NHS. Decisions about how services are arranged, should be made as closely as possible to those who use them.

Integrating care means more people can see the benefits of joined up care between GPs, home care and care homes, community health services, hospitals, and mental health services.

The mission is for people's day-to-day health and care needs to be met locally in the town or district where they live or work. Partnerships between services are therefore an important building block for this integration, often falling in line with long-established local authority boundaries.

ICSs will remove barriers between organisations to deliver better, more joined up care for local communities.

A survey was run by the British Medical Association in November 2018, asking doctors what their views on integrated care were. The results are as follows [8]:

94% of doctors asked, agreed with the statement: Collaboration between primary and secondary care doctors will improve the quality of patient services and experience.

93% of doctors asked, agreed with the statement: GPs and hospital doctors should work together more directly in a collaborative and coordinated manner.

92% of doctors asked, agreed with the statement: There should be shared pathways across primary and secondary care, with resources fairly directed to where care is delivered.

For staff, ICSs enable them to work outside of organisational silos, deliver more user-centred and personalised approaches to care, and tackle bureaucracy standing in the way of providing the best care.

They enable greater ambition when tackling health inequalities and wider determinants of health – issues which no one part of the system can address alone.

However, the measures set out in the Long-Term Plan to embed system working are ambitious. They rest on the ability of local partners to forge new relationships and to embed new ways of working within an existing legislative framework based on institutions not local systems [9].

A survey distributed by NHS Providers concluded that although there is widespread support across the sector for greater collaboration within local systems, there are mixed views as to how far integration in local systems will see positive change.

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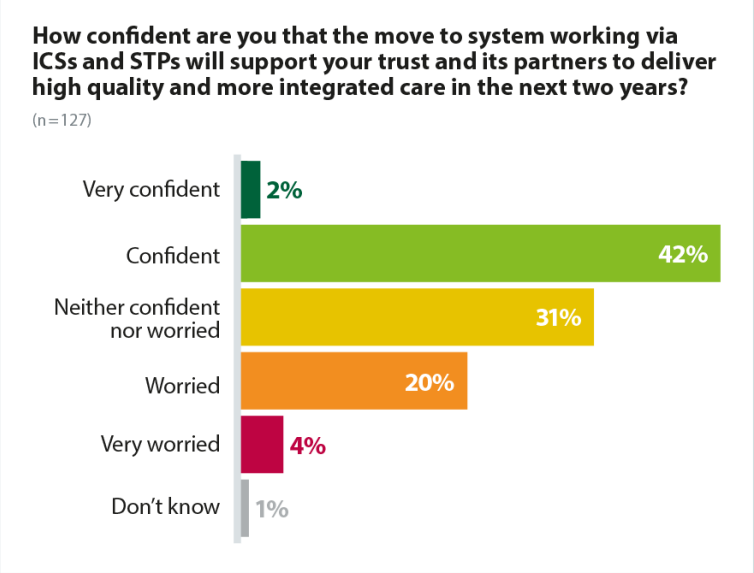
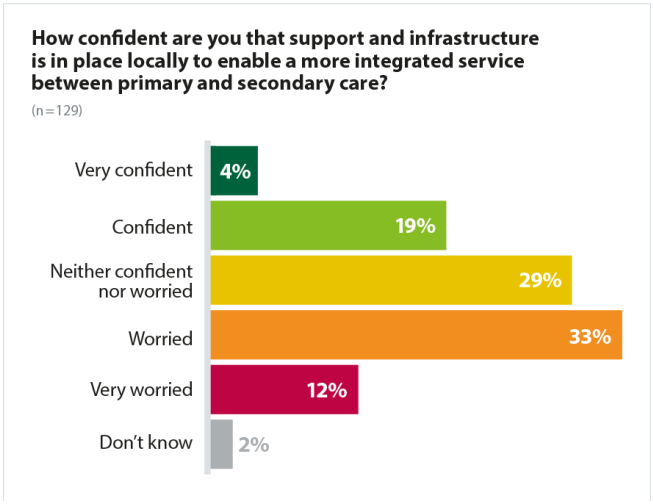
The survey results show that many trust leaders lack confidence in how far system working alone can address some of the fundamental issues facing the NHS. Particularly the need to address workforce shortages and to place the system on a financially sustainable footing.



[9] *Confidence in the potential of ICSs in delivering high quality and integrated care*

However, the figure above demonstrates that most trust providers expressed confidence in ICSs ability to deliver high quality care in the coming years.



[9] *Confidence in support and infrastructure for ICS delivery*

The above figure shows that although trust leaders have faith in the role of ICSs delivering quality integrated care, there is a lack of confidence around adequate support and infrastructure to accommodate the reform.

4.1 Mental Health Services

It is hoped that ICSs will mental health services across England.

The Centre for Mental Health reported that having a long-term physical illness doubles a person's chances of having a mental health difficulty [10]. Likewise, having a long-term mental illness increases a person's risk of physical ill health.

ICSs can help to ensure that all physical health interventions are equally accessible to people with mental health conditions, and that people with long-term physical conditions get effective mental health support.

ICSs can tackle systemic issues in mental health service provision beyond the local level, such as in addressing the prevalence of out of area placements and the overuse of long-term hospital placements for people with learning disabilities and autism under the Mental Health Act.

4.2 Addressing Multiple Disadvantage

The Making Every Adult Matter (MEAM) coalition of charities has identified the need for ICSs to help those suffering multiple disadvantage [11].

4.2.1 Involvement of Lived Experience in Local Healthcare Planning

Most ICSs have put in place engagement leads. They seek to better engage the public with the work of the ICS and to include people with lived experience in NHS decision-making processes.

For example, this could be to better connect communities with Primary Care Networks or to consult populations with historically poorer health outcomes about specialist commissioned services. People should ensure that they know who their engagement lead is and ICS's should offer opportunities for them to engage directly with people facing multiple disadvantage.

4.2.2 Opportunities for Voluntary Organisations

Third-sector organisations are invited to join ICS partnerships, bringing important perspectives and neighbourhood connections from populations that have poorer health outcomes. This presents an opportunity to ensure that voluntary sector expertise is embedded in wider health structures, enabling community involvement in health planning and commissioning, as well as agreeing local responsibilities around health and wellbeing.

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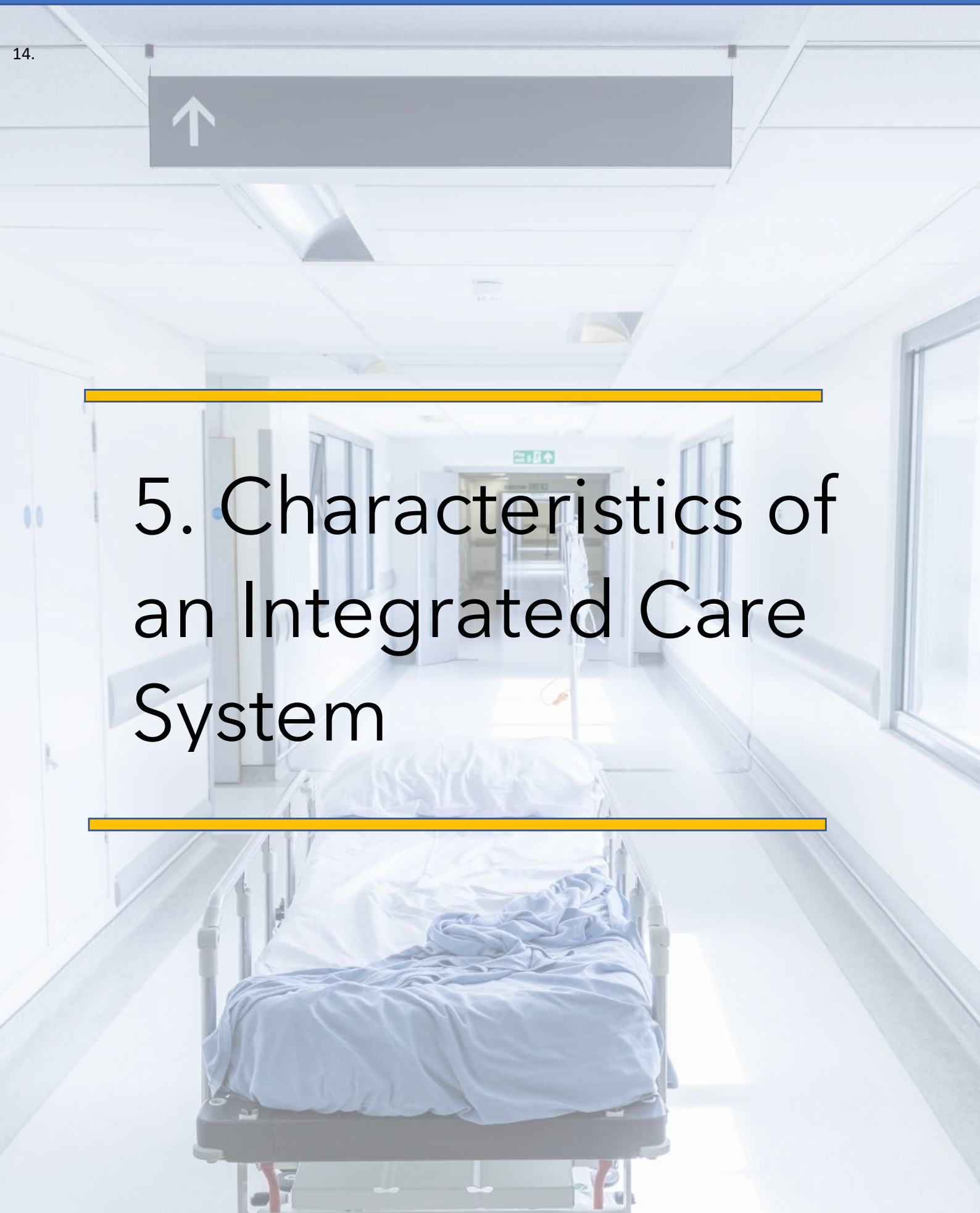
4.2.3 Joint Strategic Needs Assessments

Joint Strategic Needs Assessments (JSNAs) are carried out to understand the health needs in a local area. They often provide a rich source of health data to consider and provide evidence on which services should be commissioned.

JSNAs remain the responsibility of Health and Wellbeing Boards, and ICSs have to have regard to them. Local areas should engage with any future opportunities to feed into JSNAs highlighting the specific needs of people experiencing multiple disadvantage [11].



5. Characteristics of an Integrated Care System

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The NHS states that every ICS should have [12]:

- A partnership board, drawn from and representing commissioners, trust, primary care networks, and – with the clear expectation that they will wish to participate – local authorities, the voluntary and community sector, and other partners

- A non-executive chair (locally appointed) and involved non-executive members of boards/governing bodies

- Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes

- All providers within an ICS will be required to contribute to ICS goals and performance

The Social Care Institute for Excellence spoke to leaders of ICSs to understand how they define an effective integrated system [13].

They found that leaders emphasised the importance of partners within a system, having open and collaborative conversations to produce a shared vision.

Workshops involving people from many organisations and professional disciplines aimed at identifying priorities, outcomes, and goals, without a pre-set agenda – are useful in achieving these collaborative partnerships.

Such an approach builds relationships of trust and enables people to better understand each other's perspectives. It helps generate a shared commitment to collaborative ways of working, and to the priorities and outcomes that are agreed as a result.

In many ICSs, systems leaders are increasingly expected to build system-wide learning and evaluation frameworks which enable them to capture and act on the lessons from innovation. Pilot programmes are also commonplace in ICSs – it is important that arrangements are in place from the start to support formative learning.

The NHS Confederation said that the measure of success of an ICS is whether the resulting service feels integrated to the user [14]. ICSs are being designed to address the needs of the whole population – central to this is the need for these systems to be visible and navigable by everyone.

The system needs to be continually modified as the appetite and expectation of the population will change with societal norms and events such as Covid-19.

6. Implications for Providers

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Providers must accommodate place-based partnerships to effectively implement an ICS. In many places, there are already strong and effective place-based partnerships between sectors. The most successful ICSs have the full involvement of all partners who contribute to the place's health and care.

The place leader works with partners such as the local authority and voluntary sector in an inclusive, transparent, and collaborative way. They have four main roles [12]:

- To support and develop Primary Care Networks which join up primary and community services across local neighbourhoods
- To simplify, modernise, and join up health and care (including through technology and by joining up primary and secondary care where appropriate)
- To understand and identify (using population health management techniques and other intelligence) people and families at risk of being left behind and to organise proactive support for them
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups

6.1 ICS Leadership

According to The Social Care Institute for Excellence, good ICS leaders should be skilled at [15]:

- Identifying and scaling innovation (e.g. from pilots)
- Having a strong focus on outcomes and population health
- Building strong relationships with other leaders, and often working with them informally to develop joint priorities and plans
- Establishing governance structures which drive faster change, often going where the commitment and energy is strongest
- Setting the overall outcomes and expectations on behaviours, but handing day-to-day decision-making to others
- Supporting the development of multidisciplinary teams (MDTs)
- Designing and facilitating whole-systems events and workshops to build consensus and deliver change
- Understanding and leading cultural change
- Building system-wide learning and evaluation frameworks
- Fostering a learning culture across the whole system.

6.2 Data and Digital

During the ICS reform, there was a necessity to consolidate the various systems that patient information is stored. GPs, hospitals, community teams, and councils all use different systems to store information about users, which can make sharing and collaborating a huge challenge. Bringing everything onto one system makes this much easier [16].

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Data and digital technology are at the heart of creating effective local systems, helping local partners in health and social care work together. They help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation, and stimulate improvement and research.

To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, providers need to:

- Build smart digital and data foundations
- Connect health and care services
- Use digital and data to transform care
- Put the citizen at the centre of their care

6.2.1 Building Smart Digital and Data Foundations

Providers are required to have a system-wide digital transformation plan. It outlines the journey to digitally driven, citizen-centred care.

The transformation plan states that ICSs should build the digital and data literacy of the whole workforce as well as specific digital skills such as user research and service design.

They should invest in the infrastructure needed to deliver on their transformation plan. This should include shared contracts and platforms to increase resilience, digitise operational services and create efficiencies, from shared data centres to common electronic patient records (EPRs).

6.2.2 Connected Health and Care Services

Providers should develop or join a shared care record, joining data safely across all health and social care settings. This improves direct care for individual patients and service users and underpins population health and effective system management.

They should follow nationally defined standards for digital and data to enable integration and interoperability through thorough data architecture and design.

They should build the tools to allow collaborative working and frictionless movement of staff across organisational boundaries. This includes shared booking and referral management, task sharing, radiology reporting and pathology networks.

6.2.3 Use Digital and Data to Transform Care

Providers should develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including:

• Actionable insight for frontline teams

• Near-real time, actionable intelligence and robust data (financial, performance, quality, outcomes)

• System-wide workforce, finance, quality, and performance planning

They should ensure transparency of information about interventions and the outcomes they produce. This drives more responsive coordination of services, better decision making and improved research.

6.2.4 Put the Citizen at the Centre of their Care

Providers should develop a road map for citizen-centred digital channels and services, including access to personalised advice on staying well, accessing their own data, and triage to appropriate health and care services.

They should roll out remote monitoring to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions [16].

7. Case Studies

Since the emergence of ICSs, many systems have already started to see the benefits of integrated, collaborative care structures and processes.

7.1 South Yorkshire and Bassetlaw Integrated Care System (SYB ICS).

Hundreds of children in South Yorkshire who needed emergency surgery during the Covid-19 pandemic got fast, joined-up care. This was thanks to hospitals, GPs and ambulance services working closely to direct patients to the right place.

Workforce pressures increased during the pandemic with trusts converting operating theatres into critical care beds and anaesthetists having to re-allocate focus on the intubation of critical Covid patients. South Yorkshire and Bassetlaw recognised that this would have a significant negative impact on children.

A new integrated care pathway ensured that children were assessed on pickup by ambulance crews which were supported remotely by a clinician at Sheffield Hospital to decide whether to admit them. This ensured that children got timely emergency surgery, freeing up space in general hospitals for Covid patients and elective care.

Children under 16 that needed emergency surgery went straight to Sheffield Children's Hospital and those needing time-critical surgery went to the nearest district general hospital emergency department. Any walk-in patients to GP practices or emergency departments were assessed and transferred to Sheffield Children's Hospital if they needed surgery.

This new pathway helped over 630 children during the pandemic.

Professor Des Breen, SYB ICS Medical Director, said:

"Transferring children who needed emergency surgery to a single site at Sheffield Children's Hospital allowed children and families to continue to receive high quality and safe emergency care at a time when health services were struggling with demand and within the agreed waiting times.

"We were also able to lower the Covid risk to those children and their families; and at the same time, increase capacity in our local hospitals, enabling them to care for greater numbers of adult COVID patients and higher levels of elective activity."

Partners in the SYB ICS which helped design the pathway include the local clinical commissioning group, hospital trusts, general practices and ambulance services.

Professor Breen:

"Working together during two waves of the pandemic and having had to stand down the emergency pathway and then stand it back up again has enabled all partners involved to see the speed at which such mutual aid action, ie working together, can really benefit patients.

"The legacy of this joint working approach is that services for children are more unified across South Yorkshire, children should receive the same standard of care, it should be equal, and this new way of working has definitely helped achieve that." [17]

7.2 Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS)

Health and social care teams in Oxfordshire identified a low uptake in bowel cancer screening by men in Wantage. In response, they sent social prescribers to support them to take up the offer.

Staff from the primary care network, Cancer Research UK, Age UK and other stakeholders in the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS), worked together to design the system to improve cancer outcomes.

Men aged 65 to 74 who had not had bowel screening, the influenza vaccine and had poor engagement with health services in the last two years, were identified as most likely to need support.

Social prescribers first undertook extra training on patient activation and cancer screening in general, as well as bowel screening training, and initially contacted 50 men. Almost half took up the screening and the team now offers more preventative care where needed.

Close relationships were developed in the primary care network team, especially between the social prescribers and care coordinators. Enthusiasm for a proactive approach to improving the health and wellbeing of a vulnerable group, ensured the development of new partnerships with other organisations such as Cancer Research UK [18].

7.3 Integrated Referral Scheme in Devon

A new project run by partner organisations in Devon has helped regular users of accident and emergency and other emergency services to tackle issues such as housing and finance. Consequently, this has improved the lives of these service users, reduced their A&E visits by 60%, and saved taxpayers £200,000.

The One Northern Devon programme was set up by police, social care, the NHS, and other partners in Devon. In turn, this group set up the 'High Flow project' to identify and provide support to individuals with highly complex, multiple needs who frequently accessed services – but not necessarily those services most appropriate for their needs.

The High Flow project identified the top 15 users of A&E with complex needs. It helped them attend medical and counselling appointments, find housing or suitable alternatives, and gave advice and guidance on budgeting and form-filling.

Andrea Beacham, One Northern Devon Programme Manager said:

"We're very committed to this approach, working with these individuals and getting to know them and recognising how the trauma they have experienced in their past has affected them and their ability to cope with the circumstances they find themselves in.

"The 'Flow' approach is not about just dealing with the presenting issue but recognising other factors at play and working together as a team, with the individual, to address what's going on in their life and what matters to them."

The selected service users now attend A&E 60% less than before and spend 9% fewer days in hospital. Further evaluation showed improved housing stability, financial status, family relationships, living conditions and reduced homelessness.

Feedback from High Flow clients suggested that individuals feel more in control and have an improved experience of the system. Professionals are better able to provide holistic support; and the stigma associated with frequent attendance has been reduced [19].

7.4 Integrated Mental Health Support in West Suffolk

The Haverhill LifeLink project is a two-year social prescribing project and a pilot scheme run by ONE Haverhill Partnership, St Edmundsbury Borough Council, and several partner agencies.

The £130,000 project was funded by Public Health England, Suffolk County Council and the Department for Levelling Up, Communities and Local Government, and builds on ONE Haverhill Partnership's priority to improve health and access to services in the town.

The scheme helps with low level mental health issues such as loneliness and anxiety or those with social isolation, wanting to improve their life skills or long-term health conditions.

Once referred by their GP nurse, or self-referral, patients meet with a LifeLink Coordinator who spends some time getting to know them and helping them connect with people and activities in their area.

The programme aims to reduce pressure on GPs and the NHS by reducing repeat GP appointments, wider NHS appointments and prescription costs and increasing employment opportunities.

One disabled patient, who was encouraged to join community activities in favour of traditional medicine, says it changed his life.

John was referred by his GP due to his low mood as he was getting bored at home and is already benefitting from attending a weekly lunch group.

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He said: *"LifeLink has made a difference to my life because I have met new people, got out of the house and feel more positive overall. I feel brighter and more upbeat since starting with Haverhill LifeLink."* [20].

8. Forward View

The NHS Confederation has always supported ICS reform. However, they do understand the importance of looking forward to how these systems can be maintained and improved [14].

The pandemic has further reinforced this view, therefore any proposed changes to national policy and the legislative framework must build on what has been achieved during this time of crisis.

According to the NHS Confederation a future framework for ICSs should be structured around two key pillars:

- ICSs should be given a statutory footing through legislation

- To incentivise greater joint working across health and care services, a new statutory duty should be introduced on all partners within systems (including local authorities) to deliver against shared objectives.

Additionally, Infinity Health have highlighted the importance of effective digital systems as the foundation of ICSs. There's no doubt that meaningful and sustainable integration of services need appropriate digital tools that connect staff and enhance existing ways of working [16].

Underpinning this ambition is the need for all organisations in an ICS to have basic digital infrastructure in place, and for all staff to be digitally proficient and confident. Looking forward, digital systems should be routinely reviewed and updated to ensure optimal handling of data and processes.

Access to adequate Wi-Fi, mobile internet-enabled devices, and digital literacy support are essential to create services that support NHS sustainability and are fit for the future.

ICSs are relatively new, and the Health Foundation has identified that it takes time to understand the full impact of complex change. Although there is promising evidence that integrated care has the potential to reduce hospital use over the longer term, it is important to allow sufficient time before judging the success of a complex initiative [21].

The Health Foundation further highlight that this doesn't mean that evaluations conducted within the first years of a programme aren't useful. They can provide valuable insight into how changes are affecting people's health and health needs in the short term. This information can then be used to fine tune the design and delivery of an initiative. However, policymakers need to allow initiatives to run their course – otherwise, they run the risk of drawing conclusions too early that could lead to abandoning potentially effective changes.

9. Conclusions

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Overall, ICSs have arisen out of years of concern in the NHS around prevention. The foundation of a successful ICS is collaboration and partnership, with the aim to bring together a variety of services to provide more joined-up and thorough care.

The NHS Long Term Plan kickstarted the reform and existing commitments in the Five Year Forward View and national strategies will all continue to be implemented in 2019/20 and 2020/21 as originally planned for cancer, mental health, learning disability, general practice, and maternity.

ICSs are central to the delivery of the Long Term Plan with full coverage expected by April 2021. They have been identified as necessary so that people's day-to-day health and care needs to be met locally in their town or district. Partnerships between services are crucial building blocks of integration, with the aim to help vulnerable members of society, suffering from multiple disadvantage and mental health conditions.

Providers have had to accommodate for place-based partnerships, developing and welcoming new digital and data systems to join up patient records and services. Additionally, ICS leaders have had to step up and work build strong relationships with other leaders, whilst facilitating cultural change from the top down.

South Yorkshire and Bassetlaw, Buckinghamshire, Oxfordshire and Berkshire West, Devon and West Suffolk ICSs have experienced the benefits of the healthcare reform. Timely emergency surgery for children, and an increase in cancer screening were amongst the positive changes seen because of ICSs.

Consistent and strong leadership and regular digital and system updates are pivotal to the continued success of ICSs. ICSs are still new and we are yet to experience the long term impact of the reform.

9. Glossary

Integrated Care:

Integrated care, also known as integrated health, coordinated care, comprehensive care, seamless care, or transmural care, is a worldwide trend in health care reforms and new organisational arrangements focusing on more coordinated and integrated forms of care provision. It is care that is planned with people who work together to understand the service user and their carer(s), puts them in control and coordinates and delivers services to achieve the best outcomes.

Primary Care:

Primary care services provide the first point of contact in the healthcare system. They act as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

Comorbidities:

The presence of one or more additional diseases or disorders co-occurring with (that is, concomitant or concurrent with) a primary disease or disorder.

Interprofessional:

Defined as a group of individuals from different disciplines working and communicating with each other. In the interprofessional environment each member provides their knowledge, skills, and attitudes to augment and support the contributions of others.

Vanguards:

50 localised groups selected to take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

[1] The Governor Support Team, NHS Providers. *Integrated care systems explained: making sense of the new NHS structure*

[2] Department for Health and Social Care. 2018. *Prevention is Better than Cure*

[3] The NHS Long Term Plan. 2019

[4] The Kings Fund. 2017. *Sustainability and transformation plans (STPs) explained*

[5] The Kings Fund. 2016. *Health and wellbeing boards (HWBs) explained*

[6] The Health Foundation. *The NHS Long Term Plan*

[7] GOV.UK. 2021. *Integration and innovation: working together to improve health and social care for all (HTML version)*

[8] The British Medical Association. 2018. *Caring, supportive, collaborative? September 2018 Doctors' views on working in the NHS*

[9] The Health Foundation. 2020. *Integrated care programmes: We need to think long term when implementing and evaluating complex change*

[10] The Centre for Mental Health. 2020. *Briefing 55: Integrated Care Systems and mental health*

[11] Making Every Adult Matter. *Integrated Care Systems and Multiple Disadvantage*

[12] NHS. 2021. *Integrating care, next steps to building strong and effective integrated care systems across England*

[13] Social Care Institute for Excellence. 2018. *Leadership in integrated care systems (ICSs)*

[14] NHS Confederation. 2021. *If you can't navigate an integrated care system, it isn't a system*

[15] Social Care Institute for Excellence. 2021. *How might leadership roles evolve in integrated health and care systems?*

[16] Infinity Health. 2021. *What the new NHS Integrated Care Systems need to do to be successful*

[17] South Yorkshire and Bassetlaw Integrated Care System

[18] Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

[19] NHS. *Integrated referral scheme helps reduce accident and emergency visits by 60 per cent*

[20] NHS. *People feeling isolated or lonely helped by innovative health and social care partnership*

[21] The Health Foundation. 2021. *Have integrated care programmes reduced emergency admissions?*