

Briefing Integrated care systems

What are they, and what do they mean for doctors?

ICSs (integrated care systems) are a new way of planning and organising the delivery of health and care services in England. They bring together NHS, local authority, and third sector bodies to take on collective responsibility for the resources and health of the population of a defined area, with the aim of delivering better, more integrated care for patients. The model is seen by NHS leaders as the next step for health and care integration in England, with every area in the country now expected to be covered by an ICS by 2021.

Integration has the potential – if implemented with the full input of clinicians – to improve both patient care and doctors’ working lives. A recent survey of BMA members found significant support for integration throughout the UK. Within England, 94% of respondents answered that greater collaboration between primary and secondary care will improve patient services, and 93% that GPs and hospital doctors should work together more closely.

The ICS model could deliver on some of these opportunities. However, to date, ICSs’ engagement with frontline clinicians is sub-par and there is a need for greater accountability within the model.

This briefing is intended to support BMA members to understand the latest developments regarding ICSs and integration in England. It also sets out BMA policy on ICSs and establishes five principles, which we believe ICSs and any other model of integration must meet if they are to be successful. We believe any model must:

- ensure the pay and conditions of all NHS staff are fully protected
- protect the partnership model of general practice and GPs’ independent contractor status
- only be pursued with demonstrable engagement with frontline clinicians and the public, and must allow local stakeholders to meaningfully and constructively challenge plans
- be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
- be operated by NHS bodies, free from competition and privatisation



Background: towards ICSs

ICSs are at the heart of NHS England’s vision for the (foreseeable) future of health and care. In 2016, England was divided into 44 STP (sustainability and transformation partnership) footprints, which brought together NHS, local authority, and third sector providers to collaboratively develop five-year plans for the future of their health and care system. For more information on STPs, [read our briefings](#).

Since then, the emphasis has moved beyond simply planning and towards the co-ordination and delivery of services as a system. This has led to the introduction of more ‘evolved’ models of integration – the most prominent of which is now the ICS. [Watch the BMA webinar on ICSs](#).

First introduced in 2017, ICSs represent a more advanced, formal approach to integration. Within an ICS, member organisations take on collective responsibility for managing resources, delivering care, and improving population health across their local system. As of February 2019, 14 ICSs are in place but, in its Long Term Plan, NHS England has announced that they are now expected to cover the whole country by 2021.¹ All STPs and ICSs are also required to produce new five-year plans by Autumn 2019, replacing those developed in 2016.² These plans will establish how and when the remaining STPs will make the transition to an ICS. [Read the BMA briefing on the Long Term Plan](#).

A more controversial model of integration, the ICP (integrated care provider) has also been introduced by NHS England. ICPs involve merging multiple services into a single contract, held by a single provider. The BMA opposes the introduction of ICPs, as they increase the risk of the privatisation of NHS services and are incompatible with the independent contractor status of GPs. NHS England confirmed in the Long Term Plan that ICP contracts will be available from 2019 and that legislation may be introduced to simplify their creation. Only one ICP is known to be in development, in Dudley, and is expected to be in place by 2020.³

There are a number of important differences between ICSs and ICPs, which are set out in Figure 1 – for more information on ICPs and what they may mean for doctors [see the BMA webpage](#).

Figure 1: ICSs and ICPs – Key differences

ICSs	ICPs
– Characterised by ‘Integration by collaboration’	– Integration by contract
– An ‘alliance agreement’ is held collectively by the bodies involved	– Require a single contract, held by a single organisation, for the majority of health and care services
– Do not necessarily require formal organisational change	– Involves major organisational change
– Retains GP independent contractor status	– Incompatible with GP independent contractor status
– No ‘contract’, so no increased risk of large-scale privatisation	– Competition law means ICP contracts can be won by private providers

ICs mapped

There are 14 ICSs already in place in England, which have emerged in two waves.

The first 10 were announced upon the launch of the model in March 2017, as part of NHS England's Next Steps in the Five Year Forward View, with the second wave revealed in May 2018. See **Figure 2** for a map of the 14 ICSs.^a

Adapted from: NHS England: 'Integrated Care Systems'. Available at: www.england.nhs.uk

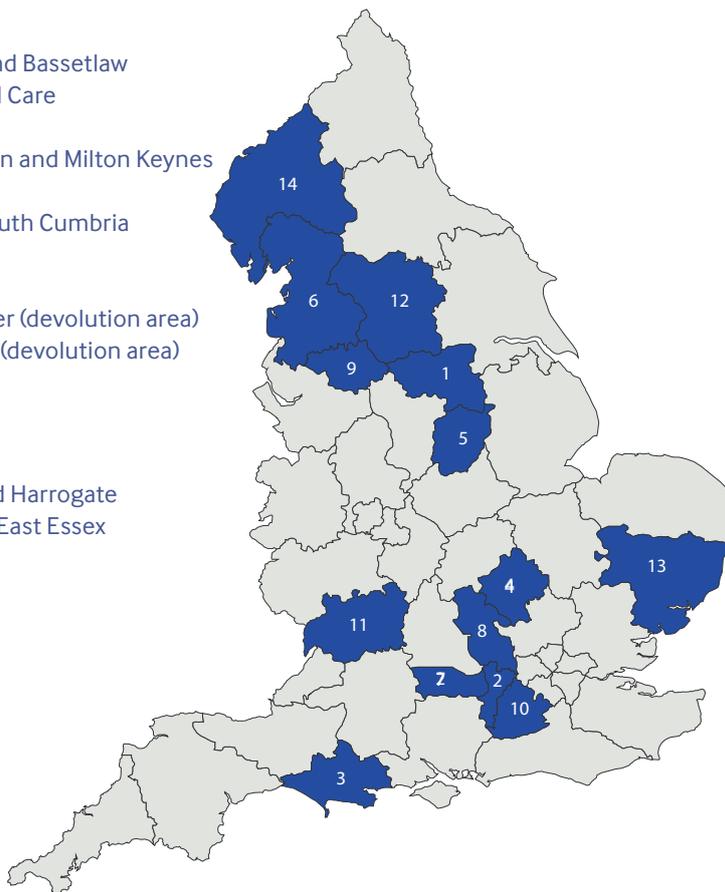
Figure 2: ICSs Mapped

First wave:

1. South Yorkshire and Bassetlaw
2. Frimley Health and Care
3. Dorset
4. Bedfordshire, Luton and Milton Keynes
5. Nottinghamshire
6. Lancashire and South Cumbria
7. Berkshire West
8. Buckinghamshire
9. Greater Manchester (devolution area)
10. Surrey Heartlands (devolution area)

Second wave:

11. Gloucestershire
12. West Yorkshire and Harrogate
13. Suffolk and North East Essex
14. North Cumbria



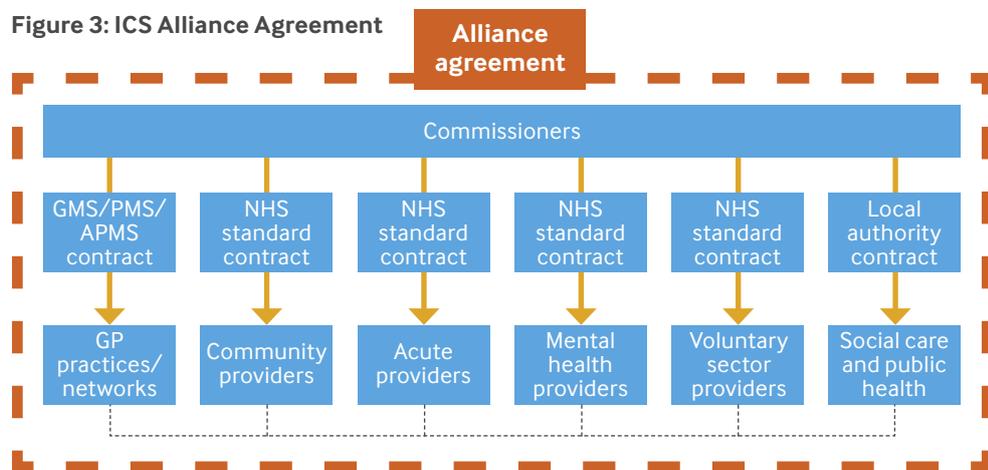
^a The North Cumbria ICS is part of a planned merger with the Northumberland, Tyne and Wear and North Durham STP and Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby STP, to create a North East and North Cumbria ICS.

What is an ICS?

ICSs are characterised by their focus on delivering integration through collaboration and within existing structures. In an ICS, NHS bodies, local authorities and third sector providers take collective responsibility for the resources and health of the population of a defined area, with the intention of delivering better and more joined-up care for patients and ensuring collaboration between health and care organisations.

The constituent organisations of the ICS enter into an alliance agreement, which overlays (but does not replace) regular commissioning processes and contracts.^b The alliance agreement should set out a shared commitment to achieving greater integration, including how resources will be managed, how services will be delivered operationally, and what shared governance and risk-sharing arrangements will be put in place. The agreement is owned by the organisations that are party to it and is supplemented by a memorandum of understanding between them. **Figure 3** visualises how this agreement would work.

Figure 3: ICS Alliance Agreement



ICS leaders also take on additional responsibility for the financial and operational performance of the organisations within their system. This includes a role in assuring the quality of care provided throughout the ICS and at each individual member organisation, as well as the financial position of each NHS body within the system.

There are currently no clear, nationally-set responsibilities ICSs are expected to meet. As a result, the exact scope of services covered by an ICS will vary from system-to-system, although in most cases it will include all secondary, community and primary care services.

^b An ICS 'alliance agreement' is a single, overarching agreement between commissioners and providers which establishes a common strategy, sets joint goals, and establishes a commitment to collaboration, but does not necessitate any organisational integration.

ICS structures

There is no blueprint that ICSs are expected to follow, so their appearance and approach varies. While the ICS model has been established by NHS England and is now being implemented in a number of areas across the country, it has no statutory basis and there continues to be no uniform guidance for how it is expected to operate. As a result, there has been significant variation in the development of ICSs to date.

However, a general structure for ICSs has emerged. This operates on three levels: 'system', 'place', and 'neighbourhood' (also referred to as locality). A fourth level, 'region', has also been suggested, at which individual ICSs can co-operate with each other on larger scale issues. The terminology used to describe these levels varies between individual ICSs, but their roles and size are broadly typical.

– **Region (Pop. 5-10m)**

Activity at the 'region' level is intended to focus on co-operation between ICSs within their wider geographic area – for example on the planning and delivery of specialist services. This will be particularly important for smaller ICSs and those which share services with other systems, such as the ICSs that border London

– **System (Pop. 1m+)**

Work at the 'system' level is focused on ICS-wide strategy, workforce planning, and overall integration. This includes strategic commissioning, service reconfiguration, and broader financial and resource management for the whole system. Management of an ICS's collective resources and financial performance will also take place at this level, alongside overall quality assurance and regulation

– **Place (Pop. 250-500k)**

A 'place' is broadly on the scale of a city or town, though it could also be a broader defined area within an ICS. Work at the 'place' level is centred on the planning of localised services and the delivery of secondary and community care. Oversight of, and strategic planning for, primary care will also take place at this level. This is also where NHS and local authority services are most likely to be integrated

– **Neighbourhood/locality/network (Pop. 50k)**

The 'neighbourhood' or 'locality' level has a significantly smaller footprint and will be based around PCNs (primary care networks); networks of GP practices typically covering populations of 30,000–50,000 people. MDTs (multi-disciplinary teams) will be central to PCNs, with clinicians and health and care professionals from a wide range of services working together to provide primary and community care.

According to King's Fund research, ICS leaders have suggested that 70–90% of work within an ICS should occur at the place and neighbourhood levels, with the remainder carried out at the system level.⁴ However, the size and make-up of each ICS varies significantly, with some covering populations of over one million people and others closer to 500,000 people. As a result, not every system will necessarily operate on this basis.

The NHS Long Term Plan set out broad criteria every ICS should meet. Every ICS is expected to have:

- a partnership board drawn from commissioners, providers, PCNs (primary care networks), local authorities, and third sector organisations within the ICS
- a locally appointed non-executive chair – subject to the approval of NHS England
- named accountable clinical directors for each PCN within the ICS, to facilitate proper engagement with GPs
- clinical leaders based within or aligned with the ICS to add accountability, with clinical senates and cancer alliances made coterminous to ICS footprints.

Key themes and priorities

Although the development of ICSs has been highly variable, there are common themes across the 14 established to date.

ICSs have a specific focus on enhancing the role and scope of primary and community care services. This will revolve around the development of PCNs and the use of integrated MDTs across primary and community care. NHS England see PCNs as central to the provision of integrated, at-scale primary care, encompassing services beyond core general practice and working closely with acute, community and mental health trusts, as well as with pharmacy, voluntary and local authority services.⁵ The NHS Long Term Plan announced that an additional £4.5 billion would be invested in primary care and community services, with a particular aim of facilitating the expansion of PCNs and the use of MDTs. GP practices will be encouraged to create or join PCNs and this has been agreed as part of the new GP contract. [Read more about the GP contract here.](#)

Many ICSs have prioritised improving the overall health of their population to prevent ill-health. The current Secretary of State for Health and Social Care, Matt Hancock, has been clear that prevention is a national priority and it is a major element of the NHS Long Term Plan, which also includes increased promotion of self-care and social prescribing. The wider determinants of health are also an emerging focus for a number of ICSs. Buckinghamshire ICS has, for example, looked specifically at the impact housing, employment and access to green space can have on population health, with an indication that local government will have a leading role in this work.⁶

The current and future workforce has been highlighted as a major issue across all ICSs. Some ICSs are prioritising the use of new clinical roles to support their work, including employing physician associates and advanced nurse practitioners. The South Yorkshire and Bassetlaw ICS, for example, views these new roles as a means of tackling workforce challenges and freeing-up clinicians' time in both primary and secondary care. ICSs are also considering how doctors can work differently and, in some cases, across the system as a whole. This includes the use of 'passporting' and portability systems, to allow staff to move and work between different sites and organisations within the ICS. ***Appendix one provides more information on how staff portability and passporting may work in practice.***

ICSs are focusing on better use of data, technology, and innovation to improve care and support prevention. This is centred around improving IT interoperability and the sharing of patient records. It is perceived that the challenges that have plagued these initiatives previously may, in part, be overcome through system-working. Data sharing is a core focus, with several areas, including the Dorset ICS, working towards establishing shared patient records within their systems.⁷ Dorset ICS is also operating what it calls '360 degrees transparency', with all NHS member organisations expected to share and be transparent with their workforce, finance, and performance data. There are longer-term hopes that sharing data throughout individual systems will support efforts to improve population health, by providing a more detailed view of patterns of ill-health and health risks.

Several ICSs are exploring possible service reconfiguration, including centralising specialisms at certain sites and, in some areas, trust mergers. Dorset and South Yorkshire and Bassetlaw ICSs, have, for example, undertaken reviews of their existing services, with a view to potential future reconfiguration of secondary care.

The South Yorkshire and Bassetlaw review recommended that clinical, or 'hosted' networks be established, with different hospitals taking responsibility for different specialist services, concentrating speciality care at specific sites.⁸ In Dorset, a longstanding and controversial merger between the Royal Bournemouth and Christchurch Hospitals Foundation Trust and Poole Hospital Foundation Trust is being pursued.⁹ The NHS Long Term Plan includes a call for legislative change to ease the merger of NHS bodies, including Trusts, which may mean that trust mergers become more likely in the future. Any service reconfiguration must be led by clinicians, be based on clinical evidence, and must not be driven by financial pressures.

Commissioning and CCGs (Clinical Commissioning Groups) will change as ICSs develop. The NHS Long Term Plan includes an aspiration to have a single set of commissioning arrangements within individual ICSs. According to the plan, this will typically involve a single CCG covering a single ICS. The total number of CCGs has been in decline for some time and a large number already share accountable officers, but formal mergers are now increasingly likely.¹⁰ However, ICSs will continue to vary in size and may not be coterminous with existing CCG boundaries, which may make this process highly complex in some areas.

Commissioning within ICSs is also expected to change, with the possibility that providers will increasingly take responsibility for some of the day-to-day functions currently carried out by CCGs, such as the design of care pathways. This shift would then see CCGs focus on more strategic issues, such as patient outcomes, population health, and financial governance.¹¹

ICSs will take on collective responsibility for the resources and financial performance for the whole system. This includes making arrangements for risk sharing and decisions on how services will be paid for. They will also be required to approve a system control total, defined by NHS England as the aggregate required income and expenditure position for trusts and CCGs within the system.¹² Access to sustainability funding will be linked to performance against the totals.

The move towards system-wide working is changing regulation too. NHS England have promised that ICSs will be subject to a new form of regulation that focuses less on the performance of individual organisations and more on the system, with the ICS leadership taking on a wider assurance role. CQC and NHSI (NHS Improvement) inspection regimes are adapting to match this new approach for secondary care. Joint NHS England and NHSI regional teams will also play a major role in supporting the development of ICSs, assuring their accountability, and reviewing their plans. Alongside this, national regulators will give targeted support to the least advanced STPs to assist their progress towards ICS status.

Implications for doctors

BMA members have told us that existing barriers between services and competition between providers are hindering patient care, and that change is sorely needed. ICSs may, if pursued with proper clinical input, present a genuine opportunity to deliver that change. However, their development so far has shown that the model will have a range of implications for doctors, presenting both challenges and opportunities. As more ICSs emerge these will become clearer and we will be monitoring this closely.

ICSs could create greater opportunities for doctors to lead system transformation, but engagement is lacking so far. NHS England and individual ICSs have stressed that clinical input will be central to their progress and to their leadership. However, clinical engagement remains an area where ICSs, like STPs, have been lacking so far. A number of LMCs (local medical committees) have, for example, reported only limited, if any, engagement efforts from their local ICSs. We therefore welcome the commitment in the NHS Long Term Plan that every ICS should actively engage with a Clinical Director from each PCN within its system. Equally, engagement with secondary care clinicians has been poor, with very few frontline hospital doctors involved in the development of their ICS. It is pivotal that ICS leaders and NHS England commit to genuinely and actively engaging with LMCs and LNCs (local negotiating committees), to ensure that the views of doctors and their representative bodies are actively sought as ICSs develop. This should include thorough engagement with LNCs and the BMA on workforce planning, which has been limited within ICSs and STPs thus far.

It is also essential that ICSs effectively engage and involve local authorities in their work, particularly in respect of efforts to improve public health and social care. Again, this has been a considerable challenge in several of the existing ICSs to date. In February 2019, Luton Council withdrew its support from the Bedfordshire, Luton and Milton Keynes ICS citing a lack of genuine input in its development.¹³ Similarly, in December 2018 Nottingham City Council suspended its involvement in the Nottinghamshire ICS for six months, due to a lack of transparency and democratic oversight of the ICS and its planning process.¹⁴

Without a statutory basis or a clear blueprint for their development, ICSs continue to lack accountability. While the BMA supports the idea of local, place-based planning for care, the lack of oversight or guidance for the development of ICSs means that there is no clear, shared sense of what the model should look like or what its responsibilities should be. This limits the accountability of ICSs and makes it inherently more difficult for clinicians and the public to determine how their health and care system is changing. Moreover, the lack of any statutory footing means that opportunities to meaningfully challenge the direction or decisions of an ICS are severely limited.

While ICSs are intended to overcome existing organisational boundaries, there remains significant concern among GPs that the model is often dominated by NHS Trusts. Therefore, ICSs must also allow for proper local challenge of their plans so that organisations within the footprint, whether NHS Trusts, CCGs, or GP practices, are collaborating fairly and can challenge their leadership.

ICSs will need time and resources to develop. This was one of the most prominent failings of the initial STP process, where plans were drawn up on the premise of producing rapid, unrealistic savings and delivering service transformation without the additional funding. This situation cannot be repeated if ICSs are expected to succeed. The focus for ICSs, particularly as they enter a new planning process in 2019, must be on improving care and delivering integration, not on savings. It is, therefore, particularly important that the 2019 spending review allocates sufficient capital funding to back the plans put forward by each ICS.

Equally, many NHS Trusts face a precarious financial position, with the provider sector reportedly facing a deficit of £800 million this financial year.¹⁵ This means that many individual trusts may struggle to adhere to their own individual control totals, placing enormous pressure on ICSs to meet a system-wide total. Moreover, drastic cuts to local authority funding have severely stretched budgets in both public health and social care, which in turn reduces the capacity of those services to relieve pressure on the NHS and risks undermining integration more widely. NHS England must take this into account when system control totals are set and when priorities for integration are agreed.

ICSs and the shift toward system-wide working and workforce planning may significantly change the way doctors work. The co-ordination of care across wider areas is expected to increasingly involve doctors working across multiple sites and as part of multi-disciplinary teams. This could include, for example, GPs working in A&E departments and consultants working in the community. In theory, this could give doctors from all branches of practice the chance to work in different environments and more closely with colleagues across primary and secondary care, something which has been identified as one route towards improving patient care by doctors.

However, this could also mean that doctors' patterns of work may change. Passporting and staff portability systems are likely to be introduced in all ICSs, to allow doctors and staff to work in different sites across the whole system. In addition, where mergers do take place contracts may be transferred to other Trusts via TUPE (Transfer of Undertakings (Protection of Employment)). In the event of any changes to working patterns or places of work, all doctors should at the bare minimum be employed on nationally agreed terms and conditions, with their training time fully protected. Any changes must only happen in consultation and with the agreement of the BMA.

Changes to ways of working may also impact on workplace negotiations. It may be the case that as individual hospitals and staff increasingly operate as part of the wider system, place-based negotiations will need to take place on a wider scale, potentially at 'place' or even 'system' level. Equally, the pay and conditions of doctors working in different or atypical environments may need to be altered to reflect their new roles and responsibilities. This could, for example, apply to GPs working in A&E departments or, as in Wolverhampton, those working as employees in GP practices that have been taken over by an NHS Trust.¹⁶

In all cases, doctors should at the very least be employed on nationally agreed terms and conditions. Equally, changes to negotiations must only happen in consultation with doctors and with the agreement of the BMA.

ICSs could fundamentally move the NHS away from competition and towards collaboration – if properly supported by legislation. The BMA has been consistently critical of competition within the NHS, which we believe is bad for patients, staff and integration. Pitting providers against each other for resources does not foster closer working and will undermine efforts to overcome organisational barriers. The ICS model's focus on collaboration over competition could, then, allow integration to flourish. But to ensure that this can happen, costly and burdensome rules on competition should be removed.

The NHS Long Term Plan has set out calls for legislative change to remove several of the major competitive elements of the 2012 Health and Social Care Act, which the BMA strongly supports, though it is still unclear when the legislation will be put forward, let alone passed. As a result, it is likely that ICSs will continue to operate under the existing rules for some time.

Many STPs are not yet in a position to become ICSs and may not be for some time. Many STPs have faced significant challenges in their development and are still some way from becoming an ICS. In contrast, the existing 14 ICSs are continuing to progress with their plans and should be well established by 2021. This disparity presents the risk that a two-tier system could emerge, with levels of integration varying widely between different systems. The NHS Long Term Plan does include a welcome commitment to provide additional assistance for the least advanced systems, which may help to alleviate this issue. However, if ICSs are expected to be the future of the NHS, every system should be given support to develop on an equitable and fair basis.

Conclusion

While there remain questions about their development, ICSs may well be able to break down barriers between services, support doctors to collaborate, and facilitate the move towards a model of co-operation over competition.

If they are to be successful, we believe that they need to meet five principles. These establish that any model of integration must:

- ensure the pay and conditions of all NHS staff are fully protected
- protect the partnership model of general practice and GPs' independent contractor status
- only be pursued with demonstrable engagement with frontline clinicians and the public, and must allow local stakeholders to meaningfully and constructively challenge plans
- be given proper funding and time to develop, with patient care and the integration of services prioritised ahead of financial imperatives and savings
- be operated by NHS and publicly accountable bodies, free from competition and privatisation

We will judge each new STP and ICS plan against these criteria and expect NHS England's priorities for integration to meet them.

Advice for BMA members and what you can do

As we have highlighted above, it is vital that any service change or development is clinically led. It is therefore important for members to be aware of these proposals and to get involved in discussions locally. Different areas will be at different stages of development; members should try to engage as early as possible, but even if plans are further advanced, doctors are still in a powerful position to influence changes for the benefit of patients and the NHS more widely.

BMA members across all branches of practices have a vital role to play in deciding the future direction of services in their areas. We therefore encourage you to engage with local decision-making structures in your area:

- CCGs remain accountable to parliament for the commissioning of care; engaging with your local CCG is, therefore, an important means of influencing reform of the healthcare system in your area
- similarly, Trusts are likely to play a key role in the development and running of any ICS, and it is important that you continue to engage through existing structures and influence your Trust's leadership
- contact your LNC and ask that they raise both ICS/STP engagement, and staff portability with your Trust
- we also encourage members to get involved in local bodies such as LMCs, LNCs, and BMA regional councils, so that the profession's collective voice is as strong as possible at a local level

Appendix 1: Staff portability and employment rights

A number of different options for staff portability may be proposed by employing organisations, including the following:

Joint employment

A doctor can be employed by two separate organisations at the same time provided there is nothing in their contract with the first employer which would prevent them from agreeing the second employer's terms of employment. In this arrangement the doctor has two contracts of employment and the two employment relationships continue in parallel with each other. A good example of this is the nationally agreed Honorary Consultant Contract (England) which allows for clinical academic consultants to have joint employment.

Joint employment may be a more suitable arrangement where the doctor will be working for the second employer for an indefinite period and the nature of the engagement between the doctor and the second organisation has the characteristics of a standalone employment contract.

Secondment

Secondment refers to an agreement between an employer and a second organisation (referred to as the host) for a worker (or group of workers) to be assigned to the host for a limited period. The employer and the host usually intend for the worker(s) to return to work for the employer at the end of the secondment period. Workers can also be seconded to work in different parts of the same organisation.

The reasons for a secondment may include:

- the chance for an employee to gain new skills and experience;
- applying existing skills or experience in a different part of the organisation;
- preserving specific employee benefits with the original employer, such as membership of a pension or share option scheme;
- building links with other organisations;
- providing staff cover for short-term projects or short-term absences;
- avoiding redundancies;
- charitable purposes (where the secondment is to a voluntary organisation).

Secondments require an agreement between the employer and the host which clarifies the legal rights and responsibilities in the relationship. Where the secondment is to an entirely separate organisation, the employer and the host are likely to need a detailed secondment agreement that is clear on how the secondment works with the employee's existing terms of employment.

License to attend

A license to attend gives a worker permission to attend another organisation's premises. Licenses to attend in the context of employment will only usually be suitable in very limited circumstances, for example where the placement is very short term and or where the worker has very limited functions to perform that do not interact in any complex or risk-related way with the employer's normal operations.

Honorary contracts

Honorary contracts are used when an individual is employed by an organisation and is then asked or expected to work at another organisation either temporarily or for part of the working week. Traditionally, honorary contracts have been used to allow clinical consultants from one organisation (including universities) to access another NHS organisation's facilities in order to see patients or to allow research to be conducted. An honorary contract is not intended to result in any payment obligations between the individual and the host employer, though there will be between the employer and the host and the precise arrangements for meeting on-call or out of hours costs can vary. It is usual and sensible to ask the individual to respect the specific policies and procedures of the Host. In the case of a clinical academic arrangements should be put in place for the joint management and appraisal of the individuals concerned. The host would also be expected to assist with the appraisal and revalidation of other doctors working for it under honorary contracts. As honorary contracts are commonly used for clinical attachments, clinical indemnity provisions will usually be included. The termination of honorary contracts should be done in discussion with the employing organisation.

It is vital that where any of the above arrangements are proposed they are agreed in consultation with the doctors affected and their trade union representatives, and that they are completely clear as to where legal employment responsibilities lie. A wide range of related issues such as arrangements for travel to other worksites, data transfers, indemnity, pre-employment checks and IT access for example will need to be considered as part of these arrangements.

There are also a range of existing portability arrangements in place for doctors, in particular to allow trainees to rotate frequently between different employers for training placements and for medical academics to split their work between NHS and university employers. Such existing arrangements should not be superseded or amended by new portability plans for all staff, and it is important that the unique working patterns and contractual arrangements for doctors are protected.

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