Integrated care services: Developing strategies for integrated care – A relational content analysis

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A B S T R A C T

Objectives: The Health and Care Act, 2022 established 42 Integrated Care Systems [ICSs] to oversee strategy, planning, and funding for health and social care within designated areas. Concerns have emerged about the ability of ICS strategy writers to balance national targets with local needs. There is recognition that initial strategies lacked sufficient depth and breadth, necessitating revisions. This paper aims to support ICS strategy writers to meet the requirements of these revisions.
Study design: A two-phase, relational content analysis was performed. First phase producing aims for future ICS strategies. The second phase, a thematic analysis, produced guidance on intervention themes.
Methods: The first phase relational content analysis synthesised four foundational documents in the creation of the Health and Care Act, 2022. This allowed a second phase of analysis which aims to offer ICS strategy writers support in the form of a strategy framework.
Results: The first phase analysis identified two aims: 1) to provide a sustainably streamlined, collaborated and personalised approach to health and social care access; 2) to be proactive in enabling people to stay healthy from their homes and communities.

The second phase of analysis produced four themes to support the creation of a strategy framework, designed to support ICS strategy writers.
Conclusions: This paper identified key national policy drivers and expectations that ICS and Joint Future Plan-ning should consider while preparing their strategies. It highlighted components of effective ICS strategy with the aim of moving towards a personalised, joined up health and care system; the need for data in ensuring evi-dence-based interventions are prioritised in future ICS/ICB strategy; stronger connection to community and the important role of community led workers; prevention and early detection across the care pathway—delivered through a joined-up approach between clinicians and community-led workers; and addressing wider socio-economic determinants of the communities.

Keywords:

Public health Prevention Qualitative research Community health

INTRODUCTION

The concept of integrated care was introduced in North America and Europe almost three decades ago, in response to the growing complexity in healthcare and health needs of the population, as a framework to develop better and more cost-effective health systems [1]. As recognised by Lewis et al., [2] the impact of budget division among health providers, institutions, and professions on the population's health, has highlighted the need for cooperation among organisations that provide care, such as NHS trusts, local authorities, and NGOs. Three decades later in England, the enactment of the Health and Care Act, 2022 [3] introduced 42 Integrated Care Systems [ICSs] to formally oversee the strategy, planning and funding of Health and Social Care within its newly formulated geographical areas. Each ICS in England brings health and care organisations together to develop shared plans and joined-up services [4]. In addition to the NHS organisations and upper-tier local councils, the ICSs include the voluntary sector, social care providers and other partners. Each ICS is responsible for somewhere between 500,000 and 3 million people [5]. Research has already highlighted concerns of the complexity of establishing ICSs with no 'natural fit' between the health and local government footprints [6] and the need to ensure ICS come together to collaboratively meet the needs of the people within their care and not 'lose sight' of the ultimate goal of improving people's health and care [7][8]. The introduction of the 2025 Ten Year Health Plan [9] for England has begun to address issues around health and social care partnership working by streamlining how local government and the NHS work together and a move towards making Integrated Care Boards [ICB] more coterminous with authorities within which they work. The Ten Year Health Plan proposal aims to bring a range of services from housing and employment into combined authorities with NHS services such as GP surgeries and emergency care. Yet

the new plan is bringing major organisational changes which need to be carefully addressed to ensure no disruption in the delivery of care.

With this in mind, concerns have been raised that ICS strategy writers will find 'tension' in meeting national targets and addressing local needs [10]. As outlined by Lewis et al., [2] some integrated pilot projects suffered issues of restructuring and engagement of some stakeholders, interoperability in its three forms, cross organisational working relationships, suitable technology and providing an enabling environment [11]. This 'tension' involves services understanding the roles, responsibilities 'language' of each other with ICS and Joint Future Planning [JFP] strategy writers required to have a clear vision of which national targets and policy mandates must be addressed under ICS strategy, as well as ensuring that it is fit for purpose in the local communities that it serves. The Department of Health and Social Care [DHSC] has acknowledged that strategies will require revision as first iterations may have had limited depth and breadth [12]. This paper therefore aims to support strategy writers by providing a collated and synthesised set of overarching aims and themes that meet the requirements of the prior foundational national policies.

Firstly, through reading the Government White Paper "Integration and Innovation: Working together to improve health and social care for all" [13], a set of documents were identified for analysis. Further 'snowballing' revealed additional documents that created the foundations for the Health and Care Act, [2022] [3] [Figure 1]. Secondly, through a relational content analysis of these documents, a set of synthesised aims and themes provided a framework for a set of guiding principles [Figure 2] for ICSs and JFP strategy writers to ensure strategies are addressing the 'tension' outlined by the National Audit Office [10] by bringing together the shared understanding of the foundational driver documents of the Health and Care Act, [2022]

[3]. This paper will inform strategy writers of the shared aims and themes of all policies that form the foundations of updated ICS strategies, thus reducing the burden on ICS leaders of needing to individually determine how to create strategies that meet the needs of their local populations using a consistent foundational base.

The proposal for the formalised creation of Integrated Care Systems was first outlined in the Government White Paper for the Health and Care Act [2022]. 'Integration and Innovation: working together to improve health and social care for all', foregrounded the creation of the ICS and ICB model which formalised the Government's aim for an integrated approach to health and social care. As stated in the White Paper, 'this bill is about backing our health and care system and everyone who works in it. Our proposals build on the NHS's own – those in the Long Term Plan' [13], pg 6 and this underscores the NHS Long Term Plan [14] as a vital component of the current Health and Care Act, 2022. In addition, the NHS Long Term Plan refers to the Better Care Fund [BCF] [15] as the mechanism that will support integrated health and social care which is echoed in the BCF itself. Finally, the latest BCF planning requirements 2023-25 crossover with the Fuller Stocktake [16] 'Whilst there is no specific requirement to fund implementation of the Fuller Stocktake, there are clear overlaps between the delivery of the vision for Primary Care Network [PCN] level multi-disciplinary teams supporting prevention and focussing on people in the Core20PLUS5 population, and the aims of the Better Care Fund' [15] . The four documents identified for analysis 'hang together' [17], through their relationship to outlining the future shape of integrated health services post-Health and Care Act, 2022 in England. This phase of policy and data collection was performed from October 2023 to October 2024.

METHODS

A relational content analysis was performed on the four documents identified as being foundational in the creation of the Health and Care Act, [2022] that has shaped the introduction of ICS in England. The analysis was performed in two phases guided by two key research questions: [1] What are the aims of ICSs in England? and [2] What are the key themes that are intended to shape the strategy of ICSs in England? The two phase research process was hermeneutic and iterative, put simply 'In a hermeneutic stance, the researcher re-reads all of the original data and lets it sit in their mind like stew on the stove in a thick metal pot, slowly simmering – not boiling too fast and creating too many ideas – like a gentle meditation, allowing ideas and thoughts to bubble up, questioning and revealing what is concealed' [18], pg 127 and the first phase began with a content analysis of the documents where an interpretivist analysis produced two synthesised aims of Integrated Care Systems [**Table 1**].

To answer our first research question, the first phase began with a content analysis of the documents where an interpretivist analysis produced two synthesised aims of the ICSs Integrated Care Systems [**Table 1**]. The selected documents were read and their overarching aims were identified and collated. From here key words were extracted from the documents' aims and grouped into first order codes. First order grouping was based on semantic similarity and allowed the connections between terms to become clearer. Second order coding focused on understanding relationships of meaning between codes. This process refined the first order codes into prose that aligned with the researcher's interpretation of the content of the document's purpose and the meaning of codes. These second order coded statements were discussed amongst the research team, referring back to the original documents to reach consensus in interpretation, before synthesising the coding into two succinct, strategy framework aims [**Table 1**].

Our second research question seeks to offer guidance on intervention themes that would allow strategy writers the opportunity to more easily frame their strategies. The second phase followed the six-step thematic analysis process outlined by Braun & Clarke [19]. The process began with 'eyeballing' [20] the documents to gain familiarisation and highlighting emerging keywords within the documents. As an iterative process, the keywords were first numerically tallied where they most often appeared in each document [**Table 3**] whilst simultaneously re-searching alternative keywords based on similar meaning. To ensure word groups could be identified as codes, the thematic words and phrases were used to rescan the documents for further evidence of 'thematic fit' [21], pg 107. For example, the terms "access" [of health and social care services] appeared significantly as a term next to 'data' 'data driven / aggregate' as a phrase meaning 'data access' [**Table 2**]. This process allowed connections to become more visible across the documents and as an iterative process, the emerging second order coding was used to further support thematic fit and allowed the development of codes into emerging themes [**Table 2**]. Second order codes were then further synthesised where coherence appeared and formulated into the themes found in Figure 2. The themes were shaped by the research team where discussions were used to explore emerging interpretations but were presented based on word or phrase frequency [**Table 3**] to present the themes that were represented most frequently in the documents first.

To check our interpretation, we explored patterns which emerged by placing the documents in publication date order and acknowledging the length and focus of each document. Although there were some keywords or phrases that gained, or lost traction from 2019 to 2023, there were no obvious signs of this at the theme level which would influence the recommendations provided. Total page content acknowledges that some key words and phrases appear more

heavily used; when considered against page number/usage ratio we only found further consistency in our interpretation and support of the themes as presented here.

The interpretation then utilised 'existing theory and existing interpretations of similar phenomena to help frame and enrich the interpretation' [22], pg 124. The analysis resulted in the creation of the Strategy Framework [**Figure 2**]. As this work is a systematic content analysis of publicly available national documents, pertaining to the development of the ICS strategies, it did not involve any direct input from patients or public.

RESULTS

The first part of the analysis brought together all the aims from the identified driver documents and produced two cross-cutting synthesised aims [**Figure 2**]. The first aim: **To provide a sustainably streamlined, collaborated and personalised approach to health and social care access [to enhance and prolong life]** is focused on health and social care intervention with enhancement and prolonging of life the overall focus. This aim brings together ideas around sustainability, collaboration, integration and personalised healthcare. It represents ideas for how the health service can deal with increasing demand. The second aim: **To be proactive in enabling people to stay healthy from their homes and communities** is focused on utilising community-based care as an enabler to better health outcomes. Moreover, it represents ideas for reducing or better prioritising and understanding demand for health services through prevention and moving care to homes and the community and away from acute care settings.

To achieve these two aims four overarching themes have been identified.

Theme 1 - Interventions and goals must be evidence based and rooted in data which is shared across the service[s]

The NHS Long Term Plan highlights the need for a clear set of measurable goals and mechanisms for measuring impact of interventions and suggests that 'NHS England, working with Public Health England and our partners in the voluntary and community sector and local government, will develop and publish a 'menu' of evidence-based interventions that if adopted locally would contribute to this goal.' [14], pg 40. Even with the dissolution of Public Health England in 2021, the new NHS Ten Year Plan continues to place emphasis on those goals and mechanisms aimed at reducing health inequalities over the next 5 to 10 years through data driven and evidence-based practices. Examples of tangible, measurable outcomes for interventions aimed at those groups who disproportionately suffer health inequalities within society include increasing the uptake of existing services, increase of early cancer diagnosis and decrease of maternity-related deaths [14] along with an increase of discharge wait times [15] and patient satisfaction [16].

One identified aim of the ICS is to assess the potential benefit of evidence-based interventions to ensure that there is minimal unwarranted variation in service provision. The BCF outlines the importance of evidence-based interventions by explaining that 'As part of this local areas should explain why particular services and schemes have been prioritised and what outcomes they are trying to achieve' [15], pg 6. The Long Term Plan [14] emphasises a focus on 'A new service model for 21st century', which aims to expand access to evidence-based interventions. ICS strategy writers need to decide which interventions should be adopted based on the evidence provided in terms of cost-benefits and health goals for their targeted population [23]. This assumes that strategy writers have access to current, high quality data on the population they are working with, and this is required to ensure that unwarranted variation of health and

social care provision within a geographical area is addressed to avoid unnecessary health inequalities within the population. The Fuller Stocktake document highlights the need for local data to be made available to integrated neighbourhood teams in order to produce appropriate interventions that meet priority needs in a cost-effective manner [16], pg 16. To achieve the vision that data drives the success of integrated services and transforms care [13], there is a need to have a measurable and evidence-based set of interventions, rooted in data that can be shared across the service[s]. It is vital to find interoperability in order for intervention outcomes to be shared across the health and social care sector where the intervention has enhanced and prolonged life as outlined in Aim 1 of the framework above. In 2024, the NHS introduced a Multi-professional Practice-based Research Capabilities Framework [24], which has highlighted ways that practitioners can increase their research awareness, although this is not open to all levels of professional and does not address how strategy writers should implement evidence based practice that results from an increase in research awareness, into future strategy where there are skill gaps or a lack of capacity in the system.

Theme 2 - Connection between service and service users creates environment for personalised care provision and increases access

At its most simple, the White Paper [13] makes clear the need to make access to services easier. It recognises the importance of connection, highlighted in the paper as: Connect, Communicate and Collaborate within each ICS. The idea of connection provides the service users a conduit to accessing the services they may not have previously known about or felt were unavailable to them. Part of this connection involves considering ways to get the most appropriate services to the most appropriate service users. The NHS Long Term Plan makes clear that NHS England will develop a ‘menu’ of evidence-based interventions that supports a personalised approach

to health intervention for service users [14], pg 40 and this personalised provision requires that the ICS understands the community for which it serves. In the Fuller Stocktake [16] it is clear that this connection between ICS and its community takes place when services engage in genuine co-production and personalisation of care [16], pg 7. Where health interventions have been identified through suitable data, the NHS Long Term Plan suggests that the use of personalised advice and provision has a larger impact than generic intervention on long term health change [14], pg 35. Choice and access to provision allows service users to achieve autonomy in the personalisation of their care and as outlined in The Better Care Fund [15], personalisation of care is also vital in ensuring that service users remain independent for longer, which means where possible staying in their home, which again supports the need to focus on community led workers in the delivery of ICS strategies.

Theme 3 - Prevention and early detection of mental and physical conditions are best achieved by a joined-up approach between clinicians and community led workers

Where interventions need to be rooted in appropriate and meaningful data, strategy writers need to make decisions on distribution of upstream or downstream intervention[s]. The NHS Long Term Plan focuses on the need to improve upstream prevention, those that address the social factors that contribute to health and prevent illness such as housing, employment, education [25], such as smoking cessation, diabetes prevention and also emphasises that the way this is achieved is through providing better support for patients and carers and to support aspects of 'supported self-management' [14], pg 33, which can be linked to an enhancement of personalised care provision. Where focus is given to the use of community led workers, the NHS Long Term Plan highlights that interventions are not about additional training for highly trained professionals, but instead a focus on leveraging community health and wellbeing workers to work directly with clinicians to support clinical input into primary prevention. These

workers operate as health care providers, who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors [26]. This suggests that in line with this theme, community 'led' workers could take a more prominent role in delivering information that addresses illness prevention and works to improve early detection of mental and physical conditions within the community that they operate within. It is highlighted in the Fuller Stocktake that as health and social care becomes increasingly more integrated, then this integration should be done so with a focus from national partners supporting local populations in a 'support' not 'dictate' manner, to empower neighbourhood teams to integrate in the most appropriate way for their community [16], pg 18. The use of community led, or neighbourhood teams is designed to ensure the needs of the individual communities are met. This whole patient approach, otherwise referred to as holistic and/or psychosocial interventions addresses the need for community health and wellbeing workers to have a personalised approach to care [16], particularly in regards to the treatment of mental health conditions and the need to treat these on an equal footing to physical conditions [15]. This community led, integrated approach to all forms of health intervention requires a focus on the relationship between service users and the services as a means of delivering personalised care provision, but also vitally resource[s] need to be allocated to community working to allow this to take place.

Theme 4 - Interventions need to address wider Socio-Economic considerations within communities

As outlined in the NHS Long Term Plan [14] pg 43, stable employment increases positive mental health, which in turn supports an improvement in service users' socio-economic outcomes. The White Paper outlines the importance of considering, addressing and improving

community members' life chances where a focus is on being proactive as a form of enhancement to health and overall wellbeing as well as or rather than reactive. Fuller Stocktake [16] pg 14 highlights the importance of a preventative healthcare system as a means to addressing the socio-economic determinants of health. This is in line with the Robert Wood Johnson model that suggests that socio-economic factors - education, employment, income, family and social support and community safety - as one of the largest relative contributions of determinants of health [27]. The need to know the communities for which strategies are going to be written and implemented, highlights the need of ICS strategy writers to utilise Joint Strategic Needs Assessment [JSNA] and Joint Health and Wellbeing Strategy data in such a way that funding can be aligned to provide personalised intervention for the socio-economic considerations of the area [13]. This personalisation is vital as the White Paper outlines the importance of service users being their own decision makers on health and wellbeing in their current and future lives, which improves overall community health and wellbeing outcomes.

DISCUSSION

This content analysis aimed at synthesising the themes of four national driver documents that are precursor documents to the creation of ICS strategy. Four key themes were identified: the need for interventions to be evidence based and rooted in national as well as local data; prevention and early detection of mental and physical conditions are best handled by a joined up approach between clinicians and community led workers; connection and relationship between the service[s] and service users is vital to increasing access and moving towards enhanced personalised care provision; interventions need to address wider socio-economic considerations within the communities that they serve.

It is important in terms of strategy development that any interventions utilise available data to ensure that they are fit for purpose. Any proposed health intervention should be accompanied by a complete and justified equality and health inequalities impact assessment, which Anderson et al [28], pg 8 highlights by suggesting that 'Moving forward, the evidence based intervention programme will need to focus on developing strategies to facilitate and monitor these collaborations at the local level to balance both bottom-up and top-down implementation in a manner that could foster more sustainable and consistent reductions in low value care'. A focus on evidence-based interventions offers strategy writers the opportunity to ensure that interventions meet health inequality needs with the completion of the equality and health inequalities impact assessment, as well as local need through utilising data from JSNA as well as NHS Oversight Metrics and any other national drivers such as Core20PLUS5 [29]. This use of data allows strategy writers to feel confident of meeting the needs of the communities with which they are aiming to reach, that is rooted in appropriate data that highlights local needs. The Association of Medical Royal Colleges [23] highlights that it will be a role of the ICS in deciding which interventions should be used based on long and short term costs, benefits and health goals of their population and their prioritisation. The use of data then allows clear targets to be set for evaluation. Both the NHS Long Term Plan [13] and the Government White Paper [14] highlight the use of data within the Vanguard Project[s], which highlights that a reduction of emergency hospital admissions [its aim] by between 3.1% - 4.2% is deemed a successful evaluative target and therefore strategy writers should be able to utilise similar figures as evidence of successful impact or outcome; it will require a level of interoperability that allows the shared availability of data in the first instance, which currently is not always available. As outlined by Li et al., [30] pg 2 'Despite numerous policy initiatives aimed at tackling this issue, little success has been found in rectifying this issue to improve effective data sharing.'

The introduction of ICB and ICS highlights a willingness to move towards place and neighbourhood-based partnership. The national driver documents highlight an increase in personalised care for service users within their allocated place and neighbourhood. With a focus on prevention and early detection, this paper has highlighted in the documents analysed, the importance that place based, community led work can have on reducing health inequalities. The findings of this paper also help to support the Government's direction as outlined in the Ten Year Plan, that outlines the Government's desire to further increase health and social care partnership going forward.

As outlined by Cortis [31], the key issues around the connection between service and service users fall under four categories: Overcoming access barriers, building relationships, networking/partnership and staffing. In overcoming access barriers, one suggestion given is in targeted support with consideration of place, space and face. The terms ‘place, space and face’ are used to highlight the need for community-based interventions in locations that reduce the barriers to access and are led by individuals with lived experience of the issues of the community. The use of ‘soft’ entry points, a term adopted from community health interventions in Australia [32] that are not structured surgeries or service buildings, assist in overcoming access barriers. ‘Face’ refers to the use of community healthcare workers who are familiar to the service users i.e. a ‘friendly face’ as someone they may recognise from their locality and in turn are more ‘relatable’ [33], pg 3. This should allow relationships to be built more easily and offer a conduit between members of the community and the health and social care system and highlights the importance of relationships and connections to enhance personalised care provision within the health and social care system [34]. The advantages to utilising community led workers is that they often operate as a conduit between the service[s] and service users. This in turn has the ability to increase access and uptake of downstream interventions [35]. Where interventions are designed to address health inequalities in areas where socio-economic

determinants of health drive intervention need, then it is also possible that these community led workers will see an increase in employment, income and education, all of which impacts the health determinants of the community they not only work in, but live in as well [36]. A consideration for strategy writers in the future should be how interventions can be more than downstream interventions but also have an upstream intervention potential as well.

Where neighbourhood-based interventions operate utilising members of the community to deliver the intervention, then it also benefits from making quick connections and relationships with members of the neighbourhood, owing to their shared member identity. This shared community identity allows service users to perhaps ask questions that they would not feel comfortable speaking to a highly trained professional about and may arise from historical hesitancy of State care, poor prior experience or disengagement from care more generally [37]. It would therefore allow a member of their community to offer them a connection and relationship in which they can ask questions, gain information that they may have previously not known where to go. Interventions will only be successful if the right people attend them, at the right time. Community led workers offer a conduit to these interventions.

Owing to the connections between health inequality and socio-economic determinants of health, interventions should aim to address the wider socio-economic considerations of the communities they serve. Again, this requires data that is up to date and that services are able and willing to share to enhance success and ensure personalised care can be provided. Previously, these socio-economic factors have not presented with such significance in healthcare planning as it may have in social care planning and this also highlights the emphasis for enhanced relationships between care services within communities. With these enhanced relationships comes a need for all services from the wider health promoting system to delivery

to be integrated. Consideration needs to be given that health campaigns need to be suitably funded at the point of delivery to ensure integration and better higher outcomes are met.

This paper has identified key national policy expectations and drivers that ICS/JFP should consider within the creation of their ICS strategies, but also it has highlighted appropriate components of an effective ICS strategy with the aim of moving towards a more personalised and joined up health and care system. The analyses highlight the need for data in ensuring evidence-based interventions are prioritised by ICSs moving forward. The connection to community and the potential for community led workers became a strong component of the analysis and discussion. ICSs will clearly have a range of ways to meet this, depending upon their needs and requirements, but nonetheless a focus on upstream as well as downstream interventions will allow service users the opportunity to personalise their care as well as increase their ownership of the decision-making processes. There is an opportunity for ICBs/ICSs to explore the potential of community led health workers who originate from the community and operate within their community to deliver low level health intervention as well as operate as the conduit to members of the community who may be reluctant to engage with the services. Finally, interventions and the data that is collected based on their uptake provides ICS's with the data of those in the population that are service users, but as the Long Term Plan outlines, the emphasis is on those 'in contact with NHS services' [14] pg 35 but ICS's may wish to consider how they reach those in communities who have not engaged with the services yet, for reasons such as hesitancy or lack of information, and may suggest that community led worker's provision is proactive, universal and irrespective of need to address the issue of those in the community the services do not yet know about.

AUTHOR STATEMENT

Ethical Approval

Ethical approval was not required for this study as it is based solely on the analysis of previously published and publicly available documents.

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Competing interest

There are no competing interests for any author.

Figure Legend

Table 1 - Extracts from Policies (example of methodology and analysis)
Table 2 - Extracts from texts (example of methodology and analysis)
Table 3 – Keyword Frequency
Figure 1. Selection of foundation, national driver documents of the Health and Social Care Act, 2022
Figure 2. Framework of Guiding Principles

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Figure 1. Selection of Foundation, national driver documents of the Health and Social Care Act, 2022

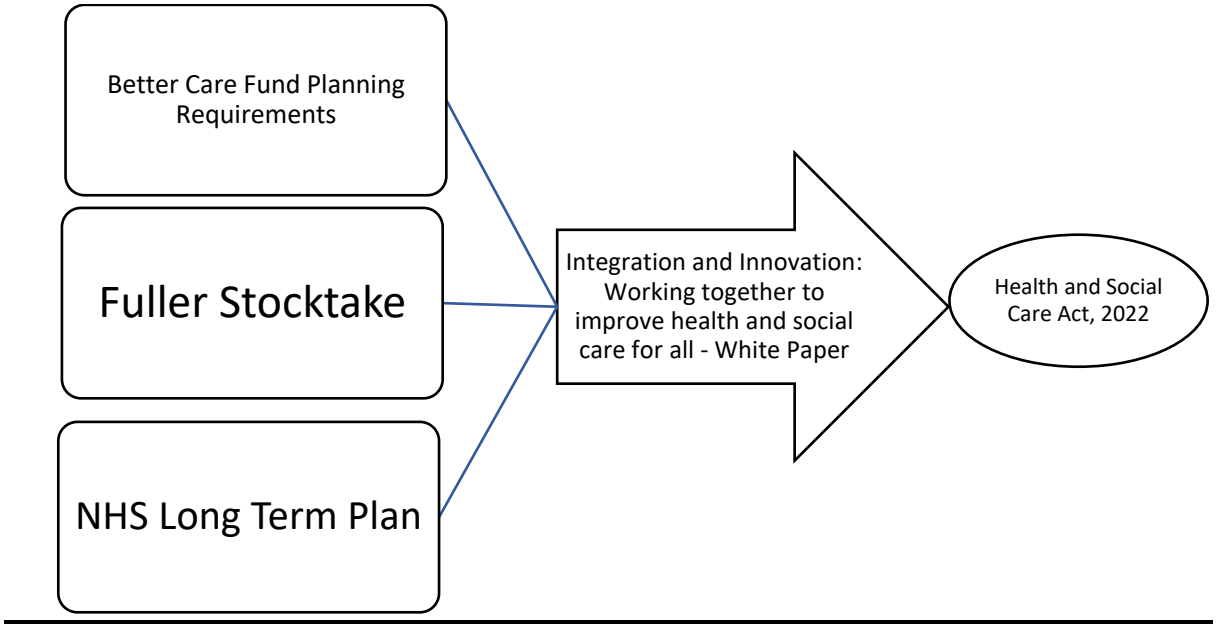

Figure 2. Framework of Guiding Principles

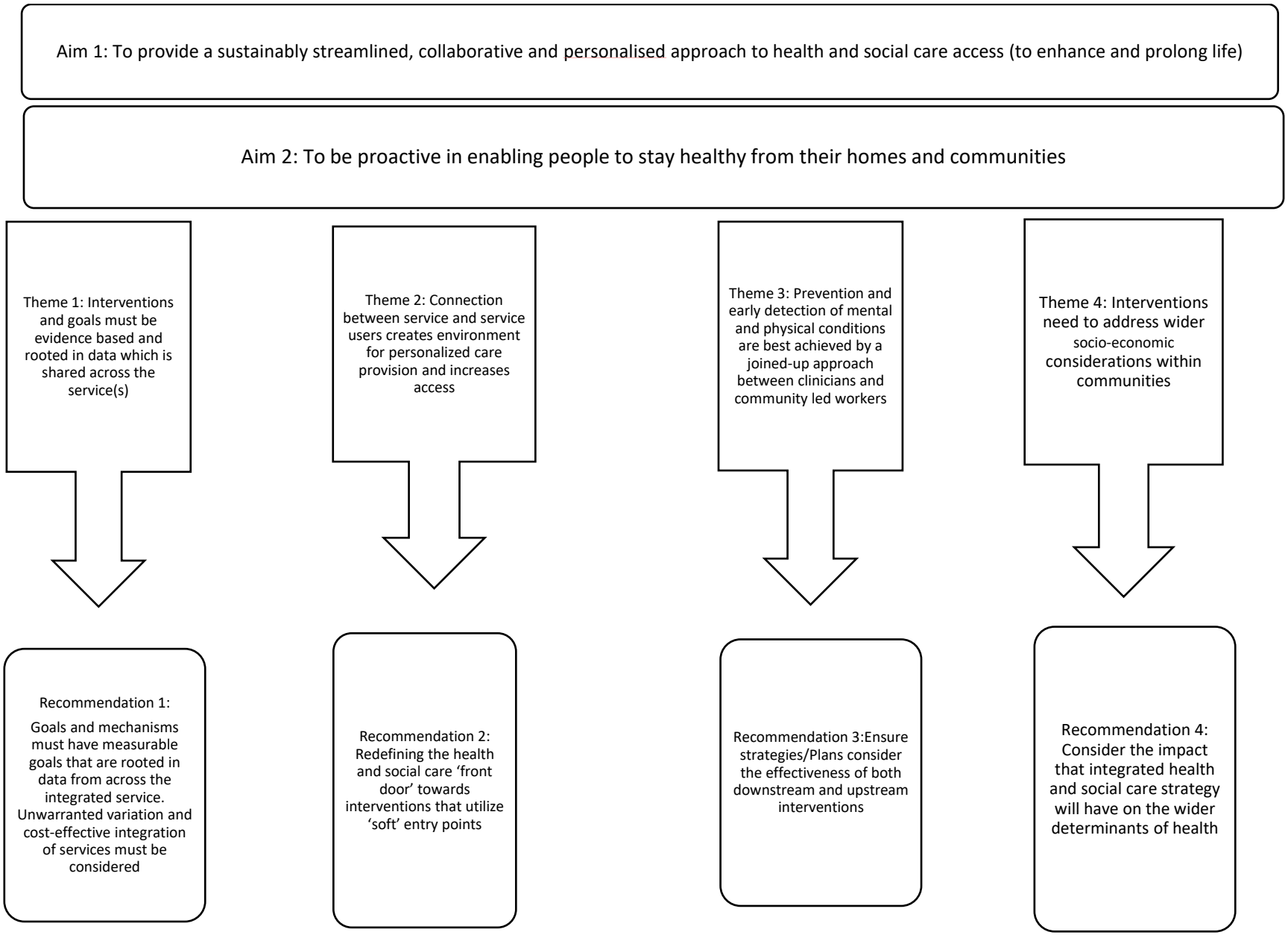
Aim 1: To provide a sustainably streamlined, collaborative and personalised approach to health and social care access (to enhance and prolong life)
Aim 2: To be proactive in enabling people to stay healthy from their homes and communities
Theme 1: Interventions and goals must be evidence based and rooted in data which is shared across the service(s)
Theme 2: Connection between service and service users creates environment for personalized care provision and increases access
Theme 3: Prevention and early detection of mental and physical conditions are best achieved by a joined-up approach between clinicians and community led workers
Theme 4: Interventions need to address wider socio-economic considerations within communities
Recommendation 1:
Goals and mechanisms must have measurable goals that are rooted in data from across the integrated service. Unwarranted variation and cost-effective integration of services must be considered
Recommendation 2: Redefining the health and social care 'front door' towards interventions that utilize 'soft' entry points
Recommendation 3:Ensure strategies/Plans consider the effectiveness of both downstream and upstream interventions
Recommendation 4: Consider the impact that integrated health and social care strategy will have on the wider determinants of health

Table 1 - Extracts from Policies (examples)

	Keywords	First Order Coding	Second Order Coding	Final Synthesised Aims
To meet the many aims within the plan it is suggested that NHS needs to - Increase Collaboration, Increase Proactive Care, More differentiated approach to care (13) Better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources (Page 37) (12) Providing more proactive, **personalised** care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions, **helping people to stay well** for longer as part of a more ambitious and **joined-up** approach to prevention. (15)	Better/ Enhance Everyone / all Sustainable/long term Collaborative Proactive Supportive Joined up Seamless Integration Streamlined	Sustainable Enabling Enhancing Streamlined Seamless Integrated Collaborative Joined up	Access to sustainable, collaborative and integrated care that focuses on personalised health enhancement and prolonging of life.	· To provide a sustainably streamlined, collaborative and personalised approach to health and social care access (to enhance and prolong life)
Support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF. outcomes: • Enable people to stay well, safe and independent at home for longer; • Provide the right care in the right place at the right time (14) Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it, (15)	Enabling Choice Personalised Right Care, Right Place Available in the community	Personalised Choice Supportive Proactive Right Care, Right Place Community	Enabling people to make proactive choices about access to care and care location	To be proactive in enabling people to stay healthy from their homes and communities

Table 2 - Extracts from texts (examples)

	Keywords	First Order Coding	Second Order Coding	Synthesised themes
Theme 1 NHS England, working with PHE and our partners in the voluntary and community sector and local government, will develop and publish a 'menu' of **evidence-based interventions** that if adopted locally would contribute to this goal.(13) Working across the whole of primary care, PCNs should be given the tools to make routine use of **population data to inform how they design care** for the people they serve. (15) As a condition of receiving Long Term Plan funding, all major national programmes and every local area across England will be required to set out specific **measurable goals** and mechanisms by which they will contribute to narrowing health inequalities over the next five and ten years. (13) Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF funded services are being delivered to address these, **including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups (**for example those experiencing homelessness) in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these. (14) This population health approach will be **informed by better data** and understanding of local populations, identifying those who are at risk and who we can impact, **with a view to designing a more proactive way of planning and delivering care**.	Access Community led / community-based Connect/Connection Data Driven (when mentioned as part of use for enhancement) Data sharing & aggregation / access Early detection Environment Evidence-Based Personalised Measurable Prevention Socio-Economic / determinants	**Evidence-Based** **Data Driven (when mentioned as part of use for enhancement)** **Measurable** **Data sharing & aggregation / access**	Interventions and future integration will require decision making process(es). Interventions need to be formulated from an evidence-based approach. Data needs to play a role in the whole process from planning, delivery and evaluation. The process of data sharing across services needs to be available to ensure a personalised approach to health outcomes.	**(Interventions) Must be evidence based and rooted in data which is shared across the service(s).**

It both relies on the power of digital and data to **join up care** and uses that power to drive transformation of care. (12)				
Theme 2 Care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, **prevention** and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives. (12) Using a proactive population health approach focused on moderate frailty will also enable **earlier detection and intervention** to treat undiagnosed disorders, such as heart failure. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which will include musculoskeletal conditions, cardiovascular disease, dementia and frailty. (13) NHS England should work together with systems – recognising they will all have locally driven workforce plans – to identify what measures can be introduced to better support local recruitment and training of key **community healthcare teams** such as community nurses, care support, community psychiatric nurses and district nurses **to work alongside** primary care in **integrated neighbourhood teams.** (15) At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across		**Prevention** **Early detection** **Community led / community-based**	In order to improve peoples' lives, prevent illness and increase health outcomes, it is important to focus on prevention strategy and early detection programmes. This is true of all forms of illness both physical and mental. Integration of health and social care allows local, community healthcare teams to more effectively deal with their local issues and provide personalised care (theme 2) through local evidence-based	**Prevention and early detection of mental and physical conditions are best handled by community led workers**

primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities. (15)			intervention (theme 1)	
Theme 3 The enduring **connection** to people is what makes primary care so valued by the communities it serves: creating the conditions where we can use integrated neighbourhood teams to support practices by providing **personalised** care to those people with greatest need, and on-the-day urgent care where appropriate, keeps the **connection** in place for the future. (15) **Creating a home environment** that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans, including social care. (14) The NHS Comprehensive Model of **Personalised Care**, developed in partnership with over 50 stakeholder groups, is now being implemented across a third of England. By September 2018, over 200,000 people had already joined the **personalised care programme** and over 32,000 people had Personal Health Budgets (PHBs) – nearly a quarter of which were jointly funded with social care. We will roll out the **NHS Personalised Care model** across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade. (13) We want to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of		**Connect/Connection** **Environment** **Personalised** **Access**	How does an integrated service move to a more personalised approach to health and social care? There needs to be more done to ensure people know where they can receive care and this needs to be done in a proactive environment of wellbeing to increase access to services of those who are currently not accessing, for reasons that need to be explored through data (Theme 1).	**Connection between service and service users creates environment for personalised care provision and increases access**

people and their families in **accessing** high quality care and support, regardless of where they live. (12) The point was summed up with great clarity in the recent consultation on integrated care issued by NHS England which set out the following four purposes for systems: (a) Improving population health and healthcare; (b) Tackling unequal outcomes **and access;** (c) Enhancing productivity and value for money; and (d) Helping the NHS to support broader social and economic development.				
Theme 3 Care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, **prevention** and helping people live more independent lives for longer. We need the different parts of our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives. (12) Using a proactive population health approach focused on moderate frailty will also enable **earlier detection and intervention** to treat undiagnosed disorders, such as heart failure. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which will include musculoskeletal conditions, cardiovascular disease, dementia and frailty. (13) NHS England should work together with systems – recognising they will all have locally driven workforce plans – to identify what measures can be introduced to better support local recruitment and training of key **community healthcare teams** such as community nurses, care support, community psychiatric nurses and district nurses **to work alongside** primary care in **integrated neighbourhood teams**. (15)		**Prevention** **Early detection** **Community led / community-based**	In order to improve peoples' lives, prevent illness and increase health outcomes, it is important to focus on prevention strategy and early detection programmes. This is true of all forms of illness both physical and mental. Integration of health and social care allows local, community healthcare teams to more effectively deal with their local issues and provide personalised	**Prevention and early detection of mental and physical conditions are best handled by community led workers**

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities. (15)			care (theme 2) through local evidence-based intervention (theme 1)	
Theme 4 As a nation, life expectancy since 2010 has been stalling, while the amount of time people spend in poor health has been increasing. This trend is driven in large part by wider **socio-economic determinants** and a failure to address the health inequalities that result, and it masks significant variability in outcomes, especially between more affluent and more deprived areas where healthy and overall life expectancy are lower. (15) Each ICS will be required to implement integral services that prevent avoidable hospitalisation and tackle the wider **determinants of mental and physical ill-health**. (13) There is no contradiction between wider collective action on **health determinants**, and a recognition that different individuals will benefit differently from tailored prevention. Indeed one-size-fits-all statutory services have often failed to engage with the people most in need, leading to inequalities in access and outcome. It enables greater ambition on tackling health inequalities and the **wider determinants of health** – issues which no one part of the system can address alone. (12)		**Socio-Economic / determinants**	The wider determinants of health must form part of the personalised approach to health and social care interventions to ensure the needs of most vulnerable in society are met.	**Interventions need to address wider Socio-Economic considerations within communities**

Table 3 – Keyword Frequency

	NHS LONG TERM PLAN	White Paper	Fuller Stocktake	BCF	Total
Publication Date	**Jan-19**	**Feb-21**	**May-22**	**Apr-23**	
Pages	**136**	**80**	**37**	**38**	**291**
Theme 1					
Data Driven (when mentioned as part of use for enhancement)	29	15	1	6	51
Data sharing & aggregation / access	5	11	16	5	37
Evidence-Based	16	1	1	1	19
Measurable	5	0	0	0	5
Theme 1 total	*55*	*27*	*18*	*12*	*112*
Theme 1 total (%)	*40.4%*	*33.8%*	*48.6%*	*31.6%*	*38.5%*
Theme 2					
Community led / community-based	32	5	21	5	63
Prevention	17	2	7	3	29
Early detection	2	0	0	0	2
Theme 2 total:	*51*	*7*	*28*	*8*	*94*
Theme 2 total (%)	*37.5%*	*8.8%*	*75.7%*	*21.1%*	*32.3%*
Theme 3					
Access	13	3	18	2	36
Personalised	16	1	8	1	26
Connect/Connection	6	2	4	0	12
Environment	0	1	3	1	5
Theme 3 total:	*35*	*7*	*33*	*4*	*79*
Theme 3 total (%)	*25.7%*	*8.8%*	*89.2%*	*10.5%*	*27.1%*
Theme 4					
Socio-Economic / determinants	3	3	5	0	11
Theme 4 total:	*3*	*3*	*5*	*0*	*11*
Theme 4 total (%)	*2.2%*	*3.8%*	*13.5%*	*0%*	*3.8%*