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BJPsych Advances (2023), vol. 29, 41–43 doi: 10.1192/bja.2022.78

Integrated care systems: can they deliver?†

COMMENTARY

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SUMMARY

This commentary is a response to three articles on integrated care systems in this journal. It explores some aspects of the latest transformation of England's National Health Service (NHS) and raises some questions on the extent to which the proposed NHS Long Term Plan can deliver on the current challenges.

KEYWORDS

National Health Service; transformation; integration; finances; delivery.

NHS England has been subject to continuous change: since 2000 it has seen at least six major national plans, accompanied by at least ten reforms at various levels. From Tony Blair's NHS Plan in 2000 to the 2014 Five Year Forward View, they all aimed to create tangible, widespread changes in the health service that would give patients and taxpayers a fundamentally better deal (Nuffield Trust 2018). The latest of these reforms is 'integrated care systems' (ICS), introduced in the 2019 NHS Long Term Plan (NHS England 2019). Tracy *et al* published a series of three articles on the subject which discuss the evolution of this model of care, the historical context, possible models of integration and approaches to evaluating this (Tracy 2020a, 2020b, 2022). They clearly outline the concept and opportunities and conclude by suggesting that there is a 'very clear, unavoidable move towards more integrated services'. The benefits of integration at one level are clear but what is worrisome is a lack of evidence for what works. It is imperative to look at these issues from both a clinical and a strategic perspective.

Integrated care systems: how will they work?

The NHS Long Term Plan does set out a clearly ambitious aim for targeting some of the major challenges facing the National Health Service (NHS), with a focus on population health and integrated care approaches, and one cannot disagree with the ambition but the proof as ever in NHS reforms is missing. Considering the repeated waves of change over the years, there is a bound to be increasing scepticism about whether this is 'old wine in a new bottle'. The changes to ICS came into effect in July 2022 against a backdrop of political uncertainty, the war in Ukraine, the cost-of-living crisis and the impact of pandemic and climate change. The management structures are yet to be consolidated, and it is anticipated that there will be a matrix structure across all the organisations that will be part of ICS in a given region. What remains unclear is the operational framework for delivery of the strategic plans by the ICS board. Would the existing organisations within the ICS change radically or retain their current structures and aim to work together to deliver on key priorities? If it is the latter, what influence would the ICS board have on the ground in delivering on the strategic priorities?

The focus on population health is indeed a welcome initiative and forms the basis for understanding the wider population health needs, both for illness prevention and health promotion through public health. In isolation, primary or secondary care services will not be able to get a comprehensive picture of the needs of the entire population within a borough. To understand the mental health needs, population data from the local authority are essential – specifically, index of social deprivation, housing, employment, overcrowding, access to public transport, noise levels and other social indicators. Significant challenges remain in pulling together the data from these sources into one platform from an information technology (IT) perspective owing to differing clinical systems. Although primary and secondary care data can be integrated by using the unique NHS ID, considerable thought needs to be given to joining up the local authority data. Once the IT challenges are overcome, there will need to be some thought put into how to support the public health infrastructure to deliver on developing a baseline of population health needs from a mental health perspective. This would need to be a priority for every ICS and may require some new investment to kick-start this process.

Acute psychiatric care and social care

The past decade has seen substantial challenges to accessing acute in-patient beds, leading the Royal College of Psychiatrists to commission a piece of

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First received 31 Aug 2022
Final revision 28 Oct 2022
Accepted 31 Oct 2022

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†Commentary on… Why care about integrated care? Parts 1–3. See this issue.

https://doi.org/10.1192/bja.2022.78 Published online by Cambridge University Press

work to explore this in some detail. The Commission on Acute Adult Psychiatric Care (Crisp 2016) chaired by Lord Nigel Crisp reviewed available evidence and collected views of front-line clinicians, patients and carers. They also visited some acute in-patient services. They made 12 key recommendations – most notable among them are a 4 h target from assessment to admission to an acute in-patient bed, elimination of out of area placements within a defined time frame, and for each local area to have a 'demand and capacity assessment' with regard to acute care provision. Despite the clear recommendations, the number of out of area placements remains persistently high across England, at about 600 every month and a cost of about £103 million over the past 12 months (NHS Digital 2022). Considering the effect of out of area placements on patients and carers and their impact on finances, there is an urgent need to address this issue and for the recommendations to be translated into policy at a local level. A significant majority of delayed discharges are due to social care problems such as housing and social services funded rehabilitation. This poses a significant challenge to already stretched social services budgets. In the absence of a parliamentary Green Paper on social care, it remains to be seen how the ICS can pull together a system-wide response to address this.

Budgets and funding

Mental health problems account for 23% of the burden of disease in the UK but spending on mental health services consumes only 11% of the NHS budget (King's Fund 2015). Despite the Mental Health Investment Standard, there remain gaps in access to care across the spectrum of ages. NHS Providers highlighted a number of challenges for mental health trusts and national bodies, which include, among other things, a need for capital investment and funds to reach front-line clinical services (NHS Providers 2020). The Royal College of Psychiatrists has noted that 62% of mental health trusts (34 out of 55) at the end of 2016–2017 reported lower income than for 2011–2012 (Royal College of Psychiatrists 2018). It asserted that mental health services have been underfunded, and made the case for an extra £13.5 billion and for the spend to increase from 10.8–13.1% of the NHS budget over the next few years, along with additional mental health staff. Considering the context of integrated care, there will be understandable anxieties about mental health budgets subsidising overspends on a different part of the system, for example the acute sector. The key question for ICS would be: How will the underfunded mental health budgets get new investment, and whether and how will this be ring-fenced?

Moving out of the silos: priorities and opportunities

With the current NHS structures operating in silos and the apparent lack of integration between the NHS, social care and the voluntary sector, the NHS Long Term Plan offers potential solutions to the existing challenges. This is a radical departure from the previous plans and should be driven not by the need to make savings but rather by the goal of creating innovative structures that embrace the spirit of integration. Critical to making this a success is strong leadership for the new structure and this is the subject of recent paper on the evolution of roles in the new systems (Social Care Institute for Excellence 2021). Among the key qualities outlined are the need for leaders who will encourage, incentivise and support innovative pilots across organisational boundaries that deliver on the vision of the ICS board.

The mental health priorities are outlined in the Long Term Plan. However, a clear focus on comorbid mental and physical illness and expanding access to services for children, apart from addressing the demand/capacity for acute psychiatric in-patient care need to be on top of the agenda for ICS boards. The identified priorities need to be monitored through the governance and performance structures to ensure progress on delivery.

Unlike the previous restructures of the NHS, ICS provide a real opportunity for the silos and it needs to be seen how this evolves. As Tracy et al state in their conclusion 'there are considerable challenges: the drive for "localism" has left us without a road map; practical factors and local politics are most likely to determine which services will come together; staff will have understandable concerns despite the putative gains; and we lack evidence of what works, or even detail on what we should evaluate' (Tracy 2022).

Funding

This article received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

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