Delivering on the promise of integration in health and care

The development of an index to measure the success of ICSs

Within the context of the NHS rallying to prepare for significant winter pressures, an urgent need to kickstart the elective recovery and to continue the roll out vaccinations, **statutory Integrated Care Systems (ICSs) are being introduced as part of the largest NHS reform in the last decade**. ICSs will need to balance the these pressing NHS priorities while also fulfilling the reason that they were created – to provide care the **integrates three 'chasms': mental and physical health; community-based and hospital-based care; and health care and social care.**

Countless patients will benefit from an integrated approach to care. Historically, systems have not always been able to effectively coordinate services to meet this need to ensure that approaches align to deliver holistic and joined-up care in the most appropriate setting. **Addressing this problem is critical for improving patient outcomes, reducing health inequalities and relieving pressure on the NHS,** both operationally and financially.

As ICSs set up as new organisations they need to have to an evidence-based view of their current position in relation to their priorities (see article from Donna Hall and Chris Ham). This means understanding the current needs of the population and how well these are being met. We suggest that ICS reflect on what they were set up to do by examining the existing levels of integration between these chasms, to establish a baseline from which to measure progress and prioritise areas which require the most focus. As a contribution to this, **CF have worked with the Institute of Public Policy Research (IPPR) to create a draft integration index** based on metrics that seek to quantify the level of integration across mental and physical health, community-based and hospital-based care, and health care and social care. The index covers 23 metrics that have been picked to be holistic and representative of integration.

CF have made this integration index publicly available to allow ICSs to understand where they are and consider their own priorities. It is recognised that the specific metrics included in this first draft of the index may be subject to improvement and iteration so **feedback is invited on our approach and methodology** so that this should become a recognised index to drives progress in integration and sees that patients receive appropriate care. We will be engaging with ICSs to codevelop this index.

The **key findings** from our index demonstrate firstly the **sheer degree of variation** in integration maturity between ICSs. For example, East London Health and Care Partnership has only a third of hospital admissions as a result of self harm for 10-24 year olds compared to the national average, and a sixth compared to the worst performing ICS. To take a less extreme example we looked at the opportunity if each ICS matched outcomes in the top 25% of ICSs. This would result in 42,600 bed days saved in hospitals due to fewer delayed discharges; 63,300 more patients with severe or complicated mental health illnesses having a care plan and 9,100 more patients getting cancer treatment within 2 months.

Below we highlight three metrics as examples to explain how they represent integration within a system.

Community-based and hospital-based care: One measure we have used is Two Month Wait / 62 day from GP Urgent Referral to a First Treatment for Cancer. The variation in this is from 64% of cancer treatments being within two months of referral, to 92% of cancer treatments being within two months of referral.

The typical cancer pathway requires engagement with a multitude of healthcare professionals. From an initial presentation to primary care, a GP will make a 2-week-wait (2WW) referral for the patient to be seen by a specialist. The oncologist will then access the patient and book further examinations and investigations such as blood tests and CT scans. These tests can be done in an acute setting but are increasingly carried out in community diagnostic hubs which releases hospital capacity for non-elective and emergency care. Finally, an acute multi-disciplinary team (MDT) of oncologists, radiologists and cancer experts will review the test results and book the treatment or surgery which should be received within 62 days of the referral. The breaches of the 2 week or 62-day thresholds are often a result of a lack of smooth transition between in and out of hospital care and therefore this metric is indicative of integration across this chasm.

Health care and social care: Delayed discharge - days of delayed discharge in quarter. The variation in this is from 9.5 days of delayed discharge per 1,000 bed days, to 97 days of delayed discharge per 1,000 bed days.

A typical case of delayed discharge would be where an elderly patient is admitted from their home (where they may have had a fall or contracted a UTI) to receive care in hospital. After a few days in hospital, they are considered medically fit for discharge, meaning that there is no clinical reason for them to remain in an acute care setting. Patient discharge teams in hospitals work at the intersection of hospital and social care, to make an assessment as to where the patient should be discharged to. This may be back home with a package of care (such as mobility support or regular house visits); to a step-down bed in an intermediate care setting for a more in-depth assessment with an Occupational Therapist; or to a care home. Delayed discharge is therefore often a product of a lack of coordination between the hospital and social care in providing a safe environment for the patient and is indicative of integration across this chasm.

Mental health and physical health: Percentage of children and young people referred to ED for mental health reasons and seen within 4 weeks. The variation in this is from 55% of children and young people being seen within 4 weeks, to 99% of children and young people being seen within 4 weeks.

There is a target of 4 weeks for all mental health referrals, which some more acute conditions having a shorter referral wait target. Where this target is exceeded it increases the likelihood of presentation in an acute setting such as A&E, particularly in the case of untreated depression which can lead to self-hard and attempted suicide and have a number of physical health implications. Therefore, a lack of integration in the coordination of service provision for mental health services can result in patients being treated in an inappropriate

setting. The proportion of children and young people referred to ED for mental health reasons and seen within 4 weeks is therefore indication of integration across physical and mental health.

Interestingly, our findings, ICSs that are strongly integrated between health and social care, are also strongly integrated between community and hospital care, whereas **ICSs which have strong integration between physical and mental care, do not always have strong integration between hospital and community care, or health and social care**.

In order to contribute to the potential for learning, we examined which ICS have the highest level of integration according to the index. The five ICSs with the **highest levels of integration** across all 3 chasms are as follows:

1. Buckinghamshire, Oxfordshire and Berkshire West
2. Surrey Heartlands Health and Care Partnership
3. South West London Health and Care Partnership
4. Dorset
5. Bath and North East Somerset, Swindon and Wiltshire

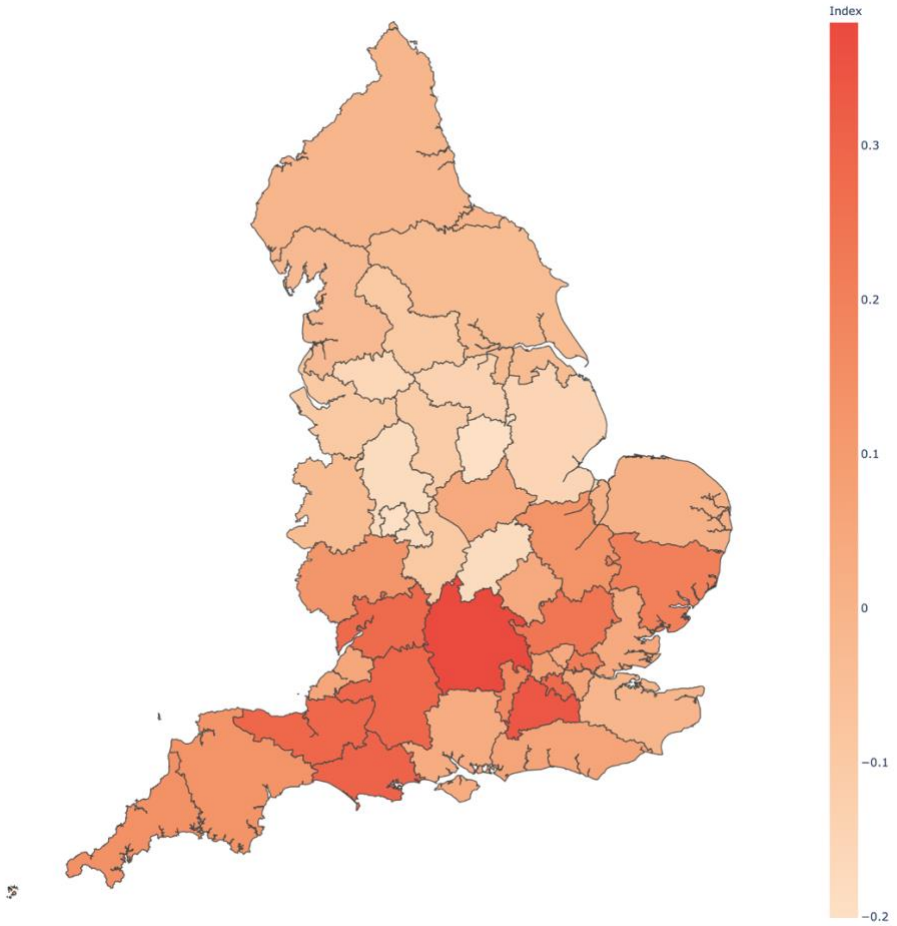

Figure 1: Overall integrated care index

It will be important to explore and understand as ICSs: what is our starting point in integration and what does this mean about our priorities? It will be also useful we hope to

see to understand why is there so much variation in levels of integration? And what can we learn from areas with higher levels of integration? The starting point in all of this is using data as the foundation for informing decision making about priorities in ICSs.