BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

ARTICLE

Why care about integrated care? Part 2. Integrated care systems: an irresistible force changing mental health services*

Derek K. Tracy, **Frank Holloway**, **Kara Hanson**, **Nikita Kanani**, **Matthew Trainer**, **Iain Dimond**, **Adrian James**, **Sridevi Kalidindi** & **Sukhwinder S. Shergill**

SUMMARY

Part 1 of this three-part series on integrated care discussed the drivers for change in healthcare delivery in England set out in the NHS Long Term Plan. This second part explores the evolution of mental health services within the wider National Health Service (NHS), and describes important relevant legislation and policy over the past decade, leading up to the 2019 Long Term Plan. We explain the implications of this, including the detail of emerging structures such as integrated care systems (ICSs) and primary care networks (PCNs), and conclude with challenges facing these novel systems. Part 3 will address the practical local implementation of integrated care.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the wider development of psychiatric services within the NHS since its foundation in 1948 and the challenges of the relationship with social care
- appreciate the aims and impact of major legislative and policy documents over the past decade, particularly the Health and Social Care Act 2012 and the NHS Long Term Plan
- understand the emerging integrated structures, notably integrated care systems (ICSs) and primary care networks, and some of the major challenges and criticisms they face.

DECLARATION OF INTEREST

None.

KEYWORDS

Integrated care; integrated care system; integration; NHS long-term plan; primary care network.

The NHS Long Term Plan sets out significant changes in the way healthcare will be delivered in England, and its proposed relationship with social care. Part 1 of this three-part series on integrated care discussed the drivers for these changes: continuing growth in the quantity and complexity of clinical need; funding challenges; and a workforce recruitment and retention crisis (Tracy 2020a). This second article continues the discussion, exploring the evolution of mental health and social services from the birth of the National Health Service (NHS) to the present day. Box 2 lists key acronyms and initialisms used in the field.

From 1948 to 2020 – the NHS at 72

Psychiatric services from the birth of the NHS

When the UK's National Health Service (NHS) came into existence in July 1948, it took on responsibility for a large network of psychiatric hospitals that had previously been run by local authorities. A founding principle of the NHS, which is funded by central government, has been that healthcare is free at the point of need. In contrast, the provision of social care has always been subject to need and means testing and funded through local government. The history of mental health services since the founding of the NHS is complex and contested (Turner 2015); there is an intertwined and equally knotty history of social care (Jones 2007). However, it is an incontrovertible fact that a historical and institutional distinction between health and social care is hardwired professionally, legally and financially.

Deinstitutionalisation and the rise of community care

Psychiatric bed numbers in the UK peaked in 1953. From a very high level, the UK now has one of the lowest numbers of beds per head of population of any high-income country. Acute in-patient provision initially moved to units in general hospitals and then

Derek K. Tracy, FRCPsych, is a consultant psychiatrist and Clinical Director at Oxleas NHS Foundation Trust, London, and a senior lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK. **Frank Holloway**, FRCPsych, is a retired consultant psychiatrist and Clinical Director at South London and Maudsley NHS Foundation Trust, London. **Kara Hanson**, ScD, is Professor of Health System Economics and the Dean of the Faculty of Public Health and Policy at the London School of Hygiene and Tropical Medicine. **Nikita Kanani** is a general practitioner in South East London and Medical Director of Primary Care at NHS England/Improvement. **Matthew Trainer** is Chief Executive of Oxleas NHS Foundation Trust, London. **Iain Dimond** is Chief Operating Officer at Oxleas NHS Foundation Trust, London. **Adrian James**, FRCPsych, is President at the Royal College of Psychiatrists, London, and a consultant psychiatrist at Devon Partnership NHS Trust, Exeter, UK. **Sridevi Kalidindi** is a consultant psychiatrist at South London and Maudsley NHS Foundation Trust, London, National Clinical Lead, Mental Health Rehabilitation NHSEI, and Visiting Senior Lecturer at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK. **Sukhwinder S. Shergill** is a consultant psychiatrist at South London and Maudsley NHS Foundation Trust and Professor at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK.

Correspondence to: Dr Derek Tracy. Email: derek.tracy@nhs.net

First received 25 Nov 2019
Final revision 6 Jan 2020
Accepted 8 Jan 2020

*This is the second of three articles in this issue focusing on integrated care.

https://doi.org/10.1192/bja.2020.3 Published online by Cambridge University Press

into small stand-alone services. The traditional mental hospitals shrank and almost all shut in the decade from the first closure in 1986. Former long-stay patients moved into a wide range of residential and supported housing services: in reality 'deinstitutionalisation' was often 'transinstitutionalisation'. Although policy supported the development of a network of medium secure units for the short-term treatment of offender patients, the need for rehabilitation services for people who failed to respond to short-term treatment was often ignored and out-of-area placements for people with complex needs proliferated (Holloway 2005). The NHS Benchmarking Network, which all mental health trusts in England fund each year to collate and benchmark their data, has identified a particularly significant reduction in beds over the past 5 years (NHS Benchmarking 2019). The linked increase in the use of private-sector beds has made quality of care harder to oversee, with individuals often far from family, local community care teams and known local communities, and duration of stay has been shown to increase in such units.

The historical process of in-patient deinstitutionalisation was associated with a gradual development of community care for people with a mental illness, the elderly and those with an intellectual disability. The importance of community care, policy since the Mental Treatment Act 1930, was emphasised by the Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission) of 1957 (Mills 1962), which led to the Mental Health Act 1959. Successive policy documents outlined visions for comprehensive community-based services, for example *Better Services for the Mentally Ill* in 1975, The *Health of the Nation Key Area Handbook: Mental Illness* in 1994, and *National Service Framework for Mental Health: Modern Standards and Service Models* in 1999 (Turner 2015).

BOX 1

The complex South East London (SEL) 'system of systems' (illustrated in Fig. 1) covers 16 hospitals, 112 mental health sites, 250 other NHS sites and 292 GP practices, all serving a population of approximately 2 million residents. The SEL sustainability and transformation partnership (STP) is evolving into the SEL integrated care system (ICS). The SEL STP contains two mental health trusts: Oxleas NHS Foundation Trust and South London and Maudsley (SLAM) NHS Foundation Trust. Of note, part of SLAM (the Borough of Croydon) is in the South West London (SWL) STP.

Each of the six London boroughs covered by the SEL STP (Lambeth, Southwark, Lewisham, Greenwich, Bexley and Bromley) has a corresponding local authority and clinical commissioning group (CCG). However, as part of a move from an STP to an ICS, the six CCGs have agreed to merge into a single commissioning unit to both streamline finances and provide more effective longitudinal strategic commissioning and care planning in the SEL 'footprint'. Adding to the complexity, acute hospital provision is provided by different organisations crossing these boundaries: Guy's and St Thomas' NHS Foundation Trust provides care to Lambeth and Southwark (and part of the SWL STP); Lewisham and Greenwich NHS Trust provides acute care to those boroughs; King's College Hospital NHS Foundation Trust provides acute care to Southwark, Lambeth and Bromley. These acute hospitals also have tertiary functions and have significant amounts of activity with 'non-STP' patients. There is no acute hospital in Bexley – although Queen Mary's Hospital in Sidcup provides non-urgent and step-down medical facilities – meaning that residents will access emergency care from either Lewisham and Greenwich NHS Trust or King's College Hospital NHS Foundation Trust. Bexley, as an emerging potential integrated care partnership (ICP), will be discussed in more detail in part 3 (Tracy 2020b).

Integrated interagency working

Over the decades multiple initiatives sought to improve interagency working in a more 'integrated' manner for better patient care. Problematically, there is an almost endless way to define 'integration'. One broad description labels 'internal' integration as the better working between primary, secondary and tertiary healthcare, with 'external' integration describing the link with other agencies, primarily social care (Shaw 2011). The drivers for this are top-down and bottom-up: top-down include proposed efficiency savings from better join up of related services and reduced bureaucracy; bottom-up include improved clinical and social care, better and more personalised individual experience and improved longer-term outcomes (Dunn 2016). However, such descriptions do not detail the specifics of the services, and the depth and nature of any integration of them and, in general, early integration attempts had limited success until the introduction of the NHS Plan in 2000, which had mental illness as one of three clinical priorities (the other two being cancer and heart disease).

During the subsequent decade joint commissioning of mental health and social care services became the norm, pooled budgets were common and community mental health teams invariably included social workers. Funding for mental health services increased rapidly during the decade to 2010. Since then an era of austerity has led to modest disinvestment in healthcare (Appleby 2018), significant cuts in social care and the break-up of previously well-established joint commissioning arrangements, although the actual causes of the last remain contentious and debated. One consequence has been a return to the health–social care divide. In more recent times there has been a particular focus on improving this. This has been recognised with the renaming of the Department of Health as the Department of Health and Social Care (DHSC) in January 2018, with an equivalent change in the governmental title of the now Secretary of State for Health and Social Care.

The contemporary NHS in 2020

Although support for the NHS and its public funding remains high, public satisfaction has fluctuated. Following large improvements between 2001 and 2010, more recently satisfaction has fallen, with the

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

BOX 2

Acronyms and initialisms commonly used in relation to health and social care in England

ACO: accountable care organisation. The term can refer to US or UK models. US models – there are subtypes – involve grouped service providers who contractually deliver all care to a given population for a fixed period of time, measured against agreed budgets and outcomes. In the UK, ACOs have not yet come into existence, but are proposed as a more formal, contractually based version of an integrated care partnership (ICP), providing a range of health and social care services to a given population. Differences in background healthcare models mean that it is anticipated that primary care will have greater roles in UK ACOs. The association with US models has made the term unpopular and contentious for some in the UK, and NHS England now refers to integrated care providers (not to be confused with ICPs, below).

ACS: accountable care system. An early term, now seldom used, for an integrated care system (ICS).

CCG: clinical commissioning group. Statutory, clinically led NHS bodies that plan and commission healthcare for their local area.

DHSC: Department of Health and Social Care. Responsible for government policy on health and social care in England. Formed in 2018 by a merger of the Department of Health and the Department of Social Security.

FYFV: Five Year Forward View. A 2014 NHS England publication that promoted greater localism and preventive work.

FYFV-MH: Five Year Forward View for Mental Health. A 2016 publication by the Mental Health Taskforce that sought parity of esteem between physical and mental health services, and set standards for some services, including liaison psychiatry, and waiting times for patients with first-episode psychosis.

HSCA: Health and Social Care Act. Legislation from 2012 that established clinical commissioning groups (CCGs) and embedded a quasi-marketplace of choice and competition in the NHS, with a focus on payment by results.

ICP: integrated care partnership. Care delivery units that sit underneath the strategic integrated care systems (ICSs). Various models are possible, such as those described by multispecialty community providers (MCPs) and primary and acute care systems (PACS). They lack the more formal contractual elements of accountable care organisations (ACOs).

ICS: integrated care system. An evolution of sustainability and transformation partnerships (STPs) enhancing partnership between NHS providers, commissioners and local authorities (LAs) to improve local population 'footprints'. They will have less centralised involvement and strategically plan, commission and manage care. However, care delivery will be provided by integrated care partnerships (ICPs).

LA: local authority. Local government, with responsibility for the delivery of a variety of functions: these can vary regionally. Funded by central government grants, and locally set council tax and business rates.

LTP: Long Term Plan. A 2019 policy document from NHS England (NHSE) setting out healthcare priorities for the coming years. It emphasises 'doing things differently' via integrated care and primary care networks (PCNs).

MCP: multispecialty community provider. An early integration model proposed by the Five Year Forward View (FYFV) bringing a range of multispecialty community providers together. An MCP could be a contemporary type of integrated care partnership (ICP) or accountable care organisation (ACO).

NHSE: NHS England. The statutory and independent executive public body of the Department of Health and Social Care (DHSC) responsible for budgeting, planning and delivery of healthcare in England.

NHSI: NHS Improvement. Oversees NHS trusts, foundation trusts and independent providers, ensuring their safety and quality and that finances are adequate and sustainable.

PACS: primary and acute care system. An early integration model proposed by the Five Year Forward View (FYFV) where general practitioners (GPs) would work more closely with acute hospitals, focusing on streamlined discharging from the hospital and better longer-term and preventive management of chronic illnesses. A PACS could be a contemporary type of integrated care partnership (ICP) or accountable care organisation (ACO).

PCN: primary care network. Emerging clusters of GP practices covering populations of 30–50 000. PCNs are envisaged as being small enough to provide local and personal care, yet sufficiently large to have economies of scale to better influence the local health economy and longer-term clinical outcomes.

STP: sustainability and transformation partnership (STP). Set out in 2015 NHS guidance to partner NHS providers with clinical commissioning groups (CCGs) and local authorities (LAs) to develop 'place-based' plans focused on developing new locally relevant models of care to improve well-being on a balanced budget. They are anticipated to evolve into integrated care systems (ICSs).

overall level at its 70th anniversary in 2018 (53%) the lowest for a decade (Robertson 2019). The main reasons for dissatisfaction were perceptions of unduly long waiting times, staff shortages, a lack of resource and inefficiency with money. In a joint report written to mark the 70th anniversary, the Health Foundation, the Institute for Fiscal Studies, the Nuffield Trust and The King's Fund noted (Dayan 2018):

- the NHS does less well than international comparators in terms of mortality from stroke, several forms of cancer and myocardial infarctions; it also has fewer doctors and nurses, less imaging equipment and a slightly lower than average spend
- it does well at protecting people from health costs and in managing some long-term illnesses, such as diabetes.

Moving to more preventative care

The Five Year Forward View (FYFV) (NHS England 2014) called for the 'triple aims' of better outcomes, better experiences for patients and staff, and better

use of resources. To attain these, 'three gaps' needed redress: better preventive work; harnessing technology and reducing variations in quality and safety; and enhancing funding and efficiency. The first, and most important, of these follows the oft-repeated finding that improvements in the health of populations have come from societal change and preventive strategies rather than better treatment for established illness. For example, perhaps two-thirds of improvements in cardiovascular disease are from tackling hypercholesterolaemia, hypertension and smoking, with only one-third from direct treatment (Capewell 2011). In part 1 (Tracy 2020a) we noted the limitations of even an optimally funded healthcare service in tackling such factors alone.

'Reactive' healthcare and its effect on emergency/acute care

However, at its core the NHS remains a service reactive to illness, providing treatment to people when they become unwell. Emergency departments' activity increased by an average of 4.7% a year over the past decade, compared with 2.2% for elective inpatient admissions. In the coming 5 years, the projected rise in demand of 2.7% a year is expected to fall primarily in acute care (Charlesworth 2019). Legislation and policy over the past decade have tried to rectify this 'reactive' nature through a series of initiatives aimed at improving efficiency, joined-up care and preventive work.

Key recent legislation and policy documents

2012: The Health and Social Care Act

The Health and Social Care Act 2012 (HSCA) amended the National Health Service Act 2006, which remains the legislation governing the organisation of the NHS. Arguably, the HSCA was the largest reorganisation of the NHS in England since its inception. It established NHS England as an arms-length body with overall strategic control (and quite specific budgetary and operational responsibilities over, among other things, forensic and secure psychiatric services), as well as transferring public health funds back to local authorities. It abolished primary care trusts (PCTs), moving responsibilities and finances to newly formed clinical commissioning groups (CCGs). Competitive tendering had existed before the HSCA, but the Act further embedded market-based approaches, emphasising a diverse provider market, competition and patient choice as key mechanisms for improving healthcare. It was envisaged that commissioners would be able to choose their providers from within a well-regulated 'marketplace' – with the Care Quality Commission providing assurance for quality and Monitor overseeing finance – with minimal need for ministerial involvement.

Opposition to the HSCA, and introduction of the Care Act 2014

These so-called Lansley Reforms, named after the then Secretary of State for Health Andrew Lansley, were widely unpopular with healthcare professionals, largely owing to fears that they fostered a move towards privatisation (Peedell 2011). The HSCA was opposed by the British Medical Association and led to a motion of no confidence in Andrew Lansley by the Royal College of Nursing. There has indeed been a subsequent growth in provision of healthcare by non-NHS providers – which include charities and third-sector organisations as well as private organisations – estimated at £8.7 billion in 2017–2018 (Campbell 2019). However, while there is evidence that the Act led to a large number of contracts being awarded to private providers, it did not result in a significant increase in spending on the private sector. This is in part because these contracts tended to be relatively far smaller than those awarded to NHS providers (King's Fund 2019). A review of the HSCA by The King's Fund (Ham 2015) maintained that the feared 'mass privatisation' had not occurred; however, the governance systems were described as 'complex and confusing', with an 'absence of system leadership' when the NHS 'needs to undertake major service change' (p. 84). Furthermore, although principled on driving down costs and improving efficiency, there has been little evidence that such aims were achieved by the Act.

Nevertheless, aspects of the HSCA, which remains in place, were argued to create a fairer system of funding long-term care and have informed more recent emphasis on collaborative and coordinated care models. The HSCA was complemented by the Care Act 2014, which includes a duty on local authorities to promote integration with health provision. The Care Act established in legislation the boundary between health and social care needs, although this is somewhat blurred by individuals who are subject to section 117 aftercare under the Mental Health Act 1983.

2014: the NHS Five Year Forward View

The 2014 Five Year Forward View (FYFV) (NHS England 2014) was, in part, a response to perceived weaknesses in the NHS Plan of 2000: although the NHS Plan was generally considered positively in terms of highlighting mental health as a priority, it was quite 'centralised' and criticised for often inflexible national targets. In contrast, the FYFV called for greater localism and a move away from uniform

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

models of care. It highlighted both preventing the development of complex longer-term conditions through healthier lifestyles, and their appropriate management where they did exist, noting that 70% of the NHS budget was spent on the 15 million individuals with such illnesses.

Integrated care via MCPs and PACs

The FYFV noted the potential development of accountable care organisations (ACOs) – these are described in more detail below – and emphasised the concept of integration through two approaches: first, in community settings that could provide a range of specialist physical and mental health inputs, so-called multispecialty community provider (MCP) hubs closely linked with primary care; second, bringing general practitioners (GPs) into acute care settings in what were labelled primary and acute care systems (PACs), with the 'acutes' envisioned as leading networked patient discharge and longer-term community management. There was huge initial anticipation when the contracts for PACs and MCPs were first published, but service change was slower to occur. These different new care models were eventually further developed through implementing them in 'vanguard' sites (Charles 2018), which will be discussed below, but at a far less rapid pace than first expected.

Technology was highlighted as an enabler in appropriate self-management of health conditions and in accelerating health innovation. Empowering patients and engaging communities were promoted, with a call for the NHS to be a 'social movement'. The FYFV was updated in 2017, and stated an aim to 'make the biggest national move to integrated care of any major western country' (NHS England 2017: p. 31).

2016: the Five Year Forward View for Mental Health

Parity of esteem

The Five Year Forward View for Mental Health (FYFV-MH) (Mental Health Taskforce 2016) was a parallel, but independent, document to the FYFV. A central tenet was that mental health had been relatively ignored and underfunded compared with physical health, and that too often the NHS 'treats […] minds and bodies separately' (p. 3). It set out recommendations to achieve parity of esteem, highlighting the importance of social determinants of health, including 'a decent place to live, a job or good quality relationships in [people's] local communities' (p. 3). The concept of parity of esteem has been a critical one, with greater funding arriving via the Mental Health Investment Standard (MHIS), wherein CCGs are required to increase investment in mental health services in line with their overall annual financial allocation, a figure that can be publicly checked.

Service standards and their reception

The FYFV-MH provided explicit waiting times, and proposals on the availability and quality of eating disorder, perinatal and improving access to psychological therapy (IAPT) services (Royal College of Psychiatrists 2019). The FYFV-MH also envisaged an increase the percentage of those with a first episode of psychosis being seen within 2 weeks of referral, 'core 24' (24 hours a day, 7 days a week) liaison psychiatry services in at least half of the country, elimination of inappropriate out-of-area placements and a proposed 10% reduction in deaths by suicide.

The FYFV-MH was, in general, well received for setting out standards in terms of service availability and waiting times. However, its emphasis on specialist services was at the cost of 'core' general adult community mental health services. The strategy also largely excluded a number of populations: older adults with functional and organic mental disorders; substance use, neurodevelopmental and personality disorders; rehabilitation for people with longer-term and complex psychotic illnesses; and intellectual disability services. These problems are being redressed, in part, with the recent publication of the *Community Mental Health Framework for Adults and Older Adults* (National Collaborating Central for Mental Health 2019).

2019: the NHS Long Term Plan

The 2019 NHS Long Term Plan (NHS LTP) (NHS England 2019a) sets out a strategy for the NHS for the coming decade. Its principles include: better obstetric and perinatal care as part of making sure everyone gets 'a strong start in life'; educational and preventive work for long-term health conditions, including additional spending on mental health; and supporting people to age well through better coordination and personalisation of care (including self-management), recognition and support of carers, and a focus on dementia and end-of-life care.

Essential planks of the LTP are 'doing things differently' through integrated care systems (ICSs) and a central model of care through primary care networks (PCNs): ICSs and PCNs will be detailed below. There is a focus on enhancing out-of-hospital care, dissolving 'the historic divide between primary and community health services' (p. 13), and preventive work emphasising cutting smoking and obesity rates, reducing alcohol-related emergency department attendances and improving air quality.

The NHS LTP also aims to redistribute funding to target areas where these are most problematic. The policy states that there will be growth, and better training and development, of the workforce, partially through more flexible and productive working, with 'leadership and talent management' (p. 89) (this will be further developed through the 'People Plan', a workforce strategy due for publication in 2020). It lays out an ambitious plan for digital technology, including patients having access to their records. Achieving these large-scale demands is proposed to be achieved through enhanced funding, integration of care and preventive work (thus reducing demand) and increased productivity.

The RCPsych's response to the NHS LTP

The Royal College of Psychiatrists recently published a response to the NHS LTP addressing its likely impact on mental health services (Royal College of Psychiatrists 2019). It supported the broad principle of integrated care through ICSs, but called for: a clear commitment to parity of esteem between mental and physical health; pragmatic implementation over time to ensure that plans are embedded in a manner that wider systems and also patients can manage; an inclusive approach to change involving the public, patients and staff; and transparency, especially in the allocation of funding. The College called for an additional 70 000 mental health staff by 2028–2029 and an extra £13.5 billion in funding over this period, to increase spending on mental health from 10.8% of the NHS budget (in 2017–2018) to 13.1%. It also addressed the historical lack of emphasis on core community mental health services and described new models of working with primary care and the use of social prescribing and well-being coordinators. The document noted that those with multimorbidities and long-term conditions may be best served by integrated and personalised mental healthcare.

The missing Social Care Green Paper

The Social Care Green Paper was first announced in March 2017, with an initial target release date of the end of that year. It has been delayed more than five times, with no clear delivery date in sight, and it is not certain that it will in fact be published at all. A crucial challenge will be whether such a plan could provide proportionate and sustainable funding increases equivalent to those promised to health, and how these might be funded. At this time all major political parties have made statements about a need to 'fix' social care, but with little specificity, and the UK political agenda has been notably tied up with other issues. Ham has pointed out that, in the past 20 years, there have been four independent reviews and twelve green and white papers on social care but that no government has been able to implement their recommendations (Ham 2019).

The debated funding mechanisms – discussed in part 1 (Tracy 2020a) – highlight, perhaps, key reasons for the lack of progress across all political parties: it is generally recognised that adequate funding will require greater taxation of some form from the home owning, wealthier (often from accrued property value over time) older individuals most likely to use social care. But this demographic is among the most likely to vote, making the issue potentially electorally toxic.

Without the Social Care Green Paper it is difficult to see how the proposed gains from the NHS LTP can actually be delivered. Further, without it, it is difficult for local authorities to plan ahead, and there is currently no clear indication what types of reform it might contain; for example the amount of money an individual could retain before qualifying for public funding, the ceiling or cap on pay-outs and whether a compulsory or partially state-funded insurance scheme might be introduced (Atkins 2019).

The alphabet soup of evolving integrated structures

STPs (sustainability and transformation partnerships/plans)

Sustainability and transformation partnerships/plans (STPs) join NHS organisations (both providers and CCGs) with local authorities to deliver 5-year 'place-based' plans for the well-being of relatively large but recognisable population 'footprints'. Unveiled by NHS planning guidance in 2015, England is covered by 44 such areas, in populations that vary from about 300 000 to almost 3 million. Since April 2017, STPs have been the mechanism for accessing NHS transformation funding.

STPs are required to address so-called local answers to local priorities in three major areas: health and well-being; quality and models of care; and efficiency of services. They emphasise better integration between health and social care, while ensuring a balanced financial budget. All 44 STP regions submitted plans over a two-stage process commencing in 2016, covering a period to June 2021, and are all publicly available (Eddie 2016). These plans have been described as 'initial "Mark 1" proposals' by NHS England (NHS England 2017: p. 34), with national leaders stating that they do not expect all proposals to be delivered (Health and Social Care Committee 2018a). New plans have been developed following the publication of the NHS LTP, and their publication is imminent.

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

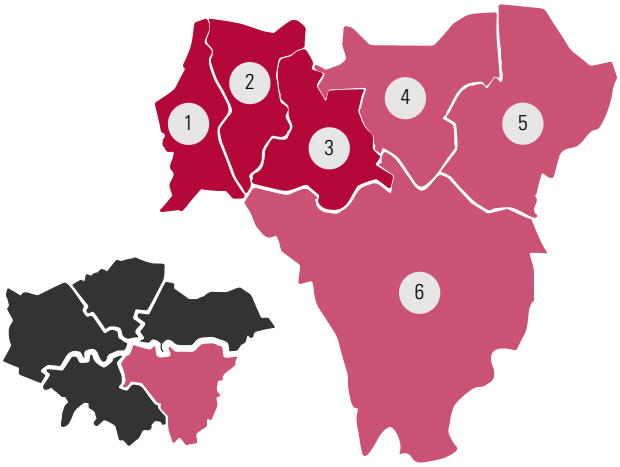

FIG 1 The South East London (SEL) 'system of systems' (described in Box 2). The smaller map shows the SEL STP in context as one of five London STPs. The larger map details the SEL STP. This contains two mental health trusts: Oxleas NHS Foundation Trust in light red and South London and Maudsley (SLAM) NHS Foundation Trust in dark red. The SEL STP covers six London boroughs: 1, Lambeth; 2, Southwark; 3, Lewisham; 4, Greenwich; 5, Bexley; 6, Bromley.

An example: the South East London STP

Although they map onto a geographically appropriate 'footprint', STPs cross a range of traditional organisational boundaries that may have competing pressures and priorities. For example, the South East London STP (SEL STP), in which several of this article's authors work, covers a population of about 2 million and is projected to grow by several hundred thousand over the next decade or so (Our Healthier South East London 2016). It contains: six CCGs, six local authorities, five secondary healthcare providers, and 292 GP practices with boundaries that do not always overlap (Box 2, Fig. 1). Exemplifying the complexity from a mental health perspective, one of the two constituent NHS mental health trusts is split, with part of it also in the South West London STP, which will have different partners and priorities.

Early opposition and counteraction

An early review argued that STPs did not sufficiently involve patients and staff in their initial stages, remained top-down in orientation and emphasis, and that organisational structures and management lines mitigated against collective performance and success (Alderwick 2016). Regarding this last point, the Health and Social Care Act remains important, as *regulation* remains at an organisational level – for example, within a mental health NHS trust – potentially disincentivising STP work. In an effort to counter this and foster STP development the 'P' is now typically referred to as 'Partnership' rather than 'Plan' (Kershaw 2018). In 2019 NHS England and NHS Improvement published operational planning and contractual guidance (NHS England 2019b) as a single process for commissioners (CCGs) and providers (NHS trusts) to assist in convening local leaders to agree collective priorities. These will be composed of two parts: an overview of specialist and direct commissioning based on activity, capacity, efficiency and workforce plans, and system data on how individual constituent organisations will align with this.

ICSs (integrated care systems)

The NHS LTP set an ambition for all STPs to evolve into a closer form of partnership – integrated care systems (ICSs) – by April 2021. Their overarching principles include less involvement and interference from centralised bodies and regulators, and greater local control of finances and performance monitoring. They were originally branded accountable care systems (ACSs) (NHS England 2017), a term now seldom used. ICSs provide a mechanism for strategic planning, commissioning and managing the types of local population-level changes recommended in STPs' plans. However, they are not seen as *delivering* care.

ICSs have potential for 'vertical integration', focusing from acute through to primary care, and 'horizontal integration', linking groups of hospitals, clinics and community services. Since 2017, some areas of England have begun to work as ICSs, and this has progressed in the following different ways (Health and Social Care Committee 2018b): at 'neighbourhood' levels of typically 30–50 000 inhabitants, where ICSs are emphasising integrating primary care with community physical health, mental health and social care; at 'place level', where the focus has been on enhancing integrative work between the

acute hospital and other local providers; and at 'systems level', looking at scaled issues such as information technology, workforce and estates.

ICSs offer the potential of a single regulatory relationship for NHS England and NHS Improvement; indeed, these two bodies are themselves coming together at the regional level to support such single relationships. This should lead to a more rationalised approach to evaluating population outcomes and foster collaborative approaches across organisations. It should also reduce the massive reporting burden on healthcare providers, moving away from multiple local specifications: for example, the six early intervention services across the six SEL STP boroughs currently each have different service models. However, aligning culture, vision, governance, leadership, finances, performance and regulation across a federation of multiple organisations is clearly an enormous challenge.

Partial devolution of commissioning

The NHS LTP calls for streamlining of commissioning, and it is anticipated that there will typically be a merging of existing CCGs so that there is only one per ICS. This fits with the aim of less fragmented health planning and should also save money through reduced running costs. Devolving more of the traditional commissioning function to providers is also significant in that it allows provider collaboratives to produce, in particular, specialist services across organisations within and outwith STPs. For example, the South London Partnership, which includes the three mental health trusts from both the South East and South West London STPs, has come together to provide specialist forensic and child and adolescent services that no one single organisation could do alone. However, it is important to clarify that NHS England is not proposing to abolish commissioners or have them in a single organisation with providers; rather their boundaries are envisaged as becoming 'blurrier', with commissioners working more closely together (Collins 2017). However, equally, there are concerns that this might undermine clarity on accountability and mechanisms to manage quality, and some local authorities have expressed concern about losing local NHS connections, albeit that borough or equivalent 'place-based boards' and 'health and well-being boards' should fill these particular gaps (Curry 2019).

ICPs, ACOs and 'the other ICPs' (integrated care partnerships, accountable care organisations and integrated care providers)

Integrated care partnerships (ICPs) will serve as the functional *delivery* units of care; multiple ICPs can exist under a single ICS, though in smaller ICSs, delineation between them may be less clear. ICPs can take differing forms, and can, for example, include varying combinations of primary care, physical and mental healthcare, and acute hospitals. This plurality extends to who can operate such units – in addition to the NHS, potential operators include local authorities, third-sector or independent organisations – although to date they have all been NHS-provider led. The model allows flexibility in contracting and risk sharing, as well as in whether to pool budgets, and it does not require competitive procurement. Both the MCPs and PACS envisioned by the FYFV are examples of ICPs, and indeed as new models arise, clear differences between these may become more blurred.

Accountable care organisations (ACOs) are a proposed, more formal, development of an ICP, with a single organisation (which can involve amalgamation with an existing one) competitively contracted to provide a wide-range of long-term ICP health and social care services to a given population (although an ACO could further subcontract work). ACOs could include contractual control of primary care, although it is not clear whether or how often that might occur in practice. Contracts must be managed via the NHS England/NHS Improvement Integrated Support and Assurance Process (ISAP), which assays the strength of the financial proposal. Adding confusion to the alphabet soup of terms, NHS England now prefers the term 'integrated care provider' over ACO for this model, but this clearly has the potential for significant confusion with ICPs.

Primary care networks

Primary care networks (PCNs) build on current primary care services to enable greater provision of proactive, personalised, coordinated and more integrated health and social care in general practice. PCNs are based on GP registered lists, typically serving 'natural communities' of 30 000–50 000. This aims to be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. They will, over time, offer more comprehensive community teams that include clinical pharmacists, social prescribing link workers, physiotherapists, paramedics and physician associates, alongside social care and the voluntary sector.

NHS plans for 2018–2019 required CCGs to actively encourage every GP practice to be part of a local PCN so that PCNs would cover the whole country as far as possible by the end of 2019. The

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

2019–2020 General Medical Services (GMS) contract offered every practice the opportunity to join a network through a multiyear directed enhanced service (DES) that brings additional resource, development support and workforce (20 000 additional staff by 2023–2024).

Networks will be required to deliver seven national service specifications over the duration of the contract, in partnership with community services. Five will start in April 2020: structured medication reviews, enhanced healthcare provision in care homes, anticipatory care, personalised care and supporting early cancer diagnosis. Two further ones will be instigated in 2021: cardiovascular disease case-finding and locally agreed action to tackle inequalities.

Next steps: criticisms and challenges

Finances, privatised care and US and early UK models

Although more effective care and increased efficiencies are dual aims of ICSs, discussions of financial savings have led to calls that initiatives presented as being about integrated care are 'more about solving the NHS's financial woes' (Buckingham 2018). In April 2018, there was a legal challenge to stop the development of ACOs, with campaigners stating that they may lead to clinical decisions based on funding rather than healthcare need. In parallel, the campaign group '999 Call for the NHS' secured a judicial review, with the argument that ACOs are unlawful under the Health and Social Care Act (Campbell 2018). Both were dismissed (Brennan 2018).

ACOs' origins lie in the US healthcare system, generating some anxieties that similar developments in the UK might lead to increasingly privatised models of care contrary to the spirit of the NHS. However, the background healthcare systems are very different. The interested reader might wish to read The King's Fund's evaluation of ACOs in the USA (Shortell 2014). But in brief, as ICSs in the UK have no contractual element, being instead a partnership of existing organisations, they are more likely than not to exclude private providers, and indeed legislative proposals from NHS England suggest that future contracts could only be held by statutory bodies (NHS England 2019c). Further, The King's Fund has argued (Ham 2018) that private organisations are less likely to be able to provide the wide range of services that ACOs require, whereas existing NHS structures are already relatively well placed to do so. In addition, the involvement of social care in ACOs may render them unattractive to private bidders, as this is unlikely to generate significant revenue. Nevertheless, discrete clinical, technical and analytical functions and estates within a UK ICP/ACO could be subcontracted out to the commercial sector, although it is important to highlight that this already occurs under existing models of care.

In the UK, ten initial 'vanguard' ICS sites were chosen, on the basis of an appraisal of their ability to deliver STP plans, and four 'second-wave' ICSs were named in May 2018 (the South East London ICS will be part of the third wave). A common theme has been of primary care practices federating or forming closer networks. Early examples have emerged of preventive work, including social prescribing and pharmacy screening. Some pilot PACS and MCPs have shown relatively reduced primary care referrals and emergency hospital admissions, although the emerging data need to be interpreted with caution. A review of their progress described how they all remain at early stages, with notable efforts to demonstrate 'early wins' and the battle for local 'hearts and minds' (Charles 2018).

Debating the 'right' model(s)

ICSs continue to develop as strategic planning, commissioning and managing vehicles for England's 44 population footprints. Debate is ongoing as to whether ICPs or ACOs would better represent the potential constituent care delivery units underneath them: at a conference on integration in 2018 it was argued both that ACOs were unnecessary to deliver the gains that an ICP alliance could equally deliver and also that, without the contractual element of an ACO, ICPs would be slower and less effective (Richardson 2018). Of course, it is entirely possible that both of these arguments is true: there is not one 'correct' solution, and what is right for one area might not be for another.

The House of Commons Health and Social Care Committee (HCHSCC) has called for primary legislation to assist with the introduction of ACOs. NHS England commenced a consultation process in 2018 on the contracting arrangements for ACOs. This has now concluded, and in September 2019 proposals were put to government by NHS England. These go wider than the integrated care provider contract, extending also to other legislative changes that might support integration (NHS England 2019c).

Wider discussions have been hindered by a lack of understanding about the models. The HCHSCC issued a report in 2018 stating that there has been poor communication and use of confusing and overlapping terms 'poorly understood even by those working within the system' (Health and Social Care Committee 2018b: p. 4), and that local leaders, clinicians, commissioners and patient

MCQ answers
1 e 2 a 3 d 4 e 5 b

groups had not been adequately engaged in this process. Debates to date have primarily been on the role of the NHS within new integrated systems, with mention of non-NHS organisations – particularly local authorities, although it also applies to independent providers, voluntary and community sector organisations – described as being 'largely absent' (Buckingham 2018).

Conclusions

There are strong legislative and policy drivers towards greater integrated care, and at a high level these align with the demographic, clinical and workforce pressures noted in part 1 (Tracy 2020a). The divide between health and social care has been structurally and culturally hardwired since their inception, and proposed changes bridging them face enormous challenges in implementation. Nevertheless, ICSs are starting to form in England, and this looks likely to continue. The models intentionally offer flexibility in terms of timeframes, constituent partners and the care delivery vehicles underneath. However, this flexibility can also make them confusing and means that there is a lack of clear guidance or advice on potentially effective models.

Criticisms of past initiatives

In 2017, the National Audit Office issued a report on the broader case for integrating health and social care and the progress of erstwhile national initiatives (National Audit Office 2017). It noted that 20 years of such programmes had not bridged the gap between health and social care, and that expectations on their rate of progress were typically overoptimistic. There was a particularly marked failure to engage local government as a more equal partner, with earlier plans being NHS led and focused on health priorities. The report criticised governance across a range of initiatives for failing to systematically address the three main identified barriers to integration: misaligned financial incentives, workforce challenges and reticence about information sharing. Crucially, it also highlighted the lack of a robust evidence base that integration improved patient outcomes, resulted in financial savings, or reduced hospital activity. Further, it was not clear whether approaches that dealt with the minority of patients with 'complex' needs adequately addressed the needs of the wider population.

What of the new models of care?

These concerns ring true for the new models of care. In light of the very real and growing demand–supply challenges that all services face, it is evident that things need to be done differently. ICSs, ICPs and ACOs are proposed to do this. However, there is currently no meaningful evidence to support their implementation, in terms of financial savings, effectiveness of breaking down barriers or, crucially, of delivering better care. Indeed, there are enormous challenges in how one might even measure some of these outcomes in a large moving system. In this context, it is informative to contrast national policy on integration, which forces major tectonic structural changes on providers and commissioners despite a lack of clear evidence or guidance, with the parallel trend in healthcare of quality improvement (QI) methodology, that seeks a bottom-up, staff empowered/devolved model of change within a defined framework, sharing ideas, doing things quickly, learning from what works and changing what does not. Part 3 in this series (Tracy 2020b) will address these issues, describing different models of integrated care currently forming across the country, and the challenges, opportunities and learning they have encountered.

References

Alderwick H, Dunn P, McKenna H, et al (2016) *Sustainability and Transformation Plans in the NHS: How Are They Being Developed in Practice?* The King's Fund.

Appleby J (2018) *70 years of NHS spending* (blog post). Nuffield Trust (https://www.nuffieldtrust.org.uk/news-item/70-years-of-nhs-spending).

Atkins G (2019) *The Government must not continue delaying the social care green paper*. Institute for Government (https://www.instituteforgovernment.org.uk/blog/government-must-not-continue-delaying-social-care-green-paper).

Brennan, S (2018) NHS England wins second legal challenge. HSJ, 5 July.

Buckingham H, Curry N (2018) *Working across boundaries: realising the vision of integrated care* (blog post). Nuffield Trust (https://www.nuffieldtrust.org.uk/news-item/working-across-boundaries-realising-the-vision-of-integrated-care#what-is-standing-in-the-way-of-an-integrated-future).

Campbell D (2018) NHS England faces first legal challenge to plans for health shake-up. Guardian, 23 April.

Campbell D (2019) NHS chiefs tell Theresa May it is time to curb privatisation. Guardian, 7 January.

Capewell S, O'Flaherty M (2011) Rapid mortality falls after risk-factor changes in populations. *Lancet*, **378**: 752–753.

Charles A, Wenzel L, Kershaw M, et al (2018) *A Year of Integrated Care Systems: Reviewing the Journey so Far*. The King's Fund.

Charlesworth A, Gershlick B, Firth Z, et al (2019) *Briefing: Investing in the NHS Long Term Plan. Job Done?* (June 2019). Health Foundation.

Collins B (2017) *Sending shockwaves through the NHS* (blog post). The King's Fund (https://www.kingsfund.org.uk/blog/2017/03/sending-shockwaves-through-nhs).

Curry N (2019) *The age of integration is officially here but how is it going to happen?* (blog post). Nuffield Trust (https://www.nuffieldtrust.org.uk/news-item/the-age-of-integration-is-officially-here-but-how-is-it-going-to-happen).

Dayan M, Ward D, Gardner T, et al (2018) *How Good is the NHS*? Health Foundation/Institute for Fiscal Studies/The King's Fund/Nuffield Trust.

Dunn P, McKenna H, Murray R (2016) *Deficits in the NHS 2016* (briefing). The King's Fund.

Eddie S, West D (2016) Mapped: all 44 STPs published – full coverage. *HSJ*, 15 December.

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3

Ham C, Baird B, Gregory S, et al (2015) *The NHS Under the Coalition Government. Part One: NHS Reform*. The King's Fund.

Ham C (2018) *Making sense of integrated care systems*, integrated care partnerships and accountable care organisations in the NHS in England. The King's Fund (https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems).

Ham C (2019) The future of social care. *BMJ*, **364**: l252.

Health and Social Care Committee (2018a) *Oral Evidence: Integrated care: Organisations, Partnerships and Systems (HC 650)*. Health and Social Care Committee (evidence presented over 3 days: see https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/publications/).

Health and Social Care Committee (2018b) *Integrated Care: Organisations, Partnerships and Systems: Seventh Report of Session 2017–19 (HC 650)*. HSCC (https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf).

Holloway F (2005) *The Forgotten Need for Rehabilitation in Contemporary Mental Health Services: A Position Statement from the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry (Faculty Report FR/RS/04)*. Royal College of Psychiatrists.

Jones R (2007) A journey through the years: ageing and social care. *Ageing Horizons*, **6**: 42–51.

Kershaw M, McKenna H, Charles A, et al (2018) *Sustainability and Transformation Partnerships in London: An Independent Review*. The King's Fund.

King's Fund (2019) *Is the NHS being privatised?* The King's Fund. (https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised).

Mental Health Taskforce (2016) *The Five Year Forward View for Mental Health*. Department of Health.

Mills E (1962) *Living with Mental Illness: A Study in East London*. Routledge and Kegan Paul.

National Audit Office (2017) *Health and Social Care Integration*. NAO.

National Collaborating Central for Mental Health (2019) *The Community Mental Health Framework for Adults and Older Adults*. NHS England.

NHS Benchmarking Network (2019) *2019 Mental Health (Inpatient/CMHT) Project – Results Published*. NHS Benchmarking Network (https://www.nhsbenchmarking.nhs.uk/news/2019-mental-health-inpatientcmht-project-results-published).

NHS England (2014) *Five Year Forward View*. NHS England.

NHS England (2017) *Next Steps on the NHS Five Year Forward View*. NHS England.

NHS England (2019a) *The NHS Long Term Plan*. NHS England (https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf).

NHS England, NHS Improvement (2019b) *NHS Operational Planning and Contracting Guidance 2019/20*. NHS England.

NHS England, NHS Improvement (2019c) *The NHS's Recommendations to Government and Parliament for an NHS Bill (September 2019)*. NHS England (https://www.england.nhs.uk/wp-content/uploads/2019/09/BM1917-NHS-recommendations-Government-Parliament-for-an-NHS-Bill.pdf).

Our Healthier South East London (2016) *South East London: Sustainability and Transformation Plan. 21 October 2016*. NHS.UK.

Peedell C (2011) Further privatisation is inevitable under the proposed NHS reforms. *BMJ*, **342**: d2996.

Richardson J (2018) Divided views rule implementation of integrated care. *BMJ*, **361**: k1620.

Robertson R, Appleby J, Evans H, et al (2019) *Public Satisfaction with the NHS and Social Care in 2018: Results from the British Social Attitudes Survey*. The King's Fund.

Royal College of Psychiatrists (2019) *NHS Priorities and Reform in Developing a Long-term Plan and Multi-year Funding Settlement for England: The Royal College of Psychiatrists' Proposals for Change*. Royal College of Psychiatrists (https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych's-proposals-for-the-nhs-ltp—submission-to-nhs-england.pdf?sfvrsn=e50faa2b_4).

Shaw S, Rosen R, Rumbold B (2011) *What is Integrated Care? An Overview of Integrated Care in the NHS*. Nuffield Trust.

Shortell S, Addicott R, Walsh N, et al (2014) *Accountable Care Organisations in the United States and England. Testing, Evaluating and Learning What Works* (briefing). The King's Fund.

Tracy DK, Holloway F, Hanson K, et al (2020a) Why care about integrated care? Part 1. Demographics, finances and workforce: immovable objects facing mental health services. *BJPsych Advances*, this issue.

Tracy DK, Hanson K, Shergill SS, et al (2020b) Why care about integrated care? Part 3. Delivering integrated care and measuring success. *BJPsych Advances*, this issue.

Turner J, Hayward R, Angel K, et al (2015) The history of mental health services in modern England: practitioner memories and the direction of future research. *Medical History*, **59**: 599–624.

MCQs

Select the single best option for each question stem

1 Which of the following statements is wrong?

a prior to the founding of the NHS in 1948, psychiatric hospitals were run by local authorities
b from having one of the highest, the UK now has one of the lowest numbers of psychiatric beds per head of population in high-income countries
c the decade 2000–2010 was notable for significant funding increases in healthcare
d although support for the NHS remains high, in recent times satisfaction with it has dropped
e growth in demand in the coming 5 years if expected to fall primarily in planned in-patient admissions.

2 As regards the Health and Social Care Act 2012:

a the Act emphasised a competitive market-based approach to commissioning
b the Act resulted in a significant increase in spending on the private sector
c the Act was generally welcomed by professional bodies
d the Act was replaced by the NHS Long Term Plan
e the Act transferred public health funding back to NHS England

3 Which of the following about the NHS Long Term Plan (NHS LTP) is wrong?

a integrated care systems (ICSs) are seen as a core national development
b the NHS LTP has a focus on education and self-management of long-term conditions
c the NHS LTP recommends redistribution of funding to areas most in need
d the NHS LTP has been largely rejected by the Royal College of Psychiatrists for failing to adequately account for mental health needs
e the NHS LTP aims to dissolve the historic divide between primary and community health services.

4 Integrated care systems (ICSs):

a will be responsible for the delivery of care to 'population footprints'
b should eventually be superseded by sustainability and transformation partnerships (STPs)
c are anticipated to merge or split so as to map onto the footprint of the relevant local clinical commissioning group (CCG)
d should contain no more than one NHS mental health trust
e offer the potential of a single regulatory relationship with NHS England and NHS Improvement.

5 Which of the following is not a recognised challenge or criticism of the contemporary integrated care environment in the UK?

a acronyms and initialisms are confusing for many people
b there is a lack of evidence that the public want more integrated services
c discussions have focused on healthcare and inadequately involved social care partners
d there is a lack of evidence that integrated care produces better outcomes or realises financial savings
e integration initiatives are perceived as solely being aimed at 'saving money'.

BJPsych Advances (2023), vol. 29, 19–30 doi: 10.1192/bja.2020.3