Supporting the establishment of New Models of Care Integrated Care Systems

1. Situation

NHS England outlined ambitions for sustainability and transformation partnerships (STPs) to evolve into 'integrated care systems' (ICSs). They are a response to the growing financial and service pressures and work to put in place new care models that integrate services 'to provide joined up, better co-ordinated care breaking down the barriers between GPs and hospitals, physical and mental healthcare, social care and the NHS'. The first eight areas of England have now been identified to lead their development. Integral Health Solutions worked collaboratively with one of the eight successful first wave ICSs and US integrator - Centene on the design and development of the new ICS for their local population.

2. The Task

Developing the vision of an Integrated Care System

Working in partnership on the design and development of a new ICS for one of the successful first wave ICSs, all parties acknowledged that, while there are several national and international integration models that offer valuable learnings and insights, the highest performing systems are those that most effectively promote innovation while continuously recalibrating their finite health and care resources to the changing needs of the local population. This will only be successful by capitalising on the knowledge held by the local citizens, patients, providers, and commissioners to develop a successful ICS. The work involved two phases of work:

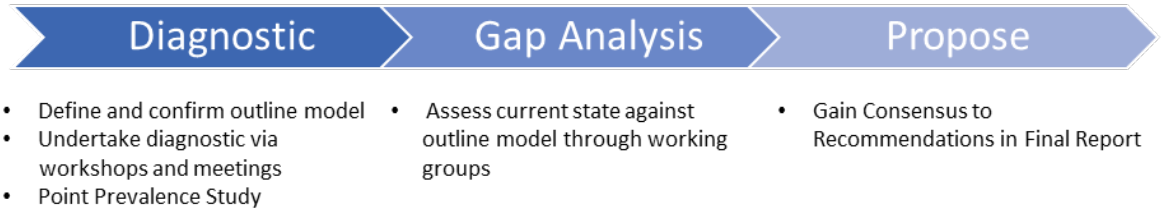
- Phase 1 – A detailed actuarial review of the health and care economy
- Phase 2 – Design a new person-centered model of care for the health and care system, to be delivered through an ambitious ICS transformation programme.

3. Action

This case study focuses on the work undertaken in Phase 2, where Integral Health Solutions supported the Patient Pathways work-stream, which was about improving the way patients are managed within the health and care system, with a particular focus on appropriate utilisation of primary and secondary healthcare services, as patients are transitioned to different care settings. Three core elements comprised the Patient Pathway workstream:

1. **Primary care referrals**: ensuring that the patients are receiving 'the right care, in the right place at the right time' (adherence to referral management guidelines for elective and non-elective admissions);
2. **Non-elective admissions:** how patients presenting at Accident and Emergency (A&E) are evaluated and either discharged or admitted to an inpatient or observational care setting;
3. **Acute hospital discharge**: the process for assessing patient readiness for clinical discharge from an inpatient setting to an appropriate alternative level of care, and co-ordination for patients with complex needs.

A 3-stage structured approach was applied to the three elements of the work stream:



The diagnostic assessment and gap analysis highlighted a range of strengths, weaknesses, opportunities and threats. A full report containing specific examples was produced, some of the key findings highlighted the following issues, which are not unique to this particular health and care economy:

- **Engaged System-wide Leadership and direction** is essential to ensure the successful development of integrated referral management guidelines, patient pathways and appropriateness criteria for admission/continued

stay (Clinical Utilisation Review). It is often the case that clinical leadership sits in isolated pockets within a health and care system, with a lack of system-wide accountability to address issues faced across health and social care. This frequently results in adopting a culture of organisational blame regarding problems faced by the health and care system, with system-wide approaches developing reactively as a result of a crisis situation. A more collaborative approach to focus on the development of integrated care is being developed to ensure system-wide accountability versus individual organisational accountability.

- **System-Wide Integrated Pathways** - The requirement for system-wide integrated pathways for both health and care services using best practice and evidence-based guidelines is an essential enabler of a successful ICS. By having system-wide integrated pathways, reduction in unwarranted clinical variation, including variation in access to care and duplication of services, will help provide greater secondary and community specialty capacity.

- **Referral Management based on one set of referral guidelines.** There is often wide variation across health economies in terms of referral management guidelines. These are often developed within individual CCGs. A successful ICS should have one set of consistent, evidence based referral management guidelines, supported by robust governance structures to update and review existing guidelines. Standard workflow processes are essential, regardless of the clinical condition or pathway, with adherence to appropriate procedural, timeliness, and quality performance standards.

- **Clinical Utilisation Review to Assure Patient Flow.** Many health systems do not have a robust, internationally recognised CUR tool that determines appropriateness of admission or continued stay. Clinical Utilisation Review (CUR) criteria will need to initially be focused on acute providers to ensure that patients presenting to secondary care are managed in the right care

setting according to their clinical needs. CUR can improve patient flow, supporting organisational sustainability and ensuring that patients are receiving the right levels of care, in the right setting, at the right time.

- **Acute Hospital Discharge.** Responsibilities for discharge planning are often unclear and complicated for staff to keep track of as discharge planning responsibilities often vary by ward and/or commissioner responsible for the patient.

Phase 2 concluded with all relevant partners signing up to the following:-

- To adopt a set of standardised pathways across the footprint, with localisation to these being the exception not the rule.
- To adopt an agreed set of best practice referral management guidelines and thresholds, stored in a single repository, used across the footprint; to ensure appropriate referrals to secondary care. The requirements for the referral repository have been developed, reviewed and agreed, and built into a specification. Consensus to further explore a potential IT solution to adopt a consolidated set of consistent, evidence-based referral management guidelines was agreed.
- To adopt a single Referral Management Hub across the footprint. The Referral Management Hub would triage referrals to secondary and social care and would include a support function including secretarial/administrative support and provide 'pre-referral' support from a clinical specialist to help to determine necessity of a referral.
- Agreement that there is a requirement for evidence-based appropriateness guidelines that will help to understand appropriateness of admissions and continued stay patients. It was agreed to further explore how CUR can influence patient flow and the benefits of standardising in this way. This was further supported by a CUR point prevalence study that determined the opportunity afforded by adopting CUR as an approach.

4. Results – what we have achieved

Key to the success of this work-stream and in securing the health and care economy as one of the first 8 ICSs has undoubtedly been achieved through demonstrating expertise and credibility locally, but more importantly through relationship building; working collaboratively and extensive engagement from the start. Listening to key stakeholders, being sympathetic to the challenges being faced on a daily basis and working flexibly was essential to building trusted relationships with primary care and secondary care clinicians and managers as well as facilitating and supporting the US integrator in its wider ICS development role.

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