Integrating Care and Transforming Community Services: What Works? Where Next?

Chris Ham and Debra de Silva, Health Services Management Centre, University of Birmingham

Integration of care is receiving increasing attention, both within the NHS and between the NHS and local authorities. In parallel, the Department of Health's transforming community services programme has led to a review of the services provided directly by PCTs. This programme has created opportunities for closer alignment between PCT directly provided services and services delivered by GPs and acute hospitals. At the same time, there are risks that the establishment of new organisations to manage PCT directly provided services might put obstacles in the way of closer integration.

To explore these issues, the Health Services Management Centre at the University of Birmingham organised a seminar in June 2009 bringing together experts from the US and the UK. The seminar focused on the evidence for integration; the current policy context in the NHS

in England; case studies of integration from different parts of the country; and the contribution of the independent sector. This report summarises the presentations made at the seminar and draws out the implications for policy and practice.

In summary, the main messages are:

- integration can take a variety of forms: horizontal, vertical and virtual
- care coordination may occur within both vertically integrated organisations and virtual networks
- there is evidence that integration improves clinical outcomes but the impact on costs is more mixed
- strategic, cultural, technical and structural components of integration need to be aligned for lasting impact
- current NHS examples of integration have developed through care trusts, social

enterprises and PCT-led practice based commissioning
- there is emerging evidence of the benefits of integration within the NHS e.g. in improving access to care, managing demand, and reducing delayed transfers
- the national integrated care organisation (ICO) pilots are testing out different approaches to integration and are being evaluated to identify lessons for the NHS
- some policies, such as transforming community services and policy on competition, may create obstacles to integration
- incentives are needed to support integration and current payment systems within the NHS do not always do so
- the independent sector has a potentially important part to play in facilitating integration
- IT and the electronic patient care record are likely to become more significant in future

Integrated care in the current policy context

Professor Sir Liam Donaldson, Chief Medical Officer, Department of Health

The potential to integrate healthcare is receiving increasing attention, but Professor Sir Liam Donaldson encourages the NHS to think carefully about how integration might be linked to the broader objectives of the NHS and whether or not integration will help the NHS achieve its core goals.

Key themes within our healthcare system at the moment include quality, choice, competition, collaboration, and empowerment. The first step when considering the value of integrating healthcare services is to ask whether the notion of integrated care is compatible with these themes. For example, the Next Stage Review states that quality should underpin the NHS and be its guiding principle. We must ask whether integration would support this or act as a barrier.

What problem does integrated care solve? Could it improve clinical outcomes, ensure patients receive better support, improve patients' quality of life, improve diagnosis rates, improve patient safety, improve health promotion and population health, reduce repetition or improve communication between teams? Integrated care should be able to resolve some of the underlying problems that service users identify.

Some people question whether we can have integrated care at the same time as having both a philosophy of competition and a philosophy of collaboration. Other systems of integrated care don't necessarily include both factors, but some authors believe that it is possible to have competition and collaboration in the NHS and that integration might support this.

There are four determinants of whether someone's care is integrated: the design of the healthcare system itself, the procedures of healthcare organisations, patient behaviour and clinician behaviour. People sometimes make the mistake of thinking that integration is solely about merging organisations, but this is not the only form of integration. It may be helpful to think about integration as a continuum.
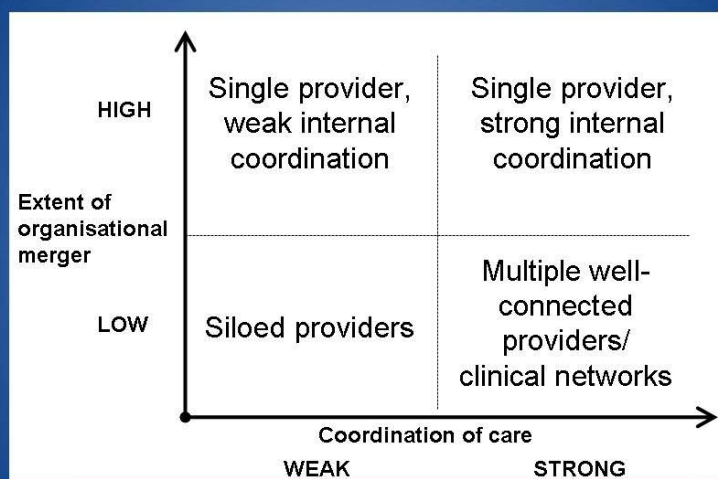
Some types of integration focus on co-ordinating care, perhaps through different disciplines working together in virtual or real teams. Other types of integration focus on reorganising services, such as merging primary and secondary care, but this type of integration does not necessarily achieve joined up services for patients. The following matrix illustrates four possibilities

Coordination of care is especially important for people with chronic diseases. Coordination hinges on the following factors:

- Culture of communication and cooperation
- Shared care record
- Agreed pathways and protocols
- Clearly defined roles and responsibilities

The NHS needs to compare the relative merits of a single provider with strong internal integration (the Kaiser model) with well co-ordinated care between multiple organisations working as part of provider or clinical networks. The Department of Health is initiating and funding 16 integrated care pilots to explore different approaches. The pilots are being evaluated to identify lessons for the NHS as a whole.

Key learning point: many different types of integration are possible and integration needs to be developed alongside care coordination

What does the evidence tell us?

Professor Stephen Shortell, School of Public Health, University of California

Health care organisations in the United States are increasingly seeing the benefits of working with others says Stephen Shortell, Blue Cross of California Distinguished Professor of Health Policy and Management and Dean of the School of Public Health at the University of California, Berkeley.

An integrated delivery system is a network of organisations which provides or arranges a co-ordinated continuum of services and is clinically and fiscally accountable for the health of the population served. Key features of an integrated delivery system include:

- shared values and goals
- alignment of incentives
- physician leadership
- a culture of teamwork

Integration can be horizontal (whereby organizations work together), vertical (whereby primary and secondary care work together, for example), or virtual (where services share information and ideas electronically).

Chronic conditions are one of the key drivers for integrated care. People with chronic conditions need co-ordinated services and chronic care has significant economic implications for the healthcare system. Over the next 10 years it is estimated that chronic disease will cost the UK more than £20 billion (including lost productivity costs).

A number of models have considered the value of integration for people with long term conditions. The NHS and Social Care Model is similar to Wagner's chronic care model which has been implemented throughout the world. These models acknowledge the interrelationship of infrastructure, how services are delivered and outcomes. There is also a focus on co-ordinating care from different providers.

There is growing evidence that these types of models improve clinical outcomes but evidence about costs is more mixed. Most outcomes are shorter term or focus on process issues rather than real clinical outcomes. The evidence suggests that it is a bundle of factors that work well together, rather than individual interventions, that make a difference.

One of the key success factors in these models is integrated teams, such as adding pharmacists to primary care teams to help with medicines management. Technology alone does not necessarily improve integration. The evidence suggests that disease management programmes may help to control symptoms but may have limited effects on mortality. The evidence on their ability to contain costs is mixed.

Research at the University of California at Berkeley on the use of care management processes by type of chronic condition has shown wide variations in practice. Analysing the use of six processes across four conditions – asthma, congestive heart failure, depression and diabetes - revealed that less than four per cent of practices employed all 24 recommend care management processes. There were variations among conditions, with diabetes ranking highest, and among processes, with patient registries being the most commonly used.

Overall, only about half of the recommended care management processes were used. Factors associated with greater use included patient-centred management behaviours, participation in quality improvement programmes, ownership of hospitals or health systems by the medical groups, external evaluations of quality and the size of the group, with very large groups performing best.

Medical home models are about providing patients with a continuous point of care with a primary care provider who coordinates the patient's care across the continuum, sometimes virtually via shared records and/ or through working together in groups. The four cornerstones of medical home models include:

- ensuring that primary care is provided comprehensively across the lifespan
- emphasising patient centred care in order to meet the needs and preferences of actively involved patients
- using data to inform practice, including population based registries, performance measurement and improvement, electronic health records and decision support tools

- introducing payment reform, including payment for care co-ordination and payments based on episodes of care

Research in the U.S. suggests that few practices contain all of the desired features of a medical home. Also, only the larger medical groups, with over 140 physicians in the network, showed significant differences in performance on the key components of the medical home.

Drawing on the work of the Institute of Medicine, the following figure illustrates a framework for thinking about what needs to be done.

There is a need to think holistically about the strategic, cultural, technical and structural dimensions of change. All four components need to be in place and aligned for lasting system-wide impact

Key learning point: there is evidence that integration improves clinical outcomes but the impact on costs is more mixed. There is some evidence that larger physician groups are more effective in delivering recommended care management processes than smaller groups

Making change possible — CARE SYSTEM

Supportive payment and regulatory environment → Organizations that facilitate the work of patient-centered teams → High performing patient-centered teams → • Outcomes: • Safe • Effective • Efficient • Personalized • Timely • Equitable

REDESIGN IMPERATIVES: SIX CHALLENGES
- Redesigned care processes
- Effective use of information technologies
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time.
- Use of performance and outcome measurement for continuous quality improvement and accountability

Source: Institute of Medicine, Crossing the Quality Chasm, p. 127, 2001.

Torbay case study: integrating health and social care services to meet the needs of older people

Peter Colclough, Chief Executive, Torbay Care Trust

Torbay was one of the first sites to try integration between health and social care. Peter Colclough says that Torbay did not originally set out to develop integrated care with merged organisations, but found that this was in the best interests of patients.

Torbay has a population of 140,000 with a much higher proportion of over-65s (23 per cent) than other areas. It has a low-wage economy and differences in life expectancy of eight years between wards at the extremes. The care trust is based on a previous history of good relations between the PCT and the Council, coterminous boundaries, political support, involvement in the NHS Kaiser Beacon site programme and a joint desire to improve performance and service delivery.

The most important reason for moving in this direction was a concern to deliver better and more coordinated outcomes for patients. This was epitomised by Mrs Smith, a fictitious 85-year-old requiring support from different health and social care professionals. The test of integration is whether it achieves this result and overcomes the fragmentation and lack of coordination that often characterises the experience of users like Mrs Smith.

Key features of the service are five integrated health and social care teams organised in zones or localities that are aligned with general practices. Each team has a single manager, a single point of contact and uses a single assessment process. Budgets are pooled and can be used by team members to commission whatever care is needed by service users like Mrs Smith. The aim is to ensure that service users experience care that is effectively coordinated with different professionals aware of what each other is doing and working together within an agreed framework.

These features were developed through a pilot in Brixham, a locality serving 23,000 people. The early results from the pilot were impressive but the existence at that time of a PCT and a local authority, each with its own systems, was a barrier to full integration of care. Recognition of this led to discussions which eventually resulted in the formation of the care trust. Local authority staff were transferred to the NHS under the TUPE procedures.

For each team, the focus is on knowing their population, focusing on the most vulnerable, and managing their care. This is done in partnership with GPs and the teams deal with all cases, including long-term conditions, palliative care and people with disabilities. They seek to proactively manage vulnerable service users making use of patient-held yellow folders accessible to any professional involved in their care. Referral processes have been streamlined and are now much simpler.

The Brixham pilot found in early analysis that there were around 83 users who were at the tip of the Kaiser triangle in a population of 23,000 and therefore most at risk. Similar proportions have been found in the other localities that have been established. These are users who need to receive intensive support from community matrons and the integrated teams. However, implementation has not yet been established on a consistent basis because of variation in interpretation of the criteria, and increases in the number of people identified. A further experiment is under way to try to bring consistency in this key element of integrated practice.

A number of improvements have occurred. Intermediate care services are now available in each of the zones via the single point of contact, and these enable access to occupational therapists, physiotherapists, and district nurses within three and a half hours if urgent (these cases comprise 25 per cent of the total), and five working days for non-urgent cases. A weekend working pilot scheme has recently started, and a support worker in intermediate care role has been developed, with posts in each zone team. One of the most tangible benefits has been to reduce delayed transfers of care in the acute hospital to almost zero.

Torbay is now one of the national ICO pilots and through the pilot is testing out ways of achieving closer integration with local acute hospital services with a particular focus on services for older people.

Key learning point: integrating health and social care services is beginning to deliver positive results for older people in Torbay and has led to organisational integration through the creation of a care trust

Nottingham case study: integrating teams in primary care

Dr *Steve Shortt, PEC Chair, Nottinghamshire County Teaching PCT*

Principia Partners in Health is a social enterprise, not for profit company which aims to improve the co-ordination of care and develop a new community facing clinical services model through:
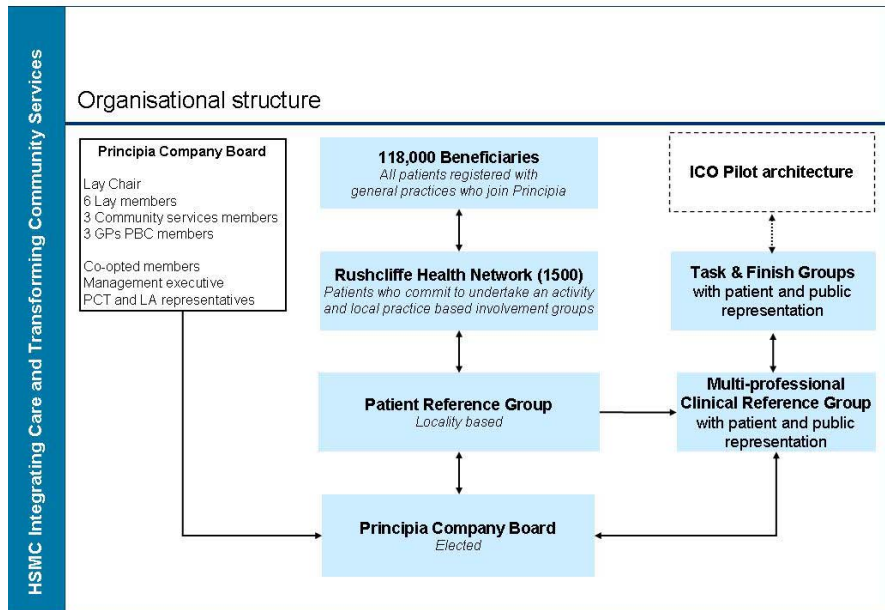
- *Collaborative practice based commissioning*
- *Reformed community services*
- *Comprehensive community engagement*

Founder and GP Dr Stephen Shortt says that the organisation was set up as a creative solution to dealing with the pressures and future challenges in the local NHS and its origins lay in the concerns of GPs, community staff, and patients and the public.

This example of integration focuses on practices working together to make primary care more organised; somewhat along a business model. GPs came together to share opportunity (influence and freedoms) and risk (contestability, regulation and loss of income due to fair shares allocation formula under practice based commissioning (PBC)); community staff wanted greater autonomy and voice in the local system; and patients were eager to work in partnership with the health services.

Principia serves a population of 118,000. There are 16 general practices in the area made up of over 100 GPs. These practices work collaboratively with the PCT provided community services comprising around 140 community matrons, district nurses, health visitors, allied health professionals and other staff. It works under an APMS contract with the PCT and is one of the DH social enterprise pathfinders.

In many ways Principia started from a defensive position: setting up as a way to mitigate risks for GPs and in particular, the financial risks from splitting funds with the acute sector. However, the organisation has quickly moved to try to increase the value in the local system of care by designing a system that delivers care sooner, earlier and nearer to patients. This is achieved through new relationships, accountabilities and incentives within and across professional groups and with the public.
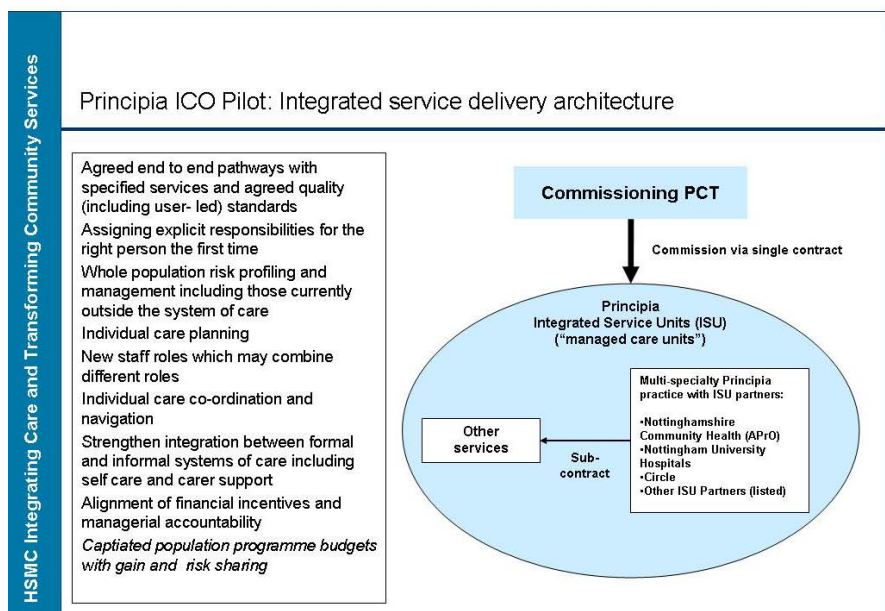

Organisational structure

As a social enterprise, Principia is self governed and self-managed. One unique feature is the governance arrangements: the board is elected by patients and has a majority of lay members. The organisation focuses on horizontal integration (teams working together). The longer term aim is to move from a focus on GPs to broader multidisciplinary teams, and a vertical partnership with acute care underpinned by alignment of financial incentives and managerial accountability.

Of fundamental importance has been the positive attitude of the PCT to PBC. A PBC escalator has been developed in which greater autonomy and entitlements are granted in return for increased accountability and achievement. Building on this, Principia is now one of the 16 national ICO pilots and its approach is illustrated in the following figure.

To date, key successes of Principia include:

- a dynamic multi professional collaboration
- genuine patient and public involvement
- savings of £900,000 on non-elective admissions through demand management
- extended hours of primary care services with weekend diagnostics and improved long term conditions management
- mandatory evidence based clinical pathways that cut across the whole system

Principia ICO Pilot: Integrated service delivery architecture

Obstacles and barriers also exist, and include the impact of Transforming Community Services on the PCT provider arm, the fit with the Cooperation and Competition Panel, procurement rules that do no always sit easily with an integrated approach, the future of PBC and the possibility of PCT reorganisation.

The organisation was set up in a high performing PCT area with no financial deficit, in an affluent borough with strong general practice and community services, and excellent patient and public involvement. This is important because the same developments may not be as easy to achieve in other areas.

Key learning point: virtual integration of primary care and community health services with patient and public involvement is having an impact on the demand for hospital services

Cumbria case study: data and leadership to integrate care

Sue Page, Chief Executive and Dr Hugh Reeve, Cumbria Teaching PCT

When PCT Chief Executive Sue Page began her role in Cumbria a few years ago, the area faced financial meltdown. Co-ordinating the provision of primary and secondary services, led by GPs, has made a real difference to turning the county's fortunes around.

There are significant health inequalities in Cumbria, with a male life expectancy variance of 20 years between the most affluent ward and the poorest. The county is also very large and geographically diverse. This means local solutions are the best for delivering tailored health and social care services.

Cumbria has put GPs in the driving seat to deliver these changes. They lead the six localities in the county which now hold their own commissioning budgets and the real power to make effective change. The county is piloting two ICOs to help accelerate the shift in power base from the acute trusts to primary care.

Cumbria's overarching 'closer to home' strategic programme involves major downsizing for acute care and building up primary care to provide more efficient and effective services. It is about developing a strong primary care base and empowering service users to support self care. The model assumes unnecessary admissions to hospital are a failure of the system. Community hospitals are being redesigned to deliver effective and efficient intermediate care.

GPs now run community hospitals and have their own medical beds. A single point of access for all healthcare services is being developed and partnership working with social care is increasing rapidly. Acute trusts are having their budgets reduced. In some cases the size of acute hospitals is being halved.

GP Dr Hugh Reeve reports that core components of the programme were strong leadership, clinical engagement, quality driven target setting using data, incentives, and accountability. There was investment in alternatives to hospital care, despite a very difficult financial climate. This has paid off.
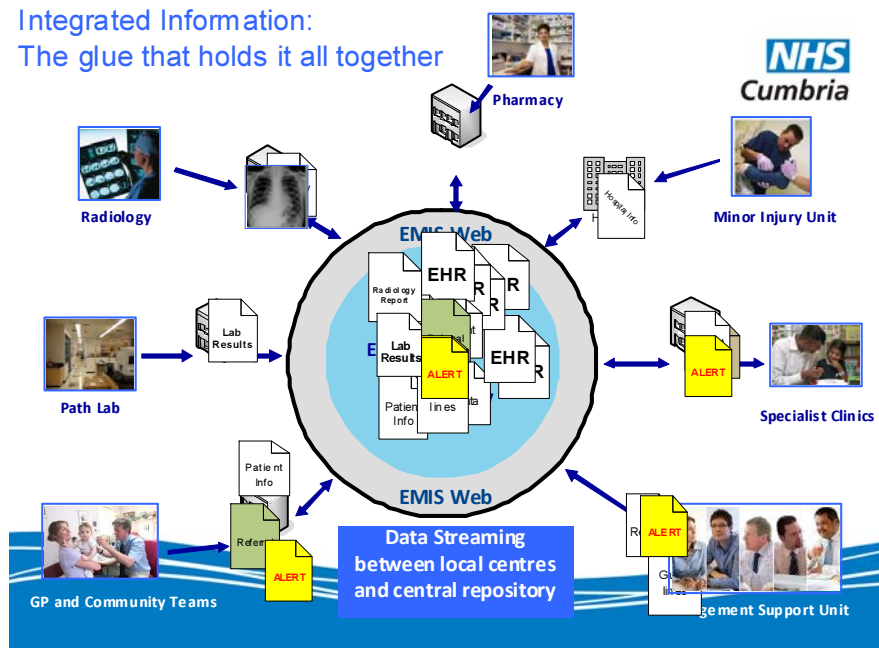
GPs are engaged in making positive change. The PCT has given clinicians responsibility and accountability for decisions and budgets. There is partnership with the local authority and voluntary sector. To get clinicians involved, you need to tell a story: is the result better for patients and society and ultimately for the health of their business and themselves. The team had to build a belief in the cause and the cause was care closer to home. Having this joint vision was important as was strong clinical leadership. A lot has been invested in IT to ensure practices are all using the same data system to allow sharing of information with practices, minor injuries units, specialist clinics, laboratory results, and community nursing teams.

Sue Page and Hugh Reeve report that while there is a national increase in emergency admissions to hospital and A&E attendances, in Cumbria this trend is flat-lining or even decreasing. The length of stay has fallen because there is a new approach to the way that people are flowing through the system with the development of step down care, rapid response teams and other initiatives focused on integration and co-ordination.

Key learning point: clinical leadership linked to the use of information and incentives is starting to demonstrate results and has the potential to radically reshape the delivery of services

Integrated Information:
The glue that holds it all together

Case study: working with the independent sector

Mike Sadler, Chief Operating Officer, Serco

Mike Sadler suggests that there are many opportunities for integration with the independent sector. The key is to ensure that form follows function: the NHS needs to look at the objectives it is trying to achieve and then think about how to get the right expertise to support that.

Partnership allows the NHS to do things that may not otherwise be possible, including drawing on extra capacity and specialist skills, or sharing the risks for investment in health promotion or improvement initiatives.

Serco has a number of contributions to partnership. These include:

- innovation from world wide experience
- organisational change and development
- process redesign and integration
- exploitation of information and information systems
- new sourcing strategies and better supplier management
- direct clinical, facilities management and back office service provision

Often the public sector is not ambitious in working with partners. The focus might be on outsourcing one or two services rather than full partnership working. There are many opportunities, including joint equity

models. Partnership enables risks to be shared.

Examples from outside health care include Serco's work with the Atomic Weapons Establishment and the National Physical Laboratory. In the case of the former, an output based contract was agreed, with flexibility on how the outputs would be delivered. Serco earns a risk based performance fee under the contract.

Trust is important. The NHS should set targets: outcomes and outputs for private sector partners to achieve. The NHS then needs to stand back a little and allow partners to achieve those goals in their own way. Robust monitoring and communication is important.

One example in the NHS is GSTS – Growth, Science, Trust and Service. Guys and St Thomas' pathology services work in partnership with Serco. The pathology service is a joint venture model with a 50/50 equity share. Serco brings business expertise and the foundation trust can focus on providing the highest quality clinical services.

In the case of integrated care, Serco's vision is of health and social care convergence, the development of single IT systems, an increased role for assistive technology, and single accountable providers with capitation based funding. Key features of the service are illustrated in the following figure.

Key learning point: the independent sector has a potentially important part to play in facilitating integration

Transforming community services

Helen Parker, Senior Fellow and Co-Director, Health Services Management Centre

There are many interlinkages between providing integrated care and the Department of Health's new Transforming Community Services programme says Helen Parker, who is a member of the Transforming Community Services Board.
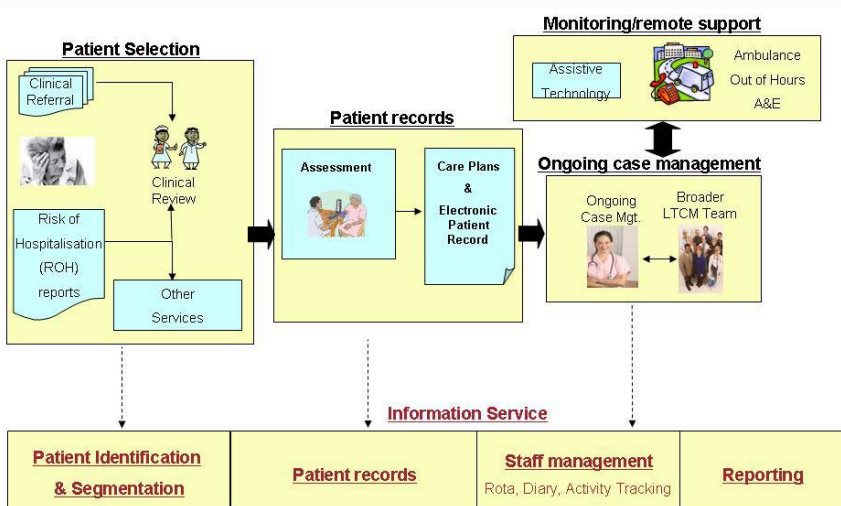
Transforming Community Services is a national programme that aims to shape future provision and achieve a robust commissioner and provider separation. Key elements of the programme include:

- providing national leadership and direction for more integrated and personalised community provision
- transforming the commissioning of services through shaping of the local market
- transforming provision through local leadership, new organisational arrangements and service development

The current reform spotlight on community health services is unprecedented and has been welcomed by community staff as creating a platform for identifying and addressing longstanding concerns that act as barriers to integration such as poor data management, information systems and clear strategic objectives.

The Programme also sets out the process for commissioner and provider separation including establishing Community Foundation Trusts and Social Enterprise as potential new organisational forms for these services. However, the danger with a programme that has a strong element of organisational reform is that it can perpetuate a disproportionate focus on structure at the expense of other dimensions necessary for integration and a risk that we once again realise only minimal change towards closer integration but with maximum organisational disruption and cost. A change in the governance model will achieve very little in developing integration without equal focus also spent on transforming professional behaviours and working practices.

Key features of the service

Integrated care may be better served by the Programme's emphasis on commissioners identifying pathway alliances between individual community services and other providers to develop integrated horizontal or vertical organisations, thus 'unbundling' the current homogeneity of community services. The Programme encourages the NHS to explore the use of Section 75 arrangements and joint ventures as levers to encourage innovative models.

Perhaps, more importantly, if sustainable integration is going to be realised there needs to be investment in developing local clinical leadership to provide the direction of travel and entrepreneurship. The Transforming Community Services Programme recognises this and sets out the transformational attributes and skills expected of those who lead community service development to ensure that staff can engage effectively and confidently in local commissioning and service redesign debates.

Key learning point: the focus on transforming community services offers the potential to achieve closer integration of care provided that the emphasis is placed on clinical leadership and care pathways rather than organisational change

Adapting lessons from the US for the NHS

Richard Gleave, Director of Patient Experience and Planning, Department of Health

Leadership and management are crucial for integration. Richard Gleave spent a year in the US learning about how to integrate services effectively and how to adapt the lessons learnt in the US for the NHS.

The US does not have a cohesive healthcare system so its perspective on integration is different. There are three key players: health plans (insurance), physicians (undertaking outpatient care and with admitting rights) and hospitals (delivering inpatient care). The focus is on addressing fragmentation between doctors, who usually work alone or in very small teams, and other parts of the health care delivery system.

In the UK there is a sense that the NHS is one system, albeit potentially fragmented. There is more focus on horizontal integration with multidisciplinary teams. Improvement programmes which are led and developed by clinicians are highly effective yet many of the models the UK seeks to adapt from the US are programmes developed by health plans e.g. United's Evercare. We may need to think more carefully about what we are seeking to adapt, and draw on evidence about what works and why.

Key success factors

1. Leadership and governance are essential for integrating care.

There are many different models of integrated practice. Structural integration is not essential, yet merging organisations is often the first thing that people think of when talking about integration.

In the US, Kaiser Permanente is actually three separate organisations (medical group, health plan and hospitals) in each region but they present themselves as a single brand. The glue that holds them together includes: aligned incentives; shared accountability; and a focus on membership / the interests of patients and a deep seated knowledge of what patients want and need.

A learning point is that whatever governance structure is used, this needs to be underpinned by a shared organisational culture.

2. There needs to be a balance between minimising risks and aligning incentives

Integrated systems establish ways of aligning the financial risks and rewards between physicians, hospitals and payers. Without this clarity, integrated networks can struggle to have constructive partnerships and individual organisations focus on minimising their own risk rather than innovating across organisational boundaries. You have to be upfront about risk: what it is, how it will be managed and who will be responsible.

Traditional fee-for-service payment systems do not encourage integrated care but in the US there are some innovative approaches to using funding packages which enable integrated services for patients with multiple morbidities who traditionally receive poor quality care yet require high levels of resources. The financial models in the US mean it is difficult to transfer some lessons to the UK. More interesting is how the US

uses pay for performance approaches to incentivise specific services that could be part of an integrated care model.

3. IT may be essential for integration

The US experience is that whether you are large or small, IT is essential to successful integration. The IT systems do not need to be large or complicated, but they do need to provide patient level information to staff as well as management information to enable performance improvement.

US integrated care systems use IT as a selling point to attract members and so they have invested significantly in providing online support, telecare and direct access to the medical record.

4. It is important to understand people's needs

American health care organisations invest in understanding members' wants, aspirations and needs in order to design services that keep them as customers . This is important for all organisations, whether in an integrated system or not but in integrated systems, this helps to ensure that patients do not chose other systems where there is, in theory, a wider choice of providers. Integrated health systems can succeed in chronic care where single organisations cannot. These organisations know that they must work together to manage costs and improve care.

A key learning point is that the US experience suggests that there is not a template for integration that definitely works. There is scope for professionals, managers and patients to shape integration to meet the local situation.

Implications for policy and practice

Chris Ham, Professor of Health Policy and Management, Health Services Management Centre

The evidence and experience summarised in this paper demonstrates both the case for integrated care and practical ways in which NHS organisations are working to make it happen. After almost a decade in which many of the NHS reforms have been designed to support patient choice by stimulating competition between a diverse range of providers (aka fragmentation), there is increasing interest in integrated care as a way of addressing the needs of an ageing population in which long term conditions represent the major burden of disease. The final report of the NHS Next Stage Review, High Quality Care for All, lent support to integrated care through the pilot programme that has been established, and many areas not included in the programme are also testing out ways of achieving closer integration.

Based on the discussions at the seminar, a number of implications for policy and practice can be identified. First, it is essential that policy makers make it clear that competition and cooperation receive equal emphasis in the next stage of NHS reform. The early signals from the Cooperation and Competition Panel seemed to indicate that opening up the market to new providers was the main priority. While this is an important objective in some areas of provision, in others there is a need to encourage greater cooperation and the development of integrated care. A nuanced approach to the role of competition and cooperation is required in which both the Panel and policy makers show that they understand the complexity of health care and the contribution that each can make.

Second, it is important to avoid the interest in integrated care translating into an argument for further structural change. As this paper has amply demonstrated, integration can

take various forms, and can be pursued through virtual networks and alliances as well as through innovations such as care trusts. In view of the well known disadvantages of structural change, other approaches should receive priority, whether through networks of practices and community services as in Principia, or through the opportunities created by practice based commissioning in Cumbria. Structural integration does not necessarily lead to service integration, and in the first instance there is a strong argument for focusing on ways of bringing clinical staff together to integrate care with the organisational implications being worked through subsequently.

Third, some of the barriers to integrated care need to be removed. One example is the setting up of new kinds of organisations to run PCT provider services, such as Community Foundation Trusts, which risk putting an organisational boundary around a specific set of services, thereby making it more difficult to integrate. Another example is incentives that encourage organisations to look after their own self interest. Payment by results is the most obvious illustration. In the next stage of reform, there should be active exploration of new forms of bundled payments that offer incentives for providers to collaborate across pathways of care rather than to deliver discrete episodes of care. The use of pooled budgets in care trusts is a tangible example as is PBC where it has fully engaged GPs. Work now needs to be done to build on these examples and extend them to other areas of provision. In parallel, further progress is needed in using information to promote integration, as is beginning to happen in Cumbria.

Fourth, within the NHS it is essential that more work is done to engage managers and clinicians in acute trusts in integrated care. The case studies summarised in this paper illustrate the potential of integration mainly in relation to horizontal integration between health and social care and between primary care and community services. As the NHS enters much more challenging financial times, integration needs to extend to secondary care and specialist services to

enable care to be provided closer to home, and for resources currently locked up in acute hospitals to be released for redeployment in alternative settings. There is compelling evidence of the potential for the NHS to reduce its reliance on hospitals through improved prevention, primary care and community services, and this potential is only likely to be realised when all elements in the care pathway are aligned and supported by appropriate incentives.

Finally, the role of the independent sector in working with the NHS to achieve closer integration needs to be exploited. The evidence summarised in this paper from other sectors underlines the importance of this observation, as does the involvement of the independent sector in some of the national ICO pilots. The use of innovative gain sharing contracts between the NHS and the independent sector should help to ensure that this is done in way that creates the right framework of incentives and optimizes value for the public purse.

Summary

International evidence and NHS experience offer important pointers for the next stage of NHS reform. Integrated care may not be a panacea but it clearly has an important contribution to make in ensuring that resources are used as effectively as possible and that the quality agenda set out for the NHS is delivered. Building on the work of the national ICO pilots, the time is right to explore how more ambitious approaches can be promoted to enable the NHS to rise to the financial challenges that lie ahead.

HSMC's Programme on Integrated Care

Our programme of work on integrated care includes a learning set for clinical and managerial leaders, support for the NHS Kaiser beacon sites, study visits to learn about models of integration in other countries (including an advanced study visit to Kaiser Permanente in March 2010), a review of the evidence on integrated care to be published in December 2009, and development work with NHS organisations. HSMC staff have also published a number of papers and articles on integrated care. If you would like to find out more about this programme of work, please contact Chris Ham or Ingrid Leeman.

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HSMC Policy Papers

Policy paper 1
Individual Patient Budgets: Background and Frequently Asked Questions
Jon Glasby, HSMC in association with NHS West Midlands
www.hsmc.bham.ac.uk/publications/pdfs/individual_patient_budgets_13Oct08.pdf

Policy paper 2
Choice and Competition in Primary Care: Much Ado About Nothing?
Jo Ellins, Chris Ham and Helen Parker
www.hsmc.bham.ac.uk/publications/pdfs/choice_competition_primary_care.pdf

Policy paper 3
Personalisation and the social care 'revolution': future options for the reform of public services
Simon Duffy, John Waters and Jon Glasby

Policy paper 4
Supporting patients to make informed choices in primary care: what works?
Jo Ellins and Shirley McIver, in association with NHS West Midlands
www.hsmc.bham.ac.uk/publications/policy-papers/Supporting_patients-PP4-4.pdf

About HSMC

HSMC has been one of the leading UK centres for research, personal and organisational development in health care for over thirty years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit:
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