

Towards integrated care in Trafford

Research report

Sara Shaw and Ros Levenson

November 2011

Nuffield Trust work on integrated care

This research report is part of the Nuffield Trust's programme of work on integrated care, which is examining the potential of new forms of care that are intended to benefit patients and taxpayers.

Other related projects include:

- *Integration in action: four international case studies.* A study of four international organisations that have attempted to improve integration between health and care services. Interviews, documentary analysis and literature review are used to identify the main stimuli for integration and the issues that help or hinder progress; drawing out lessons for the NHS.
- *What is integrated care?* This research report investigates what is actually meant by integrated care and explains the distinction between the terms 'integrated care' and 'integration'. It explores integration from an NHS perspective, identifies the concepts that underpin integrated care and suggests how these can be used to inform practical integration efforts both within and beyond the NHS.

Further details of our integrated care work can be found at:

www.nuffieldtrust.org.uk/integratedcare

Acknowledgements

Many thanks to Jennifer Dixon, Pam Garside, Rebecca Rosen, Judith Smith and Nicola Walsh for their comments, all of which have helped to shape this report. Thanks also to all those in Trafford who have contributed time and energy to the work, and especially Mark Brandreth, Martin Connor, George Kissen, Sam Nicol and Graham Wallis.

Contents

| | |
|-------------------------------------|----|
| Key points | 4 |
| 1. Background | 5 |
| 2. An overview of the story to date | 6 |
| 3. Learning from Trafford | 12 |
| 4. Conclusions | 26 |
| 5. Next steps | 28 |
| Appendix | 29 |
| References | 30 |

NHS organisations in Trafford, a borough of 215,000 people in Greater Manchester, have been working on the development of a new integrated care system across the whole health economy. This research report examines the Trafford experience, with an emphasis on the process of change required to achieve integration, describing the main phases of work, and the successes and challenges associated with each. What has taken place – and continues to develop – in Trafford will be useful for others who see integrated care as a route for delivering more efficient and patient-focused care.

Key points

- Integration can take a number of forms – ranging from a loose collaboration between different providers, through to full mergers (vertical or horizontal). In Trafford, the emphasis has been on bringing together community-based primary, general acute medicine, specialist outpatient and diagnostic care into a new community-based integrated care organisation.
- Meaningful collaboration across professional groups has proven critical. Six multidisciplinary clinical panels are now responsible for redesigning services. They are supported by a locally-tailored international clinical leadership programme. Furthermore, the work of the panels is underpinned by a clear, widely-understood vision that clinicians, managers, patients and local residents have helped to shape.
- Trafford is well-placed to be a test case for emerging policy on integrated care given the focus on clinical leadership, patient and public involvement, and outcomes-based service evaluation. Its experience also demonstrates that it is feasible to make progress on service redesign, even while structural issues are being worked through.
- Clinical leaders in Trafford have sought to differentiate between the services they can deliver to a high level of quality and efficiency, and those that are best provided by others. Appropriate use of technology and effective data sharing are essential to make informed ‘make or buy’ decisions, as well as for monitoring performance.
- Although the basis for change was secure in Trafford, a leap of faith was necessary to invest in implementation, given the evidence underpinning integrated care. The Trafford experience suggests that two years of initial development, followed by a minimum of one year of ‘live’ working, and almost certainly longer, is required to show the initial effects of major changes to service organisation and provision, particularly financial savings.
- Following completion of the ‘proof of concept’ year, leaders in Trafford anticipate further learning about the impact of integrated care on utilisation, cost and patient experience. Future reports by the Nuffield Trust will examine the service changes brought about as a result of adopting integrated care in Trafford.



1. Background

Trafford was the birthplace of the NHS. On 5 July 1948, the then health secretary Aneurin Bevin opened the first NHS hospital in Trafford, with the ambitious plan of bringing health care to all. Over 60 years later, the focus of care in the NHS has progressively shifted from hospitals into the community, and from the treatment of infectious disease to the management of long-term conditions. In Trafford, this has prompted moves to develop a new integrated care system.

NHS organisations in Trafford have been working for more than three years to develop integrated care. Integrated care is an approach to organising services that enables better coordinated and more proactive care. The aim is to address fragmentation in patient services, particularly for patients with multiple chronic health needs, and to achieve greater efficiency and value from health delivery systems (Shaw and others, 2011).

The impetus to develop integrated care in Trafford has arisen from a long history of financial problems in the area. It had become increasingly apparent that the local acute NHS trust (Trafford Healthcare NHS Trust) could not retrieve its own financial position without causing severe financial difficulty for the Trafford system and consequences for the population – the money was simply not there to sustain existing patterns of health services.

Furthermore, demand for NHS-funded care in Trafford is rising: there is a growing population, particularly those aged over 65 years, and chronic disease is a significant burden, with approximately 80 per cent of deaths in Trafford resulting from cardiovascular disease (CVD), cancer and chronic obstructive pulmonary disease (COPD). Thus, the primary care trust (PCT) has shifted its strategic focus from the management of long-term conditions and the acute care of older people, towards trying to reduce avoidable hospitalisation and treating people at or near to their homes wherever possible.

Integration can take a number of forms – from a loose collaboration between different providers through to a commissioned service model and/or an organisational merger (vertical or horizontal) between providers. In the middle of this spectrum, providers can be coordinated through means such as joint budgets, governance, information systems and flows of data (without organisational merger). These joint processes have been described as ‘integrative processes’ (Rosen and others, 2011).

In Trafford, efforts to develop integrated care have focused on primary, community health and general acute services, as well as mental health and social care. This report outlines the story so far, drawing out emerging lessons for others working to achieve similar aims. Future reports will focus on the impact of integration in Trafford.

2. An overview of the story to date

In January 2008, Trafford PCT outlined plans to develop more integrated care in their *Commissioning and Strategic Plan 2008–13*. In September 2008, the first ‘Clinical Congress’ was held – an event bringing together 110 people (mainly clinicians and other care professionals) – which provided further support and leadership to developing the ideas. Four similar Clinical Congress meetings have since followed, each involving clinicians, managers and local people.

The early strategic development work within Trafford (from the beginning of 2008 to March 2010) focused on clarifying the concept of integrated care, and developing it in clinical areas of greatest priority. The aim was to improve patients’ experience of care in Trafford whilst achieving greater efficiency and value. What emerged was a plan to develop much closer collaboration between community-based primary, general acute medicine, specialist outpatient and diagnostic care, to enable more care to be delivered outside of hospital. For example, delivering care to patients in their homes, or via medical centres and community-based clinics, and bringing together named consultants, nurses and social care staff within a neighbourhood-based service model of groups of general practices. It was intended that the needs of the population registered with general practices would increasingly be used as the basis for planning care, rather than necessarily the patients who currently use health care. The vision of care as articulated locally by the Clinical Congress is outlined in Table 1.

Table 1: What does community-based care mean for patients and clinicians in Trafford?

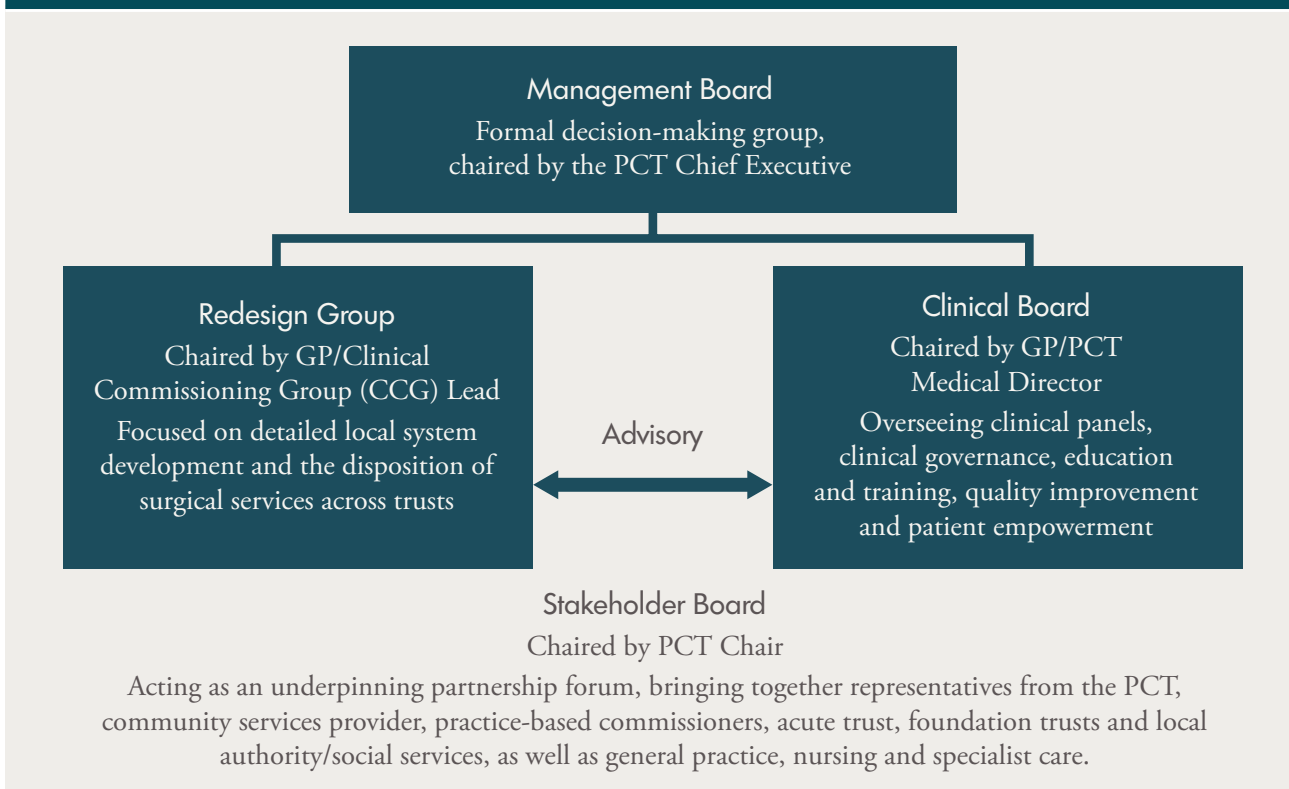
| Patients and the public... | Health care practitioners... |
|--|--|
| ...will access health care services differently, with hospitals delivering emergency care/specialist surgery; and large general practices and community hospitals delivering many of the other services they might need. | ...will organise and deliver care outside of traditional hospital settings, in local communities, and by teams that are organised on the basis of four neighbourhoods across the local health economy. |
| ...will receive some specialist care (such as cardiology, endocrinology and dermatology) and medical investigations (such as blood tests or x-rays) in clinics much closer to their home. | ...will work in close cooperation and will be supported by neighbourhood care coordinators who will ensure integrated patient pathways across primary, community and specialist services (including diagnostics). |
| ...will have contact with different practitioners, particularly when they have long-term conditions: patients’ GPs will be pivotal and will be supported by named nurses and consultant specialists; and care coordinators will help both patients and GPs to organise their care. | ...will increasingly work in community settings, with GPs retaining a holistic perspective and being supported by named office consultant specialists providing clinical decision-making assistance and support for patients outside of the hospital setting; and named lead nurses responsible for the coordination of all non-medical aspects of care. |

The governance arrangements for developing integrated care in Trafford evolved over time, and are outlined in Figure 1. A Management Board provides formal oversight of the emerging integrated care programme, with a Stakeholder Board alongside this acting as a forum for a wider group of partners, some located beyond the borders of the PCT.

The Clinical Board brings together nursing and medical leaders from across the health system to coordinate clinical input. It is accountable to the Management Board and acts as the main clinical authority, signing off service redesign proposals recommended by the Redesign Group which sits alongside it.

A separate legal vehicle, Trafford Primary Health Ltd, owned by the local general practices, was established to enable a coordinated view from GP practices as providers in Trafford (for instance, centrally negotiating clinical compacts on behalf of GPs). Whilst Trafford Primary Health Ltd is a decision-making partner, it is not formally incorporated within the proposed governance arrangements shown below.* Representatives from Trafford Primary Health Ltd are included within each of the groups.

Figure 1: Overview of Trafford's integrated governance arrangements for integrated care



By February 2009, Trafford PCT had approved a strategy to develop integrated care and a business case to attract further funds from the strategic health authority (SHA) to implement the plans. In the autumn of 2009, Trafford Healthcare NHS Trust was identified by the Audit Commission as having inadequate performance with respect to financial management and financial standing (Audit Commission, 2010). The SHA, having received the business case for funding an implementation plan for integrated

* At the time of developing governance arrangements, plans focused on developing an integrated care organisation, comprising the acute trust and PCT community provider organisation. At this stage, it was decided not to include Trafford Primary Health Ltd due to VAT implications of including a limited company as part of this planned organisation.

care in Trafford, supported the proposed model of care, but recommended a rethink with respect to the funding needed and the pace of change.

In April 2010, the PCT agreed to fund a 'proof of concept' year, providing £2 million of investment funding to support initial implementation and lay the foundations for more extensive integrated care across the Trafford area. This initial implementation involved nine 'vanguard' general practices working with community, acute and social care to redesign selected care pathways, share data, identify patients at risk of unplanned hospitalisation, and generally to act as a test bed for implementing and evaluating integrated care.

At this stage, the plan was to create an integrated care trust – comprising the acute trust and PCT community provider, following the national policy of Transforming Community Services. A business plan was submitted to the SHA for the new integrated care trust. The intention was that the integrated care trust would work more closely with the nine vanguard practices and social care providers to offer better coordinated care. More details of how this was to be achieved are shown in Table 2, including how the £2 million from the PCT was to be spent. The focus was not only on creating an integrated care trust, but also on redesigning services across the health economy on the basis of integrated models of care. To achieve this level of change, seven work streams were planned to: enable engagement of clinicians, managers and patients in a process of continuous quality improvement; reshape clinical teams to support delivery of integrated care; and better target health care through real-time data-sharing and improved use of the GP list. The proof of concept year ran from April 2010 to March 2011. The allocation of funding for the proof of concept year was managed by a governance process agreed by the PCT Board.

Trafford planned to establish the integrated care trust in October 2010, proposing bringing together 2,600 staff from the local acute trust and community services provider into one health service provider organisation. To do this, approval for the plans was needed from the Cooperation and Competition Panel (CCP)*: a 'fast track' application was made following informal advice from the panel early in 2010. However, with Trafford Healthcare NHS Trust having been rated as 'weak' in financial management and standing, the CCP was concerned that this might have an adverse impact on patients and taxpayers. The CCP therefore recommended that the plans for the Trafford integrated care trust underwent 'full' rather than 'fast track' review (a more detailed and time-consuming procedure). The panel also advised Trafford to address concerns about a potential loss of patient choice through vertical integration – that is, preserving choice for those patients receiving community services within the proposed trust and requiring onward acute treatment. In response to the panel's decision for full review, the timetable for developing the Trafford integrated care trust shifted to April 2011, with detailed business and financial planning submitted to NHS North West (the SHA) in October 2010.

By November 2010, however, the SHA had announced that it was unable to support the financial plans underpinning the proposed integrated care trust in Trafford, on the basis of longer term financial viability. Given the challenging financial climate, the SHA was not confident that the proposed integrated care trust could make either the efficiency savings required, or help to reduce the deficit at Trafford Healthcare NHS Trust at the necessary pace, without significantly affecting the quality of patient care.

* The CCP's role is to ensure that the set of rules governing the behaviour of NHS-funded commissioners and service providers is applied in such a way that it enables patient choice, competition and cooperation, and helps deliver benefits to patients and taxpayers (Cooperation and Competition Panel, 2010). The CCP then advises the Department of Health or Monitor on whether a merger should be allowed to proceed, whether certain conditions should apply, or if the merger should be prohibited.

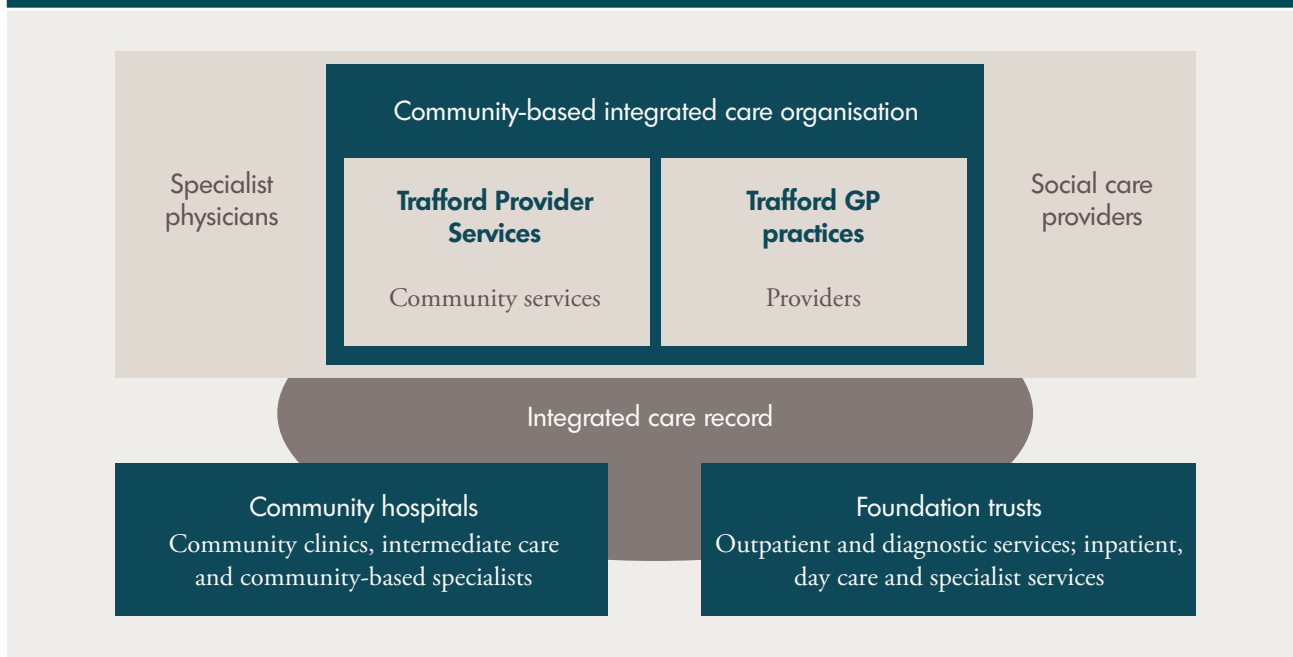
Table 2: Overview of Trafford's plans for a 'proof of concept' year

| Work stream | Estimated cost (£) | Planned initiatives (April 2010–March 2011) |
|--|--------------------|--|
| Service redesign, including clinical panels and compacts (see Appendix) | 1,200,000 | <ul style="list-style-type: none"> • Bring together consultants, GPs, patients, specialist nurses and allied health professionals (AHPs), to develop and publish the standards with which clinicians will be expected to comply. • Facilitate the work of clinical panels through dedicated project management and quality improvement methodology. • Develop and publish pathways through Map of Medicine.* • Appoint nine 'vanguard practices' to act as the 'laboratory' where the integrated approach can evolve. • Develop community geriatrician roles, reshape existing physician teams, establish ten community-based outpatient sessions and provide telephone advice to GPs and community matrons during lunchtimes and evenings seven days a week. • Appoint five community matrons to reshape community teams, act as the named leads for vanguard practices, identify at-risk patients and work to prevent admissions as appropriate. • Appoint two advanced nurse practitioners, one attached to the medical assessment unit and the other on general wards, to provide backfill nursing and undertake some of the care planning and discharge functions carried out in the acute setting. • Develop telehealth by introducing remote monitoring of diabetes and heart failure to three local practices and, in each of these areas, link with telecare initiatives provided by adult social services. |
| Information and reporting | 350,000 | <ul style="list-style-type: none"> • Develop data sharing across general practice, hospital, community and social services systems; facilitating a systematic approach to managing population risk, improving health outcomes and reducing hospital utilisation; developing information management systems and generating reports to enable clinical teams to make 'real-time' decisions. |
| Patient experience and coordination | 150,000 | <ul style="list-style-type: none"> • Incorporate the patient voice within the strategic development of services through representation on clinical panels and the monitoring of patient experience. • Develop signposting for local services to enable improved coordination of care by aligning the PCT referrals management service and the acute trust booking office. |
| Vertical integration | – | <ul style="list-style-type: none"> • Create an integrated care organisation, bringing together local general practices and community services, with social care and community-based specialist services wrapped around this (building on work in other work streams). |
| Leadership and quality improvement | 100,000 | <ul style="list-style-type: none"> • Develop an international-class clinical leadership programme to build the capability of clinical teams to deliver ongoing quality improvement. |
| Project office and evaluation | 200,000 | <ul style="list-style-type: none"> • Provide support costs for the programme office throughout the year, including evaluation and contingency. |

* See www.mapofmedicine.com

Trafford partners then changed their plans to develop a community-based integrated care organisation (ICO) in which general practices and specialist staff would share facilities, staff and income. The aim was to bring together local GP practices (as providers) and Trafford Provider Services (the community health services arm of the PCT) into a single integrated organisation, and to develop much closer working with social care and specialist services based in the community (see Figure 2). Trafford PCT has had a major role in these developments, and NHS North West has been supportive.

Figure 2: Overview of the emerging integrated care organisation in Trafford



The intention is for a new community-oriented provider to operate as a fully functioning ICO, bringing together GPs (through Trafford Primary Health Ltd) and hospital consultants to develop the 'office medicine' model. Funding is intended to flow via a single contract from the PCT to the new community-based ICO, which will sub-contract for services as needed by the local population. At the time of writing, details such as the legal form (for example, a limited company) and governance arrangements have yet to be worked through. However, the intention is for GPs and consultants to be employed on a sessional basis, with community physicians offering advice and planning of care as part of community teams.

Trafford Primary Health Ltd has been actively engaged in discussions about how this new community-based ICO should develop and the different organisational forms it might take. Trafford GPs continue to be motivated by the vision for integrated care. The focus is on aligning incentives more closely with outcomes to enable integration; something that is considered a critical 'integrative process' within developments of this nature (Rosen and others, 2011).

At the time of writing, the focus is less on developing the vehicle for an ICO and more on ensuring that the methodology for developing integrated care across the whole health economy becomes central to the commissioning and provision of health and social care.

In the meantime, the Trafford Healthcare NHS Trust Board decided that it would be unable to achieve foundation trust status within the time required by the Coalition Government's reform agenda (Department of Health, 2010a). It therefore sought an acquisition partner that is committed to developing integrated care.* At the time of writing, Central Manchester University Hospitals NHS Foundation Trust has been selected as the recommended preferred bidder. The acquisition process is expected to be completed by March 2012.

In April 2011, the community services provided by the PCT were temporarily transferred to Bridgewater Community Trust. Following advice from NHS North West, a permanent home is now being sought for the community provider through a procurement process. It is intended that procurement be against a service specification founded on the integrated care service model and formulated by the PCT and shadow Trafford clinical commissioning group.

Alongside these local developments, there have been concurrent changes in national policy arising from the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010a). In addition, the financial challenge faced by the local health economy grew when taking account of the budget settlement for 2011 and the need to make four per cent efficiency savings each year to 2015 (the 'Nicholson challenge').

Trafford GPs have established a clinical commissioning group, building on the existing Trafford-wide practice-based commissioning consortium, ensuring a fresh mandate from local GPs and enabling them to fully engage with, and make early decisions about, the development of integrated care. By December 2010, Trafford Commissioning Consortium had been awarded 'pathfinder' status, enabling it to take on some commissioning responsibilities, manage local budgets and commission integrated care directly with other NHS colleagues and local authorities.

In light of these changes, the approach to integrating care in Trafford has shifted to focus on an integrated service system, with organisational form being a second order issue. Trafford Commissioning Consortium is committed to the vision of integrated care and, along with Trafford PCT, has outlined their commissioning intentions to support this vision. The focus is on making a series of careful investments to increase collaboration across the health care system and change the way that existing functions work. Commissioners then intend to offer all integrated community services (through due process) to the emerging ICO, with phased transfer of redesigned services from April 2012 onwards. This includes those areas of work currently undertaken by clinical panels (see Table 2), as well as other outpatient, diagnostic, day case and specialist nurse services. There will still be a need for short intervention acute beds and for outward-facing support from local acute clinical teams to support community-based integrated care.

Commissioners are currently exploring ways to ensure this service offers patient choice and allows more flexible contracting approaches based on capitation/individual care pathways. The main criteria for judging the success of these commissioning intentions will be achievement of measureable improvements in the quality and effectiveness of clinical services, tackling health inequalities, assuring choice, and increasing cost-effectiveness through integration. Future Nuffield Trust studies will focus on these areas.

* Criteria for evaluating bids for the trust's future management included a commitment to the development and delivery of integrated care.

3. Learning from Trafford

Trafford's experience of developing integrated care demonstrates steady progress along with significant setbacks. Five challenges are now outlined which identify the key lessons for others considering such an approach.

Challenge 1: Recognise that major change is needed

“ The integrated care organisation is not an acute trust with a community division

Senior Manager

Lesson: Ensure a clear and agreed vision

Major organisational changes are invariably rooted in big ideas – a radical vision for how services can be delivered differently. A clear articulation of the values and principles underlying the vision helps to ensure that plans are not blown off course by distracting factors. In Trafford, six founding principles have proved invaluable in this respect (see Box 1). The explicitness with which these have been articulated has

Box 1: Principles used to guide the development of an integrated care system for Trafford

Principle One: ‘Nothing about me, without me’ – the patient voice must be at the heart of all provision

This requires a cultural change in all services, with a new emphasis on the patient voice and patient experience, and the way in which this is incorporated into planning and ongoing evaluation of services.

Principle Two: General practice should be the ‘locus of integrated services’

Integrated services are based on the practice-based registered list: a list of the population who may need NHS care, and the most complete record of their health care needs.

Principle Three: Specialist expertise is an essential component of effective integrated services

The unique authority of consultant specialists to identify a definitive differential diagnosis and plan care for patients remains central. Achieving a shift from consultant-based to consultant-integrated services requires new ways of working (such as specialists working more in the community) and an increase in their contribution to the overall management of clinical care provided to populations.

Principle Four: The delivery of integrated services will rest primarily on extended roles for nurses and AHPs

The development of integrated care across primary and secondary care requires a new relationship between nurses/AHPs working in general practice and community teams, and those associated with acute care. This involves changes to clinical education and training, and the establishment of more formal networks between locations of care to ensure the effective delivery of new pathways and the development of nursing/AHP leadership roles.

Principle Five: Integrated services must incorporate social care

Closer working between health and social care is needed to enable: more effective management of the risks of hospitalisation (leading up to and following admission, as well as preventing the need for admission); the delivery of better coordination between services to promote independent living; and to prevent illness and social isolation.

Principle Six: Future integrated services should bring together the full range of primary care services

Incorporating new diagnostic technology, and developing further patient choice within a network of inter-linked services, opens up the prospect of a greater role for pharmacy and optometry in the delivery of the future model of care.

increased over time, and they are used as the acid test for any revisions to the strategy and its implementation.

Efforts in Trafford have focused more on developing integrated care across a network of providers, rather than on structural change in one integrated organisation. In practice, this enabled Trafford to:

- facilitate a vision for an integrated care system across all clinicians, including GPs and a diverse range of specialists
- clarify the commissioning needed to support the integrated delivery system
- allow other developments (such as estates or workforce planning) to follow from the system-wide vision, rather than steering it
- involve a range of stakeholders, for example foundation trusts beyond Trafford borders
- pave the way for more extensive integration across services by involving other providers, for example, mental health trusts, third sector health providers and social care providers
- adapt to changes in the external policy context.

This vision for integration in Trafford aims to support choice and competition between providers whilst encouraging collaboration. It has sought to achieve this by making a compelling case for integrated care as one of several service providers and thereby enabling patients to choose from a network of providers (largely within, but also outside, Trafford borders) brought together through an overall framework of collaboration. The intention is to maintain competition between providers, whilst simultaneously providing high-quality integrated care that is the service of choice for local residents.

Lesson: Work simultaneously with commissioners and service providers

In Trafford, the PCT wanted to develop a clear description of services on offer from local providers, while the latter first wanted details about commissioning intentions. An impasse was avoided by seeking agreement between commissioners and potential service providers on issues such as:

- the likely available budget and an agreement to scope future services within this
- the pursuit of quality improvement as part of the core business of organisations
- a commitment to developing objectively quantifiable ways of measuring quality
- the development of a challenging and agreed set of health outcomes which local services and organisations can achieve.

Trafford PCT signalled its intention to shift to developing integrated care and included a simple set of principles that any willing provider could respond to (see Box 1). It is intended that the same principles will be used by Trafford Commissioning Consortium when contracting with providers in future. The intention is that all organisations offering care to patients in or from Trafford are asked to reconsider their service development plans in the light of these principles.

Lesson: Make a clear case for change and clarify the journey towards integration

“ There’s a limit to how much you can prove things. It is intuitively obvious that if you’ve got someone with a long-term condition, and you stop them going into hospital five times a year and cut it down to one, then... that must be a better experience for the patient

Senior Manager, acute trust

The case for change should be robust, especially with respect to expected gains in quality and efficiency. The difficulty for Trafford, as elsewhere in the NHS, has been how to gain financial support for its plans before positive results can be demonstrated. Leaders developing integrated care were however successful in securing a total of £2 million funding (from the PCT) for a ‘proof of concept’ year (see Table 2). While this was a pragmatic way of getting started, after several months the consensus was that one year was insufficient to show the full effect of initial changes, particularly in relation to financial savings which were only anticipated after the ‘proof of concept’ year.

When organisations are financially challenged, or there are other compelling reasons to make improvements, there is rarely time to wait for proof of effectiveness before embarking on change. In Trafford, it has been sufficient for senior executives leading the development of integrated care to have an indication that the direction of change is likely to work. An example is the use of telehealth, the remote exchange of data between an individual and a health care professional, such as remote blood pressure monitoring, to assist in the diagnosis and management of health care conditions. There are indications of the value of telehealth (Bensink and others, 2006; Bergmo, 2009; Darkins and others, 2008; Paré and others, 2007; Tran and others, 2008). However, there is, as yet, insufficient robust, independent evidence that telehealth will work as anticipated, nor are there reliable data on the savings in a particular period, relative to the costs. Nevertheless, experience from other organisations indicates that technologies such as these can promote integrated care. On this basis, Trafford plans to use telehealth to facilitate integration and monitor its impact, as part of the ongoing evaluation.

In short, a leap of faith has been required, particularly in relation to how new ways of working will achieve the financial savings hoped for. This leap of faith has been supported by appropriate governance arrangements and a balanced attitude to risk.

Lesson: Be realistic about the pace of change

“ So much of this is in flux, so you start with an idea of something you can see would work... and that idea then generates something and turns into something else, but then it shifts and it’s implemented slightly differently, and you don’t quite know. But the important thing is starting that process

GP/Medical Director

In practice, what has made sense in Trafford is evolutionary rather than transformational change, especially when engaging such a necessarily large group of stakeholders. The pace of change has also been set by external processes, such as the need to satisfy the requirements of the Cooperation and Competition Panel, as outlined above. If morale and the impetus for change are to be maintained, realistic timescales for such processes need to be factored in, and understood, by all stakeholders.

The Trafford experience exemplifies the frustrations inherent in trying to make major change to a whole local health system. A good example is the development of integrated governance arrangements (shown in Figure 1), which has required continual negotiation throughout the planning and implementation phases to:

- develop tangible and workable structures to support integration
- combine effective clinical leadership (across primary, community and secondary care) with strong general and project management
- incorporate community services, acute trusts and GPs (and possibly social services and mental health), as well as patients and the public.

Agreeing and establishing complex governance structures whilst plans for integration were evolving was challenging, particularly with more stakeholders involved.

The Trafford experience of developing governance structures highlights a tendency for proper caution to develop into risk aversion. Change management must be based on a proportionate attitude to risk, with an awareness of the need to ensure reasonable safeguards without resorting to unreasonably bureaucratic measures (Chambers, 2006).

Since change rarely follows the predicted course, it is important to keep track of what is happening so that refinements can be made and properly accounted for. As Trafford shifted into the 'proof of concept' year, so the management approach changed, placing more emphasis on monitoring performance and fine-tuning developments.

Lesson: Ensure high-level support for integration

Gaining high-level support for radical strategic plans has been a key priority for senior managers and clinicians in Trafford NHS organisations, as well as the local authority and stakeholders outside Trafford. Backing from NHS North West, although conditional, has been strong and constructive: financial support has been needed to allow Trafford Healthcare NHS Trust to run with a deficit while making plans for financial recovery. External political support from, for instance, the Department of Health, has also been important to ensure confidence in the direction of travel, before tangible progress is evident. Trafford also forged a relationship with the Nuffield Trust to provide external challenge, enable reflection, and to access a greater range of learning from national bodies, as well as connecting with similar sites in the NHS seeking to develop integrated care such as Cumbria and Nottingham.*

* For further information about these integrated systems see Ham and Smith, 2010.

Challenge 2: Put patients at the centre



The theme is not discharge or need to follow up, but the best care for the patients at the right time and place without duplication of service

Consultant, acute trust

Change on the scale proposed in Trafford has necessitated significant patient and public engagement. This comprised six key elements, as shown in Box 2.

Box 2: Six mechanisms for engaging patients and the public in Trafford

1. Assessing **public/patient opinion** through engagement events, neighbourhood forums and a residents' survey. This led to identification of seven 'People's Priorities' underpinning integration in Trafford (for instance, development of a holistic, joined-up service and accessible services located close to people's homes) and establishment of a 16-member Citizens' Panel, acting as an independent review and validation group for plans for integrated care.
2. Developing **Patient Congress events** (one in the initial planning stages, one close to the start of the 'proof of concept' year in July 2010, and one in November 2010) to provide input from local voluntary sector organisations and individual service users into emerging plans (ongoing since 2008).
3. Recruitment of, and training for, two to three **patient representatives within each of the six clinical panels** (involving a formal application process and follow-up workshop) to ensure that the patient voice is formally incorporated within service redesign (ongoing since April 2010).
4. Developing a programme of **accessible community engagement events** bringing together patient representatives from the clinical panels with a wider local constituency of service users to scrutinise developments, provide support for clinical panel representatives, and validate the process of service redesign (ongoing since June 2010).
5. Increasing resources available to **support the establishment of GP-attached patient forums** to strengthen health networks that are representative at a community level (ongoing since September 2010).
6. **Tracking patient experiences** via the collection of quantitative information from a representative sample of patients to assure health care professionals, the PCT and the wider Trafford population of the improved experience for patients accessing new integrated models of care (ongoing since October 2010).

Lesson: Secure senior staff time to ensure effective and ongoing engagement

As a result of the initiatives set out in Box 2, public and patient involvement is perceived by those leading integrated care developments in Trafford to be progressing slowly but surely. Significant input from senior staff has helped, recognising that there is no substitute for the time needed for genuine engagement. Fostering partnerships between health professionals and patients, for instance through clinical panels, has also required professionals to develop their own knowledge and skills to understand and take account of the patient's perspective.

Challenge 3: Engage with stakeholders when developing integrated systems

“ If you were to analyse only one thing, which is how relationships have changed between the time that we started in this process and where we are now, I think that would be the thing that would demonstrate the biggest change

GP/Medical Director

In Trafford, large-scale change would have been virtually impossible without the continual engagement of commissioners, providers and service users. This engagement has encouraged ‘buy-in’ to plans for integrated delivery.

Lesson: Actively engage clinicians across primary and secondary care

The active support of clinicians is vital to making change happen in health organisations (Golden, 2006; Scott and others, 2000). In Trafford, clinical engagement has proceeded in four key ways (see Box 3).

Box 3: Key clinical engagement activities in Trafford

Engaging clinicians in developing integrated care: for instance, through a series of Clinical Congresses, the first held in September 2008 (to obtain support for integrated services and to start to build a whole system clinical view), the second in January 2009 (to continue redesign work for 24 clinical areas, describing services and detailing outcomes), the third in April 2010 (to engage clinicians in ‘proof of concept’ work streams) and the fourth in January 2011 (to obtain support for changes to plans for integrated care).

Leading service redesign: for instance, through six multidisciplinary clinical panels selected in April 2010. These focus on clinical services (diabetes, respiratory, mental health and learning disability, and ear, nose and throat) and ‘whole system’ areas (unscheduled and end-of-life care). Panels bring together consultants, GPs, specialist nurses/AHPs and social care staff. They are supported by patient representatives, project managers and facilitators (the latter to facilitate process mapping and quality improvement approaches).

Developing local clinical leaders: for instance, through development of an ‘advanced training programme’, a tailor-made clinical leadership programme focused on quality improvement and leadership.

Engaging vanguard practices: for instance, in service redesign and implementation through dedicated events to ensure they are aware of, and supportive of, the range of integration activities that they are due to provide.

Encouraging clinical leaders has been critical in Trafford. This has entailed formal appointments to substantive managerial posts (such as a consultant geriatrician being appointed as medical director within the acute trust) or through, for example, chairing committees (including the Clinical Board or clinical panels) and leading the work of vanguard practices. Many GPs have been active, for instance, as leaders in practice-based commissioning groups or the shadow GP clinical commissioning group, and

three GPs have been appointed as locality medical directors within the local acute trust. Other GPs have been much less involved and have focused on, for instance, ongoing participation in Clinical Congresses and attendance at practice-based commissioning meetings. This differential level of involvement in the early stages was not considered to be a problem so long as GP opinion-formers were actively engaged and able to communicate progress clearly to other GPs. As noted above, nine vanguard practices – where the new integrated approach is being developed – were identified during the ‘proof of concept’ year, and the GP leaders supported.

Lesson: Make integrated care attractive to all clinicians

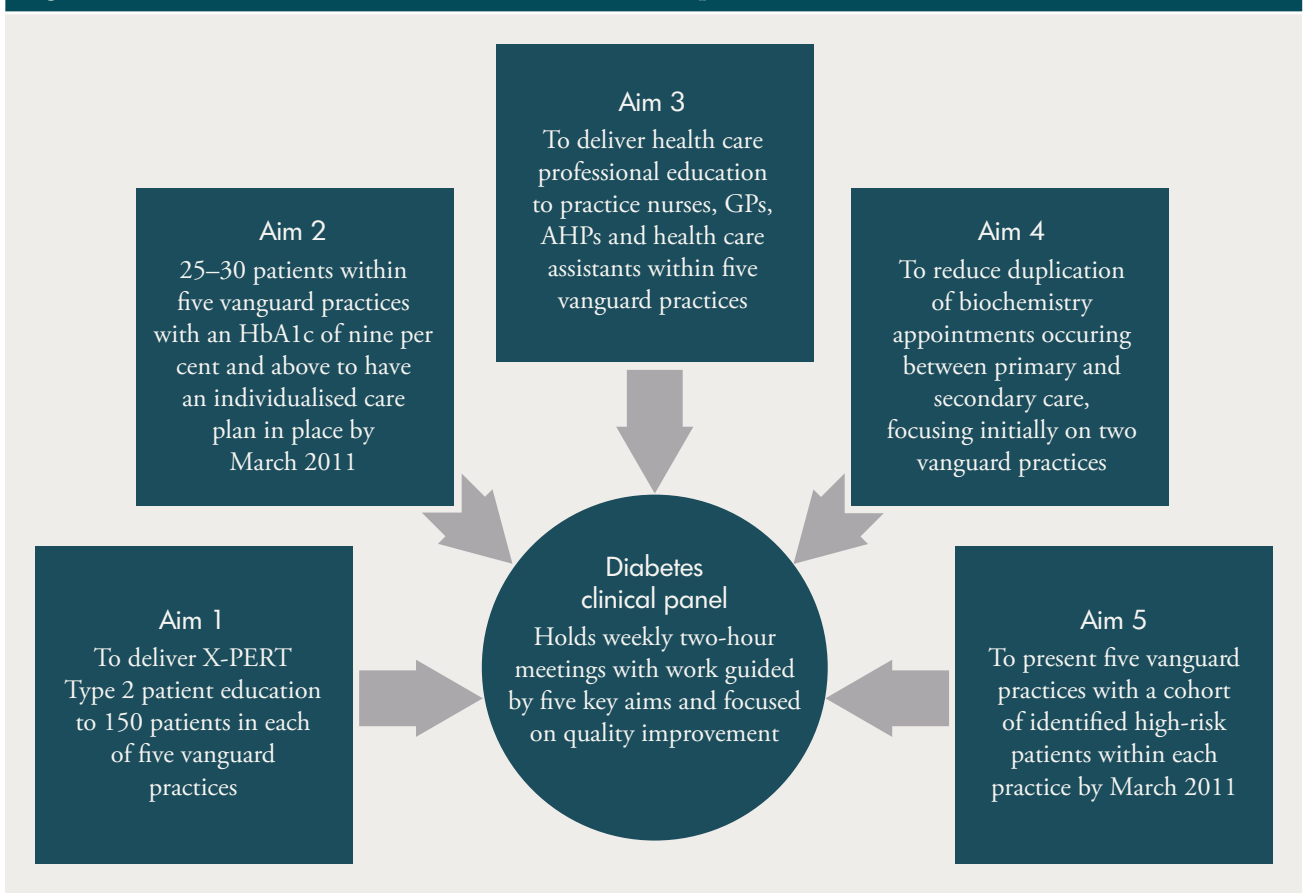
For Trafford residents, GPs currently refer patients to the local acute trust, as well as two foundation trusts situated on the borders of the district.

The development of integrated care in Trafford (Figure 2) aims to preserve competition and patient choice by ensuring a high-quality service offer for integrated care on the part of the new community-based ICO, whilst at the same time ensuring continued competition amongst providers aligned with the Trafford health economy. For the community-based ICO to be competitive, it is necessary to continually work, not only with general practices within and beyond Trafford to increase referrals into this ICO, but also with other clinicians involved in designing and delivering care. For GPs (particularly for those working on Trafford borders), this means developing programmes of care for individuals with long-term conditions (particularly those at high risk of hospitalisation), developing locally accessible community hospitals, and working to enable easier access to community-based specialists.

Making integrated delivery systems attractive to nurses and other health professionals is equally important, since integrated care relies on extended roles and new ways of working by these staff groups. For nurses, the emphasis is on encouraging advanced practice in community settings, providing training opportunities and developing local leadership and management skills. For consultants, the shift to ‘office medicine’ offers opportunities to develop a comprehensive service for a population, supervision of neighbourhood-based teams and support for the management of patients by GPs and nurses in primary care.

Perhaps unsurprisingly, aspects of change, such as the work of clinical panels, have taken longer than anticipated in Trafford. The work of the diabetes panel has progressed most rapidly (see Figure 3). This speed of change reflects the strength of professional relationships and developments that have occurred over a number of years, in contrast to unscheduled care or care for those at the end of their lives.

Figure 3: Overview of the work of the diabetes clinical panel



The focus of the diabetes panel in the first eight weeks was on mapping the pathway for both scheduled and unscheduled care, and on identifying five key aims to be tested from mid-December 2010 to April 2011 (the intention being to deliver against these aims with the support of vanguard practices). In contrast, the unscheduled care and mental health panels have encountered problems in identifying and agreeing aims, establishing a pattern of working, and using quality improvement processes. This has led to a degree of frustration amongst the leaders and contributors to clinical panels. Since then, work within all of the panels has been facilitated by:

- the appointment of project managers to each of the panels, bringing a strategic approach to the cycle of work (PDSA: plan-do-study-act)
- the appointment of dedicated facilitators to panels to assist with process mapping, identifying/collating data, and quality improvement approaches
- monitoring and review of activities by the Programme Director developing the integrated care system
- dedicated time to support planning, meetings and implementation.

There is a need for closer working between specialists and primary care staff to develop shared integrated care pathways further, for example using telehealth, video-conferencing, email and telephone contact, as well as setting up dedicated clinics in community settings.

In the first instance, the clinical panels are working independently. However, as progress is made, it is anticipated that there will be opportunities for collaboration to develop more complex clinical pathways, for example for people with multiple co-morbidities.

Lesson: Ensure space and time to build relationships

The Trafford experience has shown that the nature and quality of professional relationships is as important to developing integrated care as robust business and financial planning. A key to this has been to nurture informal contact (such as practice visits and social events), as well as the more formal committee-type interactions (such as clinical panels) – a key role of the Programme Director. As the sense of ‘being in it together’ has grown, there has been more sharing of the likely consequences of changes in service redesign and an apparent reduction in ‘gaming’ between organisations, which in turn made negotiations about contracts and performance more straightforward.

Lesson: Engage social services from the outset

At the outset, a key individual from adult social services at Trafford Council was involved in developing plans and formal events (for example chairing the selection panel for vanguard practices).

Social services staff may not need to be involved in the detail of developing clinical pathways, but it is important that they are in dialogue with key players, such as GPs in the vanguard practices. In Trafford, the initial stages of developing integrated care focused on bringing together health care organisations, with a participant from social services described as a ‘sitting member’. This provided initial legitimacy to the concept of integration from the perspective of all partners (both commissioners and providers), although further work was needed to ensure understanding of the contribution made by social care to health care.

With the shift to implementation, staff from social services have become more actively involved, for example aligning service boundaries with community services, co-locating social workers with district nurses, and enabling joint identification and management of high-risk patients. This is to be developed further (see Box 4).

Box 4: Plans for closer working across health and social care in Trafford

- **Develop a formal joint partnership** to plan the integration of adult health and social care on the ground
- **Continue to work with adult social services** to reduce hospital admissions and support discharges from hospital by providing care at home
- **Sustain the benefits of an integrated ‘virtual’ organisation** for children already in place in Children and Young People’s Services
- **Align work on telehealth** with the council’s work on telecare
- **Work with the evolving local authority public health team** to ensure that integrated services provided are tailored to the needs of local people
- **Contribute to the work of wider stakeholders** associated with the local authority, including the Trafford HealthWatch.*

* Current health reforms for patient and public involvement in health (Department of Health, 2010a; 2010b) are focused on the creation of HealthWatch England, a new independent consumer champion. It is intended that existing Local Involvement Networks (LINKs) will become the local HealthWatch, which will be funded by, and accountable to, local authorities. The function of local HealthWatch organisations will be to ensure that views and feedback from patients and carers are an integral part of local commissioning across health and social care.

Lesson: Use appropriate language

Communication with all stakeholders must be honest and open, with sensitivity to the language used. For example, recently those leading change in Trafford have talked about development of an ‘integrated care system’ rather than an ‘integrated care organisation’, enabling stakeholders such as foundation trusts on the boundary to feel included. Also, words like ‘repatriation’ (of patients, to care nearer home) can give the wrong signals; appearing to be concerned with protectionism rather than best care for patients.

Challenge 4: Facilitate effective local leadership

“ This is clinical service redesign, being led by clinicians and we’ve tried to put some supporting process around it... [that’s] probably the bit that I’ve seen which has worked more effectively here than anywhere else... put the service in the hands of clinicians, and you get the best outcome really

PCT Senior Executive

Unsurprisingly, the drive for large-scale change has been highly dependent on effective leadership. At the outset, visionary leaders who are able to paint the broad picture were required. Later, leadership focused on the detailed management of implementation became more critical. Both require credible and influential authority derived not only from their own personality, skills and the dynamics of their relationships with other individuals (Locock and others, 2001), but also from their working knowledge of the local health system. Such leaders have been vital in persuading colleagues to change their practice, creating a more favourable climate for change, and adapting plans in the light of new developments.

Lesson: Acknowledge the integral role of existing and emerging boards

Developing integrated care requires leadership and commitment at board level. New executive leadership roles are envisaged in Trafford relevant to emerging integrated care plans. In the meantime, it has proven important to appoint a *de facto* ‘shadow chair’ as transition lead for the emerging community-based ICO (Figure 1), even if current governance structures limit the shadow chair and board’s authority to acting with delegated authority from the boards of current established organisations. Non-executive directors with experience of implementing change can help move the process on considerably.

Lesson: Promote integrated care thinking amongst senior executives

In Trafford, the chief executive’s role within the SHA, the PCT and the acute trust has remained central throughout the change process. As plans have changed over time, there has been a requirement for a fundamental shift in thinking on the part of senior executives. They have had to shift their thinking away from plans to merge

organisations, towards collaborative leadership of the creation of a new community-based ICO; in other words a form of network organisation. Leadership that truly reflects integrated care thinking, rather than a traditional hospital-based approach, has been vital in this process. In Trafford, such thinking was facilitated by a programme director, who was immersed in developing a vision for an integrated system and who invested considerable time and energy in encouraging other executives to think similarly. This appointment of a senior executive dedicated to the development of integrated care across the whole health economy has been crucial.

Lesson: Actively develop and support local leaders

“ Any effective organisation needs a quality improvement methodology to underpin its behaviours

Senior Executive, community services

In Trafford, great importance is placed on sharing experiences and learning from others. An Advanced Training Programme has been developed, based on a unique relationship with a US-based high-performing integrated care organisation, Intermountain Healthcare in Utah. The programme is thought to be the first of its kind in the UK, bringing together clinicians, senior/middle managers, finance directors and commissioners. The focus is on service redesign, quality improvement and leadership. The intention in Trafford is to give all staff some exposure to the Advanced Training Programme, developing local leaders and placing quality improvement at the heart of the integrated care system. To help with this, Trafford is working with The King's Fund and the NHS Institute for Innovation and Improvement to develop and evaluate the programme.

The approach in Trafford has been to develop distributed leadership, combining existing leaders with those who emerge informally during the change process and who can be especially persuasive to peers (Locock and others, 2001). Most of the senior executive team participated in the first Advanced Training Programme (May to October 2010), with others following in subsequent cohorts from 2011 onwards. The mix of managers and clinicians from community and acute settings within the programme creates opportunities to develop teamwork and new relationships across different sectors.

Challenge 5: Focusing on improving quality and efficiency

“ The real problem we've got is financial viability... There's nothing in anything that's changed in the General Election that deviates one iota from our need to be absolutely clear about how, whether and to what extent we're going to achieve financial balance... and that's also about quality amongst other things

Senior Manager

Lesson: Be clear about the role and activities of each of the stakeholders within an integrated care system

In Trafford, leaders developing integrated care have been clear that the need to make efficiency savings means reducing some clinical services, especially in the local acute trust. But this has also meant developing new services, for example a local orthopaedic surgical centre, in partnership with one of the local foundation trusts, to increase local access to elective services, reduce length of stay in hospital and thus increase efficiency.

The current focus is on developing a community-based ICO, bringing together GP practices and community services into a network in which general practice and specialist staff share facilities, staff and income. To make efficiency savings in this context means clarifying the roles, activities and performance targets of each of the stakeholders, and competing more effectively for new referrals to a community facility in the south of the borough (by modernising the site and establishing access to a range of consultant-led clinical teams that are co-designed in consultation with patient groups and practices). It may be necessary to invest to save, particularly in ensuring that the right staff teams are in place to deliver safe and efficient services.

Table 2 provides a breakdown of the investments made in 2010/11 to support such changes and includes, for instance, recruitment and training of nursing staff. These changes form part of Trafford's QIPP (Quality, Innovation, Productivity, Prevention) plan.*

Lesson: Use data systems, intelligence and information sharing to deliver integration

Trafford is aiming to achieve daily data flows from the GP and hospital clinical systems as the foundation of its integrated care record and population risk management system (see Figure 4). The intention is to feed data into a central warehouse, using it to identify cohorts of patients at risk of hospitalisation, and monitor progress against intended outcomes. This process began in December 2010 by feeding relevant data into the work of clinical panels to help design integrated care. Eventually, it is intended that clinicians are fed back almost 'real-time' data on the use and costs of care by patients to help them make informed decisions about how best to coordinate care.

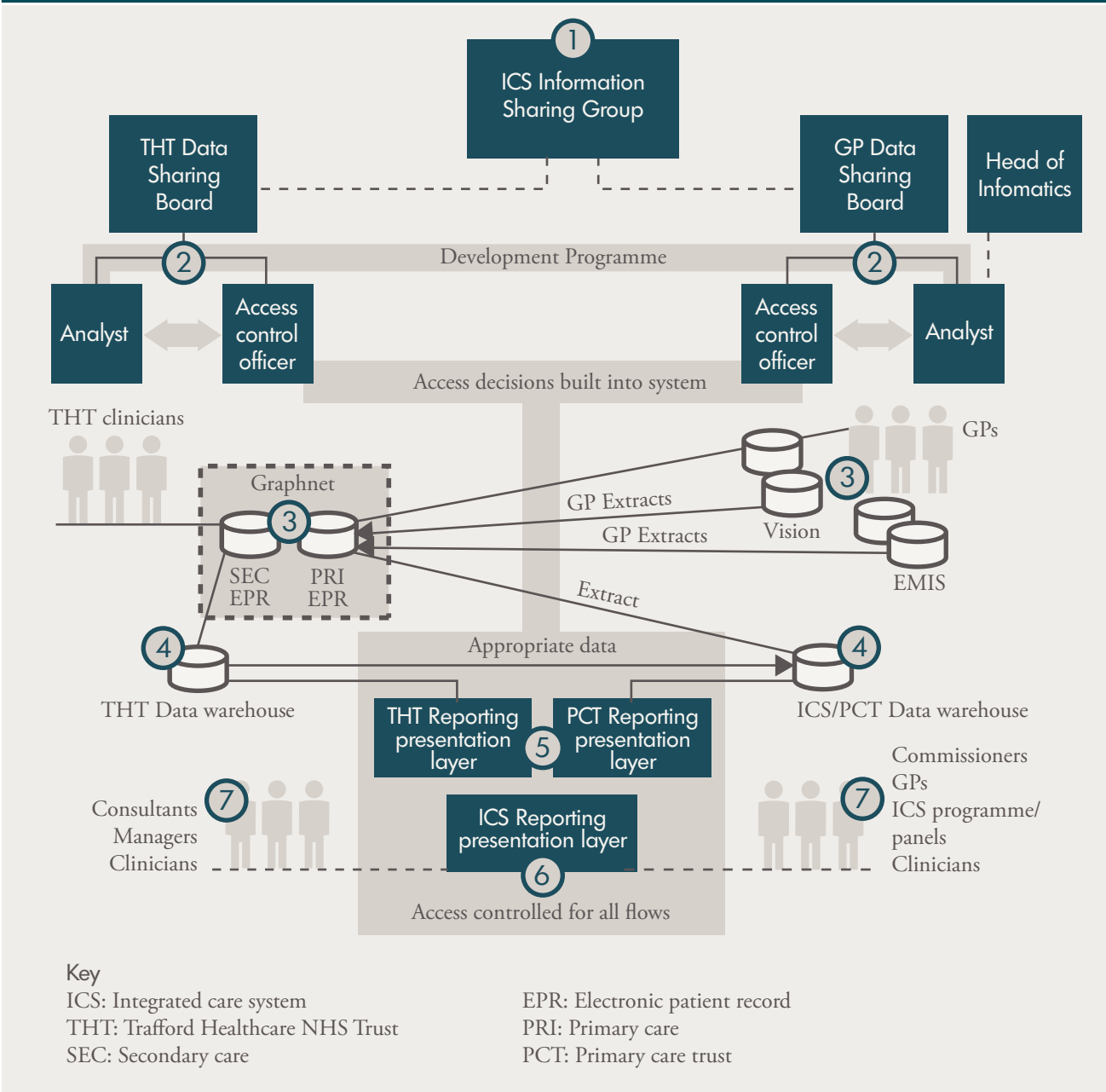
Achieving data flows in this way is ambitious: an established solution from Graphnet Health Ltd was favoured because local managers already had experience in implementing it. The Graphnet technical infrastructure allows both health and social care data to be brought together. A range of local data providers (such as social care and local foundation trusts) have been involved in developing these plans.

Each provider organisation (for example, Trafford Healthcare NHS Trust, or the local general practices, via Trafford Primary Health Ltd) has its own clinical information system (3 in Figure 4), which stream data into a file currently held on the Trafford Healthcare NHS Trust site. Here the data from primary and secondary care are combined (in line with established data sharing agreements) in a data warehouse (4). Data are transferred from here to a PCT data warehouse. Both data warehouses then feed organisation-based reporting (5) in relation to specific activities and/or areas, such as diabetes or unscheduled care (6). Clinicians and commissioners will eventually be

* QIPP is a programme focused on improving the quality of NHS care while simultaneously making up to £20 billion of efficiency savings by 2014/15 (see www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm). This is to be achieved through a number of national work streams, some focused on how to commission care (for example covering long-term conditions), and others focused on how to run, staff and supply NHS organisations (for example covering the use and procurement of medicines).

able to access a shared data system (7), but only on the basis of explicit access control policies.

Figure 4: Overview of data sharing arrangements



The overall approach to data sharing is overseen by a multi-stakeholder steering group (1), which brings together many of those involved within the integrated care system. Control over data management has been ceded to the GPs themselves through Trafford Primary Health Ltd, and a ‘GP Data Sharing Board’ that advises on data governance (for example, issues of data confidentiality, anonymisation, access to data from clinical panels and the need for patient permissions). Trafford Healthcare NHS Trust also has a data sharing board, with similar functions. Both data sharing boards (2) receive requests for data from the clinical panels, decide whether to agree to the request and, if so, provide the relevant extracts (using supporting analysts). The steering group collates

the demands and in some cases negotiates data sharing, in the interests of supporting the aspirations of the panels.

It is the work to integrate care in Trafford that has driven the development of the information system to share data (and not the other way round). The PCT is now considering the legacy it will leave the clinical commissioning group: the emerging commissioning framework will require all providers of care to comply with information requirements to support real-time (or at least daily refreshed) tracking of use of care by patients.

Lesson: Use technology effectively

The use of new technologies, including summary care records and telehealth equipment, facilitate the process of change in Trafford, and are likely to assume similar importance elsewhere. Clearly, new technology can effectively serve well-designed systems, but it cannot substitute for them (Cortese, 2010).

Box 5: Summary of challenges and lessons for integration from Trafford

Challenge 1: Recognise that major change is needed

- Ensure a clear and agreed vision
- Work simultaneously with commissioners and service providers
- Make a clear case for change and the journey towards integration
- Be realistic about the pace of change
- Ensure high-level support for integration

Challenge 2: Put patients at the centre

- Secure senior staff time to ensure effective and ongoing engagement

Challenge 3: Engage with stakeholders when developing integrated systems

- Actively engage clinicians across primary and secondary care
- Make integrated care attractive to all clinicians
- Ensure space and time to build relationships
- Engage social services from the outset
- Use appropriate language

Challenge 4: Facilitate effective local leadership

- Acknowledge the integral role of existing and emerging boards
- Promote integrated care thinking amongst senior executives
- Actively develop and support local leaders

Challenge 5: Focusing on improving quality and efficiency

- Be clear about the role and activities of each of the stakeholders within an integrated care system
- Use data systems, intelligence and information sharing to deliver integration
- Use technology effectively

4. Conclusions

Trafford's journey towards integrated care is work in progress. Considerable work has already been undertaken to identify and address key challenges by those seeking to integrate care (see Box 5). Leading and coordinating such change during a major national reform of the NHS (the abolition of PCTs and SHAs, and the setting up of local clinical commissioning groups), as well as at a time of significant financial constraint, could not be more challenging.

In Trafford, the focus has been on having a clearly articulated vision endorsed by multiple stakeholders, and leading change rather than being 'swept along' by external events. Flexibility and compromise have been important. Although the basis for change is secure, a lack of evidence about how best to develop integrated care across organisations and care settings in England has meant that a leap of faith has been necessary to invest in implementation. A *minimum* of one year, and almost certainly longer, is thought to be required to show the initial effect of changes, particularly potential financial savings.

The Trafford story demonstrates that it is feasible to make progress on service redesign, even while structural issues are being worked through. Thinking beyond structural changes (for example organisational mergers) and towards an 'integrated care system' is therefore essential, as demonstrated elsewhere (Alakeson, forthcoming; Curry and Ham, 2011; Ramsey and Fulop, 2008). Not only has structural integration between health care delivery systems often failed to achieve anticipated savings, but the structural elements of mergers can also result in lost opportunities in building effective links and shared aspirations between professional groups (Rosen and others, 2011).

Since integrated care is ultimately about achieving improved patient care through better coordination (Shaw and others, 2011), the emphasis on patient involvement and improved outcomes and experiences needs to be at the heart of any integration initiative. In Trafford, patient experiences are used in strategic planning and service redesign, in tangible and measurable ways. This is not a static process but requires sensitive and persistent understanding of patients' experience from the outset and on an ongoing basis (Coulter and others, 2008). Senior staff time therefore needs to be made available to make this happen.

Meaningful collaboration across professional groups is critical to success. A combination of informal relationships and formal structures is required to realise such engagement. Clinical engagement and involvement with business and financial planning, as well as service redesign, is pivotal, and the Clinical Congress meetings in Trafford and subsequent work carried out in six clinical panels have proved to be effective vehicles for engagement.

Institutional divisions between health and social care have tended to obstruct the collaboration that is required to deliver high-quality, efficient care tailored to patient needs (Rosen and others, 2011). As shown in Trafford, the involvement of local authority social services is therefore critical from the outset.

Leadership poses particular challenges in the context of developing integrated systems as stakeholders have different agendas and levels of understanding. Developing integrated care has required different skills at different times (for example, engagement, strategic planning, creativity, implementation and monitoring) and these need not be embodied in the same person. The Trafford experience indicates that a locally-tailored clinical leadership programme is an important component.

Those pursuing integration need to differentiate between those services in which they can attain high quality and efficiency, and those that are best provided by others. Appropriate use of technology and effective data sharing are essential to inform these 'make' or 'buy' decisions, as well as support needs assessment, clinical improvement and service redesign, monitoring and reporting performance.

There is no blueprint for how to meet these challenges – local solutions need to be found – but the Trafford experience to date can provide useful lessons for others undertaking a similar journey.

5. Next steps

Work to develop integrated care has provided the foundations for promoting collaboration and coordination of clinical services in Trafford within the context of ensuring choice for patients and appropriate competition among service providers. With the SHA having rejected plans for the development of an integrated care trust (bringing together Trafford Healthcare NHS Trust and Trafford Provider Services), Trafford is now in the process of developing a new multi-specialty community-based ICO. The focus is now firmly on developing a new medical group practice, bringing together GPs and their practice staff across Trafford, along with community-based specialists, community services and social care to provide high-quality, community-based integrated services to the Trafford population.

At the time of writing, the exact form of this ICO has yet to be decided. However, the concept of 'office medicine' remains central, with community-based integrated services clearly identified as the means of delivering improved quality and significant efficiencies. With the emergence of a Trafford-wide GP-led clinical commissioning group, plans for integration have to reinforce the opportunity for GPs, as both providers and commissioners, to work with colleagues in the wider NHS and in social care to deliver higher quality care, a better patient experience and more efficient use of NHS resources (Department of Health, 2010b).

The commitment to integration is firmly established within Trafford, with the wider programme of work continuing to engage clinicians, redesign services and develop the infrastructure to support quality improvement. Following completion of their 'proof of concept' year, leaders in Trafford anticipate further learning about the impact of integrated care on utilisation, cost and patient experience. Future Nuffield Trust publications will report on their achievements in these areas.

Appendix

The concept of ‘clinical panels’ is a hybrid of the form of standards development and implementation at Intermountain Healthcare, Kaiser Permanente and Geisinger integrated delivery systems in the US.

Trafford colleagues have been inspired by discussion in the research literature about the contribution a ‘clinical compact’ – between clinicians and managers – can make to changing professional relationships and practice (see Box A) (Silversin and Kornacki, 2000; Edwards and others, 2002).

Multidisciplinary clinical panels in Trafford are working to develop a new ‘clinical compact’ that describes how integrated services between practices and specialist teams could work, and the corresponding obligations on professionals.

Box A: Clinical compacts and their relevance in Trafford

- Clinical compacts aim to align clinical and managerial objectives, clarifying and sharing goals and obligations. They are a response to the recent cultural changes in health service management which now incorporate greater accountability, patient-centred care, more personalised services, collective work with other practitioners, and evaluation by non-technical criteria and patients’ perceptions.
- Development of a new compact involves analysing and potentially redesigning services, as well as securing commitment from clinicians to new working practices. In Trafford, this has occurred through the work of six clinical panels focused on: diabetes; respiratory; mental health and learning disability; ear, nose and throat; unscheduled care; and end-of-life care.
- Essentially, the sum of clinical panel outputs (for example, statements on respective specialist and GP roles, standard pathways, definitions and tolerances for variation monitoring to ensure quality and guide interventions, and competency requirements in different settings) add up to a new clinical compact describing how services will work in the integrated system between practices and specialist teams, and what the corresponding obligations and expectations on professionals will be.

References

- Alakeson V and others (forthcoming) *Integrated Care and Efficiency* (working title). London: Nuffield Trust.
- Audit Commission (2010) Evaluation and Use of Resources scores 2009/10. Summary results for NHS trusts and primary care trusts. London: Audit Commission.
- Bensink M, Haily D and Wotton R (2006) 'A systematic review of successes and failures in telehealth: a preliminary review', *Journal of Telemedicine and Telecare* 12, 8–16.
- Bergmo TS (2009) 'Can economic evaluation in telemedicine be trusted? A systematic review of the literature', *Cost Effectiveness and Resource Allocation* 7, 18 doi:10.1186/1478-7547-7-18.
- Chambers N (2006) 'Governance and the Work of Health Service Boards', in Walshe K and Smith J (eds) *Health Care Management*, Open University Press.
- Cooperation and Competition Panel (2010) *Guidance on Fast-track Procedure for Certain Categories of Mergers*, 6 April. London: CCP. Available at http://www.ccp-panel.org.uk/content/Fast_track_guidance_for_certain_mergers.pdf
- Cortese D (2010) *High Value Delivery Systems: How to achieve them*. Seminar organised by the Nuffield Trust, Cambridge Health Network and Royal College of Physicians, 7 September. London: Royal Institute of British Architects.
- Coulter A, Parsons S and Askham J (2008) *Where are the Patients in Decision-making About Their Own Care?* Copenhagen, WHO Regional Office for Europe. Available at: <http://www.pickereurope.org/reports>
- Curry N and Ham C (2010) *Clinical and Service Integration: The route to improved outcomes*. London: The King's Fund. Available at: http://www.kingsfund.org.uk/publications/clinical_and_service.html
- Darkins A, Ryan P, Kobb R, Foster L, Edmonson E, Wakefield B and Lancaster A (2008) 'Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions', *Telemedicine and E-health* 1118-26, doi: 10.1089/tmj.2008.0021.
- Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. London: Department of Health.
- Department of Health (2010b) *Liberating the NHS: Local democratic legitimacy in health. A consultation on proposals*. London: Department of Health.
- Edwards N, Kornacki MJ and Silversin J (2002) 'Unhappy doctors: what are the causes and what can be done?', *British Medical Journal* 324, 835–838.
- Golden B (2006) 'Transforming Healthcare Organizations', *Healthcare Quarterly* 10(Sp), 10–19.
- Ham C and Smith J (2010) *Removing the Policy Barriers to Integrated Care in England*. London: Nuffield Trust.
- Locock L, Dopson S, Chambers D and Gabbay J (2001) 'Understanding the role of opinion leaders in improving clinical effectiveness', *Social Science and Medicine* 53(6), 745–757.
- Paré G, Jaana M and Sicotte C (2007) 'Systematic review of home telemonitoring for chronic diseases: The evidence base', *Journal of the American Medical Informatics Association* 14, 269–277.
- Ramsey A and Fulop N (2008) *The Evidence Base for Integrated Care*. London: King's Patient Safety and Service Quality Research Centre.
- Rosen R, Mountford J, Lewis R, Lewis GHL, Shand J and Shaw S (2011) *Integration in Action: Four international case studies*. London: Nuffield Trust. Available at: <http://www.nuffieldtrust.org.uk/publications/integration-action-four-international-case-studies>
- Scott WR, Martin Ruef M, Mendel PJ and Caronna CA (2000) *Institutional Change and Healthcare Organizations: From professional dominance to managed care*. Chicago: University of Chicago Press.
- Shaw S, Rosen R and Rumbold B (2011) *What is Integrated Care?* London: Nuffield Trust. Available at: <http://www.nuffieldtrust.org.uk/publications/what-integrated-care>
- Silversin J and Kornacki MJ (2000) *Leading Physicians Through Change: How to achieve and sustain results*. Tampa: American College of Physician Executives.
- Tran K, Polisena J, Coyle D, Coyle K, Kluge EH, Cimon K, McGill S, Noorani H, Palmer K and Scott R (2008) *Home Telehealth for Chronic Disease Management* (Technology report number 113]. Ottawa: Canadian Agency for Drugs and Technologies.

About the authors

Sara Shaw

Sara Shaw is a Senior Lecturer in Health Policy Research at Queen Mary, University of London and Visiting Senior Fellow at the Nuffield Trust. Her background is in medical sociology and policy studies. She has published widely on topics including the organisation of primary care, shaping national health research policy and critical approaches to policy analysis. Her current research interests focus on health care commissioning and integrated care.

Ros Levenson

Ros Levenson is an independent researcher, evaluator and policy consultant with wide experience of working on a range of health and social care topics. She has a particular interest in patients' experiences of services, and in patient and public engagement. She has served on a number of health-related organisations, and is currently a lay member of the General Medical Council.

For more information about the Nuffield Trust,
including details of our latest research and analysis,
please visit www.nuffieldtrust.org.uk

 Download further copies of this research report from
www.nuffieldtrust.org.uk/publications

 Subscribe to our newsletter:
www.nuffieldtrust.org.uk/newsletter

 Follow us on Twitter: [Twitter.com/NuffieldTrust](https://twitter.com/NuffieldTrust)

Nuffield Trust is an authoritative
and independent source of
evidence-based research and
policy analysis for improving
health care in the UK

59 New Cavendish Street
London W1G 7LP
Telephone: 020 7631 8450
Facsimile: 020 7631 8451
Email: info@nuffieldtrust.org.uk

 www.nuffieldtrust.org.uk

Published by the Nuffield Trust.
© Nuffield Trust 2011. Not to be reproduced
without permission.