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Integration in action: four international case studies

Research summary

Rebecca Rosen, James Mountford, Geraint Lewis, Richard Lewis, Jenny Shand and Sara Shaw

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The challenge of delivering coordinated, high-quality care is becoming more pressing as the population ages and the prevalence of chronic conditions increases. Such patients typically receive care from multiple providers, with a risk of duplication, inefficiency, and poor coordination and experience. Delivering integrated care is particularly challenging for organisations that have recently merged in response to the Department of Health's Transforming Community Services programme, and for clusters of providers working under emerging forms of integrated or network contract. This report describes case studies of four organisations working to deliver integrated care, focusing on the approaches developed and examining how the policy, financial and regulatory context affects their ability to deliver integrated services.

Key points

- Four organisations – each notable for their delivery of high-quality and cost-effective integrated care – were analysed. They were Community Care North Carolina (a government-funded network that aims to improve access and quality levels for Medicaid beneficiaries); Greater Rochester Independent Practice Association (an independent practice association in upstate New York); Regionale HuisartsenZorg Huevelland (a Dutch organisation providing support to GPs to deliver integrated diabetes care); and the North Lanarkshire Health and Care Partnership (an NHS and social care partnership in Scotland).
- Overall, their experiences of integrating health (and in one case social care services) suggest strongly the influence of six, interacting 'integrative processes' that can help to align incentives and coordinate care across team and organisational boundaries. These processes are: clinical, organisational, informational, financial, administrative and normative. The processes also appear relevant to attempts to align and coordinate the work of different teams and professional groups within newly merged organisations.
- Of these, leadership and effective governance arrangements were particularly critical to developing shared objectives and mutually reinforcing interactions between clinical tools, and the intelligent use of data and information technology systems. In some cases, targeted payments linked to the performance of specific tasks were also used to encourage greater coordination of care.
- National policy, regulation and payment systems were also found to be important determinants of the development of integrated care – being able to stimulate integration in some situations and constrain it in others. Revisions to the Health and Social Care Bill, which for the first time introduces an explicit duty to promote integration, mean there is now a major opportunity to construct a more supportive policy framework in England.
- In particular, the NHS Commissioning Board and Monitor may wish to consider developing more radical models for bundling payments across pathways, as well as devising regulations that more actively support further integration where it can be shown that this will deliver measurable benefits to service users.

Background

The NHS is entering a period of unprecedented economic challenge (Hunter, 2010) and the need to deliver greater value is more pressing than ever. A significant proportion of demand for NHS services comes from the increasing numbers of frail older people and from others with chronic, complex health problems who receive care from many different providers. For these groups of individuals, the challenge for health services will be to try to provide more preventive care, and better care coordination and integration across different providers, including across health and social services.

This research summary adds to the small list of case studies that describe how people working in other health care systems, that face similar issues as the NHS, have tried to develop integrated care. Much of the focus in previous case studies has been on organisations that are structurally integrated and have matured over many decades. Examples are Kaiser Permanente in California, Geisinger Health System in Pennsylvania and the Veterans Health Administration across the United States (US). The aim of this current work was to study organisations that were relatively young in their development of integrated care, and that had organisational characteristics that were similar to the NHS – either involving multiple doctors in small practices with registered populations working collaboratively, or integration between health and social care services. The case studies aimed to identify the factors that supported or hindered integration, and examine in detail the organisational methods used to align incentives and coordinate professional practice in order to deliver integrated care.

In this research summary we use the term 'integration' to describe a set of methods, processes and tools to support the alignment and coordination of health and care services across separate institutions, teams and operating units. We use 'integrated care' to describe the 'end products' of integration in terms of services designed to deliver high-quality, cost-effective care and high levels of patient satisfaction (Shaw and others, 2011).

Selection of case studies

There were no validated and widely-used measures of integration with which to select study sites. Instead, leading academics, policy-makers and practitioners with an established interest in integrated care (see the accompanying research report, Rosen and others, 2011) were approached and asked to nominate three services or organisations outside England that they considered to be at the leading edge of work on integration across health and/or social care services. The cases were to be recognised as making good progress, and to be achieving integration that was deemed to be associated with high-quality care. The experts were asked to identify datasets or measures that would support comparison of the extent of integration and quality of care provided between different organisations.

A long list of nominated organisations was compiled, and clustered according to organisational type: whether structurally integrated into a single 'system' or operating as a network; and whether they included a payer function. No measures were identified that would allow direct comparison between them (across international boundaries) of the quality of care offered, or of the extent that care was integrated. Instead, four study sites were selected from the long list according to the following criteria:

- variety in organisational type in the final selected list
- variety in the scope and scale of integration in the final selected list

- having a population focus to efforts to integrate care
- working across independent practitioners in community settings
- at least one site to be working across health and social care.

The four case studies selected were:

- a government-funded network to improve access to and quality of services for Medicaid beneficiaries: Community Care North Carolina (CCNC), US
- an independent practice association in upstate New York, US: Greater Rochester Independent Practice Association (GRIPA)
- a Dutch organisation providing support to general practitioners (GPs) to deliver integrated diabetes care: Regionale HuisartsenZorg Heuvelland (RHZ) in Maastricht
- an NHS and social care partnership in Scotland: North Lanarkshire Health and Care Partnership.

Data collection

Case study data were collected through semi-structured interviews and document analysis. The focus of the investigation was to identify factors that supported or hindered efforts to develop integrated care. Interviews were conducted with senior executives, clinicians and managers from each organisation, with between nine and 15 interviews conducted at each site. In the absence of internationally comparable datasets on the extent of integration and the quality of integrated care, no attempt was made to compare any quantitative data on the case study organisations.

Analysis was informed by the conceptual model of integrated care by Shaw and others (2011), which identified five main types of integrative process. Summaries of key findings and emerging hypotheses were sent to interviewees for comment on accuracy and to obtain their views on our findings.

Characteristics and details of the four sites

For a more detailed comparison of the main characteristics of the four case study organisations, see Table 3.1 in the research report that accompanies this summary (Rosen and others, 2011).

Community Care North Carolina

CCNC is funded through the state Medicaid programme to improve the quality, cost, accessibility and utilisation of services for Medicaid recipients. Medicaid is a health programme for low-income adults and their children, and people with certain disabilities, which is funded jointly by the Federal and State governments, and administered by the states. There were three stimuli to develop more integrated care: unhelpful duplication of services received by Medicaid beneficiaries; perceived fragmentation of care; and pressure to reduce the state Medicaid budget. All of these factors led to innovations in service delivery.

CCNC uses multiple methods to promote integration through coordinated and standardised clinical practice. These include locally adapted clinical guidelines, case management services, financial incentives, data review and analysis, and feedback on clinical practice. At the time of the case study, the programme covered over 3,000 physicians who provide care for over 880,000 Medicaid enrolees across the state. In return

for a fixed monthly payment (US$2.50 per patient, per month for people under 65 years old, and US$5 per month for older people), participating doctors are supported by CCNC staff and resources to adhere to disease management protocols for common chronic conditions. Doctors must also agree to report selected data to CCNC. Selected patients with complex health problems also receive care coordination services from CCNC staff.

The central CCNC programme office provides medical leadership, operational support including IT and data analytics, and developmental support to 14 regional networks. The network offices received US$3 per Medicaid-enrolled patient per month at the time of the case study to support physicians in the CCNC programme. Each network is led by a medical director and network manager, and employs a case management team that may include nurses, pharmacists, social workers and selected other staff, depending on local need. The network offices work with participating doctors to disseminate guidance and support, monitor changes in clinical practice, and enable more integrated care to be delivered to patients.

Box 1: Factors influencing progress – Community Care North Carolina

Enablers of integration:

- Governance and incentives: monthly payment to networks and to participating physicians who agree to follow care pathways and allow CCNC auditors to review clinical records; networks report clinical performance to central CCNC office.
- Data feedback to doctors, supported by an evolving integrated electronic information system.
- Active medical leadership in charge of developing care standards and resources, and raising awareness about expected standards of practice.
- Multi-professional teams supporting care coordination and review of selected high-risk patients.

Challenges to successful integration:

- Slow uptake by some physicians – limited consequences for non-compliance.
- Relatively limited resources of regional networks.
- CCNC has no performance management role/line management authority over local providers, so its influence on clinical practice is indirect.

Greater Rochester Independent Practice Association

GRIPA is an independent practice association (IPA) that provides administrative and clinical support to around 800 member physicians serving a mixed urban/rural population in upstate New York. The doctors mainly work in small, independent practices, similar to GP practices in England, and include primary care doctors and specialists.

GRIPA's clinical integration work started when it was prevented from negotiating with insurers on behalf of its members unless it met the characteristics set by the Federal Trade Commission (FTC) of a 'clinically integrated system'. In order to comply with this definition, GRIPA drew on many of the improvement tools and processes that it had established during the previous decade to support 'risk contracting'. This is where it received an annual sum per patient to provide full care, dividing any savings made between member doctors. GRIPA received FTC approval as a 'clinically integrated' organisation in

2007. Since then, GRIPA has implemented a clinical integration programme to improve and standardise the quality of care provided by the IPA's member doctors.

For the patients of GRIPA's member doctors, clinical integration has resulted in more standardised care, since participating doctors work to shared, evidence-based clinical standards and actively seek to address gaps in care for each patient. For those patients with complex health problems, GRIPA's case managers work to coordinate care from different providers and avoid the duplication and confusion that is often associated with transfers between services. The clinical information system used to support clinical integration allows clinicians to share information between generalists and specialists. This has permitted new forms of 'virtual consultation' in which the patient may not need to be physically present in the clinic.

Box 2: Factors influencing progress – Greater Rochester Independent Practice Association

Enablers of integration:

- Development of a web-based clinical portal accessible to clinicians and patients, and a central data repository to synthesise and analyse clinical data.
- Tools such as point-of-care alerts to support and prompt best clinical practice.
- Governance and incentive arrangements to support clinical practice, in line with agreed guidelines and pathways (still evolving).
- Respected medical leaders and a high trust in GRIPA that is based on its past track record of delivery.
- Multi-professional team supporting care coordination, case management and pharmacy management.

Challenges to successful integration:

- Time and resources needed for Federal Trade Commission approval.
- Benefits to doctors are limited until at-risk clinical integration contracts have been negotiated with insurers and employers.

Regionale HuisartsenZorg Heuvelland, Maastricht

RHZ is an umbrella organisation for all 89 GPs in the Dutch city of Maastricht, which has a population of 170,000. The organisation was established in 2006 to redesign diabetes care in the Maastricht area and has subsequently extended to other long-term conditions. RHZ grew quickly after national policy was introduced to improve the care for people with chronic conditions, through which integrated payments were developed for specific disease-treatment combinations (DTC, or 'DBC' in Dutch). Insurers buy a pre-agreed annual package of diabetic care for an agreed sum of money per patient, which is adjusted to reflect case severity. RHZ negotiates with health insurance companies on behalf of GPs and holds the contracts for integrated diabetes services.

The stimulus for integration was political – a national policy to implement DBC/integrated payment for diabetes and a requirement by insurers to negotiate DBCs with GP groups. This triggered a rapid growth of RHZ to support GPs and enable them to deliver integrated diabetes care.

DBCs consist of numerous modules of care for different levels of severity of diabetes. Modules may be provided by GPs and specialist nurses in the community, or by hospital specialists, with explicit criteria for transferring patients between the two settings. They are negotiated region-by-region with insurers in response to local agreements between specialists and generalists about who will provide each module in the DBC pathway. In Maastricht, where hospital specialists are salaried and therefore have little personal financial incentive to retain clinical responsibility for patients with diabetes, around 95 per cent of diabetes care is now provided through the primary care DBC. The DBC budget includes funding for specialists to review selected patients and advise on their future management, without taking on long-term responsibility for a patient.

Multidisciplinary, integrated teams involving GPs, nurses, hospital specialists and other clinicians are now the norm. Only care for severe and complex diabetes is led by hospital doctors. This situation is different in some other regions of the Netherlands, where GPs have a more limited role in providing diabetic care.

Box 3: Factors influencing progress – Regionale HuisartsenZorg Heuvelland

Enablers of integration:

- High levels of trust between GPs, specialists, nurses and other relevant stakeholders such as dieticians and physiotherapists, built through previous collaboration.
- Specialists are salaried by the hospital, so their income is not affected by the transfer of work to GPs.
- Developmental support from RHZ and local GP leaders to raise awareness about diabetes DBC, engage the GP community in service developments and monitor performance.
- Web-based diabetes electronic record allowing shared clinical information, supporting guidelines implementation and performance review.
- Planned increase in provider competition by developing a competitive market in diabetes care, which is stimulating GPs to act together to improve care.
- Consistent and highly respected medical leaders in the Maastricht community.
- Involvement of all relevant health care providers of diabetes services, and some patient involvement in the development of the DBC protocol to create broad support for its content and implementation.

Challenges to successful integration:

- Policy of separate DBCs for primary and specialist care has divided GPs and specialists, and fragmented incentives exist regarding admission avoidance.
- Development of a single-condition service risks creating silos for chronic conditions and fragmenting care for people with multiple, chronic, complex problems.

North Lanarkshire Health and Care Partnership

The North Lanarkshire Health and Care Partnership in Scotland brings together the work of North Lanarkshire Council and NHS Lanarkshire to deliver better integrated services to four care groups: older people, and people with disabilities, addictions and mental health problems. The partnership builds on many years of joint work, in particular a cluster of partnership agreements developed between 2002 and 2004. It reflects the emphasis in NHS Scotland on the role of networks and partnerships as drivers of quality and efficiency. A joint governance and accountability framework was launched in 2008 to formalise the arrangements for partnership work.

The stimulus for integration was a central policy initiative called Joint Future (Scottish Executive, 2000) and other subsequent national policy documents. From a service user or patient perspective, the partnership has led to the establishment of integrated health and care teams with links to wider resources in the health care, social care and voluntary sectors. Many patients now benefit from single shared assessments, which have been refined in response to user feedback, and from members of integrated teams working to shared protocols, pursuing common outcomes and, in some cases, being able to refer directly to each other's services without going via a GP.

The integrated governance framework establishes mechanisms by which the strategy is set and implemented across each care group, allowing adjustment for geographic variations and creating accountable local groups ('care partnership groups') to operationalise integrated care locally. It also sets out reporting arrangements through which each tier of the partnership is accountable for delivery against the national community care outcomes framework and other locally agreed performance standards and outcome measures. There is no emphasis on using financial incentives.

Box 4: Factors influencing progress – North Lanarkshire Health and Care Partnership

Enablers of integration:

- Joint vision shared by senior officers in both health and social care linked to a joint governance system to stimulate integration across four key care groups and spanning all localities.
- History of partnership work and joint planning over many years.
- Skilled leaders with the ability to 'win the hearts and minds' of front-line staff.
- Staff commitment and a strong sense that integration is 'doing the right thing for service users'.
- Joint training and development including job shadowing, joint education and organisational development work.
- Taking an incremental approach and seizing opportunities as they arise.

Challenges to successful integration:

- Inconsistencies in national policy: for example employment conditions and pension rights are different for health and social care.
- Difficulties in developing a supportive IT system.
- Variable progress in different localities and care groups, dependent on local leadership.

Key ingredients for progress with integration

External context

In each case study site, a cluster of 'stimuli' was identified that were external to the study organisations, but which drove their work on integration. Three groups of external influences were particularly important: national policy, local payment systems, and legal and regulatory requirements.

National policy was a direct prompt for integration in the Netherlands, where the creation of DBC integrated payment systems for the management of common chronic conditions had led GPs to form collectives in order to negotiate DBC contracts with insurers. Equally, the Joint Future policy in Scotland (Scottish Executive, 2000) had stimulated closer work between health and social care organisations over several years, which was reflected in the shared strategic vision and partnership between health and social care. This was important for translating the implications of national policy into meaningful changes across four service groups in North Lanarkshire. However, progress was still hindered by inconsistencies in national policy, such as differences in the terms and conditions of health care and social services employees, which make it harder to build integrated health and social care teams.

Changes in reimbursement rates were also important external influences. The prospect of reduced payments to doctors by insurers was a key driver of integration in GRIPA and RHZ. In CCNC, reductions in the state Medicaid budget created the prospect of significant reductions in physician incomes and openness to trying new ways of providing more cost-effective care. Equally, US anti-trust legislation and the requirement that collaboration between physicians must be linked to integrated care that provides benefits to patients, underpinned GRIPA's clinical integration programme.

At times, these external factors constrained integration. Policy from different government departments could create conflicting requirements for the organisation and delivery services, data protection regulation constrained the extent to which personal information could be shared between different professionals, and payment systems could be used to discourage integration between providers. However, the case study organisations sought to find ways around these constraints and identified solutions to many of them, thus integration was a dynamic and adaptive process. Whilst constantly vigilant for changes in the external environment, their primary focus was on developing operational processes to support the alignment and coordination of services across team and organisational boundaries. Six such 'integrative processes' were identified.

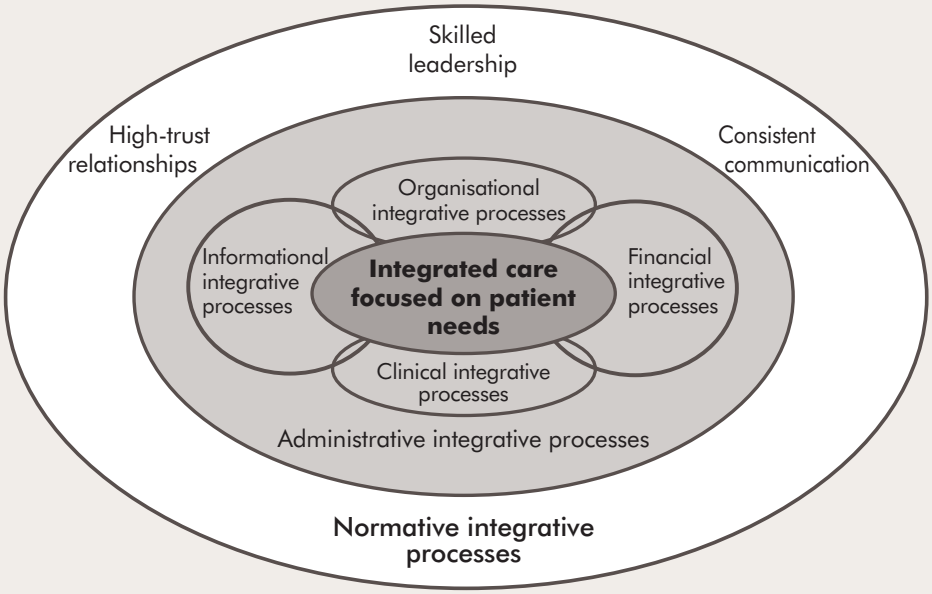
Mutually reinforcing integrative processes

Six groups of operational activities – termed integrative processes – were identified across the case study sites. The interactions between integrative processes were mutually reinforcing and served to embed coordinated care into daily practice. They created an apparently inseparable web of activities to align professional behaviour and deliver integrated care (see Figure 1, page 10).

Clinical integrative processes

These processes aimed to achieve consistent clinical standards across different settings, for example across community clinics, hospitals and day centres. They were underpinned by guidelines in clinical settings, or shared working practices such as a shared single assessment in the health and social care context. These processes resulted in shared standards of care across different groups and settings.

Figure 1: Interactions between integrative processes



The clinical integrative processes observed across the sites included the following ingredients:

- standardisation of care for common conditions through supported adherence to evidence-based guidelines
- clinical prompts and gap analyses for patients on disease registers
- care coordination targeted at individuals with complex problems and a high risk of clinical deterioration, delivered by multi-professional teams
- peer review and professional incentives to change clinical practice in line with agreed guidelines.

Informational integrative processes

This was a challenging aspect of integration in each site and was an area of significant variation between them. Electronic medical or care records were not in universal use, so the integration of information across a care pathway required either a web-based portal that could operate in parallel with existing records (seen in GRIPA, RHZ and under development in CCNC), or an electronic link between different systems (seen in North Lanarkshire). In addition, data protection regulations restricted the scope for data sharing and required explicit rules about rights of access to confidential data.

However, the following features were observed during the case studies:

- use of population registers to identify gaps in care and preventive care opportunities in support of clinical integration
- clinical 'point-of-care' prompts to support adherence to guidelines and standardise care along clinical pathways and across organisational boundaries
- patient access to parts of the medical record to support self-management of care such as checking results, and for self-organisation such as booking appointments

- secure messaging and shared access to selected clinical data between primary and specialist clinicians, enabling new forms of 'consultation' and advice-seeking
- data and information sharing between teams for care coordination
- performance review and benchmarking of clinical practice.

Organisational integrative processes
These processes relate to the governance arrangements between participating organisations. They encompass: the relationships between organisations, such as partnership; structural integration through merger or contractual relationships; the arrangements in place to define and implement goals and objectives; and the assurance frameworks to ensure that agreed objectives are achieved. Each site had crafted different governance arrangements in response to their local context, details of which can be found in Box 4.3 of the research report that accompanies this summary (Rosen and others, 2011).

Financial integrative processes
These processes relate to budgetary arrangements and payment systems in place across the organisations participating in integration. Again, this was an area of difference between sites, which varied in their use of micro-incentives (payments linked to the performance of specific tasks) and in the financial context in which they operated.

Box 5: Summary of micro-incentive systems in the case study sites

Community Care North Carolina: There is a monthly payment for each Medicaid patient registered with a physician participating in the CCNC programme, in return for offering continuity of care and disease management, and supplying data to CCNC. Payment varies from US$2.5 to US$5 depending on the age of the patient. No further financial rewards or sanctions were applied to participating doctors.

Greater Rochester Independent Practice Association: Money is allocated to each physician according to relative performance against agreed performance measures. Typically there is a 70 per cent difference between highest and lowest payment.

Regionale HuisartsenZorg Heuvelland: Payment for each patient contact is required by the DBC protocol. Any savings made from the DBC contract with insurers (for good primary care management and low use of specialist referrals) is allocated as a gain share amongst doctors.

North Lanarkshire Health and Care Partnership: No micro financial incentives are used for clinical staff. Middle grade managers are on a performance-related pay system linked to integration and improvement against the national outcomes framework. Key incentives were described as being professional – service improvement and providing better care for individuals.

Administrative integrative processes
These processes relate to administrative and functional links across participating organisations, such as human resource management and seconded staff. They are particularly useful for small groups of practising doctors who may otherwise lack the necessary scale to run these functions efficiently. Examples are: shared administrative functions, such as contract and claims management; central employment of shared staff; and joint education and training across professional groups. GRIPA and RHZ also provide management support to their member practices, aiming to reduce the burden of

administrative work and free up time for improving clinical practice. North Lanarkshire has an integrated management structure, and has developed shared procedures for health and care services that are not fully integrated.

Normative integrative processes
These processes relate to developing shared values and aligned professional standards across participating individuals, groups and organisations. The approach was different in each case study site, but it was clear that across all sites the purpose of integration was to improve the quality of care provided and to optimise service users' experiences of that care. This 'mission' helped both to select the right staff into the organisations concerned, and develop trust in each other. Methods to achieve this included:

- communication of goals and values to front-line staff by trusted leaders
- techniques such as job shadowing to understand different professional roles
- social events to unite participating individuals.

Leadership and integration

Each case study site had one or two people who were described as 'leaders' by multiple interviewees. The leaders were widely respected in the professional community and had typically worked locally for many years and been associated with previous successful developments. Their commitment to, and enthusiasm for, integration was critical for progress. Equally important was their ability to communicate their vision among their colleagues, particularly the potential benefits for patients and staff. Leaders were visible, had frequent contact with front-line staff and were supportive of colleagues when they encountered barriers to integration. They fulfilled a range of roles:

- identifying and demonstrating the values that underpinned efforts towards greater integration
- identifying the goals of integration as members of executive committees and governance groups, and communicating these to professional staff
- engaging professionals, and building involvement and understanding
- maintaining a clarity of vision and emphasising the benefits of integration to patients and staff.

However, building trust was reported to take a long time. In each site, work to strengthen integration was founded on a decade of prior work in which trusting relationships had grown slowly. Many of the physicians interviewed for this study were not employed by the case study organisations. Instead, they were linked together through their involvement with the case study organisation, and were willing to participate in this because of their trust in the colleagues who were leading the work and their belief in the mission.

Discussion

All four sites revealed the importance of the external context in encouraging integration, and the influence of six sets of operational actions or 'integrative processes' that between them acted synergistically and drove progress towards integrated care.

Structural merger of organisations was not necessary to achieve integrated care, although the contribution of integrative processes to align incentives and coordinate care is likely to be just as relevant where organisations have merged. Furthermore, developing integration took time, and relied on expert leadership and an unerring focus on delivering high-quality care to service users.

The integrative processes found in the case studies are similar to those found in health systems in which integration has been associated with high-quality, cost-effective care (Shih and others, 2008). Feachem and Sekhri (2005) considered the integration of leadership and management to promote a partnership between governance and administration. This is equivalent to the organisational integrative processes seen in the case studies and is seen as a key element of integrated health care. The Commonwealth Fund found that the roles of care coordination – clinical decision support (equivalent to clinical integrative processes) and 'interoperable information infrastructure' (equivalent to informational integrative processes) to establish and track metrics on processes and quality – were fundamental to high performance (Shih and others, 2008).

Robinson and others (2009) have linked better performance with a higher uptake of the information technology needed to support the delivery of standardised clinical care by medical groups (larger medical groups tend to have better infrastructure; Rittenhouse and others, 2008). Baker and others (2008) describe a range of characteristics associated with high-quality care. These include: culture, value and identity (normative integrative processes); effective communication channels; resources and administrative support for skills training (administrative integrative processes); and the need for time and support for change management.

Recommendations

Several proposals in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010), the subsequent Health and Social Care Bill and the government response to the report of the NHS Future Forum (Department of Health, 2011) have the potential to support integration between health services and between health and social care. These include: the centrality of patients' needs as the basis around which care should be organised; a focus on whole pathways or systems of care, reinforced through the requirement for whole pathway outcome measures; and the introduction of health and well-being boards to help promote whole-system integration. Monitor will have a duty to support integration, and GPs, specialists and nurses will work together to promote integration through clinical senates and clinical commissioning groups. The case studies here offer insights into how policy and regulation could be developed and implemented to support integration between services.

At national level

1 An early priority for Monitor will be to link the regulation of integration to a requirement to demonstrate improved patient experience and clinical outcomes, as seen in the GRIPA case study. Regulations could also promote choice and competition within integrated systems where possible (for example by including more than one provider of a specific service within an integrated network).

2 Standard contracts and outcome measures are needed that will promote the coordination of care between providers and measure outcomes across whole pathways of care. This would encourage the delivery of care through clinical networks or integrated care organisations, and encourage clinical commissioning groups to commission services from such providers.

3 There should be an audit of all current methods of paying for clinical care, in order to assess the extent to which they encourage integrated care for people with chronic, complex health and social care needs. The development of the national tariff in particular needs to be aligned with this objective. To this end, Monitor and the NHS Commissioning Board should work together to develop a pricing strategy to incentivise integration where it provides better quality and more efficient care.

4 The NHS Commissioning Board should support local commissioning groups to develop new ways to secure integrated services: for example, through commissioning from integrated provider organisations. Local organisations should be allowed to develop bundled payments and local tariffs for key conditions and pathways. This is particularly important in long-term conditions, where fee-for-service incentives for episodes of hospital care are inconsistent with community-based models and do not encourage keeping patients well in community settings. Furthermore, innovative forms of payments *within* provider networks should be piloted.

For local clinical commissioning groups and providers

1 Local government and clinical commissioning groups should actively promote integration between health and care services, and between different health care providers for people with long-term conditions and those requiring service from multiple providers. For example, this could happen through commissioning services from integrated service providers, and leading service redesign work to develop integrated care pathways and integrated provider networks.

2 Providers should focus on developing a full set of integrative processes, with mutually supportive links between clinical, organisational, informational and financial processes, in order to enable the delivery of integrated care for patients. Four areas where focused, practical support for integration could be particularly useful for providers and commissioners are:

   – help with developing integrated governance arrangements that can develop strategic objectives for integration and respond rapidly to changes in the policy, regulation, financial and organisational context

   – developing methods for linking, analysing and sharing information on clinical care and finance through a focus on data interfaces rather than developing new IT systems

   – providing education and training to develop a workforce with the skills and values needed to deliver integrated care, organised around the needs of patients

   – evaluating the impact of changes on how care is delivered and paid for – this should include the ability to measure impact across whole pathways of care and multiple providers, and evaluating patients' views through patient-reported outcome and experience measures.

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Nuffield Trust work on integrated care

This research summary 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. It also forms part of our work to examine international best practice and use this intelligence to inform policy-making and practice in the UK.

The full research report, by Rebecca Rosen, James Mountford, Geraint Lewis, Richard Lewis, Jenny Shand and Sara Shaw, that this research summary is based on, is available to download from: **www.nuffieldtrust.org.uk/publications**

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59 New Cavendish Street
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Facsimile: 020 7631 8451
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