



# Where next for integrated care organisations in the English NHS?

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# ABOUT THE NUFFIELD TRUST

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Its focus is on reform of health services to increase the efficiency, effectiveness, equality and responsiveness of care.

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59 New Cavendish Street  
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Telephone: 020 7631 8450  
Facsimile: 020 7631 8451

Email: [info@nuffieldtrust.org.uk](mailto:info@nuffieldtrust.org.uk)  
Website: [www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

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## FOREWORD

One could argue that a design flaw in the NHS is the organisational separation between general practice and hospital care.

Healthcare systems worldwide face the twin challenges of rising demand as consequence of an ageing population who are living longer with long-term conditions and the rising costs of paying for that care, particularly in the current economic climate. Even the most optimistic of funding scenarios suggests that the NHS in England will have to achieve a step change in productivity. It is unlikely that increased technical efficiency will be enough to bridge the gap between demand for care and the funding available.

The NHS has been committed for some time to improving the care for those with long-term conditions – shifting care into the community and closer to home, making care more personalised and supporting people to live independently for longer. Yet it is clear that the health system continues to fall short of its ambition. People with long-term conditions are still admitted for expensive hospital stays, causing much anxiety for those affected as well as being a wasteful use of expensive acute hospital services. Supporting these people to stay healthy and avoiding crises must remain a key priority for the NHS.

Meeting this challenge will require radical thinking. It is likely to require changes to both the incentives and structures which were designed for

an era of plenty when increasing activity to reduce waiting times was the priority. Better coordination between different providers and across the boundaries of care is needed. Lord Darzi's NHS Next Stage Review introduced the concept of integrated care organisations (ICOs), various models of which are now being piloted across England as a way of exploring whether better coordination can reduce utilisation and ultimately healthcare costs.

This report, published jointly by The Nuffield Trust and The King's Fund, examines some of these new models and their potential for delivering better outcomes at lower cost. It focuses in particular on the potential for integrated care organisations to combine commissioner and provider roles and how these might evolve from the current approach to practice-based commissioning.

This report, together with a companion volume *Where Next for Commissioning in the English NHS?* builds on previous work by researchers at both organisations. We hope that the combined efforts of our organisations will contribute to the debate about how the NHS should evolve to meet the pressing challenges that our health system faces.

**Dr Jennifer Dixon**

Director, The Nuffield Trust

**Dr Anna Dixon**

Acting Chief Executive, The King's Fund

## EXECUTIVE SUMMARY

As the population ages, the growing complexity of healthcare and health needs, together with the approaching financial challenge, is prompting a fundamental rethink of how healthcare should be organised in future.

There are longstanding fault lines in the current provision of care that result from historic divisions between budgets (that is, between major groups of health providers and between health and local authority funders of social care), institutions and professions. The consequences are sub-optimal care, avoidable ill health and use of care, duplication and waste, as patients fall through the gaps in these fault lines.

Commissioners of NHS-funded care (such as primary care trusts (PCTs) and practice-based commissioners have not been able to overcome these problems, despite various opportunities open to them (for example, the flexibilities in Section 31 of the Health Act 1999 that allow pooled budgets across health and social care in localities).

The NHS Next Stage Review (Department of Health, 2008b) emphasised the concept of integrated care, and integrated care organisations (ICOs) as a means to achieve better care for patients. The premise of integrated care is that it will not only help to improve the coordination of care for patients and therefore prevent avoidable ill health, but also that it will result in greater value for money. While the formal evidence underpinning this premise is as yet underdeveloped, the wide variations in avoidable

use of hospital care, in particular, suggest the scope for large gains in efficiency and health.

Integrated care may be achieved through a variety of arrangements, for example, multi-professional integrated care teams working to shared goals but employed by different organisations, networks of provider organisations operating under a single integrated budget, or single organisations consisting of merged providers. It is important not to assume that organisational integration (or merger) is the optimal way of achieving integrated care for patients.

The effectiveness of these different arrangements in delivering truly integrated care for patients depends upon the extent to which:

- the incentives (financial and non-financial) and governance arrangements under which they operate are aligned to support shared goals and effective collaboration
- they focus on patients with specific clinical conditions, which may result in fragmented care for patients with multiple co-morbidities
- there is effective leadership within the organisation or network
- there are linked or integrated information systems allowing the quality, use and costs of care to be identified per patient and by clinicians and their teams.

Importantly, integrated care can also be achieved through integrated commissioner–provider organisations. It is on this form of integration

that this report focuses. Integrated commissioner–provider organisations may well be the next evolution of practice-based commissioning, where practice-based commissioning consortia link with providers to secure all necessary care for an enrolled population, and bear the financial risk of doing so by taking on a capitation-based budget. The authors of this report believe this form of integration could align incentives for efficient and effective care across a range of providers.

The NHS Next Stage Review provides new encouragement to such developments, building on earlier but unexploited initiatives such as ‘Personal Medical Services Plus’ pilots. The Review has initiated a programme of 16 integrated care pilots that will run for two years from April 2009. And an ‘extended community’ of integrated care initiatives has recently been announced by the Department of Health, suggesting that integrated care is gaining momentum.

Commissioner–provider ICOs of this type would share a number of key characteristics. First, these organisations would be rooted in general practice, which is the only part of the current health system with an enrolled patient population and is closest to the role of care coordinator across providers. ICOs could evolve multi-specialty clinical groups, like some of those seen in the US, in which generalists and specialists work in the same organisation with more opportunity to work collaboratively than is currently the case. However, the precise constitution of ICOs should be determined by local circumstances.

Second, budgets would be set using risk-adjusted capitation methods. This would provide strong incentives to manage resources effectively (and there would be potential for the organisation to be rewarded for its efficiency). Importantly, capitation budgets would provide incentives to invest more in upstream prevention – keeping patients healthy today would save money in later years. Third, ICOs would formally contract with PCTs to deliver the agreed range of services. The ‘virtual’ nature of current practice-based commissioning does not provide sufficient power or accountability for integrated care to be delivered at scale.

If vertically integrated ICOs are implemented, a number of key wider policy challenges arise:

- How could they best be regulated or ‘kept honest’?
- How can they develop in a policy environment that encourages competition, where integration may seem to be uncompetitive?
- Should patients be able to choose which ICO they want to belong to?
- Can free choice for patients be reconciled with the need for ICOs to manage patient care within pre-determined care pathways and networks of providers?
- Can ICOs develop with national contracts for GPs still in place?

The authors suggest a range of potential measures that could address the tensions and policy



challenges identified above. These include rules by which choice and competition might be managed, the regulation of patient enrolment to prevent abuse such as ‘cream skimming’ and new forms of governance that incorporate consumer interests.

The transition of the care system to a more extensive use of ICOs is not without problems. History tells us that while clinically-led commissioning based on general practice consortia can lead to better integration, progress has always remained limited to a small cadre of volunteers. If ICOs are to become an effective force within the NHS, and succeed as a model of care where others have failed, significant reform to the GP contract may be needed to either embed new incentives for integrated care or, more controversially, give PCTs greater discretion over the retention of GP contracts. However, it will remain important to the success of any ICO approach to have a strong base of clinical support.

While the barriers are real, none appear to be insurmountable. However, the road towards integrated care will take time and careful steering. The promise of an evolutionary growth towards better and more efficient healthcare is large. As outlined in this report, integrated care means stronger incentives better aligned among providers and commissioners to improve health. This offers a route by which healthcare might be re-orientated towards better value and more efficiency in the light of slower economic growth and rising demand for health services.

# 1. INTRODUCTION

As healthcare becomes ever more complex – with increasing specialisation and new options for treatment, diagnosis and care – the need for more coordination for patients within healthcare and between health and social care has grown. The characteristics of poor coordination are easily recognisable; fragmented services which duplicate or, worse, omit important parts of the care process, with poor communication between care teams and patients, and significant avoidable costs to funders and to patients.

Poor coordination is a problem in many developed health systems, most notably in America (Shih and others, 2008). The result is suboptimal care, higher costs due to duplication, waste and avoidable ill health. Tackling this problem has long been a goal of governments across the UK and abroad, and recently this has been made more acute by straitened economic circumstances.

Policies to address poor coordination in the NHS can be seen as far back as the 1950s when mental health was integrated into the mainstream of the NHS. Reforms in the 1960s and 1970s saw the introduction of joint planning teams between health and local government and growing emphasis on collaboration between community care and primary care. The current government's early policies in England focused on getting the NHS to work in partnership by breaking down organisational barriers, forging stronger links with local authorities and proposing to replace the internal market with 'integrated care' in the 2000 White Paper *The New NHS* (Department

of Health, 1997). *The New NHS* further stressed the need to achieve integrated care across the NHS and social services to support people with multiple needs who had previously been 'passed from pillar to post' between various agencies. More recently, the NHS Next Stage Review re-emphasised the need to promote integrated care.

However, significant barriers to achieving integrated care remain in the NHS in England. First, the separation of budgets in key care areas, for example, between primary and secondary care, and between budgets for health and social care, although important new flexibilities in the Health Act 2006 and through Personal Medical Services (PMS) contracts for primary care allow these barriers to be overcome. Second, institutional separation between primary care (as independent small businesses generally owned by general practitioners (GPs)) and hospital care (as entities effectively owned by the NHS) and social services (owned or commissioned by local authorities). Third, professional separation between the staff working in all three domains, resulting in different cultures, pensions and contracts. Fourth, lack of integrated data and information systems between major care providers. Fifth, repeated reforms of NHS commissioning bodies have disrupted efforts to develop effective joint commissioning and these have only recently taken root in response to the White Paper *Our Health Our Care Our Say* (Department of Health, 2006).

Commissioners of NHS care have a potentially important role to encourage coordinated care, in

particular GPs via practice-based commissioning – in place since 2005. Practice-based commissioning offers indirect financial incentives (on top of direct incentives through the quality and outcomes framework as part of the standard GP contract) for general practices to maintain health and avoid costly hospital admissions, potentially stimulating collaboration between GPs, community services and social care.

But practice-based commissioning has not delivered the expected gains (Curry and others, 2008; Smith and others, 2010). Recognising this, the Next Stage Review (Department of Health, 2008b) included a commitment to ‘reinvigorate’ practice-based commissioning. However, the review also introduced a new concept – the ‘integrated care organisation’ (ICO) – that might achieve truly integrated care. The premise of integrated care is that it will not only help to improve the coordination of care for patients and therefore prevent avoidable ill health, but also that it will result in greater value for money. While the formal evidence on integrated care is as yet underdeveloped, the wide variations in avoidable use of hospital care suggest there is scope for large gains in efficiency through better coordination of services.

ICOs are intended to encourage primary care and other clinicians to take responsibility for designing, delivering and, ultimately, for managing the budget for integrated clinical services. They may take many forms including:

- **networks of provider organisations** operating under a single, integrated budget (‘virtual integration’),
- **organisational mergers** (‘real’ integration) to bring together different care sectors (acute trust ownership of GP services, for example)
- **integrated commissioner–provider organisations** that combine commissioning care for a designated population with the provision of some or all of these services.

This latter form of ICO, with its implied redefinition of the ‘commissioner–provider’ split makes ICOs a potentially important innovation in the organisation of health service planning and delivery. Indeed, practice-based commissioning consortia may act as staging posts for the creation of more ICOs (Department of Health, 2009a) in which participating clinicians receive a global fully capitated annual payment for each patient on their list, and assume responsibility for ensuring access to all necessary care (except highly specialised services). This would require ICOs to decide which services to provide themselves and which to commission from other organisations in order to stay within budget and meet specified quality and patient experience standards.

This report considers the different forms that ICOs may take and what they may become within the context of the NHS in England. There are policies in Scotland and in particular Wales to encourage integrated care but these are not discussed in this report.

We briefly review the meaning of integration and distinguish this from integrated care. We focus in particular on one type of ICO: organisations that combine commissioner and provider roles, taking responsibility for a global capitated budget for healthcare, and providing a mixture of ‘in-house’ and commissioned services.

This report focuses particularly on those organisations attempting to commission and provide integrated healthcare as they most effectively align incentives for efficient care provision across primary, community and acute services. The focus here is on ICOs that are rooted in primary care because it is recognised that primary care is pivotal in preventing ill health, coordinating care in the community and reducing the risk of costly admissions to hospital.

The authors draw on research evidence to consider the likely strengths and weaknesses of commissioner–provider ICOs and outline some of the main challenges that will be faced if they are to function effectively within the NHS. The evidence on the impact on cost or quality of existing integrated care systems will be discussed in a forthcoming report, rather than here. The authors’ prevailing assumption, which needs to be tested over time in England, is that care that is better integrated across providers can provide improved quality and value for money.

## 2. WHAT IS INTEGRATED CARE?

The primary purpose of integrated care should be to improve the quality of patient care and patient experience and increase the cost-effectiveness of care (Shaw and Rumbold, forthcoming). As such, integrated care is provided with both a rationale and a common basis for judging its impact. Kodner and Spreeuwenberg (2002) distinguish between integration and integrated care, noting that the structures and processes that support greater organisational and service integration may not always result in the enhanced outcomes and patient experience associated with effectively integrated care:

*Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients ... cutting across multiple services, providers and settings. [Where] the result of such multi-pronged efforts to promote integration [lead to] the benefit of patient groups [the outcome can be] called 'integrated care'.*

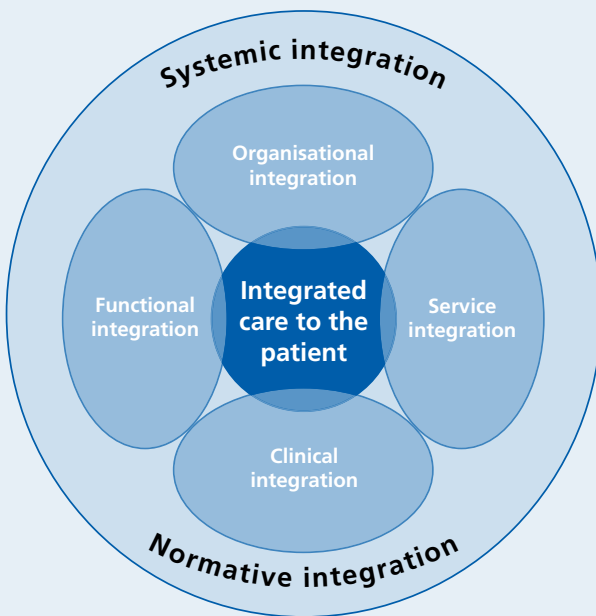
Various classifications of the 'methods and models' that contribute to integrated care have been summarised by Nolte and McKee (2008) who show that the term has been variously differentiated by type, breadth, degree and process. Moreover, as the review by Fulop and others (2005) highlighted, the various dimensions of integrated care cover a much broader spectrum

than simply the provision of care and the organisational and governance arrangements that are required to deliver it. As Figure 1 shows, the pursuit of integrated care for patients may involve a combination of 'types' of integration.

It follows that integrated care for patients may take many forms, ranging from collaborating networks of providers to formally constituted integrated (or merged) organisations. A recent systematic review of strategies to coordinate care within primary healthcare – and between primary healthcare and wider health service providers – found examples ranging from simple forms of communication and networking between providers and patients through to more structurally-based arrangements designed to support care coordination (Powell Davies and others, 2008). The review concluded that all types of strategies were associated with improved health and/or patient satisfaction and that the application of multiple strategies for coordination was more successful than using single strategies alone.

As Figure 1 implies, integrated organisations that commission or provide a range of services may or may not encompass all of the elements described in the model. They can differ markedly in terms of their purpose and scope, ranging from services for single conditions or care groups (for example, diabetes or older people) to complete health systems. They can be constituted to varying degrees of formality, ranging from loose organisational ties, or 'linkages', to those that have become 'fully integrated' organisations (see Figure 2) (Leutz, 1999; Goodwin and others,

FIGURE 1: TYPOLOGIES OF INTEGRATED CARE



- Organisational integration, where organisations are brought together formally by mergers or through ‘collectives’ and/or virtually through coordinated provider networks or via contracts between separate organisations brokered by a purchaser.
- Functional integration, where non-clinical support and back-office functions are integrated, such as electronic patient records.
- Service integration, where different clinical services provided are integrated at an organisational level, such as through teams of multi-disciplinary professionals.
- Clinical integration, where care by professionals and providers to patients is integrated into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols.
- Normative integration, where an ethos of shared values and commitment to coordinating work enables trust and collaboration in delivering healthcare.
- Systemic integration, where there is coherence of rules and policies at all organisational levels. This is sometimes termed an ‘integrated delivery system’.

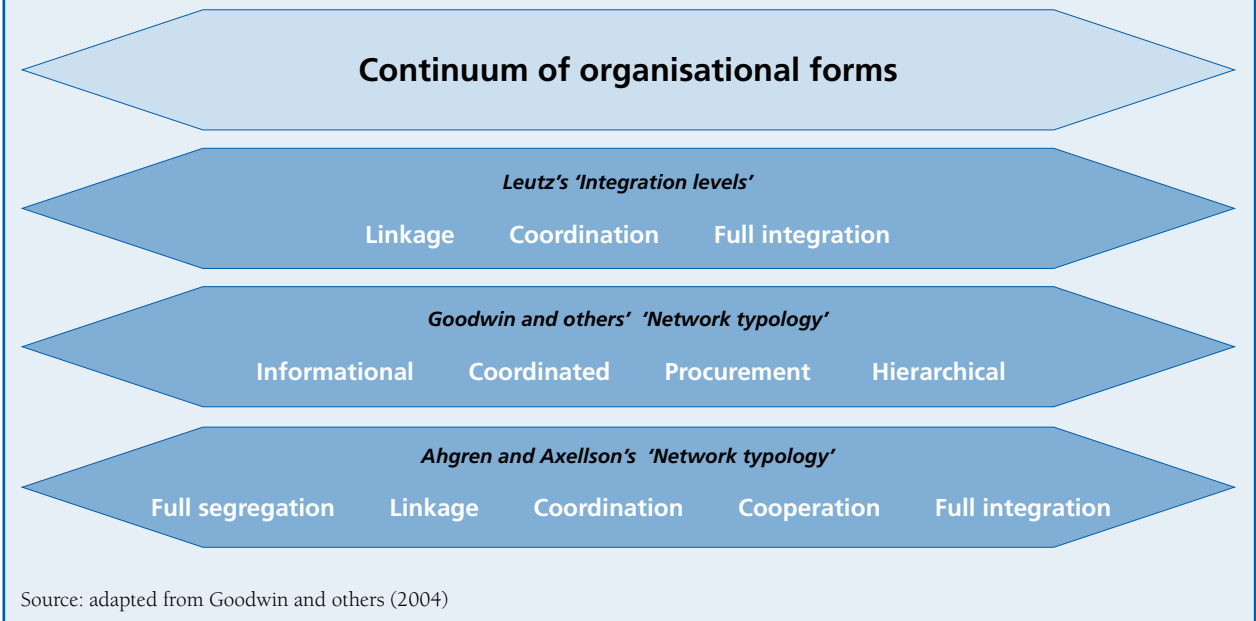
Source: adapted from Fulop and others (2005)

2004). And they can bring together teams and organisations within a single-care sector (horizontal integration) or across the continuum of care between community and hospital or specialist services (vertical integration).

The important point is never to assume that full organisational integration – as opposed to less formal collaboration between organisations – is the ‘optimal’ scenario or inevitable destination of integration activities. It may be that a care user’s needs are better served through less organisational integration and more opportunity for choice and personalisation of care across a range of

alternative providers that is well coordinated. As Fulop and others (2005) warn, there is weak evidence to suggest that a focus exclusively on organisational integration (as opposed to integrated care from the patient’s perspective) yields improvements for patients. For example, a review of organisations claiming to deliver ‘integrated care’ to the elderly in the US and Canada found that only half actually provided integrated care in the sense of more coordinated care to older people and their carers – the remainder being approaches to establish ‘clinical collectives’, group practices or multi-disciplinary

FIGURE 2: A CONCEPTUAL CONTINUUM OF FORMS OF INTEGRATED CARE ORGANISATION IN HEALTH AND SOCIAL CARE



networks that in themselves were forms of professional or organisational integration, but not providing integrated care to patients (MacAdam, 2008).

Finally, the Department of Health-funded integrated care pilots might follow any of these paths solely as a provider agency contracted to do so, or – as the vision for integrated care set out in the Next Stage Review suggests – simultaneously take on provider and commissioning responsibilities with a delegated budget through which to purchase care services on behalf of local patients. In the following section, examples

of integrated services within the NHS are reviewed, as are their potential advantages and disadvantages.

### 3. INTEGRATION IN PRACTICE – THE MANY FORMS OF ‘INTEGRATED CARE ORGANISATION’

Given the different definitions of integration set out above, it is perhaps unsurprising that many different models are seen in practice. They range from fully integrated organisations (providers or commissioner–provider organisations) to ‘virtually integrated’ provider or commissioner–provider networks, where close collaboration and coordination of care occurs between participatory teams and organisations. These illustrate some of the strengths and weaknesses of different forms of integration at delivering the overarching goals of cost-effective achievement of improved quality and patient experience.

#### Integrated service providers

Integrated service providers exist in a range of organisational forms. These forms may be ‘virtual’, that is clustering individual professionals around particular elements of care, or aligning the work of whole teams or organisations through networks or even merger. Examples include:

- **Multi-professional, integrated health and care teams** working to shared goals and standards with staff employed by different organisations. They may be aligned around GP practices or geographical localities, vary in size according to the population served and typically provide highly personalised care to a small segment of the population: identified as being at high risk of illness and hospital admission or with a specific condition (chronic obstructive pulmonary disease, for example). They are typically commissioned by primary care trusts (PCTs) with the aim of maintaining health, increasing self-care skills and reducing hospital admissions. However, they could also play a valuable role in admission avoidance in an integrated organisation with an at-risk global capitated budget, which is discussed further below.
- **Aligned teams and professionals around a detailed shared care plan.** This form of integration can be particularly useful for people with less predictable, variable, multiple and/or complex conditions such as those with long-term mental health problems. The Care Programme Approach – first launched in 1991 – demonstrates how a multi-professional group including GPs, psychiatric social workers and nurses, psychiatrists and others can develop an intensive but flexible shared care plan for people with significant health needs. The plans reflect assessed level of need and are underpinned by a single shared assessment. Critics of the Care Programme Approach have argued that it has become formulaic and process-driven rather than a dynamic process for reviewing and redesigning care (Goodwin and Lawton-Smith, forthcoming).
- **Providers’ network.** This comprises organisations that remain independent but work collaboratively to deliver contracted services with other network participants. A single PCT contract with a lead provider creates a clear line of accountability for the overall service, while sub-contracts with a



range of local organisations create a network of providers covering all required services and working to common standards and protocols.

The effectiveness of these different organisational forms depends on several things:

- The extent to which the incentives and governance arrangements under which they operate are aligned to support shared goals and effective collaboration. Contracts for integrated services can create a global budget across all participating providers, incentivising each to reduce costs – particularly if there is gain-sharing across participating organisations. However, a number of current barriers are jeopardising such arrangements: not least the impact of the NHS tariff on the ability to realise and distribute savings (typically, the tariff will financially penalise a hospital provider if admissions are reduced as a result of more integrated care); the difficulties of ‘unbundling’ tariffs; and constraints on pooled budgets across health and social care. The governance arrangements of such contracts are also of central importance in creating clear lines of accountability for service delivery and ensuring quality of care.
- The potential fragmentation associated with selecting specific conditions or services for integrated delivery. For patients with co-morbidities, commissioning multiple condition-specific integrated services may

fragment care and increase duplication and further research is needed into if and how it is possible to weave together services for people with multiple conditions.

- The practical challenges of aligning the goals, values and working patterns of professionals employed across multiple organisations. This includes the problem of limited collaboration to date between GP commissioners as well as between providers. Significant organisational development and effective local leadership is needed, which takes time to develop.
- Integrated, or linked, information systems, allowing the care pathway, quality, cost and experience of individual patients to be tracked (in as near real time as possible).

## Integrated commissioner–providers

The previous models involve different configurations of and relationships between care providers. The role of commissioners in this spectrum is distinct; they may act as a motivating force for developing integrated care, but remain separate from those delivering care.

A further form of integration – one upon which the remainder of this report focuses – involves that between commissioner and provider. In this approach, some commissioning responsibilities are delegated to providers to increase the scope for innovation and for financial responsibility.

While much of this report focuses on the commissioner–provider integration involving general practices, this innovation is not without precedent. Structural mergers between health and care services were seen in the introduction of care trusts in the late 1990s, bringing together payer and provider functions across health and parts of social care. Such mergers can, at least in theory, enable different professional groups to work more collaboratively through co-location and shared standards of care, goals and priorities; staff contracts; information systems, and education and training.

Importantly, they can create a global budget through which hospital, community and social care services can be aligned. With the prevention of high-cost emergency admissions heavily dependent on effective health and social care in community settings, there are potentially significant financial rewards associated with creating cost-effective integrated services.

An early evaluation of care trusts concluded that structural integration did not necessarily deliver integration of teams and effective team working could be just as well achieved in other ways (The King's Fund, 2005). However, more recent experience in Torbay Care Trust suggests that the gradual alignment of health and social care professionals in a single organisation creates opportunities for new ways of integrated working and achieves results (Ham, 2009).

Other models of commissioner–provider integration emerged with the creation of new general practice contracts that allowed additional

services to be included as part of a wider bundle (known as 'Personal Medical Services Plus' contracts). This stimulated the creation of medically-led groups that offered both primary and secondary care services. The spread of such innovations has remained relatively limited (Lewis and others, 2001), but why is unclear. A number of factors may be at work, including inertia on behalf of PCT commissioners to champion this approach, competing priorities among GPs (most notably the diversion of energies into managing their new contract after 2004), and a degree of risk aversion among both commissioners and GPs given the relatively radical nature of the innovation required.

Why PCTs have not championed the commissioner–provider model of integration is curious, given that the incentives created would appear at first glance to be aligned with PCT interests – in particular the transfer of financial risk to a clinically-led body. But competing priorities such as the recent emphasis on world class commissioning assurance and perhaps a nervousness about the capacity of primary care providers to assume such an extended role may be reasons why.

However, the interest in integrated care organisations within the NHS Next Stage Review, together with the challenging financial context, provides a far more encouraging context for wider take up of this approach.

How this form of integration might evolve is considered in the following two sections. However, a number of prior assumptions

need to be identified. First, there is no single organisational type that is best suited to delivering integrated care – the challenge is to adapt form to desired function and to create a way of working that will successfully deliver integrated care according to population health needs. That form will almost certainly look different in different locations in England.

Second, efforts to integrate services must be balanced against other policy objectives such as patient choice and competition. The approach taken to integration may be different in a rural health economy with a single district general hospital compared to an urban setting with multiple providers that could form competing integrated organisations or networks.

Third, the scale and scope of proposed integration of services need to be very carefully defined. System-wide reform (for example, a whole PCT) would have the advantage of a critical mass large enough to sustain investment in information technology, training and other infrastructure. But this would also require a root and branch change which would take significant management and clinical time to develop. Condition-specific initiatives to develop a network of providers may be a more pragmatic stepping stone to wider integration in some health economies.

Finally, there is a need to assess, in each context, which model provides the best alignment of financial and other incentives to achieve integrated care for patients. This alignment of incentives may be greatest when the global budget-holder is responsible for a registered

population but is subject to at least some competitive tension (Dixon and others, 2004). It is on these systems that we now focus attention.

## 4. UNDERSTANDING INTEGRATED CARE ORGANISATIONS AND INTEGRATED COMMISSIONER–PROVIDERS

### The integrated care pilots

The integrated care organisations proposed in the Next Stage Review of 2008 have emerged as a programme of Department of Health-sponsored pilots, 16 of which will run for two years from April 2009. While there is no ‘standard model’ ICO, the initial Department of Health ‘prospectus’ for the ICO pilots identified a number of core characteristics that were expected (Department of Health 2008a):

- Clinical leadership of the pilot
- A registered general practice population that will receive ICO services (in other words, the pilot must be based on a registered population)
- Services that span different elements of health and/or social care and partnerships between providers of these services
- Maintenance of patients’ rights to choose provider, treatment and setting when they are referred to secondary care.

The variety of pilot ICOs that have emerged can be seen in Table 1.

The scope of the pilots varies considerably from a single disease focus (such as dementia care) to a comprehensive approach to the care of people with multiple long-term conditions. Similarly, the partners that have committed to integration also vary widely, including community health services, hospitals, third and private sector organisations and local authorities. Pilots also encompass different types of integration. Church View

Medical Practice, for example, is piloting formal ‘vertical integration’ with its local hospital. Other pilots, such as Cumbria Integrated Care Pilot, involve horizontal integration among general practices and between general practice and community health services.

However, ICOs are not confined to the national pilot programme. Other sites in the NHS in England are trying to achieve better care coordination, through developing integrated healthcare, for example in Trafford, Hampshire and Redbridge. Still further sites are using flexibilities introduced under the Health Act 2006 to improve integrated care across health and social care, for example Torbay Care Trust, Knowsley Primary Care Trust and North East Lincolnshire Care Trust Plus (Ham, 2009).

The recent announcement by the Department of Health that an ‘extended community’ of integrated care will be created means that the concept is likely to develop widely and in different ways (Department of Health, 2010). Indeed, the type of ICO that this focuses on – the ‘commissioner–provider ICO’ – is largely absent from the sites that are currently part of the national pilot scheme.

TABLE 1: CHARACTERISTICS AND AIMS OF THE 16 NATIONAL INTEGRATED CARE PILOTS

Pilot name	Description
Bournemouth and Poole	Early intervention and signposting of services for people with memory impairment and diagnosed dementia. The pilot involves GPs, consultants, specialist mental health nurses, social workers and allied health professionals, among others.
Cambridgeshire	A model of end-of-life care integrating primary, secondary and community health services. Pilot activities include the development of practice registers, data-sharing across agencies and provision of a service directory for patients/carers.
Church View Medical Practice (Sunderland)	Vertical integration between a medical practice and hospital. The pilot will prevent avoidable admissions among the at-risk population through a multi-disciplinary team of consultants, GPs, nurses and carers.
Cumbria	Two models of integrated care in different localities. Both involve horizontal integration between GP and community services and vertical integration with specialist care. A whole system of care will be designed involving community hospitals and a 'virtual ward' in the community.
Durham Dales	Provision of a single point of access to multiple services, involving primary and secondary care, mental health and social care.
Newquay	A virtual dementia team drawn from a range of health and social care organisations which will offer tiered levels of integrated case management for individuals registered on GPs' dementia registers.
Northamptonshire Integrated Care Partnership	Services include proactive early intervention services, extended case management, medicines management for those discharged from hospital, depression management for people with long-term conditions, integrated end-of-life pathway, personalised healthcare budgets and urgent care schemes to reduce emergency admissions.
Norfolk	Six integrated local pilot teams comprising general practices, health and social care teams will identify at-risk populations, develop a common assessment process and manage care through key workers.
North Cornwall	A mental health pathway for the rural population which links members of a virtual team. Aims to reduce variation in assessment and service delivery and improve working between general practices and third sector organisations.

TABLE 1: CHARACTERISTICS AND AIMS OF THE 16 NATIONAL INTEGRATED CARE PILOTS	
Pilot name	Description
North Tyneside	Development of a comprehensive rapid access falls and syncope (fainting) service in the community with identification of high-risk individuals and services delivered through a multi-disciplinary team within a community-based clinic.
Northumbria	Care planning for patients with chronic obstructive pulmonary disease (COPD) through a named skilled key worker responsible for coordinating health and social care as well as offering care navigation to patients and patient-held records.
Principia Partners in Health (Nottinghamshire)	A social enterprise company in Rushcliffe that brings together health practitioners, managers and patients to decide on and deliver local health services. The pilot will establish community wards through horizontal integration and integrate care for COPD through vertical integration.
Tameside and Glossop	A new service model for cardiovascular disease delivered through a virtual integrated care organisation involving social services, primary and secondary care. Services will include raising risk awareness, screening, health improvement and self-care.
Torbay	Integrated hospital discharge across acute, community and intermediate care settings for people over 65 with co-morbidities following complex care pathways. In addition, an integrated end-of-life strategy for people with congestive cardiac failure and COPD. Pilot will develop a virtual pooled budget for older people's care across partner organisations.
Tower Hamlets	The development of eight provider networks and developing and commissioning care packages for diabetes and immunisation and vaccination. The pilot will integrate adult social care and community health services into locality multi-disciplinary teams.
Wakefield Integrated Substance Misuse Services	The pilot will undertake four streams of work: implementing a balanced scorecard, sharing patient records and data, communication and social marketing for service users, and enhanced shared care to support GP practices.

Source: adapted from Department of Health (2009)

## New accountabilities and new incentives

ICOs that combine commissioner and provider functions have been developed on the hypothesis that clinicians are able and willing to take on the responsibility for managing the care needs of a registered population within a given budget – that is they bear the financial risk for the budget. We call this type of ICO the ‘commissioner–provider ICO’ and it bears significant resemblances to some ICOs common in the US.

Practice-based commissioning, of course, is underpinned by a similar hypothesis, although it is a voluntary scheme with little consequence for general practices that perform poorly in their role as commissioners. Our vision for commissioner–provider ICOs goes further. First, these ICOs may be based on multi-specialty groups (in which generalists and specialists are both members of the ICO). This echoes the Department of Health Prospectus when it refers to the creation of a new ‘locus of accountability’ for a range of healthcare resources, including the delegation of ‘hard’ budgets derived from capitation payment for a registered population (Department of Health, 2008a).

As noted above, this brings ICOs more into line with those US ICOs that hold the financial risk for delivering comprehensive healthcare services for

an enrolled population (although these ICOs are not necessarily clinically-led).

Second, the use of capitation funding is vital. Annual capitation funding paid to clinically-led organisations – linked to the potential to keep savings made against their budget – presents them with incentives to avoid unnecessary care, to seek cheaper alternatives for necessary care and to invest in health promotion and disease prevention to guard against the future costs of ill health. This contrasts with ‘fees for service’, where clinicians and their organisations are simply incentivised to deliver more activity.

It also contrasts with the current system which applies different financial incentives to different elements of care; hospitals are incentivised largely according to the activity they carry out whereas primary care teams are broadly remunerated by capitation with some fees for service, such as for preventive care and community health services by a ‘block contract’.<sup>1</sup> Under these circumstances, hospitals are rewarded for doing more (where they can provide services at lower cost than the national tariff). General practices and community services are rewarded financially for doing less (except for a minority of activities where they are paid fees for service) and face little incentive to increase their clinical scope, indeed will be financially better off if they transfer patients as quickly as possible to hospital. Of course, the

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1. A block contract assigns a predetermined sum of money to a provider that is not explicitly linked to levels of activity.

incentives faced by the individual clinicians will again vary; hospital and community clinicians are largely employed, whereas general practitioners are largely self-employed. For the former, the goals of the individuals may not be the same as for their employers.

Importantly, we envisage that the capitation budget would ultimately incorporate all elements of care funding. In particular, it would bring together funding for GP services (General or Personal Medical Services) into a single budget. This would mean that budget-holders would be less likely to ‘compartmentalise’ their funding decisions and make more rational trade-offs between care options.

In this way, commissioner–provider ICOs are predicated on incentives that cross NHS sectoral boundaries (and also, potentially, the boundary with social care).

The factors that account for high performance among some US managed care organisations in the care of people with long-term conditions are in part these financial incentives, and in part the better information about the quality and costs of care of individual patients, coupled with clinical leadership to tackle poorly performing teams and individuals (Dixon and others, 2004).

In England, a workable person-based risk-adjusted method of capitation funding has been developed for commissioning practices (Dixon and others, forthcoming). But the ability of current primary care organisations to manage the financial risk on this scale remains untested.

The management infrastructure and support for primary care organisations (practice-based commissioning consortia) to develop integrated care and manage a budget, is likely to come, at least initially, from PCTs (Smith and others, 2010). Some commissioner–provider ICOs may form partnerships with third-party private sector organisations that offer risk capital and an existing management infrastructure. Few ICOs will be able to manage without significant external support, at least initially.

This approach to creating both the clinical relationships and the required incentives to deliver integrated care to patients holds out a tantalising prospect for unifying incentive structures that for too long have pulled in different directions. Importantly, it will take time to develop.



## 5. HOW MIGHT A COMMISSIONER–PROVIDER ORGANISATION WORK IN PRACTICE?

As noted above, Department of Health guidance states that an integrated care organisation (ICO) can take many organisational forms but has to involve GPs who alone can register patients.<sup>1</sup> This is critically important because it is recognised that primary care is pivotal in preventing ill health, coordinating care in the community and reducing the risk of costly admissions to hospital.

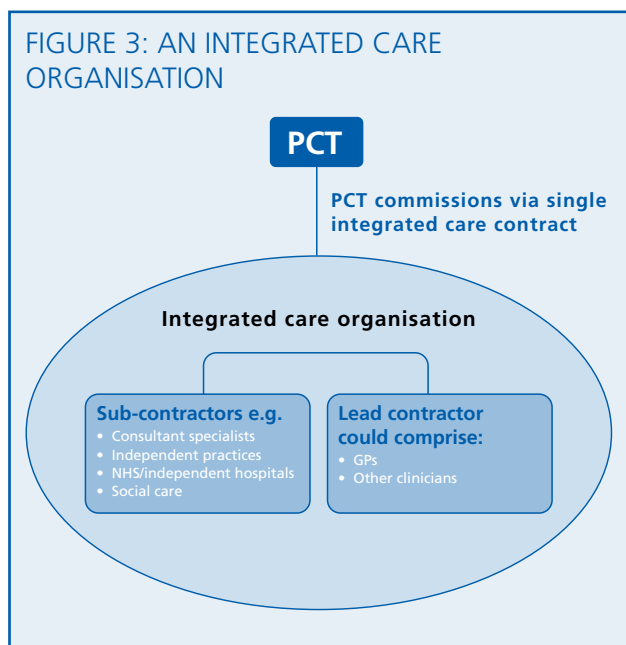
The ICO will take on a contractual obligation to the PCT to supply services and will be held to account through this contract. ICOs may choose to meet these contractual obligations by providing services directly or by contracting with another independent organisation that will provide on their behalf. In this sense, ICOs are likely to carry out both providing and commissioning activities. In business terms they face a ‘make or buy’ decision (see Figure 3).

There is, of course, no magic formula for how an ICO should constitute itself. This will have to be determined by local circumstances. However, options include:

- **Primary and social care organisations.**
- **GP partnerships** (sub-contracting all other care)
- **multi-specialty partnerships**, for example, incorporating GPs, a range of outpatient-based consultants and community nurses (sub-contracting some other care), for example the Local Clinical Partnership concept discussed by Smith and others (2009)
- **Hospital–primary care integrated organisations** (sub-contracting little extra care)

Similarly, a range of governance types are likely to emerge, including not-for-profit social enterprises (such as the current Principia pilot in Nottinghamshire), for-profit partnerships and NHS trusts.

As noted above, these organisations will need time to develop, and strict criteria set to convince that they have the right management expertise, information systems, governance and technical leadership to be viable and succeed. These criteria urgently need to be developed.



1. In theory, a commercial company could establish an ICO using an Alternative Provider Medical Services contract, provided that they could obtain a contract from a PCT. However, it is very likely that ICOs will be created mainly among existing general practices with current registered populations.

## Will ICOs succeed where practice-based commissioning has failed?

ICOs come from a similar philosophical tradition to practice-based commissioning, and it is, therefore, interesting that practice-based commissioning has not, as yet, evolved into integrated care. A common experience among previous schemes – such as GP fundholding, total purchasing and GP commissioning pilot programmes – was the integration of primary, community and often social care services in an attempt to provide an extended range of locally accessible care services to patients registered with them. For example, it was common for fundholders to contract in work by physiotherapists, ophthalmologists, and to offer counselling, dietetics and access to social

care (Goodwin, 1998). The main objective of this activity was to prevent avoidable admission to hospital, where appropriate.

For example, in the larger primary care organisations, alternatives to hospital-based care were often encouraged through various types of integrated primary and community healthcare teams (Wyke and others, 1999; Goodwin and others, 2000). Social care services were often major partners within these, coordinating community-care provision, or leading multi-disciplinary care teams providing joint assessments and commonly delivered services for client groups with complex needs – such as older people and adults with mental health needs (Smith and Goodwin, 2006).

There are distinct reasons why practice-based commissioning has so far had limited impact on

TABLE 2: SOME DIFFERENCES BETWEEN PRACTICE-BASED COMMISSIONING AND ICOS

	<b>Practice-based commissioning (PBC)</b>	<b>Integrated care organisations (ICOs)</b>
<b>Function</b>	Advice to PCT on service design and clinical priorities.	Contractual responsibility to deliver agreed services directly or through sub-contracts with others.
<b>Funding and incentives</b>	Notional budget agreed with PCT. PBC has discretion over the reinvestment of a proportion of any financial savings resulting from their commissioning advice.	PCT funds ICO through contract with real budget. Financial incentives to be agreed as part of the contract but could include direct financial rewards for ICO contractors.
<b>Governance</b>	PBC has advisory status only and PCT places all service contracts.	ICOs likely to be a formal organisation that holds a contract with PCT.

care integration. These include weak incentives and more practical considerations such as inadequate management infrastructure and information (Lewis and Gillam, 2007; Smith and others, 2010). Furthermore, ICOs and practice-based commissioning have some significant differences (see Table 2).

The key question is whether the stronger incentives of ICOs together with the greater emphasis on multi-disciplinary collaboration and clinical leadership will allow them to address some – if not all – of the barriers that have for so long prevented primary care commissioning groups from impacting significantly on patient care.

## 6. WHAT CHALLENGES WILL BE FACED IF 'COMMISSIONER-PROVIDER INTEGRATED CARE ORGANISATIONS' BECOME MAINSTREAM?

The model of integrated care organisation outlined above is a radical vision that has yet to be implemented, but is clearly hinted at in current government thinking. If ICOs are to bring about truly integrated care, where so many other initiatives have failed, they face a number of obstacles arising from the national policy framework that will need to be overcome.

### What is the current policy framework?

ICOs are being born into a regulated market environment.

In the current NHS market, patients have the right to choose from among competing providers for much hospital care and increasingly for community healthcare. Hospital providers are increasingly autonomous through foundation trust status and there are no formal market entry restrictions on independent sector providers other than registration with the Care Quality Commission. Moreover, all community health services currently provided 'in house' by PCTs are in the process of being relocated into other organisations, leaving PCTs as 'pure' commissioners. Thus community health services are taking many forms, including becoming fully autonomous social enterprises, being absorbed by other NHS organisations or, exceptionally, being established as community foundation trusts.

For providers, of course, the scope for central

'interference' remains. The recent scandal at Mid Staffordshire Foundation Trust<sup>1</sup> demonstrates that the Department of Health or politicians are unlikely ever to be divorced completely from the operation of a tax-funded health system. However, effective regulation of providers is allowing more autonomy by NHS providers from the Department of Health and politicians. Monitor, the financial regulator for foundation trusts, grants operating licences to these trusts and assesses their ongoing operating risks, intervening only where there is perceived to be a risk of failure. Monitor has the power to 'de-authorise' a trust of foundation status due to poor performance.

The independent Care Quality Commission now has the power to register and de-register all NHS and non-NHS providers on the grounds of quality, again intervening where there is a risk of failure. The new Cooperation and Competition Panel (CCP) considers and recommends action to ensure that appropriate levels of competition are maintained. PCT commissioners, on the other hand, are still subject to direct performance management from the local SHA, and in turn from the Department of Health.

The concept of the ICO presents some challenges to this policy framework. In the next section we consider these challenges and how ICOs might be designed to accommodate existing policies and how the policy framework itself might need to adapt.

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1. Following a Healthcare Commission inquiry, higher than average deaths at Stafford Hospital were attributed to deficiencies in emergency care, prompting a Ministerial apology and review.

## ICOs, patient choice and competition

Integrated care has clinical collaboration at its heart. This collaboration can be ‘vertical’ (uniting elements of primary and secondary care together), or ‘horizontal’ (uniting primary, community and social care), or both. Collaboration within an ICO can pose challenges to the notion of competition. For example, if an ICO network chooses to move ‘upwards’ along a care pathway, incorporating primary care clinicians and specialists within the same team or managed network, this is likely to reduce the choice available to patients at the point when they would normally be referred to a hospital for further care, which means the managed network of providers would include a predetermined set of providers.

The in-built incentives associated with capitation funding will lead ICOs to attempt to keep patients within their network rather than allowing revenue to ‘leak out’.

This form of collaboration can be considered ‘anti-competitive’ in that parts of the upstream care pathway are ‘captured’ by an alliance between one group of referrers and one group of suppliers. It is for this reason the new Cooperation and Competition Panel (CCP) recently investigated, yet ultimately approved, a vertically integrated ICO pilot (Cooperation and Competition Panel, 2009). The broad tests used by the CCP were whether:

- competition in the local area would be reduced by the plan for vertical integration
- integration was in the interest of patients and taxpayers.

In the US context it is the choice of managed care organisation that becomes important, not specific providers. Those people for whom choice is important will choose a managed care organisation where they are permitted (albeit often at extra cost) to select any provider they wish whether or not they are part of the network. Other managed care organisations, such as Kaiser Permanente in California, insist that for the most part, care enrolees are only permitted to use services ‘within plan’; that is as part of the managed care network.

The reality in the NHS in England is that a shift to ICOs within the current rules and context could lead to reduced opportunity for patient choice and greater inter-professional or inter-organisational cooperation (and perhaps better care) unless there was enough geographical overlap of the enrolled population of a neighbouring ICO.

The right of patients to choose is a fundamental principle at the heart of both Labour and Conservative health policies, and has now been enshrined as a right for patients under the NHS constitution. ICOs must therefore adapt to accommodate this choice requirement.

There are a number of ways in which this might be achieved. One option would be for PCT

commissioners to specify (and monitor) that the ICO provides a choice for patients of different care settings and, even, providers *within* their network. But this would not provide the competitive tension at the heart of the market-based policy framework.

A further alternative would be to ensure that patients are able to seek care from outside the ICO network at the point of referral for all or some specialist care. This latter requirement would be the minimum necessary to maintain the current 'free choice' policy in relation to hospital care.

Whether choice for patients would be promoted by primary care referrers with a vested interest in keeping activity within the ICO must be doubted. As the CCP noted in its decision on the vertical integration proposed by City Hospitals Sunderland, current patient flows were so heavily concentrated on the local hospital that a material reduction in competition was difficult, in practice, to achieve. However, no further loss of competition in a highly concentrated market is of little comfort if a key policy consideration is to increase the level of competition.

A more radical option, therefore, would be to regulate the market 'concentration' of ICOs; that is, to ensure that the market shares of different ICOs within an area do not get too great and lead to dominance. This would increase competitive forces between ICOs and the choice available to patients on registration. However, a consequence of this might be that existing groups

of collaborating general practices may have to be forcibly broken up if such a policy was pursued enthusiastically. A more gradual option would be to promote competition between ICOs by restricting their ability to set firm geographical boundaries. This, of course, mirrors the recent announcement that GP geographical practice boundaries are to be abolished (Burnham, 2009).

Over time, more choice and competition might emerge and, ultimately, national 'chains' of ICO operators could enter local markets by natural expansion or by merging with existing general practices. Of course, it is also possible that existing geographical clusters of practice-based commissioners may themselves disintegrate once ICOs introduce greater responsibilities and financial risks for general practices. Once the consequences of collaboration become greater, the selection of participants may become more than simply a case of geographical proximity.

Policy-makers will need to balance the positive and negative effects of competition, in particular, on patients with long-term conditions for whom better-integrated care is likely to offer most health and cost benefit. While choice may be required to stimulate responsiveness to patient need and cost control among ICOs, too much choice (and therefore patient 'churn' as people frequently re-register) would reduce the incentive facing any ICO to invest in the longer-term health of their population. In some US managed care markets the average enrolment term is short, reducing the investment case for health promotion activities (Leatherman and others, 2003). The early

experience of health insurance reform in the Netherlands demonstrated that high numbers of the general population appeared willing to switch between competing insurance providers in search of lower cost or higher quality (21 per cent switching rate in 2006, immediately after the reform, compared to 3 to 6 per cent pre-reform (De Jong and others, 2008)) although switching rates fell sharply thereafter (Maarse, 2008).

## Commissioning and regulating ICOs

There is little evidence as yet that patients choose their healthcare providers on the basis of comparing relative performance using NHS Choices and other comparative data sets. However, there is some evidence to suggest that patients use their own experience and advice from doctors to make choices on the hospital of treatment, and that quality of care is a significant factor in making these choices (Robertson and Dixon, 2009).

But relying on patient choice alone is unlikely to be sufficient basis on which to assure quality of ICO services. The role of an NHS commissioner (PCTs or, if they are, ultimately, merged, SHA-level commissioners) will be important. But PCTs are currently weak commissioners (Smith and others, 2010) and the metrics available to assess quality remain underdeveloped.

The more sinister aspects of the incentives created by capitation funding, especially if ICOs compete, are that ICOs could be tempted to

- ‘cream-skim’ – attract the healthy rather than the sick
- ‘skimp’ – reduce care for the particularly sick and therefore expensive patients
- ‘dump’ – remove the registration of expensive patients.

More positively, evidence from GP fundholding in the 1990s, where fundholders shared some of these same incentives, found no evidence of these negative outcomes (Goodwin, 1998). Setting an accurate properly risk-adjusted capitated budget for ICOs will be critical if these unwanted effects are to be minimised (Dixon and others, forthcoming).

Nevertheless, the task of keeping ICOs ‘honest’ remains and is accentuated by the likelihood that some ICO markets may have only weak competition and limited patient choice. In these circumstances, internal ICO governance and other control systems have a role to play in ensuring that the organisations focus on quality and take patient needs and views into account as a form of ‘market proxy’.

Some form of community governance arrangements could be adapted from the NHS foundation trust mutual membership approach (Lewis and others, 2006). It will also mean that internal control over quality and efficiency will need to be significantly strengthened through better information management systems reporting patient-level information, and peer reviewed stringently by clinical leaders. This is lacking at present.

The quality regulator – the Care Quality Commission – also has a role to play in providing an external challenge, but at present this role is underdeveloped.

It is also important to recognise that ICO development does not start with a clean sheet of paper. Because ICOs are founded on a list of registered patients, these are currently assigned to existing GPs. Therefore, the nascent ICO market is already fully stocked with incumbent providers. PCTs are therefore very limited in their ability to bring in fresh blood to develop a market. While they could let a new ICO contract to a new supplier, until that ICO registered patients it would receive no money other than any agreed subsidy from the PCT. Double running costs for PCTs would be significant.

If market entry is fraught, so too is market exit. In theory, unsuccessful ICOs would face pressure from consumers as they switched to better alternatives. In practice, we know that patients are often unwilling to change their GP. Given that ICOs would be founded on additional contracts with incumbent GPs (a PMS plus contract, for example), these could easily be revoked if performance proved unsatisfactory. However, most incumbent GPs enjoy a ‘return ticket’ to the traditional national GP contract. In effect, ICOs that ‘fail’ are highly likely to revert to traditional general practice rather than exiting the market and allowing others to enter.

Within current regulations, there is no ability for

government to force on GPs a transition to ICO status. Therefore, the current GP contract could be a significant constraint on the development of ICOs.

If ICOs are to become an effective force within the NHS, a new and controversial strategy of GP contract reform may be needed if the stream of willing volunteers proves inadequate. One strategy would be to give PCTs greater discretion over the retention of GP (and therefore ICO) contracts, for example, by making the current ‘contracts for life’ time-limited. However, this would signal a significant departure from current policy and would, no doubt, be forcefully opposed by medical interest groups. A different strategy would be to focus financial growth and new incentives into ICO-style contracts, allowing the traditional GP contract to be replaced gradually. In this way, a more purposeful transition towards ICOs might be achieved.

## Infrastructure and management capability

ICOs must take on financial and clinical risk to a degree that no general practice-based organisation has so far been required to do. PCTs will, ultimately, transfer via contracts with ICOs their own obligations to manage healthcare within pre-determined budgets. While it is likely that risk-sharing arrangements will be agreed (such as the ‘stop-loss’ insurance in the case of high-cost patients under GP fundholding),<sup>1</sup> ICOs will need

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1. Insurance that goes into effect when costs rise above a certain pre-determined limit.



to develop enhanced skills in risk management, contracting and financial control.

To ensure that ICOs take on an appropriate level of financial risk, an accurate risk-adjusted capitated budget must be set as noted earlier. The Department of Health has sponsored such work for allocating budgets for practice-based commissioning, and this is due for introduction in April 2010 (Dixon and others, forthcoming).

ICOs may typically seek to manage a budget over a longer period than a year to spread financial risk, or use third-party companies prepared to offer management support and working capital. If this proves to be the case, there is at least a risk that the notion that ICOs remain 'clinically led' may prove to be more theoretical than real.

However, perhaps the biggest obstacle to the widespread development of ICOs is the resistance likely from many existing GPs and hospital doctors to collaborate effectively in one organisation. As noted, ICOs are currently a voluntary activity and have attracted enthusiasts keen to innovate. By their very nature, ICOs involve their members in potential risks as well as potential rewards. It is by no means clear whether many existing GPs or consultants will embrace this future. Without powers to direct the transfer of existing GP contracts to ICOs, for example they may remain simply a minority sport for enthusiasts.

## 7. CONCLUSIONS AND RECOMMENDATIONS

The search for the magic formula to deliver integrated care has been frustrating and the goal elusive. Successive governments have rightly identified that, whatever the precise formula, a key ingredient is some form of commissioning, led by clinicians and based on a registered population delivering primary care.

Practice-based commissioning has languished, with largely underpowered incentives and little emphasis placed on implementation (Curry and others, 2008; Smith and others, 2010). Lord Darzi's announcement of integrated care organisations in the NHS Next Stage Review looks set to herald the next attempt to evolve primary care-led commissioning into clinically-led organisations that take clear financial accountability for living within (now economically straitened) means. Commissioner–provider ICOs, in particular, imply much stronger incentives on clinicians to engage in service redesign, to shift the balance between treatment and prevention and to manage the health of a registered population while living within a cash-limited budget.

However, by dint of these strong incentives, ICOs are controversial. Not least they present a different future for GPs and possibly specialist colleagues. ICOs make most sense if they are based on registered populations and rooted in primary care. Currently, only general practices can register patients and it is general practice that is closest to the image of ICOs as the coordinator of multiple care services. Even so, traditional general practice has a significant distance to travel if it is to fulfil

the ICO vision. The managerial capacity of a small business will be wholly unable to meet the challenge of managing financial and clinical risk for a population. Crucially, much greater support will be needed from PCTs (or third parties) at least in the initial stages. Some PCTs are unsupportive and block change (Curry and others, 2008). This will need to be remedied through central action.

For many GPs, integrated care will be a step too far; they will be content to offer face-to-face clinical services rather than take on the responsibilities and risks of a commissioner–provider organisation. If ICOs are to spread beyond a few small pilots, a way must be found for those GPs to align themselves with more dynamic organisations; one way of doing this might be to evolve multi-specialty local clinical partnerships, as examined in a recent Nuffield Trust/NHS Alliance report (Smith and others, 2009).

Others will relish the opportunity. One outcome may be a twin track for GPs – one for those that wish to focus exclusively on patient care and another for those prepared to become significant clinical leaders. In many ways, the rapid growth in salaried GPs, alongside their GP employers suggests that this twin track is already in the making.

The government will also need to reconsider its competition policy and how patients' rights to choose are interpreted in practice. Integration has at its heart collaboration rather than competition, though of course these are not mutually exclusive.

In this report we have described three scenarios, each of which is consistent with broad ICO policy (at least so far as it has been currently described):

- non-competitive ICOs with extended choice of specialist care
- competition between ICOs, but with little choice of specialist care within ICOs
- non-competitive ICOs with a closed network of specialists offering limited choice overall.

While ICOs may appear to be a radical departure from the current NHS process for commissioning and providing services, it is worth remembering that, in fact, powers to develop something akin to the ICO were created in 1997 in the form of 'PMS Plus' albeit little used in practice (Lewis and others, 2001). Even before this, some of the larger total purchasing pilots in the 1990s were beginning to develop approaches that were not dissimilar. Therefore, while ICOs may appear to be revolutionary, they have antecedents that reach back into more familiar NHS history.

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## The authors

### Richard Lewis

Dr Richard Lewis is a healthcare consultant, and a Senior Associate at The King's Fund. His current health policy interests include commissioning, primary care, foundation trusts and the potential role of social enterprises in healthcare. He recently spent a year on secondment to the Prime Minister's Delivery Unit.

### Rebecca Rosen

Dr Rebecca Rosen is a Senior Fellow at The Nuffield Trust with a background in policy analysis and public health. She also works as a GP within a multi-site practice where she has led work to improve care continuity and quality for people with complex chronic health conditions. She is a Senior Associate and former Senior Fellow at the King's Fund, and was previously Medical Director of Humana Europe.

### Nick Goodwin

Dr Nick Goodwin is a Senior Fellow at the King's Fund. His research interests lie in the organisation and management of primary care, practice-based commissioning, integrated care systems and care networks, and international health issues. He has previously held lectureship posts at the Health Services Management Centre, University of Birmingham and the London School of Hygiene and Tropical Medicine.

### Jennifer Dixon

Dr Jennifer Dixon is Director of the Nuffield Trust. She has researched and written widely on healthcare reform in the UK and internationally. Jennifer has a background in paediatric medicine, public health and policy analysis; her recent research interests include developing risk stratification and adjustment techniques for use in the NHS, and helping to design the evaluation of the Department of Health's 'whole-system demonstrator' project. Previous posts held include Director of Policy at The King's Fund and Policy Advisor to the Chief Executive of the NHS.









# Where next for integrated care organisations in the English NHS?

Since the 1950s, the NHS has been looking at ways of improving care coordination. Lord Darzi's NHS Next Stage Review introduced a new concept, that of the integrated care organisation (ICO). Since then, the Government has begun piloting schemes that offer different models of integrated care. This report, published jointly by The Nuffield Trust and The King's Fund, examines some of these new models. It focuses in particular on organisations that combine commissioner and provider roles. These, the authors suggest, offer the most promise for aligning incentives to produce efficient care across primary, community and acute services.

*Where next for integrated care organisations in the English NHS?* forms part of work by both The Nuffield Trust and The King's Fund examining new forms of structuring and delivering care over the coming decade.

This report will be of interest to healthcare policy-makers, senior managers and clinicians, and others involved in commissioning, as well as academics and students in the fields of healthcare and social policy.