

# Removing the policy barriers to integrated care in England

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This briefing paper uses five case studies of health economies in the English NHS as a basis for examining how local clinicians and managers are working together to develop closer service integration and less fragmented care for patients. It focuses on what is facilitating or impeding change and sets out proposals for policy-makers that are designed to enable more rapid progress towards developing better coordinated services. It is intended as a contribution to discussions about the direction health reform should take under the new Coalition Government following the publication of the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010).

## Key points

- International experience demonstrates that integrating healthcare services can deliver more efficient, patient-focused care. The White Paper *Equity and Excellence* provides an opportunity to move the NHS towards more integrated systems.
- In the UK, health and social care organisations in a number of areas are at the forefront of this initiative. However, several policy barriers need to be overcome if integrated care systems are to be established more widely.
- Policy-makers should explicitly recognise the need for competition in some areas of care and collaboration in others and should develop competition rules accordingly.
- There should be active encouragement of the use of incentives and financial flows 'beyond the tariff'; this will enable the development of capitated budgets and other means to support integrated care.
- GP commissioning should be used to support new forms of care and should encourage the involvement of secondary care clinicians alongside primary care teams.
- There should be renewed efforts to encourage NHS organisations and local authorities to use the flexibilities available to them to work in a more integrated way, including the integration of commissioning resources.
- The activities of Monitor and the Care Quality Commission (CQC) need to be aligned in support of integration, with a particular emphasis on the regulation of organisations as part of local systems of care and on the experience of patients across the whole care pathway.
- The importance of system leadership at a local level should be recognised in the light of the proposed abolition of primary care trusts (PCTs) and the development of GP commissioners.
- Policy-makers should articulate the case for change to service delivery and organisation with the support of professional bodies and patient groups.

### Introduction

While there have been major improvements in the performance of the NHS in the last decade, particularly reductions in waiting times for treatment and significant investments in areas of clinical priority like cardiac and cancer care, there is a great deal of unfinished business. The agenda for the future includes giving high priority to prevention, shifting care closer to home and addressing the needs of people with long-term conditions. Tackling this agenda requires releasing resources from existing services to fund new models of care in the community and developing closer integration between primary and secondary care, and health and social care.

The importance of integration was recognised in the final report of the NHS Next Stage Review, which led to the establishment of sixteen integrated care pilots in England. Integration is also seen as necessary in relation to cancer care, cardiac care, urgent care and other services where networks linking different providers have been established in some areas of the country in order to improve outcomes and reduce duplication. The financial pressures facing the NHS – and in particular the need to release £20 billion from existing budgets in order to fund new developments – have added urgency to the interest being shown in integration.

It was against this background that the Nuffield Trust organised a series of seminars to explore the policy barriers to integrated care. The series built on previous work by the Trust (Ham, 2008a; Rosen and Ham, 2008; Ham, 2009) and involved presentations by managers and clinicians from five health economies in England who were actively seeking to achieve closer integration. These presentations focused on the facilitators and barriers to integration, and sought to identify the policy changes needed to enable collaboration to be taken forward alongside competition.

The starting point of the seminar series was that policy-makers had given more attention to the development of competition in the NHS than the promotion of collaboration and integration. Contributors to the series were therefore asked to address the following questions:

- Can integrated care be developed while also enabling patients to exercise choice?
- Do current incentives such as payment by results (PbR) and practice-based commissioning support (PBC) closer integration of care?
- Where does integrated care fit into the world class commissioning agenda?

- How are foundation trusts contributing to the development of integrated care?
- What impact does the regulatory regime for foundation trusts have on integration?
- Does the current NHS operating framework and performance management regime facilitate or inhibit integration?

This briefing summarises work going on in the areas involved in the series and draws on this experience to identify the nature of the policy changes needed to support integration.

### Case studies

In this part of the briefing we summarise the work going on in the five areas involved in this study, drawing on more detailed reports available at [www.nuffieldtrust.org.uk/events](http://www.nuffieldtrust.org.uk/events)

#### Torbay

Torbay, in the southwest of England, has a population of 140,000 with a high proportion of older people. Integration is based on five health and social care teams organised in localities and aligned with general practices. Each team has a single manager and point of contact, and uses a unified assessment process. There is also a shared health and social care electronic record.

The driver for integrating care was to deliver better and more coordinated outcomes for older people who are heavy users of services. For each health and social care team, the focus is on knowing their population, concentrating on the most vulnerable, and managing their care in a proactive manner. This is done in partnership with GPs, and the teams deal with all cases, including long-term conditions, palliative care and people with disabilities.

The establishment of the care trust – a joint health and social care organisation – in 2005 was facilitated by:

- a history of good relations between the PCT and the council
- coterminous boundaries of the PCT and council
- political support
- involvement in the NHS Kaiser Beacon site programme
- a joint desire to improve performance and service delivery.

A number of improvements have occurred. Intermediate care services are available in each zone via the single

point of contact, enabling access to occupational therapists, physiotherapists, social workers and district nurses, within three and a half hours if urgent (these cases comprise 25 per cent of the total) and five working days for non-urgent cases. A weekend working pilot scheme has recently started and one of the most tangible benefits has been the reduction to almost zero of the number of delayed transfers of care from the acute hospital to the community. The rating of social care services has also improved.

Recent analysis has shown that Torbay has made measurable progress in reducing reliance on acute hospitals and avoiding admissions, including:

- reducing the average number of daily occupied beds used in both the district general hospital and community hospitals from 750 in 1989/99 to 528 in 2008/09
- using 2,025 emergency bed days per 1,000 population aged 65 and over, compared with an average of 2,778 per 1,000 population in the southwest as a whole
- using only 47 per cent of emergency bed days for people experiencing two or more admissions for its benchmark group of people aged 85 and over (Ham, 2010).

Torbay is now one of the national integrated care organisation (ICO) pilots and is testing out ways of achieving closer integration with local acute hospital services, with a particular focus on services for older people. The ICO pilot brings together the Care Trust, the South Devon Healthcare NHS Foundation Trust, mental health and local authority services. There are several elements to the pilot including: putting more emphasis on prevention; bringing expertise into the care of older people in accident and emergency (A&E); strengthening the role of discharge coordinators; and reviewing the role of community hospitals.

The commissioning challenges posed by the pilot include: developing integrated service delivery; exploring pooled budgets across all four providers; managing financial risks in relation to PbR and PBC; and managing relationships with national health and social care regulators.

In relation to the policy context, the main tensions relate to:

- **Choice and contestability:** because of the nature of the community being served and the geography of southwest Devon, this is not being pursued

actively and would be difficult to reconcile with the requirements of the Cooperation and Competition Panel.

- **Regulation:** while the establishment of the CQC as a single regulator for health and social care should help support integration, Monitor's focus on foundation trusts delivering bottom-line financial results may create real difficulties for organisations seeking to collaborate and in the process sacrificing opportunities to maximise income.
- **PbR and PBC:** it is not clear how far current financial incentives will facilitate or inhibit integration of care.

## Nottingham

Principia Partners in Health is a not-for-profit social enterprise based in Nottingham, which aims to improve coordination of care and develop a new community-facing model of clinical services. Principia serves a population of 118,000 and encompasses 16 general practices made up of over 100 GPs who are all involved in PBC. These practices work collaboratively with PCT-provided community services comprising around 140 community matrons, district nurses, health visitors, allied health professionals and other staff. As a social enterprise, Principia is self-governed and self-managed. One unique feature is the governance arrangements, as the board is elected by patients and has a majority of lay members.

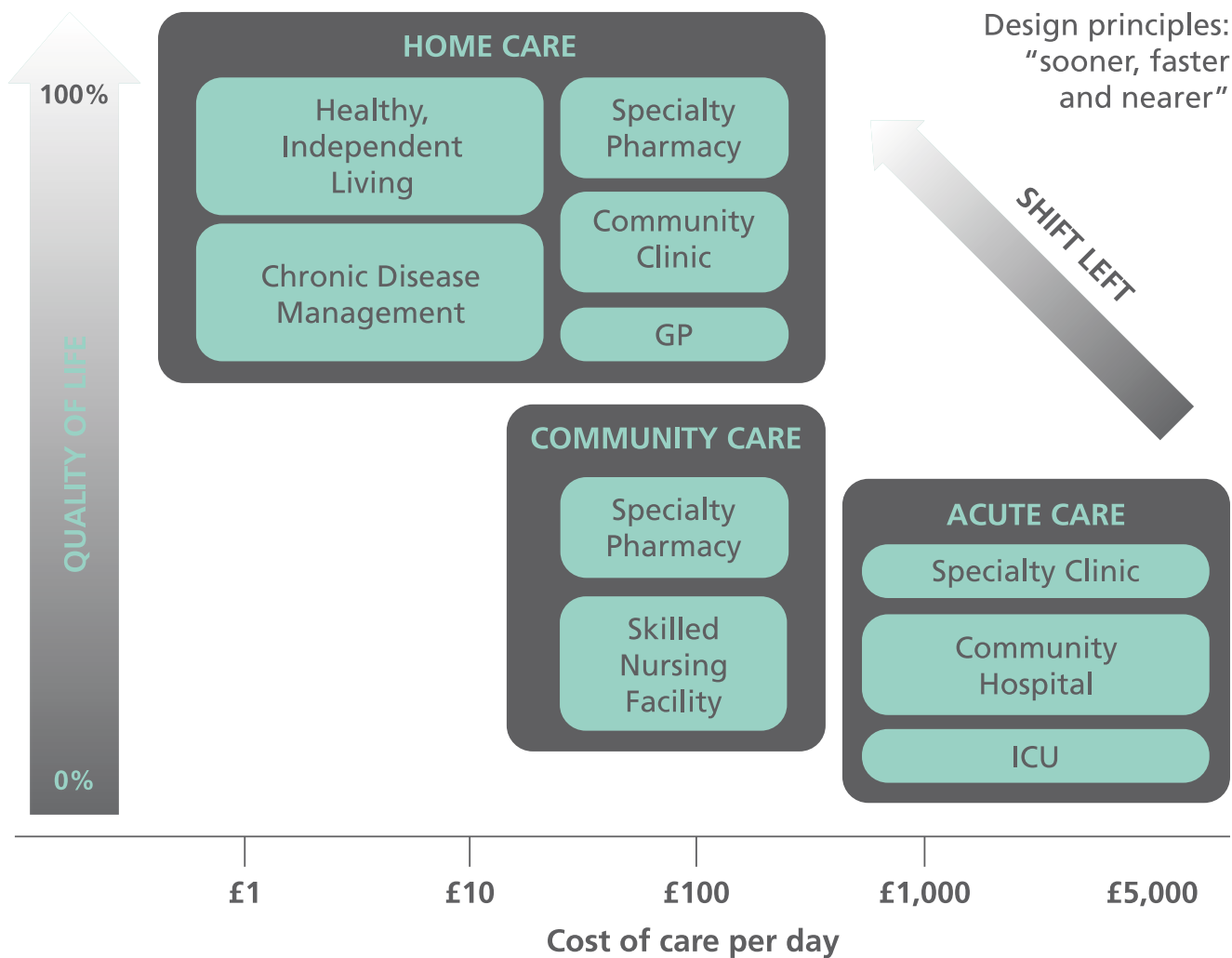
The new service model, illustrated in Figure 1, aims to reduce reliance on acute care and increase investment in community and home care. To date, key successes of Principia include:

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

Principia is now one of the 16 national ICO pilots with the long-term aim of moving from a focus on GPs to broader multidisciplinary teams, and a vertical partnership with acute care underpinned by alignment of financial incentives and managerial accountability.

Figure 1: The shift to a community-facing healthcare model in Nottingham

Care in the local NHS was characterised by delays, duplication and inefficiencies leading to prolonged, more expensive care, further away from home. The total-system healthcare 'win' was dependent on a new community facing service model



The 'total-system health care win' is in the home:

- Lower cost (good for commissioners)
- Higher quality of life (good for consumers)

The key focus for all competitors will be on home-based, consumer-centric healthcare solutions

**Home care focus:**

- Prevention
- Knowledge
- Fitness
- Wellness
- Communications

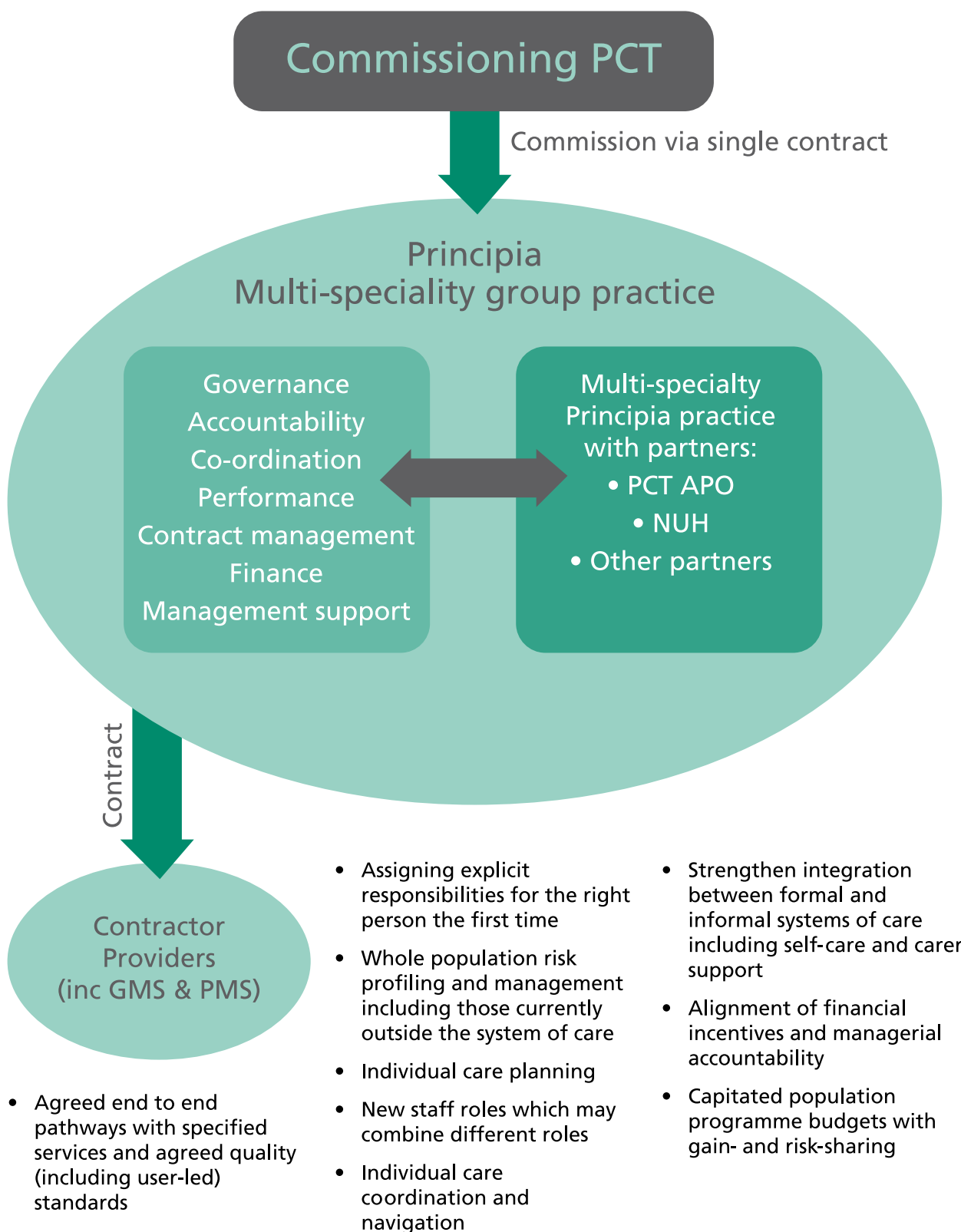
**LTC care and OPD**

- Medications
- Monitoring
- Community
- Medical communications

**Admissions avoidance**

- Sub acute
- Post acute

Figure 2: Principia ICO integrated service delivery



Experience in Principia is that working with clinicians across primary and secondary care to design new care pathways is critical to the overall approach. Achieving a clinical consensus on pathways for chronic obstructive pulmonary disease (COPD) and diabetes has been relatively easy. However, agreeing accountabilities and transactional issues has proved more challenging.

Principia has learnt about integration from the experience of Kaiser Permanente and the need to work both on the science of evidence-based medicine and the sociology of change in organisations. The latter entails getting the culture right through engagement and leadership, which is fundamental if models of care that link community services, primary care and secondary care are to be implemented. Learning from Kaiser Permanente and others, the ambition is to develop into an NHS version of a multi-specialty group practice, as illustrated in Figure 2.

A major challenge for Principia is how to achieve a shift of care from hospitals to the community, and how to handle the effects of this in a context in which there is strong local attachment to hospitals. Obstacles to further progress include:

- **the impact of the Transforming Community Services national policy**, which requires community health services to move out of PCT management
- **the fit, or otherwise, with the rules of the Cooperation and Competition Panel**
- **procurement rules** that do not always sit easily with an integrated approach
- **the recently announced changes to local commissioning arrangements.**

### Redbridge

PCTs across London now work together in sectors to commission hospital care and individual PCTs focus on work at the borough level to develop care outside hospitals. In Redbridge, a borough serving a population of 240,000, the challenges include: to decommission 20 per cent of outpatient activity and 6 per cent of elective activity; to prevent 35 per cent of admissions that arise from people with long-term conditions; and to improve the quality of care. There are financial deficits of £140 million in the health economy and these are growing. Consultation has also been taking place on the redesign of acute services with an option being to move A&E six miles to another acute hospital. This is causing public and political anxiety. Figure 3 illustrates the approach being taken in Redbridge to redesigning services.

Redbridge works through five localities, each with around 50,000 people. The core idea is of a locality being a 'polysystem' that:

- focuses on health and wellbeing
- maximises independence and quality of life
- proactively manages people with a long-term condition
- improves services for people with non-critical acute care needs.

As Figure 3 shows, people's homes are considered to be the heart of each polysystem, with specialist care at the circumference.

Fundamental to the approach is the devolution of budgets to federations of practices, with savings to be shared between practices and the PCT. Information and information technology will drive change at all levels, with the emphasis on risk stratification of the population and identification of those most at risk and in need of proactive care.

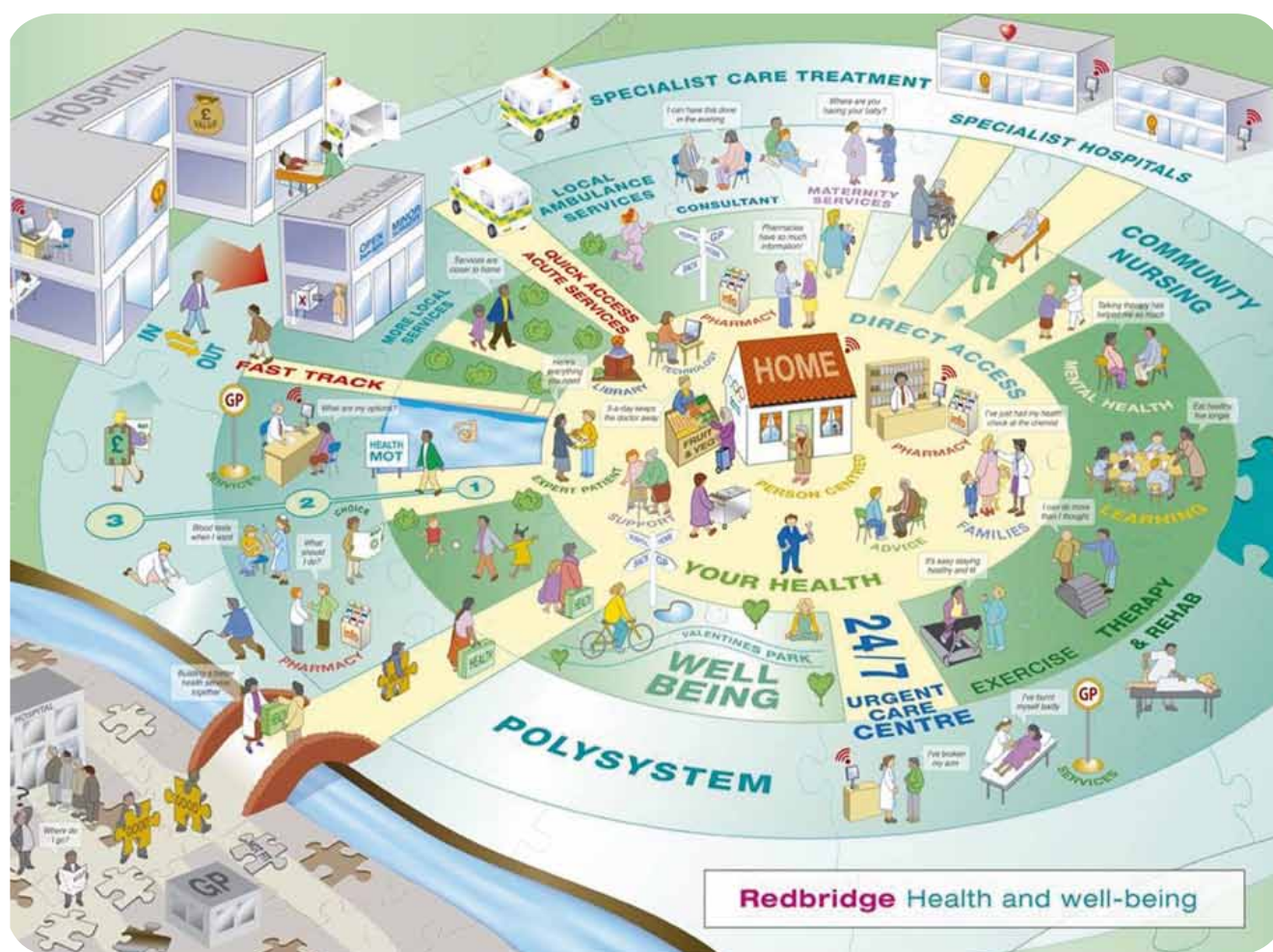
The model is based on clinical commissioning with a clinical board that seeks to bring together the best of PBC and PCT commissioning. The plan is to move 80 per cent of budgetary decision-making to polysystems during 2010. PCT staff will move into the polysystems to ensure that sufficient expertise and support are available to clinicians. Developing clinical leadership will be important and polysystems will be expected to collaborate with each other where appropriate, such as on needs assessment and developing new care pathways.

Underpinning this approach is a view that in the current system there is unnecessary service fragmentation and duplication. It is important to recognise that financial challenges provide a burning platform to drive change – the Redbridge health economy has been overtrading for years, and there is deemed to be significant waste at the interface between services and organisations. The ambition is to use polysystems to bring together primary and secondary care clinicians in order to transform services: polysystems will be held to account for overall health system and performance and health outcomes.

As in other areas, further progress hinges on tackling a number of policy challenges, including:

- **ensuring that GPs and practices work together in federations** to become the engines of change in the polysystems

Figure 3: Health and well-being in Redbridge



- **balancing integration in polysystems with choice for patients** and ensuring that polysystems do not become monopolies that act as a barrier to innovation
- **working through the implications for hospital services** with the expectation that hospitals would become leaner
- **finding the funding to establish new services** while continuing with current provision
- **persuading the public and politicians of the benefits of this model of care** and the need to relocate some services.

### Trafford

NHS organisations in Trafford, a borough of around 213,000 people in Greater Manchester, have come together to develop a new integrated health system across primary, community and hospital care. The 'burning

platform' for this is recognition of unsustainable local hospital services, both from a clinical and financial perspective. The approach developed in Trafford focuses on the introduction of innovative models of care using new technologies. It is intended that some elements of mental health services will be included within the 'integrated domain' in the future. The shift from current service configuration to a new and integrated local health system is shown in Figures 4 and 5.

Central to this approach is the concept of 'office medicine', meaning community-based and community-focused primary/secondary and outpatient specialist and diagnostic care. This is driven by a desire to meet the challenge of long-term conditions and will require a new relationship between doctors who are currently based in hospitals and local GPs. As a first step towards this, community-based physicians are being appointed to nine local 'vanguard' practices, with a brief to:

Figure 4: Current service sectors in Trafford

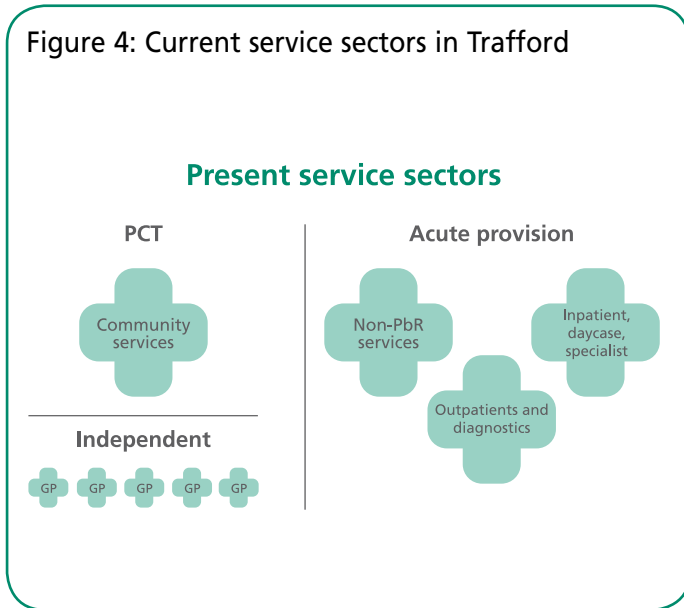
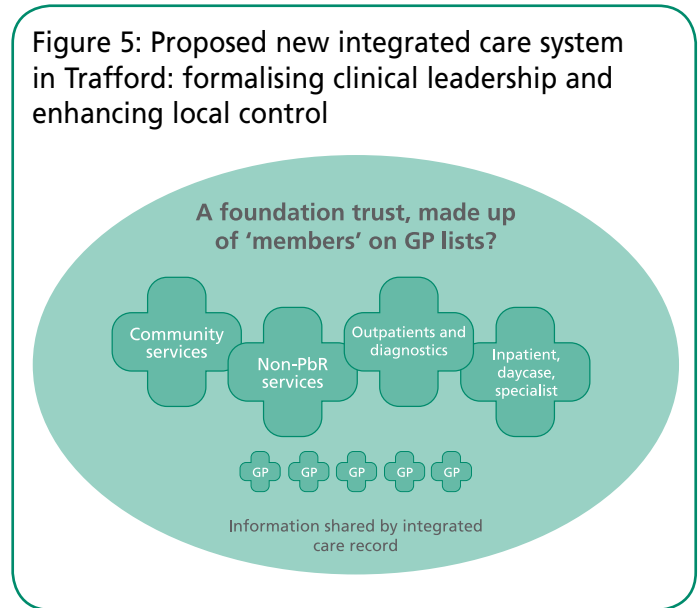


Figure 5: Proposed new integrated care system in Trafford: formalising clinical leadership and enhancing local control



- focus on caring for those people identified as being at high risk of hospital admission
- oversee the implementation of telehealth
- develop the approach to population risk management
- implement new models of care within the integrated care system (ICS).

Those clinicians and managers planning the Trafford ICS have discussed the possibility that ‘medicine and surgery are different in kind’, with surgery requiring increased horizontal integration, through the networking or merging of a number of services into larger units, while medicine needs vertical integration between family medicine as delivered through general practice, office medicine, and acute medicine.

Clinical leadership is central to the ICS and a number of ‘clinical congress’ meetings have been held at which clinicians from primary, community health and secondary care have come together to explore how a different service model might work. Twenty-four disease areas have been identified as having the potential to benefit from integration; six have been identified as the focus for 2010/11. Each will establish multidisciplinary clinical panels responsible for designing models of care and quality measures. It is intended that the panels will oversee the move from an outpatient to ‘office medicine’ approach and that, in due course, they may hold a programme budget to fund services for their particular speciality or service and oversee standards of provision.

The PCT has agreed £2m of investment funding for the year 2010/11 in order to lay the foundations for the

ICS, and has agreed a ‘whole health economy’ approach to delivering cost-improvement programmes associated with new models of care and with closer working across primary, community and acute care. The local authority is very supportive of the development and has indicated that it will consider the possibility of encompassing social care within the ICS once some of the vertical integration of primary, community and acute care starts to become embedded.

Policy challenges in Trafford include:

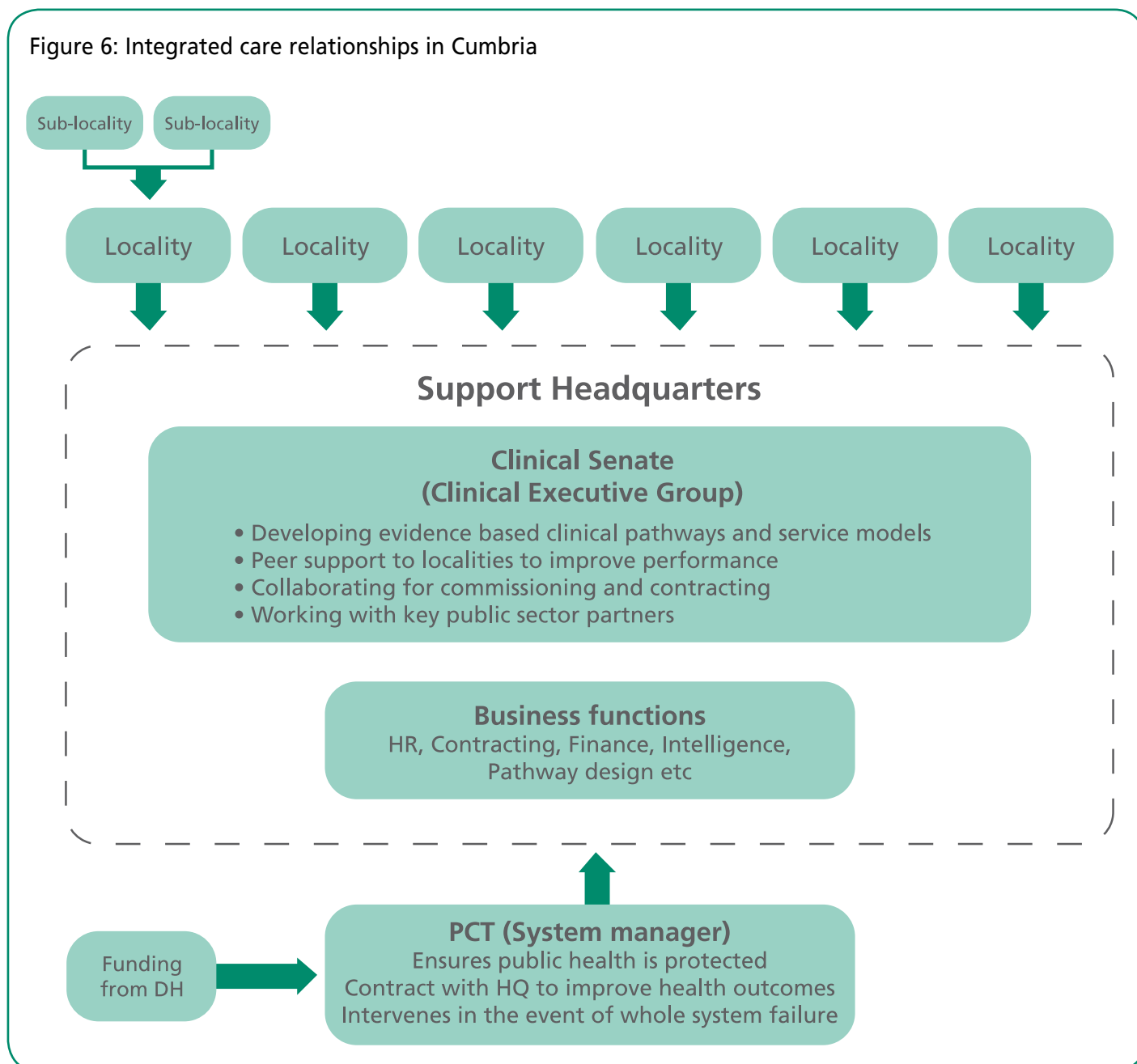
- **Choice and contestability:** can integration be reconciled with the requirements of the Cooperation and Competition Panel?
- **World-class commissioning and Transforming Community Services (TCS):** the assurance processes for these have been distracting at a time of major redesign of the health economy.
- **PbR** creates perverse incentives as it drives hospital activity and in its current form PBC lacks the ‘clout’ to manage demand across the system.

### Cumbria

NHS Cumbria serves a population of around 500,000 across a large geographical area; there are long travel times and wide variations in health. The PCT is devolving budgets to six localities that are integrated care organisations taking responsibility for both the commissioning and provision of many services. The arrangements being developed in Cumbria are illustrated in Figure 6 opposite.



Figure 6: Integrated care relationships in Cumbria



This shows that with devolution of budgets to localities and sub-localities, the PCT support headquarters comprise the clinical senate (GP leaders from each locality and the lead on out-of-hours, who lead overall service design and delivery) and core business functions like human resources, contracting and finance. The role of the PCT becomes that of system manager, focusing on public health and intervention in the event of whole system failure. Cumbria is developing community engagement from the bottom up, via lay members of locality boards. Use is also being made of local authority community engagement mechanisms and parish

councils (often very active and important in rural areas). The philosophy is one of distributed leadership and devolution to the lowest possible level.

The approach in Cumbria centres on strengthening primary care (which is already very good) and achieving closer integration with community health services. There has been a major focus on developing a new community-based approach to providing diabetic services across the county, and this is seen as a prototype for further service development by, and within, GP-led local organisations.

One of the priorities has been to streamline acute inpatient care within Cumbria. This has included reducing excess bed days and using case managers to move patients from acute to step-down beds. There is a 'step-up, step-down' facility of 51 beds in Kendal that acts as a virtual community hospital. This includes a short-term intervention service that manages crises and supports early discharge from hospital. Emergency admissions have fallen by around 2 per cent compared with an increase of around 5 per cent in the rest of the strategic health authority.

Work to achieve closer integration has been supported by the sharing of information making use of EMIS Web – enabling data from primary care, community health teams, diagnostic services, pharmacy, GP-led wards and specialist outpatients to be shared and linked.

In relation to policy challenges, the experience of Cumbria is that PBC has helped in building relationships and enabling devolution to GP leaders, though this has taken time. The policy on transforming community services could have been a major barrier if the Department of Health had insisted on vertical integration with acute trusts. Cumbria's preferred approach is integration with PBC at the locality level and this is being pursued.

Specific policy barriers to progress have included:

- **Access to pensions** within a social enterprise arrangement.
- **PbR** and its focus on incentivising hospital activity.
- **Foundation trust status** leading to providers seeking to expand activity and income in relative isolation.
- **Choice and competition:** in a rural area like Cumbria it is difficult to envisage how ICOs could compete. Patients can choose their GP (and satisfaction levels are high). The principal aim is to develop care closer to home by making good use of community hospitals and working to align specialists with practices and community services.

Cumbria's work has taken on added importance since the General Election because of the interest shown by the current Health Secretary in this work.

## Emerging themes

The above case studies reveal similarities and differences between the five health economies.

### Integrating primary medical and community health services

In all areas, the main focus to date has been on achieving closer integration between primary medical care services and the community health services run by PCTs. Social care involvement has been limited, with the notable exception of Torbay, where considerable progress has been made in establishing integrated health and social care teams organised on a locality basis and aligned with GP practices. The involvement of secondary care has varied between areas, with both Redbridge and Trafford giving this priority, but it is generally less well advanced than work to integrate primary medical care services and community health services.

### Managing demand and developing new care models

An important rationale behind integration in the case study sites has been the concern to manage demand for hospital services and develop new models of care, in particular for older people and those living with long-term conditions. An approach common to each of the sites is to develop much more effective care management and coordination for people with complex long-term conditions. Specific examples of this are the Torbay integrated care teams and the Trafford vanguard practices with extensive community health services based in these practices. Torbay is able to demonstrate more measurable results in terms of reduced use of hospital beds and lower rates of emergency hospital admissions for people aged 65 and over, than in comparable areas (Ham, 2010).

Other areas have also worked to develop new models of care. Examples include work in Cumbria on diabetes, in Redbridge on cardiovascular disease and in Nottingham on COPD and diabetes. The development of new service models is seen as a powerful way of engaging clinicians from primary and secondary care and lays the foundations for such models to be implemented subsequently within stronger local clinical commissioning arrangements.

### Addressing an unsustainable acute sector

In two areas, Trafford and Redbridge, the interest in integration is related to the existence of acute hospital services that are unsustainable in their current form.

This has stimulated work to strengthen services out of hospital and to find ways of building closer linkages between these services and those provided in hospital. Trafford has done this through a sustained and extensive programme of clinical design work that brings together clinicians from primary, community health and secondary care in 'clinical congress meetings' and specialty-specific panels to design new models of care.

### Developing general practice federations

A recurring theme is the importance of networks or federations of practices. Examples include Principia in Nottingham bringing together 16 practices serving a population of 118,000, and the six localities established in Cumbria serving a total population of 500,000. The size of the population covered by networks/federations varies from these larger units to polysystems of around 50,000 in Redbridge and localities of 25,000 to 40,000 in Torbay.

### Establishing effective clinical leadership

Regardless of population size, in all areas it is recognised that GP and other clinical leaders have a critical role to play in making integration work and each area has examples of key individuals who are doing this. Cumbria has taken its work on clinical leadership forward through the establishment of a clinical senate. This group has at its core the GP leads in each of Cumbria's six localities and it has taken over many of the functions of the professional executive committee (PEC). As a consequence, the role of the PCT is changing: becoming that of system manager, focusing on public health and intervention in the event of whole system failure.

In Cumbria and most of the other sites, PBC has been a catalyst for clinical engagement and service redesign. In Trafford and Redbridge, secondary care clinicians have been involved in this work and there are plans to do the same in the other areas as work on integration extends beyond primary medical care services and community health services. In two sites, Cumbria and Redbridge, external clinical expertise has been drawn in to assist in this work and to support the development of new service models.

### Using data and IT to integrate patient information

Finding ways of drawing together clinical data from different parts of the local health system is a common feature of the work taking place in the sites and has been a key concern for colleagues in Trafford, Redbridge, Cumbria and Torbay. The goal in each case is for a

single patient record and a single joint needs assessment process for users. The use of EMIS Web in Cumbria is a vivid example of how clinicians are working together to use information as a core part of managing the care and health of the local population. Similarly, in Torbay progress has been made in the development of an integrated health and social care record by building on existing systems, rather than waiting for the national programme to deliver.

### Involving the public

An issue that has not received much attention to date is public involvement. The two main exceptions are Principia in Nottingham, and Trafford. Principia has developed a governance arrangement in which there is a board elected by patients and with a majority of lay members. Principia also has lay members within its organisation, many of whom interact regularly with the organisation through its website, as well as in its meetings and service design groups.

Trafford carried out extensive public engagement work in the early phases of developing the concept of its ICO. This included holding public engagement events and neighbourhood forums and carrying out a residents' survey. This led to the development of a set of People's Priorities, including both calls for public information about care options, and for greater efficiency of provision in relation to cleanliness and safety of providers.

Furthermore, patients are actively involved in the clinical service redesign panels and have received training for this role.

### Establishing new forms of organisation and governance

All of the case sites have developed new forms of organisation and governance to shape and run their integrated services. Torbay has opted for a formal merger of services into a care trust, while Principia in Nottingham has established a social enterprise organisation based on PBC. Cumbria has set up six clinically led localities whose leadership resides in a clinical senate; Redbridge has developed five polysystems led by local GPs; and Trafford has established an integrated care system that draws together the local trust, a PBC company owned by local GPs, and PCT provider services. In all cases, organisational innovation was used to support integration rather than being the driver of the process.

### Learning from experience of integration abroad

As a final comment on emerging themes, it is striking that all areas have benefited from links with integrated healthcare systems in the US. Kaiser Permanente was the organisation whose experience was mentioned most frequently, for example in Torbay, Nottingham, Redbridge and Cumbria. Trafford by contrast has developed links with Inter Mountain in Utah and is receiving support from Inter Mountain in developing clinical and managerial leaders to take forward integration. The Veterans' Health Administration was another organisation whose experience was known to these areas.

### Policy barriers

The seminars highlighted several policy barriers to integration and in this section we discuss the barriers most frequently mentioned by the contributors.

#### Policy on choice and competition

Efforts to integrate services have to confront the argument that integration could result in the emergence of new kinds of organisations or alliances that inhibit choice and competition through the creation of monopoly or near-monopoly providers. A specific illustration of the tensions that have arisen is the approach taken to Transforming Community Services. PCTs have been required by the Department of Health to separate their commissioning responsibilities from their role as direct service providers, leading to rapid consideration (due to very tight policy timescales) of where responsibility for service provision should rest in future. The rationale behind this policy was to enable PCTs to concentrate on their role as commissioners and encourage new community service providers to enter the market to compete with PCT providers.

The difficulty with the policy of Transforming Community Services is that it risks running counter to moves, in many areas, to create stronger links between community services and primary medical care services. These risks are particularly apparent when PCT providers have been expected to consider options such as organisational integration with mental health and acute services when their main priority is to work more closely with GP practices, for example with Principia. Similarly, the option of creating large organisations to run PCT provider services across a number of areas may make it more difficult to integrate these services with those of

GP practices at a locality or GP commissioning group level. The route taken in Cumbria, where the PCT has been allowed to align its community services with GP-led localities with a view to establishing a social enterprise, illustrates that there is a way of avoiding these risks.

What is clear is that the case study sites are all committed to offering patients choice of type and location of care, yet want to do this within care pathways that are much more effectively coordinated than has typically been the case in the past. Policy on choice and competition seems at times to lack the sophistication to accommodate service developments such as those set out in this paper: developments that have at their heart a desire to address profound fragmentation within the services patients use. It is possible to envisage how the health reform programme might evolve to enable there to be choice and competition between integrated systems (Ham, 2008c). Evidence from the US suggests that competition between integrated systems may offer greater benefits than competition between a fragmented provider market; this point is discussed further in the final section of the paper.

#### The focus within foundation trusts on expanding hospital activity

Another barrier has been the emphasis placed on developing NHS foundation trusts as semi-autonomous organisations and the regulatory regime put in place by Monitor. Specifically, the requirement by Monitor that NHS foundation trusts not only balance their budgets but also create surpluses for future investment, may make it difficult to agree on new models of care that reduce reliance on hospitals. This is because the leaders of NHS foundation trusts are expected to maximise the income and margins they earn from the work they do, leading to a focus on increasing hospital activity rather than exploring ways of avoiding admissions and delivering care closer to home. Monitor's approach makes eminent sense when viewed from the perspective of NHS foundation trusts but there is a clear risk that it will conflict with the aims that lie behind moves to develop new forms of care that transcend primary, community and hospital services.

#### Perverse incentives associated with PbR

The same applies to PbR, the activity-based system used for funding hospital activity in the English NHS. Although in theory PbR ought to create incentives for PCTs and practice-based commissioners to manage demand for hospital services more effectively,

commissioners have found it difficult to do so. This is due to the problems faced by PCTs and practice-based commissioners in trying to manage demand, especially when many hospital admissions happen without any referral to a GP and, when in hospital, patients are often referred from one specialist to another, causing additional PbR activity to be clocked up.

As a result, more resources have been sucked into hospitals just at the time when they need to be released from acute services to support the development of new models of care. The inability of commissioners to stem increases in A&E attendances and emergency admissions, as highlighted in a recent Nuffield Trust report (Blunt and others, 2010), has led the Department of Health to amend the PbR tariff for 2010/11 to reduce the income providers receive for increases in these admissions over those recorded in 2008/09. The broader point here is that the weaknesses of commissioning have prevented PbR having the intended effects by sharpening the incentives to avoid hospital care. (See Smith and others, 2010 for a fuller assessment of the performance of commissioning.)

### World class commissioning

World class commissioning (WCC) was put in place to address these weaknesses but evidence from the areas that contributed to the seminar series was that the WCC assurance process was both bureaucratic and distracting. Not only did the process consume a large amount of time and effort on the part of PCT boards and senior managers, but the resulting benefits were reported to be limited in relation to the time that was put in. Concerns about the continuing weaknesses of commissioning have led to moves in some regions to organise PCTs into clusters with a view to reducing their number in the medium term.

The prospect of another reorganisation was, however, seen by the case study participants as a further threat to attempts to achieve closer integration of services, in that it would mean NHS leaders having to turn their attention to organisational issues and that changes in leadership might undermine the relationships on which integration was being built. Research has demonstrated the challenges involved in establishing effective commissioning organisations outside the UK (Ham, 2008b) and this reinforces the argument for exploring ways in which organisations that integrate commissioning and provision can be developed.

### The impact of regulation

The emphasis in the regulatory regime on assessing the performance of individual organisations rather than local systems of care is a further barrier to integration. This is particularly evident in the work of the CQC and its predecessors, and has led NHS leaders to focus on achieving good results for their organisations almost irrespective of the consequences for the wider local health and social care system. At worst, as in the approach adopted by Monitor in relation to NHS foundation trusts, this may result in the sum being less than the total of the individual parts.

An illustration of the impact of regulation is the way in which national targets focus the attention of managers and clinicians on organisational performance. The four-hour maximum waiting time target for patients to be treated in A&E is an example, insofar as it leads managers to concentrate on one aspect of access to urgent care to the exclusion of other aspects, in order to achieve a positive rating from regulators. The more important and challenging question of how to redesign the urgent care pathway to provide appropriate access to services in different settings has not received the same attention because regulators have not focused on this question in the same way as they have assessed organisational performance against key national targets such as the four-hour target in A&E.

### Making the case for service reconfiguration

A final barrier is public and political concerns about service changes that might result from integration. Specifically, if local access to acute hospital services is threatened by the strengthening of services out of hospital, then it is recognised that it could be difficult to persuade key stakeholders that this would be beneficial. The key point here is that the benefits of centralising some services in terms of better outcomes of care need to be articulated to overcome concerns that valued local services are being downgraded.

The approach taken in Trafford in relation to both clinical and public involvement in shaping plans may offer some pointers in this regard. Trafford's work to horizontally integrate surgical services across a number of providers, with the aim of improving quality and safety, while at the same time pursuing vertical integration for medical specialities and primary care in order to enable better coordinated diagnosis and treatment of long-term conditions, demonstrates how trade-offs can be made. Likewise the work done in Cumbria to strengthen the

role of local hospitals as hubs of new primary care-focused services for people with long-term conditions illustrates the possibilities available to acute services when local health economies seek to develop new forms of better integrated care.

### What needs to be done?

Our analysis of five innovative attempts to develop local health systems offering better integrated care for patients highlights an important paradox. On the one hand, clinical and managerial leaders in this diverse set of health economies have made a start in shaping new services and organisations, using elements of the current policy context, such as PBC and the flexibilities that exist to bring health and social care closer together. On the other hand, they have been held back by policy mechanisms such as PbR and the foundation trust regime, which at times get in the way of attempts to reshape care in ways that have been exhorted in White Papers calling for community-based care centred on the needs of patients and carers (such as Department of Health, 2006).

This paradox suggests that what is needed is the refinement and amendment of existing policies so that local clinicians and managers can make progress with reshaping services in ways that enable both better integrated care for patients and improved efficiency for the wider NHS. In this final section of the paper we propose seven practical ways in which this can be done at a time when the new Coalition Government is developing its plans for the future. Our proposals are made in the context of a comment made by David Nicholson, NHS Chief Executive, that in seeking to rise to the financial challenges that lie ahead it is important to recognise that 'many of the most significant quality and productivity opportunities lie in the interfaces between organisations' (Nicholson, 2009).

The proposals we make are not exhaustive and are intended to highlight some of the most important changes that now need to be made.

#### Policy on competition and collaboration

**Our first proposal is that policy-makers should explicitly recognise the need for competition in some areas of care and for collaboration in other areas of care and should develop competition rules to reflect this need.**

The experience of NHS reform in the last decade is that competition has a contribution to make to improving performance but it needs to be used alongside collaboration. Patients who require rapid access to diagnostic tests and planned care are best placed to exercise choice and in this area of care the argument for competition between providers is particularly strong. The same applies to the choice of general practitioner and to other areas of care in which patients have the time to make decisions on where to receive care and the inclination to travel to non-local providers if they perceive there to be benefits in so doing. By contrast, patients with one or more chronic conditions who require access to care from different providers at different times need these providers to work together to offer effective coordination across the care pathway. This includes the NHS working closely with social care.

Similar arguments apply to urgent care where competition between providers is likely to lead to fragmentation of services, inefficiencies in the use of resources and confusion for service users. Urgent care is in fact an excellent example of the importance of developing integrated service networks at a local level in which hospitals, the ambulance service, NHS Direct, primary care providers and the out-of-hours service coordinate their contributions as part of a single system of care. Collaboration and integration are also important in many specialist services including cancer and cardiac care where networks have helped to raise standards and enabled services to be planned across different providers. Highly specialised services illustrate the necessity of planning and collaboration on a national basis to ensure that the best outcomes are achieved, for example in recent proposals on the future of paediatric surgery.

#### Incentives to support integration

**Our second proposal is that policy-makers should actively encourage the use of incentives and financial flows 'beyond the tariff' to enable capitated budgets and other means to be developed to support the development of integrated care.**

If policy-makers wish to achieve competition and collaboration, then they must also be prepared to provide the means for them to be implemented. Many of the current means of reform in relation to incentives and financial flows were designed primarily to support competition and choice, PbR being a good example. The means to support collaboration and integration are much less well developed, or have been taken up on a limited

basis. Examples include the flexibilities to pool health and social care resources and the opportunities available to practice-based commissioners to use their control of budgets to provide more services in their practices.

Debate about incentives and financial flows in recent times has been dominated by suggestions on how the PbR tariff should be refined, whether by moving to normative pricing (based on best practice rather than average costs) or by unbundling the tariff to support new models of care. The experience reported in this paper suggests that tariff refinement is unlikely to be sufficient to support the emergence of integrated models of care where these are needed. This is because the tariff is designed primarily to pay for episodes of activity rather than to incentivise coordinated care along the care pathway. Experience in integrated systems in the US points to the need to move beyond the tariff and to explore ways in which capitated funding can be used to enable integration to develop.

In a related project, we have been studying ways in which PCTs have been seeking to commission integrated care and the incentives and financial flows that are being developed to support this. While much of this work is at an early stage and the ideas still under development, it is clear that a promising approach is for commissioners to use their leverage to provide one or more providers with a capitated budget for the delivery of a service in different settings, for example diabetes or end-of-life care. The budget is linked to agreed performance standards and may include incentives in the form of bonus payments to motivate providers to improve performance.

### GP budget-holding

**Our third proposal is that policy-makers should use GP commissioning to support new forms of care delivery and should, from the outset, actively encourage the involvement of secondary care clinicians alongside primary care teams.**

One of the ways of doing this is to use GP commissioning as a means for federations of practices to achieve closer integration of care. The rationale here is that in allocating capitated budgets to practices, policy-makers are overlaying responsibility for commissioning on to a strong system of primary care provision. This puts GP commissioners in the position of taking 'make or buy' decisions because they combine responsibility for commissioning and many elements of service provision – in other words, they are embryonic integrated care

organisations. The advantage of GP commissioning as a focus for capitated budgets compared with disease-based approaches is that it avoids the danger of cost-shifting.

The bigger prize on offer as GP commissioning is implemented is for secondary care clinicians to work alongside their colleagues in primary care in order to achieve closer integration. Examples include specialists based in hospitals whose work is increasingly moving to out-of-hospital settings, such as diabetologists and rheumatologists. As this happens, it is possible to envisage the emergence of new forms of multi-specialty commissioning and provision that start from GP commissioning but go beyond this particular mechanism to make a reality of care closer to home and over time to reduce reliance on hospital services (Ham, 2008c; Smith and others, 2009).

To link back to our earlier discussion, a key question that needs to be addressed is whether there should be competition between clinically integrated groups. In some parts of the country it would be neither feasible nor desirable for this to happen, for example in Cumbria, a large rural county, where it makes sense to work through natural communities or localities. In other parts of the country, particularly in densely populated urban areas, it is much easier to envisage how choice and competition could emerge. The issue then is whether the benefits of competition between overlapping clinically integrated groups would outweigh the costs and potential disadvantages, for example the loss of a focus on a single population.

Our view is that this is an empirical question that should be investigated through evaluations of the performance of clinically integrated groups in both competitive and non-competitive environments. While in principle the argument that integration combined with competition is likely to offer more benefits than integration on its own is persuasive, this argument needs to be tested in practice.

### Social care

**Our fourth proposal is that there should be renewed efforts to encourage NHS organisations and local authorities to use the flexibilities available to them to work in a more integrated way, including the integration of commissioning resources where appropriate.**

Just as secondary care clinicians need to work more closely with primary care teams, so too social care needs

to be at the heart of integrated care in the future. The experience of Torbay provides compelling evidence of the benefits of integrated health and social care teams with the ability to use resources flexibly and, yet, areas like Torbay remain the exception rather than the rule. At a time when social care funding is going to be even more constrained than NHS funding, the case for there to be much greater pooling of resources seems unanswerable, particularly in meeting the needs of frail and vulnerable people who require the expertise of social care professionals as well as the skills available in the NHS.

### Smarter regulation

**Our fifth proposal is that the activities of Monitor and CQC need to be aligned in support of integration with a particular emphasis on the regulation of organisations as part of local systems of care and on the experience of patients across the whole care pathway, including at key points of transition.**

As the role of a new economic regulator is explored, there will be an opportunity to examine how the incentive structure for foundation trusts might be adapted so that it is less focused on expanding activity and income. A new incentive structure might emphasise instead collaboration with primary care and community health service organisations, for example in achieving reductions in inappropriate admissions and improved local health outcomes. Given that some foundation trusts have assumed responsibility for community health services, it would seem timely to build into the foundation trust accountability regime a requirement to demonstrate improved integration of services and evidence of ability to work constructively with PCTs and other agencies in rising to the collective financial challenges faced by the NHS.

The CQC also needs to move beyond regulation of individual primary, social, mental health and hospital care providers, and find ways of assessing the quality and safety of care across different providers and sectors. It is the regulation of **care systems** that should be the concern of CQC, as such systems present ways of testing out the effectiveness of organisations as entities and within networks. This will be of particular importance in a policy context that encourages diversity of provision across statutory, charitable and private sectors.

As this happens, there is a need for more nuanced indicators of success for NHS providers, and in particular ones that transcend organisations and enable regulation of patient experience, health outcomes and financial

performance across care pathways or whole services. Patients experience care in a continuous manner and not in organisational 'chunks'. Patient-reported outcome measures need to focus on experience along the pathway and not simply experience of individual episodes of care.

### The need for system leadership

**Our sixth proposal is that the importance of system leadership at a local level should be recognised in the light of the proposed abolition of PCTs and the increasing role of GP commissioners.**

The experiences reported in this briefing paper underline the need for there to be leadership at a local level to facilitate the emergence of integrated care. In most of the case study sites, this leadership was provided by PCTs who worked with a range of stakeholders, including GPs, local authorities and NHS trusts, to develop new models of care and to overcome barriers to integration. The Coalition Government's plans envisage the abolition of PCTs in 2013, as GP commissioners take on responsibility for commissioning under the oversight of the proposed Independent Commissioning Board and its regional offices.

As these plans are worked out in more detail, it will be essential to clarify where responsibility for system leadership at a local level will rest. Arrangements such as those in Cumbria, where the clinical senate brings together GP leaders, may offer part of the answer; equally important will be the involvement of patients and the public. There must also be the capacity for NHS organisations to work with local authorities and other agencies in overseeing how the local system of care functions and to enable collaboration and networks of care to be supported in those areas of care where choice and competition are less relevant.

### The case for service integration

**Our seventh proposal is that policy-makers should articulate the case for change to service delivery and organisation with the support of professional bodies and patient groups, in order to communicate to the public the reasons for moving in the direction set out in this paper.**

Finally, there is a fundamental need to create a compelling narrative for NHS professionals and the public about the need for new and better integrated forms of care. Such care pathways and systems challenge long-held assumptions about what services are delivered and how and where professionals carry out their clinical



work. The forms of care being developed in Trafford, Cumbria, Torbay, Nottingham and Redbridge call for doctors, nurses and other professionals to work in significantly different ways, both in primary and secondary care.

It is for this reason that clinicians must be central to the design and commissioning of services; for only if they support and embrace such approaches will there be a

chance of widespread implementation. Organisations like the Royal College of Physicians, the Royal College of General Practitioners and the NHS Alliance have led the way in this regard (Royal College of Physicians and others, 2008; Smith and others, 2009) and we believe the arguments set out in this paper will be welcomed by many of the professional bodies in healthcare and by patient groups.

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## Conclusion

These seven practical proposals are offered as a linked package of suggestions that need to be acted on together. The need for both competition and collaboration to have a role to play in the future must be supported by giving serious attention to:

- incentives and financial flows
- the role of GP commissioning
- the involvement of secondary care clinicians and social care
- smarter regulation
- the development of a compelling narrative that makes the case for change.

New policy initiatives will also need to be tested in relation to their impact on integration to avoid them having adverse effects, as has happened with the Transforming Community Services policy (Department of Health, 2009).

It is imperative that the NHS of the future gives much more attention to the development of systems of care to further improve performance and to enable the efficiency challenge that has been laid down by the government to be met. Experience shows that changing policy direction takes time and requires the policies that are put in place to be coherent and aligned if they are to make a positive difference.

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