Integrated Healthcare: from aspiration to implementation

A response to the Next Stage Review

The NHS Alliance
Association of British Clinical Diabetologists
British Geriatrics Society
British Society for Rheumatology
British Thoracic Society (GPIAG and IMPRESS)
Primary Care Cardiovascular Society
Society for Endocrinology

nhsalliance

July 2008

Integrated Healthcare:
from aspiration to implementation

A response to the
Next Stage Review

Contents

Executive summary 2

Introduction 4

Defining integrated healthcare 4

The road to integrated healthcare 5

Clinical networks and patient pathways 6

Practice based commissioning 7

Necessary building blocks 7

Competition and patient choice 8

Conclusion and recommendations 9

References 11

Appendix one:
Contributors and participants at the
Integrated Healthcare Workshop, London, 19 June 200 12

Appendix two:
The organisations contributing to this paper 13

July 2008. NHS Alliance, Goodbody's Mill, Albert Road, Retford, DN22 6JD.
01777 869080. office@nhsalliance.org www.nhsalliance.org

Integrated Healthcare:
from aspiration to implementation

A response to the
Next Stage Review: our vision for primary and community care,
from:

The NHS Alliance
Association of British Clinical Diabetologists
British Geriatrics Society
British Society for Rheumatology
British Thoracic Society (GPIAG and IMPRESS)
Primary Care Cardiovascular Society
Society for Endocrinology

Executive summary

This brief paper summarises the multi-speciality consensus achieved at a recent workshop hosted by the NHS Alliance on the best way forward to integrate primary, community and specialist health care in England where clinically appropriate. In addition to a focus on the Integrated Care Organisation pilots, announced in the *Next Stage Review: our vision for primary and community care*, published by the Department of Health July 2008, it provides a wider perspective on integrated healthcare together with proposals to ensure successful implementation.

For many medical specialities, there is no clinical reason why at least some services should not be provided in community settings. Primary and community healthcare would be enhanced by the facility to work in collaboration with specialist colleagues. Integrated healthcare has the potential to:

- Make a considerable contribution to the quality agenda described in the Next Stage Review;
- Include social care partners in the commissioning, planning and implementation of services for those with long term conditions, where appropriate;
- Reduce costs, particularly for the treatment of long term disease, by avoiding clinical and administrative duplication, and by ensuring that interventions are timely and appropriate.

The concept of 'Teams Without Walls' is crucial to the success of integrated healthcare systems, especially for the increasing challenge of providing high quality and cost-effective healthcare for patients with long term medical conditions, including the elderly.

While the potential benefits of integrated healthcare are clear, not inconsiderable barriers to progress exist. These include inappropriate competition between primary and secondary care arising from the mechanisms of Payment by Results. At the same time, the collective expertise necessary for world class commissioning is too often lacking.

July 2008. NHS Alliance, Goodbody's Mill, Albert Road, Retford, DN22 6JD.
01777 869080. office@nhsalliance.org www.nhsalliance.org

There is a reluctance to engage practising clinicians in commissioning – including specialist doctors – based on the assumption that clinicians are necessarily on the wrong side of the provider/commissioner split. Yet clinical expertise is crucial to effective service specification and evaluation. Action will be needed to overcome these barriers.

Two routes to integrated healthcare are considered:

- The development of clinical networks; and
- Designing Integrated Care Organisations (ICOs) around clusters of mature Practice Based Commissioning Groups.

Necessary building blocks to success include:

- Funding and incentives;
- Efficient shared information systems;
- A range of professional education, training and employment options;
- The involvement and participation of all medical specialities relevant to the health needs of local populations;
- Patient participation at individual and collective levels
- Annual health reviews for patients with long term conditions.

Action at all levels of the NHS is recommended in order to put these building blocks in place and maximise the potential benefits of ICO pilots:

- The Department of Health needs to consider funding and incentives, and act to encourage Foundation and Acute Trusts to allow specialist clinicians to contribute to integrated healthcare by working in community settings.
- Strategic Health Authorities and PCTs should identify sites where there is a population need for integrated healthcare; encourage collaboration between secondary, community and primary care, and develop outcome and performance measures. In addition, PCTs should act to include practising clinicians in commissioning, in particular in service specification and evaluation.
- Foundation and Acute Trusts should enable specialist medical and nursing staff to work in community settings where clinically appropriate.
- Clinicians across primary, community and secondary healthcare should look beyond tribal boundaries and develop more collaborative ways of working, with the aims of improving the patient experience and delivering high quality services.

Introduction

Integrated care organisations (ICOs) are now firmly on the health policy agenda. They were first proposed by the NHS Alliance specialists' network almost a year ago, and the concept developed in their discussion paper: *Integrated healthcare services – the future of commissioning and provision of out of hospital healthcare in the NHS*[1], published January 2008.

The concept of integrated healthcare and clinical integration has been supported by medical Royal Colleges[2] and experts in health policy.[3,4,5] There is widespread agreement that integrating primary, community and secondary care has the potential to provide better patient outcomes at the same time as saving NHS money.

The new Primary Care Strategy: *NHS Next Stage Review – Our vision for primary and community care*[6], part of health minister Lord Darzi's review of the NHS, has announced that bids are to be invited to set up between ten and fifteen pilots where clinicians from primary, community and specialist services will be able to work on a collaborative basis, and with social care too.

In order to broaden the scope of debate and discussion about Integrated Healthcare Systems within the clinical community, NHS Alliance hosted a workshop on 19th June 2008. This explored the aspirations and concerns of senior clinicians, leaders of various medical specialty organisations and GP representatives about integrated healthcare systems. (See appendix 1 for a list of the participants at this workshop.)

This position statement is a summary of the multi-specialty consensus achieved at this workshop. In particular, integrated healthcare should:

- Have the primary aim of improving the health of the population;
- Focus on quality and clinical outcomes;
- Involve patients and clinicians early in the development process;
- Explore evidence based treatment pathways before considering organisational or structural changes;
- Foster an ethos of collaboration between primary, community and specialist clinicians so as to improve the patient experience of healthcare;
- Include social care partners in planning and implementation of services that support patients with long term conditions, those who are elderly and vulnerable patients with mental health problems.

Defining Integrated Healthcare

An integrated healthcare system, in its broadest sense, should aim to improve the long-term health status of the community. Ideally, it should be designed to function as a seamless system of services, where

information will flow freely between the components of the service and its individual clinicians. It would provide a basis for:

- Improving patient access and experience of the service
- Improving the quality of the service by a continuous process of patient and provider learning, and
- Containing costs by improving the delivery process and avoidance of clinical duplication.

Workshop participants agreed unanimously that, while the aims of Integrated Healthcare could be achieved through a range of different approaches, there is an urgent need of at least an overarching quality framework based upon the best available evidence. This would ensure that clinical outcomes are not adversely affected and, further, that outcomes are clearly measurable where local mechanisms are employed to realise integrated healthcare in early implementation sites.

The concept of 'Teams without Walls' was endorsed. The role of clinical teams (medical, nursing, therapies and other primary care professionals) was emphasised as crucial to the success of integrated healthcare systems, especially for the increasing challenge of providing high quality and cost-effective healthcare for patients with long term medical conditions.

An integrated healthcare system would also be able to develop more efficient links with partners in social care and voluntary support organisations, since patients with long term healthcare needs often required these services too.

The road to Integrated Healthcare

Clinicians have positive experience of delivering services designed along integrated care pathways and managed clinical networks. However there are many examples where even the best networks and pathways have failed, not because of lack of clinical commitment but because of unintended consequences of system reform, particularly those concerned with commissioning and Payment by Results.

The current Payment by Results(PBR) system based on a nationally set tariff ensures that patient activity in hospital based care remains the dominant mechanism for financial reward in NHS secondary care. This is changing, but too slowly. The ability to unbundle HRGs and to include clinical outcomes and patient experience is welcome. Nevertheless, rather than providing incentives for Acute and Foundation Trusts to collaborate with PCTs in shifting care outside hospitals into community settings, PBR mechanisms discourage co-operation and can even result in inappropriate competition (or at least adversarialism) across the health care system.

One consequence of this is that secondary care Trusts are often reluctant to permit their specialist clinicians to work in community settings in

collaboration with primary care colleagues and PCTs. It will be essential to overcome this barrier if integrated care is to succeed.

Meanwhile, commissioning, both at PCT and practice level, in its current form does not encourage specialists to participate in meaningful commissioning processes. The current trend towards distancing PCT provider services risks further propagation of this weakness, and may result in further separation of clinical provision from appropriate clinical input into commissioning decisions.

In practice, this means that the collective expertise necessary for world class commissioning is too often lacking. While PBC groups are most often GP-led with participation from other primary care clinicians, there remains a need to harness specialist clinical input from specialists – including doctors, nurses and others – in commissioning activity at all levels. They are all too often seen as being providers only with a vested interest in service provision.

While these arguments have some merit, multi-disciplinary engagement in commissioning is the only way forward if the NHS is to achieve cost-efficient and effective commissioning that serves patient and public needs. Indeed, clinical services cannot be properly commissioned in the absence of expert clinical knowledge.

Commissioning is everyone's business: managers, GPs, specialist doctors, nurses and other professionals together with patients and the public. It requires clinical and administrative knowledge, clear evidence, expertise and maturity. Provided robust governance systems are in place, there is no reason to exclude any one of the groups listed above and every reason to benefit from their collective experience.

It should not be forgotten that commissioning does not end with the definition of a service and the selection of a provider. It is a circular process, beginning with service specification, going through procurement and then evaluation – which should inform the next commissioning round. It is in specification and evaluation that clinicians have a particular role. Indeed, just as it is incumbent upon providers to demonstrate high quality provision, commissioners are responsible for ensuring they measure the right outcomes, not just those that are easy to measure.

Clinical networks and patient pathways

Clinical networks and patient pathways offer significant routes to clinical integration. However a number of enablers are urgently required, including:

- multi-specialty involvement in commissioning decisions;
- tariffs for community services so as to enable commissioning along patient pathways through primary and community care;
- shared funding between primary and secondary care so as to facilitate commissioning along patient pathways; and

- safeguards against aggressive commissioning which could fragment care pathways by offering increased volume of activity to selected providers.

Considerable care will be needed in developing tariffs for community services. Patients with co-morbidities need more than a single pathway. Interaction between – and integration across – specialities must be taken into account. This is one area where primary care and Practitioners with Special Interests (PwSIs) can play a crucial role in ensuring that integration is a reality for the patient and rather than a paper exercise.

Practice Based Commissioning

Practice Based Commissioning (PBC) provides an additional approach to achieving integration between primary, community and specialist healthcare.

While the Primary Care Strategy does not require a link between PBC and pilot Integrated Care Organisations, there is an inescapabe logic to designing ICOs around mature and innovative GP-led PBC Groups. Generally, it is anticipated that clusters of PBC Groups would come together with specialist doctors, nursing and other healthcare professionals, and explore close working relationships with social care partners. These prototype ICOs would commission and provide a range of primary, community and specialist healthcare services on behalf of the local population. They would be funded by a risk adjusted capitated budget. The number of PBC groups involved would vary from place to place according to population size, geography and other local factors.

PBC would require a level of maturity and inclusiveness to make this possible. However the benefits are worth considerable effort. Financial integration within this approach would provide incentives for each provider to be sensitised to overpriced, inappropriate or poor quality care, while constantly aiming to teach the patient both preventative healthcare and appropriate self care so as to reduce utilisation without compromising quality.

Necessary building blocks

The NHS Next Stage Review announced that proposals for integrated care pilots will be invited. However there is as yet no indication of what **funding and incentives** will be available. It is vital that PCTs and secondary care Trusts act in collaboration, and that neither finds itself financially disadvantaged by supporting these pilots or by releasing clinicians to take part.

Integrated information systems will be critical to support the free information flow essential for integrated healthcare. It is encouraging to see the commitment contained in the Next Stage Review to good quality and timely data for Practice Based Commissioning. This needs to be

extended to support integrated care. The sharing of information between the various components of the healthcare system is essential for:

- Improving clinical care through patient pathways;
- Enabling the monitoring of population healthcare needs, and
- Effective commissioning and contracting purposes.

Evidence supports the move to out of hospital healthcare where clinically appropriate[7,8]. However, in the long term, widespread adoption of this policy would be impossible without the availability of an appropriately skilled clinical workforce to manage it. A range of **training, job structure and employment options** would be necessary to enable specialists to carry out clinical and education roles in primary and community care without compromising their specialist skills. At the same time GPs should be supported to develop essential specialist skills which would enable them to share the outpatient type consultations and first contact care with specialist colleagues.

Success will depend on the involvement and participation of **all medical specialities** that are relevant to the health needs of local populations. ICOs based on one or two specialities would not be viable. The significant numbers of patients with co-morbidities makes that a necessary component.

Patient participation at individual and collective level should be the central consideration in designing integrated healthcare services. Patients should be involved throughout the process—defining priorities for services and care pathways, defining outcomes, monitoring new developments in services and advising priorities for spending any financial surplus that is earmarked for clinical services. Patient involvement in decision making is a potentially powerful tool for improving both the quality and cost-effectiveness of services.

Annual reviews for patients with long term conditions and stable disease is one approach that is supported by good clinical outcome data. It has also proved popular with patients. This involves collaboration between primary and specialist care to ensure ongoing monitoring of disease activity and progression, and to step up care where required. In this way, integrated care could ensure timely management of the overt and covert manifestations of disease and co-morbidity, resulting in improved patient outcomes and cost effectiveness.

Competition and patient choice

While Integrated Healthcare systems would demand a high level of collaboration between groups of clinicians – and between clinicians and managers – the economic era of competition cannot be ignored.

Clinicians have always been sensitive to patient choice. The challenge is to ensure that the choice menu is supported by evidence of clinical effectiveness and measurable clinical outcomes and is designed to meet

healthcare needs of the population in addition to measuring patient experience of the service.

Although adversarial competition between primary and secondary healthcare can never be good for the patients, it is reasonable to expect competition between integrated parts of the healthcare system through patient choice. This would encourage providers to develop collaborative arrangements to provide seamless care for contracting purposes. More importantly, it would ensure that GPs, specialists and other clinicians developed solid working relationships where all parties depended on each other for improved patient care and the resulting economic benefits.

Competition may present difficulties for the frail, elderly and vulnerable population, often with co-morbidities and mental health problems. Particular care is necessary to ensure their voice is heard. Unless that happens, competition through patient choice would have limited impact in practice.

Conclusions and recommendations

A high level of enthusiasm and commitment amongst clinicians for integrated healthcare services remains largely unexplored within the NHS. Yet it is clear that this approach would deliver a more clinically effective – and considerably more cost efficient – health service.

This commitment to improving patient care by developing a system of seamless healthcare requires a high level of support from policymakers and senior NHS managers to ensure that barriers to clinical integration are removed and clinical leadership is valued as the most effective route to designing a modern and sustainable health service for the 21st Century.

There are mainly two routes to integrated healthcare, each capable of adjustment to meet local needs:

- Forging clinical alliances across organisational boundaries through clinical networks and patient pathways; or
- Creating organisational – and hence financial – integration alongside clinical integration, building on the implementation of Practice Based Commissioning.

It is anticipated that both routes should be tested through the implementation of the Next Stage Review pilots. For both, success is more likely if the focus on clinical quality and patient involvement is maintained. Clinician and patient involvement at an early stage in the process is vital. Adequate attention to workforce, training and governance issues; common information systems, and evidence based evaluation of clinical and health economy outcomes will be equally crucial.

In some areas, population healthcare needs will require a range of collaborative mechanisms between health and social care commissioners and providers; integrated healthcare services are expected to interface much better with social care than a fragmented healthcare system.

July 2008. NHS Alliance, Goodbody's Mill, Albert Road, Retford, DN22 6JD.
01777 869080. office@nhsalliance.org www.nhsalliance.org

The benefits of the Integrated Care Organisation pilots would be maximised by prompt action:

1) By the Department of Health to:

- Establish clear arrangements for funding and incentives;
- Encourage secondary care Trusts to remove existing barriers that prevent specialist doctors and other clinicians from working in community settings.

2) By Strategic Health Authorities and Primary Care Trusts to:

- Identify appropriate pilot ICO sites where there is a need for integrated care dictated by the clinical needs of the local population;
- Enhance multi-discplinary commissioning by the involvement of specialist doctors, GPs and non-medical clinicians in service specification and evaluation;
- Enable clinicians to develop and lead integrated care services;
- Develop outcome quality measures and appropriate performance management for ICO pilots;
- Encourage collaboration between primary and community care services – including Practice Based Commissioning Groups – with local Foundation and Acute Trusts so as to build Teams Without Walls.

3) By Foundation and Acute Trusts to:

- Enable specialist doctors and nurses to provide services in community settings in collaboration with ICO pilots.

4) By secondary, primary and community care clinicians to:

- Collaborate together to create services that meet the needs of the local population;
- Look beyond professional self-preservation and focus on the patient experience in designing integrated healthcare services;
- Provide clinical leadership to enable integrated healthcare to be implemented successfully.

By adopting these measures, policy, development and implementation will be integrated at all levels within the NHS. That provides the ideal environment in which integrated healthcare can contribute effectively to the quality agenda set out in the Next Stage Review.

July 2008. NHS Alliance, Goodbody's Mill, Albert Road, Retford, DN22 6JD.
01777 869080. office@nhsalliance.org www.nhsalliance.org

References

1. Irani M. Integrated healthcare services: The future of commissioning and provision for out of hospital healthcare in the NHS. NHS Alliance, 2008

2. Teams without Walls: The value of medical innovation and leadership. Royal College of Physicians, London, 2008

   http://www.rcplondon.ac.uk/professional-Issues/Documents/teams-without-walls.pdf

3. Ham C. Clinically integrated systems: The next step in English health reform? London, The Nuffield Trust, 2007

4. Integrating NHS Care: Lessons from the front line. The Nuffield Trust, 2008

5. Ham C. Competition and Integration in the English National Health Service, BMJ 2008; 336: 805-807

6. NHS Next Stage Review: our vision for primary and community care. Department of Health, June 2008.

7. Gruen RL, Weeramanthri TS, Knight SE, Bailie RS. Specialist outreach clinics in primary care and rural hospital settings. The Cochrane database of Systematic Reviews 2004, Issue 1, Art No CD003798

8. Bowling A, Stramer K, Dickinson E at al. Evaluation of specialists' outreach clinics in general practice in England: process and acceptability to patients, specialists and general practitioners. J Epidemiol Community Health 1997; 51: 52-61

Appendix 1

Contributors to this paper and participants at the Integrated Healthcare Workshop, London, 19 June 2008

Organisation	Participant	Role
Association of British Clinical Diabetologists	Dr Peter Winocour	Chair ABCD & Consultant Diabetologist
	Prof Ken Shaw	Immediate past chair ABCD & Consultant Diabetologist
	Dr Shirine Boardman	Member ABCD; member NHS Alliance Specialists' Network, & Consultant Diabetologist
Association of British Neurologists	Dr Graham Venables	President & Consultant Neurologist
British Geriatrics Society	Prof Peter Crome	President & Consultant Geriatrician
British Society for Rheumatology	Dr Chris Deighton	Chairman BSR Clinical Affairs & Consultant Rheumatologist
British Thoracic Society (IMPRESS)	Dr Anthony Davison	IMPRESS co-chair & Consultant Respiratory Physician
NHS Alliance	Dr Michael Dixon	Chair & GP, Devon
	Mr Michael Sobanja	Chief Executive
	Dr Brian Fisher	PPI lead & GP, London
	Dr Minoo Irani	Specialists' Network Lead & Consultant Paediatrician
Primary Care Cardiovascular Society	Dr Terry McCormack	Chair & GP, Whitby
Society for Endocrinology	Prof John Wass	Chair & Prof of Endocrinology

Appendix 2

The organisations contributing to this paper

The NHS Alliance is a collaboration of clinicians, managers and board members who put patients first. It is the independent body that represents NHS primary care. Values based, it is the only organisation that brings together PCTs with GP practices, clinicians with managers and Board members – and NHS primary care with its patients. The Alliance membership and its hard working national executive is fully multi-professional. Its *Specialists in Primary Care Network* has taken the lead in promoting integrated healthcare and has produced a series of publications on the role of specialist doctors working in primary care.
www.nhsalliance.org

The Association of British Clinical Diabetologists (ABCD) represents the majority of diabetes consultants in the UK, along with training registrars. This professional organisation was established in 1997 with the principal objective of ensuring high quality care for all UK diabates patients.
www.diabetologists-abcd.org.uk

The British Geriatrics Society (BGS) is an association of doctors, nurses, therapists and scientists with a particular interest in the medical care of the frail older person and in promoting better health in old age. The BGS is the only professional association, in the United Kingdom, of doctors practising geriatric medicine.
www.bgs.org.uk

The British Society for Rheumatology is a medical society committed to advancing knowledge and practice in the field of rheumatology. We work at national and local level to promote high quality standards of care for people with these conditions.
www.rheumatology.org.uk/

IMPRESS: Improving and Integrating RESpiratory Services in the NHS. A joint initiative between the British Thoracic Society and the General Practice Airways Group (GPIAG), IMPRESS represents both primary and secondary care clinicians with an interest in respiratory disease. Our core beliefs are that integration of services along care pathways that stretch across primary and secondary care are necessary for high quality care, and that current policies endanger this integration. We also believe that patients need to be offered generalist and specialist care, particularly if they have co-morbidities, and that policies must acknowledge the value of both; provided at the right time in the right place.
www.impressresp.com/

The Primary Care Cardiovascular Society supports the advancement of cardiovascular society in the community. The PCCS membership is multidisciplinary and includes primary care and specialist doctors, primary care and specialist nurses and pharmacists as well as healthcare managers. *www.pccs.org.uk*

The Society for Endocrinology was set up in 1946 to promote the advance of endocriniology. The Society currently has around 1,900 members and is increasing its size and range of activities rapidly. It is the major endocrine society outside North America. Membership is open to anyone anywhere in the world working in an endocrine-related field, at any stage of their career. *www.endocrinology.org*