



Healthcare is not a simple, standardised service. For many people it should be a bespoke package of treatments, tailored to their own needs. These treatments may be provided by several different health and social care professionals, perhaps across different providers. For example, cancer patients may need to access specialist care centres far from home, but receive follow-up care at their local hospital. Those who suffer from multiple long-term conditions, including older people, could find themselves simultaneously under the care of a hospital consultant, a community nurse and a local dementia liaison service. A person, approaching the end of their life, may receive treatment from their GP, the local hospital, social care and charities.

Where this works well, we know the NHS can deliver world-class care. But we also know that too often patients can slip through the gaps, and experience delays in treatment, or be obliged to repeat information or tests when a provider changes. Improving this picture could bring better care to many people.

The Health and Social Care Act gives Monitor a responsibility to enable integrated care where this improves quality or efficiency, or reduces inequality. We take this responsibility very seriously and so we commissioned this research from Frontier Economics, the Nuffield Trust, the Kings Fund and Ernst & Young. We asked these advisers to help us define integrated care and identify the ways in which it might benefit patients. We also asked them to consider the different bodies that have a role to play in relation to integrated care. Finally, we asked for some initial recommendations on how Monitor could use its tools and powers to best enable the delivery of integrated care.

We believe there are significant opportunities to promote the interests of patients through the integration of care. Of course, this integration will take time to achieve and we have much to learn from examples of integration in this country and elsewhere. The research report suggests some early steps Monitor might take to enable improvements in the integration of care. These are contained in section 8 of the report, and range from recommendations around tariff design - a joint responsibility for Monitor and the NHS Commissioning Board - to suggestions for guidance which providers and commissioners might find helpful in understanding the relationship between integrated care and competition.

This research is only the first step in a journey that will see Monitor working with others to develop an integrated care work programme for the coming months and years, but it is an important first step for a regulator determined to set out its plans on the basis of sound evidence. So we felt it was important to publish this research, and to ask our stakeholders and partners to comment on it, and on the specific recommendations it makes, before we make any firm decisions about the scale and scope of Monitor's work on integrated care. We welcome your feedback.

A handwritten signature in black ink, reading "Adrian Masters". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Adrian Masters

Director of Strategy

How you can respond

Monitor welcomes comments on this report. In particular, we would like your views on the Recommendations for Monitor's role (set out in Chapter 8).

Please send your answers and/or general comments to integration@monitor-nhsft.gov.uk.

If you do not have internet or email access please write to: Integration, Monitor, 3rd Floor, Wellington House, 133-155 Waterloo Road, London, SE1 8UG.

This document was published on Monday 11 June 2012. Please submit your responses to the questions and any other comments that you have by **5pm on Friday 13 July 2012**.

Please note that we may use your details to contact you about your responses or to send you information about our future work. We do not intend to send responses to each individual respondent.

You can sign up to receive emails when we publish further information related to this report and on our new role in general, [here](#) on our website.



Enablers and barriers to integrated care and implications for Monitor

A report prepared for Monitor

May 2012

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1. Introduction

Introduction

A consortium, led by Frontier Economics, and including The King's Fund, The Nuffield Trust and Ernst & Young, was appointed by Monitor to consider issues relating to the delivery of integrated care. This report sets out the evidence, analysis and findings.

Objectives of this report

Under the Health and Social Care Act Monitor has a duty to “enable” integrated healthcare and integrated health and social care. In order to fulfil that duty Monitor must first gather and build on existing evidence. This report is intended as a first step in that direction.

A very wide-ranging discussion exists about integrated care. The existing discussion covers what is meant by integrated care, the evidence for its benefits and costs and commentary on who should do what to improve integrated care. This report attempts to synthesise as much of that discussion as possible and then comment on Monitor's role in relation to integrated care.

Our process

The consortium was deliberately assembled to represent a range of expertise and contributions to the discussion of integrated care. In addition to the expertise present in the consortium, we have consulted a very wide range of stakeholders through the course of the project and reviewed the key literature. We describe this process and the findings in the main body of this report.

Structure of this report

The report is structured as follows:

- Section 2 discusses our methods and process
- Section 3 sets out the context for this work
- Section 4 summarises what is meant by integrated care, and suggests a definition
- Section 5 describes the evidence for the benefits from integrated care
- Section 6 develops a framework for thinking about the barriers to integrated care
- Section 7 provides an overview of the range of regulatory and other institutions who will have a role in developing greater integration of care
- Section 8 makes recommendations about Monitor's role.

There are also two annexes. The first provides further case studies and the second sets out a selected bibliography of relevant literature.

2. Methods and process

We have adopted an approach that provides us with access to a very wide range of stakeholders and thinking on integrated care.

The discussion of integrated care spans:

- The definition of integrated care, including the spectrum of options from full mergers to informal networks and working arrangements
- Integrated care within healthcare services
- Integrated care across health and social care services
- A very wide range of models of integrated care, with distinct clinical and governance structures and payment regimes
- An equally large range of evaluation studies, ranging from anecdotal evidence to very formal evaluations.

Some of this experience has been captured in academic, journalistic and grey literature, some exists only in the notes and heads of those involved. We have tried to gain some insight into as much of this landscape as possible within the timeframe available for this project. In particular, we have:

- Undertaken a thorough literature survey, including snowball searches of references found in the initial papers that we examined
- Led three workshops involving stakeholders from across health and social care to discuss specific issues
- Arranged bilateral interviews and meetings to follow-up specific issues in more depth
- Taken advantage of the expertise across the team doing the work, within Monitor and present on the Steering Group for this project to scrutinise initial findings and suggest new areas to explore.

Despite this thorough approach, we were aware from the beginning that a relatively short (3 month) project would not be able to capture the full debate around integrated care. Therefore our approach also incorporates two further elements.

First, we have sought to place a framework around our thinking about integrated care. The framework, elaborated in the main report, consists of examining the evidence about integrated care in different areas of healthcare and social care (e.g. ongoing health management, planned episodic care, etc). We use the framework to illustrate where we have found evidence and where we have not. To the extent that we have not found evidence in important areas it may indicate the need for further work or may prompt someone with experience of that area to come forward with relevant evidence. We pick up these “gaps” in our final recommendations.

Second, this report closely follows the requirements placed on us to focus on the role of Monitor in “enabling” integrated care. Where relevant and where time permitted we discuss other institutions and their role. However, that is mainly in the context of describing the limits to Monitor’s role, rather than setting out what others might do themselves. In that respect, the evidence that was most of interest to us was evidence that shed light on how Monitor might act or questions or issues of relevance to Monitor’s future role. That served to narrow the scope of this report, albeit at the risk of not providing a fully comprehensive discussion of every issue.

The review of the literature considered formal and informal sources of information.

The King's Fund has published a comprehensive reading list relating to integrated care. It is available here: http://www.kingsfund.org.uk/library/reading_lists.html. It contains over 100 references across formal and informal literature relating to integrated care. It forms a good basis for an initial consideration of the issues. Our work also looked much more widely, based on literature searches in specialist databases (e.g. Econlit, Social Science Research Network), searches of grey literature and recommendations from people we interviewed or attended the workshops.

The literature review included:

- Investigating existing reviews of the literature, for example the major effort of Powell Davies et al who reviewed the entire literature to 2008 looking for evidence linking integrated care to health outcomes, measures of patient satisfaction and cost improvements
- Formal evaluations of pilots, including the Integrated Care Pilot programme being run in England
- International experience, including particularly work that investigated integrated care in Northern Ireland, Scotland, as well as the Commonwealth Fund's comparison of European, Australian, New Zealand and North American healthcare systems and the role of integrated care
- Informal newsletters and discussions of the development and experience of integrated care across England, such as the case studies produced by the NHS National End of Life Care Programme.

A selected list of references is available in Annexe 2, with specific sources also referred to throughout this paper.

We used three workshops to bring together stakeholders to consider specific issues in relation to integrated care. The workshops were supported by discussion papers that allowed the Steering Committee and others to comments on specific findings.

Workshop 1 – Definition of Integrated Care

- The first workshop considered the definition of integrated care
- It discussed in detail different features of integrated care (its type, intensity, level, reach, breadth and structure)
- It focused particularly on developing a patient-centred view of integrated care.

Workshop 2 – Benefits and barriers to integrated care

- The second workshop discussed in detail the range of benefits that can arise from integrated care and barriers that prevent their realisation
- Following the development of a patient-centred view of integrated care, this workshop focused particularly on certain areas of care (e.g. end of life, mental health, long term conditions, specialist care) and collected thoughts from experts in each area about the role, benefits and barriers to integrated care.

Workshop 3– Role of Monitor in enabling integrated care

- The third workshop took evidence from the first and second and from the ongoing work in the project to consider specifically the role of Monitor
- In doing so, it examined indirectly the role of other institutions (e.g. commissioners, Care Quality Commission, NHS Commissioning Board, NICE etc) in order to understand where Monitor fit in and its potential impact
- In considering the role of Monitor, the workshop examined in particular levers Monitor has as sector regulator (e.g. pricing, competition, licensing).

The workshops were attended by a cross-section of clinical and operational experts, NHS and local authorities commissioners, patient and public representatives and others.

Those attending the workshops included:

Patient representatives	Providers & their representatives	Commissioners and those supporting them	Regulatory and policy bodies
<ul style="list-style-type: none">● National Voices● Specialist institutions, such as Diabetes UK, Alzheimer's Society, Learning Disabilities Coalition, Macmillan Cancer Support● Social Care Institute for Excellence● London Health Programmes	<ul style="list-style-type: none">● NHS Trust, FTs● GPs● Residential and nursing home providers● Integrated Care organisations● Independent providers● Community providers● National Care Forum● FT Network	<ul style="list-style-type: none">● PCTs● Local Authorities● Strategic Health Authorities● NHS Confederation● Specific national programmes, such as NHS End of Life Care Programme	<ul style="list-style-type: none">● Monitor● Care Quality Commission● Cooperation and Competition Panel● NHS Commissioning Board● Department of Health,● Department of Communities and Local Government
			<p data-bbox="1580 1058 1783 1093"><i>And others...</i></p> <ul style="list-style-type: none">● Expert academics and researchers● Solicitors

We also held bilateral meetings with attendees at the workshops and others to follow up specific issues in detail

Bilateral meetings were held with specific institutions in order to:

- Follow up particular case studies and have a more detailed discussion about how particular areas of integrated care came about, their benefits and barriers
- Understand the wider institutional landscape and the role that different institutions currently play and the roles they anticipate playing in the future with the implementation of the Health and Social Care Act
- Get more detailed insight into particular international examples of cooperation and integrated care and their relevance for England
- Get feedback on specific areas of thinking as they have been developed through the course of the project.

We also presented to various internal forums at Monitor through the course of the project to receive feedback and thinking from experts in the areas of immediate concern to Monitor.

3. Context

This work stems from Monitor's new duty to enable integrated care.

Key messages

- Monitor has a duty to “enable” integrated care.
- This sits alongside other primary and secondary duties
- It also sits alongside similar (but distinct) duties on other bodies created under the Act..

New regulatory framework and Monitor's role

The Health and Social Care Act includes a duty on Monitor to “exercise its functions **with a view to enabling** the provision of **healthcare services** provided for the purposes of the NHS **to be provided in an integrated way**” where that would improve quality or efficiency and reduce inequalities with respect to either access or outcomes.

The Act further specifies that Monitor must exercise its functions to **enable NHS services to be integrated with the provision of health-related services or social care services**, under the same conditions of improving quality and reducing inequality.

The Act establishes other organisations that we discuss below.

Monitor

The Act sets up a new institution under the Monitor name that will become the sector regulator.

Monitor's sector regulator role would have a core duty to protect and promote patients' interests. This is to be done by “prompting a provision of health care services which:

- Is economic efficient and effective; and
- Maintains or improves the quality of the services.

The Act also includes a number of further, secondary duties. These include the duty set out above on Monitor to enable services (whether NHS or NHS and social care services) to be provided in an integrated way where that would:

- Improve quality or efficiency
- Reduce inequalities with respect to either access or outcomes.

In carrying out its duty to enable integrated care, Monitor must have regard to how the NHS Commissioning Board and clinical commissioning groups carry out their duties.

Monitor also has other secondary duties to prevent anti-competitive behaviour.

This sits alongside the role of other organisations.

NHS Commissioning Board

The Act also outlines the proposed new commissioning architecture for the NHS. The NHS Commissioning Board (NHSCB) will be established as an independent statutory body and it will take on some formal statutory accountabilities, including the establishment of clinical commissioning groups and the planning for 2013–14.

Among its duties is one to “secur[e] that that health services are provided in an integrated way” and that the “provision of health services is integrated with the provision of health-related services or social care services”, both subject to where it considers this would improve quality or reduce inequalities.

Health and Wellbeing Boards

Additionally, the Act establishes that a local authority must establish a Health and Wellbeing Board, with a membership of key stakeholders. The Board is to have the responsibility of delivering the local authority’s functions, of making a strategic needs assessment and a health and wellbeing strategy for the area. It will also have a duty to encourage “*persons who arrange for the provision of any health or social care services in that area to work in an integrated manner*”. The strategy is intended to contribute to this duty.

Other institutions

There are also a number of other existing institutions whose actions may directly or indirectly affect how integrated care moves forward. These include:

- Care Quality Commission (CQC) who oversee quality standards in health and social care
- National Institute for Health and Clinical Excellence (NICE): who publish best practice guides for the delivery of healthcare, develop guidelines, set quality standards for some areas of care, make drug recommendations and other activities.

Commissioners

Finally, individual commissioners – with the support of the NHSCB – will play a crucial role at a local level in determining how care will be delivered. The creation of Clinical Commissioning Groups and Clinical Senates under the Act create the organisations that will oversee the design of local healthcare services.

4. What is meant by
'integrated care'?

Integrated care seeks to improve quality and cost effectiveness of care; its organising principle is the patient or user's perspective.

Defining integrated care

“Integrated care” is a concept that has been defined in many different ways. A recent review of the literature on integrated care by Armitage *et al.* (2009) revealed some 175 definitions and concepts.

There is now a clear consensus that successful integrated care is primarily about patient experience, although all dimensions of quality and cost-effectiveness are relevant. As was stated in the Future Forum report: *integrate around the patient, not the system*. Integrated care is not about structures, organisations or pathways – it is about better outcomes for service users. National Voices also mentioned that the first principle of integrated care should be that it has to be organised around the needs of individuals. They use the term ‘person-centred’ in order to recognise that a) integrated care should meet the needs of people who may not continuously be NHS patients, and b) services are likely to be better for their users if the people who deliver them (staff) are also cared for.

Similarly, the Health Select Committee affirmed that integrated care is clearly not an end in itself. Rather, it is an essential tool to improve outcomes for individuals and communities. Moreover, the King’s Fund and Nuffield Trust report to DH stated that keeping the needs and perspectives of the individual at the heart of any discussion about integrated care is critical.

A definition of integrated care that combines the experiential dimension with that of cost and quality means there are potential benefits from integrated care for current and future service users, the public, providers and commissioners.

This means that a working definition of integrated care may be around the smoothness with which a patient or their representatives or carers can navigate the NHS and social care systems in order to meet their needs.

While this experiential dimension is the main component of integrated care, there are two further characteristics that form part of integrated care. Integrated care also aims to (1) deliver cost efficiency for the system; and (2) to improve clinical and wider quality outcomes.

In that respect three dimensions of what integrated care means can be identified:*

- *Integrated care seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well co-ordinated around their needs - it is by definition both 'patient-centred' and 'population-oriented'*
- *Integrated care is necessary for anyone for whom a lack of care co-ordination leads to an adverse impact on their care experiences and outcomes*
- *The patient or users perspective is the organising principle of service delivery*

Reducing gaps and duplication in service delivery may bring benefits across each of these three dimensions. However it is important to point out that more integrated care is not always the right answer to improving the patient’s experience and system efficiency. Integrated care also carries some risks, such as that of reducing competition, and incentives to improve quality.

*: These three dimensions are drawn from: Goodwin N Kodner D “Passing the ink-blot test: towards a standard definition of integrated care”, International Journal of Integrated Care, forthcoming

Work to consider how to measure the degree of integrated care provides further clarity to the definition and begins to suggest what might be monitored to determine success.

The service user perspective

A patient-centred view suggests possible measurements based primarily on patient experience. The view of National Voices is revealing in this aspect. According to them people want care, and where it comes from is secondary. Service users want to be listened to, to get good explanations from professionals, to have their questions answered, to share in decisions, and to be treated with empathy and compassion.

Below we present some statements patients and service users could make if care services were better joined up to illustrate what an integrated system would look like:

- There were no big gaps between seeing the doctor, going for tests and getting the results
- I was always kept informed about what the next steps would be
- I always knew who was the main person in charge of my care
- I know what is in my care plan. I know what to do if things change or go wrong
- When I was discharged from a service, there was a plan in place for what happened next. This was delivered without unnecessary delays
- If I moved across geographical boundaries I did not lose entitlements to care
- If I needed residential care, I had a choice of provision so that I could find one to meet my particular needs.

Care Transitions Measures

The Care Transitions Measure (CTM) was designed to assess the quality of care transitions. Its primary objective has been to develop a measure that is both substantively and methodologically consistent with the concept of patient-centeredness, and useful for the purpose of performance measurement and subsequent public reporting. CMT comprises a set of 15 questions that look into the time spent in hospital by the patient, leaving the hospital, follow-up with doctor, and the use of medications.

15 questions of the CTM. Patients should answer using the following categories: Strongly disagree, disagree, agree, strongly agree, don't know/don't remember/not applicable

1. Before I left the hospital, the staff and I agreed about clear health goals for me and how these would be reached.
2. The hospital staff took my preferences and those of my family or caregiver into account in deciding **what** my health care needs would be when I left the hospital.
3. The hospital staff took my preferences and those of my family or caregiver into account in deciding **where** my health care needs would be met when I left the hospital.
4. When I left the hospital, I had all the information I needed to be able to take care of myself.
5. When I left the hospital, I clearly understood how to manage my health.
6. When I left the hospital, I clearly understood the warning signs and symptoms I should watch for to monitor my health condition.

Work to consider how to measure the degree of integrated care provides further clarity to the definition and begins to suggest what might be monitored to determine success.

15 questions of the CTM (con't.)

7. When I left the hospital, I had a readable and easily understood written plan that described how all of my health care needs were going to be met
8. When I left the hospital, I had a good understanding of my health condition and what makes it better or worse
9. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health
10. When I left the hospital, I was confident that I knew what to do to manage my health
11. When I left the hospital, I was confident I could actually do the things I needed to do to take care of my health
12. When I left the hospital, I had a readable and easily understood written list of the appointments or tests I needed to complete within the next several weeks
13. When I left the hospital, I clearly understood the *purpose* for taking each of my medications
14. When I left the hospital, I clearly understood *how* to take each of my medications, including how much I should take and when
15. When I left the hospital, I clearly understood the possible *side effects* of each of my medications.

Source: The Care Transition Program

Even though these measures do have the potential to measure and monitor the success of integrated care, generally they are designed to be used in relation to single episodes of care, like consultation with a GP, or following a surgical treatment in hospital.

...and other attempts

Lloyds and Wait (2006) mentions that no agreed definitions of measures of integrated care exist.

Strandberg-Larsen and Krasnik (2009) discuss in detail how integrated healthcare delivery can be measured. They survey 24 methods that are available. However, five methods had a shared theoretical framework.

The authors compared all the available methods and concluded that: (i) almost all methods are based on a theoretical model; (ii) in most papers the concept being measured is clearly defined and all papers have described the level of analysis; (iii) structural and process aspects are often included in the measurement methods, while cultural aspects are rarely part of the methods; (iv) only one paper describes a method that measures integrated care compared to a perceived optimal target; (v) almost all the identified methods allow evaluators to quantify their findings but only a few allow the evaluator to calculate sums and mean ranks of a combined measure of integrated care; and (vi) while a test for some degree of internal validity has been described in 9 of 19 papers published in scientific journals (including the academic working paper), none has been thoroughly validated across different settings.

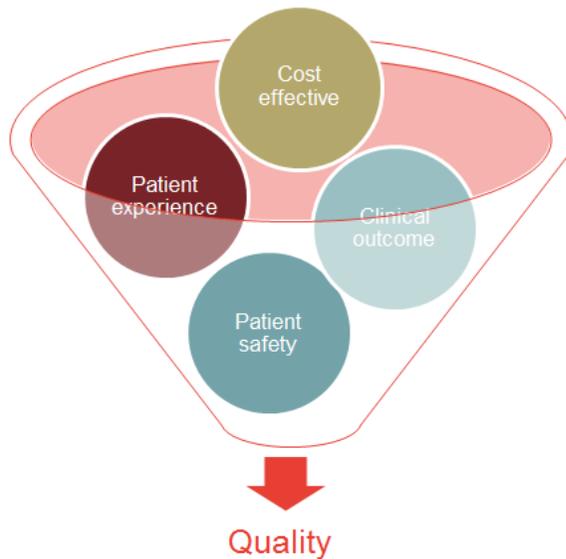
Nevertheless, the authors concluded that due to the relative newness of attempts to measure integrated care, established, off-the-shelf measures that suit any given purpose are not yet available.

5. Benefits of integrated care

A precise approach to benefits is confounded by difficulties measuring each element of quality; but...

Key messages

- Given the definition, benefits focus on patient experience, although there is also some evidence of positive impacts on clinical quality and, again in a few instances, on cost
- Overwhelmingly the evidence indicates that benefits depend on the specific design and approach to integrated care. There are no general rules, with the exception of some clinical outcomes that depend on scale.



Types of benefits of integrated care

Integrated Care should improve **quality** of health care. Quality can have several dimensions and interpretations. However, according to the evidence that we have reviewed, integrated care should improve quality based on four types of benefits:

Patient experience: according to the NHS Confederation, improving patient experience as a whole is complex. It involves looking at every aspect of how care is delivered, including how the patient comes into contact with the 'health system' in the first place.

Clinical outcome: based on Frommer et al. (1992), a clinical outcome is the "change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions". It could include lower admission and readmission rates, shorter hospital stay, reduction in the use of hospital beds, shorter recovery periods, etc.

Patient safety: the Department of Health's report on patient safety states that healthcare relies on a range of complex interactions between people, skills, technologies and drugs. Sometimes things can – and do – go wrong. While progress has been made, patient safety is not always given the same priority or status as other major issues such as reducing waiting times, implementing national service frameworks and achieving financial balance.

Cost efficiency: reducing the overall cost of health-related concerns is complicated by defining the scope of such concerns and the extent to which prevention, actual treatment and post-treatment recovery, rehabilitation and re-integration and ongoing support are included in the calculation of costs.

...the existing literature surveys provide some evidence for benefits in terms of patient experience, limited evidence in terms of clinical quality and very little information on cost impacts.

One of the few systematic studies to examine the results of integrated care in the dimensions discussed above (patient experience, clinical outcome and cost) was led by Powell Davies. Powell Davies et al (2008) conducted a literature review on the outcomes of integrated care, examining 80 studies on integrated care measures from Australia, New Zealand, UK, U.S., Canada and the Netherlands.

They assessed the effectiveness of each type of integrated care strategy as the proportion of studies using that strategy that measured health status, patient satisfaction or economic outcomes and reported a statistically significant positive result. Overall, they found that integrated care strategies were associated with improved health and/or patient' satisfaction in more than 50% of the studies. They found that data on economic outcomes were generally of poor quality and only 5 studies reported significant outcomes in this area. The table on the next page provides a summary of their findings.

Other studies have come to similar conclusions. Øvretveit (2011) provides a summary of the evidence in the literature on whether clinical coordination improves quality and saves money. The author concluded that the brief answer to the question 'Does clinical coordination improve quality and save money?' is 'Yes, it can.'

However, the results depend on which approach is used, how well it is implemented, and on features of the environment in which a provider is operating, including the financing system. Øvretveit found that:

- Poor quality as a result of under-coordination: there is considerable evidence, both from research and from different analyses of adverse events or poor-quality incidents, where the lack of coordination is the most common indirect or contributing cause of poor-quality outcomes
- Cost of under-coordination: there is less evidence about any costs of under-coordination. It is also less strong because most of the costing has been made in studies where the link between under coordination and patient outcomes is likely, but uncertain.

A summary of the work led by Powell Davies is provided below

Main objectives of intervention	Strategy type	Example of measure	Proportion of studies which found positive outcomes for health	Proportion of studies which found positive outcomes for patient satisfaction
Having structured relationships between service providers and with patients (33 studies)	Structural arrangement for coordination	Co-location, case management, multidisciplinary teams and assigning patients to a particular primary health care provider	19/29 (65.5%)	8/12 (66.7%)
Using structured arrangements for coordinating service provision between providers (37 studies)	Structural arrangement for coordination	Coordinated or joint consultation, shared assessments, and arrangements for priority access to another service	19/31 (61.3%)	4/12 (33.3%)
Using systems to support care coordination (47 studies)	Structural arrangement for coordination	Care plans, shared decision support, patient-held or shared records, shared information or communication systems, and a register of patients	23/38 (60.5%)	7/19 (36.8%)
Providing support for service providers (33 studies)	Coordination activities	Support/supervision for clinicians, training (joint or relating to collaboration), reminders, and arrangements for facilitating communication	16/28 (57.1%)	8/14 (57.1%)
Improving communication between service providers (56 studies)	Coordination activities	Case conferencing	26/47 (55.3%)	12/22 (54.5%)
Providing support for patients (19 studies)	Coordination activities	Education (joint or relating to sharing care). Reminders, and assistance in assessing primary health care providers	6/17 (35.3%)	3/6 (50%)

There is now a relatively well-known library of pilots and evaluations of different attempts at integrated care.

There is a growing number of evaluations of different attempts at integrated care. The National Integrated Care Pilots evaluation looks at 16 specific integrated care pilots. We discuss this evaluation in more detail on page 27. Alongside the national pilots, there is a growing number of specific examples. Torbay, summarised below, is one of the most widely quoted. There are many others. We illustrate experience in Brent below and provide an overview of other examples. More details can be found in Annexe 1.

Torbay - Description
<ul style="list-style-type: none">● The system is based on 5 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● Torbay integrates health and social care by sharing the functions of PCT and Council adult social services.
Benefits achieved
<ul style="list-style-type: none">● Patient experience: improved access to services, through single point of contact for multiple services and provided a more efficient assessment● Cost efficiency: reduced use of hospital beds, of residential and of nursing homes; increased use of home care services. The integrated management structure of Torbay saved approx. £250,000 in the first year. This money was used to develop services● Clinical outcomes: slow rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.

Brent Diabetes Care - Description
<ul style="list-style-type: none">● Aims at improving outcomes for people with diabetes through closer working among staff in hospitals, the community and general practice● An intermediate specialist care service acts as an interface between primary and secondary care, and cares for patients with poorly controlled diabetes or those recently discharged from hospital● A rapid access clinic treats those individuals who have minor issues but would otherwise have had to wait for a specialist appointment.
Benefits achieved
<ul style="list-style-type: none">● Cost efficiency: only patients with very complex needs are seen by specialists in secondary care● Patient experience: waiting times to see a specialist in Brent decreased from 20 to less than 4 weeks. The model removed service gaps in care whilst ensuring all people with diabetes received the care they need, when they needed it, from appropriately skilled staff in the community setting working in an integrated manner● Clinical outcome: 50% reduction in A&E attendances

It is possible to divide this into different types of healthcare: unplanned and planned episodic care...

Care cluster	Case study	Brief description	Benefits	Reference
Unplanned episode	Bolton diabetes network	Cross-organisation working: a community-based diabetes network supports the management of diabetic patients with severe and complex needs.	Patient experience: patients and staff have reported high satisfaction with the community-based service. Costs: in 2005/6, achieved the lowest number of hospital bed days per person with diabetes in the Greater Manchester area.	Irani, M. (2007) Dean, J. (2011)
	Knowsley PCT	Cardiovascular patient pathway integration: managed to award an integrated contract to deliver the full range of cardiovascular care, from prevention through to specialist treatment, to a specialist provider located outside the borough.	Cost: Savings in excess of £800,000. Patient experience: 90% of all early supported discharges had a full health and social care. Clinical outcome: unplanned A&E attendances reduced by 10%, 3,880 patients directed away from secondary care in the first 8 months of 2010/11, and shorter stay admissions for cardiology-related events have decreased by about 12%	Ham, C., Smith J., and Eastmure, E. (2011)
	NHS Kent	Out-of-hours service integration: a new integrated primary care out-of-hours and emergency primary care service in A&E. Emergency primary care clinicians were based in A&E 24 hours a day, 7 days a week, providing emergency primary.	Cost: £600,000 of activity was decommissioned from the acute hospitals for 2010/11. Patient experience: surveys indicated greater patient satisfaction, and a significant decrease in average time from arrival in A&E to assessment.	Ham, C., Smith J., and Eastmure, E. (2011)
Planned episode	Geisinger	Vertically integrated healthcare system: includes 3 acute sites and 37 community locations, plus virtual integration with more than 18,000 independent providers and community hospitals. The system benefits a wide range of patients, in particular those having surgery, whose pre and post operation care is bundled into the so-called ProvenCare pathways	Clinical outcome: Geisinger's ProvenCare pathways have reduced mortality, infection, readmission rates and length of stay.	Dentzer S. (2010). McCarthy D, et al. (2009). Shih A, et al. (2008).
	Veterans Health Administration (VA)	Cross-service integration: employs medical staff and owns and runs hospitals to manage the full range of care to veterans within a budget allocated by the federal government.	Clinical outcome: reduction of use of hospital bed days by 55%. Patient experience: In a comparison of the VA with other US systems, the VA scored higher for overall quality, long-term conditions and preventive.	Curry, N., and Ham, C. (2010).
	The Working Unit for Continuous Care (WUCC)	Cross-organisation working: a geriatric assessment unit organised within local hospitals. The WUCC aims to guarantee the discharge of older patients from hospital, by organizing and providing continuous and integrated health and social care.	Clinical outcome: avoidable hospital admissions have been reduced from 123 to 83 during 2002.	Lloyd, J., and Wait, S. (2006). Nesti, G., (2003).
	Principia Partners	Cross-service integration: 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.	Cost: savings of £900,000 on non-elective admissions through demand management in 08/09. Patient experience: extended hours of primary care services with weekend diagnostics and improved long term conditions management. Clinical outcome: a dynamic multi-professional collaboration.	Shortt, S. (2010).

...and more complex webs of care.

Care cluster	Case study	Brief description	Benefits	Reference
Ongoing health management – complex webs	Liverpool Care Pathway	Integration of multi-disciplinary care: across the range of inputs received by individuals in the final days and hours of life.	Patient experience: The LCP is designed to establish best-practice in the treatment of patients, regardless of setting. In particular, transferring methods and expertise from hospice to hospital.	The Marie Curie Palliative Care Institute Liverpool, http://www.mcpci.org.uk/index.htm
	Evercare	Individual case management: aims to improve care for people aged over 65 through introduction of case management administered by specially trained Advanced Practice Nurses (APNs). Case management was intended to support more appropriate care for the target population by bridging all key service providers (e.g. primary care, secondary care, social services).	Patient experience: changes in the ways in which people worked, Clinical outcome: altered medication to avoid adverse reactions, reduced fragmentation among services, improved patients' functional status, improved quality of life, and avoided hospital admissions. Costs: As APN became more experienced, GPs spent less time visiting patients and liaising with other services.	Goodwin N., and Smith, J. (2011). Boaden, R., et al. (2006).
Ongoing health management – complex webs	South East London Cancer Network	Cross-organisation working: The South East London network covers six PCTs, six acute trusts and a range of palliative care providers. All member organisations sign up to a common set of values around collaborative working, and agree to share good practice, information and experience.	Patient experience: The network seeks to provide seamless, multidisciplinary and multiagency care as close to a patient's home as is safe and cost-effective.	Curry, N., and Ham, C. (2010).
	NHS Trusts	Integration of health and social care: closer working between the NHS and local councils to coordinate health and social care, based on pooled budgets, lead commissioning; and some integrated provision. ¹	Patient experience: services are felt to be more accessible, flexible, building a foundation for future improvement. Costs and clinical outcomes: clear measures of effectiveness, e.g. in terms of cost and impact on health outcomes, are yet to be reported.	Miller, R., et al. (2011). Glendinnig, C. (2003).
	Wales chronic care	Cross-organisation working: a 'shared care' model of working between primary, community, secondary and social care	Clinical outcomes and costs: reduction in the total number of bed days for emergency admissions for chronic illness by 27%, 26% and 16.5% between 2007-2009	Goodwin N., and Smith, J. (2011).

1: this is just one example of integration between health and social care

Specific groups have also raised particular areas they perceive to be of benefit

The Royal College of General Practitioners launched the *RCGP Integration of Care Consultation* in 2011. The survey was not just opened to GPs and all comments were welcomed. One of the questions asked in the survey was:

What in your view are the three main benefits of integrated care?

Overall, they find that the main benefits from integrated care according to the respondents can be grouped into three categories:

- Better experience for patients
- Better experience for medical staff
- More efficient health system.

Table 1 below summarizes some of the responses that the RCGP received.

Responses to RCGP consultation

Institution	Main benefit 1	Main benefit 2	Main benefit 3
Alzheimer Society	Access services across health and social care	Tailor-made support to the individual	Support quality of life and reduce hospital admissions, as well as delaying entry into residential care
College of Optometrists, the Optical Conf. and LOCSU	Better care for patients	Better value for taxpayers	Increased job satisfaction for healthcare professionals
Royal Pharmaceutical Society	A seamless pathway that proactively promotes "wellness"	Right professional expertise used at the right point in the care pathway	Improved integration of public health and social care
Rare Disease UK	Improved experience of the NHS for patients and families	Improved health outcomes	Ensuring the most efficient use of NHS resources
Royal College of Paediatrics and Child Health	Improvement of patient experience	Improved quality of care	Greater efficiency
Royal College of Physicians of Edinburgh	Individual patient will be put at the centre of the healthcare system	Faster resolution of problems, and faster diagnosis and treatment	Effective discharge planning
Action on Hearing Loss	Better continuity of care	Better outcomes from interventions	Better patient experience and reduced inequalities

Source: Several responses to RCGP consultation

The Department of Health has also published a national evaluation of Integrated Care Pilots that draws broadly similar conclusions to previous studies.

The Department of Health initiated a two-year national programme of pilots to investigate the impact of providing integrated care. The national programme consisted of 16 specific initiatives, including:

- Structured care for dementia
- End-of-life care
- Older people at risk of admission
- Long term conditions
- Chronic obstructive pulmonary disease
- Care for diabetes
- Substance misuse.

The pilots were run by different providers from across the country. The evaluation used a combination of qualitative and quantitative approaches to assess the impacts of the particular models of integration that were proposed.

It is important to note that the precise approach to integrated care differed widely across the pilot sites. Most were based in primary care and most involved many partner organisations. However, apart from that they differed greatly in terms of how they addressed the issue of improving integrated services. This illustrates the challenge in prescribing what might be best practice in integrated care.

The National Evaluation came to four high level conclusions:

First, “integrated care comes in many shapes and sizes”. The various models dependent crucially on local circumstances. Most of the pilots focused on horizontal integration, rather than vertical integration.

Second, “staff reported improvements in care, most of which were process-related”. Staff generally believed these process improvements were leading to improvements in care but...

Third, “patients did not appear to share the sense of improvement”. The evaluation points out that this could be for a wide range of reasons, including the fact that it might be “too early to tell”. However, the authors of the evaluation believe that at least part of the explanation lies in the fact that changes were driven by the professionals rather than the users.

Fourth, “it is possible to reduce utilisation and associated costs of hospital care, but it seems to be very hard to reduce emergency admissions”. The evaluation documented reductions in some forms of admissions, but not emergency admissions.

In general the evaluation echoes other studies in finding that integrated care improves processes but that it is more difficult to document improvements in patient experience and cost.

Source: “National Evaluation of the Department of Health’s Integrated Care Pilots”, RAND Europe, Ernst & Young LLP, March 2012:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133124

6. Barriers to integrated care

Barriers to integrated care

Key messages

- There are a number of different types of barrier to integrated care
- The barriers to achieving improved patient experience vary in the different areas of health and social care because there are different structures and patient needs. **Therefore, it is useful to impose a framework over the discussion of barriers and potential actions to resolve them**
- Discussions with stakeholders – and specific case studies – highlight that there are a large number of different stakeholders in the system who can influence integrated care.

Types of barriers that exist

Drawing on existing literature and discussions with stakeholder we identified a number of barriers to integrated care. These are obstacles which can limit the effectiveness and smoothness of a patient's experience of care. Below we provide an overview of each of them.

- **Quality of IT and communication system:** having separate information systems with different formats for clinical documents and without a common access to service users' information makes integrated care more difficult (i.e. inter-operability).
- **Operating procedures between health and social care:** the absence of agreed procedures for the transfer of service users from health to social care can create delays and gaps in the pathway. Related issues include different performance frameworks, finance systems, planning and budgeting and means testing for social care services. This is typified by the poor uptake of single assessment templates.

- **Transfer of funds from one institution to another and tariff concerns:** unclear rules on which institution receives compensation for the treatment of the patient, or poorly-designed incentives on how the compensation is shared relative to the resources and responsibilities of the various providers can influence decisions to refer service users from one institution to another.
- **Risk aversion:** health professionals often work under heavy responsibilities and may be over-cautious e.g. when transferring their patients to another organisation, or collaborating with other providers.
- **Service users choosing alternative providers:** service users have freedom of choice regarding their elected place of care. However, this freedom can create deviations from the planned pathway of care and may cut across attempts to provide integrated care.
- **Governance:** it may be unclear who has ultimate clinical and/or organisational responsibility should anything go wrong. That may make individuals reluctant to discharge patients from their care into that of another clinician.
- **Clinical practice:** differences in how to treat patients between different institutions can mean a lack of consensus and unwillingness to transfer patients from one part of the system to another.
- **Cultural differences:** driven by some of the issues above but even also by management style, extent of delegation of authority, clarity over objectives and other factors that might affect willingness to share information, resources and service users.

A number of recent national reports have tried to summarise the barriers and make recommendations about how best to address them. First, the Future Forum report...

Existing work on integration of care

Three recent national reports have investigated barriers to integrated care and begun to examine how best to overcome them.

- Future Forum Report
- Kings Fund – Nuffield Trust report to DH
- Health Select Committee Report.

Future Forum Report

The FF report highlights the need for a more integrated care health system. However, the report also mentions that there are many barriers and disincentives to integrated care. The report provides principles and recommendations to policymakers to make integrated care happen.

- Integrate around the service user, not the system. Integrated care is not about structures, organisations or pathways – it is about better outcomes for service users.
- Make it easier for service users and carers to coordinate and navigate. This implies that every service user with long-term or complex needs has easy access to a named person or team who can act as the coordinating point for all of their care.
- Information is a key enabler of integrated care. Care records should be electronic and accessible at the point of care throughout the whole care journey, regardless of sector or provider.
- Health and wellbeing boards must become the crucible of the health and social care integration.

- You can only improve what you measure. A new generation of service user reported experience measures that evaluate service users' experiences across whole journeys of care, and within and between services are needed.
- Providers need to be able to work with each other to improve care. The NHS Commissioning Board should develop and test innovative approaches to incentivise care outside hospital settings.
- Clarify the rules on choice, competition and integrated care. Monitor and the NHS Commissioning Board should urgently support commissioners and providers to understand how competition, choice and integrated care can work together to improve services for users and communities.
- Freedom and flexibility to “get on and do”. Monitor and the NHS Commissioning Board need to jointly signal their methodology for establishing and policing prices to provide stability and predictability for commissioners and providers.
- Allow the funding to follow the patient. With the development of new funding models which support and incentivise integrated care.
- National level support for local leadership is essential to design and deliver integrated services for service users.
- Sharing best practice and breaking down barriers. The NHS Commissioning Board should make available a responsive facility providing advice and support to local commissioners on practical implementation issues of integrated care.

..next the Kings Fund – Nuffield Trust report...

Kings Fund – Nuffield Trust report to the Department of Health

This report is a contribution to the work of the NHS Future Forum and in support of the government's aim of placing integrated care at the heart of the programme of NHS reform. The aim of the report is to provide a framework for the Department of Health to help meet the challenge set out by the NHS Future Forum and support the development of integrated care .

It is stated that integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives. In order to achieve this, the report present useful recommendations to the DH, NHSCB and Monitor. They include:

- Provide a compelling and supporting narrative for integrated care. A strong case for integrated care is needed. This should be based on its potential to improve significantly the lives of millions of individuals with complex needs and of their carers.
 - Allow innovations in integrated care time to embed locally . This requires longer planning cycles.
 - Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies. It is essential that local commissioners are able to modify financial incentives in order to reward good outcomes.
 - Support commissioners in the development of new types of contracts with providers.
- Allow providers to take on financial risks and innovate as approaches to integrated care often work best when some of the responsibilities for commissioning services are given to those who deliver care .
 - Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework.
 - Ensure clarity on the interpretation of competition and integrated care rules. Similarly to what was said in the FF report, Monitor must adopt a proportionate approach that encourages both of these where this benefits patients and service users.
 - Set out a more nuanced interpretation of patient choice. Patient choice should be intrinsic to the provision of integrated care, however, it could also be a barrier to integrated care. Much more needs to be done to empower patients and users to make informed choices about their care and treatment .
 - Support programmes for leadership and organisational development like building leadership, investing in the development of information technology, support to commissioners on several topics, encouraging networks to share learning and ideas and deploying approaches that promote quality and consistency in care provision.
 - Evaluate the impact of integrated care. DH should outline how integrated care will be evaluated at a national level and emphasise the importance of appropriate evaluation at a local level.

...and finally a Health Select Committee report.

Health Select Committee report

The fourteenth report considers the issues facing the future of social care, and makes recommendations for consideration by the Government. The aim of the report is to paint a picture of how a fully integrated system could be achieved with more efficient use of resources and the improved outcomes that it could deliver.

The Committee recommends that, whilst integrated care is not an end in itself, it can be a very powerful tool to improve outcomes for older people and people with disabilities and long-term conditions. It is also an essential tool in delivering quality and efficiency in the public sector.

In order to achieve the level of integrated care that is required, a number of steps need to be taken:

- Real progress towards integrated care must begin with a clear commitment to create a fully integrated approach to commissioning. To that end, each area should establish a single commissioner who will bring together the different pots of money that are spent on older people.
 - The Care Trusts are the most integrated health and social care organisations. Alongside the provision of services to people, some Care Trusts also combine parts of the health and social care commissioning budgets into one statutory body. The committee recommends that the Government should allow communities to have the option of retaining Care Trusts as commissioners of health, housing and social care.
- The new outcomes frameworks for the NHS, public health and social care systems are crucial as they will become the primary means through which the Government will establish whether services are delivering better outcomes for the public.
 - The Government must face the issue of the existing "funding gap" in social care services i.e. the gap between the number of people who need care (and the level of their care need) versus the amount of money that is currently in the system to deal with their needs.

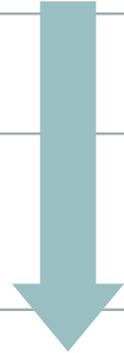
It is useful to consider the barriers to integrated care within a framework that takes account of the different types of care and how barriers vary across them.

Barriers that exist in different areas of care

The barriers identified above vary in their relevance to particular areas of care. This is because different areas of care exhibit different characteristics, such as the frequency and duration of a service user’s interaction with services, the complexity of coordination across different specialisms or organisations, and the extent of patient choice.

In the table below we provide a high-level mapping of the barriers that were identified as most important in different areas of care. This should not be interpreted as ruling out the role of any of the barriers identified above, but highlights those barriers which were emphasised most in these areas.

The rest of this section describes these findings in more detail.

Care cluster	Characteristics	Examples	Case studies	Barriers		
				Common	Specific	
Unplanned	Low	Urgent care; trauma; walk-in-centre	RAID psychiatry liaison		Sharing best practice	
Planned episodic		Elective, some diabetes	Productive Nottinghamshire	Culture	Coordination of pre- and post- care	
Ongoing health management – complex packages		Some diabetes; heart disease; end-of-life; dementia; rheumatology	Pennine MSK; North West London ICP; Personal budgets	Information	Accountability for service user Absence of “care coordinator”	
Ongoing health management – complex pathways		High	Cancer; some mental health conditions	CLIC Sargent	Pricing	Accountability for service user Patient choice and referrals
					Measuring integrated care	

Barriers to integrated care – general feedback

Stakeholder discussions in different areas of care

We held a number of discussions with stakeholders during the workshops and bilaterally. In these discussions we explored the relevance of different barriers to integrated care, and how these applied in different areas of care.

Common themes

A number of common themes emerged from these discussions:

- **Culture.** When integrating different parts of the health system, one important barrier is the cultural differences and differences in the management style among professionals.
- **Information.** Information sharing among organisations and to service users is a key barrier to successful integrated care. This also includes poorly-connected IT system.
- **Finance.** Reimbursement is sometimes problematic and can limit the benefits of integrated care, because the separate components of care are reimbursed separately. Moreover, within existing tariff models (particularly under PbR) there is limited scope to reimburse some activities (e.g. coordination).
- **Measures.** You can only improve what you can measure. Clear guidelines on how to measure integrated care is fundamental to foster the benefits of integrated care.
- **Accountability.** Reluctance to hand-over someone to another institution or care setting often arises because of concerns over where accountability lies for their ongoing care.

Common themes raised by stakeholders

“We – the NHS – are very paternalistic; **basic information is not shared** with patients and they are not supported through the system.” *(Diabetes discussion group)*

“For care which spans organisations, there is a **financial barrier** that savings created by one organisation may benefit a different organisation. Tariff doesn’t help here.”
(Mental Health discussion group)

“One factor complicating integrated care is **patient choice** itself. While it is desirable... their choice may go out of the integrated pathway that has been created.”
(End-of-life discussion group)

“There is a lack of **basic information** for patients ... there is no single entry point and **lots of hand-over points.**”
(Children discussion group)

Barriers to integrated care – stakeholder discussions and case studies

This section presents a summary of stakeholder discussions, and a set of case studies that highlight the different barriers that service users and medical staff face and that could prevent the successful development of integrated care.

The case studies are grouped into several categories:

- Unplanned episode (End-of-Life Care, Psychiatry Liaison)
- Planned episode (Diabetes Care, Children's Care)
- On-going health management – complex webs (Mental Health, Diabetes Care, End-of-Life Care)
- On-going health management – complex pathways (Cancer Care, End-of-Life Care)
- Cross cutting (Sunderland ICO).

As mentioned above, the reason for grouping the different case studies into areas of care is because it is likely that different areas of care exhibit different characteristics and problems when integrating health and social care.

Competition itself is often raised as a barrier to integrated care. We also look at two case studies which specifically address the potential competition issues raised by (some forms of) integrated care.

Overall, we have found that one of the most common barriers for successful integrated care is the lack of information sharing. Additionally, poor coordination between different actors through the care pathway aggravates the cost of non-integration, as accountability is not clearly specified.

Stakeholder discussions

- Barriers in mental health
- Barriers in cancer care
- Barriers in diabetes care
- Barriers in children's services
- Barriers in end-of-life care.

Case studies

- Psychiatry liaison service in Birmingham City Hospital (1)
- Productive Notts (2)
- Oldham Clinical Commissioning Group / Pennine MSK (3)
- North-West London integrated care pilot (3)
- Personal health budgets (3)
- Integrated care payments in the Netherlands (3)
- CLIC Sargent (4)
- Competition assessment of Integrated Care Organisation pilot in Sunderland (competition)
- Competition assessment of Transforming Community Services transactions (competition).

Barriers to integrated care – mental healthcare

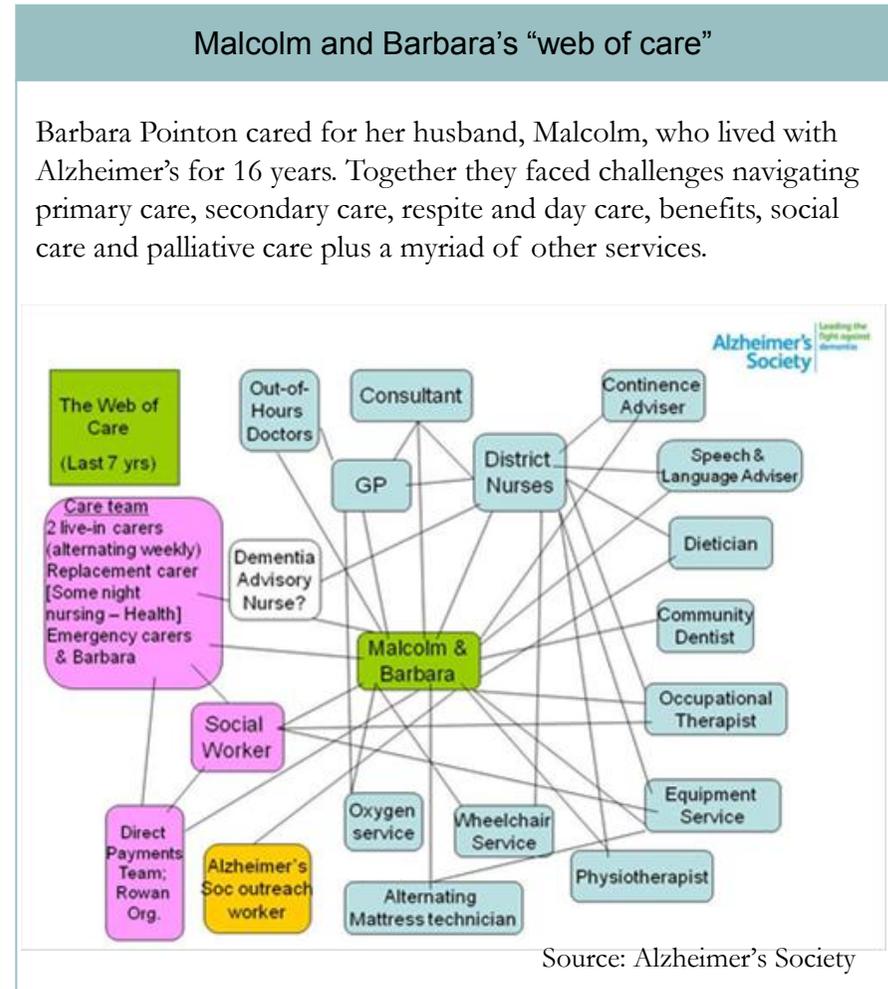
Barriers in mental health

Patients with mental health problems often have multiple needs which affect them in every area of their life. An individual suffering from Alzheimer's might experience over a dozen "touch-points" with the system. Moreover, patients (and often their carers) frequently need to navigate their way around the system themselves. These individuals often require both physical and mental health care.

According to the Alzheimer's Society, patients suffering from mental health problems, beyond a specialist response, need care and support from a range of different professionals, who need to communicate with each other to co-ordinate the care they receive. This is referred to as the "web of care". They mention that carers and people support needs to be tailor-made to the individual. Therefore, the integration of care could give commissioners the opportunity to procure a whole care package according to the needs and preferences of the person with Alzheimer's.

We believe that the main barriers for the care area of mental health are:

- **Information:** better information to the individuals, and better sharing between organisations is important.
- **Accountability** for patients is held by "everyone and no one" – needs to be one organisation, or a "broker".
- For care spanning organisations, there is a **financial barrier** created by the perceived risk that savings created by one organisation may benefit one other.
- **Cultural** barriers play a role which commissioning can help overcome or hinder.



Barriers to integrated care – cancer care

Barriers in cancer care

- Early Diagnosis and Urgent Referral

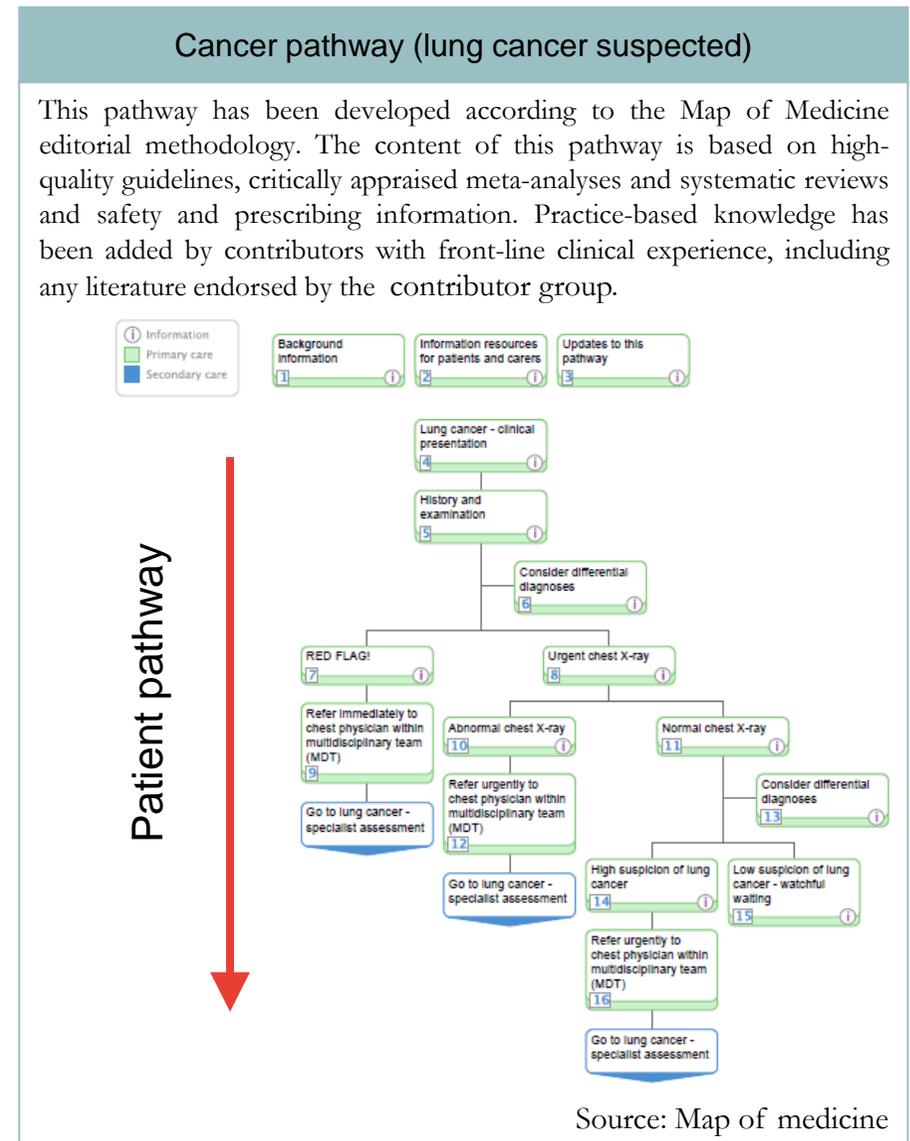
A cancer treatment may normally involve many different stages and medical staff involved. There is some evidence of late presentation of cancer to acute settings, potentially arising from late diagnosis by GPs. The barriers between primary and specialist care can work against an integrated service that diagnoses as early as possible.

- Information and data

One important barrier present in a complex pathway is information. This can be reflected by poorly-connected clinical information, IT system, or GPs picking up patients post-discharge often have no information on past treatment. Moreover, patients have very little information that they themselves can control.

- Continuity of care

Cancer patients often have a range of needs – including those relating to mental health and family and personal relationships, as well as immediate medical needs. Continuity of care across these different needs is hampered by difficulties sharing information and by clarity of accountability.



Barriers to integrated care – diabetes care

Barriers in diabetes care

- The main barrier to integrated care is information. In particular, the information flows between organisations, and to service users. In this sense, the following statement by the NHS is revealing:

“We – the NHS – are very paternalistic; basic information is not shared with patients and they are not supported through the system”.

This is reflected in the fact that patient records are not routinely shared between organisations.

- Payment by Results provides hospitals with some incentives to keep patients in hospital rather than treating them in the community.
- Alternative approaches to self-management and monitoring can be difficult to implement without sufficient GP and trust support. For example, difficulties creating “one-stop shops” for particular sets of co-morbidities. The lack of that support can create a barrier.
- Financial incentives are not strong enough e.g. within QOF, GP practices appear to be insufficiently rewarded for playing the role of coordinating care for patients.
- Finally, the existing variation in the quality of current practice and the scale of providers (many are too small to efficiently serve a population of diabetic patients) are also considered barrier.

How can organisations enable integrated care? Several measures could potentially mitigate these barriers. They may include: personal budgets, a role for a “care coordinator”, or federations of GP practices.

Diabetes UK – patient stories

Diabetes UK is the leading UK charity that cares for, connects with and campaigns on behalf of all people affected by and at risk of diabetes. They help people manage their diabetes effectively by providing information, advice and support. They also campaign for people with diabetes and with healthcare professionals to improve the quality of care across the UK’s health services. Furthermore, they fund pioneering research into care, cure and prevention for all types of diabetes.

The screenshot shows the Diabetes UK website with the following content:

- DIABETES UK** logo with the tagline **CARE. CONNECT. CAMPAIGN.**
- Navigation menu: Home, Guide to diabetes, How we help, Get involved, Research.
- Left sidebar menu: Type 1 diabetes, Type 2 diabetes, Children and d..., What type of d... do I have?, Life stages, All about diab..., Living with dia..., Food and recip..., Healthy lifestyl..., Monitoring you..., Treatments.
- Main content area:
 - Article 1: **80 years of insulin: diabetes hasn't stopped me doing anything I've wanted to**. Includes a quote: "I don't know life without diabetes: I was diagnosed with the condition as a baby in Canada, about 80 years ago, and was lucky enough to have been put under the care of Dr. Banting, one of the discoverers of insulin, who put me straight onto insulin injections. In those days, not diabetes so I say I was lucky because right time to have been treated by so treatments. At that time, we lived on a to the local hospital by kayak and it to Toronto hospital by train."
 - Article 2: **'My son was the bravest anyone could be in this situation'**. Includes a quote: "The 8th of November 2010. That was the day our whole world turned upside down. I'd walked into our doctors thinking my seven-year-old son had a urine infection as he'd started wetting the bed and would be given anti-biotics and that would be that." Below the quote is a photo of a woman and a young boy.

Source: Diabetes UK

Barriers to integrated care – beginning and end of life

Barriers in children's services

- Information is one of the main barriers to successful integrated care in the health care system. Currently there is a lack of information sharing between organisations which can delay effective diagnosis. Moreover, in the case of children's services it has been detected that there is often a lack of basic information for parents.
- Multiple agencies dealing with particular issues can create challenges for parents. This may be due to the fact that there is a shared role in diagnosis between parents, GPs, schools, specialists. This can potentially exacerbate the problem of lack of accountability for individual cases, because many people are involved. Additionally, in the case of children's services there is no single entry point and there exists many hand-over points..
- Other barriers to integrated care include the fact that there are cultural differences between health care and social care, and the voluntary sector. This can potentially limit the success of integrated care. There are risks that in the future with multiple commissioners for a single population that this can also restrain integrated care.

How can organisations enable integrated care? In the case of children's services, several measures can foster the benefits of integrated care. They could include a named caseworker who can help children and families to understand information and manage care. Also, providing better information about care, and choices, can enable service users to make better decisions. Finally, good commissioning can overcome possible fragmentation of multiple services

Barriers in end-of-life care

- Care involves multiple organisations across sectors. This is especially true for end-of-life care as it involves health and social care, domiciliary care, as well as voluntary and third sector institutions. One consequence of this is that there is potentially a lack of accountability for some service users because it is not clear who is responsible for the coordination of care.
- There is large variation in the extent of integrated care in different parts of the country in dealing with end-of-life care. In some areas acute, hospice, domiciliary and primary care are well coordinated but in many others they are not.
- We also spoke to people who think that reimbursement is sometimes problematic, because the separate components of care are reimbursed separately. Additionally, the high variation in costs per patient exacerbate this reimbursement problem because it increases the risks on providers where that is not captured through contracts.
- Choice of place of death can be difficult to implement because of fragmentation of providers and governance structures.

How organisations can enable integrated care in the case of end-of-life care and the types of care people want was set out systematically in the “End of Life Care Strategy” (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277) and subsequent work by National End of Life Care Programme (<http://www.endoflifecareforadults.nhs.uk/>)

Barriers to integrated care – psychiatry services

Case study: Psychiatry liaison service in Birmingham City Hospital

Patients with mental illness in the acute sector sometimes not identified. Birmingham and Solihull MH NHSFT launched rapid liaison service (RAID) at Birmingham City Hospital in December 2009. This multi-skilled team involves practitioners from various specialties, including substance misuse and old age psychiatry.

Benefits identified

Since the service was introduced, relevant patients have been identified, assessed and treated or referred much earlier than would have otherwise been the case.

Evidenced benefits include:

- Improved physical and mental health outcomes
- decreased length of stay and reduced readmissions
- Reduced healthcare costs for patients with unexplained symptoms
- Reduced psychological distress.

There has been an additional benefit of formal and informal training on mental health difficulties to acute staff throughout the hospital.

Barriers to integrated care

- Ability to distribute financial benefits – this is required to make the “business case” for individual organisations
- Clinical buy-in – redesigning care services to properly integrate psychiatry and medical services.

Psychiatry liaison service – impact assessment

The NHS Confederation published a briefing on liaison services and the RAID impact assessment in November 2011.

The key findings were:

- Liaison psychiatry services can save money as well as improve the health and well-being of patients
- Liaison psychiatry services are increasingly seen as an essential component of effective care in acute hospitals
- The RAID service in Birmingham is an approach which has the potential to save very significant amounts of money for the local health economy.



Source: NHS Confederation

The briefing recommends that “Commissioners should consider the value to be gained from taking a more integrated approach to commissioning physical and mental health services”.

Source: <http://www.bsmhft.nhs.uk>

Barriers to integration

Case study: CLIC Sargent

CLIC Sargent was formed in 2005 after a successful merger between CLIC and Sargent Cancer Care for Children. It is the UK's leading cancer charity for children and young people. CLIC Sargent tailors its support based on the needs of families.

CLIC Sargent offers help at different stages:

- During treatment, providing specialist nurses, play specialists, and accommodation for family
- In hospital and at home, offering specialist social care and support in the community, holidays, grants
- After treatment, helping survivors, supporting those bereaved.

CLIC Sargent believes that in the new integrated system proposed in the Bill, children and young people with complex needs will be using services commissioned at varying levels, cutting across health commissioners, local authorities, specialist education and children's social care support. For this reason it is fundamental that there is clarity on how the different levels fit together and who will be responsible for ensuring effective integration for each individual child.

Young people have emotional, psychological and educational needs as well as health needs. Achieving real integration of care therefore involves a range of other organizations beyond the NHS and adult social care.

There is also a specific challenge in meeting the needs of teenagers and young adults (TYAs). The model of age appropriate services is much less established for this group, and additional choice can complicate the pathway even further. This means integration is more difficult to

achieve because of the multiplicity of treatment and contact points. Similarly, the tariff system does not reflect age appropriate care and providers are not adequately reimbursed for work in this area.

CLIC Sargent believes that the best approach to integrating care is through a “key worker” for every child. This individual would assess the child's needs holistically and coordinate all of their care and support. This is expected to improve patient experience, and bring treatment closer to the patient's home. This would reduce the practical, financial and emotional burden that families face when their child is diagnosed with cancer, and facilitate efficient delivery of care.

Additionally, it should be ensured that clinical commissioning groups have access to specialist knowledge and advice. According to CLIC Sargent, Cancer Networks can play a significant role in integrating cancer services at a local level and in assisting with the delivery and implementation of the national cancer strategy.

Key barriers

- **Accountability.** In the current system, patients receive care from a range of different organizations, and no single organization is required to be accountable for the patient's needs as a whole.
- **Care coordination role.** Patients would be better able to manage the complex “web of care” they face if they were supported by a designated care coordinator or “key worker”.
- **Reimbursement.** Currently clinical guidance and best practice is not aligned to reimbursement e.g. the requirement to include social workers in multidisciplinary teams.

Source: interview with CLIC Sargent

It is also informative to look at how some of the those barriers have been overcome.

Alongside the barriers discussed in the previous slides, there are a number of examples of organisations or approaches that seek to overcome those barriers.

The subsequent pages provide case studies about:

- Collaborative working between commissioners, providers and Local Authorities (Productive Nottinghamshire)
- Clarifying accountability for care in order to provide integrated services (Oldham CCG)
- Creation of multi-disciplinary teams and resulting coordination of care (North-West London pilot)
- Trying to overcome existing ring fences around financing different parts of care (personal budgets and an example from The Netherlands)
- Integration of organisations and limits placed by competition concerns (Transforming Community Services).

An important point to emerge from these case studies is that a combinations of local commissioners and providers have come together in order to try to overcome some of the barriers identified. None of the cases required the intervention of a sector regulator, the definition of new currencies or other central measures. The next section takes these considerations and investigates the role of different institutions in facilitating integrated care before the final section then examines the specific role of Monitor.

Barriers to integration

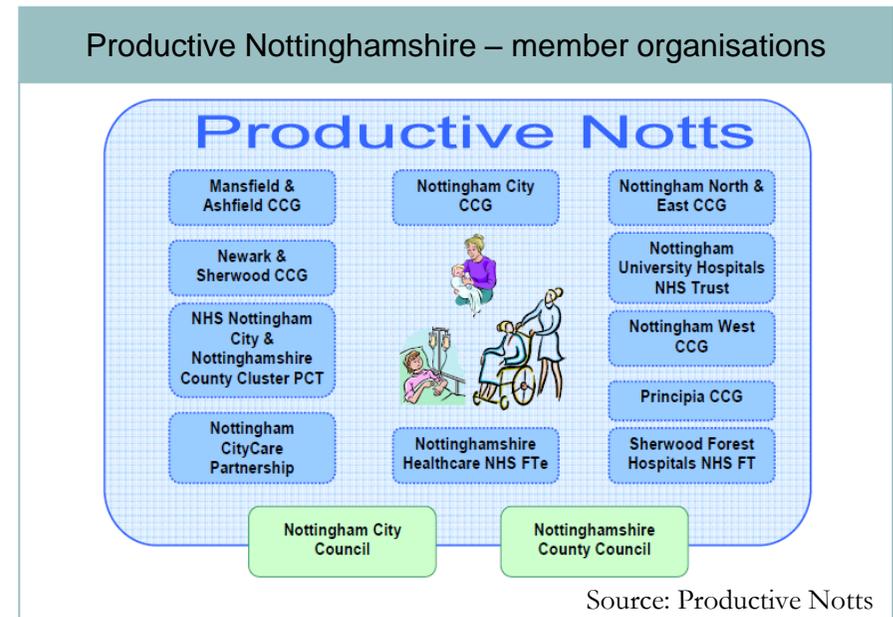
Case study: Productive Nottinghamshire

Productive Notts is an alliance of the NHS commissioner, provider and local authority organizations within Nottinghamshire. It was formed in 2009 to achieve quality, innovation, productivity improvements and prevention of ill health. A number of shared governance functions have been developed, including financial and risk management.

Productive Notts is a Board level commitment to work together on key projects that will best be delivered through a collaborative approach, aiming to improve quality and reduce the costs of services across health and social care in Nottinghamshire. Being part of Productive Notts enables organizations within the health and social care community to achieve together what they cannot achieve as individual organizations.

According to Productive Notts, the challenge is to save £425m in efficiency savings across participating organizations between 2011-12 and 2014-15 (£500m over the period 2010 to 2015). The programme has focused on four main objectives:

- Scaling – by working together as a community to apply best practice, learning and managing risks collectively
- Scoping – identifying the solutions to provide quality and productive services including seeking out innovation and ways to work better
- Co-ordinating – working together to combine learning, workforce and know-how, and deliver projects jointly
- Celebrating – achieving as a healthcare community means directing resources appropriately, taking waste out and ensuring that patients receive quality care.



The impact of Productive Notts has included:

- Organisations understanding the financial position across the health community and of each individual organization
- Organisations achieving higher levels of savings (£10m in 2011/12)
- Difficult issues being addressed (community hospitals, discharge)
- Regular dialogue between Chief Execs, Finance Directors, NEDs and workstream leads across the health community where previously there was no forum
- Increased collaboration across all organizations and with local authorities (procurement, estates, discharge).

Barriers to integration

During 2011-12 several objectives were achieved. They include:

- An improved pathway for patients at a community hospital resulting in a reduction in length of stay and delays to discharge
- Piloting a new discharge process for patients at Nottingham University Hospital and improvements to the discharge process
- Agreement of a case for change document in respect of two community hospitals
- Review of the potential for savings from back office functions and select areas for detailed scoping.

Having developed the culture and programme structure to deliver change across health and social care, Productive Notts will shift its focus from smaller transactional projects to fewer, larger transformational projects in 2012-13.

The plans for 2012-13 involve focussing on **frail older people**. This is one of the most significant areas where collaboration has been identified as needed to address complex demands. Specific clinical work streams include: (i) appropriate care of the frail older person; (ii) integrated systems for unplanned care; (iii) integrated care transfers; (iv) assistive technologies; and (v) accessing clinical information to support integrated care.

Additionally four non-clinical work streams were agreed for 2012-13. These non-clinical work streams provide support in transforming how clinical services are delivered, and include: (i) procurement; (ii) informatics; and (iii) estates.

During the last year, the programme has been associated with savings

of **£10m** and delivered transformation across a number of services, including community hospitals and acute hospital discharge.

Enablers to integration

- **Culture.** The initiatives (intentionally) represent a significant shift in existing ways of working. Clinical leadership has been crucial to effecting change, and giving organisations the “permission” to think in new ways. Board level commitment to work in a collaborative way must be shared across the provider and commissioning organisations. It has also been important to establishing accountability and allocation of risk (clinical and financial).
- **Information governance.** The legal rules surrounding data protection have created a constraint on effective integration. This has restricted sharing patient records to identify individual needs and improve care, and also the sharing of records to design better pathways and processes.
- **Reimbursement.** The savings identified by the programme do not accrue to a single organisations. As a result, savings which are created by one organisation within the programme may or may not “pay back” to that individual organisation. This barrier is compounded by the strict rules governing financial management of individual organizations, which mean a “system benefit” could be prevented by the impact on an individual organization’s accounts.
- **Competition and choice rules.** The management team have been careful to consider whether their collaborative approach to managing patient flows (for example via integrated care transfers) could represent anti-competitive behaviour. And in general, more clarity on where choice could/should be offered would be valuable.

Barriers to integrated care – Oldham Clinical Commissioning Group

Case study: Oldham Clinical Commissioning Group

The Oldham CCG brings together all GPs in the Oldham borough to act as a commissioning consortium. Members share the risk and assume accountability for the resources spent on caring for the population and for the quality of that care.

Organisational principles

Each of the health areas on which the initiative focuses will have a leading GP within the CCG, called a Clinical Director, with an assigned programme budget.

The initial budget areas are: mental health, musculoskeletal (bones and muscles), respiratory (breathing), ophthalmology (eyes), endocrinology (glands and hormones e.g. diabetes), vascular (heart) and cancer. The consortium will be responsible for deciding how around £275m of taxpayers' money is spent on Oldham people in these health areas.

The Clinical Director and an expert team will listen to patient views, look at clinical outcomes, examine costs and make sure services are of the highest quality.

In some areas one organisation may be put in charge of the care patients receive from different health professionals. In all cases the individual or organisation in charge of the programme budget will be accountable to the CCG for the cost and quality of the care patients receive.

Each of the GP practices involved in the project will be held to account to make sure they are doing the best for their patients.

An example of the Oldham model is running in musculoskeletal services. NHS Oldham has commissioned Pennine MSK Partnership Ltd, to provide a comprehensive service to the population of Oldham in Rheumatology, Orthopaedics and Chronic Pain. So, while GPs retain responsibility for the programme budget, Pennine acts as prime vendor and is accountable for delivering out of hospital specialist clinical provision.

Pennine MSK in Oldham

- Pennine MSK is a Primary Care based organisation commissioned by NHS Oldham to provide non admitted care in rheumatology, orthopaedics and chronic pain
- It is consultant led – provide 97% rheumatology and take patients to point of listing in Orthopaedics
- From May 2011, Pennine controls £23 million programme budget for MSK using prime vendor model
- Pennine has delivered 9,500 new referrals a year
- Patient Jacqueline Buckley, 66, from Royton, has osteoarthritis and rheumatoid arthritis. She said of Pennine:

“They look at me as a whole person, rather than someone who happens to have the condition they are treating. I can refer myself when I need to, or have consultations over the phone to check on my progress with any of the team. This is fantastic as it saves everyone time, yet if I need to be seen I can be. It also means we can save hospital time for those people who really do need to be seen there. I do feel much more involved in the management of my care than I have done in the past and I’m now nearly free of pain.”

Barriers to integrated care – North-West London Integrated Care Pilot

Case study: North-West London integrated care pilot

Organisations across both health and social care in North West London launched an Integrated Care Pilot in June 2011, which intends to integrate care for people who are aged over 75 or who have diabetes, from an initial population of 375,000. Eventually this model will be implemented across more practices in London.

It has been clinically led by GPs, hospital doctors and community care professionals to develop a way of providing highly coordinated and patient-centred care. Patients will see their GP work more closely with hospital doctors and social care teams (if necessary) to understand their needs and plan the best care.

The aims are to improve patient experience, ensure consistent use of guidelines to promote best practices, strengthen support care coordination across care pathways, reduce unwarranted variations or gaps in care, and prevent admissions to hospitals and nursing homes through management of long-term conditions within primary care settings. In the steady state the pilot aims to save 1 avoidable emergency admission per GP per month by providing more joined up planned care to patients in the pilot pathways.

A detailed evaluation of the pilot is ongoing. At this stage it is only the preliminary results which suggest that it may be meeting its aims.

Organisational principles

The multidisciplinary teams brings together GP, practice nurse, district nurse, social care worker, community matron and community mental health. This multi-professional group works within a system based on:

- Shared patient registry
- Risk stratification of patients through integrated IT system

- Clinical protocols and care packages
- Care plans
- Care conference among the various professionals involved
- Performance review of each case.

Key enablers

- Patients, users and carer engagement
- Joint governance through IMB with a shared performance and evaluation framework
- Aligned incentives through an innovative financial model
- Information sharing to access and analyse data in a timely fashion
- Organisation and culture development.

Example	
Joe, 85 years old, mild dementia, lives at home with his wife Annie. He develops a low-grade urine infection and as a result is increasingly confused and has reduced mobility.	Under the scheme, Joe would be identified as patient in need of an integrated care plan. His care plan would be available to all health care professionals involved in his care and in the ICP. Crucially he and his carer would have a copy of the care plan.

Barriers to integrated care – personal health budgets

Case study

A personal health budget (PHB) is an amount of money that is allocated to an individual to allow them to meet their health and well-being needs in a way that best suits them.

At the heart of a PHB is a care plan which sets out the individual's health (and social care) needs and sets out the desired outcomes, the amount of money in the budget and how this will be spent. The care plan has to be agreed between the individual and relevant professionals, before being checked and signed off by the NHS.

Pilot currently under way

PCTs were already able to offer PHBs that do not involve giving money directly to individuals. And since 2009, 75 approved PCTs, have been able to pilot direct payments. The pilot runs until 2012.

Subject to evaluation, by April 2014 everyone in receipt of NHS Continuing Healthcare will have a right to ask for a personal health budget, including a direct payment.

Principles of PHBs

- Everyone in a pilot area who is capable of managing a direct payment (either on their own or with assistance), including people with learning disabilities or mental health needs, is able to have one if they want one
- PHBs do not need to be spent on traditional NHS services (but must be spent on services which are legal and appropriate, and agreed in the individual's care plan).

Colin's personal budget

Colin is a full time carer for his father. Colin's father was diagnosed with a very rare form of dementia in 2008 and received a Personal Health Budget in 2009. Since receiving the budget his medication has been halved and he no longer requires the support of a consultant or care manager, due to the consistency in his day to day care. He still lives at home despite the complexity of his needs.

For a personal budget to be successful, Colin suggests there are three key enablers:

- Freedom and flexibility in being allowed to make choices around personal outcomes
- Equality of decision-making between the budget holder and practitioners
- Strong relationships between family and the budget holder.

Source: interview with Colin

- A nominated person can manage the PHB on an individual's behalf
- No one will ever be denied essential treatment as a result of having a personal budget
- PCTs to calculate the amount of money in a PHB. The amount allocated must meet the cost of the agreed care plan
- Care plans are subject to regular reviews to ensure that they are appropriate for meeting the individual's needs, and that the money is being spent in line with the care plan

Barriers to integrated care – reimbursement in The Netherlands

Case study: Integrated care payments in the Netherlands

In 2007, the Dutch minister of health introduced a bundled-payment approach for integrated chronic care, initially on an experimental basis with a focus on diabetes. In 2010, the concept was approved for nationwide implementation in 3 other chronic disease areas:

- Chronic obstructive pulmonary disease (COPD)
- Heart failure management
- Vascular risk management.

Principles

- Insurers pay a single fee to a contractor (the “care group”) to cover full range of chronic disease care for a fixed period
- A care group is a legal entity formed by multiple health care providers, who are often exclusively GPs
- The care group assumes both clinical and financial responsibility for all assigned patients in the care program. For the various components of care, the care group either delivers services itself or subcontracts with other care providers
- This way, health insurance companies contract care from care groups and care groups contract services from individual providers, be they GPs, specialists, dieticians, or laboratories
- The price for the bundle of services is freely negotiated by insurers and care groups, and the fees for the subcontracted care providers are freely negotiated by the care group and providers
- Services are provided free of charge to patients, since they are covered by the compulsory insurance package of Dutch citizens

Issues and evaluation

- The amounts that care groups were reimbursed for diabetes care bundles varies, reflecting the free negotiations between care groups and insurers and indicating that the care standards were interpreted by insurers in different ways
- Most care providers reported that the care delivery process improved thanks to the introduction of bundled payments and care groups - probably because care groups are fully responsible for the organisational arrangements
- The transparency of care increased, thanks to record-keeping obligations included in the contracts with individual care providers. These changes permitted more performance benchmarks to be set and provided information that can be used by care groups for quality-improvement
- It is too early to draw conclusions about the quality of care or the effects on the overall cost of care. No substantial changes in clinical outcome indicator as of today, risks have also been raised about the development of local monopolies.

Personal budgets in the Netherlands

Care users can opt for a personal budget to spend on the direct employment of carers who deliver care in their home. The Dutch system, beginning in 1995, allowed users to employ not only professional carers but also family members to care for them. Clients as well as carers were very happy with the budget and the number of users increases every year, shifting the Netherlands towards a demand-driven and market-oriented provision of care. More recently, personal budgets have been scaled back and apply across a more limited range of services because of government budget reductions.

Barriers to integrated care – Competition in The Netherlands

Example: Competition, integrated care and regulation in the Netherlands

In 2006, the Dutch health care system was reformed, with the creation of compulsory social insurance, funded jointly between the state, employers and individuals, to be delivered via competing health insurers, who purchase care from a range of providers (also private, not-for-profit) on behalf of patients

To regulate competition between insurers, the government created a health sector regulator, (the NZa), which functions alongside the general competition regulator (the NMa).

The NZa focuses on achieving efficiency, both in the short and long term, market transparency, freedom of choice, access to healthcare and quality. The interest of the consumer is central to all these goals. The aim is to achieve effective supervision in a light, proportional manner in which the benefits of regulation are weighted against costs.

Role of the health regulators

NMa issued guidance to health care providers on what forms of cooperation are desirable (for example cooperating over the care of an individual patient, sharing best practice, clinical pathways and research and development) and what forms potentially contravene competition law (such as agreements to carve up markets or agree prices).

The guidance clarifies ambiguities: for example IT systems that are interoperable to exchange clinical information are encouraged, while systems that exchange price information between competing providers are not.

NZa regulated competition amongst insurers and between providers.

In 2010, it extended its remit to regulating ‘care groups’ which were delivering care in the four chosen chronic disease areas.

NZa published guidance for the sector on competition and the integrated care groups (NMa 2010). The guidance (45 pages) provides a definition of a care group; explains when competition laws apply and how the regulator defines competition and a market. It describes the behaviours the law is designed to inhibit, i.e. collusion to drive up prices, price fixing, market sharing and the reduction in choice is a symptom of this. The guidance was widely consulted upon and was actively disseminated by the regulator to GPs across the Netherlands.

Regulator's tools

An array of legal instruments is available to NZa, including performance descriptions, cost allocation principles, smart price ceilings and supervisory rules concerning, for instance, deceptive advertising. In addition, the NZa can take action in individual cases, such as in the case of a provider that has a position of significant power on the market, if the competitive conditions are distorted.

Recent concerns of the regulator

Dutch healthcare regulator is currently more concerned with the potentially anti-competitive impact of horizontal rather than vertical mergers. The median number of GPs in care groups is 70, but some are much larger (eg 200 GPs) (Nab 2011) and the regulator is concerned that patients using these care groups are facing reduced choices while the groups negotiate higher prices with insurers

Barriers to integrated Care – Transforming Community Services

Case study: Competition assessment of Transforming Community Services transactions

Under the Transforming Community Services (TCS) initiative, PCTs were required to separate commissioning of services from provision by April 2011.

The Cooperation and Competition Panel (CCP) accepted 40 merger cases arising from this initiative. The CCP found that the majority of TCS mergers it assessed were consistent with the Principles and Rules for Cooperation and Competition.

However, the CCP identified “particular concerns in respect of patient choice and competition (most notably issues concerning provider consolidation and the primacy of the GP gatekeeper function).”

Remedies to limit adverse effect on choice and competition

The CCP determined that in order for further TCS mergers to be approved, the merging organisations would need to provide certain written assurances. These centre on the requirement to provide patients with information to allow them to choose between providers at key referral points, and for the potential impact on choice and competition to be monitored post-merger (see boxes).

These highlight the importance of organising integrated care in a way that is as consistent as possible with competition so that benefits to patients can be maximised.

Commissioner assurances required for transaction

The commissioner (PCT) must give assurances that post-transaction they will monitor:

- Patient attendance patterns
- Patient referral patterns
- Patient experience information.

If there is any indication that choice is not being offered appropriately, contract improvement mechanisms or termination should be imposed.

Specific reference is made in the assurance to integrated care: “As new integrated pathways are developed, the PCT will include in its specification the point at which choice must be offered and who will offer the choice. This will almost always be through the GP.”

Provider assurances required for transaction

The provider must give assurances that post-transaction they will:

- Implement Choose and Book to ensure patient choice
- Provide information to patients when referring them, which makes clear the choices they have available.

Source: CCP

http://www.ccp-panel.org.uk/content/cases/Cases_under_the_Transforming_CS_Prioritisation_procedure/110310_TCS_Prioritisation_Statement.pdf

7. Stakeholders involved in enabling integrated care

Stakeholders involved in enabling integrated care

Key messages

- Monitor is just one actor in the system
- Commissioners are likely to play a lead role in achieving integrated care
- To remove any of the barriers identified by this project will require the involvement of multiple stakeholders working in parallel.

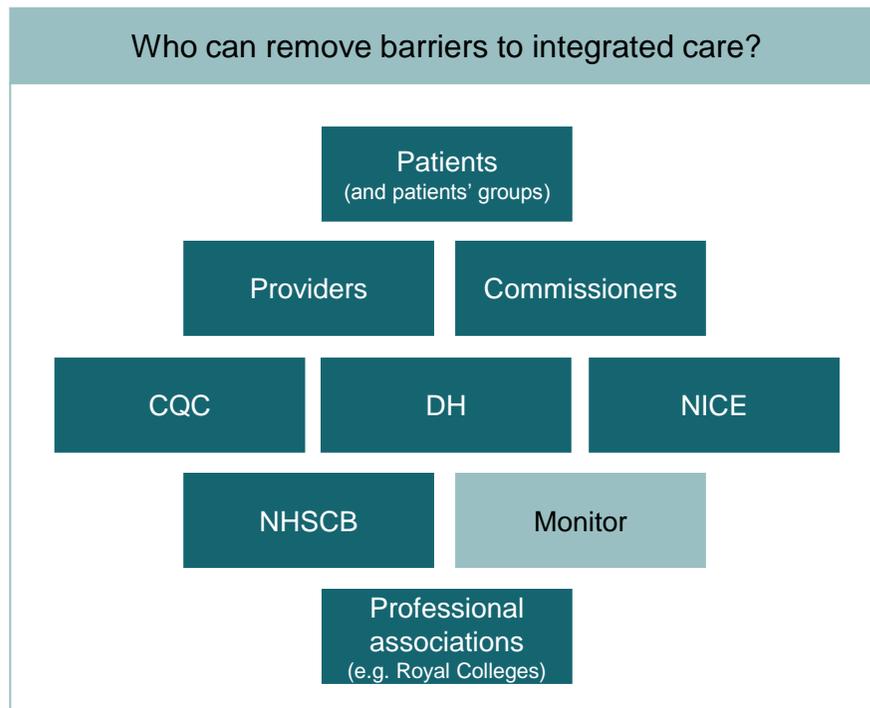
Who can remove these barriers?

Various bodies and individuals will play a role in achieving integrated care. These include:

- Providers themselves
- Commissioners (including the National Commissioning Board)
- Health and Wellbeing Boards
- Service users (including patients' groups such as Healthwatch)
- Regulatory and policy bodies (DH, Monitor, CQC, NICE)
- Professional associations (Royal Colleges, BMA etc.)

Our discussions with stakeholders, literature review, and case study evidence have suggested that commissioners should take a lead role by commissioning the integrated services they think are most appropriate for their local populations.

Who can remove barriers to integrated care?



The barriers identified through this project suggest that integrated care will require new ways of working (and culture), including an emphasis on information-sharing and accountability. It may also require specific innovations to coordinate care on behalf of individuals.

These developments will have to involve a change in provider behaviour, enforced by strong commissioning and contract management. They will be supported by national rules and guidance, sharing best practice, and specific developments in measurement and reimbursement of integrated care.

Stakeholders involved in enabling integrated care

The table below shows a summary of the various actions / roles that might be required by different stakeholders in order to remove the barriers to integrated care identified in the previous section. The table below is a simplification in so far as each institution may act differently in different areas of care. Page 33 describes different areas of care: the different barriers and characteristics that apply to each. Appropriate actions are likely to be different in each of these areas.

Barrier	Providers	NHS Commissioning Board	CCGs	Monitor	Others
Culture	Break down silos Standardise practices	Encourage multi disciplinary teams	Work with social care commissioners to join up contracting	Requirements on collaboration	LAs, CCGs, HWBs* to consider how best bridge health-social care DH through Mandate and links to Social Care
Information	Increase interoperability Increase user contact	Refine outcomes framework	Contractual requirement for information-sharing	Requirements on information-sharing	DH to facilitate systems improvement and refine data governance rules
Pricing	Develop risk sharing agreements that include social care	Currencies for integrated care payments	Innovative commissioning for integrated services	Pricing for integrated care models	NICE to provide guidance on best practice approaches
Measurement	Measure degree of integrated care	Develop metrics / framework of measurement	Manage performance against metrics	Reserve ability to publish information to support integrated care	NICE to advise on measurement in primary care
Lack coordination	Consider identifying key worker	Currencies for coordination role	Include coordination role in contracts	Consider costing coordination role and including in pricing	Healthwatch, HWBs* to assess value to users
Accountability	Develop clarity over clinical responsibilities	Provide model contract for lead providers	Contract with lead provider with freedom around delivery model		
Patient choice		Clarify contracting to be neutral to location of care	Ensure contracts not barrier to choice of location of care	Clarify role of benefits cases where choice and integrated care are not consistent	DH in its role relating to NHS Constitution
Spreading best practice	Champion successes Develop examples of successful integrated care	Repository for pilot evaluations	Manage performance through benchmarking	Pricing to signal best practice	Healthwatch and HWBs* to highlight success and failure

8. Recommendations for Monitor's role

Recommendations for Monitor's role

Key messages

- Monitor's role in enabling the provision of integrated care will cut across its responsibilities for:
 - pricing
 - competition
 - continuity of service
 - licensing
 - and its general corporate functions.
- In each area there are some actions that can be taken immediately and others that may be taken over time depending on how the sector and levels of integrated care evolve
- This section describes the key questions that Monitor will need to answer in each of these areas (through its ongoing programme of work) to fulfil its duties in enabling integrated care.

The role of Monitor

The table in the previous section illustrates that Monitor is one of a number of stakeholders influencing integration of care. Under the Act, Monitor has a duty to “*exercise its functions with a view to enabling healthcare services for the purposes of the NHS to be provided in an integrated way...*” (62(4)).

The NHS Commissioning Board, in contrast, has a duty to promote integration and specifically to “*exercise its functions with a view to*

securing that health services are provided in an integrated way...” (13N). Monitor may want to consider the extent to which the different language in the Act reflects a different strategic role with respect to integrated care. The rest of this section provides recommendations relating specifically to the regulatory levers that Monitor can use. Cutting across this is a wider decision about the strategic role for Monitor.

Determining Monitor's actions

Later in this section we identify possible actions for Monitor to take which are specific to its workstreams. We divide these actions into two categories:

- **Actions Monitor could, and should take now.** these largely consist of trying to ensure that Monitor's actions do not create barriers to integrated care.
- **Actions Monitor may want to take in the future:** these are necessarily more speculative for two reasons. First, they depend on how proactive Monitor would like to be as a thought leader in this area. That is a decision for the Board. Second, whether the actions are appropriate in 3 – 5 years will depend on how the sector evolves over that period.

There is a general consensus that Monitor can take a number of enabling actions in the near future. The speed with which Monitor chooses to take other, more direct measures is likely to be influenced by how Monitor's role as a sector regulator develops.

Recommendation: Monitor should take the enabling actions described in this section. It should consider whether it is desirable to be more proactive in some areas in light of the evidence presented.

Recommendations for Monitor's role - pricing

Possible issues for Monitor's pricing workstream

Discussions with stakeholders raised a number of issues in relation to pricing and reimbursement. These centre around creating the right incentives and support for providers and commissioners to develop integrated care models.

Creating incentives for integrated care could be achieved in a number of ways. For example, stakeholder discussions repeatedly cited the importance of a “care coordinator” in integrating services for individuals; but within existing tariff models (particularly under PbR) there is limited scope to reimburse these activities. This was noted as being particularly valuable for individuals receiving ongoing treatment from many different organisations, who often find it hard to navigate their way around the “web of care” they are faced with.

Support for integrated care could be achieved by addressing a related problem: the financial benefits of integrated care are often shared between providers. Consequently, providing services such as a “care coordinator” is not usually in the financial interests of any one organisation. These issues were also raised in case studies, such as the Birmingham psychiatry liaison service.

Currently, where integrated care has been achieved it is often “in spite of” the constraints above. Organisations have innovated in order to redistribute reimbursement between them, but have had to do so in their own way (potentially creating significant duplication of effort across the country). Examples include the Oldham CCG commissioning of musculoskeletal services and the North-West London integrated care pilot.

A key strategic question for Monitor (jointly with the NHS Commissioning Board) in responding to these challenges is how flexible it intends to be in its pricing structure.

- **Structured.** Monitor could choose to set a rigid national pricing framework, within which any exceptions at local level would need to be justified and approved, through the local variations and modification rules.
- **Flexible.** Monitor could allow much more flexibility at local level to determine pricing (and potentially also service specifications and currencies), stepping in to resolve complaints or to target particular areas of care for improvement. Under this flexible approach, Monitor would have to satisfy itself that it was acting in accordance with its duties the national tariff (para 116 of the Act) and particularly around flexibility of prices away from the nationally determined price.

Alongside this strategic question, the examples above raise a number of possible issues for Monitor's pricing workstream to consider. In particular, this includes:

- Which integration initiatives to prioritise when Monitor develops its first national tariff document
- Use of alternative approaches to tariffs in order to enable integration of care
- The type of cost and other information required to ensure future tariffs do enable integrated care.

Recommendations - pricing

We recommend that...

Monitor should ...

... ensure that **the new strategy for acute tariffs considers how tariffs can best be neutral to setting** and facilitate service provision across administrative boundaries and/or settings of care.

...ensure **cost information is collected in a way that allows pricing to reflect costs associated with integrated care** (e.g. multi-disciplinary team meetings and coordination) (*see recommendations around 'licensing'*)

In deciding whether to implement these recommendations, Monitor will need to consider:

- whether to prioritise these measures given its other priorities
- the impact of alternative tariffs on its duty to deliver economic, efficient and effective health service

Monitor could ...

...**work closely with the NHS Commissioning Board** to ensure **currencies** are being developed in a way that is consistent with its thinking on how tariffs should develop. This should include specific meetings that consider whether particular currencies, and subsequent tariffs, are likely to be a barrier or enabler to integrated care services for particular service users (e.g. older patients).

...**prioritise the more widespread consideration of alternative tariffs** for certain user groups, such as the older people or diabetics. Such tariffs (eg linked to quality premiums, outcome-based tariffs, year-of-care, tariffs for coordination) should be used as a proactive measure to enable integrated care.

Recommendations for Monitor's role – competition issues

Possible issues for Monitor's competition workstream

Based on discussions with Monitor, and other stakeholders, it is not clear that Monitor's duties with respect to integrated care and competition will necessarily be in conflict with each other.

In many circumstances they might actually reinforce each other. For instance, where greater integrated care can be commissioned directly (e.g. a contractual requirement to offer service users a single point of contact for multiple services), providers may be able to compete to deliver this outcome effectively and efficiently. One enabler could be contracts of appropriate length, which allow providers to recover overhead/capital costs associated with delivering new forms of integrated care.

However, there may be a tension between integrated care and competition in specific areas. For example, the CCP has raised competition concerns in relation to patient choice under the Principles and Rules of Cooperation and Competition that may arise from structural vertical integration when safeguards are not put in place.

- In the Transforming Community Services transactions, acute and community services were merged. The CCP highlighted possible distortions in competition caused by the referral of patients from the community service to the acute service.
- Similarly in its assessment of the Sunderland Integrated Care Organisation pilot, the CCP noted possible harm to patients as a result of the GP's "gatekeeper" role being undermined.

The Netherlands integrated care payments case study highlights that in addition to these "vertical" competition issues, integration may also lead in some cases to "horizontal" competition issues. In the

Netherlands, large groups of GPs contracted collectively for the provision of integrated care pathways, potentially limiting competition between those GPs.

Other case studies and stakeholder discussions suggested a tension between a desire to collaborate more closely with other organisations in the local health system, and a fear of competition enforcement.

The management of the Productive Nottinghamshire scheme expressed this concern in the context of integrated care transfers. This is likely to be a particular issue to the extent that integrated care focuses on collaboration to keep patients out of hospital, which was emphasised in stakeholder discussions.

Therefore in a number of areas, there is a potential (or perceived) conflict which raises questions for Monitor's competition workstream, and which should be explored further. In particular, these include issues around:

- Communication of Monitor's rules and approaches
- Clarification of how information can be used
- Role of benefits cases in Monitor's decision-making processes around competition issues.

The specific approaches or actions taken by Monitor must be consistent with (or stricter than) UK and EU competition law. This might be particularly the case in relation to rules around information-sharing. This may require legal advice as Monitor develops its thinking in these areas.

Recommendations - competition

We recommend that...

Monitor should ...

...publish **guidance that clearly sets out the criteria** it will use to determine when integrated care initiatives: are very unlikely to pose any competition concerns; may pose some concerns; and are likely to be a problem. The main report sets out some of the issues the guidance could cover

..., as part of the guidance recommended above, **clarify what types of information could be shared and with whom** without raising competition concerns. That is likely to consider three types of information (clinical, financial and strategic) and two possible institutions with whom the information might be shared (other providers, commissioners).

A consistent theme in our discussions with stakeholders has been that information-sharing is key in the delivery of integrated care. This includes sharing information between providers (e.g. patient records), but also sharing information with patients (e.g. describing pathways of care, and choices available to them).

In deciding whether to implement these recommendations, Monitor will need to consider whether setting out best practice in more detail will limit innovation and local ideas.

Monitor could ...

...set out **requirements for clear benefits cases and ways of testing whether the benefits have been realised**. This should include ways to verify whether there is a breach of commitments to benefits and to have in place ways of unwinding agreements that do not deliver the required benefits

... provide **guidance and examples of such benefits cases** to improve the evidence base developed locally

Commissioners of services will need to be able to assess potential trade-offs between greater integrated care and greater competition. Some Commissioners will struggle to do this and Monitor may be faced with complaints.

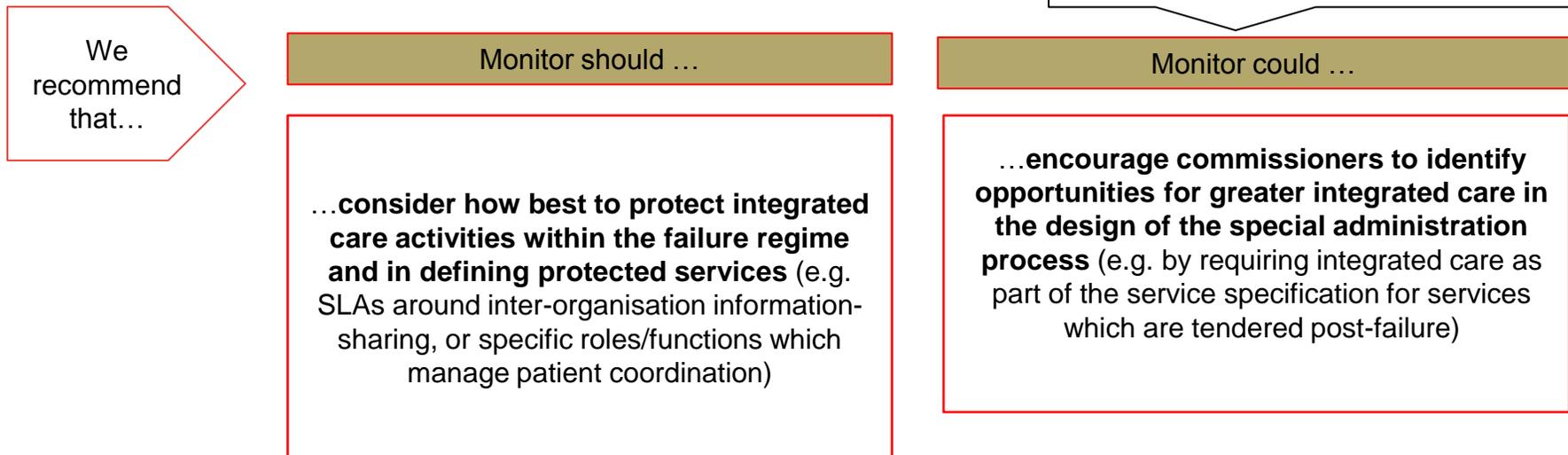
Recommendations for Monitor's role – continuity of service

Possible issues

The work around continuity of service will be considering how services are protected in the event of a provider being in financial distress. Increased integration of care means that providers may become increasingly inter-linked. Those linkages will span service user treatment, as well as financial, operational and potentially strategic links.

An important part of the development of the regime will be how these interconnections will be taken into account in the definition of the various components of the continuity of service regime (e.g. commissioner requested services, protected services). Some of those services may span very different sectors (health and social care), as well as very different types of providers (independent sector, voluntary, NHS). The evidence indicates that the most significant benefit from integrated care may be around user experience. If that experience is significantly disrupted when providers enter distress that may affect the extent to which commissioners and providers push forward with integrated care that falls short of full merger.

In deciding whether to implement these recommendations, Monitor will need to consider the complexity and cost of this for commissioners and resulting benefits.



Recommendations for Monitor's role - licence

Possible issues for Monitor's licensing workstream

Monitor's role in licensing providers will allow Monitor to influence the behaviour of providers, and require that certain information is provided by providers. The Licence is one means by which integration can be facilitated. Below we discuss other ways (e.g. through commissioners, the Information Strategy). However, licensing could become an important tool through which Monitor can enable integration of care.

At the time of writing it had not been determined precisely which providers will require a license from Monitor. This decision will impact on the role of the license in enabling integrated care.

Based on stakeholder discussions, case studies and literature on integrated care, it is clear that two key barriers to integrated care are culture and information.

The ingrained ways of working in the NHS are a barrier to innovation in new models of integrated service delivery, particularly those which cut across organisational boundaries. Through licensing, Monitor will be able to require that providers are more collaborative and open.

Information flows currently prevent the effective integration of care. Information for patients is not offered regularly enough – National Voices have illustrated this through the “webs of care” experienced by service users with insufficient information to help navigate their way. Workshop discussions revealed that information about service users is rarely passed between providers in an efficient or effective manner. For example, GPs are rarely given sufficient information about diabetes patients once they have been treated in secondary care, even though the GP will then play a crucial role in coordinating the ongoing care of those patients.

In addition to information shared between organisations, or with service users to enable them to make choices, information will also be valuable to Monitor for a number of purposes including pricing, measurement of integrated care and spreading best practice.

In considering how it uses licensing to enable integration, Monitor should take into account how integration can be facilitated through the full range of its proposed conditions. For example, Monitor may be able to use its competition oversight licence condition to prevent dominant suppliers from refusing to accept or supply services from or to other suppliers in order to deliver integrated care

For these reasons, Monitor should ensure that its license conditions are sufficiently robust to require: cooperation; information-sharing (both between organisations and with service users); and information submission.

Other stakeholders play an important role ensuring adequate information is available. The Department of Health and its Information Strategy, the Information Centre, commissioners, the CQC and NICE all provide information (in different ways) that can support the provision of integrated services.

Monitor's current consultation on license conditions

Monitor is already consulting on license conditions in this area. In particular, the conditions for “developing the competition oversight and integrate care” already place various requirements on providers.

For example, condition CIC1 requires Licensees to provide services in an integrated way. Specifically, “the Licensee shall co-operate [with others]... to ensure that health care is delivered to patients seamlessly...”

Additionally, CIC2 ensures the right of patients to make choices, and specifically to “make available... such information... conducive to the making of well informed choices between providers by users of health care services”. The proposed Pricing license conditions further support this provision of information for the purposes of setting tariffs.

These conditions should be sufficient to ensure providers can be required to collaborate and to share information effectively, although they might not adequately facilitate the collection of information for the purposes of assessing and spreading best practice.

Recommendations - licence

We recommend that...

Monitor should ...

..ensure that **licence conditions do not act to block appropriate forms of integrated care**. To do so Monitor should specifically ask as part of its formal consultation whether there are concerns that license conditions may have this impact. Monitor should then act in light of the feedback from that consultation, once it has properly weighed the range of responses. That might result in no further changes to the latest version of the licence.

In deciding whether to implement these recommendations, Monitor will need to consider:

- whether it needs an additional explicit licence condition
- is the qualification “in the best interest of patients” needed or should cooperation be required whenever it is not anti-competitive

Monitor could ...

...include the current proposed licence condition that would **require cooperation between providers** when it is not anti-competitive and is in the best interests of patients.

Recommendations for Monitor's role – corporate initiatives

Corporate cross-cutting initiatives

The evidence collected for this project has shown that there are lots of different forms of integrated care, a number of barriers which need to be removed in order for integrated care to develop, and a large number of stakeholders with a role to play in achieving integrated care.

There a wide-ranging debate across the NHS and Social Care sectors about all aspects of integrated care, including its definition.

There is also a need to make information – about costs and outcomes from integrated care – more widely available. That fits within the current information strategy being developed by the Department but will also require clear roles amongst the various institutions involved in collected and disseminating information. We pick up the issues around information in our recommendations about licensing (further on in this section).

Thought leadership: the National Quality Board

The NQB provides one potential model should Monitor decide to host or foster a forum for thinking about integrated care.

The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The Board is a key aspect of the work to deliver high quality care for patients.

The board's membership comprises a mix of skills and expertise, including representation from DH, Monitor, CQC, NICE, National Patient Safety Agency, Royal Colleges of Physicians, GPs and Psychiatrists, providers, commissioners and voluntary organisations.

Source: <http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/NationalQualityBoard/index.htm>

In deciding whether to implement these recommendations, Monitor will need to consider whether others (eg NHSCB) should lead this effort.

We recommend that...

Monitor should...

...put in place **a clear process for considering its statements and publications** in those areas where there is likely to be a significant impact on integrated care to show how this impact has been considered.

Monitor could ...

... **create and lead a sector-wide taskforce to drive progress and innovation around integrated care**, this may include commissioning research to determine how best to measure integration and progress against accepted measures.

Annexe – examples of
integrated care from
literature

Specialist care (1): Geisenger

Description

- Geisenger is a vertically integrated healthcare system which includes 3 acute sites and 37 community locations, plus virtual integrated care with more than 18,000 independent providers and community hospitals
- The system benefits a wide range of patients, in particular those having surgery, whose pre and post operation care is bundled into the so-called ProvenCare pathways, which follow best practice guidelines “hard-wired” into the organisation’s system. Heart surgery is one of the best known ProvenCare pathways at Geisenger.

Benefits achieved

- Geisenger's ProvenCare pathways have reduced mortality, infection, readmission rates and length of stay.

Barriers and enablers

- Reaching consensus is key for the system: clinicians must agree on best practices before these can be disseminated and instilled
- Bundled payments can be an enabler: physicians are motivated to be efficient and innovative where a flat fee is provided for particular procedures.

References

- Dentzer S., 2010. *Geisinger Chief Glenn Steele: seizing health reform’s potential to build a superior system*. Interview in *Health Affairs*, vol 29, no 6, pp. 1200–7.
- McCarthy D, et al., 2009. *Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives*. New York: The Commonwealth Fund.
- Shih A, et al., 2008. *Organising the U.S. Health Care Delivery System for High Performance*. New York: The Commonwealth Fund.

Specialist care (2): South East London Cancer Network

Description

- Established in June 2001, The South East London network covers six PCTs, six acute trusts and a range of palliative care providers.
- All member organisations sign up to a common set of values around collaborative working, and agree to share good practice, information and experience.
- Targets patients with cancer in London and beyond

Benefits achieved

- The Network seeks to ensure that all patients served have access to a uniformly high quality of care in the community or hospital, wherever they live.
- The Network aims to provide this care as close to the patient's home as is compatible with high quality, safe and cost effective treatment.
- To provide care in a fully collaborative multi-disciplinary, multi-professional and multi-agency setting in which all professional and administrative boundaries are invisible to the patient.

Barriers and enablers

- Professionals participating in the system must work across organisational boundaries and share information.
- An enabler of this inter-organisation collaboration is the long-term commitment to joint working that the network has managed to establish.

References

- Curry, N., and Ham, C., 2010. *Clinical and service integration: the route to improved outcomes*. London: The King's Fund.

Long-term conditions (1): Torbay

Description

- The system is based on 5 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.
- Torbay integrates health and social care by sharing functions of PCT and Council adult social services.

Benefits achieved

- **Patient experience:** improved access to services, through single point of contact for multiple services and provided a more efficient assessment.
- **Costs:** reduced use of hospital beds, of residential and of nursing homes; increase in the use of home care services. The integrated management structure of Torbay saved approx. £250,000 in the first year. This money was used to develop services.
- **Clinical outcomes:** slow rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.

Barriers and enablers

Barriers to integrated care included:

- Cultural and working practices differences between professionals across the workforce
- The initial absence of common information systems
- The difference between central and local balance: social services were centralised whereas health services more decentralised
- The initial absence of common lines of accountability.

Enablers were:

- Long-term commitment to joint working
- The need for change in adult social care services which had been underperforming
- The appointment of health and social care coordinators of multi-disciplinary teams.

References

- Thistlethwaite, P., 2011. *Integrating health and social care in Torbay*. London: The King's Fund.

Long-term conditions (2) : Bolton diabetes network

Description

- A community-based diabetes network for the management of diabetic patients with severe and complex needs.
- Bolton is served by one general hospital, one local authority and a PCT that is a significant provider of services itself with 53 doctors, 23 consultants and 7 directly managed practices.
- The ethos of the team is to facilitate and provide high quality patient centred diabetes care throughout Bolton through education and expert practice.
- The objective is to provide a fully integrated service without gaps or duplication, and with smooth and quick referral from primary care to specialist advice.

Benefits achieved

- Patients and staff have reported high satisfaction with the community-based service.
- In 2005/6, Bolton achieved the lowest number of hospital bed days per person with diabetes in the Greater Manchester area .

Barriers and enablers

Barriers included:

- Payment system: The community-based diabetes service is not covered by tariff and harder to sustain following introduction of PbR
- Set-up costs: lengthy management and implementation process.

Enablers included:

- Accountable leadership with a shared vision; defined roles for staff and organisations
- Common patient record information
- Cross-organisation working: consultant physicians and specialist nurses are linked to local primary care practices to provide support.

References

- Irani, M., 2007. *Specialist doctors in community health services: opportunities and challenges in the modern NHS*. The NHS Alliance.
- Dean, J., 2008. *Clinical integration: the Bolton experience*. London: The Nuffield Trust.

Long-term conditions (3) : NHS Trusts health and social care

Description

Integration of health and social care in NHS through:

- Closer working between the NHS and local councils, based on pooled budgets (where partner organisations contribute resources to a common budget, with staff given a say in how resources are to be used).
- lead commissioning (where one partner organisation commissions integrated services provided by both partners).
- some integrated provision (where a single organisation provides both health and social care services).

Benefits achieved

- Patient experience: services are felt to be more accessible, flexible, building a foundation for future improvement; though respondents cannot identify anything that makes Care Trusts stand out from other forms of partnership.
- Costs and clinical outcomes: clear measures of effectiveness, e.g. in terms of cost and impact on health outcomes, are yet to be reported.

Barriers and enablers

Barriers included:

- Concerns amongst local personnel over the limited focus of integrated care (which did not include the voluntary sector), and over the possibility of social care coming to be dominated by NHS targets
- Care trusts experienced difficulties working within the rules of national policy and performance systems, and under the different Terms and Conditions between health and social care staff.

Enablers:

- Well-developed governance, accountability and relationship between Care Trusts and Local Authority
- Consultations with staff and wider stakeholder which provided direction and focus

References

- Miller, R., et al, 2011. *The vanguard of integration or a lost tribe? Care trusts ten years on*. University of Birmingham: Health Services Management Centre.
- Glendinnig, C., 2003, *Breaking down barriers: integrating health and care services for older people in England*, Health Policy, Volume 65, Issue 2 , Pages 139-151

Long-term conditions (4) : Evercare

Description

- Comprehensive U.S. care model for those who have long-term or advanced illness, are older, or have disabilities.
- Nurse Practitioners (NPs) and Care Managers (CMs) work with primary care physicians, facilities, social support service providers and families to provide.

Benefits achieved

- Clinical and patient experience: case management supported more appropriate care for the target population by bridging all key service providers (e.g. primary care, secondary care, social services).
- Improved care for people aged over 65 through introduction of case management administered by specially trained Advanced Practice Nurses (APNs).
- Nurses reported improvements in appropriate treatment and patients' and carers' views of services.
- Costs: as APNs became more experienced, GPs spent less time visiting patients and liaising with other services. The nurses were able to provide more patient care themselves. Evaluation did not report significant impacts on admissions, bed days and mortality.

Barriers and enablers

Barriers:

- PCTs had poor information systems which made planning and development of the service difficult
- Rigid eligibility criteria and cumbersome administrative procedures often led to delays in the provision of services
- Nurses did not always have adequate access to alternatives to admission.

Enablers:

- Flexibility in the interpretation of care pathways, as patients do not always fit into standard approaches
- Improved focus of out of hours care on keeping patients out of hospital.

References

- Goodwin N., and Smith, J., 2011. *The Evidence Base for Integrated Care*. London: The King's Fund;
- Boaden, R., et al., 2006. *Evercare evaluation: final report*. University of Manchester: National Primary Care Research and Development Centre.

Urgent care (1) : Knowsley PCT cardiovascular pathway

Description

- Commissioned a full range of integrated cardiovascular services from a single lead provider, with the aim of meeting the needs of a deprived population with major inequalities between socioeconomic groups.
- The winner of the contract, a specialist provider located outside of the borough, provided an integrated cardiovascular patient pathway, from prevention through to specialist treatment

Benefits achieved

- Patient experience: 90% of early supported discharges had a full health and social care assessment carried out in conjunction with their carer and 91% of patients have had a reassessment 6 weeks post-discharge.
- Cost: Payment by Results savings in excess of £800,000.
- Clinical: unplanned A&E attendances decreased by 10%, approximately 3,880 patients were directed away from secondary care in the first 8 months of 2010/11, and shorter stay admissions for cardiology-related events decreased by about 12%

Barriers and enablers

Barriers were mainly on the provider's side:

- Providers needed to find significant amounts of management time and resource to participate in service developments led by commissioners
- Providers are at risk for service quality, health outcomes and financial performance
- The main enabler was the provider engagement and commitment to win the contract.

References

- Ham, C., Smith J., and Eastmure, E., 2011. *Commissioning Integrated Care in a Liberated NHS*. London: The Nuffield Trust.

Urgent care (2) : NHS West Kent

Description

- West Kent PCT commissioned an integrated out-of-hours primary care and emergency primary care service, based in the hospital accident and emergency department.
- The service was managed by a social enterprise and delivered by a team of GPs, nurses, urgent care practitioners and specialists.
- Emergency primary care clinicians were based in A&E 24 hours a day, 7 days a week, providing emergency primary care as a means of reducing avoidable hospital admissions.

Benefits achieved

- Patient experience: surveys indicated greater patient satisfaction, and a significant decrease in average time from arrival in A&E to assessment.
- Cost: £600,000 of activity was decommissioned from the acute hospitals for 2010/11.
- Clinical outcome: reduced A&E attendance and emergency admission

Barriers and enablers

Barriers:

- The process of engagement between stakeholders took far longer than was anticipated. There was a need for strong project governance, leadership, and informational management.

Enablers:

- Bold and skilful leadership: primary care doctors led plans to develop the integrated urgent care and out-of-hours general practice
- Engagement with the public, clinicians and community stakeholders in reviewing current services and in developing new service models, especially in relation to the quality of the service specification

References

- Ham, C., Smith J., and Eastmure, E., 2011. *Commissioning Integrated Care in a Liberated NHS*. London: The Nuffield Trust.

Programmed care (1) : Brent Integrated Diabetes Care

Description

- Aims at improving outcomes for people with diabetes through closer working among staff in hospitals, the community and general practice.
- An intermediate specialist care service acts as an interface between primary and secondary care, and cares for patients with poorly controlled diabetes or those recently discharged from hospital.
- A rapid access clinic treats those individuals who have minor issues but would otherwise have had to wait for a specialist appointment.

Benefits achieved

- Cost: only patients with very complex needs are seen by specialists in secondary care.
- Patient experience: waiting times to see a specialist in Brent decreased from 20 to less than 4 weeks. The model removed service gaps in care whilst ensuring all people with diabetes received the care they need, when they needed it, from appropriately skilled staff in the community setting working in an integrated manner.
- Clinical outcome: 50% reduction in A&E attendances

Barriers and enablers

Barriers included:

- Relocation of some staff to fit new model of care
- Funding was required for extra training for diabetes nurses such as prescribing and advanced nursing skills.

Enablers included:

- Close relationships between GPs, nurses, DSNs and all other multi-disciplinary teams across the primary, intermediate and secondary care through professional development and trainings.

References

- Curry, N., and Ham, C., 2010. *Clinical and service integration: the route to improved outcomes*. London: The King's Fund.

Programmed care (2): Veterans Health Administration

Description

- U.S. system based on integrated service networks (21), each of which has responsibility for resources across all care settings. Instead of a fee-for-service payment system, in which providers are rewarded for volume of activity, the VA allocates resources on a capitation basis to each network which is then responsible for providing all care with those resources.
- System employs medical staff and owns and runs hospitals to manage the full range of care to veterans within a budget allocated by the federal government.

Benefits achieved

- Clinical: 55% reduction in use of hospital beds. Number of acute and long-term care beds fell from 92,000 to 53,000, whereas ambulatory care visits and home care services increased.
- Patient experience: in a comparison with other US systems, the VA scored higher for overall quality (67% vs. 51%), long-term conditions management (72 per cent vs. 59%) and preventive care (64% vs. 44%). A study in 2004 concluded that patients in the VA system received higher-quality care than elsewhere.

Barriers and enablers

Barriers included:

- Lack of transparent, widely disseminated measurement of performance.

Enablers included:

- Culture of measurement and reporting
- Performance management system: as managers know that they are responsible for a person's entire care needs and likely to care for people throughout their lives, they have an incentive to provide health promotion and effective care management over time
- Financial and non-financial incentives within the system
- Integrated information technology
- Committed leadership.

References

- Curry, N., and Ham, C., 2010. *Clinical and service integration: the route to improved outcomes*. London: The King's Fund.

Programmed care (3): the Working Unit for Continuous Care

Description

- The WUCC is a geriatric assessment unit organised within local hospitals in the Alto Vicentino region in Italy.
- WUCC has the duty to guarantee the older person's hospital discharge, by organising and providing continuous and integrated health and social care, departing from the hospital.
- Aims to guarantee the efficient discharge of older patients from hospital by organizing and providing continuous and integrated health and social care.
- It comprises a professional nurse, physiotherapist, as well as a social worker based at the hospital who provides a link between caregivers and external social workers, in order to plan and prepare a patient's hospital discharge.

Benefits achieved

- Clinical outcome: avoidable hospital admissions have been reduced from 123 to 83 during 2002.

Barriers and enablers

Barriers included:

- Loss of flexibility, increasing conflicts among staff within the hospital but also between the WUCC and community care services, and the lack of evaluation of users' satisfaction, in contrast with its declared user-oriented approach.

Enablers included:

- Shared information system, interdisciplinary structure and multi-dimensional evaluation.

References

- Lloyd, J., and Wait, S., 2006, *Integrated Care: A Guide for Policymakers*. London: International Longevity Centre.
- Nesti, G., Campostrini, S., and Garbin, S., 2003. *Providing integrated health and social care for older persons in Italy*. Procare

Programmed care (4): Principia Partners in Health

Description

- A not-for-profit social enterprise based in Nottingham, which aims to improve coordination of care and develop a 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.

Benefits achieved

- Cost: savings of £900,000 on non-elective admissions through demand management in 08/09.
- Patient experience: extended hours of primary care services with weekend diagnostics and improved long term conditions management.
- Clinical outcome: mandatory evidence-based clinical pathways across the whole system and a dynamic multi-professional collaboration.

Barriers and enablers

Enablers included:

- Collaborative practice-based commissioning, reformed community services, and comprehensive community engagement
- As a social enterprise, Principia is self-governed and self-managed
- Its financial incentives and managerial accountability are aligned
- One unique feature is the governance arrangements, as the board is elected by patients and has a majority of lay members.

References

- Shortt, S., 2010. *Removing the policy barriers to integrated care. Principia Partners in Health*. London: The Nuffield Trust

Annexe – selected
bibliography

Below we provide a selection of papers. It is not intended to be exhaustive but to provide a good starting point for those who want to explore the topic further.

Alltimes, G., 2012. *Integration: a report from the NHS Future Forum*. NHS Future Forum. London : DH

Armitage, Gail D., et al., 2009. *Health systems integration : state of the evidence*. International Journal of Integrated Care , Vol. 9

Boaden, R., et al., 2006. *Evercare: Evaluation of the Evercare approach to case management: final report*. University of Manchester: National Primary Care Research & Development Centre.

Contandriopoulos, A., Denis, J., Touati, N., and Rodriguez, C., 2004. *The integration of health care: Dimensions and implementation*. Groupe de recherche interdisciplinaire en santé : Université de Montréal

Curry, N., and Ham, C., 2010. *Clinical and service integration: the route to improved outcomes*. London: The King's Fund.

Curry, N., and Ham, C., 2011. *Integrated Care. What is it? Does it work? What does it mean for the NHS?* London: The King's Fund.

Davies, G. P., Williams, A. M., Larsen, L., Perkins, D., Roland, M., Harris, M. F., 2008. *Coordinating primary health care: an analysis of the outcomes of a systematic review*. Medical Journal of Australia, Volume 188, No. 8.

Dean, J., 2008. *Clinical integration: the Bolton experience*. London: The Nuffield Trust.

Dentzer, S., 2010. Geisinger Chief Glenn Steele: seizing health reform's potential to build a superior system. Interview in Health Affairs, Vol. 29, No. 6, pp. 1200–7.

Duffy, S., 2011. *Personalisation in mental health: a model for the integration of health and social care mental health services*. The Centre for Welfare Reform Sheffield: Centre for Welfare Reform.

Fulop, N., Mowlem, A., and Edwards, N., 2005. *Building integrated care: Lessons from the UK and elsewhere*. London: The NHS Confederation.

Glasby J., Littlechild, R., 2009. *Direct Payments and Personal Budgets: Putting personalisation into practice*. Bristol: Policy Press.

Gleave, R., 2009. *Across the pond: lessons from the US on integrated healthcare*. London: Nuffield Trust.

Glendinnig, C., 2003, *Breaking down barriers: integrating health and care services for older people in England*, Health Policy, Volume 65, Issue 2 , Pages 139-151

- Goodwin, N., and Smith, J., 2011. *The Evidence Base for Integrated Care*. London: The King's Fund.
- Goodwin, N., Smith, J., Davies, A., Perry, C., Rosen, R., Dixon, A., Dixon, J., Ham, C., 2012, *Integrated care for patients and populations: improving outcomes by working together: a report to the Department of Health and the NHS Future Forum*. London: The King's Fund.
- Guthrie, B., et al., 2011. *Delivering health care through managed clinical networks (MCNs): lessons from the North*. University of Dundee. Centre for Primary Health and Population Care and Universities of Dundee and St Andrews. Social Dimensions of Health Institute. SDO Project 08/1518/103 Leeds: NIHR SDO.
- Ham, C., De Silva, D., 2009. *Integrating Care and Transforming Community Services: What Works? What Next?* Health Services Management Centre: University of Birmingham.
- Ham, C., 2009. *Removing the policy barriers to integrated care: the Torbay experience*. London: Nuffield Trust.
- Ham, C., de Silva, D., 2009. *Integrating care and transforming community services: what works? where next?* University of Birmingham. Health Services Management Centre. Birmingham: HSMC, HSMC policy paper 5.
- Ham, C., and Smith, J., 2010. *Removing policy barriers to integrated care in England*. London: The Nuffield Trust
- Ham, C., Smith J., Eastmure, E., 2011. *Commissioning Integrated Care in a Liberated NHS*. London: The Nuffield Trust.
- Ham, C., et al., 2011a. Clinically integrated systems: the future of NHS reform in England??. *British Medical Journal*, vol 342: d905.
- Ham, C., et al., 2011b. *Where Next for the NHS Reforms? The case for integrated care*. London: The King's Fund.
- Humphries, R., Curry, N., 2011. *Integrating health and social care: where next?* London: The King's Fund.
- Hunter, D., Perkins, N., Bamba, C., Marks, L., Hopkins, T., Blackman, T., 2011. *Partnership working and the implications for governance: issues affecting public health partnerships*. Durham University. SDO Project 08/1716/204.
- Irani, M., 2007. *Specialist Doctors in Community Health Services: Opportunities and challenges in the modern NHS*. London: NHS Alliance.
- Jonkers, K., 2010. *The Dutch National Care for the Elderly Programme: integrated care for frail elderly persons*. International Journal of Integrated Care, Vol. 10.

- Kodner D, Kay Kyriacou C (2000). *Fully integrated care for frail elderly: two American models*. International Journal of Integrated Care, Vol. 1, pp. 1–24.
- Lewis, R., Rosen, R., Goodwin, N., Dixon, J., 2010. *Where next for integrated care organisations in the English NHS?* London: The Nuffield Trust, The King's Fund.
- Lloyd, J., Wait, S., 2006. *Integrated Care: A Guide for Policymakers*. London: International Longevity Centre.
- McCarthy D, Mueller K, Wrenn J (2009a). *Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives*. New York: The Commonwealth Fund.
- McCarthy D, Mueller K, Wrenn J (2009b). *Mayo Clinic: Multidisciplinary teamwork, physician-led governance and patient-centred culture drive world-class health care*. New York: The Commonwealth Fund.
- McCarthy D, Mueller K, Wrenn J (2008). *Kaiser Permanente: Bridging the quality divide with integrated practice, group accountability, and health information technology. Organized delivery system: Case study*. New York: The Commonwealth Fund. Available at: www.commonwealthfund.org/~media/Files/Publications/Case%20Study/2009/Jun/1278_McCarthy_Kaiser_case_study_624_update.pdf (accessed on 2 November 2010).
- Miller, Robin, et al., 2011. *The vanguard of integration or a lost tribe? : care trusts ten years on*. University of Birmingham. Health Services Management Centre HSMC Policy Paper ; 10 February 2011. Birmingham : HSMC, 2011
- Nesti, G., et al., 2004. *Providing Integrated Health and Social Care for Older Persons in Italy*. In: Leichsenring K, Alaszewski A M (eds) *Providing Integrated Health and Social Care for Older Persons*, Aldershot: Ashgate
- Nye, A., 2011. Case Study Programme Budget Prime Vendor Model, NHS Oldham: Pennine MSK Partnership.
- Ouwens, M., Wollersheim, H., Hermens, R., Hulscher, M., and Grol, R., 2005. *Integrated care programmes for chronically ill patients: a review of systematic reviews*. International Journal for Quality in Health Care, 2005; Volume 17, Number 2: pp. 141-146.
- Øvretveit, J., 2011. *Evidence: does clinical coordination improve quality and save money?* Volume 2: a detailed review of the evidence. London: The Health Foundation, 2011
- Powell Davies et al., 2008. *Coordinating primary health care: an analysis of the outcomes of a systematic review*. Medical Journal, 188 (8): 65

- RAND Europe, Ernst & Young LLP 2012 *National Evaluation of Department of Health's Integrated Care Pilots*, Department of Health.
- Robertson, M., Wilkinson, H., 2010. *Local delivery of joined-up services for older people*. Department for Work and Pensions and Risk Solutions Research report 713. London: DWP.
- Rosen, R., Mountford, J., Lewis, G., Lewis, R., Shand, J., Shaw, S., 2011. *Integration in action: four international case studies*. London: Nuffield Trust.
- Ross, S., Curry, N., Goodwin, N., 2011. *Case management: what it is and how it can best be implemented?* London: The King's Fund, 2011
- Saskia, M., et al (2011) 'Evaluating instruments for regulation of health care in the Netherlands' *Journal of Evaluation in Clinical Practice* 17 pp. 411-419.
- Shaw, S., Levenson, R., 2011. *Towards integrated care in Trafford: research report*. London: The Nuffield Trust.
- Shaw, S., Rosen, R., Rumbold, B., 2011. *What is integrated care?* London: The Nuffield Trust.
- Shih, A., et al., 2008. *Organising the U.S. Health Care Delivery System for High Performance*. New York: The Commonwealth Fund.
- Shortt, S., 2010. *Removing the policy barriers to integrated care*. Principia Partners in Health. London: The Nuffield Trust
- Struijs, J., N., et al., 2011. *Integrating Care through Bundled Payments — Lessons from the Netherlands*. The New England Journal of Medicine, 364;11.
- Strandberg-Larsen, M., and Krasnik, A., 2009. *Measurement of integrated healthcare delivery: a systematic review of methods and future research directions*. International Journal of Integrated Care, Vol. 9, 4 February 2009.
- Stroetmann, k., Kubitschke, L., Robinson, S., Stroetmann, V., Cullen, K., McDaid, D., 2010. *How can telehealth help in the provision of integrated care?* World Health organisation. Regional Office for Europe. Health Evidence Network European Observatory on Health Systems and Policies. Policy brief 13. Copenhagen: WHO Regional Office for Europe.
- Thistlethwaite, P., 2011. *Integrating health and social care in Torbay: improving care for Mrs Smith*. London: King's Fund, 2011

Institutional reports

Audit Commission, 2011. *Joining up health and social care: improving value for money across the interface*. London: Audit Commission

Audit Scotland, 2011. *Review of community health partnerships*. Edinburgh : Audit Scotland.

Centre for Workforce Intelligence, 2011. *Older People Care Pathway Team Integrated care for older people: examining workforce and implementation challenges*. London: CfWI.

National Voices, 2011. *Principles for integrated care*. London: National Voices.

Nederlandse Mededingingautoriteit 2010a Richtsnoeren Zorggroepen (Guidelines for Care Groups) Netherlands Competition Authority 2010 available at: http://www.nza.nl/104107/136998/Richtsnoeren_Zorggroepen.pdf

Nederlandse Mededingingsautoriteit 2010b Samenwerken en concurreren in de zorgsector (Collaboration and competition in the health sector) Available at: http://www.nma.nl/images/NMA_Samenwerken_in_de_zorg_JUNI2010_tcm16-13899922-187924.pdf

NHS Confederation and Macmillan Cancer Support, 2010. *Coordinated cancer care: better for patients, more efficient*. Briefing 203. London: NHS Confederation.

Oxford Brookes University. Institute of Public Care, 2010. *From the ground up: a report on integrated care design and delivery*. London: DH

Oldham Clinical Commissioning Group, 2011. CCG in Oldham: A Strategy for an Accountable Care organisation.

Royal College of Practitioners, 2011. Integrated Care Consultation.

http://www.rcgp.org.uk/news/press_releases_and_statements/integrated_care_consultation.aspx

Turning Point, 2010. Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care. London: Turning Point



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