

# A report to the Department of Health and the NHS Future Forum

## Integrated care for patients and populations: Improving outcomes by working together

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### Key messages

This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. 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. It can be delivered without further legislative change or structural upheaval. The aims of integrated care are widely supported by NHS staff as well as patient groups, and taking forward the proposals set out in this paper would therefore be welcomed by key stakeholders.

In the view of The King's Fund and the Nuffield Trust, these are the main priorities for the future.

#### ➤ **Setting a clear, ambitious and measurable goal to improve the experience of patients and service users**

Developing integrated care for people with complex needs must assume the same priority over the next decade as reducing waiting times had during the last. Government policy should be founded on a clear, ambitious and measurable goal to improve the experience of patients and service users and to be delivered by a defined date. This goal would serve a similar purpose to the aim of delivering a maximum waiting time of 18 weeks for patients receiving hospital care. To be effective, it needs to set a specific objective around which the NHS and local government co-ordinate their activities to improve outcomes for populations. Improving integrated care should be seen as a 'must do' priority to ensure it receives the attention needed.

#### ➤ **Offering guarantees to patients with complex needs**

Setting an ambitious goal to improve patient experience should be reinforced by guarantees to patients with complex needs. These guarantees would include an entitlement to an agreed care plan, a named case manager responsible for co-ordinating care, and access to telehealth and telecare and a personal health budget where appropriate. Many of these measures are already an established part of health and social care policy but they have not been implemented consistently. Making them happen is therefore less to do with extra spending and more related to variations in local policy and practice that need to be tackled as a matter of urgency.

## ➤ **Implementing change at scale and pace**

Integrated care must be delivered at scale and pace. This requires work across large populations at a city- and county-wide level. There should be flexibility to take forward different approaches in different areas and to evaluate the impact, with the main emphasis being on people with complex needs. Financial incentives are needed to support rather than inhibit organisations to work together around the needs of patients, and the NHS Commissioning Board and Monitor must ensure that policies on regulation and competition facilitate integrated care where it will bring benefits. A programme of organisational development should be put in place to support NHS organisations and local authorities to make change happen.

This will require significant reform to develop capacity in primary and community care and to prioritise investment in social care to support rehabilitation and reablement. The independent sector and third sector organisations have an important contribution to make in developing new models of care. The result would be to make a reality of care closer to home and to reduce the inappropriate use of acute hospitals.

## **Introduction**

In its June 2011 summary report, the NHS Future Forum stated: '*we need to move beyond arguing for integration to making it happen*' (Field 2011, p 20). The report called for the commissioning of integrated care for patients with long-term conditions, complex needs, and at the end of life, building on the ideas that The King's Fund and the Nuffield Trust presented as part of the listening exercise on the Health and Social Care Bill. The Department of Health then approached our two institutions for help in supporting the development of its national strategy on integrated care and to feed our ideas directly into the ongoing work of the NHS Future Forum.

This report seeks 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 'at scale and pace'. It examines:

- the case for integrated care
- what current barriers to integrated care need to be overcome and how
- what the Department of Health can do to provide a supporting framework to enable integrated care to flourish
- options for practical and technical support to those implementing integrated care, including approaches to evaluating its impact.

## **The case for integrated care**

The ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.

This is a message recognised by most western developed nations, which are all seeking through different means to bring about a significant shift in the balance of where care is provided. In England, we know that standards of care for frail people with complex conditions are not always as they should be. Numerous reports have pointed to the need for significant improvements in care to frail older people that is better co-ordinated, of higher quality, and assures dignity and compassion (eg, Care Quality Commission 2011; Equality and Human Rights Commission 2011).

This lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. They add that: *'achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety'* (National Voices 2011). **Our view is that care for people with complex health and social care needs must be made a real and pressing priority for commissioners and providers as this will be the key to assuring people of high-quality care and making the health and social care system more sustainable.**

The government will have to accept and prepare for the consequences of such a change. **Significant reform is needed to develop capacity in primary and community care; prioritise investment in social care to support rehabilitation and re-ablement; and take forward the subsequent downsizing of activity undertaken in acute hospitals.** In all of the successful integrated care projects we examined, additional and improved services outside hospital were required – shining a light on the lack of current capacity and capability in community services to deliver care co-ordination and more intensive care in the home environment.

**If executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality, innovation, prevention and productivity (QIPP) challenge in the longer term** – one of the core themes in *The Operating Framework for the NHS in England 2012/13* (Department of Health 2011). This requires tackling waste and inefficiency in services in all settings to release resources for investment in new forms of care.

#### *Understanding integrated care*

Integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs. To achieve **integrated care, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery** (Lloyd and Wait 2005; Shaw *et al* 2011).

While many are enthused about the potential benefits of integrated care, others are uncertain about what it might entail or are threatened by its possible consequences. In part, such fears are related to the organisational changes that are often implied. However, **organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care.**

**No single 'best practice' model of integrated care exists. What matters most is clinical and service-level integration** that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations (Curry and Ham 2010). Moreover, **integrated care is not needed for all service users or all forms of care but must be targeted at those who stand to benefit most.**

#### *Making the case for integrated care*

It is important to define the ambitions and the goals of integrated care and to translate these into specific and measurable objectives. **Making a compelling case for integrated care, both as a national policy and in terms of local care redesign and delivery, is essential** if people are to understand why it is being promoted as a priority.

In our view, integrated care is necessary for any individual for whom a lack of care co-ordination leads to an adverse impact on care experiences and outcomes. It is an approach best suited to frail older people, children and adults with disabilities, people

with addictions, and those with multiple chronic and mental health illnesses, for whom care quality is often poor and who consume the highest proportion of resources. It is also important for those requiring urgent care, such as for strokes and cancers, where a fast and well-co-ordinated care response can significantly improve care outcomes.

**Keeping the needs and perspectives of the individual at the heart of any discussion about integrated care is critical.** One approach to this was in Torbay (Thistlethwaite 2011), where they identified that many older people were at significant risk of falling into long-term care in a nursing home and/or a long hospital stay. By invoking the fictional character of Mrs Smith – a woman in her 80s with a range of long-term health and social care needs yet encountering daily difficulties and frustrations in navigating the health and social care system – managers and clinicians created a unifying narrative to explain the purpose of integrated care, underpin the design of a new integrated health and social care system, and act as a clear point of reference for judging success.

**Without integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines, and the potential for cost-effectiveness diminishes** (Kodner and Spreeuwenberg 2002). The challenge facing today's health and social care system in England is its ability to offer high-value care in the face of a difficult financial and organisational environment. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing changes, will be significant unmet need and threats to the quality of care.

#### *The benefits of integrated care*

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011). Many different approaches have been taken, and five different examples are provided below to illustrate some of the benefits that can accrue (see box overleaf).

#### *Care for older people in Torbay*

Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support (Thistlethwaite 2011).

#### *Diabetes care in Bolton*

The Bolton Diabetes Centre, set up in 1995, has a team of community-based specialists. The team works with the local hospital for inpatient care and with general practices to provide support and undertake shared consultations. The vision is of care that is delivered in the appropriate place at the appropriate time by the appropriately trained professional. Bolton aspires to develop a fully integrated diabetes service without gaps or duplication and with quick referral from primary care to specialist advice. Patients and staff have reported high levels of satisfaction with the service, and in 2005/6 Bolton reported the lowest number of hospital bed days per person with diabetes in the Greater Manchester area (Irani 2007).

#### *Stroke care in London*

In London, implementation of a pan-London stroke care pathway and the development of eight hyper-acute stroke units has improved access and reduced length of stay in hospitals: 85 per cent of high-risk patients who have had a stroke are treated within 24 hours, compared with a national average of 56 per cent, and 84 per cent of patients spend at least 90 per cent of their time in a dedicated stroke unit, compared to a national average of 68 per cent. Five of the top six performing hospitals in the National Sentinel Audit for Stroke are now London-based hyper-acute stroke units (Intercollegiate Stroke Working Party 2011).

#### *Chronic care management in Wales*

In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and 2009. This represented an overall cost reduction of £2,224,201 (NHS Wales 2010).

#### *Integrated service networks in the Veterans Health Administration system in USA*

The experience of the Veterans Health Administration in the United States provides evidence of the benefits of transforming from a fragmented, hospital-centred system in the mid-1990s into a series of (now 21) regionally based integrated service networks responsible for the provision of all forms of health and long-term care within a fixed budget (Ham *et al* 2011). Family doctors work closely with medical specialists in managing patients with chronic diseases, and integrated working is supported by information technology, including an electronic medical record. Studies have shown that bed use fell by 55 per cent after the implementation of integrated service networks (Ashton *et al* 2003). Evidence also shows that the quality of care improved.

**Approaches to integrated care are likely to be more successful when they cover large populations** (covering a city or county, for example) and a range of groups: older people; people with particular diseases or conditions; and people requiring access to specialist services (Goodwin *et al* 2010; Curry and Ham 2010; Humphries and Curry 2011). For example, the evidence for case management and care co-ordination shows that it is less likely to succeed unless it is part of a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation, re-ablement and independent living (Ross *et al* 2011). The evidence shows that it is the cumulative impact of multiple strategies for care integration that are more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers (Powell-Davies *et al* 2008).

#### *A priority for action*

During the work we undertook with colleagues in the NHS and social care to inform this report **we uncovered a sense of urgency in turning ideas about integrated care into action, and for this agenda to be developed at scale and pace.** Moreover, there was an overwhelming sense that the future challenges in the system could be overcome only by focusing on the health *and* wellbeing of populations, and with the freedom to innovate and embed new ways of working over a minimum of five years.

The delivery of integrated care must become a clear political and managerial priority for action, so that high-quality and well-co-ordinated care for frail or vulnerable people with complex needs can be assured. **Put simply, integrated care should become the main business for health and social care. This requires the Department of Health and the NHS Commissioning Board to set a clear, ambitious and measurable goal that is linked to patients', users' and carers' experience of integrated care and that must be delivered by a defined date. This goal should be included in the annual NHS Operating Framework, and NHS and partner organisations should be held to account for its delivery.**

As there are many different ways to achieve integrated care, but no one best model for doing so, it follows that **any support framework must be permissive and based on 'discovery and not design'.** Hence, the focus should be on removing the barriers to integrated care, avoiding being prescriptive about how it should be done. We now turn to the question of how the barriers to integrated care can be overcome.

## **Current barriers to integrated care**

Significant international attention is currently being paid to the 'integrated care conundrum', typically expressed as a need to find much better ways of delivering well-co-ordinated care to people living with complex conditions and multiple health needs (eg, Canada – Baker and Denis 2011; New Zealand – Cumming 2011; England – Ham *et al* 2011a; USA – Kodner 2009; Australia – Powell Davies *et al* 2009). In all cases, there is a focus on imposing the individual's perspective as the organising principle of care delivery (Lloyd and Wait 2005), and on developing processes, methods and tools of integration that can facilitate such integrated care (Leutz 2005).

But why is it such a challenge to develop services in such a way that patients, service users and carers, particularly those struggling with complex and long-term needs, feel satisfied that care is well co-ordinated, and not reliant on regular prompts and actions by these users and carers? There is a set of systemic barriers to integrated care that need to be addressed, some organisational, and others related to health and social care policy.

### *Organisational barriers to integrated care*

In the work we carried out with NHS and social care colleagues for this report, the following organisational barriers were most frequently cited as barriers to developing integrated care.

- **NHS management culture often talks about innovation yet demonstrates a fundamentally 'permission-based' and 'risk averse' approach** to approving local service developments. This culture manifests itself through the application of rules about payment approaches, policy on competition, setting targets that lead to undue management attention being focused on certain (typically elective) areas of care, and the apparent discomfort about investing in service developments that significantly challenge the configuration of local hospital care. This last point was often expressed as an 'underlying sense of fear' that such actions would not be acceptable to higher authorities.
- **The divide between primary and secondary care in the NHS, and also that between health and social care.** Differences in staff contracts, employment arrangements, funding approaches, and approaches to service provision build allegiances to the needs of specific organisations that make it difficult for multidisciplinary teamwork to happen. As social care is means-tested at the point of access, this adds a further degree of complexity that all too often results in overlapping or missing services.
- **The lack of time and sustained project management support accorded to demonstration sites** means that integrated care has often been restricted to short-term pilot projects. Without the time and resources to demonstrate change, research results often report that integrated care has failed to achieve its desired goals (Steventon *et al* 2011).
- **The absence of a robust shared electronic patient record** that is accessible to and used by all those involved in providing care to people with complex conditions is a major drawback to supporting a more appropriate and integrated response to people's needs (eg, Curry and Ham 2010; Rosen *et al* 2011).
- **The persisting weakness of commissioning** that means they have struggled to use their power as 'paymaster' to exert changes in how providers deliver services that might avoid fragmentation and duplication (Ham *et al* 2011). Particular weaknesses are found in: the lack of active clinical involvement; an approach to procuring care services that focuses on individual organisations as opposed to partnerships; and payment based on episodic (hospital-based) care (Ham *et al* 2011).

### *Policy barriers to integrated care*

The experience of those developing integrated health and social care services is that innovations often seem to stall at the point at which they start to have a significant impact on the provision and configuration of services. Indeed, the experience of developing integrated care in places such as Cumbria, North West London, Smethwick and Trafford suggests that more support is needed at a policy level if integrated care is to become more than just a minority interest for a few enthusiasts (Ham and Smith 2010; Ham *et al* 2011b). Key policy barriers included:

- **the Payment by Results approach to funding hospital activity** that has led to increased activity and decreased lengths of stay. Incentivising hospitals to increase admissions (as long as they can find a commissioner to pay), mitigates against different providers (eg, community health, hospital and general practice) coming together as a network to develop and deliver new forms of integrated

care. Stronger incentives are required if health providers are to collaborate to address the fragmentation and duplication in care.

- **choice and competition policy** that appears at times to run contrary to the desire in many sites for more integrated care (Ham and Smith 2010). The key issue here is the *unit* of competition and whether this is defined narrowly (eg, for an annual foot check) or broadly (eg, for a year of care to a diabetic). It also begs the question as to how competition should operate – should it be competition for the market (ie, tendering to providers) or within the market (ie, patient choice of location and caregiver).
- **NHS regulation that focuses too much on organisational performance and not enough on performance across organisations and systems.** It is a specific provider (hospital, community health service, practice) that is currently subject to regulation in respect of service quality, rather than services across a continuum, which is what patients, service users and carers experience. Furthermore, the economic regulation of foundation trusts appears to focus more on how they are governed, can grow as entities and create financial surpluses, rather than on how they might shape integrated services with partner organisations and deliver new models of care.
- Policy proposals for the future of the NHS in England currently set out three different outcomes frameworks against which performance will be assessed. Currently, these three outcomes frameworks have some shared indicators, but these are quite minimal. **Action needs be taken to develop a single outcomes framework to promote joint accountability for delivering services that are joined up for patients, service users and their carers** (Humphries and Curry 2011).

For those working on the ground, none of these policy barriers is so fundamental that they cannot be overcome if there is sufficient local commitment, system leadership and the will to succeed. However, to develop integrated care at scale and pace, more energetic support, and explicit encouragement, is required.

## Overcoming the barriers to integrated care

The most fundamental prerequisite to the development of integrated care at scale is the **crafting of a powerful narrative at both a national and local level** about how services could and should be delivered for people with complex conditions - especially, but not exclusively, frail older people. At present, there is significant national and press attention on failings in the care of frail older people, but less focus on what needs to be done to re-orientate the health system towards addressing such concerns. The case for change will not be made on quality alone, but also on the basis of efficiency, for there is an increasing consensus in the NHS that to address the 'Nicholson challenge', a major shift will be required in how care is delivered (NHS Confederation 2011; Imison *et al* 2011).

As part of this narrative, there is a need for a **clear articulation of the benefits to patients, service users and carers**, backed up by regular and detailed assessment of their experience of NHS services. This assessment should not be undertaken on a purely provider basis, but across the continuum of care as experienced by the individual, enabling regular monitoring of how far integration efforts are succeeding. Such tracking of patients', service users' and carers' experience should be used pro-actively by commissioners and providers to improve quality of care and should be aggregated at a national level as part of wider regulation and performance management of the care system.



We agree, therefore, with the view of National Voices that **the Department of Health and the NHS Commissioning Board should give urgent priority to investing in approaches that measure the experiences of patients, service users and carers in relation to integrated care** – in particular, those that: measure how active and confident individuals feel about managing their own care; describe outcomes in terms of the impact on people's health and wellbeing; and describe their care experiences and whether services are being delivered that meet their needs (National Voices 2011).

A prerequisite to providing consistent, well-co-ordinated care for people will be significant investment in primary and community services. In particular, **there is a need for general practice to adapt rapidly so that it operates at a scale that can provide the platform for integrated care** (The King's Fund 2011). This requires general practice to act as the hub of a wider system of care that takes direct responsibility for co-ordinating and signposting individuals to services within the NHS as well as beyond health care on a 24/7 basis. In particular, a capability needs to be developed that enables specialist (eg, hospital consultant, community specialist, social worker) support and advice to be provided to primary care teams so that they can make sure that people receive well-co-ordinated and personalised care.

**To encourage integrated care, payment incentives and new local currencies** are needed. These might include giving a capitated budget to a local organisation (eg, a federation of GP practices, or a foundation trust and its local GP practices) and then holding the organisation to account for delivering care to specified standards of user experiences, health outcomes, and costs. In this way, the incentives to deliver proactive care to people identified as being at risk would be shared across the partners within the local organisation. Recent analysis by the Nuffield Trust (Dixon *et al* 2011) about the allocation of health resource at an individual level provides a robust basis on which to calculate accurate capitated budgets.

Another option is to use bundled payments for a range of services relating to a particular episode of care or care pathway, such as is being proposed in the Whittington Health integrated care organisation (Clover 2011). Exploring the idea of extending the 'year of care' approach to paying for care of people with long-term conditions that has been piloted in diabetes services (Year of Care Programme Board 2011) also holds some attraction. Such approaches, however, are likely to be more suitable for dealing with patients with specific diseases and will not adequately meet the needs of people with multiple needs.

There is an urgent need for experiments in changing the nature of tariffs for NHS care, to enable greater investment in primary and secondary prevention, alongside delivering community and acute health services where needed. Commissioners might also seek to increase the use of pooled budgets as a way of enabling closer health and social care collaboration. Using quality-based incentive payments across pathways of care might likewise incentivise best practice models and partnership working, while ensuring that providers are incentivised to make a contribution to the health and wellbeing of the whole population. Personal health budgets, too, might enable some patients and service users to commission their own care in ways that better meet their needs.

As well as the alignment of financial incentives, **governance needs to be aligned across the various health and social care providers to drive shared interests and accountability in care delivery for people** across hospitals, community services, general practice teams and social care. Given the complexity of designing and organising services across existing organisational and professional boundaries, careful attention will need to be paid to the governance (both financial and clinical) of new services, ensuring that accountability for an individual's care is clear to all parties.

Integrated care might also be adopted more quickly by **commissioners changing the way that they procure services**, moving away from contracts with individual organisations that specify items of delivery, to a focus on commissioning for outcomes achieved with specific populations or client groups. In particular, **commissioners need to have the ability to identify individuals in need of care and support, which requires a population-based approach with sophisticated tools** to identify those people in local communities with complex needs and to target the proactive support and management of their needs. The use of low-cost tools to stratify the risk of future ill health of individuals in the population will be crucial to help target care and support appropriately.

**Innovative approaches are needed to sharing data together with a commitment to developing shared clinical records.** This can be time-consuming and expensive, so the Department of Health should seek a streamlined approach to the governance of data sharing that can be applied across England to avoid this becoming a waste of taxpayers' money.

Finally, it is important to re-iterate here that **effective integrated care can be achieved without the need for formal ('real') integration of organisations.** What matters most is the clinical and service integration that improves care co-ordination around the needs of individual patients and service users. Demonstrating the extent of progress will require significant time and project management support, together with careful and robust evaluation. Organisational integration may be a consequence of clinical and service integration but in our view it should not be the starting point.

## **What the Department of Health, the NHS Commissioning Board and Monitor now need to do**

Our knowledge of the evidence suggests that integrated care for people with complex needs can be achieved without further legislative changes to the current Health and Social Care Bill. Indeed, a message from those working on the ground is that 'where there's a will there's a way' and any barrier can be overcome if there is sufficient local commitment, system leadership and the will to succeed.

The most pressing problem in ensuring proactive and well-co-ordinated care for people with complex conditions appears to be linked to the 'permission-based' culture in NHS management and the fear that mitigates against local innovation. **If the vision for a more integrated health and social care system is to be realised at scale and pace, then it is clear that the Department of Health, together with the NHS Commissioning Board and Monitor, must adopt an enabling framework to guide integrated care over the next five to ten years.** This framework would seek to make the assurance of high-quality care of frail people with complex conditions a 'must-do' for both the NHS and local authorities, addressing the policy barriers to integrated care described above, enabling integrated care to flourish, and requiring the achievement of outcome indicators that reflect the degree of service integration experienced by patients, service users and carers.

We have identified the following ten key elements to this framework.

➤ ***Provide a compelling and supporting narrative for integrated care***

The Department of Health's current focus on integration has begun to inspire a range of initiatives across England. However, many people remain unsure about the vision for and purpose of integrated care and about the Department of Health's long-term commitment to supporting it. Defining the ambitions of integrated care and setting out what it would look like in practice is the highest priority. We would argue that this should be part of a national strategy to address the needs of people with long-term conditions, for whom integrated care is particularly important.

We would urge the Department of Health to take up a position that provides a strong case for integrated care based on its potential to improve significantly the lives of millions of individuals with complex needs and of their carers. In addition, to be taken seriously by commissioners and strategic decision-makers, integrated care must be seen as a strategy that is central to the achievement of QIPP and the shaping of a more sustainable model of care delivery than can help turn the tide of hospital admissions. As we have argued, this vision will need specific and measurable objectives in the NHS Operating Framework if integrated care is to avoid being just a talking-shop across many local organisations.

➤ ***Allow innovations in integrated care to embed***

Integrated care must be given sufficient time to embed locally, with strong leadership and sustained project management, before significant benefits to individual service users can be demonstrated. This will require sites delivering integrated care at scale to be granted – for up to five years – certain freedoms from national constraints. Providers from the independent sector and third sector should be encouraged to support innovations in integrated care.

To enable this to happen a longer planning cycle is needed in which budgets are assured and within which new tariffs and payment systems could be tested. Current financial accounting rules constrain commissioners, and to some extent providers, as they are required to balance their books annually. Moreover, whereas we may be able to predict what the financial settlement in health care will be, it is much more volatile (and currently less generous) for local authorities, meaning that it is problematic to enter into long-term arrangements to support jointly funded health and social care services. This funding uncertainty restricts any ability to 'invest to save' across different financial years, something that is a pre-requisite in developing integrated care.

➤ ***Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies***

It is imperative that local commissioners are able to modify financial incentives and develop new currencies to support integrated care as described above. The priority should be to develop ways of paying for care that reward good outcomes (eg, evidence of well-co-ordinated care across the patient journey) and avoid perverse incentives that, for example, increase hospital activity. This is about modifying, not dismissing, the current NHS system of paying providers. Payment by Results will continue to be highly relevant for planned care where episodes and pathways are relatively easily specified and accounted for.

➤ **Support commissioners in the development of new types of contracts with providers**

The NHS Commissioning Board has a duty to support commissioners in developing a new model of contracting, for example, based on pathways of care as experienced by patients, or using risk-sharing capitation-based contracts with integrated care partnerships of GPs, community health services, and specialists. The latter approach to contracting would need to ensure that the services provided were population-orientated and comprehensive in scope. While a desire to integrate care around people with certain diseases might legitimately be part of the provider's strategy, we would caution against commissioning purely for certain diseases (such as diabetes) as there is a risk of creating new silos of clinical conditions in place of existing organisational silos. The use of carefully crafted outcome measures that assess the person's experience of care across organisations will be critical in demonstrating progress in improving the integration of care, and flagging the introduction of any new fragmentation of services across disease pathways.

➤ **Allow providers to take on financial risks and innovate**

Approaches to integrated care often work best when some of the responsibilities for commissioning services are given to those who deliver care (Christensen *et al* 2009). Giving providers freedom to take 'make or buy' decisions means that the redesign of care and services will be clinically or professionally led (Smith *et al* 2009). Importantly, it promotes collective accountability among providers for the quality, costs and outcomes of care, and there is evidence that innovations in integrated care can develop faster when providers have the incentive to improve service quality while taking on a degree of financial risk. For example, integrated medical groups in the USA that have combined responsibility for commissioning and provision have often been successful in delivering high-quality integrated care (Curry and Ham 2010; Thorlby *et al* 2011).

While such approaches would need to be carefully monitored to ensure that quality of care to patients, service users and carers is not compromised, we would support the development of integrated care partnerships where existing professional relationships are such that they are keen to take shared responsibility for delivering a range of services for a defined population (Smith *et al* 2009; Lewis *et al* 2010). These partnerships might be based on federations of general practices, but they might also be rooted in a foundation trust that seeks to be the care co-ordinator and hub for a local community or in a joint health and social care venture such as a care trust. The independent sector can also play a positive part in integrated care partnerships. Given evidence on the difficulty faced by commissioners in enabling integrated care (Ham *et al* 2011b) it is likely that many integrated care partnerships will be led by providers rather than commissioners in the first few years.

It is important to reiterate here that a prerequisite for integrated care will be the need for significant investment in developing skills and capacity in primary and community care. What is clear is that as a minimum, there will be a need for more federations of general practices (as providers) so that they are in a position to assume contracts to carry out much more extensive, 24/7 co-ordination of care, along with ensuring the provision of a range of intensive community-based services.

➤ **Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework**

There is a need to align governance and accountability arrangements centrally, and in particular the ways in which local organisations will be measured in respect of health and social care outcomes. The Department of Health, NHS Commissioning Board, Monitor, the Care Quality Commission, and Public Health England should set a central expectation

for integrated care to be delivered, using robust and extensive baseline assessment of patients', service users' and carers' experience of services across organisations. They then need to act in a concerted and consistent way to support implementation.

We would strongly support the adoption of a single outcomes framework for the NHS, social care and public health. Health and social care organisations need to be mandated to work collectively to meet common outcomes related to the health and wellbeing of the populations they serve, and this will entail indicators that examine the degree of integration/fragmentation of care given to people with complex conditions. It will also be vital, if we are to avoid any risk of the issues uncovered at Mid Staffordshire NHS Foundation Trust, that regulatory and performance management responsibilities for the care of frail people with complex conditions are absolutely clear.

➤ ***Ensure clarity on the interpretation of competition and integration rules***

Competition and integration are means not ends. Monitor must adopt a proportionate approach that encourages both of these where this benefits patients and service users. It is important that integrated care is 'hard wired' into the health and social care systems of the future, so the primary duty of Monitor should be the protection and the promotion of interests of patients and the public. Changes to the Health and Social Care Bill have supported this dual role, yet it remains unclear in practice how the rules of competition and integration will be interpreted. Monitor should work closely with the NHS Commissioning Board to provide guidance and support on the commissioning and provision of integrated care and to hold commissioning bodies to account for delivering this against a transparent outcomes framework. We are pleased that The King's Fund and the Nuffield Trust have recently been commissioned by Monitor to support them in assessing how this key task can best be performed. We envisage the independent sector playing an increasing part in the development of integrated care.

➤ ***Set out a more nuanced interpretation of patient choice***

Patient choice should be intrinsic to the provision of integrated care as it should allow people greater opportunity to make informed decisions about their care and treatment options. However, those that we talked to saw the policy of patient choice as a barrier to integrated care as it is often used as a mechanism to promote provider competition rather than to provide the sorts of choices that patients and service users would better value. There is a paradox between requiring commissioners to enable people to access a range of providers and allowing them to devise new forms of integrated care that might benefit patients. While patients and service users should always have the option to access alternative services, we agree with Sir Stephen Bubb (Chair of the Choice and Competition Stream of the NHS Future Forum) that a more nuanced interpretation of the policy is necessary as *'choice is much more than the ability to choose a different provider of elective surgery. It is about the choice of care and treatment, the way care is provided and the ability to control budgets and self-manage conditions.'*

Much more needs to be done to empower patients and users to make informed choices about their care and treatment. This can be done by putting in place a single assessment process covering health and social care and by agreeing a care plan with patients, users and their families. Where appropriate, care plans should guarantee access to a named case manager who would be responsible for ensuring effective care co-ordination between care providers to meet the goals of the plan. As discussed, personal health budgets will have a part to play in empowering some patients and users in this, and the greater use of home-based technologies that support people to remain independent and in control of their health and wellbeing should also be a priority.

Putting in place a package of measures centred on individuals is, in our view, at least as important as removing the policy barriers to integrated care and facilitating the

development of integrated care for populations. Many of these measures are already an established part of health and social care policy but they have not been implemented consistently across England. Making them happen is therefore less to do with expenditure and more related to variations in local policy and practice that need to be tackled as a matter of urgency.

➤ ***Support programmes for leadership and organisational development***

Integrated care is unlikely to happen at scale and pace unless those implementing it are given support; those we spoke to stated that programme support was what they most needed to facilitate the development of integrated care locally. A wide range of needs were articulated, such as:

- building leadership, trust, engagement, legitimacy and a common vision among key partners
- investing in the development of information technology to achieve a shared patient record, inter-operability between data systems, and the ability to use tools that identify at-risk individuals in the community
- providing advice and support to commissioners on: finance and procurement processes; new types of contract currencies and incentive schemes; prime contractor models; and public health skills for prioritising investments
- encouraging networks to share learning and ideas
- deploying approaches that promote quality and consistency in care provision.

While much of this might be sought and delivered independently, there is a need for the Department of Health and the NHS Commissioning Board to: invest resources and support the development of skills and competencies for integrated care; promote learning and share ideas to support the adoption and successful application of integrated care; commission, analyse and report on progress on integrated care, including benchmarking this against international developments.

➤ ***Evaluate the impact of integrated care***

An essential component of any integrated care programme is the ability to demonstrate its impact. The Department of Health's strategy for integrated care should outline how integrated care will be evaluated at a national level and emphasise the importance of appropriate evaluation at a local level. The NHS Commissioning Board should be tasked with developing guidance for commissioners to ensure any evaluation is appropriately conducted and can be used to inform service development.

To understand whether integrated care has been successful, it is first necessary to define the goals of integrated care and to ensure that these are what patients, service users and their carers actually want. Robert and Cornwell (forthcoming) suggest a framework for how 'what matters to patients' could be determined and acknowledge that more work is needed on how this could work in practice in the reformed NHS. There are many different methods for assessing an individual's views of care (Vrijhoef *et al* 2009); for example, the Patient Activation Measure (PAM) is used to evaluate patients' ability to manage their own illnesses; and Patient Reported Outcome Measures (PROMs) help capture impact on people's health and wellbeing (for example, reduction in pain, or increase in mobility). The best-tested measures are those used in the Department of Health's national patient survey programme. Successful integrated care as experienced by the individual is not well defined (National Voices 2011), and the degree to which questionnaires capture patients' perceptions of actual care integration is not clear. An urgent priority for the Department of Health and the NHS Commissioning Board is to invest in approaches that can be used locally and nationally to measure the experiences of patients, service users and carers.

An assessment of the utilisation and costs of care services within new integrated care developments is rarely considered. The complexity of integrated care, along with the difficulty of assigning costs to processes and outcomes delivered at a local level, make economic evaluation difficult (Vondeling 2004). The NHS Commissioning Board should provide advice and support to local commissioners on how to access the skills necessary to evaluate the costs of integrated care.

To be able to demonstrate an *improvement* in care, a baseline assessment on all of these measures is needed to track progress over time and, where possible, to use 'matched populations' to investigate whether integrated care can achieve better results compared to where it has not been implemented. Several recent evaluations – for example, of the Whole System Demonstrator pilots and the Partnership for Older People Projects programme (Steventon *et al* 2011) – have highlighted the benefits of linking routinely collected data on individuals and of monitoring interventions in as close to real time as possible. This is relatively cheap, provides results quickly, exploits existing data sources, and is at the forefront of evaluative methodology internationally.

Integrated care is complex and an assessment of its success is likely to be limited by the resources available. However, the Department of Health's strategy should reiterate the importance of appropriate evaluation and make it a core component of the strategy that seeks to promote it.

## **Conclusion**

Integrated care lies at the heart of the aims of the Health and Social Care Bill – to put patients first, improve health outcomes and empower health professionals. The amendments to the Bill that have sought to recognise the importance of integration as well as competition represent an important signal of the need to make integrated care a 'must-do' priority. If executed well, focused and sustained work that addresses the fragmented and inadequate nature of care for people with complex needs will help to create the foundations for sustainable delivery against the QIPP challenge.

The Department of Health and the NHS Commissioning Board must now develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations. This requires the setting of a clear, ambitious and measurable goal linked to the individual's experiences of integrated care that must be delivered by a defined date. This goal should be produced in partnership with patient and user representative organisations and should resonate with the experiences of every individual and their carer where good care co-ordination is essential to meeting their needs. This goal should be included in the annual NHS Operating Framework, and the NHS and partner organisations should be held to account for its delivery. Results should be made publicly available and reviewed on a regular basis.

Finally, if the vision for a more integrated health and social care system is to be realised at scale and pace, we conclude that the Department of Health, together with the NHS Commissioning Board, must adopt an enabling framework to guide integrated care over the next five to ten years. We have described in this report ten key elements of such a framework but would stress that the approach must be permissive and based on 'discovery and not design,' with performance management focused on the outcomes that are delivered to individuals and communities rather than on the means used.

The benefits of integrated care to the individual will not be realised until significant efforts are made to develop capacity in primary and community care, to prioritise investment in social care to support rehabilitation and re-ablement, and to take forward the subsequent downsizing of activity undertaken in acute hospitals. In improving care

for every person with complex health and social care needs, a population-based approach is therefore required that reaches out to local people and provides proactive care and support to meet their needs. **The prize to be won is a health and social care system centred on the needs of individuals and patients and delivering the best possible outcomes.**



## **About this work**

The work we have undertaken to inform this report has involved collating the learning from previous research by the Nuffield Trust and The King's Fund research into a slide pack of evidence about integrated care (Goodwin and Smith 2011). In addition, in October 2011, we held a half-day expert seminar with managers and practitioners from the NHS and social care at the forefront of developing integrated care. This event helped us to test ideas about how integrated care might be adopted at scale and how to support this. These elements were then further tested through follow-up interviews with representatives from nine sites known to The King's Fund and Nuffield Trust as particularly active in delivering new forms of care for people with long-term conditions and complex needs. A second seminar to examine the messages from this work was held in November 2011 with senior policy-makers, including those from the Department of Health, Monitor, and the NHS Future Forum.

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