No Magic Bullets: lessons on integrated care from the English NHS

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Overview

• Potted history of NHS policy on integration
• The role of patient groups in re-shaping policy and practice
• Case studies of integrated care
• What can we say about the impact of integrated care in the English NHS?
• Getting the ingredients right: what will help to achieve greater integration
• Concluding thoughts
The problem...

For patients:
- Fragmentation
- Duplication
- Patient/carer confusion

For the system:
- Waste/inefficiency
- Clinical Risk
- Poor quality and safety

Without integration at various levels [of health systems], all aspects of health care performance can suffer. Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes.'

(Kodner and Spreeuwenburg, 2002, p2)
‘Integration’ and ‘integrated care’

• ‘Integrated Care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion’ (WHO)

• [Integrated care]…imposes the patient’s perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless. (Lloyd and Waite 2005)

From the patient’s perspective: National voices ‘I statements’

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me”
There are many different ‘types’ of integration.....

**Figure 1 Fulop’s typologies of integrated care (from Lewis et al 2010)**

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

*Source: Adapted from Fulop et al (2005)*
Integration may occur at three organisational levels which are often inter-dependent

**Macro:** integration between whole institutions through board level collaboration or merger to deliver whole-population interventions

**Meso:** integration between depts and professional teams to deliver integrated care for specific conditions or population groups

**Micro:** integration between individuals and teams of professional to deliver coordinated care for individuals and their carers including care coordination, care planning, shared information etc
Figure 2 Conceptualisation of integrated care in terms of organisational form (from Donaldson in Ham and de Silva 2009)

Formal ‘real’ integration
- Organisational mergers (with or without subsequent coordination)

Virtual integration
- Separate organisations working in coordinated way
A short history of integration in the NHS
The idea is not new

Concern about lack of integrated care for patients dates back to the start of the NHS, and even earlier

(Rumbold and Shaw)

‘The weakness of the present structure lies in the fact that the NHS is in three parts, is operated by three sets of bodies having no organic connection with each other and is financed by three methods.’

(Guilleband Report, 1955)
Integrated care from 2000 onwards

• Care Trusts – organisational mergers between NHS community services (district nurses) and Local Government social services

• 2003 – Dept of Health analysis: 5% of patients with complex chronic health problems consuming 50% of resources

• 2005 – National programme of care coordination nurses based on US Evercare model

• 2006 National policy paper – Our Health Our Care Our Say: ‘duty of partnership’ between health and social care

• 2009 – 15 national ‘integrated care pilots – all different

• 2012 – Health and Social Care Act promoting a balance between integration and competition within the NHS
The influence of patient groups on integration
The influence of patient groups on integrated care

Longstanding involvement with single conditions

- Diabetes UK, British heart foundation, Asthma UK
- Support groups, education materials, help-lines, research

Working through an umbrella organisation ‘National Voices’ to influence policy

- Early linguistic battle: CDM → long term conditions
- ‘15 million voices’ campaign to promote care planning and self management support

Increasing involvement in commissioning services
Service user perspective: patient centred coordinated care

Summary

Person centred coordinated care

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”
The service user perspective

‘Person-centred coordinated care’

‘I statements’

All my needs as a person are assessed.
I am supported to understand my choices and to set and achieve my goals.
I work with my team to agree a care and support plan.
I have as much control of planning my care and support as I want.
I tell my story once
I have the information, and support to use it, that I need to make decisions and choices about my care and support.
Case studies of integrated care
Pennine MSK partnership: integrated planned care pathways

2002: GPSI & a specialist nurse set up a triage service funded by commissioners to divert patients from hospital OP. Paid sessionally.

2006: contract to run a community based service for all non-admitted rheum/orthopaed? MSK pain.

Established integrated community hub with GPs, specialists and therapists: assessment & treatment.

Identified a ‘programme budget’ for MSK (approx. £23m) and took on a ‘lead provider’ contract for all MSK activity including in-patient.
Drivers and impact of integration

Main drivers of integration

• Professional interest by GP
• $ available to fund a small novel service
• Development of a programme budget to allow commissioning for an integrated pathway of care

Impact of integration

• Reduced waiting times for assessment and treatment
• High patient satisfaction
• Reduced costs
• No significant incentive on hospital providers (paid FFS by Pennine MSK) to increase efficiency
Greenwich Coordinated Care Programme (1)

Builds on long-standing (macro-level) collaboration between NHS and Local Govt (social care)

Existing integrated health and social care teams are ‘wrapped around’ GPs

Targeted to patients with chronic complex problems

Key challenge is to develop effective and efficient MDT working as part of ‘business as usual’
Greenwich Coordinated Care Programme (2)

**Core team:** district nurses, social workers, care navigator

**Extended ‘menu of services’:** clinical, social care, voluntary orgs

**Excellent admin support:** to enable MDT work and pull in other services as needed

**Navigator as point of contact:** for patients

- **Clinical input from specialised teams according to need/MDT assessment**
  - COPD
  - Diabetes
  - Heart failure
  - Resettlement
  - Housing
  - Voluntary organisations

- **Administrative and clinical support from ‘care navigator’ and clinical manager**
  - Highly organised MDT work
  - Support from Skilled admins
  - Triage and allocation of clients
Drivers and impact of integration

Main drivers of integration

• Decision by local payer to invest more in community services to reduce dependence on high cost hospital care

• High level commitment by NHS and Local Govt directors that health & social care integration would deliver better value for $.

• Inspirational leadership by service directors to build teams with shared goals and values.

• Minimal formal governance, no pooled budgets and no working IT integration.

Impact of integration

• Reduction in emergency admission to hospital.

• £1m pa recurrent saving in spend on care homes.

• 12.9 day shorter length of hospital stay cf neighbouring borough.

• Increasing ability to manage frail elderly and people with complex problems in their own home or in the community.

• Starting to evaluate patient experience based on ‘I statements’.
North West London whole system integration

- Integrated IT system with shared access to care plans
- Single board involving all stakeholders, including third sector
- Financial risk and gain sharing to align incentives
- Shared clinical pathways and standards
- Support for regular MDT meetings (and payment to GPs to attend)
NW London integrated care pilot

- Large scale integration of primary, community, acute social & mental health care for people with diabetes and frail elders > 75 years
- Care planning and evidence based care for high risk individuals – 23,000 care plans now completed
- Aiming for care in community, reduced avoidable admissions and effective MDT working
- 115 orgs involved including 100 GP practices across 5 local authorities

Exhibit M: Indicative targets for reduction in emergency care: Ramp-up during IC pilot year
Drivers and impact of integration

Main drivers of integration

• ‘Overheating’ hospital on brink of financial failure – integration seen as a way of controlling demand
• Learning from Kaiser and VA about ‘integrated health systems’ operating at scale
• Significant investment (£5m)
• External support for IT, governance, and ongoing implementation

Impact of integration

• Small sample of pts report easier contact and less duplication of info provision
• MDT working has become part of routine work in participating boroughs (? Sustainable if funding is withdrawn)
• 23,000 care plans completed and some improvements in processes of care
• No significant reduction in emergency admissions
• Staff frustration with the integrated IT care planning tool
Whole system integration – Torbay Care Trust

Main characteristics

• Formal organisational merger between health care (NHS) & adult social care (Local Govt) 2005 (Macro integration) to form an integrated ‘Care Trust’

• Formed five locality integrated health & social care teams for populations of approx 30,000 (Meso)

• Risk stratification to target care to people most at risk of a hospital admission in the following year for care planning and case case management

• Developed new roles to support collaborative working: Health and social care coordinators
# Drivers and impact of integration

## Main drivers of integration

- Learning from a visit to Kaiser Permanente in 2003 by service leaders
- High numbers of frail elderly in local population
- Policy to form ‘care trusts’ (2005) with joint health and care management and pooled budget
- Committed leadership with a clear vision for how to organise the service

## Impact of integration

- Faster access to assessment and interventions
- 24% decrease in emergency bed day use 2003-2008
- Reduction in delayed transfers out of hospital
- Reduced spend by Local Govt on residential and nursing home care
Concluding comments

• Numerous and diverse initiatives to improve integration within the NHS and between NHS and social care services

• Co-ordinating care for frail older people is a particular focus for this work.

• Evidence is mixed with not much methodologically robust research to demonstrate patient satisfaction or saving to the health system

• We know common features of high performing integrated systems in other countries
  (effective governance arrangements; Integrated IT and data; aligned financial incentives; clinical leadership and integrated clinical pathways etc)
  none of the integrated care case studies described here have all the features

• No single model of integrated care that we can turn to and say ‘that works’
Concluding comment

However…..

- Visionary leaders can get you a long way
- Integrated IT – if implemented well – can help hugely but doesn’t seem to be essential.
- Mis-aligned payment systems can act as a significant barrier, but financial integration isn’t essential either….
- Building shared goals and valued in front line staff – to fundamentally change the way they work – is essential to achieve and sustain change
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