Altogether now?
Policy options for integrating care

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Executive Summary

The Next Stage Review of the NHS is likely to emphasise the need to achieve closer integration of care in the future. This paper reviews international experience and research evidence to explore options for the future. The main findings are:

International experience

- There are four main types of integration. These are: integration of GPs and other primary care professionals in the primary care team; integration of the primary care team with other health care professionals working in the community (e.g. district nurses, health visitors, allied health professionals and pharmacists); integration of the primary health care team, other health care professionals working in the community and social care professionals; and integration of the primary health care team, other health care professionals working in the community, social care professionals, and hospital-based specialists.

- International evidence has highlighted the benefits of health and social care integration. Factors identified as important in the models that have been developed include: umbrella organisational structures to guide integration at strategic, managerial and service delivery levels; case-managed, multi-disciplinary team care, with a single point of contact and co-ordinated care packages; organised provider networks, with standardised referral procedures, service agreements, joint training and shared information systems etc.; and financial incentives to promote prevention, rehabilitation and the downward substitution of services.

- In relation to primary health care integration, a review of international models carried out to inform developments in Canada identified four approaches: the integrated community model, the non-integrated community model, the professional contact model, and the professional co-ordination model. The review found that no single model met all criteria of effective primary health care but concluded that the integrated community model and the professional co-ordination model fulfilled most of the desired characteristics.

Policy options for the NHS

- There are three main options for taking forward health and social care integration. These are integrated health and social care commissioning; integrated health and social care teams; and the use of individual budgets for long-term conditions so that individuals can join up their own health and social care.

- Primary health care integration can be taken forward through integrated commissioning and provider organisations; integrated provider functions; and coordinating care between a plurality of providers in the emerging primary care market (recognizing that the last of these may make integration more difficult to achieve).

- Care co-ordination requires different professionals to take on this role at different points in the care pathway. These professionals include GPs and members of the primary care team, community matrons and other nurses working in the community, hospital-based staff such as medical specialists and transition nurses, and key workers in mental health services and social care. It is important to be clear which of these staff is the designated care co-ordinator at any one point. For some patients the option of holding an individual budget is another way of achieving care co-ordination.

- Primary and secondary care integration can be promoted in a number of ways. These include integration through commissioning, integration through provision e.g. through the use of SPMS contracts and NHS Foundation Trusts, and integration through managed clinical networks. The Next Stage Review needs to include specific proposals for strengthening the incentives and levers to support primary and secondary care integration to make these a reality on the ground.
Introduction

When the final report in Lord Darzi’s Next Stage Review of the NHS is published in the summer of 2008, the much awaited primary and community care strategy is likely to include a series of proposals for new models of care. In particular, the emphasis is likely to be on models which enable a more effective integration of primary and secondary care (and maybe even social care as well). As the interim report of the Darzi review argued, more integrated care could have a number of benefits, including:

- Responding more effectively to the needs of people with long-term conditions.
- Improving the effectiveness and safety of care.
- Encouraging more ‘seamless’ care for patients.

As previous HSMC policy work has demonstrated, current health reforms are designed to combine competition in some areas of care and collaboration in others (see, for example, Ham, 2007). To date, more emphasis has been placed on competition than collaboration, and a key challenge for the Darzi Review is how to ensure that greater attention is given to collaboration and service integration in future.

Against this background, this paper draws on international experience and research evidence to explore options for the future.

Different models of integration

From HSMC’s experience of policy, practice and research, we believe that there are four main types of integration relevant to the forthcoming primary and community care strategy:

- Integration of GPs and other primary care professionals in the primary health care team.
- Integration of the primary health care team with other health care professionals working in the community (e.g. district nurses, health visitors, allied health professionals and pharmacists).
- Integration of the primary health care team, other health care professionals working in the community and social care professionals.
- Integration of the primary health care team, other health care professionals working in the community, social care professionals, and hospital-based specialists.

Underpinning all four forms of integration is the need for more effective care co-ordination, an issue that is receiving increasing attention in a number of systems, and the involvement of voluntary sector organisations.

Care co-ordination and integration are closely linked concepts, and from a clinical and patient point of view may be indistinguishable. In this paper, we use integration as the overarching term to denote different ways in which services and clinicians can work together. Care co-ordination is used more specifically to refer to particular roles, behaviours or mechanisms that can be used to achieve integration of care.

Closer integration of care may be achieved through the integration of provision, the integration of commissioning, or the integration of commissioning and provision. This paper draws on experience of all forms of integration in order to identify policy options for the future.

Integration in the NHS

Following changes to the GP contract in the 1960s and 1990s, there were moves to achieve closer integration of GPs and other health care professionals in the primary health care team, supported by financial incentives contained within the contract. As a result, the NHS has already achieved closer integration of care through the development of primary health care teams in many other countries (McDonald et al. 2000). Despite this, integration of the primary health care team with other health care professionals working in the community is more variable. A number of reports over the years have put forward proposals for achieving closer integration of this kind, but progress in aligning the work of community nursing teams (for example) and practices has often been slow.

Much the same applies to integration of the primary health care team, other health care professionals working in the community and social care professionals. A partial exception can be found in some Care Trusts where organisational integration has been used to promote service integration of this kind, and in Northern Ireland where the existence of an integrated health and social care system has enabled integrated teams to be established in some areas.

The final type of integration, with hospital-based specialists, has been promoted in a number of areas through the work of local clinical and managerial champions (Ham, 2008). Typically, this has involved integration in relation to particular care groups (for example, older people) and specific diseases (for example, diabetes and respiratory diseases). However, a number of the health reforms in England risk creating greater fragmentation as a wider range of providers enter the healthcare market and the incentives facing providers (such as payment by results and practice based commissioning) work against the integration of primary and secondary care.

A key question for the Darzi Review is which of these different types of integration is most important in the next stage of NHS reform. Even more important is how will the Review facilitate the emergence of integrated care by removing some of the barriers that currently exist and creating stronger incentives and levers to support effective integration? This paper seeks to address these questions by drawing on international experience and research evidence.
Health and social care integration

There is a wide range of experience and evidence on which to draw in considering how to achieve closer integration of care in England. In relation to health and social care integration, Kodner (2006) has reviewed experience in the following North American models of integration:

- **PACE** (the Program for All-inclusive Care for Elderly People) in the US
- **SIPA** (Système de soins Intégrés pour Personnes Âgées) in Quebec, Canada
- **PRISMA** (Programme of Research to Integrate Services for the Maintenance of Autonomy), in Quebec, Canada

The following table summarises key features of each of these models and the results they have achieved in practice.

Kodner’s review provides some indication of the practical elements of service delivery believed to be most helpful in supporting more integrated care. These are:

- Umbrella organisational structures to guide integration at strategic, managerial and service delivery levels.
- Case-managed, multi-disciplinary team care, with a single point of contact and co-ordinated care packages.
- Organised provider networks, with standardised referral procedures, service agreements, joint training and shared information systems etc.
- Financial incentives to promote prevention, rehabilitation and the downward substitution of services.

Kodner’s findings are reinforced by a review of European models of health and social care integration undertaken by Johri and colleagues (2003). The clear message from this review is that integrated care for older people delivers positive outcomes. Key factors appear to include the importance of case management, geriatric assessment and multidisciplinary teams; a single entry point; and financial incentives to promote downward substitution of care (see table 2).

**Primary health care integration**

In relation to primary health care, a recent review (Lamarche et al, 2003) identified four model types for organising primary health care that were relevant to the Canadian context. Two of these were deemed to be ‘community-oriented’ and two to be based on a ‘professional approach’. The models were:

- **an integrated community model** (focused on co-operation and interaction with the community, and featuring healthcare service centres governed by public representatives, centres that are able to sub-contract services from other providers)
- **a non-integrated community model** (differs from integrated model in not using information technology to integrate services with those provided by the rest of the health system, does not provide 24 hour services, and has no formal mechanism to ensure longitudinal continuity of services to individuals. Provides integrated community services within a closed system).
- **professional contact model** (physicians owning their own practices or operating walk-in medical clinics. Seeks to ensure accessibility of primary health care, and focuses more on clients than subscribers. Tends to be focused on general practitioners’ care, clinical information is shared only within the organisation itself, no formal mechanisms to ensure longitudinal continuity of care for individuals, and no formal mechanism to integrate with other components of the health care system).
- **professional co-ordination model** (seeks to provide continuous services, over time, primarily to patients registered to receive care [subscribers]. It is usually funded by capitation, or a capitation/fee-for-service mix, has a care-giving team of doctors and nurses, and has a professional designated to provide follow-up and continuity for each patient/subscriber. It is used to transfer information to other parts of the health care system, and a nurse provides leadership to the process of clinical integration beyond the organisation).

Lamarche et al concluded that no single organisational model can meet all the anticipated effects of primary health care: effectiveness; quality; access; continuity; productivity; and responsiveness. They suggested that two models stand out, since they meet most of the desired effects: the integrated community model and the professional co-ordination model. They pointed to the inevitable trade-off between co-ordinated professional models whose strengths include responsiveness, and community-oriented models whose strengths include equitable access to services. What this study offers is a clear insight into the importance of determining the desired impacts of primary health care reform, before deciding on what model of provision is most likely to optimise those desired impacts.

Outside the UK, New Zealand has sought to develop closer integration of care after experimenting with market based reforms in the 1990s. Box 1 summarises recent experience in New Zealand and potential lessons for the NHS.

**Care co-ordination**

Whatever approach is taken to service integration, there is increasing recognition that effective care co-ordination is needed to meet the needs of ageing populations in which chronic conditions represent the main burden of disease. Care co-ordination is important in ensuring that providers in different parts of the health and social care system work in a joined-up way and enable patients and clients to be cared for in the most appropriate setting. Care co-ordination is particularly important during care transitions, such as discharge from hospital to home, to ensure continuity of care, as well as care that is safe and of a high quality. It is also critical in relation to unscheduled and emergency care.

A recent review by the OECD (Hofmarcher et al, 2007) has summarised experience of care co-ordination in different countries. The review found a range of approaches that had been adopted, including care and case management, disease management, and patient pathways. Primary care providers are often seen as having a key role in care co-ordination when patients are referred to hospital, while within hospitals co-ordination is usually handled by hospital specialists. Widespread difficulties were reported in transitions to long-term care, despite efforts to improve continuity during these transitions.
### Table 1: North American Models of Integration

<table>
<thead>
<tr>
<th>Model Type</th>
<th>PACE (USA)</th>
<th>SIPA (Canada)</th>
<th>PRISMA (Canada)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Description</strong></td>
<td>Adult day health centre-based comprehensive health and long-term care programme with risk-based capitation financing for elderly nursing home certifiable population</td>
<td>Community-based, primary care led, case managed health system for the frail elderly operating out of Local Community Service Centres; inspired by PACE</td>
<td>Community-based, case managed, single point of entry service network</td>
</tr>
<tr>
<td><strong>Model Type</strong></td>
<td>Fully integrated</td>
<td>Fully integrated</td>
<td>Coordinated</td>
</tr>
<tr>
<td><strong>Project Objectives</strong></td>
<td>Maintain frail elderly persons in community for as long as possible by avoiding or postponing institutionalisation</td>
<td>Maintain and promote autonomy of frail elderly people; and, promote optimal utilisation of community-based services as substitute for hospital and nursing home care</td>
<td>Integrate service delivery to ensure functional autonomy</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>1) community dwelling elderly residing in service area; 2) aged 55 and over; and, 3) certification of eligibility for nursing home admission</td>
<td>1) community dwelling elderly residing in demonstration area; 2) aged 64 and over; 3) moderate disability; and, 4) willingness of carer(s) to participate</td>
<td>1) community dwelling elderly residing in demonstration area; 2) aged 65 and over; 3) moderate to severe impairment; 4) need two or more health care or social services; and, 5) show good potential for staying at home</td>
</tr>
<tr>
<td><strong>Services Covered</strong></td>
<td>Comprehensive primary, acute and long-term care; enriched home- and community-based services; on contract basis</td>
<td>Comprehensive long-term care; acute medical and social services, including some respite housing; largely on contract basis</td>
<td>Existing acute, long-term care, rehabilitative and supportive services in region</td>
</tr>
<tr>
<td><strong>Service Management</strong></td>
<td>Multidisciplinary team, including primary care physicians</td>
<td>Multidisciplinary team working with primary care physicians and others</td>
<td>Case managers working closely with family physicians and others</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td>36 operational sites in 18 states with 10,523 enrollees</td>
<td>1,254 persons in 2 sites; half received SIPA intervention</td>
<td>272 persons (PRISMA cohort); 210 persons (control cohort)</td>
</tr>
<tr>
<td><strong>Referral Methods</strong></td>
<td>Community outreach; voluntary enrolment</td>
<td>Existing home care clients; referrals from hospitals and physicians, government agencies; and outreach activities</td>
<td>Outreach; single point of entry</td>
</tr>
<tr>
<td><strong>Payer(s)</strong></td>
<td>Capitated payments from Medicare and Medicaid programmes; some private out-of-pocket premiums</td>
<td>Government</td>
<td>Government</td>
</tr>
<tr>
<td><strong>Evaluation Methodology</strong></td>
<td>Quasi-experimental, non-randomised design</td>
<td>Randomised design (RCT) based on two geographic sites</td>
<td>Quasi-experimental, non-randomised design</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Decreased hospital inpatient and nursing home use; Increased utilisation of outpatient medical care, therapies and home- and community-based services; Positive impact on Medicare costs vis-à-vis non-enrollee comparison group; Favourable health status outcomes; Overall satisfaction with care arrangements; Inconsistent impact on physical functioning; Differences in quality of life (not statistically significant)</td>
<td>Increased access to home- and community-based services; Reduced hospitalisation of alternate level of care patients (i.e., “bed blockers”); Decreased utilisation and costs of emergency department, hospital inpatient and nursing home stays (not statistically significant); Average community care costs per person were higher in SIPA group, but institutional costs were lower with no difference in total overall costs per person in the two groups; No differences in health outcomes; Increased satisfaction for SIPA caregivers with no increase in caregiver burden or out-of-pocket costs</td>
<td>Declining trend in institutionalisation and client preference to be institutionalised; No deterioration in autonomy/ functioning at T1 and T2, but effect disappeared at T3; Little effect on utilisation of services; Positive effect on carer burden; No impact on mortality (survival)</td>
</tr>
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</table>
Based on this analysis, the OECD review argued that there were four key areas where reforms could potentially enhance the capacity of health systems to better coordinate care. These were:

- Better information transfer and the wider use of IT.
- Increased resources going to ambulatory care.
- New primary care models, based on multidisciplinary teams (see below for further discussion).
- Greater health system integration.

As the review noted, all four areas appear important for achieving improvements in performance. This includes developing payment models which encourage cooperation across sectors and reward multidisciplinary care.

The US, Germany and the UK are all examples of countries that have sought to strengthen care co-ordination using a variety of interventions. The evidence summarised by the OECD indicates that the main objective in all countries is to reduce costly hospitalisation by promoting better co-ordinated care outside hospitals. However, programmes to foster co-ordination are relatively new and clear evidence on cost savings is not available. New incentives have been introduced to provide more effective care, as in the new contract for GPs in the UK, and regulatory changes have been developed to break down barriers between sectors e.g. through incentives for sickness funds and long term insurers to cooperate in Germany.

### Primary and secondary care integration

One of the biggest challenges in all health care systems is how to achieve closer integration of primary and secondary care. Paradoxically, the United States is the country with most experience of this kind of integration, as seen in the work of integrated delivery systems such as Kaiser Permanente, the Veterans Health Administration and Group Health Cooperative. A recent analysis (Shortell and...
Box 1: Integration of Care in New Zealand

In New Zealand, 21 district health boards (DHBs) are responsible to the Minister of Health for ensuring the planning, funding and delivery of comprehensive health and disability (social) services for their local populations. DHBs have a majority of directly elected members and, as well as being the commissioning body, directly manage local hospital and community health services, and contract with mainly independent providers for many primary health services as well as for social services such as home and residential care for older people. In this respect they are integrated local commissioning and provider organisations with strong community governance.

Eighty primary health organisations (PHOs) have been established in New Zealand with a brief to address health inequalities, improve access to primary care services, develop more population health and preventive local primary care services, and improve co-ordination of services at the local level. People become a member of a PHO when they register with a general practice or other primary care provider (such as Maori health organisation). PHOs are non-governmental organisations that vary greatly in relation to size, function and management arrangements. They are contracted by the DHB to develop and co-ordinate primary care services, to allocate capitation funding to general practices, and to try and enable a broader population health approach within primary care.

Given that DHBs fund and contract for a wide range of social services, there is much less discussion about the issues of integrating health and social care, compared with the UK. The focus has been more on how to better network and support general practice and other local providers, with the intention of encouraging this part of primary care to adopt a more population health approach, prior to then using the PHO model to fund and develop (and increasingly to manage) a broader range of community services.

Whilst in theory the DHB model of integrated funding, planning and provision represents an opportunity to develop effective co-ordination across primary and secondary care, in reality, some DHBs find themselves captured by secondary care priorities and funding deficits, and hence struggle to focus on primary health care. New Zealand is therefore exploring how it can shape funding mechanisms, incentives, and performance frameworks in such a way that the benefits of strong local governance and a devolved system can deliver better integrated care that is rooted in the community setting.

Schmидt, 2004) has identified seven key features of these systems. These are:

- multispecialty group practice in which GPs and specialists work alongside each other to provide care
- health care teams that make use of the skills of nurses, allied health professionals, pharmacists and others
- defined populations that enable doctors and the wider health care team to develop a relationship over time with a ‘registered’ population
- aligned financial and payment incentives, centred on prepaid group practice for doctors, that avoid the perverse effects of fee for service reimbursement and encourages the prudent use of resources
- a medicine-management partnership that links the clinical skills of health care professionals and the management and organisational skills of executives
- enhanced information management capability through the use of the electronic patient care record, and clinical decision support systems
- explicit accountability for performance to key stakeholders e.g. through public reporting of quality and outcome data

As can be seen, there are many similarities between these features and the characteristics identified earlier in this paper by other reviews of the experience of integration in different systems.

Integrated delivery systems in the US take many different forms reflecting the diversity of health care funding and delivery in that country. The weight of research evidence has demonstrated the high levels of performance of integrated delivery systems compared with the much more fragmented approach to care evident elsewhere in the US (Enthoven and Tollan, 2004). There is also evidence that these systems perform as well as or better than the NHS on some aspects of performance (Feachem et al, 2002; Ham et al, 2003).
Implications for the NHS

Moving from international experience to more detailed proposals, a number of different models may be appropriate to consider (and are by no means mutually exclusive). These models draw on the experience and evidence reviewed in the first part of this paper to outline a menu of policy options for the future. Some of these options focus on commissioning, some on provision, and some on both commissioning and provision.

Health and social care integration

Three main options are available for strengthening health and social care integration:

1. Integrated health and social care commissioning: in previous policy work (Glasby et al, 2005), HSMC has proposed the creation of a Foundation Health and Social Care Trust. Unlike current Care Trusts (which remain NHS bodies), these could sit genuinely in between current health and social care, overcoming much of current local government hostility to this model. With all of the local electorate as members, elections of the Board/Governors could take place on the same ballot paper as for local Council elections, with some seats elected from localities and others filled by nominations from relevant user and carer groups. Such a model would have a number of advantages:

- It would combine government policies around Foundation Trusts and Care Trusts to produce a way forward which may be acceptable to both health and local government.
- It would lead to greater joint working between health and social care.
- It could increase voter turnout/public interest.
- It would introduce local democratic procedures into the heart of the local NHS.

Another option would be a Health and Social Care Commissioning Agency. With a pooled budget and delegated authority from partners, such an agency would provide a strategic lead and commission health/social care from a range of different providers. In particular, it would have a key role in receiving policy from the centre and collectively making sense of it at a local level. To be effective, this agency would need to be a tangible entity to provide a degree of permanence amid debates about possible local government and NHS reorganisation. Such a body could also provide health/social care input into wider debates around social inclusion, regeneration and other cross-cutting issues. At ground level, a strategic body such as this could be supplemented by integrated locality teams or by networks of practitioners working with a particular user group.

Underpinning any joint commissioning work could be a Shared Outcomes Framework for both health and social care, with local health and social care communities expected to embed such outcomes in local plans and processes and inspected jointly on the extent to which such outcomes are met. Evidence from previous reforms suggests that attempts to change front-line behaviour by structural solutions or via the power of ideas often do not have the desired impact. In contrast, changes in incentives and accountabilities can be more powerful (particularly when structures and the power of ideas are aligned with the new incentives and accountabilities).

Under this approach, one option would be to base such a framework on the outcomes proposed in the 2005 Adult Social Care Green Paper:

- Improved health
- Improved quality of life
- Making a positive contribution
- Exercising choice and control
- Freedom from discrimination or harassment
- Economic well-being
- Personal dignity

2. Integrated health and social care teams: while integrated teams have long been encouraged by policy, there would be scope to develop a more formal approach to this longstanding aspiration, with two slightly different possibilities: either integrated intake and assessment teams, or longer-term health and social care practices. The former might cover a specific geographical area (e.g. a town or neighbourhood) and thus be a local monopoly, providing a first point of contact, assessing, providing short-term support and referring on to longer-term services for those people with ongoing needs. In contrast, health and social care practices might focus more on providing support to people with longer-term needs (where continuity of care is paramount) and would be much smaller, enabling an overall system of joint commissioning from a larger number of small, local health and social care practices.

This latter idea builds on recent proposals in children’s services (Le Grand, 2007), which are exploring the concept of a Social Care Practice (a professional partnership between a small number – 6 to 10 - of social workers, similar to a medical or legal partnership, contracting with the local authority to provide field social work for looked-after children). Owning its own assets and paying its partners (and any staff that it might employ), the Practice may have scope to overcome some of the difficulties with current provision (such as a lack of a continuous personal relationship between the child and a local authority social worker, excessive bureaucracy and a lack of autonomy for workers). In particular, such an approach is best suited to situations and cases where longer-term input and significant continuity of care is required.

3. Use of individual budgets for long-term conditions so that individuals can join up their own health and social care: a previous policy paper, HSMC has recommended the extension of Direct Payments and Individual Budgets to forms of community health services (Glasby and Duffy, 2007). At present, these individualised forms of funding are available for social care only – even when people receiving such funding for their social care have complex needs that span the health and social care divide. With this way of working now receiving increased attention from policy makers (and seemingly enjoying cross-party political support), it may offer the chance for people with cross-cutting needs to integrate their own services and support.

In social care, Individual Budgets involve being clear with the person from the outset how much money is available to meet their needs, then allowing them maximum control over how that money is spent on their behalf and over how much control they want to have of the money itself. There are a range of support options available, ranging from taking the full amount as a direct payment through to having a social worker manage the full amount on your behalf (with several other options in between). Following very promising early results in social care, this way of working is being rolled out nationally, and is currently being piloted in health care via the West Midlands Strategic Health Authority and via the national Staying in Control project.

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Primary health care integration
As noted above, reviews of international experience suggest that the UK has already achieved closer integration of care through the development of primary health care teams than many other countries. Despite this, there is a perception that integration of the primary health care team with other health care professionals working in the community is more variable.

There are a number of options based on the integrated community care model for remodelling community health services (CHS) to improve integration with those provided by general practice. Some of these could raise professional issues relating to the extent of integrated roles and ability for retaining robust frameworks for continuing professional development. They broadly cover three options shown in Figure 1:

1. Integrated commissioning and provider organisation
Models for this are emerging as a result of practice based commissioning development, such as Principia in Rushcliffe, Nottingham (Box 2). The close relationship between the commissioning and provision of CHS could lead to a focus on re-engineering these services to achieve efficiency gains that stimulate innovation and an increased level of integration between CHS and general practice. Population based organisations smaller than PCTs have the potential for involving CHS staff in clinical and financial modelling in a manner that PCTs have failed to achieve. This may be one of the trade-offs for the reduction in the contestability of provider that this model would provide.

2. Integrated provider function
A separate and integrated provider organisation would enable commissioners to test the market in terms of value for money but retain the opportunity to integrate CHS with general practice. An ICO based on a PBC cluster population would differentiate it from the current larger PCT provider unit and would facilitate integration between general practice provision and CHS. Locality models such as this are already developing within generalist services such as the model developed by Wirral PCT (Box 3). They could also be extended to include specialist services that efficiently operate at this population level, typically diabetes and COPD.

Figure 1: Potential ICO configurations

The separate ICO provider function could be delivered under various organisational models – health and social care foundation trusts, clinical chambers (combinations of medics and other clinicians), social enterprise, health and social care practices or a vertically integrated acute and community provider. Nurse or therapy led ICOs then become an option such as Central Surrey Healthcare operating as a social enterprise.

3. Plurality of providers across the care spectrum
The third option is to use commissioning to shape a primary care market that includes a number of ICOs and delivering various aspects of care across the spectrum. There are a variety of configurations that would apply such as disease specific ICOs, and those that focus on one level of the care spectrum for long-term conditions. This option achieves the greatest level of choice and contestability where demographics allow for multiple providers but increases the risk of service fragmentation and may make integration more difficult to achieve.

The ICO could have a devolved health and social care budget for provision aligning clinical and financial decisions with agreed outcome frameworks to specialist teams for whom it is more appropriate to work across larger populations such as larger groups of consortia (e.g. sexual health, some specialist nurses (diabetes, COPD, continence depending on size) community hospitals, leisure services and PCT populations (CMHTS, other specialist nurses – Parkinsons, Continence, Macmillan)).

Care co-ordination
International developments in care co-ordination suggest the following implications for the NHS:

- Primary care has a key role in co-ordination, as GPs and members of the primary care team act as patient navigators.
- Community matrons and other community nurses also play a part in care co-ordination for people with complex chronic conditions.
- In hospitals, care co-ordination is undertaken by different staff including medical specialists, discharge nurses, transition nurses, breast cancer nurses and others.
- Care co-ordination is especially difficult and important during care transitions, and greater clarity is needed as to where responsibility for co-ordination lies.
- Experience in social care and in mental health services with key workers may be helpful in strengthening care co-ordination within the NHS.

As care co-ordination is likely to be undertaken by different professionals at different points in the care pathway, it is important to be clear which of these professionals is the designated co-ordinator at any one point to avoid patients ‘falling between the cracks’. Notwithstanding the strength of primary care in the NHS and the role of GPs as gatekeepers, it cannot be assumed that care co-ordination will happen without proper planning and clarity of roles.

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Box 2: Principia, Partners for Health, Nottingham

Principia is a Company Limited by Guarantee operating as a Social Enterprise which brings together all GP Practices across Rushcliffe to work with the community services as well as the local patient population to deliver local healthcare services. Using PBC as a driver with a budget of £100m, the 17 GP practices involved in Principia cover 115,000 patients under an APMS contract. There is a staff supply agreement with Nottinghamshire County PCT for the provision of 140 nurses, therapists and managerial staff to be part of the company. The future plan is for the staff to transfer employment once issues relating to NHS terms and conditions have been resolved.

As noted above, for some patients the option of holding an individual budget to commission packages of care and support is another way of achieving care co-ordination. In contrast to current arrangements in which patients and families end up being care coordinators by default because the formal care systems fails to take on this function, individual budgets would be a positive means of empowering service users to achieve the integration of care that an ageing population with increased prevalence of chronic diseases requires.

In the longer term, information technology has the potential to play an increasingly important part in care co-ordination. Specifically, the development of the electronic patient care record will enable providers to access information wherever and whenever patients seek care. Notwithstanding the difficulties and delays experienced in the NHS in developing the electronic patient care record, experience in other countries and systems, such as the Veterans Health Administration, Kaiser Permanente and Group Health Cooperative in the United States, is already beginning to demonstrate the role of information technology in promoting integration and co-ordination of care.

Primary and secondary care integration

A recent review of NHS experience has identified three approaches to primary and secondary care integration. These are community based specialists working closely with practices to improve care for people with defined long-term conditions such as diabetes; primary care reaching into hospitals to provide more care in the community, and closer to patients’ homes; and primary care providers working in partnership with secondary care providers (Ham, 2008). Each approach is seeking to overcome historical divisions in British medicine as well as the organizational separation of hospitals and primary care.

Looking to the future, further moves to integrate primary and secondary care will depend in part on the existence of appropriate incentives. Within the health reform programme in England, there are three main incentive systems. These are:

- **Payment by results (PbR)**, which was designed to reward hospitals for treating additional patients in order to meet targets for reducing waiting lists and waiting times

- **Practice based commissioning (PBC)**, which is intended to engage practices in managing demand for hospital services and providing care closer to home

- **nGMS** which rewards practices that provide high quality care as defined in the Quality and Outcomes Framework

In addition, the system of reimbursement for delayed transfers of care introduced in 2003 was designed to create incentives for local authorities to provide care in the community to avoid hospital beds being occupied by patients who were ready to be cared for out of hospital, and the flexibilities contained within the Health Act enable NHS organisations and local authorities to pool budgets in order to provide more integrated care for older people, and people using mental health and learning disability services.

With the exception of the Health Act flexibilities, none of these incentive systems supports the development of clinical and service integration, nor were they intended to do so. Indeed, if anything they risk creating greater fragmentation as hospitals seek to maximize income under PbR, practice based commissioners seek to retain resources for the development of services outside hospital, and the reimbursement regime creates conflict between local authorities and NHS organisations over the funding of care for people following hospital treatment.

A major risk is that existing incentives will suck more resources into hospitals at a time when policies such as Our Health, Our Care, Our Say are seeking to move care out of hospitals and into the community. This risk is heightened by the continuing strength of secondary care providers and the relative weakness and under development of commissioning. The primary and community care strategy in the Darzi review will suffer the same fate as Our Health, Our Care, Our Say (i.e. of limited implementation) unless the incentives and levers are in place to turn the vision into reality.

1. **Integrated commissioning**

One way of avoiding this fate would be through a progressive and ultimately radical expansion of practice based commissioning. This would entail practice based commissioners that have demonstrated competence taking on responsibility for all (or almost all) of the health service budget for their populations, including GMS, CHS and spending on hospital services. The budget would need to be hard and would have to be supported by a rigorous method of determining person based allocations adjusted for risk.

The implication is that practice based commissioners would seek to develop much closer relationships with medical specialists who might become equity sharing partners in practices. Other health and social care providers to access information wherever and whenever patients seek care.

Box 3: Wirral PCT Local Health Directorates

Wirral PCT has developed an arm’s length provider unit overseeing local health directorates that include all PCT-provided services, practice-based commissioning clusters, and GP provider services. The PCT has built its structure to achieve strong clinical engagement with local professionals, especially independent contractors such as GPs, pharmacists, optometrists and dentists. There are robust governance arrangements to ensure separation of commissioning and provision. The local health directorates integrate the provision of CHS with general practice and align clinical and financial decision making within the localities.
professionals might also become partners and indeed leaders in these organisations. As a consequence, practice based commissioning would become **multispecialty based commissioning**, and potentially **integrated commissioning** if social care were to be included in these arrangements. In many ways, this would entail building on the experience of the total purchasing pilots that were established in the 1990s and that enabled networks of practices to take greater responsibility for commissioning and provision.

It is possible to envisage a variety of organisational forms emerging, ranging from fully integrated models in which a single organisation employed the complete range of staff to virtually integrated models in which a core group of commissioners and providers developed relationships with a range of generic and specialist providers. As far as community health services are concerned, some of these services need to be closely aligned with primary medical care and social care services, while other more specialised community services may be better organised and provided at a different level e.g. through specialist providers working with a number of integrated commissioning groups.

There would also be variability in the degree of budgetary responsibility that commissioning groups would take on. The inclusion of potentially all services within the commissioning budget, and the use of hard rather than soft budgets, would make it much more attractive for entrepreneurial GPs and specialists to become fully engaged in the work of these groups. Not only this, but also there is likely to be strong interest from private sector organisations with relevant expertise in working with health and social care professionals in integrated commissioning groups (this is already evident).

2. **Integrated provision**
As it would take time for these arrangements to evolve, there is a strong argument for using other levers and incentives to support the development of integrated care in the interim. The focus here is more on the development of provider integration than integrated commissioning. One option would be to make greater use of the flexibilities available under specialist personal medical services (SPMS) contracts. These provide opportunities to build stronger links between primary care teams, community health service staff and specialists alongside the longer term direction of travel described here.

Experience in current SPMS contracts in areas like Oldham and Surrey indicates the potential of encouraging further use of these flexibilities, and consideration of how they might be extended.

A second option would be to enable **NHS Foundation Trusts** in some parts of the country to reach out into the community and to develop closer integration of care. In our view, this option should be used sparingly as it risks an acute service model of care dominating thinking about primary and community care in the future, as the experience of New Zealand referred to earlier shows (see Box 1), and it could limit patient choice. Nevertheless, in areas where primary and community care is relatively weak, and Foundation Trusts are strong, clinical and service integration led by Foundation Trusts may offer the best way forward, provided that PCTs are sufficiently skilled to work closely with Foundation Trusts in the development of integrated services and to act as effective commissioners.

3. **Managed clinical networks**
A third option would be to build on and adapt experience in Scotland of using **managed clinical networks** and managed service networks. Managed clinical networks have been used for a number of years to develop an integrated approach along the continuum of care from community to acute care settings. While many of these networks focus on closer integration of health care, there is increasing interest and activity in developing multi-agency networks that involve social care and other partners. Guidance from the Scottish Executive (2007) has identified the need for networks to have a lead clinician or lead officer responsible for the functioning of the network, a defined structure and an annual work plan. As in the case of Northern Ireland with its integrated health and social care structure, Scotland’s approach offers learning for England as interest in integrated care increases.

### Conclusion
The aim of this policy paper has been to set out the menu of possibilities available for promoting the integration of care in the light of the Darzi Review in general and the primary and community care strategy in particular, rather than to advocate a single approach. Our view is that England has much to learn from the experience of other countries in taking forward integration and in ensuring a better balance between competition and collaboration as strategies of reform. In bringing together international experience and research evidence, the paper is intended as a constructive contribution to the debate on the next stage of health reform, and the journey from good to great.
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About HSMC

HSMC has been one of the leading UK centres for research, personal and organisational development in health care for over thirty years. The commissioning and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings.

In particular, distinctive features of HSMC’s work and reputation have been:

- Its recognition of the interdependence between research, teaching and consultancy.
- Its dual expertise on process and content when working with health and social services.
- Its emphasis on providing research-based policy analysis, development and teaching to the health and social care community.

This approach is often summarised as a commitment to rigour and relevance in the development of people and policy in health and social care. According to this approach,

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