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Clinically integrated systems: the future of NHS reform in England?

Recent reforms to the NHS in England seem to make integration of care harder rather than easier. But **Chris Ham**, **Jennifer Dixon**, and **Cyril Chantler** argue that integration is not incompatible with competition and that it is essential for more efficient care

A recent survey of 1000 general practitioners and hospital doctors in England found that they thought increased collaboration between clinicians and better coordination between organisations were the best ways for the National Health Service to achieve efficiency savings.¹ The results underline the potential for clinicians and organisations to work together to enable the NHS in England to make the £20bn (€24bn; \$32bn) of efficiency savings that it has been challenged to find. Working together means clinicians and organisations overcoming the fragmentation

that results in “deficiencies in timeliness, quality, safety, efficiency and patient-centredness” by developing integrated models of care.²

We argue that general practice commissioning should be used as a platform on which to build integrated care in the NHS in England. There is no inherent contradiction between the government's wish to increase patient choice and provider competition on the one hand and the argument for greater integration on the other. Effort should therefore focus on developing choice between competing clinically integrated systems.



Where Torbay and care trust chief operating officer Mandy Seymour lead, can others follow?



MARK THOMAS

What is integrated care?

Integrated care takes many different forms. In some circumstances, integration may focus on primary and secondary care, and in others it may involve health and social care. A distinction can be made between real integration, in which organisations merge their services, and virtual integration, in which providers work together through networks and alliances.³

Integration may also entail bringing together responsibility for commissioning and provision. This form of integration is important because it allows clinicians to use budgets to either provide more services directly or commission these services from others. Integrating commissioning and provision helps to facilitate the development of new models of care outside hospitals that better meet the needs of an ageing population and the increasing burden of chronic diseases.

Evidence on integrated care

In England, a good example of the benefits of integrated care is Torbay, where health and social care services and budgets for older people have been brought together (box 1). Five integrated health and social care teams organised in localities have been established, and the work of each team is aligned with several general practices. Teams employ health and social care coordinators, who act as a single point of contact and use the same assessment process to evaluate the needs of patients referred to them. The unified assessment process enables doctors, nurses, and allied health professionals to pool their knowledge of patients and facilitates discussion of how their needs should be



Box 1 | Torbay: integrated care in action

The benefits of clinicians working together in integrated health and social care teams led to an agreement between the local council and the primary care trust to establish a care trust in 2005

The care trust brought responsibilities for health and adult social care into one organisation. It has a single budget for health and social care, and teams are able to use this budget flexibly to meet patients' needs

A priority has been to increase spending on intermediate care services that enable patients to be supported at home and help to avoid inappropriate hospital admissions

The results can be seen in:

- Reduced use of hospital beds (daily average number of occupied beds fell from 750 in 1998-9 to 502 in 2009-10)
- Low use of emergency bed days among people aged ≥ 65 (1920/1000 population compared with regional average of 2698/1000 population in 2009-10)

Minimal delayed transfers of care

met. The integrated teams focus on the most vulnerable older people living in the community with the aim of anticipating their needs and helping them to remain independent.⁴

The experience of the Veterans Health Administration in the United States provides further evidence of the benefits of integrated care. The Veterans Health Administration was transformed from a fragmented, hospital centred system in the mid-1990s into a series of regionally based integrated service networks. It now consists of 21 networks, each of which has responsibility for the provision of all forms of health and long term care within a fixed budget. 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. The Veterans Health Administration has also pioneered the use of telehealth to enable patients (mostly older veterans) to manage their conditions at home with appointments or visits being triggered as necessary. Care coordinators, who are usually nurses or social workers by training, manage a panel of between 100 and 150 general medical patients or 90 patients with mental health problems. Studies have shown that bed use fell by 55% after the implementation of integrated service networks and quality of care compares well with other systems.⁵

Evidence on the effect of integrated medical groups, often referred to as multispecialty medical groups, in the United States is particularly

instructive as these groups have some similarities to the general practice commissioning consortiums that are being formed under current NHS reforms in England. Integrated medical groups typically comprise family doctors and specialists who take joint responsibility for the provision and commissioning of care for particular populations. The degree of integration within groups varies from loose alliances of practices to tightly organised multispecialty groups such as those found in Mayo Clinic. Integrated medical groups that took on capitated budgets and risk contracts under managed care in the 1990s used case management programmes and prior authorisation of referrals to reduce their use of hospital services.⁶ The evidence indicates that large groups are able to provide higher quality of care at lower costs than other types of medical practice.⁷

Ingredients of integrated care

Although the evidence on integrated medical groups seems to support moves in England to allocate budgets to networks of practices to develop new models of care, the warning signs from the United States should also be heeded. Well established groups with skilful medical leaders and a strong culture were effective but many others were not. Reasons for failure of integrated groups

included weaknesses in how budgets were set, inadequate means to manage financial risk, lack of timely and accurate information about how they were using services and resources, and the challenge of building effective organisations containing medical leaders and experienced managers.⁸

It follows that integrated care is likely to deliver on its promise only if several ingredients are in place. These ingredients include team working that breaks down barriers between clinicians; aligned financial incentives that avoid overtreatment and support delivery of care in the most appropriate settings; responsibility for defined populations that enables relationships to develop over time; and a partnership between doctors and managers in leading improvement. Large integrated systems that include hospitals as well as doctors confirm the importance of these ingredients.

Kaiser Permanente is an often cited example. Its high performance is underpinned by a substantial investment in information technology, a collaborative culture in which family doctors work closely with specialists and other clinicians, an exclusive relation between the medical group and the health plan (or commissioner in NHS speak), and a system of incentives that supports the provision of care in the most appropriate settings. Studies have shown that Kaiser Permanente

makes much less use of hospital beds than the NHS in England, partly because of a focus on knowing the population it serves, designing incentives to deliver high quality preventive care, providing coordinated care to people with chronic diseases, and ensuring that patients who are admitted to hospital are discharged as soon as possible.^{9 10}

Barriers to integrated care

There are many barriers to the development of integrated care in England. The historical division between general practitioners and specialists is one of the most important. Professional barriers are accentuated by the coexistence of different organisations responsible for acute hospitals, community health services, and mental health services, and by the separation of responsibility for the commissioning and provision of services.

The pursuit of market oriented reforms has led to independent sector providers having a role in the delivery of care to NHS patients, increasing fragmentation between providers. Slow progress in implementing Connecting for Health means that an integrated electronic medical record remains an aspiration rather than a reality, while payment by results can set commissioners against providers instead of

encouraging them to work together. The divide between health and social care is a further barrier and has been overcome successfully in only a small number of areas like Torbay.

Integration and competition

It was against this background that the previous government selected 16 areas to pilot the development of integrated care (box 2).¹¹ Alongside

the pilot programme, areas such as Cumbria and Redbridge have also taken the initiative to integrate care and have sought to do so in the face of policies that make integration more difficult, such as increasing the diversity of providers and paying providers by results.¹²

The coalition government's radical proposals for reform of the NHS also focus on competition between providers. The stated aim of these proposals is to put patients at the centre of the NHS and improve outcomes. How will this affect moves to integrate care? On one reading, integrated care could stifle choice and competition if it resulted in the establishment of organisations that are monopoly providers of care in their areas. An alternative argument is that integrated systems could be in the vanguard of the changes needed to improve performance, especially if there is competition between these systems.¹⁴ In the US, organisations like Kaiser Permanente function within a healthcare market, and some analysts have suggested that competition acts as the spur that drives integrated systems to perform well.¹⁵

Taking integrated care forward

One way forward in the NHS would be to use general practice commissioning as a platform on which to build integrated care. General practitioners have been asked to take the lead on commissioning because of their role as service providers, and many are attracted to do so because of the opportunity it offers to develop new models of service provision. These models focus on ways of better meeting the needs of people with chronic diseases, providing care closer to home, and avoiding inappropriate admissions. They also emphasise the importance of prevention.

If GP commissioners are to lead the development of integrated care, the practices in commissioning consortiums need to be able to provide as well as commission services. Their role would be

analogous to that of integrated medical groups in the United States, taking on the risk of capitated budgets for their populations and working alongside specialists and community health services in clinically integrated systems or clinical partnerships.^{16 17}

In urban areas competition would hinge on consortiums being formed by like minded practices that want to work together rather than practices that happen to

be in the same area. Patients would in this way have a choice of consortiums, and this should stimulate consortiums to offer services attractive to patients. The performance of these competing clinically integrated groups could then be compared with that of integrated systems in rural areas, where geographical constraints mean that it will be difficult for consortiums to compete for patients. In this way, it should be able to test

the argument that integration and competition may have a bigger effect when used in tandem rather than separately.

We have suggested using general practice commissioning as a platform on which to build integrated care because the government has set such store on this element of the NHS reforms in England. However, hospital providers could also take the initiative in moving in this direction, especially in areas where general practitioners are relatively weak and specialists strong. London is a case in point, not least because it has several academic health sciences centres that present the potential to extend high quality care from hospitals into the community. In this context, integration might build on the strengths of academic health sciences centres by allocating them a capitated budget in conjunction with general practitioners and community health service providers. Patients would be able to choose between integrated systems based on academic health sciences centres and could also access care outside these systems in order to create an incentive for providers to deliver responsive care of high quality.

Conclusion

NHS reforms need to take account of the accumulating evidence on the benefits of integrated care. As a recent critique of healthcare in the United States has concluded, the scale of the challenges

facing health systems is such that disruptive competition between integrated systems is likely to be more effective in promoting desirable innovations than competition between fragmented systems.¹⁸ The same applies in England, where a much more nuanced debate is needed that recognises the possibility of integration and competition both having a part in improving performance. In this debate, the focus should be on the development of medical groups comprising general practitioners and specialists able to both provide and commission services.

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