Integrated healthcare services

The future of commissioning and provision for out of hospital healthcare in the NHS

An NHS Alliance discussion document
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Summary

Recent healthcare reforms have placed a disproportionate emphasis upon competition between primary and secondary healthcare services. Current policies around Practice Based Commissioning, Payment by Results and plurality of providers have introduced competition at the most vulnerable interface: between primary and secondary healthcare services.

PCTs and Foundation Trusts have exactly opposite priorities for demand management. That has led to a deterioration in relationships between GPs and Consultants, managers and clinicians, across PCTs and hospitals. Since patients with long term conditions experience the interface between primary, community and secondary healthcare, a culture of clinical collaboration would be more suitable to provide flexible and responsive healthcare services in their journey through the healthcare system.

On the other hand, the NHS economy faces three key challenges: increasing clinical productivity, improving services for prevention, and the management of long term health conditions. The NHS Next Stage Review is an opportunity to review some of the unintended consequences of the recent healthcare reforms and suggest policy which is evidence based and promotes healthy competition and collaboration between various components of the health service.

Integrated Healthcare Services could be designed to reduce the bottlenecks and duplications at the primary-secondary healthcare interface for patients with long term conditions. This integration could be achieved by strengthening Practice Based Commissioning, especially by increasing the depth and breadth of PBC to enable true world class commissioning. If Integrated Healthcare Services are designed along the business model of the proposed Integrated Provider Organisations, these services would also be able to address the productivity and prevention challenges currently facing the NHS.

This report suggests several practical approaches including:

- The development of a new medical professional – the Community Specialist or Consultant;
- The introduction of Integrated Provider Organisations, based around one or more PBC groups.

The model proposed would allow Integrated Healthcare to realise the organisational competencies of world class commissioning. Supported by PBC, clinicians would be enabled to collaborate and lead positive change within the health service through innovation, while ensuring that the local population is truly engaged with preventative healthcare and enjoys the benefits of a flexible, responsive and patient centred health service.

Government policy makes the development of Integrated Healthcare inevitable. Primary and secondary care clinicians should lead this change. The vital next step is for professional and membership bodies to collaborate in taking that development forward.
1. Policy context

The structure of health services in UK remains fundamentally unchanged since publication of the Dawson Report in 1920\(^{(1)}\). It consists of ‘primary health centres’, ‘secondary hospitals’ and ‘teaching hospitals’. GPs work predominantly in primary care while specialist doctors are hospital based. This traditional model is changing for a variety of reasons. The evolving health needs of the population (especially long term conditions), emphasis on patient choice and satisfaction and the challenges of balancing quality of healthcare with cost-effectiveness make change desirable, while developments in technology make it possible.

Since publication of the NHS Plan in 2000, there has been a sustained effort to break down traditional demarcations between different professional groups and organisations. The Government’s vision for moving health and social care further into the community (\textit{Our Health, Our Care, Our Say}) proposed shifting care within particular specialities from hospital to community settings\(^{(2)}\). Practice based commissioning was expected to promote care closer to home provided by a plurality of providers. Payment by results was intended to reform the financial system of hospital payments and offer the right incentives to reward good performance, to support sustainable reductions in waiting times for patients and make the best use of available capacity.

However, while individual aspects of policy may have appeared robust in isolation, the rush to introduce free market reforms to implement these policies has resulted in the overall policy being fragmented, incoherent and inconsistent with achieving positive change.

2. Where are we now?

The NHS Next Stage Review is tasked with developing a vision for the next 10 years of the health service. The King’s Fund Report \textit{Our Future Health Secured?} emphasises the need for increasing productivity in the NHS and strengthening commissioning as well as the prevention/public health agenda\(^{(3)}\). Practice based commissioning in its current form has enjoyed limited uptake and although there are examples of innovation and service redesign with practice based provision of specialist services, the changes are relatively small scale and have yet to make a major impact on reducing hospital referrals. At the same time, emergency and unscheduled care activity in hospitals continues to increase, offsetting any gains from reducing routine referrals to hospitals.

An uneasy equipoise currently exists between primary and secondary healthcare services and between clinicians and managers in both these organisations. PCTs and Hospital Foundation Trusts could be seen as having exactly opposite priorities about demand management as a result of National Tariffs/Payment by results. Hence, recent reforms have introduced the free market model at precisely the most vulnerable
interface of healthcare – primary and secondary care, where sophisticated incentives would be useful to promote cooperation and collaboration rather than competition, which risks an atmosphere of mistrust between the organisations which are supposed to provide seamless care along the patient pathway. At the same time, anecdotal evidence supports the widespread view within the medical profession that relationships between GPs and Consultants have suffered as a result of emphasis on competition between primary and secondary healthcare services.

3. Where do we want to be?

Research evidence about the advantages of integrated working practices between primary and secondary care clinicians is not lacking. Better communication and educational exchange(4), improved patient satisfaction, greater efficiency(5) and improved health outcomes(6). The NHS Alliance has been in the forefront of those calling for “bridging the gap between primary and secondary care”(7). In 2004, a joint NHS Alliance, RCP and RCGP document called for: “models of provision that allow primary and secondary care clinicians to work side by side to help design and deliver effective care management programmes”(8). After looking at Kaiser Permanente, Light and Dixon proposed: “integrated primary-secondary centres”(9).

However, an efficient mechanism to facilitate this integration has always been elusive in the UK NHS. Case examples of Consultants providing sessional service in GP surgeries and facilitated by PBC are not uncommon. Some PCTs are supportive of clinician-led initiatives in the management of long term conditions in community and primary care where efficient links with hospital services are maintained. These initiatives can be highly successful for management of some long term conditions, but they have not been systematically evaluated for efficiency or cost-effectiveness and critics of this model state that economies of scale favour specialist services to be limited to hospitals. Also session-based work in primary care by hospital based specialists may not be as efficient or cost-effective in the long term as hoped. Geographic and travel time consideration and a secondary care culture in some hospital based specialists (‘you may get him/her out of the hospital but you will not get the hospital out of him/her’) could be realistic barriers.

Integrated healthcare services would enable generalists (GPs) and Specialists (Consultants and SAS doctors) to co-operate and collaborate in commissioning and providing health services which are sensitive to the needs of the local population. Specialist healthcare would be provided by the most appropriate clinician in a location which was suited to the needs of the patient. These ‘community specialists’ would be sensitive to the wider health needs of the local population like their GP colleagues and maintain a more holistic and preventative focus, but also have skills which would enable them to support patients during short stay hospital admissions, if required. Although the emphasis would remain upon keeping the patient out of hospital by promoting health prevention
measures and managing outpatient care and minor complications in the community, there would be no systematic effort to fragment or destabilise the quality of highly specialised inpatient care, which a small proportion of patients would need from time to time.

This model of Integrated Healthcare Services would significantly reduce unhealthy competition and prevent contractual and cultural stand-offs between Primary Care Trusts and Hospital Foundation Trusts. They would prevent absolute monopolies from being created in the NHS (as would be the case if Hospital Foundation Trusts expanded outward and downward to provide community and primary care), but achieve the aims of productivity and financial prudence by having sophisticated incentive measures to keep patients healthy and out of hospital unless there are strong medical reasons for inpatient admission. Integrated Healthcare Services would enable GPs and Specialists to align their loyalties and best practice objectives, and to have a common vision for high quality and cost effective service provision.

In a recent briefing paper published by The Nuffield Trust(10), Ham emphasises the disadvantage of hospitals being seen as ‘profit centres’ in an era where prevention and treatment of chronic diseases and avoidance of hospital admission are the key priorities. Integrated Healthcare Services would enable the health service to move ‘upstream’ towards promoting ‘wellness’ at a population and individual patient level, rather than depend mainly upon expensive hospital based medical interventions to meet the health needs of the population.

4. What do we need to get there?

4.1 A radical re-think about Practice Based Commissioning

The economy and quality of healthcare in the UK NHS can be improved by organising the health systems so that an integrated and comprehensive care system is available for the patient in his/her journey through primary, community and secondary healthcare.

Although quality of healthcare is a complex issue and does not always correlate with access or the way healthcare is financed as a whole, focussed mechanisms which align financial incentives with improved quality performance may contribute to better quality. More importantly, improved quality may reduce costs(11). Better management of long-term conditions outside hospitals may reduce expensive emergency care and hospitalisation. There is an argument that, if we want to improve quality and reduce costs, we should focus on quality improvement first rather than cost reductions.

Practice based commissioning (PBC) as a policy has considerable potential to improve the economy and quality of healthcare if several challenges are addressed first. Integrated Healthcare Services, if developed using the principles and objectives of PBC, would be more likely to be acceptable to
healthcare staff and the public, than contracting with private sector organisations (major retailers, drug companies, insurance companies). Efficiency saving would remain within the 'NHS family' and reinvested in healthcare services rather than contributing to corporate profits.

To make PBC a success story, a significant number of GPs need convincing of the benefits of PBC to patients, while current incentive payments may need revisiting to encourage practices to collaborate and share expertise where necessary.

Specialists based in secondary care largely perceive PBC as a mechanism to fragment specialist healthcare services in hospitals and provide these services in primary care as a cost-saving initiative, where quality could be variable and patient safety compromised.

The depth and breadth of PBC, in its current form, is too restricted to allow true integration between specialists and primary care teams. If PBC is expected to be the vehicle for facilitating the reform programme, we need radical rethink of what its real objectives are.

If patient choice is an objective, then there needs to be a mechanism in place to ensure that the patient genuinely has a choice between a primary care provided specialist service locally and that provided in secondary care. Integrated healthcare services would make it more likely that the patient would no longer perceive the hospital as the only centre providing specialist healthcare. He or she may then prefer to opt out of hospital specialist services.

If provision of high quality healthcare based upon a systematic evaluation of local health needs is an objective of PBC, then specialists would need to be involved at every level: from commissioning and providing to evaluating patient feedback and quality of the service. This would be possible if PBC was an important component of Integrated Healthcare services.

4.2 Broadening the remit of specialist community based services

Specialist services in the community cover a number of medical specialties (community paediatrics, medicine for the elderly, mental health and learning disability services, GU medicine, dermatology, diabetes and more) but few surgical specialties.

The services that are provided in the community often have limited scope and may exist in isolation from both GP services and the corresponding hospital based specialist service, although potentially they could play an important role in managing patients with long term conditions and those where clinical needs span the primary and secondary care interface(12).

Consultants in Community Specialties ('community specialists') could be increased in number and their roles and responsibilities defined and developed further to make efficient use of their broad based skills and serve as an effective link between primary and secondary healthcare. This
would have workforce, training and education implications. It would also require appropriate incentives to raise the profile of community based specialist services and attract high quality doctors from medical and surgical specialties to consider this as a career option.

4.3 Process and structures: Integrated Provider Organisations

An Integrated Healthcare Service, in its simplest form, would comprise of PBC clusters (across one or more localities depending upon population and geography) consisting of GPs, specialist doctors, nursing and other primary care professionals. These clusters would be allocated a capitated budget (risk adjusted) on behalf of the local population to commission a range of primary, community and hospitals based healthcare services, and also provide primary, community and specialist services. These business entities could be referred to as Integrated Provider Organisations (IPOs) to avoid confusion with the common perception of integrated healthcare as offering alternative medical therapies.

Integrated Healthcare Services could be delivered in a variety of healthcare settings. Practice Based Commissioning clusters and PCTs could identify suitable premises for delivery of one or more specialist services in the community alongside primary care, based upon local healthcare priorities. The structure of the premises should be determined by the scope of the integrated health services in the locality, rather than the other way round. These could range from existing or upgraded ‘health centres’ to community hospitals to purpose built outpatient facilities with radiology and pathology facilities, as determined by local healthcare needs.

In urban areas where suitable facilities exist for such IPOs, co-location of several specialist services with primary care services would be possible. Elsewhere, primary care services would be provided in more than one location (large surgeries/health centres) with each of the specialist services co-located in one or two of these centres, determined by local healthcare priorities. Even if all primary and specialist services are not co-located, the principles of integration would hold true in a common business model.

4.4 Contractual issues and incentives

Primary care contracting and commissioning of specialist services would need to be re-visited:

- GPs would be expected either to enter into larger partnerships or to form closer and more co-operative relationships with other, probably neighbouring, partnerships. Both forms would accept the total capitation payment for the population covered by IPOs.

- Specialists would be reluctant to move out of hospitals unless contractual terms and conditions in IPOs were at least equivalent to hospital colleagues and included preservation of NHS Pension benefits.
Sophisticated incentive measures for GPs, specialists, nursing and allied primary care staff would be necessary. Incentives could be linked to productivity, health outcomes, reduction in emergency care and inpatient admission to hospitals and patient satisfaction. IPOs providing the total range of healthcare could reallocate resources within their organisations from savings made as a result of reduction in hospital admissions and length of hospital stay. These savings could then be allocated to further develop outpatient and homecare nursing services, provide financial incentives for clinicians and also re-invested to provide a range of preventative services for the local population.

Population health promotion and prevention of ill health would serve as a self propagating incentive for all IPO staff, if savings were to directly contribute to further service development and financial and contractual incentives for staff.

4.5 Competition, regulation and governance

The free market model of competition - where IPOs would aim to drive local hospitals out of business or where neighbouring IPOs could potentially drive each other out of business - would be unpopular and risk a return to some of the drawbacks discussed earlier of the healthcare reform programme, with the inevitable impact on healthcare staff morale and eventually patient satisfaction and healthcare quality.

At the same time, IPOs risk creating local healthcare monopolies, especially when GPs and specialists have aligned incentives and perform the dual functions of commissioning and providing health services for the local population. Safeguards to ensure an appropriate level of competition, clinical quality and public and patient involvement could be put in place to reduce the risk of these local monopolies.

Patient choice would allow patients to move to an IPO of their choice. The aim here is not to dissociate geographical populations from their locality IPOs (and GPs), but assist patients in making an informed choice about their healthcare provider by ensuring public availability of comprehensive performance data (quality, access, patient satisfaction) for each IPO. In practice, populations along locality (and IPO) boundaries would be more likely to make this choice.

IPOs offering the whole spectrum of primary care and specialist services, could develop mechanisms for competition based upon provision of additional holistic healthcare services (looking beyond the traditional biomedical model of healthcare), where patients would be empowered to choose between IPOs based upon their choice of such additional services.

Effective public and patient involvement would ensure responsiveness to local needs as well as enhancing the promotion of health and self help. This might develop along the lines of the patient participation groups recently developed in some GP practices and could even include patient membership of the IPO.
The final safeguard could be a model of regulation developed for PCT implementation designed to ensure that quality, health outcomes and patient satisfaction are built into the contractual model and also to determine the proportion of savings which could be retained for financial incentives for IPO staff.

4.6 Management support

For Integrated Health Services to be viable as efficient commissioning and provider services for primary and specialist healthcare, high quality management staff will need to be recruited and retained in primary care. Practice managers in GP surgeries make an important contribution to the success of the ‘business model’ in primary care\(^\text{13}\). PCT management experience would also be valuable for the regulation and monitoring of IPOs.

In the longer term, it would be expected that clinicians would be supported to develop management skills as part of their education and training, to enable them to take on greater clinician-manager roles in healthcare organisations.

4.7 Integrated Information Systems

It is not uncommon for information systems in primary, community and secondary healthcare services to be designed in order to effectively perform their function in each of these settings, but rarely interfacing effectively with each other to enable sharing of clinical information across the various components of healthcare the patient comes in contact with.

Integration of the various information systems would be necessary to enable Integrated Healthcare Services to function effectively. Electronic clinical information systems capable of tracking patients across multiple providers and settings of care would facilitate effective commissioning and provision of patient care via care pathways.

4.8 Co-producing health with the patient

The Health Foundation believes co-production – the ability of participants to actively work together to shape their own services over time – will deliver radical and effective measures for self-management of long term conditions\(^\text{14}\).

At its heart the process gets under the skin of the patient/user, the carer and health professionals to see what it is that leads them to behave the way they do – what motivates them, what is their lived experience. Co-producing health could be at the individual, service or organisational level.

Integrated Healthcare Services would be eminently suitable to dramatically improve health services for the local population by working collaboratively with patients, users and communities. Co-production between specialist and primary care in collaborative partnerships would
enable the health service to be flexible and responsive to patient needs, especially for the management of long term conditions.

4.9 Interface: GP surgeries and hospital/Foundation NHS Trusts

Integrated Healthcare Services provided via the IPO model would have important interfaces with the current small business model of GP surgeries and, at the opposite end of the spectrum, with Hospital and Foundation NHS Trusts.

Research evidence about Kaiser Permanente (California) seems to point to better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition and greater investment in information technology\(^{15, 16}\). However some contend that the Kaiser model could not be as effective within the NHS where services are available to the total population. The World Health Organisation advises that horizontal rather than vertical structures provide the most cost effective and efficient services with better patient outcomes\(^{17}\).

The full integration of clinical services across the primary/secondary care boundary is critical. Whatever model is preferred, the join between different organisations at different levels within the NHS should be invisible to the patient, who should be able to feel that he or she is being dealt with by a single organisation – the National Health Service – rather than by several disconnected and fragmented parts. This does not imply that hospitals, secondary care or Foundation NHS Trusts should be organisationally responsible for the provision of primary and community services.

In practice, a 'big bang' change may not be popular or even desirable. It would be more sensible to develop the operational models by working with a number of early implementation sites. The learning and evaluation could then be rolled out incrementally depending on local circumstances. Hence, it is proposed that that the IPO model could include the majority of GP practices in some localities, but collaborate with those practices which choose to remain outside the model in other localities. A system of contractual incentives would be required to enable the model to be as inclusive of primary care as possible.

Some large IPOs may consider integration with hospital NHS Trusts in selected localities for maximum efficiency. That might be particularly appropriate in the case of small district hospitals. Elsewhere, IPOs could develop a model of collaboration and partnership with Foundation Hospitals, aligning incentives to achieve the best care for individual patients.
5. Next Steps

Integrated healthcare is no longer a distant shadow on the horizon that can be comfortably ignored. Government policies to shift care closer to home demand closer working and eventual integration between primary and secondary care. It is inevitable that, in the future, we will see more Consultants and Specialists working within community settings. That implies radical changes to the working patterns for both specialist doctors and GPs. If these changes are to be achieved effectively and clinical quality maintained, then it is critical that they should be led by primary and secondary care clinicians working together.

Obstacles to change should not be underestimated. A significant cultural shift would be necessary for specialists and generalists to be able to work across organisational boundaries and in a collaborative fashion as ‘equal partners’ to realise the clinical and professional benefits of an Integrated Healthcare Service.

Specialists who have had almost exclusive experience of hospital based patient care during their training and employment, may struggle to appreciate the need for change in their working practice. There is also a risk that some specialists may perceive working in primary/community care as loss of ‘consultant status’.

Some GPs could have reservations about including Consultants as equal partners in decisions about commissioning and service provision.

There would also be significant workforce and postgraduate training implications if specialists and generalists are expected to have broad based clinical skills and work across organisational boundaries.

The development of Integrated Healthcare must be taken forward by clinicians rather than waiting for the imposition of organisational change from above. Specialty and membership organisations and the Royal Colleges have the potential to play a crucial role in helping win the hearts and minds of their members, and to facilitate the necessary cultural shift.

The challenge and the most important next step is about mobilising the leadership potential which already exists within members of these organisations, bringing them together to build a consensus about the best way forward to design a modern and sustainable health service for the 21\textsuperscript{st} Century.
References


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