

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

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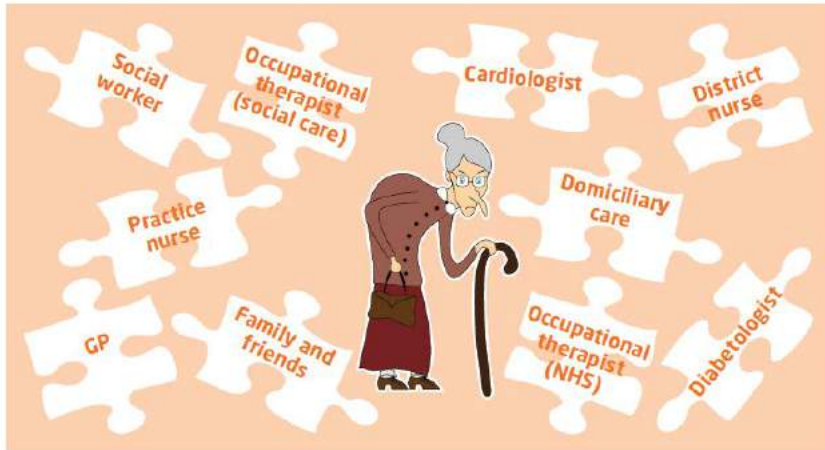
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Overview

- Defining integration and the problems we are trying to solve
- The role of patient groups in re-shaping policy and practice
- Case studies of integrated care
- A role for new models of general practice in delivering integrated care?
- Concluding thoughts

The problem...

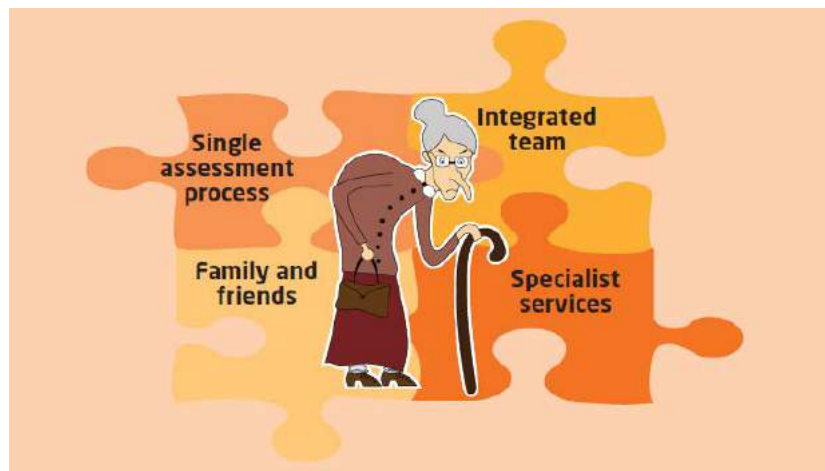


For patients:

- Fragmentation
- Duplication
- Patient/carer confusion

For the system:

- Waste/inefficiency
- Clinical Risk
- Poor quality and safety



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

(Kodner and Spreeuwenburg, 2002, p2)

Defining Integration

175 definitions identified in a literature review!!

- **Levels of integration**
 - **Macro – between institutions, Meso – between departments and Micro – between individual professionals/clinical teams**
- **Real or virtual**
 - **Institutions mergers vs ‘partnership agreements and JVs**
- **Intensity**
 - **Integration - pooled resourced/shared management vs coordination- shared protocols/eligibility criteria vs linkages- eg sharing info**
- **Horizontal and vertical**
 - **Within a care sector (eg community integration between community nursing/social care/primary care) or across care sectors (primary/acute hospital/specialist hospital)**

A short history of integration in the NHS

A potted history of integration in the NHS...

The idea is not new

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

(Rumbold and Shaw)

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

(Guilleband Report, 1955)



A potted history of integration in the NHS...

- Care Trusts – organisational mergers between NHS community services (district nurses) and Local Government social services
- 2003 – Dept of Health analysis: 5% of patients with complex chronic health problems consuming 50% of resources
- 2005 – National programme of care coordination nurses based on US *Evercare* model
- 2006 National policy paper – *Our Health Our Care Our Say*: ‘duty of partnership’ between health and social care
- 2009 – 15 national ‘integrated care pilots – all different. Evaluation showed little impact on resource use and little enthusiasm among patients

NHS reforms: 2010 - 2012

- Coalition (Conservative /Liberal) Government elected 2010
- Health plans announced within 6 weeks – July 2010
 - Major structural reorganisation
 - GPs to lead payer side of NHS – clinical commissioning
 - New role for local government through ‘health and wellbeing boards’
 - Introduction of an economic regulator to promote competition - Monitor
 - Greater patient sovereignty ‘no decision about me without me’
- The ‘outcry’ – privatisation by stealth
- ‘The Pause’ – need to balance competition and integration
- Health and Social Care Act 2012
 - Creation of a health specific economic regulator (Monitor) to ensure that *‘choice and competition operate in the best interests of patients’*

A new competitive context for the NHS

- **Monitor** polices the rules on choice and competition and acts to prevent anti-competitive behaviour by commissioners or providers where it is against patients' interests.
- Monitor has a duty to consider how it can enable or facilitate the delivery of integrated care for patients where this would improve quality of care or improve efficiency

'One of Monitor's responsibilities is to enable better integration of care so services are less fragmented and easier to access.'

'It is our view that competition and integration are not mutually exclusive and competition does not and should not have to come at the expense of beneficial coordination.'

The influence of patient groups on integration

Patient group influence on integrated care

Longstanding involvement with single conditions

Diabetes UK, British heart foundation, Asthma UK

Support groups, education materials, help-lines, research

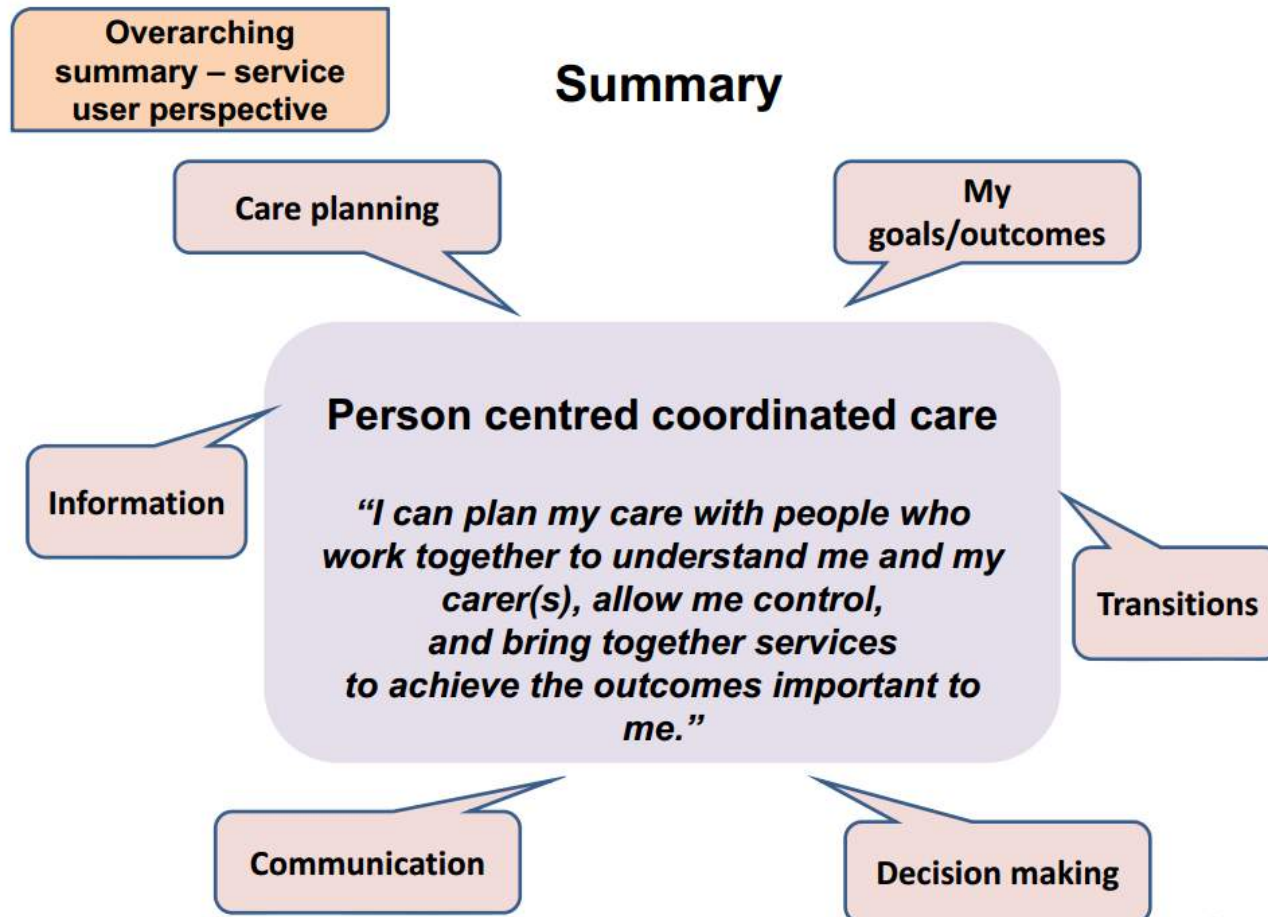
Working through an umbrella organisation 'National Voices' to influence policy

Early linguistic battle: CDM → long term conditions

'15 million voices' campaign to promote care planning and self management support

Increasing involvement in commissioning services

Service user perspective: patient centred coordinated care



The service user perspective

‘Person-centred coordinated care’

‘I statements’

All my needs as a person are assessed.

I am supported to understand my choices and to set and achieve my goals.

I work with my team to agree a care and support plan.

I have as much control of planning my care and support as I want.

I tell my story once

I have the information, and support to use it, that I need to make decisions and choices about my care and support.



Case studies of integrated care

Pennine MSK partnership: integrated planned care pathways

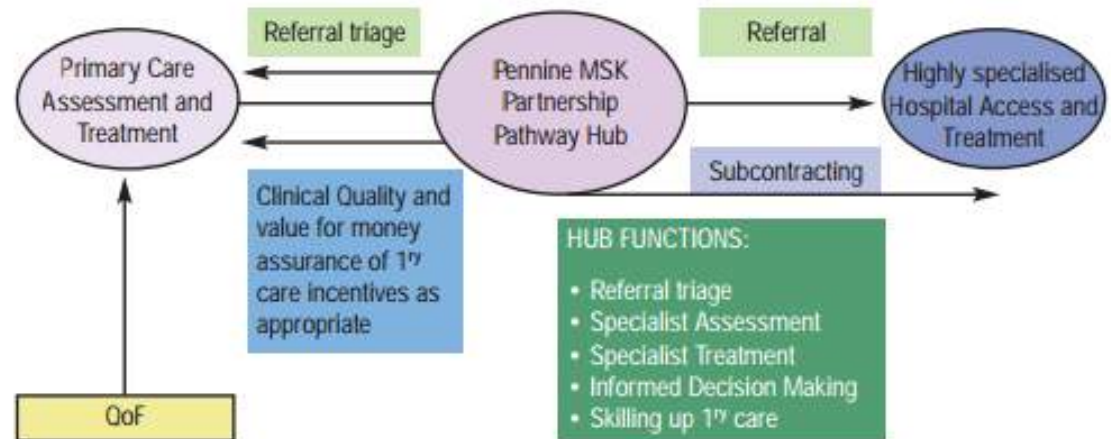
2002: GPSI & a specialist nurse set up a triage service funded by commissioners to divert patients from hospital OP. Paid sessionally

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

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

Identified a 'programme budget' for MSK (approx. £23m) and took on a 'lead provider' contract for all MSK activity including in-patient

Figure 7. The Pennine MSK Partnership Pathway [with thanks to Dr Steve Laitner]



Drivers and impact of integration

Main drivers of integration

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

Impact of integration

- Reduced waiting times for assessment and treatment
- High patient satisfaction
- Reduced costs
- No significant incentive on hospital providers (paid FFS by Pennine MSK) to increase efficiency

Greenwich Coordinated Care Programme (1)

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

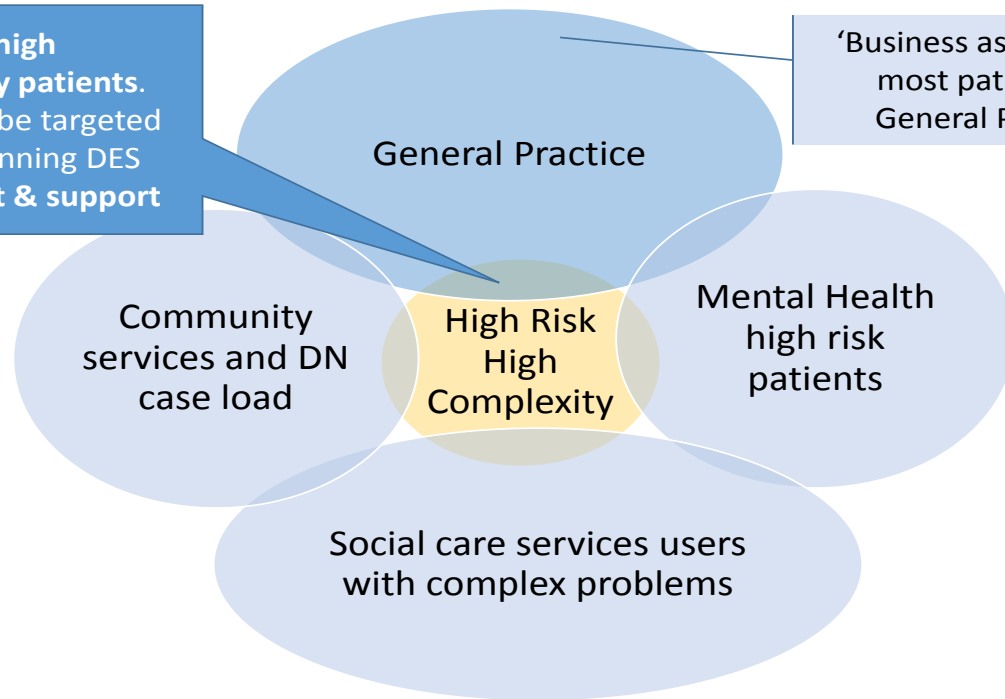
Existing integrated health and social care teams are 'wrapped around' GPs

Targeted to patients with chronic complex problems

Key challenge is to develop effective and efficient MDT working as part of 'business as usual'

High risk, high complexity patients. Many will be targeted in care planning DES MDT input & support

'Business as usual' for most patients in General Practice



Greenwich Coordinated Care Programme (2)

Core team: district nurses, social workers, care navigator

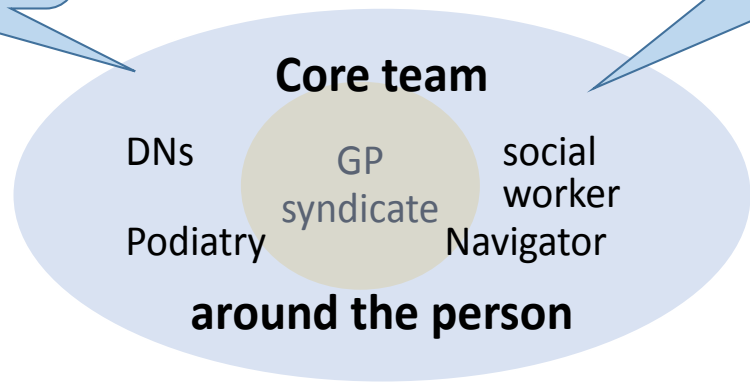
Extended 'menu of services': clinical, social care, voluntary orgs

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

Navigator as point of contact: for patients

Clinical input from specialised teams according to need/ MDT assessment

- COPD
- Diabetes
- Heart failure
- Resettlement
- Housing
- Voluntary organisations



Administrative and clinical support from 'care navigator' and clinical manager

- Highly organised MDT work
- Support from Skilled admins
- Triage and allocation of clients

Drivers and impact of integration

Main drivers of integration

- Decision by local payer to invest more in community services to reduce dependence on high cost hospital care
- High level commitment by NHS and Local Govt directors that health & social care integration would deliver better value for \$
- Inspirational leadership by service directors to build teams with shared goals and values
- Minimal formal governance, no pooled budgets and no working IT integration

Impact of integration

- Reduction in emergency admission to hospital
- £1m pa recurrent saving in spend on care homes
- 12.9 day shorter length of hospital stay cf neighbouring borough
- Increasing ability to manage frail elderly and people with complex problems in their own home or in the community
- Starting to evaluate patient experience based on 'I statements'

North West London whole system integration

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

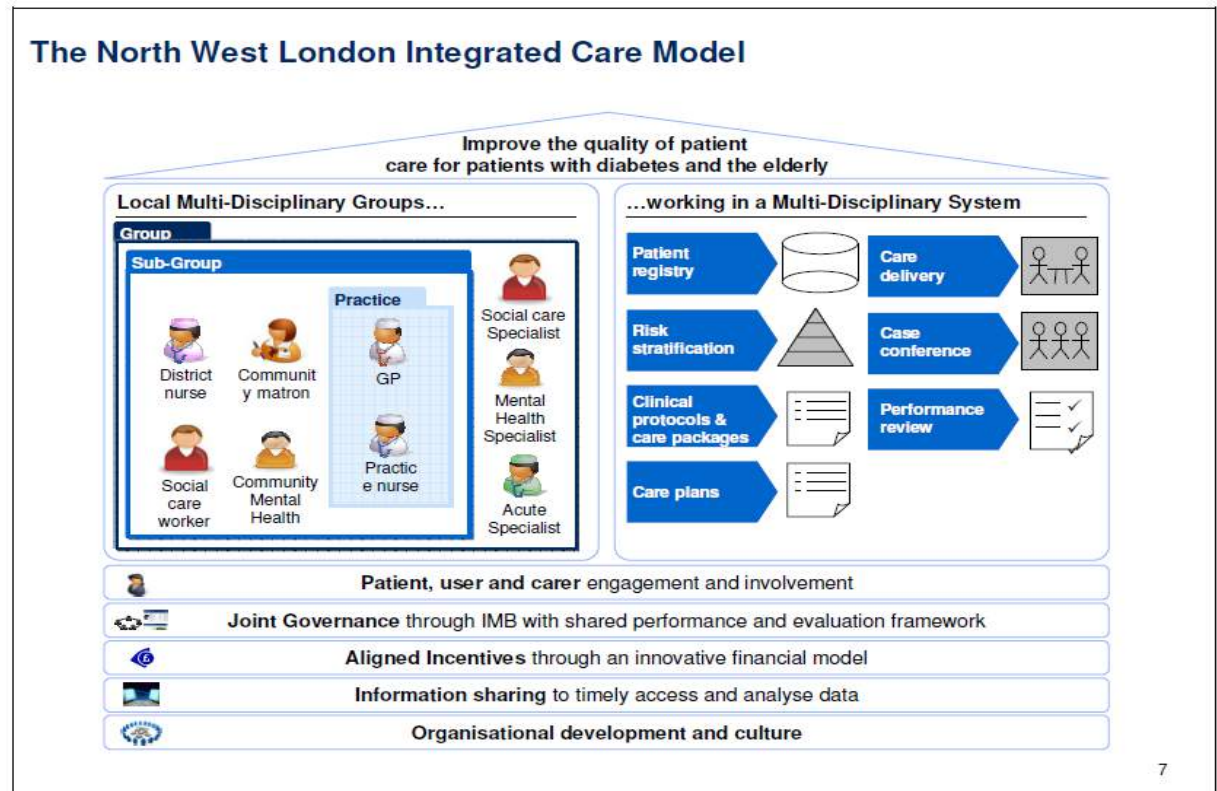


Exhibit B: The North West London Integrated Care Model

NW London integrated care pilot

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

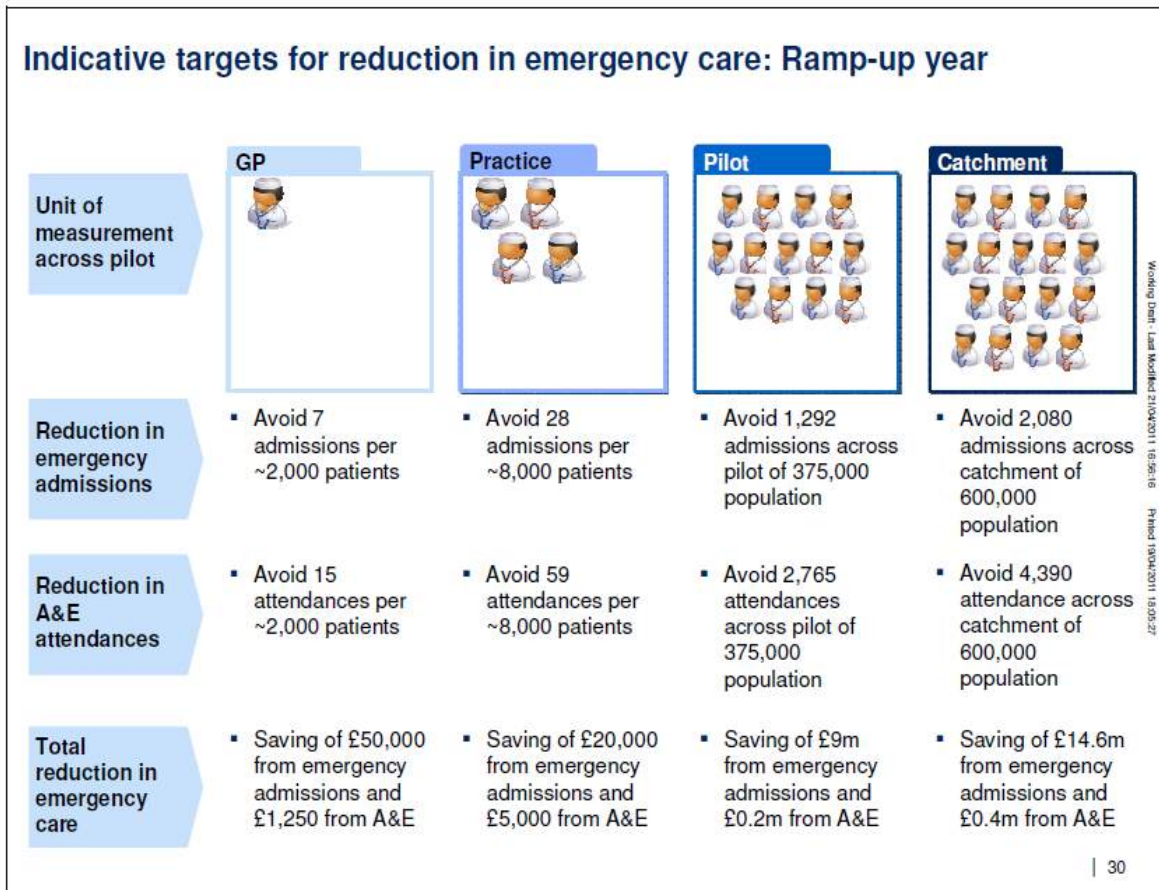


Exhibit M: Indicative targets for reduction in emergency care: Ramp-up during IC pilot year

Drivers and impact of integration

Main drivers of integration

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

Impact of integration

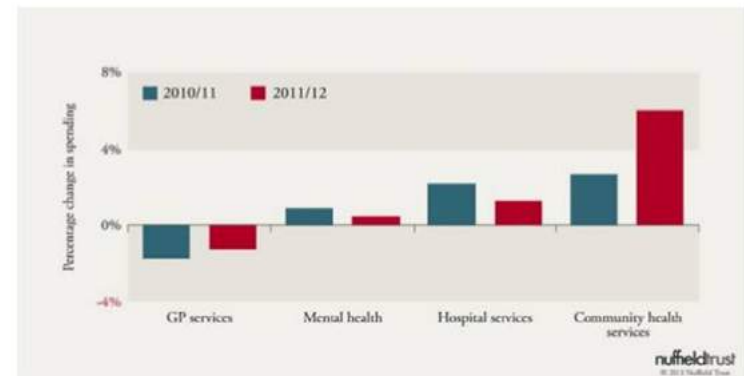
- Small sample of pts report easier contact and less duplication of info provision
- MDT working has become part of routine work in participating boroughs (? Sustainable if funding is withdrawn)
- 23,000 care plans completed and some improvements in processes of care
- No significant reduction in emergency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

A role for new models of general practice in delivering integrated care?

The case for change in general practice

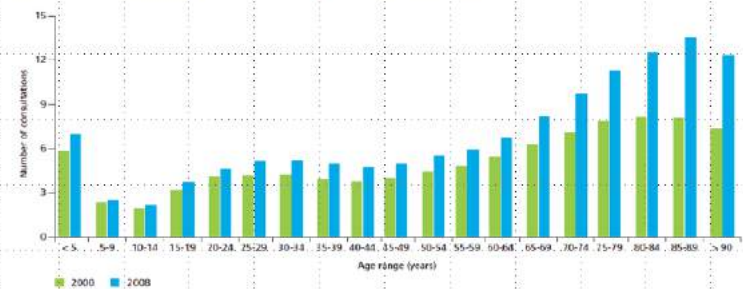
- As small businesses GP practices are vulnerable to marginal reductions in income – need to diversify income streams
- Typically have insufficient staff to accommodate new clinical, administrative and regulatory roles and requirements
- Reduced income requiring more efficient business model
- Potential to increase scope of business but need scale
- Flat partnership structure not sustainable long term
- Slightly bored of the status quo and looking for a fresh challenge
- CCG duty to improve primary care – but they are slow to drive change

Income is falling: Percentage changes in spending by types of care: 2010/11 to 2011/12
Source: Source: Jones and Charlesworth, 2013



Relentless rise in number of GP consultations

Figure 3: Change in average number of primary care consultations per person, 2000 and 2008
Source: NHS Information Centre, cited in Gerada and others, 2012



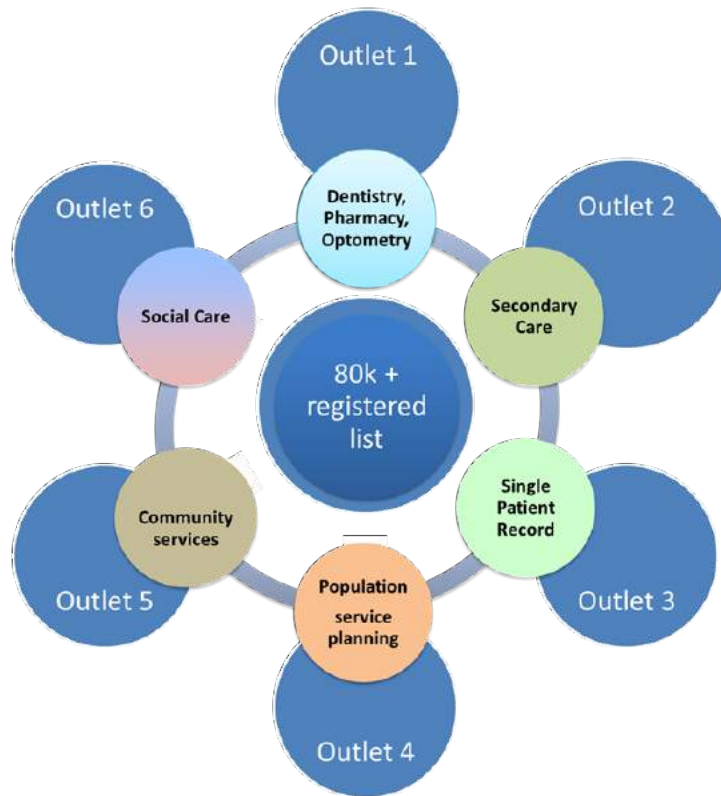
Making it happen: New models of general practice

Super partnerships: Large practices on several geographically local sites. Formed through practice mergers. GP led. Single legal entity created.

Networks and federations: Collaboration of local practices, which remain independent. The collaboration may be informal (a network) or formalised as a legal entity which can hold contracts. The aim is to increase scope of provision and create efficiencies whilst maintaining core small business model.

Regional and national multi-practice models: Multiple practices distributed on a regional or national basis, owned by a single parent organisation which may be a traditional GP partnership or a public or private company.

Super partnership model



Main characteristics:

Keeping what's good about 'small and local'

Built on local general practice with local GPs

Delivery at scale: 80k+ patients: practice mergers

Expanded general practice teams

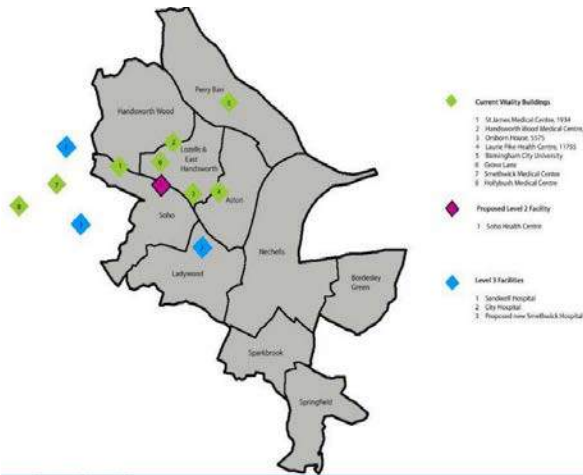
Clinically and quality focused, managerially smart

Integrated planning and delivery of generalist, specialist and community services

Provider-led population health care management

Foundation for large education provider

Services offered by the Vitality partnership



Vitality: Vital Statistics

List size:

2009	26k
2010	32k
2011	38k
2012	51k

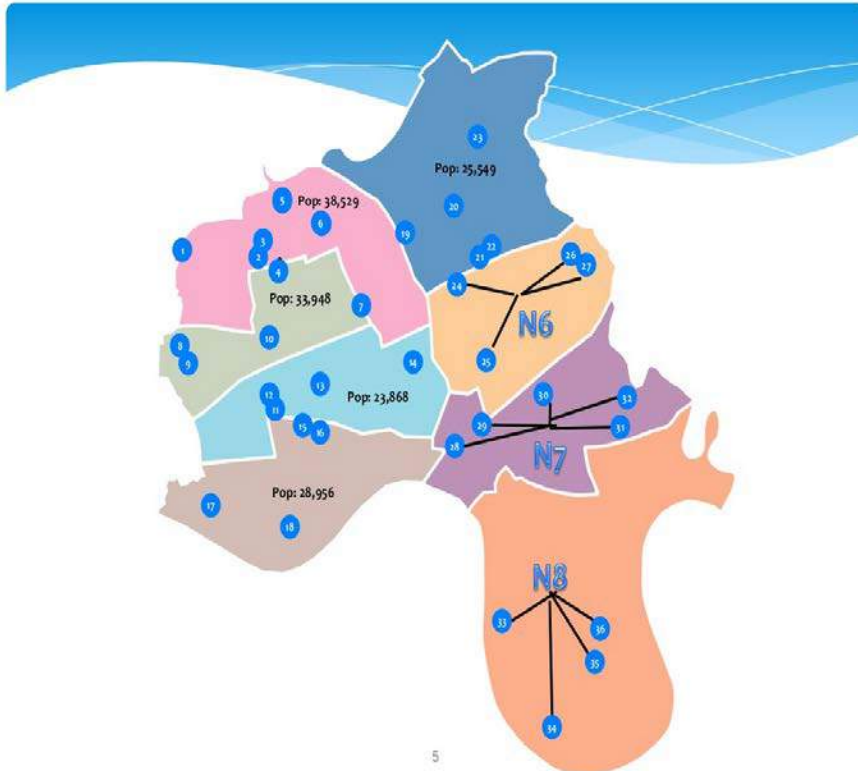
(LCG 125k, CCG, 550k)

- 7 mergers
- 14 equity partners (11 wte)
+ 1 fixed share partner
+ 2 associate partners
- PMS/GMS contracts
- 150+ staff
- 9 NHS specialist services
- 2 private services
- 7 primary care sites (plus university site)
- Integrated IT: EMIS Web across all sites



Networks and Federations

London Borough of Tower Hamlets has established eight GP networks



Main characteristics:

36 practices were formed into 8 networks 2006/7.

Geographically aligned. 4 – 5 practices per network.

Initially formed to improve diabetes care, then extended to address other conditions

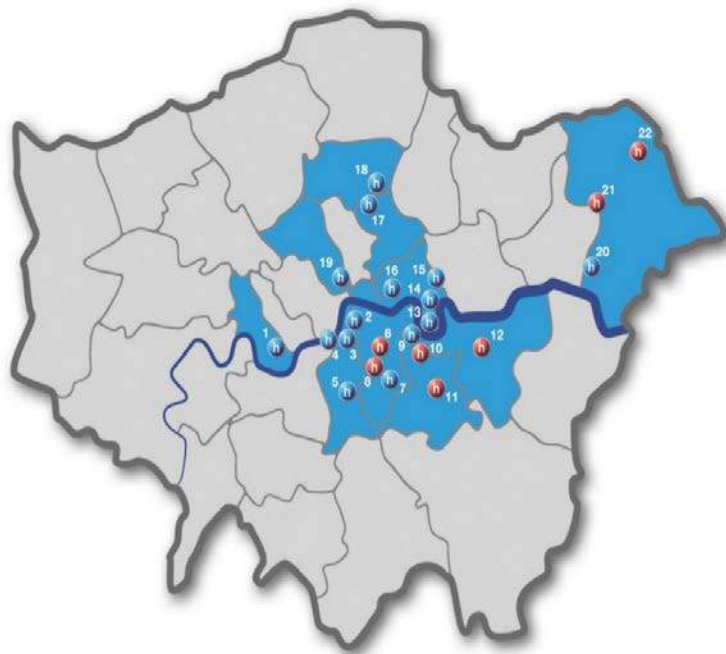
Substantial investment (£8m over 3 years) in admin staff to support networks, IT, care planning and incentives for quality improvement

Focus for peer led change and improvement with a linked education and training programme

Care coordination enabled by care planning, shared electronic record and monthly MDT mtgs

Peer led performance review against KPIs for incentive payments

Multi-practice models



- Hammersmith & Fulham**
 - 1 Cassidy Medical Centre
- Lambeth**
 - 2 Hurley Clinic Kennington
 - 3 Riverside Medical Centre
 - 4 Practitioner Health Programme
 - 5 Streatham Place Surgery
- Southwark**
 - 6 Peckham GP Walk in Centre
 - 7 Sternhall Lane Surgery
 - 8 King's College Urgent Care Service
- Lewisham**
 - 9 New Cross Health Centre
 - 10 New Cross GP Walk in Centre
 - 11 Lewisham Urgent Care Centre
- Greenwich**
 - 12 Greenwich Urgent Care Centre
- Tower Hamlets**
 - 13 Docklands Medical Centre
 - 14 Island Medical Centre
 - 15 All Saints Practice
 - 16 Whitechapel Health Centre
- City & Hackney**
 - 17 Allerton Road Medical Centre
- Haringey**
 - 18 St Ann's Road Practice
- Camden**
 - 19 Brunswick Medical Centre
- Havering**
 - 20 Orchard Village GP Walk in Centre
 - 21 Queens Hospital Urgent Care Centre
 - 22 Harold Wood GP Walk in Centre

- Partnership and PLC versions
- Run multiple practices and services through multiple contracts
- Variety of services offered: standard general practice; urgent care centres walk-in centres
- Geographically scattered
- Variable governance arrangements
- Examples: The Hurley Group, The Practice PLC



Concluding thoughts

Concluding comments

- No single model of integrated care that we can turn to and say ‘that works’ – no magic bullet
- Many promising approaches with methodologically weak evidence of changes in service use & patient experience
- User involvement is starting to re-shape the way we design and evaluate integrated services
- Integrated payments systems to incentivise collaboration between providers can be a powerful lever
- Can get a long way with inspirational professional leadership if support is there from senior execs in participating organisations
- Scaled up general practice has an important role to play



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