

# All Together Now



## Competitive integration in the NHS

Henry Featherstone

Edited by David Skelton

Foreword by David Prior



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While at Policy Exchange he produced a number of influential reports including *Which doctor?*, introducing the concept of the ‘patient premium’; recommending that NHS funding be given directly to GPs and suggesting that doctors be incentivised to work in areas of deprivation. The societal cost analysis in *The cost of cancer* produced a figure which is now used by the government’s Cancer Strategy. *Hitting the bottle* modelled a new alcohol duty regime to encourage the production and consumption of lower alcohol products and has now been implemented by HM Treasury; whereas *Cough up* has, amongst other things, seen the coalition government adjust the tax differential on hand rolled tobacco.

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Published by

Policy Exchange, Clutha House, 10 Storey’s Gate, London SW1P 3AY

[www.policyexchange.org.uk](http://www.policyexchange.org.uk)

ISBN: 978-1-907689-34-5

Printed by Heron, Dawson and Sawyer

Designed by Soapbox, [www.soapbox.co.uk](http://www.soapbox.co.uk)

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## Acknowledgements

The authors would like to thank UK Specialist Hospitals (UKSH) for their generous support, and for their exceptional patience with the production of this report. The views expressed in this report remain those of the authors. We would also like to thank Serco for contributing support to this project in the form of Damien Gilchrist.

Thanks also go to Damien Gilchrist himself, Sam Barker, Zaki Moosa, Glenn Anley, James Kanagasooriam, Neil O'Brien and the late Steve Collins for their contributions to this report. Omissions and errors are the sole responsibility of the authors.

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# Foreword

David Prior

Chairman of the Norfolk and Norwich University Hospital NHS  
Foundation Trust

In healthcare we are all looking for the magic bullet that will transform the way we look after the elderly and especially those suffering from chronic long term conditions. At the moment far too many of these people are admitted to hospital as an “emergency” and then languish there for too long as it is so difficult to discharge them. The media refer to them as “bed-blockers”. In more polite NHS circles they are labelled “delayed discharges”. In fact, they are usually frail, elderly and vulnerable men and women suffering from a range of unpleasant chronic conditions such as Alzheimer’s, coronary heart disease and diabetes. Many of them could and should have been treated at home and never have come near a hospital.

Once they have been admitted to hospital a lot can go wrong both medically and psychologically; and social care networks at home, formal and informal, can breakdown. A short stay can quickly become a long stay and discharge arrangements can become horrendously complicated and protracted. Bad news for the patient and their family, dreadful news for the Treasury as an acute stay is so expensive and disappointing news for the elective patient whose operation may be cancelled as there are no beds free in the hospital.

If we could provide integrated care bringing together primary, community, acute and social care we could provide better care for the frail elderly and save a great deal of money. No wonder everyone is in favour of it and the arguments are well researched and presented by Policy Exchange. Moreover this is not just theory. Policy Exchange cite a great deal of evidence, especially from parts of the USA, which shows that integration can and does work in practice. Integrated care driven by efficient IT, adherence to clinical protocols and strong, consistent financial incentives to keep people out of hospital will deliver better health outcomes probably (but there is less evidence for this) at lower cost.

But we are a long way from this in the NHS, as indeed they are in most parts of the world and certainly in the USA as a whole. As Policy Exchange points out structural change in the NHS notably the purchaser/provider split, Foundation Trusts, Payment by Results and the different funding mechanism for Health and Social Care makes integration more difficult. Successive governments have relied more on top down targets and competition than integration to secure sustainable improvements in performance, with limited success. Indeed attempts to create competition, particularly in rural areas, has unquestionably done more harm than good, getting in the way of sensible integration (for example between acute and community care) and fragmenting existing services. Absurdly, competition

has been allowed to become an end in itself rather than used as a legitimate instrument used to deliver more efficient and better patient care.

The NHS is now facing a long period of financial austerity whilst demand driven by demography and patient expectations remains strong. Integration does offer a way of reconciling these two opposing forces. I have discussed the benefits of integration many times with my successor as MP for North Norfolk, the new Health Minister, Norman Lamb. He is a believer. Come on Norman, it's time to give integration a serious whirl.

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## Executive Summary

Often thought of as a single entity, the NHS should, in theory, be one of the most integrated organisations in the world. In practice, it is a confusing picture of separate organisations purchasing, providing and organising healthcare under a single NHS brand. As a result care can sometimes be fragmented for patients who see a doctor in one place, only to have blood tests and x-rays in another before being referred elsewhere for treatment.

Over the last twenty years, successive governments have divided the NHS into smaller ever more manageable pieces. Multiple organisations have been created, each with their own legal identity, culture, behaviours and incentives. Primary Care Trusts (soon to become Clinical Commissioning Groups (CCGs)) are separated from providers of care, while these providers have been disaggregated around clinical professional silos into hospitals, community services and GP practices. These divisions mean that the patient experience and pathway is also fragmented and those with long-term conditions face a disjointed service which can lead to unnecessary and costly admissions to hospital.

From a policy perspective, the NHS is fragmented in a number of ways. The purchaser-provider split, introduced in the 1990s, in order to drive efficiency actually consumes up to 14% of the NHS budget in transactional costs according to some reports. There is also an artificial division between health and social care, with separate budgets issued to different government departments only to be joined at a lower level in an attempt to improve coordination of care for patients. These divisions are compounded by the system of NHS payments which rewards and incentivises hospital activity, rather than improved outcomes for patients.

By international standards patients in England with chronic diseases, such as chronic obstructive pulmonary disease, are more likely to be admitted to hospital; and on a system wide level average lengths of hospital stay for all patients are above the average compared to countries in the Organisation for Economic Cooperation and Development (OECD). We should be clear that the NHS still delivers excellent care, but missing notes, incorrect prescriptions and inadequate future care plans occur all too frequently in a fragmented NHS. It is patients that fall between the organisational divisions.

Clinical professional fragmentation is exacerbated by flawed NHS pay contracts, introduced under the previous government, which lack rewards for improving productivity, implementing preventative measures or multidisciplinary working. Improvements in productivity for taxpayers and quality of care for patients have not been measured and aligned in return for substantial improvements in pay for doctors.

In addition to high basic levels of pay (£117,000 on average) hospital consultants can also receive Clinical Excellence Awards (bonuses) of up to an additional £75,000 per annum for those who perform “over and above the standard expected of their role”. The problem, however, is that about 60% of all consultants receive



some level of Clinical Excellence Award so they are more properly bonuses for average and above performance, rather than clinical excellence.

In general practice, the Quality and Outcomes Framework (QOF) has linked payments to GPs for completing defined process measures. But this framework rewards GPs for performing simple activities like maintaining disease registers and recording clinical tests, rather than delivering outcomes such as preventing patients with chronic conditions from being admitted to hospital. For example, GP practices are paid up to £760 for maintaining a disease register and £4,100 for arranging blood tests for patients with diabetes, but there are no financial incentives for reducing admissions to hospital for this disease, which are going up.

On average, GP practices achieve 95% of the QOF funding available, about £1 billion each year, yet emergency admissions to hospital have risen for a decade, with recent albeit modest falls under the coalition government. Emergency admissions represent the unexpected and usually sudden destabilisation of a patient's condition to such an extent that they require immediate hospitalisation. Not only are they the largest single source of admissions to hospital they are also one of the greatest costs because of the intensity of investigation and treatment of acutely unwell patients. Since the introduction of a fee for service mechanism in the NHS (perversely called Payment by Results (PbR)) emergency admissions to hospital have increased by 858,000 (19.4%) to 5.29 million, while admissions overall have increased by 2.79 million (23%) to almost 15 million each year.

### Lessons from overseas

In parts of the USA, and also in Spain, there are examples where systems of integrated care are improving outcomes for patients at reduced cost for the taxpayer. For example, the Geisinger Health System has improved coordination of patient care with dramatic results for its sickest patients with chronic conditions – a 25% reduction in admissions; a 23% drop in length of hospital stay and a 53% drop in emergency readmissions.

Kaiser Permanente is the most well-known system of integrated care and it has been compared to the NHS for many years. The consensus is that the Kaiser model has considerably fewer admissions and shorter lengths of hospital stay than the NHS or even many other American healthcare providers. However, perhaps even more than Kaiser, Geisinger Health has become recognised as a model of efficient and joined-up healthcare. In his speech on healthcare reform in June 2009, President Barack Obama explained the need to “ask why places like Geisinger Health systems...can offer high-quality care at costs well below average, but other places in America can't.”

Where Geisinger is different is in its approach to incentivising primary care clinicians to keep patients with chronic conditions from ending up in expensive acute hospital care. By offering to share half of the money saved from preventing acute readmissions, doctors have been incentivised to redefine their clinical behaviour and coordinate the way they transfer important medical and family information as patients move from one clinical environment to another. This spend to save approach is much more likely to be adopted in an integrated system where clinical and financial decision making are aligned. Moreover, the environment of competing integrated care organisations also helps to improve performance and drive up quality for patients. Competition should be seen as a driver of integration in the NHS.

The turnaround of the Veteran's Health Administration is another example where investing in a preventative approach has improved care for patients. The central idea

was about “funding care for populations rather than facilities”, and this was complimented by a move to capitated budgets, performance-related pay for top managers and a right to fire incompetent doctors. It saw a radical programme of closing nearly half the system’s inpatient beds coupled with a large increase in the use of outpatient visits. The results were impressive with inpatient admissions reduced by 32%; outpatient visits up by 42% and outpatient surgery increasing from 35% to 75% without adverse impact on quality of treatment. Meanwhile, system wide staffing decreased by 11% against an 18% increase in patient numbers.

Closer to home, the ‘Alzira model’ of healthcare in Valencia, Spain is gaining widespread support. This model has seen the provision of the entire health system contracted out to a company which is, in effect, a privately run integrated care organisation created amongst a mixed health economy of publically provided primary and secondary care. It operates under a capitated payment system for primary and secondary care (there is no division between purchasers and providers of care) which encourages substantial investment in preventative care, as there are no additional payments to the private company for patients who require expensive healthcare due to poor health.

Patient satisfaction with the Alzira model is extremely high: the hospital was voted the best large hospital in Spain five times running between 2000 and 2005, 91% of patients considered themselves happy with the service they received and 95% said they would return to use the company’s services. Interestingly, 80% of people were unaware of how the system was funded, suggesting there has been little controversy about this new method of funding public services.

## Integration in the NHS

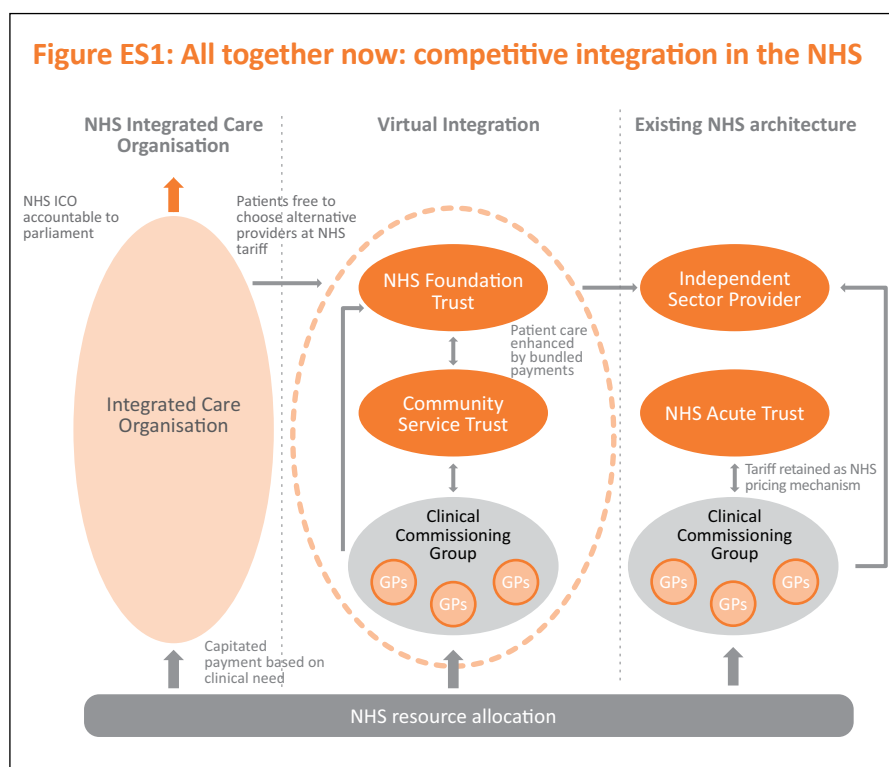
Although we support the current direction of travel of the coalition government’s NHS reforms, we are concerned that integration in a reformed NHS will not happen soon enough. We believe that the NHS needs to quickly learn and implement the lessons seen overseas and it should do this by piloting substantial models of integrated care. Indeed, the Health and Social Care Act ensures virtually all NHS organisations now have a duty to encourage integrated working. We propose here a series of recommendations which will enable the NHS to realise the benefits of integrated care within a competitive system of patient choice.

The central idea is to have the NHS working as one seamless organisation, in the way that most people expect that it should. The economic rationale is that the improved economies of scope and scale are greater than the increased costs of co-ordination and the loss of flexibility delivered by having separate organisations delivering different parts of the process. Moreover, the financial pressures in the NHS mean that the impetus for creating NHS integrated care organisations are most likely come following the financial failure of one or more acute hospitals. We believe that the conditions for integration under these circumstances will be very much different from when organisational integration has been studied previously.

**Recommendation:** We recommend that the Department of Health run a pilot programme of ten full-scale integrated care organisations (ICOs) in the NHS, each covering a population of around 250,000. These NHS ICOs would encompass bringing together primary, community and acute NHS services into one organisation, with a single budget for purchase and provision of NHS services. In

effect, there would be a suspension of the NHS Tariff and the purchaser-provider split would be reversed. To ensure that these pilots are allowed to run their course, the chief executive of these ten NHS ICOs should be accountable directly to Parliament through Monitor and not the NHS Commissioning Board.

A programme of ten full-scale NHS ICOs equates to approximately 5% of NHS capacity, which is, according to academics studying competition in healthcare, the figure required to drive contestable behaviour. The effect of NHS ICOs on the existing architecture of CCGs, foundation trust hospitals and community services will, it is suggested, drive further system-wide efficiency in the same way as Independent Sector Treatment Centres (ISTCs) exerted competitive pressure beyond their walls.



### Alignment of incentives for doctors

Organisational form and its governance are important, but focusing on organisational structures alone without addressing internal incentives is likely to be unsuccessful. A common theme from successful integrated care models overseas is the alignment of clinician incentives which in turn encourage multidisciplinary care – generalists (GPs) and specialists (consultants) working together. We need to move away from considering each professional group as an isolated case.

**Recommendation:** We recommend that both the Quality and Outcomes Framework and the Clinical Excellence Awards scheme be overhauled to include indicators which incentivise GP and consultants to work together in multidisciplinary teams to provide integrated care for patients. The National Institute for Health and Care Excellence (NICE) should develop a set of indicators which focus on cooperation and integration; for example, reducing admissions to hospital for a range of chronic diseases which can easily be controlled by modern, preventative medicine.

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## Pooling of funds

The pooling of funds, as a necessary step in delivering integrated care, is well-recognised in the academic and policy literature. However, while some believe that suspending the NHS Tariff and reversing the purchaser-provider split should be adopted on a national basis, we believe that it should only be introduced in limited circumstances, as part of our pilot programme described above.

We also propose that integrated tariffs – essentially a micro-capitation fee – for specific illnesses should be developed so that providers of care can take on both risk and management of patients with chronic conditions. For example, the year of care pilot programme for diabetes has shown how services can be integrated to improve the quality of care at no increased cost. By adding more services to some NHS Tariffs and facilitating greater choice and competition of providers, integration will also occur as a ‘natural’ response from providers to patients’ needs.

**Recommendation:** We recommend that the Department of Health commission academic work to calculate the current healthcare-related costs of the most common long-term conditions, including asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease, including adding services such as diagnostics and treatment to NHS Tariffs. This should be accompanied by a framework to enable financial pooling arrangements between purchasers and providers to begin delivering care for patients in a virtual model of integrated care.

## The role of Information Technology (IT)

From the continuous availability of medical notes to the engagement of patients in managing their own conditions, IT is a fundamental backbone of a successful system of integrated care. However, on most measures, the NHS National Programme for Information Technology (NPfIT) has been a failure. In the NHS, patients have been disappointed with the amount and type of data available from their medical records and uptake of access to medical records has been low. Only 0.13% of patients invited opened an account, compared with 5–10% anticipated. In contrast, Kaiser expects around 80% of its patients to self-manage much of their care and the ability for the patient to gain access to their data, and discuss it via email with their doctor where necessary, is key to this model.

In recent years we have seen attacks on NHS management as an easy political target. The Coalition Government came to power committed to substantially reducing NHS management costs. However, the focus on reducing the quantity of managers could be seen as being misplaced, as management is essentially a co-ordinating and integrating function. A different perspective, and one which would be consistent with driving integrated care, would be a focus on the qualities of NHS managers, rather the quantity per se. Leaders capable of driving and delivering integrated care organisations need the powers to manage and freedom from central control. Aligned with this is the necessity to achieve clinical buy-in to the enabling power of data and clinical information systems.

**Recommendation:** High-performing integrated care systems such as the Veteran’s Health Administration have long-recognised the pivotal role of IT and the Chief Clinical Information Officer (CCIO) in order to drive integrated care for patients. We believe that this role should be extended throughout the NHS as a necessary pre-cursor to delivering integrated IT systems for healthcare organisations.

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# 1

## What do we Mean by Integrated Care?

As we will set out in this report, we strongly believe that greater integration in healthcare will result in better outcomes for patients and a more seamless patient experience. Further integration will also help the NHS deliver necessary cost savings whilst also delivering higher standards of patient care.

Often thought of as a single entity, the NHS should, in theory, be one of the most integrated organisations in the world. In practice, the NHS is a confusing picture of separate organisations purchasing and providing care under a single NHS brand. As a result, care can sometimes be fragmented for patients who see a doctor in one organisation, only to have blood tests and x-rays in another before being referred elsewhere for treatment. In this chapter, we set out what we mean by integrated care and why we believe it has such an important role to play in the future of UK healthcare.

### What is integrated care?

The World Health Organisation (WHO) defines integrated care as a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. For the WHO, integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.<sup>1</sup> Another more comprehensive definition for integrated care, “is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.”<sup>2</sup>

Integrated care is an increasingly important strategy in health system reform around the world. Integrated care provides a framework for coordinated multi-disciplinary working enabling professionals across separate organisations to provide better healthcare to patients, more efficiently. Although there is no common definition most agree that integrated care is about achieving patient centred care, bringing together previously fragmented services into a system that improves the quality, experience and coordination of care for patients across their entire journey. In short, integrated care means that the patient should not notice the organisational join in their relationship with separate health and social care providers. The patient journey should be a seamless one.

In the NHS, integrated care has become synonymous with services focussed on the patient and the management of their disease, rather than a focus on artificial professional and organisational divisions. By extension, this implies a healthcare system structure that incentivises a patient focus.

1 Gröne, O & Garcia-Barbero, M, Trends in Integrated Care – Reflections on Conceptual Issues. World Health Organization, Copenhagen, 2002, EUR/02/5037864

2 Integrated care: meaning, logic, applications, and implications – a discussion paper (2002) Dennis L. Kodner, Cor Spreeuwenberg

**We believe that an integrated healthcare structure with a real patient focus is essential to the future of healthcare and will set out in this report how such a vision can be achieved.** In order to continue providing affordable, quality healthcare, many believe that the NHS must develop ways to enhance efficiency and reduce fragmentation, and that integration should be a principal driver of reform.<sup>3, 4</sup> However, the recent focus on integrated care during the unusual passage of the Health and Social Care Bill through Parliament arose because the NHS is set to undergo an unprecedented period of funding restraint. The Office for Budget Responsibility estimates that current spending levels of £103.8 billion equate to 8.2% of GDP, but with only limited increases in NHS funding this will fall back to 7.4% by 2016.<sup>5</sup> By integrating care, removing artificial organisational boundaries and pushing healthcare delivery from the hospital into the community, the NHS will be helped in meeting its funding challenge.

### What are the essential components of integrated care?

The focus of this report is on the operation of integrated systems – what others have called ‘macro-integration’.<sup>6</sup> We are concerned here with the integration of primary care (GPs, practice nurses and community pharmacies), community care (district nursing, occupational therapy, physiotherapy, community and NHS maternity services) and secondary care (hospital services). This is called vertical integration. The idea is to have the NHS working as one seamless organisation, in the way that most people expect that it should. The economic rationale is that the improved economies of scope and scale are greater than the increased costs of co-ordination and the loss of flexibility delivered by having separate organisations delivering different parts of the process.

In previous work we have suggested how new entrants to the healthcare environment should be encouraged – through the use of capitated budgets – to improve care for discrete disease populations, such as patients with diabetes<sup>7</sup> – what you might call ‘meso-integration’. In this report we do not consider the integration of health and social care services because we believe policymakers will soon have to accept that the inevitable march of demographic change will increasingly pull together the NHS and social care systems. We have previously recommended that the NHS and Social Care systems should be merged.<sup>8</sup> That view has now largely been endorsed by the government’s Commission on Funding Care and Support and the Chairman of the influential House of Commons Health Select Committee.<sup>9, 10</sup>

Integration at the micro level includes many approaches, such as in the use of multidisciplinary teams to meet the needs of patients.<sup>11</sup> Sadly, these initiatives which have been shown to seek to improve the coordination of care for individual patients and carers are all too thin on the ground in the NHS. We consider some of these approaches in the report and recognise that they are critical to the success of patient centred care, whether deployed in integrated organisations or not.

Over the last decade in the UK, the policy focus has sought to promote organisational separation and competition across the health service.<sup>12</sup> We strongly agree in principle with promoting a competitive environment; however, at the same time, we also note that NHS care coordinated around the needs of patients has not developed in any meaningful way. It has been suggested that competition is mutually exclusive with integration. We do not agree. After considering why

3 Ham C, et al. Where next for the NHS reforms? The case for integrated care. Kings Fund 2011

4 Lewis CL, et al. Where next for integrated care organisations in the English NHS? Nuffield Trust 2010

5 Office for Budget Responsibility. Fiscal Responsibility Report. 2011

6 Curry N, Ham C. Clinical and service integration, the route to improved outcomes. King’s Fund 2010.

7 Featherstone H, Whitham L, Chambers M. Incentivising wellness: improving the treatment of long-term conditions. Policy Exchange 2010.

8 Featherstone H, Whitham L. Careless: funding long-term care for the elderly. Policy Exchange 2010.

9 Commission on Funding Care and Support. Fairer Care Funding. July 2011.

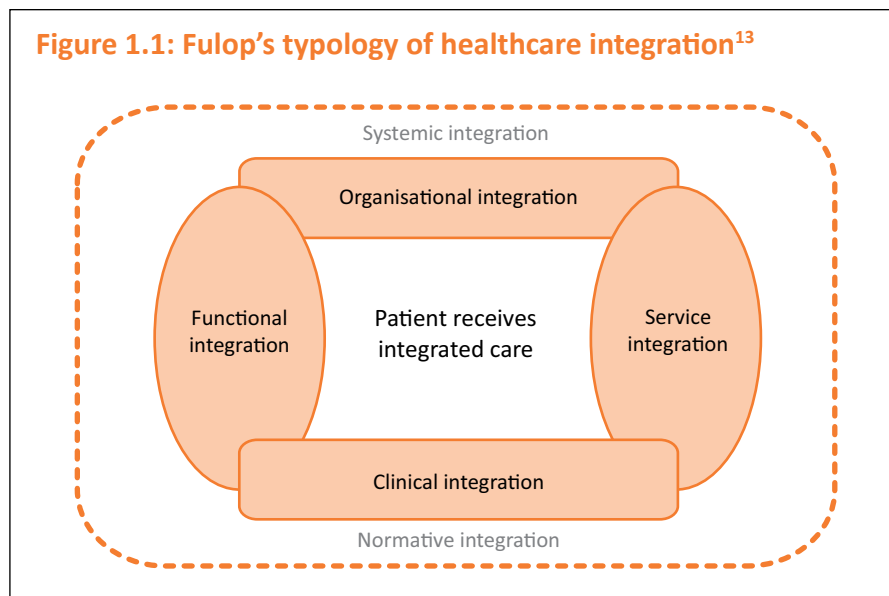
10 Dorrell S. Comment. The Times 16 May 2011.

11 Irani M, Dixon M, Drinkwater C, Reader P. Specialist Doctors in Community Health Services: opportunities and challenges in the modern NHS. NHS Alliance 2005. [www.networks.nhs.uk/nhs-networks/nhs-alliance-specialists-network/documents/Specialist%20Doctors%20in%20Community%20Health%20Services.pdf](http://www.networks.nhs.uk/nhs-networks/nhs-alliance-specialists-network/documents/Specialist%20Doctors%20in%20Community%20Health%20Services.pdf)

12 The NHS Plan: a plan for investment, a plan for reform. Department of Health 2000.

integrated care has not developed, this report explores how integrated care organisations could sit amongst the primary and secondary care architecture comprising Clinical Commissioning Groups and Foundation Trusts.

Figure 1.1, below, sets out four key elements of effective integration:



- **Organisational integration:** how the organisation is brought together. This is likely to involve the creation of a single organisation or organisational entity – with a single, patient facing brand. This change will be facilitated by mergers or more effective systems of joint working between organisations. For example, many acute hospital trusts have taken over responsibility for delivering community services in their local area thereby bringing together the skills and expertise of different sets of staff to improve care for people in their own homes and communities.
- **Clinical integration:** how care by clinical teams is integrated into a single process for patients. This is likely to be through the use of shared guidelines and protocols in the single or joint working organisation, as well as joint training. For example, ensuring accident and emergency departments have primary care teams to assess and treat non-emergency cases will reduce unnecessary hospital admissions by ensuring that the patient is seen and treated by the appropriate clinician for their condition.
- **Functional integration:** how non-clinical support and back-office functions are integrated, bringing together the back office workings of primary care, community care and secondary care. This will involve the sharing of patient records, integration of back office teams and, crucially, the integration of IT systems to ensure effective communication across the new organisation.
- **Service integration:** how different clinical services provided are integrated at an organisational level. This will involve the use of multidisciplinary teams, as well as integrated working across the organisation. For example, bringing together consultants, GPs, physiotherapists and occupational therapists for patients with musculoskeletal conditions such as arthritis means that many patients receive appropriate treatment in just one visit.

<sup>13</sup> Fulop N, Mowlem A, Edwards N. Building Integrated Care: Lessons from the UK and elsewhere. London: The NHS Confederation 2005



- **Systemic integration:** how the rules and policies at the various levels of organisation contribute.
- **Normative integration:** the creation of an ethos of shared values and commitment to co-ordination in delivering health care.

The final element of integration is crucial – cultural change. Change management theory suggests that achieving cultural change is a critical factor in achieving successful organisational integration, so too with integrated care. Without cultural change, professionals will not deliver the changes to services and accept new ways of working. To be effective, the process and ethos of integration needs to break down cultural barriers between different elements of healthcare which all too often block the way to joined up care for patients.

### Why is integrated care important?

The *economic* case for integrated care rests on the proposition that ‘unplanned acute episodes’ (the episodes when an otherwise manageable disease destabilises and the patient ends up in hospital) are entirely avoidable. They are intrinsically bad for the patient. They are bad for patient care – hospitals are high-risk places to be with infections and mishaps and, however good the care, the majority of patients would rather be elsewhere. They are also bad for the taxpayer – admissions to hospital, especially in an emergency, are expensive and indirectly these costs affect other patients as an opportunity cost: where money is wasted on avoidable events it cannot be spent elsewhere, such as on newer treatments and technologies for cancer and cardiovascular disease.

Our focus on integrated care is to reduce the use of acute admissions to hospital as the default position for failure elsewhere in the healthcare system. There are also benefits to be gained from patients spending less time in hospital – improvements in anaesthetics and surgical techniques make day case surgery the norm for increasing numbers of conditions.

In chapter 3 of this report, we consider examples where integration abroad has delivered real cost savings and performance improvement. In parts of the United States of America, integrated care has moved from concept to reality. Accountable Care Organisations (ACOs) bring together payer, primary care, and secondary care. Instead of each group of professionals or organisation competing, their needs, and rewards, are balanced. This drives better coordination between healthcare providers: secondary acute care organisations have no financial incentive to admit people to hospital unnecessarily.

Indeed, through Multi-Specialty Groups, specialist expertise from secondary care is brought into the primary care setting: consultants are no longer tied to hospital consulting rooms. The system treats patients at the most convenient place for the patient, which is a more preventative approach and has lower unit costs.<sup>14</sup> But more importantly, this is the *earliest* time for dealing with conditions and the place for proper and comprehensive care management. Information technology also has a part to play in bringing generalist and specialist clinicians together around the needs of the patient, to prevent ‘silo’ treatments. Fundamentally, improved case management is both achieved and enabled by advances in information technology, and is a key part of the success of integration.

<sup>14</sup> Stone S. A Retrospective Evaluation of the Impact of the Planetree Patient Centered Model of Care Program on Inpatient Quality Outcomes. Health Environments Research and Design Journal. 1(4):55–69. 2008



## Who will benefit from integrated care?

All patients will benefit from further integration of care. A more patient centric approach to patient care will lead to an enhanced and more seamless experience for all patients. However, approximately 70% of the NHS budget is directed towards the management of patients with long-term conditions, but despite NHS funding being constrained for the next few years the number of these patients is set to increase.<sup>15</sup>

Integration will benefit those patients who manage a particular long-term condition; it will bring most benefit to the complex cases, where the patient has more than one long-term condition.<sup>16</sup> Integration will help to bring care for patients suffering from long term conditions out of the hospital and into the community, GPs surgery and other more local settings, including the patient's home. The proactive, more personalised management of long term conditions will be substantially aided by organisational integration.

Integration is not a panacea; it should be viewed as one of a range of policies, including the creation of Clinical Commissioning Groups (CCGs) with the right incentives in place, which will all contribute to help the NHS meet its efficiency challenge of delivering savings of at least £20 billion by 2015.

In the rest of the report, we will consider how this integration can be made a reality.

15 NHS 2010–2015, From Good to Great. Department of Health 2009

16 Sing D, Ham C. Improving Care for People with Long Term Conditions. a Review of UK and International Frameworks. Birmingham: Health Services Management Centre, University of Birmingham. 2006

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# 2

## Why Integrated Care is Needed

This chapter will set out why integrated care is a priority. The fragmentation of the NHS has led to duplication and waste, with patient outcomes often suffering in the process. Unnecessary hospital admissions have increased in the past decade as clinicians have viewed hospital as the most suitable way to deal with a variety of conditions. In this chapter we set out how integration is essential to bring together clinicians with a real focus on patient outcomes, whilst also relieving pressure on NHS resources and hospital beds.

### A fragmented service

Although the NHS is in theory a single entity, in reality it is characterised by cultural and organisational fragmentation. Successive governments have divided the NHS into smaller more manageable pieces with purchasers of care (primary care trusts soon to become CCGs) transacting with providers (hospitals and GP practices) at a cost of up to 14% of the NHS budget.<sup>17</sup> This division means that the patient experience and pathway is also fragmented, with many sufferers of long-term conditions facing a disjointed service. Perverse incentives layered upon fragmentation have resulted in rising hospital admissions.

Fragmentation in the NHS is caused by three things. First, the split of purchaser and provider functions; second, the organisational separation of primary and secondary care; and third, the artificial divide between health and social care. We support the competition and contestability created by the separate purchaser and provider functions in terms of improved quality and technical efficiency, assuming that the appropriate mechanisms and incentives for increased care coordination are in place.

There is, however, an inevitable tension between competition and integration in the NHS. Whereas competition is an important way of driving quality and efficiency; it also adds excess capacity and contributes to system fragmentation as patients are able to choose which provider (NHS, private or not-for-profit) delivers their treatment. There are limits of a competitive market in an overall cash limited system such as the NHS, where there are no additional streams of revenue to draw upon. Commissioners of services have a defined amount of money in which to purchase health services while providers' income is predominantly the result of admitting or treating more patients. In times of plenty this arrangement results in an increase in admissions and NHS activity.

### Financial fragmentation

The NHS is undergoing another period of structural re-organisation. Irrespective of their clinical, financial or managerial composition, the new structural

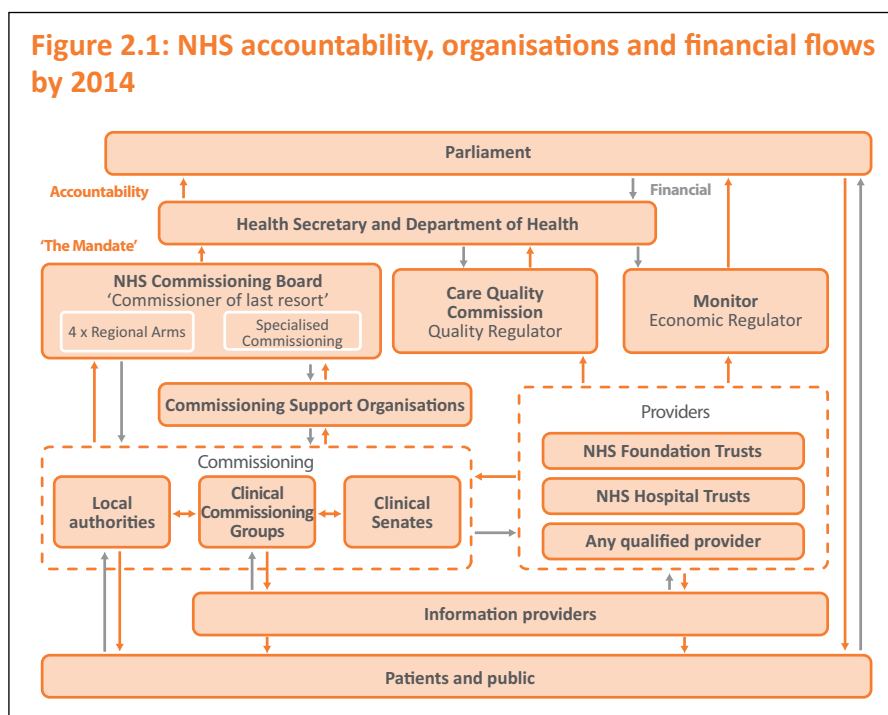
17 Health Select Committee.  
Fourth Report of 2009–10 –  
Commissioning. Parliament 2010

relationships created by the Health and Social Care Act will see the NHS remain a highly fragmented system, in organisational, funding, and accountability terms. See Figure 2.1 for a schematic representation of the new NHS structures. Annex 1 has a more detailed description of financial fragmentation in the NHS.

In the reformed NHS, Clinical Commissioning Groups will purchase healthcare for their populations; the consensus from the Department of Health is that commissioning by primary care trusts has been weak.<sup>18</sup> The current set of reforms seeks to engage clinicians, principally doctors, in the process of commissioning.<sup>19</sup> There is good evidence for this approach of aligning clinical and financial responsibility.<sup>20, 21</sup> However, the watering down of the NHS reforms, with central NHS Commissioning Board control over Clinical Commissioning Groups will not be sufficient to create integrated organisations.

The NHS Commissioning Board will now both set the test and judge whether Clinical Commissioning Groups are authorised to spend NHS funds. And for those groups that do not meet all aspects of the test the NHS Commissioning Board will be able to impose conditions, or even act on their behalf commissioning services and thereby spending NHS funds. We believe, therefore, that Clinical Commissioning Groups, just like primary care trusts before them, will be too far removed from the actual provision of care to be effective as an agent for integration alone.

**Figure 2.1: NHS accountability, organisations and financial flows by 2014**



The issue with this fragmentation is that patients do not engage with just one organisation, but many. A typical journey for a patient with respiratory disease such as COPD might take them from their local GP surgery to a community service provider through the services of an acute trust, then perhaps back to community services before ending back at their GP. These multiple organisations receive the majority of their income through the NHS Tariff system (perversely called Payment

18 Department of Health. Overview of the PCT Fitness For Purpose and Development Programme. May 2006

19 Department of Health. Equity and excellence: Liberating the NHS. 2010

20 Featherstone H, Storey C. Which Doctor? Putting patients in control of primary care. Policy Exchange 2009

21 Thorlby R, Rosen R and Smith J. GP commissioning: insights from medical groups in the United States. Nuffield Trust 2011

by Results) but this is really payment for individual activity and could be said to incentivise the overuse of hospital services at the expense of preventive medicine.

We believe that aligning clinical and financial decision making at primary care level should be viewed as Phase I of the government's NHS reforms. Phase 2 which will last beyond 2015 should focus on vertical integration of primary, secondary and community care to begin to align the NHS with the change in burden of disease: more services for people with dementia and other long-term conditions. The original intention behind the government's White Paper where control of clinical budgets would see GPs and specialists collaborate to treat patients at the lowest level of care is considered further in Chapter 4.

The internal incentives within the various NHS organisations also matter greatly, and arguably contribute to the fragmentation of patient care. The actions of doctors are critical in this regard, with GPs and hospital clinicians working in different organisations and having different remuneration systems, neither of which is aligned towards delivering integrated care for patients. This lack of coordination, where one doctor has reasons to limit the use of hospital care, while another has incentives to increase hospital usage does not make of efficient use of resources.<sup>22</sup>

In general practice the Quality and Outcomes Framework (QOF) has linked payments to GPs for completing defined performance measures. However, this framework rewards GPs for processes like maintaining disease registers and recording clinical measures, rather than outcomes such as preventing patients with chronic conditions from being admitted to hospital. For example, GP practices are paid up to £760 for maintaining a disease register and £4,100 for arranging blood tests for patients with diabetes, but there are no financial incentives for reducing admissions to hospital for this disease.<sup>23</sup>

On average, GP practices achieve 95% of the QOF funding available,<sup>24</sup> yet emergency admissions to hospital continue to rise. The criticisms against QOF are manifold. First, that the bar for measuring GP performance has been set too low, with the cost of meeting QOF payments to the NHS a staggering £1bn per annum. Second, that QOF rewards processes rather than outcomes; currently it has just one outcome measure, for epilepsy. And third, the process of exception reporting allows GP practices themselves to exclude patients from data collected to achieve QOF funding; for example it is interesting to note that the only outcome indicator for epilepsy has a rate of exception reporting over three times the national average for other indicators.<sup>25</sup>

Similarly, in hospitals the implementation of the NHS consultants' contract saw earnings on average increase by 25 per cent in three years, but at the same time consultants were working the same number of hours or less.<sup>26</sup> A common failing of the NHS pay contracts introduced under the previous government was that no productivity measures were introduced along with these pay deals. As a result improvements in productivity and quality have not been measured and aligned in return for improvements in pay.

In addition to high basic levels of pay – £117,000 on average<sup>27</sup> – hospital consultants can also receive Clinical Excellence Awards (bonuses) of up to an additional £75,000 per annum to those who perform over and above the standard expected of their role. These merit award schemes for consultants have been in operation since the introduction of the NHS in 1948, although they are currently being reviewed by the government. Since these payments are pensionable, the

22 Fox, R. Editorial: 'Efficiency in the NHS', *Journal of the Royal Society of Medicine*. 95(12), 579. 2002

23 NHS Employers. Quality and Outcomes Framework guidance for GMS contract 2011/12

24 NHS Information Centre. Quality and Outcomes Framework Achievement Data 2010/12

25 NHS Information Centre. Quality and Outcomes Framework Exception Data 2010/11

26 National Audit Office. *NHS Pay Modernisation: A New Contract for NHS Consultants in England*. April 2007

27 NHS Information Centre. NHS Staff Earnings, estimates, July 2011 to September 2011

reality is that they are considered by the British Medical Association and by consultants themselves as part of an overall remuneration package. Moreover, since about 60% of all consultants receive some level of Clinical Excellence Award they are more properly bonuses for experience and above average performance, rather than clinical excellence.<sup>28</sup>

The objective should be to align incentives that develop and encourage multidisciplinary care – generalists (GPs) and specialists (consultants) working together – rather than considering each professional group as an isolated case. Of course, organisational form and governance are important, but focusing on organisational structures alone without addressing internal incentives is likely to be unsuccessful.

### Organisational fragmentation

Despite being thought of as a single organisation the NHS consists of many separate entities. This physical separation of NHS organisations, not only results in cultural and professional differences between their respective employees, but also impacts upon patient care.

Roughly speaking the NHS can be divided into the purchasers of care – Primary Care Trusts (soon to be replaced by Clinical Commissioning Groups) – and providers of care – hospitals, GP practices and community services. The purchasers of NHS services are essentially engaged with the commissioning of care through the annual commissioning cycle of planning, procuring and reviewing services for patients. Estimates commissioned but not published by the Department for Health suggest that these costs constitute up 14% of total NHS costs – around £14.5 billion per annum.<sup>29</sup>

“ This functional and geographic fragmentation of the NHS can get in the way of delivering high quality, affordable patient care ”

Those that provide NHS services are: acute hospital trusts which provide ‘traditional’ hospital care, such as for cardiovascular disease or cancer; community service trusts provide district nursing, speech and language

therapy, occupational therapy, physiotherapy, podiatry and sexual health. Although providing NHS services, GPs are independent practitioners operating as small businesses owning their own premises and employing their own staff, albeit almost totally dependent on NHS funding.

There are care trusts which can both commission and provide services, usually to deliver mental health or social care services. Many of these provider organisations have ‘foundation’ status, which gives them various freedoms and makes them separate legal bodies, which further adds to the problem of fragmentation, even if desirable in other ways. There are, of course, also private providers to the NHS, which mostly provide diagnostic services and high volume elective procedures such as hip and hernia operations.

This functional and geographic fragmentation of the NHS can get in the way of delivering high quality, affordable patient care. Different organisations have different incentives and the need to maintain the financial viability of the organisation is paramount: hospital trusts are incentivised to admit and discharge patients within a specified length of stay, and commissioners to buy the most cost-effective services from many competing providers. Moreover, the purchaser-provider split

28 Of the 39,088 consultants working in the NHS in 2011 a total of 19,593 were in receipt of a local Clinical Excellence or Distinction Award, with a further 3,865 in receipt of a National Clinical Excellence Award.

29 Health Select Committee. Fourth Report of 2009–10 – Commissioning. Parliament 2010

actually separates the State and its providers; thereby creating a perverse incentive for the State as tariff setter and commissioner to transfer financial risks on to hospital providers. This organisational fragmentation on the provider side can result in problems at the interface of these different organisations.

When a patient passes from the care of one organisation, department or professional to another this ‘hand off’ of care can lead to problems. Missing notes, incorrect prescriptions and inadequate future care plans occur all too frequently in the fragmented NHS. GPs as the coordinators of patient care have virtually no incentives to keep patients out of hospital, especially those with long-term conditions. The Quality and Outcomes Framework rewards process driven activity rather than clinical outcomes or preventative care.<sup>30</sup> Incentives for NHS hospitals to prevent readmissions are in their infancy.

Moreover, the typical GP consultation of 8–10 minutes is an inadequate period of time for generalist physicians to assess and review complex clinical conditions. NHS funding arrangements exacerbate this problem by providing a mechanism for GPs to refer patients to acute hospitals without affecting their own budgets for patient care or levels of remuneration. When GPs refer their patients to hospital specialists, or their patients have unscheduled admissions to hospital, the PCT bears the cost, not the GP or GP practice. Overall, the incentives for cooperation between NHS organisations are perverse.

### NHS culture

It would be naïve at this stage to overlook the importance of NHS culture. Health policy development in the UK has been constrained, and indeed exacerbated, by the artificial divide between primary and secondary care. This division is largely historical in nature and reflects evolutionary divisions within the development of medicine, rather than as a result of how services should be designed around the needs of patients.

From a medical perspective primary care is focused around General Practitioners – who treat and diagnose the majority of cases, but because of their wide knowledge base they tend to lack the specialist skills to treat fully every patient that walks through their door. Secondary care – mainly hospitals – is staffed by specialist consultants who, because of increasing medical specialisation, tend to focus on treating just one anatomical or physiological system. These divisions result not just in professional rivalry, but have over time developed into considerable organisational and departmental boundaries, each with their own cultures, rituals and ways of working.

Although the caring culture in the NHS is strong, the reality is that individuals tend to associate themselves with their own NHS organisation and all of its drivers, values and ways of working. Moreover, evidence presented in detailed reports on clinical integration indicates that organisational integration will not deliver benefits if clinicians do not change the way they work.<sup>31</sup>

### Evidence of fragmentation

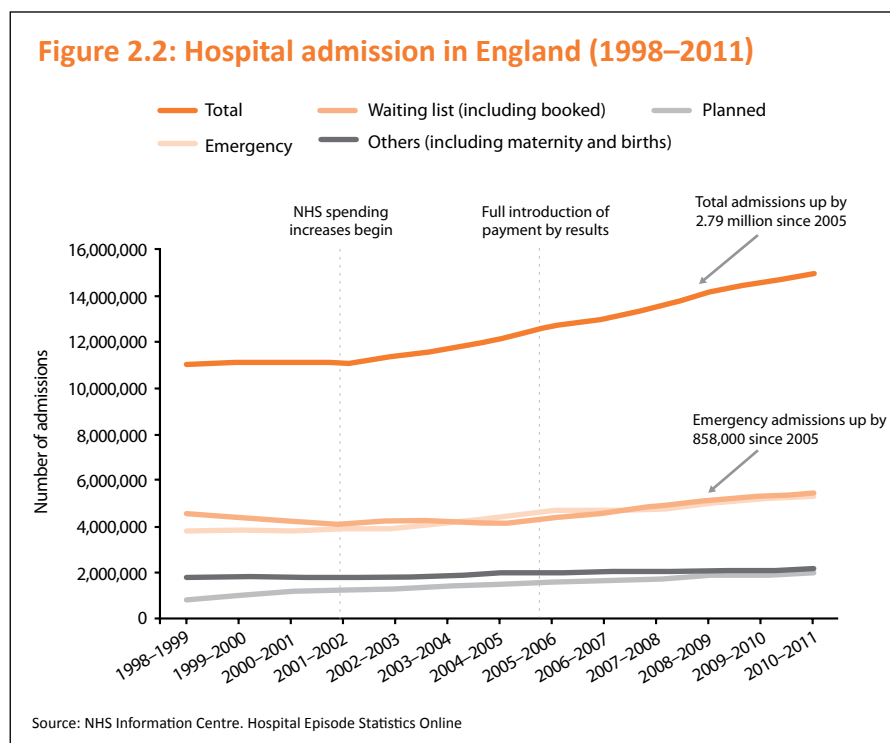
The overriding public memory of the NHS in the 1990s was one of lengthy waiting lists and waiting times for hospital treatments and, to a lesser extent, GP appointments. In a resource-limited system, waiting lists were the mechanism for rationing. However, over the last decade health expenditure has doubled in

30 Featherstone H, Whitham L. Incentivising wellness. Policy Exchange 2010

31 King’s Fund. Clinical and Service Integration. 2010

real terms to £103.8 billion<sup>32</sup> and this has been coupled with the introduction of progressively shorter waiting time targets to just 18 weeks for referral to treatment. But, as the spending taps were turned on, the rationing mechanism was also removed.

Over the last decade the NHS has been geared for growth. Hospital admissions have constantly increased: 353,000 in England in the year to March 2011 alone, with 109,000 of them emergency admissions. As the graph below shows, the five-year trend for admissions has grown by 3.5% compound representing an increase in hospital admissions of over 2.79 million since 2004–05. This can't go on.



Of course, some of the early rise in hospital admissions can be attributed to the reduction in waiting times which was made a priority by the last government, as we can see in the period from 2001 to 2005 in the diagram. But the trend line in admissions is now steepening rather than easing off and, most notably, researchers have discovered that the rise has, in part, been caused by a lowering of the clinical threshold for emergency admission to hospital.<sup>33</sup> The inference is that hospitals are admitting patients unnecessarily to generate income. Perverse incentives appear to be in operation.

Emergency admissions are a concerning example of this relentless rise in hospital admissions. They represent the unexpected and usually sudden destabilisation of a patient's condition to such an extent that they require immediate hospitalisation. They are virtually the largest single source of admissions to hospital and also one of the greatest costs because of the intensity of investigation and treatment activity of acutely unwell patients.

So from the perspectives of both quality and cost, emergency admissions are to be avoided. And yet they are going up with an increase of 858,000 (19.4%) to

32 Spending Review 2010. HM Treasury 2010. Cm 7942

33 Trends in Emergency Admissions 2004–2009. Nuffield Trust

5.29 million between 2004–2005 and 2010–2011.<sup>34</sup> This is the time period in which Payment by Results has seen hospitals paid to admit patients and GPs no longer provide out of hours services to patients.

Moreover, hospital admissions and lengths of stay in hospitals in the UK are out of line with comparable countries in the Organisation for Economic Co-operation and Development (OECD). In essence there is too much capacity in the NHS. We consider further high rates of admissions and lengths of stay in Appendix 2.

It is widely accepted that hospital admissions and lengths of stay are higher than they need to be. Even the current NHS Chief Executive; David Nicholson recognises that 25% of patients in hospital beds don't need to be there and could be looked after by NHS staff at home.<sup>35</sup> In considering the challenges ahead his report remarked, "While the NHS has had a good year, can we say we have done our best when 25 per cent of patients in hospital beds don't need to be there and could be looked after by NHS staff at home?" A more integrated service would shift this burden towards more cost effective out of hospital care, ensuring that clinicians do not view hospital admission as the only or the easiest option.

## Conclusion

Our rationale for moving to a more integrated model of healthcare is to both reduce the rise in avoidable admissions to hospital and to better co-ordinate care around the needs of the patient. As we will see in the next chapter experience from around the world suggests that if costly hospital care is to be reduced, then payment systems need to both discourage admission and create incentives which ensure that unplanned admissions are treated as a cost, rather than a source of income.

34 Hospital Episode Statistics.  
Department of Health  
[www.hesonline.nhs.uk](http://www.hesonline.nhs.uk)

35 Department of Health. Annual  
Report – The Year 2008–09. 2009



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# 3

## Integrated Care: International Case Studies

Further integration of care can play an important role in improving the patient experience, enhancing health outcomes and we believe that the NHS can learn some valuable lessons from examples of integrated care overseas. Integrated care models in parts of the USA and also in Spain provide examples of where integration has moved beyond the theoretical and has been improving patient outcomes for, in many cases, a number of years.

This chapter will consider four internationally recognised integrated healthcare systems: Kaiser Permanente in California, Geisinger in Pennsylvania; the Veterans Health Administration, and the Alzira Model of Integrated Care in Valencia, Spain. We also outline the main lessons that the NHS can learn from these models.

### Kaiser Permanente

Kaiser Permanente has its origins in a system set up by Dr Sidney Garfield to provide healthcare to workers on two large construction sites in California during the 1930s. After running into financial difficulties by refusing to turn sick workers away from his hospital, Garfield arranged for insurance firms to pay 5¢ a day per worker, with the option for workers of paying an additional 5¢ per day to cover non-work related illness. As a result, Garfield had an incentive to emphasise well-being and not just treat the sick and injured. He was later invited to provide a similar service to Henry Kaiser's wartime shipyards, and once the war had ended opened his scheme to the public.<sup>36</sup>

The organisation today is made up of eight regional bodies of which the most studied is Kaiser Permanente Northern California (KPNC), which is made up of three separate bodies: the for-profit Permanente Medical Group, of which all practicing clinicians are employee members (due to Californian law requiring clinicians to be managed only by other clinicians), a Health Plan and a Hospitals Foundation, which are both non-profit and share a board of directors.

This in turn creates a system in which payer (the patient via their choice of insurance plan), doctors and hospitals are intermeshed in one structure – similar to the NHS. Patients with Kaiser insurance can only be treated within the system, providing an inbuilt incentive for the organisation to focus on keeping patients out of hospital. Unlike the NHS where admissions to hospital are a source of income, Kaiser sees unplanned hospital admissions as a 'system failure'.

<sup>36</sup> "A History of Kaiser Permanente", available at <http://xnet.kp.org/newscenter/aboutkp/historyofkp.html>

It is much smaller than the NHS: with around 8.5 million members and 180,000 staff nationally, it has around 8,500 staff and 3.3 million members in Northern California. Its total operating budget was \$42.1 billion in 2009.<sup>37</sup>

In common with other integrated systems Kaiser primary care clinicians are organised into multispecialty groups where generalists work alongside specialists in the primary care setting. Through telecare and telehealth, patients have access to specialists (and vice versa, where case management drives it) in the primary setting, rather than secondary care. Group practice also works against silo approaches to disease. Most importantly, generalists work alongside and build relationships with specialists, supporting broader dissemination of information. Because they deal with each other on a daily basis, protocols for when and when not to transfer care, and how to divide work, become part of everyday practice.

KPNC patients are generally treated in out-patient primary care centres with a full range of facilities such as clinical specialists, nurses and a small A&E department, similar to a minor injuries unit in the NHS. Where admission to hospital is necessary, this is followed by subsequent care in a Skilled Nursing Facility, which is provided by independent centres contracted to KPNC.

From the beginning, Kaiser has been incentivised to provide integrated care focussing on the needs of its patients. In the face of great opposition to its prepaid budget model, it had to build its own hospitals due to Kaiser Permanente clinicians being barred from other facilities. Today, it only provides capacity to the point of necessary admissions, theoretically making unnecessary admissions impossible and in practice, removing from primary care any idea that a case can be soaked up by the hospital system.

It has benefited from the recruitment of clinicians who are attracted to its model of care, and has focused on preventative care to ensure patients stay out of acute services. For example, KP has implemented Disease Management programmes for chronic diseases such as asthma and diabetes. This service encompasses disease management, outreach and care teams, with care backed up by a unified IT system which allows a specific focus on patients with chronic conditions.<sup>38</sup> This IT system, 'HealthConnect' represents a significant investment. The patient facing element, Kaiser online, allows members to communicate by email, access their medical records, order repeat prescriptions and make appointments.

The chronic care model that Kaiser and other Health Management Organisations (HMOs) have put into place involves six steps:

- Drawing on external support for patients
- Improving quality of care in line with best practice
- Better self-care
- Proactive team working in the provision of care
- Helping patients make decisions
- Using information systems to support chronic conditions<sup>39</sup>

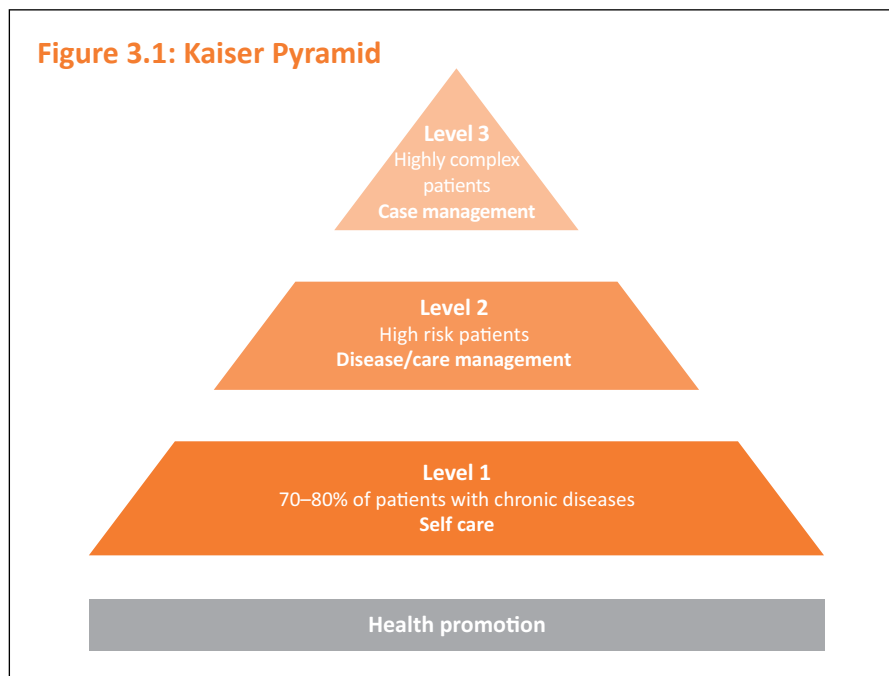
As part of its focus on the care of patients with chronic conditions, the organisation has developed the "Kaiser Pyramid", which charts the care approach relevant to these patients. It divides them into three groups: the 70–80% of patients who can self-manage their conditions with access to the usual levels of health care, those who need regular contact with a multi-specialty group to ensure that their treatment is

37 <http://xnet.kp.org/newscenter/aboutkp/fastfacts.html>

38 See for example Strandberg-Larsen et al, Kaiser Permanente Revisited – Can European health care systems learn? in *Eurohealth* Vol 13 No 4

39 OECD Working Paper 30: Improved Health System performance through better care co-ordination.

progressing effectively (“High risk members”), and finally a smaller group (“Highly complex members”) who may require specialist support – perhaps from an allocated case manager – to cope with their condition, any co-morbidities and an increased risk of the condition deteriorating to the point of needing specialist acute treatment.<sup>40</sup>



### Cost comparisons with the NHS

The Kaiser model clearly provides a number of lessons for the NHS to learn. A 2002 BMJ article compared costs at Kaiser Permanente and the NHS.<sup>41</sup> Adjusting for the different costs and reach of healthcare in California and the UK, they claimed that “healthcare costs per capita in Kaiser and the NHS are similar to within 10%” but “Kaiser members spend one third of the time in hospital compared to NHS patients”.<sup>42</sup> The adjustments made included taking into account special circumstances, the relative costs of the medical environment and the demographics of the area served. To explain the drastic difference between bed stays, the authors put forward a number of factors:

- Achieving real integration between clinicians and administration, allowing it to exercise control throughout the patient pathway and thus care for chronic conditions where appropriate;
- Using this integration to reduce length of stay in acute settings;
- The additional benefits of competition between providers acting as a spur to patient satisfaction, as patients can choose to go elsewhere if they feel they aren’t receiving a satisfactory service from their insurance plan or the healthcare facilities they can access;
- Advanced and sophisticated use of IT.<sup>43</sup>

Comparing health services in different countries is notoriously difficult<sup>44</sup> and it is true to say that the original article which compared Kaiser to the NHS

40 See Ham, The ten characteristics of the high-performing chronic care system, in *Health Economics, Policy and Law* 5:71–90 2010

41 Feachem et al, Getting more for their dollar: a comparison of the NHS with California’s Kaiser Permanente, *BMJ* 2002:324:135–43

42 Ibid

43 Ibid

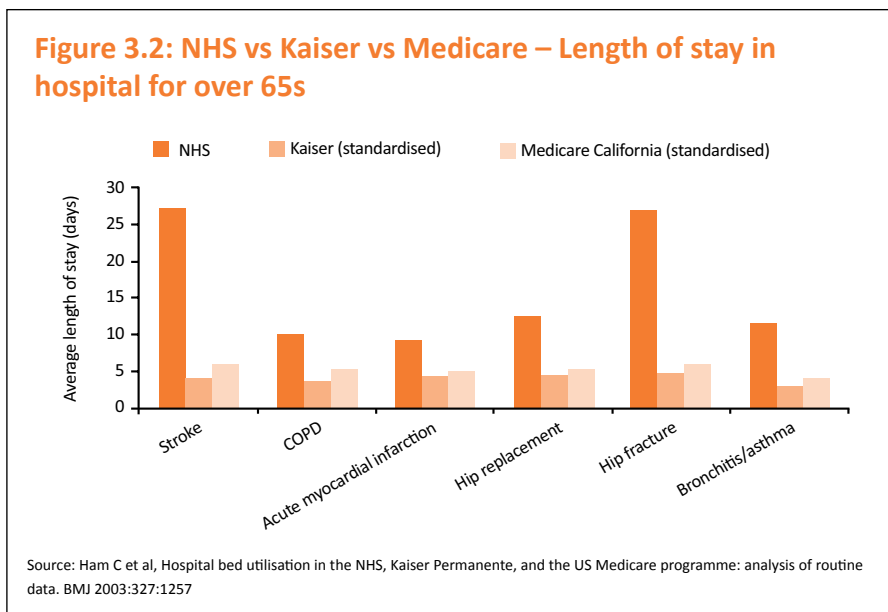
44 Blank and Burau, *Comparative Health Policy*. Basingstoke: Palgrave Macmillan p.33

attracted some criticism.<sup>45, 46</sup> One paper emphasised the importance of care for the over-65s, who are more likely to place pressure on health resources, and contended that the researchers were wrong to suggest that Kaiser and the NHS provide similar services to the over-65s.<sup>47</sup> However, academics know to favour the integrated care model found in support of Kaiser with regards to care for the over-65s, and found that “total bed day use in the NHS is three and a half times that of Kaiser’s standardised rate”.<sup>48</sup>

Such a debate is in danger of going round in circles. There will always be objections to the use and adjustment of cross-border data, but as the graph below shows, whatever the increased costs and limited reach of Kaiser’s service, there must be lessons for the NHS in how to reduce bed stays.

### Lessons learned from Kaiser

As we set out earlier, too many people are being admitted to hospital in the NHS and most of these are unplanned emergency admissions. This dramatically increases the costs for the NHS and diminishes the patient experience. As the graph below illustrates, the Kaiser model in the USA has considerably fewer bed stays than the NHS or even other Californian healthcare providers.



Where the NHS all too often views hospital admissions as a normal part of the process, the Kaiser model regards unplanned hospital admissions as a failure. This has encouraged practitioners within Kaiser to develop innovative and integrated models and has meant that healthcare professionals – generalists and specialists – have had to work together side by side. The Kaiser experience illustrates the importance of integrating clinically, organisationally and culturally.

### Geisinger Health System

The Geisinger Health System provides healthcare for over two million people throughout rural Pennsylvania, covering a deprived and ageing population in an economy dependant on coal mining. Founded in 1915 by a wealthy widow, like Kaiser it was originally focused on providing integrated care to local citizens.

45 *BMJ* 2002;324:1334–1335

46 *Ibid*

47 Talbot-Smith, A et al (2004), Questioning the claims from Kaiser, in *British Journal of General Practice* 54:415–421.

This points out that even if many patients in this age range choose Kaiser treatment as part of the government-funded Medicare scheme, they in fact have to pay \$420 per year subscription plus the first \$250 of all drug charges plus 25% of further drug charges up to \$2250, while UK citizens receive this for free from the NHS. The paper neglects to mention NHS charges like prescription charges or cancer top-ups.

48 Ham C et al, Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. *BMJ* 2003;327:1257

From the beginning it was based on the idea of group practice – different specialists working together to offer the best possible care – which is the model it still operates today.

Access to its services is not linked to choice of insurance plan – its own plan only has around 235,000 members. The organisation employs 650 clinicians (of whom 200 work in community practices and the remaining 450 are specialist doctors), and its main facilities are a primary care centre, two hospitals and numerous community clinics. Uniquely among US healthcare organisations, Geisinger’s clinicians are paid salaries pegged to 80% of the national average, and then paid 20% more through bonuses – not for the amount of patients they see (creating a perverse incentive to see more patients) but for the quality of care they provide to patients.<sup>49</sup> This provides an incentive for clinicians to provide the right care rather than that which will allow them to bill the most, but also means that doctors’ pay is in effect linked to cost containment. There is a balance to be struck.

Perhaps even more than Kaiser, Geisinger has become recognised as a model of efficient and joined-up healthcare. In his speech on healthcare reform in June 2009, President Barack Obama explained the need to “ask why places like Geisinger Health systems...can offer high-quality care at costs well below average, but other places in America can’t.”<sup>50</sup> The system focuses on care for chronic conditions as well as an innovative flat-fee, high-quality tariff for certain operations, allowing for the “bundling” of care. It is also a national leader in using an integrated and accessible IT network to provide back-up to clinicians. Its innovations haven’t cost it financially: it makes \$1.5 billion a year from premiums and has a solid AA credit rating.

As Time magazine noted in a story on Geisinger, “Americans buy health care the same way they buy furniture, clothes and food: one item at a time...physicians bill by the visit; radiologists bill by the X-ray; hospitals bill by the day. That drunken spending has led to the familiar horror-story numbers: a health-care system that gobbles up 16% of gross domestic product, compared with 9% in other industrialized countries, yet leaves the U.S. trailing those countries in such critical metrics as life expectancy and infant mortality”.<sup>51</sup> Geisinger instead focused on providing a continuous and quality service to patients admitted for particular operations, the first example being coronary artery bypass grafts (CABG). A planning group of clinicians turned existing guidelines “into one or more verifiable, actionable care processes with unequivocal definitions...each care process change was designed to be consistent with best practices, be practical and measurable, and be accountable to a specific individual”.<sup>52</sup> 40 such guidelines were introduced, to ensure that all patients received the highest care possible in all instances.

Geisinger is acknowledged as a leading user of integrated IT systems to provide continuity of care to its patients. It has had an Electronic Health Record (EHR) system in place for 14 years, with the records of three million patients available, and has also developed the local information sharing platform, the Keystone Health Information Exchange. Patients’ records can be assessed by Geisinger employees, non-Geisinger clinicians in the community and, most importantly, by the patients themselves. This means patients can see their records, including lab results, email clinicians and nurses and even book appointments themselves.<sup>53</sup> This has led to a 40% rate of people not attending appointments (DNA rate) being reduced to 5%.<sup>54</sup> The NHS currently wastes £600 million per year through people not turning up for hospital appointments.<sup>55</sup>

49 Anna Fifield, *Financial Times*, 7 Jan 2010. Innovative hospitals offer model for reforms, available at [www.ft.com/cms/s/0/8837e026-fbbc-11de-9c29-00144feab49a.html](http://www.ft.com/cms/s/0/8837e026-fbbc-11de-9c29-00144feab49a.html)

50 From [www.whitehouse.gov/blog/A-Town-Hall-and-a-Health-Care-Model-in-Green-Bay/](http://www.whitehouse.gov/blog/A-Town-Hall-and-a-Health-Care-Model-in-Green-Bay/)

51 Kluger, J. Is there a better way to pay doctors? Available at [www.time.com/time/magazine/article/0,9171,1930501-2,00.html](http://www.time.com/time/magazine/article/0,9171,1930501-2,00.html)

52 Casale A. et al (2007). Proven Care: A provider-driven pay-for-performance program for acute episodic cardiac surgical care, in *Annals of Surgery* 246:4: 613–623

53 Ibid

54 Fifield, A. FT article

55 Dr Foster analysis. <http://www.drfoosterhealth.co.uk/features/outpatient-appointment-no-shows.aspx>

### Lessons learned from Geisinger

Geisinger's focus on procedure shows that "a large, integrated healthcare delivery system...can successfully reengineer complicated care processes to reliably deliver consensus-derived and evidence-based best practice".<sup>56</sup> A similar focus on acute care in the NHS could use this example to overcome the perverse incentives that exist for hospitals to focus on quantity as much as quality. The NHS, with high levels of readmission, would also do well to adopt Geisinger's strongly-held belief that "if a patient is readmitted to a hospital after a procedure or an in-patient stay, we believe we have failed that patient".<sup>57</sup>

By changing the incentives available to primary care clinicians, Geisinger has also been able to work to keep patients with chronic conditions out of acute care. As we have demonstrated in a previous report about in the NHS,<sup>58</sup> GPs are not provided with the right incentives. Geisinger discovered that primary care clinicians were being incentivised to see as many patients as possible and not having the time to provide health management to patients. It therefore took the long-term view that preventative care would save money through reduced acute admissions and funded nurses in private primary care clinics who could work with patients. This spend to save approach is much more likely to be adopted in an integrated system. It also incentivised doctors to take part by offering to share half of the money saved from preventing acute readmissions. One clinic, with 900 just Geisinger patients, received \$320,000 in one year.<sup>59</sup> Geisinger reports that its "bundling" of care for chronic conditions has led to a 25% reduction in admissions, a 23% drop in length of stay and a 53% drop in emergency readmissions.<sup>60</sup>

The NHS also has a great deal to learn from Geisinger's use of IT to support integration and enhance the patient experience. Their use of IT has dramatically reduced the number of people not attending appointments, which remains a major and recurring problem and cost for the NHS.

### The Veterans' Health Administration

Until the mid-1990s, the Veterans' Health Administration (widely known as the VA) was a failing organisation, providing substandard care to American veterans. However, a sustained focus on quality improved both its mortality rates and its levels of customer satisfaction, which are now among the highest for any healthcare services in the US. The VA is also the section of the US health system which can be most easily compared to the NHS.

The branch of the United States department for Veterans' Affairs that is responsible for providing healthcare to veterans, runs hospitals, clinics and long-term facilities such as nursing homes across the US. Due to the demographics of the patients it provides for (although veterans' access to VA is not a legal right), the VA treats a more challenging population than self-selecting private systems such as Kaiser are obliged to. One example of this is the fact that 40% of America's homeless men are ex-veterans, meaning that the VA finds itself treating up to 65,000 homeless patients a year.<sup>61</sup> Moreover, VA patients also suffer from much higher rates of substance abuse and mental illness, and have a higher disease burden than the general population.<sup>62</sup>

From 1994 to 1999, under a new Undersecretary for Health for the VA (essentially the CEO) Kenneth Kizer, the VA began a move towards implementing a system of integrated care. Kizer himself was formerly Director of the California

56 Ibid

57 See [www.geisinger.org/about/healthier/index.html](http://www.geisinger.org/about/healthier/index.html)

58 Featherstone H, Whitham L, Chambers M. Incentivising Wellness: improving the treatment of long-term conditions. Policy Exchange. 2010.

59 Abelson, R, A health insurer pays more to save, New York Times 21 June 2010. Available at [www.nytimes.com/2010/06/22/business/22geisinger.html?pagewanted=1](http://www.nytimes.com/2010/06/22/business/22geisinger.html?pagewanted=1)

60 See [www.geisinger.org/about/healthier/62520-1%20SenateFinance%20Tstmnl-ReaderSprds.pdf](http://www.geisinger.org/about/healthier/62520-1%20SenateFinance%20Tstmnl-ReaderSprds.pdf)

61 Kizer, K (1999). The "New VA": A national laboratory for health care quality management, in *American Journal of Medical Quality* 14:1:3-20

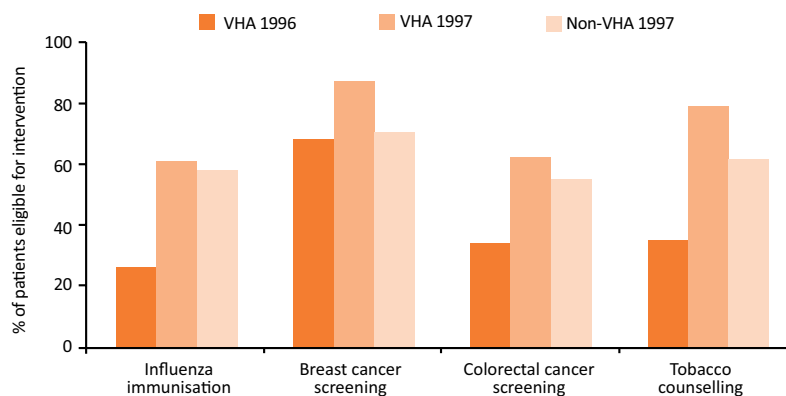
62 Ibid

Department of Health Services and California’s top health official. Prior to that, he was Chief of Public Health for California and, before that, Director of Emergency Medical Services for the state. As has been noted, Kaiser Permanente is one of the major health providers in California.

Under Kizer’s leadership, the organisation was restructured into 22 Veterans’ Integrated Service Networks (VISNs – pronounced “visions”), with nearly half the system’s inpatient beds closed and a large increase in outpatient visits. VISNs were designed around the idea of “funding care for populations rather than facilities”, and are typically made up of 7–10 hospitals, 25–30 primary care clinics and 4–7 nursing homes.<sup>63</sup> This was complimented by a move to capitated budgets,<sup>64</sup> performance-related pay for top managers and a right to fire incompetent doctors.<sup>65</sup> The administration employs around 300,000 people and has a budget in 2010 of \$48 billion.<sup>66</sup>

As part of its focus on quality healthcare, the VA put into place a prevention index listing nine important checks to diagnose early major illnesses. The graph below shows how in only a year the VA’s performance on preventative healthcare improved drastically from its own performance the year before, but also led it to overtake the national averages for other healthcare providers. Subsequent analyses have confirmed these substantial improvements in quality of care.<sup>67</sup> Even complex conditions were dramatically improved with transplant patients treated by the VA having better survival rates than both private and Medicare patients despite VA treatment being much cheaper.<sup>68</sup>

**Figure 3.3: Improvements in screening processes at Veteran’s Health Administration**



Source: Kizer, K The “New VA”: A national laboratory for health care quality management, in *American Journal of Medical Quality* 14:1:3–20. (1999)

### Information Technology reforms

The Veterans Health Administration has used IT to help deliver a significant improvement in its service quality, which formed part of a fundamental shift in its shape and mission. As a result, it has been named as a US exemplar for the use of electronic patient records. It now holds electronic records on 7.7 million people. It is used by medical researchers outside the Veterans’ Association, as it is the largest US patient database. This development has largely been driven by

63 Ibid.

64 Gardner, J. VA on the Spot, in *Modern Healthcare* 28:5:39–41. (1998)

65 [www.washingtonmonthly.com/features/2005/0501\\_longman.html](http://www.washingtonmonthly.com/features/2005/0501_longman.html)

66 Taken from [www1.va.gov/VETDATA/Pocket-Card/4X6\\_summer10\\_sharepoint.pdf](http://www1.va.gov/VETDATA/Pocket-Card/4X6_summer10_sharepoint.pdf)

67 Kizer, K.W et al. (2003). Effects of the Transformation of the Veterans Affairs Health Care System on the Quality of Care. *New England Journal of Medicine*. 348(22)

68 Kizer, K (1999). The “New VA”: A national laboratory for health care quality management, in *American Journal of Medical Quality* 14:1:3–20



in-house programmers experimenting at the margins, but the implementation of the IT strategy has been driven by the Chief Medical Information Officer.

The VA has had automated information systems in its medical facilities since 1985, beginning with the Decentralized Hospital Computer Program (DHCP) information system. This was built around a series of databases on individual conditions, including some of military interest such as artificial limbs and exposure to Agent Orange. Because information systems generally, and eHealth systems specifically, were in their infancy, this emphasised primarily hospital-based activities, although it included both clinical and administrative capabilities.

From 2003, the VA began to roll out the next stage of its eHealth reforms under a strategy called 'HealtheVet'. It is seen as an ideal health information system to support the ideal veterans' health system. Moreover, the VA has also invested in a telehealth and telecare programme which has reduced bed days by 25%, cut admissions by 19%, achieved a patient satisfaction score of 86% and cost \$1,600 per patient per annum.<sup>69</sup> This is significantly lower than their home-based primary care service \$13,121 per annum, and nursing home costs \$77,000 per annum, although does require high initial investments.

### Effect of the VA reconfiguration

Between September 1994 and September 1998, 52% of all VA acute care hospital beds were closed (27,319 of 52,315 – the NHS has around 160,000 beds). The VA's bed-days of care per thousand patients decreased 62% (from 3530 to 1333). Comparing 1998 figures with 1994 figures, inpatient admissions were 32% lower (284,500 fewer), and outpatient visits increased 42% (10.8 million more). The percentage of all surgeries performed in outpatient settings increased from 35% to 75%. The management and operations of 50 hospitals were merged into 24 local systems. System wide staffing decreased by 11% (figures are not available for the clinical/non-clinical ratio), against an 18% increase in patients. Compliance with nationally recommended pathways increased from 34% to 67% between 1996 and 1998.<sup>70</sup>

A number of academic studies of this reform programme at VA suggest that the quality of medical care provided by the organisation over this period improved drastically. One paper in 2003 found that the VA performed better than the government Medicare system in 12 out of 13 indicators of quality of care,<sup>71</sup> a performance it put down to "the principles adopted by the VA in its quality-improvement projects, including an emphasis on the use of information technology, performance measurement and reporting, realigned payment policies, and integration of services to achieve high-quality, effective, and timely care".<sup>72</sup> Regarding information technology: the influential Institute of Medicine notes that the VA's "integrated health information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation."<sup>73</sup>

### Lessons learned from the VA

Like the Secretary of State for Health in the UK, the VA has a legal mission to improve health; like the NHS, it was 'integrated' in name – operating under a single 'brand'. But this did not deliver integration for patients, and as a result, was failing in the mission of improving health. This was transformed by intensive

69 Coye MJ, Haselkorn A and DeMello S. Remote Patient Management: Technology-Enabled Innovation And Evolving Business Models For Chronic Disease Care. *Health Affairs*, 28, no. 1 (2009): 126–135. doi: 10.1377/hlthaff.28.1.126

70 Kizer, K (1999). The "New VA": A national laboratory for health care quality management, in *American Journal of Medical Quality* 14:1:3–20

71 Jha, A et al (2003). Effects of the transformation of the Veterans Affairs Health Care system on the Quality of Care, in *New England Journal of Medicine* 348:2218–27

72 Jha, A et al (2003). Effects of the transformation of the Veterans Affairs Health Care system on the Quality of Care, in *New England Journal of Medicine* 348:2218–27

73 [www.washingtonmonthly.com/features/2005/0501.longman.html](http://www.washingtonmonthly.com/features/2005/0501.longman.html)



efforts to fully integrate care, which have resulted in improved patient outcomes. The NHS should take note from the transformative impact of integration.

The creation of VISNs – integrated service networks – moved the focus of the VA from independent, competing hospital centres, to a holistic regional network. This was accompanied by a Chief Information Officer focussing on producing locally integrated IT networks and rigorous work to enhance and standardise quality, cut costs, improve information management and decentralise decision making. The results have been impressive and provide real lessons to the NHS in how to move to a genuinely integrated health environment, facilitated by IT, that produces real advances for patients.

### Alzira, Valencia, Spain

In recent years, Spanish health care has been decentralised down to the country's 17 regions, thereby allowing an element of freedom between regions. These regions are further divided up into health areas, which provide healthcare facilities and planning for populations of around 200–250,000 people. One of these, the Alzira area in the region of Valencia, required a local hospital. The Valencia Health Department (VHD) explored different methods of funding the new facilities, settling on what has since become known as the “Alzira model”.

This model saw the provision of the entire health system contracted out to a company called UTE-Ribera (founded by a private insurer and two savings banks). UTE-Ribera was originally contracted to provide only acute services, but in 2003 the contract was renegotiated to hand the company responsibility for both primary and acute care for a 15 year period, extendable for a further five years. In effect, a privately run integrated care organisation had been created amongst a mixed health economy of publically provided primary and secondary care.

The Hospital de la Ribera is paid an annual capitated budget per citizen by the VHD, which is adjusted each year to reflect the annual increases in the region's health budget. This meant that the annual fee in 2008 was €578 per head, which is about 20% less than the equivalent costs in directly-run public services.<sup>74</sup> The firm is allowed to keep profits of up to 7.5% of turnover, with remaining profits are returned to the government. The firm has invested €68m in new facilities.<sup>75</sup> Furthermore, if patients choose to go elsewhere for treatment the private company is required to pay 100% of their treatment costs, but is only reimbursed for 80% of the cost of treating non-departmental patients in its hospitals. As a result of the contractual arrangements, the VHD has effectively organised a risk transfer to UTE-Ribera, meaning that its budgets can be pre-determined (as “money follows the patient”). A commissioner from the VHD is based in the hospital full-time, to retain public scrutiny and governance over the services provided.

UTE-Ribera has built a new 301-bed hospital in the area, as well as a new primary-care centre. As with the PFI arrangements in the UK, once the concession expires the company is required to hand the buildings and equipment that it inherited over to the VHD, in the same audited condition as it was given them: this incentivises the company to keep them updated. The “money follows the patient” ethos gives the company an incentive to invest in ensuring that patients

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<sup>74</sup> Hospital de la Ribera. [http://www.ribera10.com/english/alzira\\_model/03.htm](http://www.ribera10.com/english/alzira_model/03.htm)

<sup>75</sup> Hospital de la Ribera. [http://www.ribera10.com/english/alzira\\_model/03.htm](http://www.ribera10.com/english/alzira_model/03.htm)

receive the best level of care possible. Patients are free to choose to go to different providers, but there is an inbuilt financial incentive to retain patients within Alzira system, as it will have to pay for more expensive care if patients go elsewhere. In market terms, contestability is preserved, thereby driving up productivity and efficiency, but without some of the disadvantages of price competition in healthcare.<sup>76, 77</sup>

Most importantly, however, the capitated payment system for primary and secondary care encourages substantial investment in preventative care, as there are no additional payments for patients who require expensive healthcare due to poor health. The integrated provider has also invested in patient-centred care. There has been investment in facilities such as MRI scanners and diagnostic equipment while at the same time waiting lists have reduced and patients are offered a choice of surgery times from 8am to 10pm, compared to many public hospitals where operations end at 3pm.<sup>78</sup>

As with the NHS, the purchaser-provider split in Spanish healthcare occurred in the early 1990s, when a report commissioned by the national parliament found “that the health service suffered from a lack of efficiency and administrative rigidity, excessive centralization and staff apathy and lack of involvement in formulating health policies”.<sup>79</sup> The Alzira model offers all the patient-centred advantages of an integrated system as well as the benefits of private-sector expertise, such as management expertise, patient choice and a focus on patient satisfaction.

To reduce the division between primary care and acute services, the company has attempted to implement a “flat” structure in which there is no step between the two, in particular by creating unified patient pathways and integrated medical processes. There has been an investment in primary care facilities and specialist doctors are used as a link between primary and acute care. Primary care centres provide specialized tests that may have been done in an acute setting, and as we would expect with an integrated care system the IT system is fully integrated.

### Lessons learned from the Alzira model

The Alzira model in Spain emerged from a similar conundrum presently facing British policy makers, namely that fragmentation of the system affected the patient experience. By creating a flat structure, through unified pathways and integrated processes, the Alzira model illustrates to the NHS how fragmentation can be broken down, with positive results for patients. The full integration of IT in Alzira has also illustrated to the NHS how IT can be a real driver to effective integration and effective reform.

Indeed, patient satisfaction with the Alzira system is extremely high: the hospital was voted the best large hospital in Spain five times running between 2000 and 2005, 91% of patients considered themselves happy with the service received and 95% said they would return to use the company’s services.<sup>80</sup> In addition, 80% of people were unaware of how the system was funded, suggesting there has been little controversy about this new method of funding public services.

“By creating a flat structure, through unified pathways and integrated processes, the Alzira model illustrates to the NHS how fragmentation can be broken down, with positive results for patients”

76 Propper C, Market structure and prices: The responses of hospitals in the UK National Health Service to competition, J PUBLIC ECON, 1996, Vol:61, Pages:307–335, ISSN:0047-2727

77 Cooper Z, Gibbons S, Jones S, McGuire A. “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms” LSE Health Working Paper No 16. 2010

78 [www.ribera10.com/english/alzira\\_model/03.htm](http://www.ribera10.com/english/alzira_model/03.htm)

79 Taken from *Euro Observer* Vol 12: Number 1 Spring 2010

80 Ribera presentation

### Box 3.1: IT case study – Heartland Health, USA

Given the importance of IT to the success of integrated care, a member of the study team visited the Heartland Health system in America.

Heartland Health is an integrated health system and insurance plan which provides services to around 300,000 people, across 22 counties in Missouri, Nebraska and Kansas. It provides a range of services, including a regional medical centre with 350 beds, 65 regional specialty clinics, a hospice, a Community Health Foundation and an associated Community Health Improvement Solutions focussing on public health. Collectively the system has 3,000 annual admissions and 500,000 outpatient visits. It employs around 2,700 staff including 110 physicians and approximates to the size of a Primary Care Trust catchment area in England.

Following the implementation of an IT system by Cerner, Heartland is regarded as having one of the most advanced integrated Health IT systems in the United States. As such its organisational structure includes a Chief Medical Information Officer – a strategic role focussing on how IT and medical information supports the overall organizational strategy. Heartland aims to spend around 4% of its operating budget and 32% of its capital budget on IT, which amounts to a total of around \$16m per year.

One of the most important driving forces behind the implementation of such an integrated system was the need to cut down on adverse drug events. Such events are enormously expensive in the USA with around 2–7 per 100 admissions, amounting to 770,000 per year in the United States and a cost in litigation of around \$5million for every hospital. Heartland has taken a pro-active approach by identifying where these medication errors occur and then developed IT solutions to ensure they are reduced.

Location (% of all errors)	Heartland action
Ordering (49%)	Provider Order Entry system (POE) <ul style="list-style-type: none"> <li>• Point of care matching of patient/ problem/medication/dose</li> <li>• Offering other advice where appropriate</li> </ul>
Pharmacy (14%)	Pharmacy IT system and robotic dispensing system to ensure: <ul style="list-style-type: none"> <li>• Right medication</li> <li>• Right dose</li> <li>• Right order for the correct patient</li> <li>• Controlled distribution</li> </ul>
Administration of medicine (26%)	Bar coding at bedside to ensure correct medicine for the right patient <ul style="list-style-type: none"> <li>• Documentation system to ensure right patient/dose/medicine/route</li> </ul>

The aim of such a large investment in IT systems is not only to reduce clinical errors, which it has done, but also to allow the patient pathway to be seamlessly integrated throughout Heartland’s services, thereby improving care for patients especially those with chronic conditions. Research has shown that the installation of a computerised Provider Order Entry (POE) that has clinical buy-in, can reduce the mean monthly adjusted mortality rate by a staggering 20%.<sup>81</sup>

81 Longhurst, C.A et al (2010). Decrease in Hospital-wide mortality rate after implementation of a commercially sold computerized physician order entry system. *Pediatrics* 2010 Jul;126(1):14–21

Heartland Health's overriding goals for the implementation of their IT system were:

- Improving patient care
- Simplifying working processes for clinicians
- Reducing unnecessary costs (which can be invested back into patient care)
- Ensuring that regulatory standards are met
- Supporting clinical research through collection of information

The beauty of the fully integrated IT system at Heartland Health is that all staff are able to access a modified version of the patient's records, as appropriate, which provides them with the relevant useful data at the point of care – not just access to the patient's medical history but also information such as compliance with medication, diagnostics, test results, key events and tracking of the patient's condition over the previous 24 months.

This information is also available to the patient, both whilst they are in inpatient surroundings and when they are at home. The software also allows them to communicate directly with their doctor. As with the Veteran's Health Administration, patient access to IT enabled healthcare records is a key component. Allowing functionality such as appointment booking better engages patients in their own healthcare.

### What can we learn from successful integration overseas?

The case studies profiled show that effective large scale integration of services is both possible and beneficial. They illustrate that integration can bring about real improvement to the patient experience and deliver genuine cost savings to the NHS. Moreover, the environment of competing integrated care organisations also helps to improve performance and drive up quality for patients. Competition should be seen as a driver of integration in the NHS.

Although it isn't possible to directly transfer learning experiences from one national health culture to another, it is possible to learn lessons from other healthcare cultures. In particular, the examples quoted above show that:

- **Integration delivers real results** – All of the successful models of integration illustrate the importance of achieving integration at the clinical level, facilitated by mutually agreed protocols. These agreed protocols involve agreement over preferred pathways (with the patient at their heart) and agreements over what the correct hand offs should be for a variety of conditions at various parts of the pathway.

Full integration of care has been shown by the examples overseas to be capable of delivering genuine benefits to patients, particularly those with long-term conditions, whilst also providing substantial cost savings to the health care system.

The examples illustrate the importance of cultural as well as organisational integration. As has been shown by change management theory across industries, people will only play a full part in an integrated entity if they understand:

- The reasons for the integration; and
- The benefits of integration for the patient, the system and themselves.

“Selling the benefits” to staff and to patients, therefore, needs to be an integral part of the shift towards further integration, with clinicians and staff feeling a sense of “ownership” of the integration.

- **Getting the “incentives right” is crucial for effective integration** – As discussed in chapters 1 and 2, as well as the health infrastructure in the UK being fragmented, health professionals also have no disincentive to prevent them from using unscheduled hospital stays, rather than seeking alternative routes. The overseas examples quoted show the importance of providing the right financial incentives for the right decisions for the patient. The Geisinger model and the Alzira model both illustrate the benefits of financial models that provide the right incentives, including, in some cases, providing clinicians with financial rewards that both improve patient and system level outcomes.
- **Information technology is a fundamental backbone of successful integration** – A crucial part of all of the examples of integration quotes was a fully integrated IT structure, which fully supports the integration of healthcare. All of the examples quoted have fully integrated IT, as well as providing a technological structure that can ‘nudge’ patients away from unnecessary appointments and provide the support for front line professionals to act in a fully joined-up way.

It should be remembered, however, that the role of IT is to support clinical and organisational integration. Integrated IT cannot be used as a substitute for proper cultural, organisational, economic and clinical reform. However, integrating IT must support, rather than lead, integration at the ground level.

The examples discussed above present lessons for the NHS to learn from. They do not represent shovel-ready blueprints for NHS integration. It must be remembered that the fully integrated US systems discussed have grown organically over a period of years. During the 1990’s a number of US hospitals bought up primary care providers thinking they could create integration out of nothing.

Possibly of most interest to the NHS is the Alzira model which has not grown organically, but been inserted into the existing healthcare infrastructure over a short period of time and developed into a high performing health system.

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# 4

## Integration in the NHS

Thus far we have seen that integrated care organisations could be an effective way of delivering and organising healthcare services in the NHS. However, we should re-iterate that there is no one size fits all approach for integration. In the USA, it has grown organically. We explore a Valencian-style big bang approach below, however we propose that this model should be introduced in the NHS as part of a substantial pilot scheme.

Thus, for the most part integration is likely to develop incrementally. We expect to see closer working of providers and commissioners, the development of sophisticated financial incentives and, subsequently, alignment of patient flows to the most appropriate level of care. Out of these drivers integrated organisations will grow and here we explore the models of integration that we expect will soon come to operate in parts of the NHS. They are neither exclusive nor necessarily comprehensive, but designed to generate debate and cast a vision for how integration might develop in the future. Recognising that variation should exist in both the scale and scope of integrated care organisations remains central to our approach.

We also re-iterate our recommendation from earlier work that we believe NHS and social care budgets should be combined.<sup>82</sup> We appreciate the complexity and upheaval that this would involve at a national level, but a substantial pilot programme would allow some of these complexities to be assessed and addressed. We believe that capitated budgets for health and social care need should be distributed through the Department of Health and Clinical Commissioning Groups, rather than social care budgets being distributed by HM Treasury through local authorities only to be re-joined with health budgets further down the administrative chain.

An obvious perceived conflict to health and social care being delivered as one service is the fact that the NHS is largely free at the point of use, whereas aspects of social care are not. In reality this is simply not true; fundamentally, the NHS is not completely free at the point of use. Those with relatively limited means already pay for prescription and dental charges, the so-called co-payments.

The introduction of the Cancer Drugs Fund has removed the need for top-up payments in cancer care for the time being; nevertheless we expect top-up payments to creep into other disease areas such as diabetes where the cost of medicines is escalating rapidly.<sup>83</sup> To ensure that health and social care provision continues to remain affordable for the State, and that no-one is left behind because they are unlucky enough to have a particular disease, we believe that it is more important to extend the principle of top-up and co-payment in the NHS, rather than free care at the point of need into social care.

82 Careless: funding long-term care for the elderly. Featherstone H, Whitham L. Policy Exchange 2010

83 NHS Information Centre. Prescribing for Diabetes; England, 2005/06 – 2010/11

## When will integration take place?

The financial cost pressures in the NHS are well described elsewhere. The need to make £20bn of efficiency savings will eventually see a significant number of hospitals threatened with financial viability.<sup>84</sup> In circumstances of organisational failure within a local health economy, the public, political and clinical outcry could be addressed by the creation of a full-scale integrated care organisation, as part of a substantial pilot programme of integrated care as described below. We should be clear that we do not wish to see all financially failing acute hospitals bailed out with public funds; it is likely to be the case that some hospitals will need to be closed down over the coming period of tight NHS funding.

## Models of integration in the NHS

### Organisational integration

Although there is evidence that organisational integration alone does not necessarily achieve the benefits seen in the case examples at Kaiser and the Veterans Health Administration, we consider it here because the example in Valencia suggests this approach does have some merit.

Any programme of integrated care organisations must fundamentally change the way in which doctors practice medicine and collaborate with other health care professionals. What we are suggesting is not just organisational integration, but financial integration too **with a reversal of the purchaser provider split**. This is a dramatically different proposition from the current policy debate on integrated care, which focuses largely on joining just health and social care provider organisations.

In our model the NHS integrated care organisation (NHS ICO) as a whole would decide, and provide, what services were required. The single organisation would combine hospital, community care and primary care services and would cover a population of around 250,000. This equates roughly to the size of a Primary Care Trust (when there were 152 across England) coupled with a medium sized acute hospital trust of approximately 300 beds and community facilities such as cottage hospitals, minor injuries units and multiple GP surgeries.

There would be an explicit requirement that the integrated care organisation provide its registered population with a universal health service, although there should not be a requirement that the organisation provide all the services itself. For example, the NHS ICO might not provide tertiary services such as neurological and cardiac surgery, which might be better provided elsewhere. These patients could be referred to neighbouring centres of excellence, and patients would also be able to choose to have their treatment at neighbouring or other NHS trusts. The NHS Tariff rate would be payable for these external transactions.

Achieving care-coordination within the ICO could evolve along any number of established models and examples.<sup>85</sup> The guiding principle, however, is to avoid the 'acute care mind-set' which places the hospital at the centre of the integration process.<sup>86</sup> What is critical in this respect is the intertwining of clinical, managerial and financial disciplines in order to facilitate new ways of working across previously siloed disciplines. For example, the extension of Service Line Reporting from NHS Foundation Trusts into community and primary care services. This management methodology uses data on cost and quality to enable clinicians and

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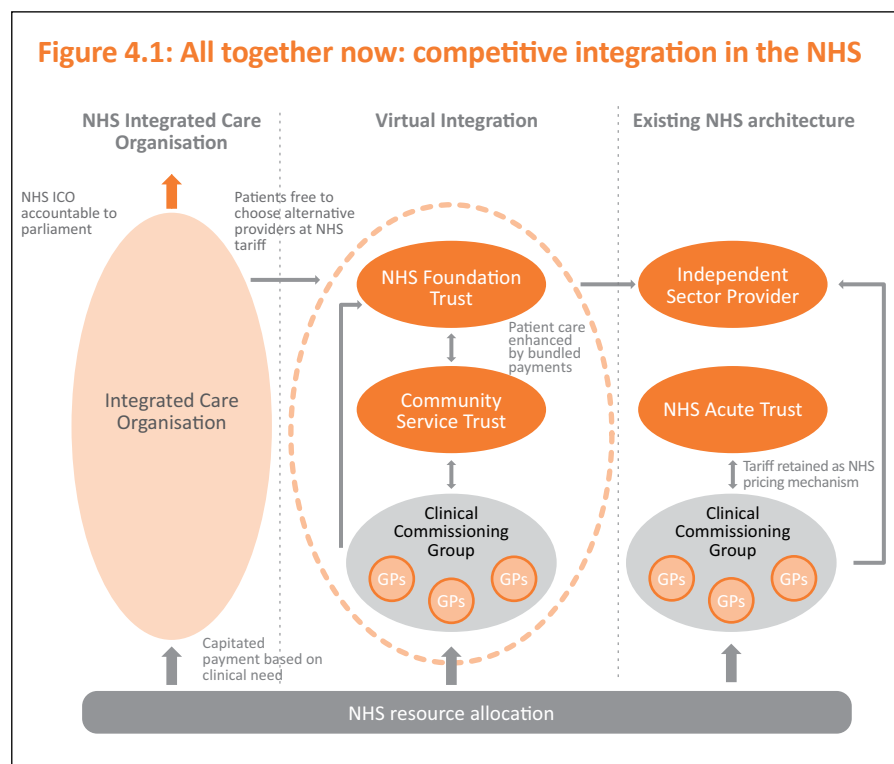
84 Public Accounts Committee - Sixtieth Report. Achievement of foundation trust status by NHS hospital trusts. UK Parliament 2011

85 Curry N, Ham C. Clinical and service integration. The route to improved outcomes. King's Fund 2011

86 Shortell, S.M., R.R. Gillies, D.A. Anderson, J.B. Mitchell and K.L.Morgan. 1993. "Creating Organized Delivery Systems: The Barriers and Facilitators." *Hospital & Health Services Administration* 38: 447-66

managers to better manage their services.<sup>87</sup> These collaborative efforts of service teams could help clinicians to lead change at a system-wide level.

The incentive within a Service Line Reporting arrangement that extended into community and primary care is to highlight hospital use as a cost centre, as with Kaiser, thereby focussing efforts on reducing admissions to hospital through combined clinical groups establishing clear protocols and processes for managing patient care. Organisations that are correctly incentivised to deliver integrated care will do just that, combining medical services and collaborating at the level of individual clinicians.



There would, of course, be significant financial and legal hurdles to creating large integrated care organisations, not least the question of how to bring GPs into such an arrangement given the fact that they are essentially private contractors to the NHS. We believe that many GP's currently practising under a partnership model might be encouraged to work on a salaried basis for the integrated care organisation. The 'price' for relinquishing their independent partnership status could be the value tied up in the goodwill of their practice lists.

In this context, goodwill is an accounting concept meaning the value of an entity over and above the value of its assets. Government regulations prevent the goodwill of a GP practice from being sold in the same way as for other business such as solicitors, dentists and accountants. This goodwill is currently valued at approximately £160,000 per GP partner.<sup>88</sup> It would cost the government nothing to let GPs to trade the goodwill of their surgeries, but it would allow GPs to become part of the integrated care organisation rather than remain as independent contractors to the organisation. Alternatively, other GPs currently working on a salaried basis (not partners) might be attracted to the integrated care organisation

<sup>87</sup> How Service-Line Reporting can improve the productivity and performance of NHS foundation trusts. Monitor – Independent Regulator of NHS Foundation Trusts. 2006

<sup>88</sup> Healthcare Republic. Practice Finance – buying and selling goodwill. Laurence Slavin, Chartered Accountant, Ramsay Brown. August 2009



by improved rates of pay. The most recent NHS data puts the average income for GP partner in England at £107,667 while that for a salaried GP is just £53,940.<sup>89</sup>

A much more fundamental question is the ownership and management of the ICO. The suggestion in this report is that the integrated care model would most likely come into operation following financial failure in the NHS. The options for ownership in these circumstances will be either public, private, joint venture or mutual model, although a full discussion on the merits of different ownership models is beyond the scope of this paper. The administration and management of the ICO is a much more interesting question. The NHS has already accepted

“Leaders need the managerial freedoms and resources to be able to develop incentives and rewards for their staff who adopt new ways of working to deliver integrated care for patients and these will not come by being beholden to the old ways of working”

(although not proved) the principle of private sector management of an acute hospital trust, with the awarding of the contract to run Hinchingsbrooke Health Care NHS Trust to the Circle partnership. We suggest, therefore, that further private sector involvement in running NHS ICOs should not be controversial in principle.

The toughest question for integrated care organisations in the UK context is the preservation of patient choice. The NHS ICO will be dependent on the saving it can make between the total capitated sum it is paid for delivering all health and social care services for its registered population, and the cost of care provided. To keep the costs at their lowest, the ICO will guide patients along the most efficient care pathway. We suggest, however, that in order to preserve the principle and freedoms offered by patient choice patients should be allowed to choose another provider at each stage of their pathway. This will place the onus on the NHS ICO to retain the patient in the same way that NHS trusts currently compete for patients. If a patient chooses to go to another hospital, then the ICO must pay that hospital 100% of the NHS Tariff cost of treatment. If the NHS ICO had treated the patient, they would have saved the difference between the NHS Tariff cost, and their actual cost. The incentive therefore for the NHS ICO is to retain patients by delivering patient centred services, with improved clinical outcomes.

#### a) Pilot programme

We recommend that organisational integration in the way we have described should be piloted in the NHS. As part of a national scheme ten NHS Integrated Care Organisations (NHS ICOs) should be created combining hospital, community care and primary care services. Each of the ten organisations should have a single chief executive accountable to Parliament through Monitor, the economic regulator of the healthcare sector, and not the NHS Commissioning Board.

We cannot understate the importance of proven top quality management and leadership for these senior NHS positions. The implementation and operation of an integrated health system requires leadership with vision, and the capability to drive an organisational culture that is aligned with the vision. Moreover, leaders need the managerial freedoms and resources to be able to develop incentives and rewards for their staff who adopt new ways of working to deliver integrated care for patients and these will not come by being beholden to the old ways of working.

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<sup>89</sup> NHS Information Centre. GP Earnings and Expenses Enquiry 2006/07. May 2009

As we have stated previously, the financial pressures in the NHS mean that the impetus for creating NHS integrated care organisations will most likely come following the financial failure of acute hospitals. We believe that the conditions for integration under these circumstances will be very much different from those studied previously for organisational integration.<sup>90</sup> There will be financial necessity; political and public support and deep clinical support also. The drivers will be different too: the focus will be about recovering deficit; preserving services for patients; ensuring organisational viability and a recognition that the current system of financial and organisational fragmentation had failed. The impetus for clinically-led service change would be strong.

**Recommendation:** We recommend that the Department of Health run a series of ten full-scale NHS ICO pilots each covering a population of around 250,000. These NHS ICO pilots would encompass bringing together primary, community and acute NHS services into one organisation, with a single budget for purchase and provision of NHS services. The chief executive of these NHS ICOs should be accountable directly to Parliament through Monitor and not to the NHS Commissioning Board.

Ten full-scale NHS ICO pilots equate to approximately 5% of NHS capacity, which is, according to academics with an interest in competition in healthcare, the figure required to drive a contestable market. The contestable nature of NHS ICOs on the existing architecture of CCGs, foundation trust hospitals and community services is, perhaps, the most interesting and intriguing aspect of integrated care in the NHS.

#### Box 4.1: Integration in NHS Cumbria

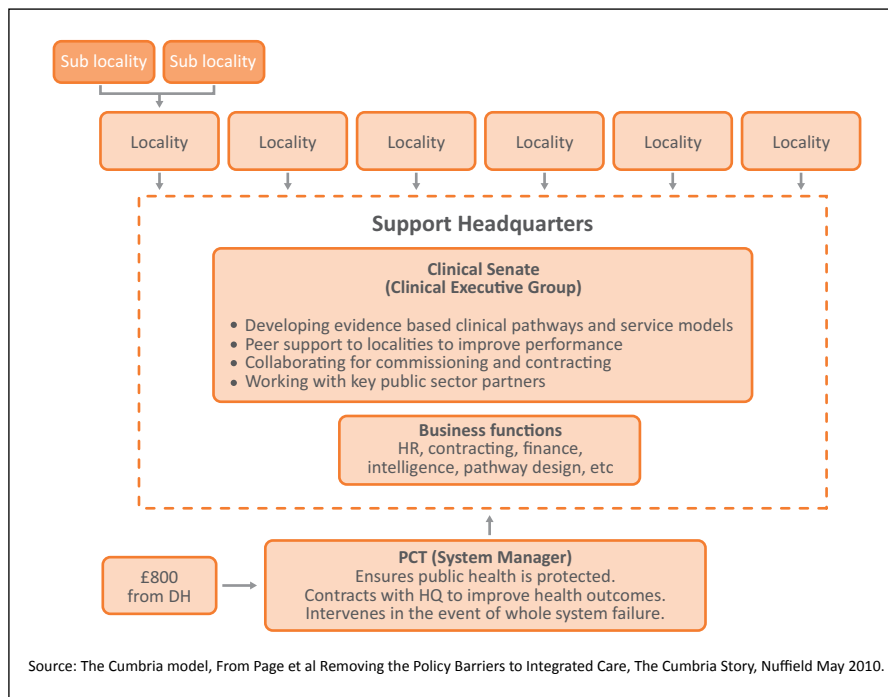
One of the most highly praised integrative innovations in the UK is in Cumbria. By integrating services under the leadership of a dynamic chief executive the PCT has wiped out an historic debt of £36.7 million and a projected deficit of £100 million. Sue Page came to lead the trust in 2006. She quickly established 6 'localities' through which funding is disbursed. These localities are integrated care organisations that oversee commissioning and service provision. They are focussed on preventative care, integrating services for older people, supporting self-management for long term conditions, providing high quality primary care, access to urgent care and on the efficient use of elective services.

The model has made good use of a 'step up step down' facility in Kendal with 51 beds, which can get people out of hospital, or upgrade homecare without a hospital admission. The PCT has reduced emergency admissions by around 2%, against a regional rise of 5%. In Cockermouth Hospital, the length of stay is down from 36 days to 11 days, with costs per admission reduced by more than half. Interestingly, and exactly as one would expect, the model is putting additional (contestable) pressure on the local acute trusts. It is also working to engage the public through lay members of the locality boards, and through local authority mechanisms such as parish councils.<sup>91</sup> The PCT had also explored spinning out the commissioning to a social enterprise, but this has been scrapped because of staff concerns over NHS pay, pensions and benefits.<sup>92</sup>

90 Curry N, Ham C. Clinical and service integration. The route to improved outcomes. King's Fund 2011

91 Case study from Page et al *Removing the Policy Barriers to Integrated Care, The Cumbria Story*, Nuffield May 2010

92 <http://www.whitehaven-news.co.uk/news/social-enterprise-scrapped-1.756406?referrerPath=/1.60007>



### b) Virtual integration

Integration may be ‘real’ (i.e. into a single new organisation) as above or ‘virtual’ (i.e. a network of separate providers, often linked contractually) and for the NHS as a whole virtual integration will be by far the dominant model. Integration in this context may involve providers collaborating, but it may also entail integration between commissioners, as when budgets are pooled. These case examples have been considered in reports elsewhere in great detail and we will emphasise just a few examples here.<sup>93</sup>

Although the case for integration has been clearly outlined with reference to international evidence what remains uncertain is the systemic framework upon which models of integrated care – short of full-scale organisational integration – can be developed and incentivised to evolve. We explore in the next chapter how information technology, estate structures and greater risk sharing between commissioners and providers can be developed nationally to facilitate clinical integration.

In the context of integrated care developing in the architecture of Clinical Commissioning Groups and Foundation Trusts we believe that budgetary pooling offers the greatest potential for change. However, these pooling arrangements need to be real with rewards accruing to those organisations and professionals that adopt different behaviours and not just theoretical, as occurred with Practice Based Commissioning. The pooling of funds and the distribution of savings in virtual integration needs to be contractually enforceable between organisations that cooperate to improve patient care. As we have stressed earlier, consideration should also be given to internal incentives to doctors to complement those at an organisational level.

We have previously suggested that the Department of Health should commission academic work to calculate the current healthcare-related costs of the most common long-term conditions.<sup>94</sup> This would enable capitated budgets for populations with

93 Curry N, Ham C. Clinical and service integration. The route to improved outcomes. London: The Kings Fund 2010

94 Featherstone H, Whitham L and Chambers M. Incentivising wellness. Improving the treatment of long-term conditions. Policy Exchange 2010

these conditions to be easily distributed by Clinical Commissioning Groups to dedicated providers of care. For example, population based budgets for conditions such as diabetes and cardiovascular disease would act as an appropriate financial incentive to develop and encourage greater coordination and integration of clinical services for these conditions.

Further, we would also expect to see new entrants into the market, delivering integrated care for specific disease populations. These might be social enterprises, consistent with the government's push for new models of delivery, or even joint ventures between primary and secondary care clinicians with private sector backing. With appropriate support and information primary, community and secondary care providers should be encouraged to develop independent 'road-maps' towards integration based on a national framework. A range of 'suggested' models could be provided to commissioners and providers as guidance and should be based on international examples, clinical evidence, recognised best practice and the emerging results of the NHS ICO pilot programme.

## b) Clinical integration driving organisational integration

*Will acute hospital foundation trusts dominate the landscape?*

An alternative conceptual model is for Foundation Trusts to utilise their freedoms and integrate vertically down through community services into primary care. For example, by providing more services through outpatient departments and more community services, either on their existing sites, or on convenient sites in the community. More radically, foundation trusts could even hold capitated budgets for patient care and begin to deliver primary care services, manage long-term conditions and provide the full breadth of community services.

The question for foundation trusts is whether they would wish to compete with local GPs which are their only source of revenue by way of referral of patients. For this reason we doubt that foundation trusts en masse will develop into integrated care organisations. In the short-term, we foresee greater collaboration in disease areas which are more properly managed outside the hospital setting, such as diabetes and arthritis. The historical division of primary and secondary care means that some specialists reside in hospitals when their patients are in the community. In these circumstances, it is the clinical expertise from within the hospital that will allow them to deliver integrated services. There are two examples that stand out from many recent reports and papers.

The first, in Wales, saw three Chronic Care Management (CCM) Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneering co-ordinated care for people with multiple chronic illnesses. Based on international evidence a 'shared care' model of working was implemented between primary, community, secondary and social care. Evaluations of the three demonstrator sites found that they were able to reduce the total number of bed days for emergency admissions for chronic illness by 27%, 26% and 16.5% between 2007 and 2009. This represented an overall cost-reduction of £2,224,201.<sup>95</sup>

The second example is the use of a technology in Northumbria where, in 2002 the health service in started an on-going relationship with Kaiser Permanente utilising some of the tools deployed in the USA. One tool that Kaiser uses is McKesson's InterQual to assess the appropriateness of hospital admissions, level

95 Goodwin N, Smith J. The evidence base for integrated care. King's Fund & Nuffield Trust 2011

of care and length of stay. Northumbria wanted to reform emergency care and part of this involved freeing up space and expertise in the hospital, by bringing acutely ill patients together in wards under the sight of senior staff, and putting patients with less acute needs (i.e. those who needed nursing or therapeutic care) on other wards. Using InterQual to inform these judgements the team found that nearly a quarter of patients were receiving the wrong level of care – most too high, although a few too little. The Trust has employed teams of nurses called ‘care facilitators’ to use these results to manage how long patients stay in hospital. It has delivered average lengths of stay that are half the national average. Most interestingly, the initial resistance to the Interqual project from clinicians has dissipated as they have seen the benefits to patient care, and to their workload.

A final aspect to consider in relation to hospitals is the value of the money spent. Hospital productivity has fallen over the last ten years, according to the National Audit Office, by around 1.4 per cent a year.<sup>96</sup> But if the NHS is to deliver efficiency savings of £20 billion by 2015, hospitals will need to make productivity gains of approximately six per cent per annum. Since most spending in hospitals derives from clinical decision making, doctors will need to begin to work differently.

Looking at the internal incentives of acute hospitals the consensus is that the NHS pay contracts introduced since 2003 have increased costs, but they have not been used effectively to drive improvements in productivity or integration of care for patients. In 2010, the hospital consultants pay bill cost the NHS £4.2 billion. We recommend therefore that the Clinical Excellence Awards scheme for hospital consultants be overhauled so that financial rewards are available for delivering integrated care for patients, improving productivity or making contributions to the NHS’s wider objectives, in addition to the more familiar rewards for research, innovation and leadership.

#### *Will Clinical Commissioning Groups take on their role as originally envisaged?*

In moving commissioning functions to what are now Clinical Commissioning Groups, the central aim of the NHS White Paper, Equity and Excellence, was to deliver greater alignment between clinical decision making and the financial consequences of these decisions. Moreover, the role for Clinical Commissioning Groups in driving integrated care was explicit, “*There will be clearer incentives for more integrated and preventative care where those closest to the decision – the GP and the patient – think this is appropriate.*”<sup>97</sup> However, concerns over NHS reform have seen these incentives watered down.

An example of the alignment envisaged in the White Paper is the Pennine Musculoskeletal (MSK) Partnership. This service was set up in conjunction with NHS Oldham to provide an integrated multi-disciplinary service in rheumatology, orthopaedics, and chronic pain. The service is led by consultant rheumatologists, and the partnership employs a clinical assessment nurse, specialist rheumatology nurses, physiotherapists, occupational therapists, orthopaedic consultants, liaison psychiatrists, and podiatric surgeons.

The service was designed to screen GP referrals into secondary care, managing those patients who did not need to see a consultant rheumatologist and ensuring those patients referred on to secondary care were fully investigated before seeing the consultant. The service was managed by the PCT (now known as NHS

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<sup>96</sup> National Audit Office. Management of NHS hospital productivity. 2010 HC491

<sup>97</sup> Equity and excellence: Liberating the NHS. Analytical strategy for the White Paper and associated documents. Department of Health 2010.

Oldham) and was highly successful with 70% diversion of GP referrals away from secondary care, with high levels of patient, staff and GP satisfaction. Pennine MSK is now able to triage patients within 24 hours, has low waiting times for assessment (over 80 per cent now within one to three weeks), and most patients are seen and discharged from the service within seven weeks.<sup>98</sup>

By giving responsibility for commissioning and some aspects of provision to clinicians on the ground then budgets can be used to either to provide more services directly or to commission these services from others: so-called 'make or buy' decisions. The example of GP fundholding in the 1990s demonstrated that GPs in control of clinical budgets were able to attract on-site services from hospital specialists – thereby beginning to move services from secondary care into cheaper and more convenient primary care settings.<sup>99</sup> There was some clinical integration, but it was limited.

Another example of multidisciplinary care that needs to be incentivised is Dr Tim Richardson's Practice in Epsom which began integrating under the GP fundholding pilots in the 1990's. The practice bought the Old Cottage Hospital. The practice ran out of the ground floor, leaving the two floors above available to providing community services. Fundholding (the precursor of GP commissioning) provided the incentive to look after patients in the practice rather than sending them to hospital.<sup>100</sup> Soon after, the top floor was converted by a private healthcare company, and Epsom Day Surgery became the first independent day surgery unit.<sup>101</sup> The practice took over from the private partner in 1998. By then, it was delivering specialist clinics, diagnostics including x-rays, ultrasound and vascular Doppler, physiotherapy, chiropody, audiology and dietetics, endoscopy and a full range of specialist day surgery.

The implication of GP's providing more services in the community is that hospitals will have fewer patients. This may bring neighbouring hospitals to the point of shutting down wards, services, even entire units. This is a necessary, even desirable, state of affairs. The consequence of reducing admissions to hospital and reducing lengths of stay in hospital is that, over time, hospital capacity will need to be reduced. Although beyond the scope of this report, the future of the district general hospital, including location, size and services on offer needs to be explicitly considered by the Department of Health.

As we have seen previously, Kaiser's multi-speciality groups bring consultants into the primary setting and Geisinger invested in nurses to work with patients, to give GPs more time to manage patient's health. The incentive in each case is a financial one: Kaiser's physicians can earn up to 10% of their annual salary in an incentive payment that is based half on quality and half on service which is measured by patient satisfaction. Geisinger's doctors could share half the money saved from preventing acute admissions, and have 20% of salary performance related.

The problem in the NHS is that the pay for performance scheme introduced for GPs, the Quality and Outcomes Framework (QOF) rewards processes rather than outcomes such as preventing patients with chronic conditions from being admitted to hospital. There is a disconnect between the incentives paid to GPs and the need for the NHS to become more integrated around the needs of patients. On average, GP practices achieve 95% of the QOF funding available,<sup>102</sup> yet as we have seen earlier emergency admissions to hospital continue to rise.

98 <http://www.pmskp.org/>  
Accessed 20 December 2011

99 Harris A. Specialist outreach clinics. *British Medical Journal* 1997; 308: 1053

100 Ham, *Integrating NHS Care, Lessons from the Front Line* Nuffield 2008

101 In 1996, the Department of Health rolled out 'Total Purchasing'. GP fundholding allowed GPs to manage the budgets for their patients' elective and community care. Total Purchasing enabled them to manage the budgets for almost all the care their patients might need. Embracing this, the practice then employed a Registrar at the local hospital to assess the practice's patients there, and move those who could be cared for into the community, back into the Old Cottage Hospital

102 NHS Information Centre. Quality and Outcomes Framework Achievement Data 2010/12

For example, the National Diabetes Audit finds that some 444,000 patients have glucose levels that put them at risk of diabetic complications such as blindness or kidney failure and episodes of admission to hospital with critically high glucose levels, diabetic ketoacidosis, is at an all-time high.<sup>103</sup> But GP practices achieved 96.1% of their QOF scores and hence payments for diabetes.<sup>104</sup> Overall GP practices can receive up to an additional £120,000 for meeting QOF targets. There needs to be a much more joined up approach to remunerating doctors to reward multidisciplinary care and achieving improved clinical outcomes for patients.

**Recommendation:** We recommend that both the Quality and Outcomes Framework and the Clinical Excellence Awards scheme be overhauled to include indicators which incentivise GP and consultants to work together in multidisciplinary teams providing integrated care for patients. NICE should develop a set of indicators which focus on cooperation and integration; for example, reducing admissions to hospital for a range of chronic diseases which can easily be controlled by modern, preventative medicine.

103 NHS Information Centre.  
National Diabetes Audit Executive  
Summary 2009/10

104 NHS Information Centre.  
Quality and Outcomes Framework  
Achievement Data 2010/12

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# 5

## Creating the Conditions for Integration

Despite the growing enthusiasm for integration, there is little guidance for planners and decision-makers on how to plan and implement integrated health systems. While we do not profess to offer all the answers here, we focus on four enablers which implemented at a national level could help to achieve integration in the NHS.

### Financial integration between commissioners and providers

As we have seen earlier, the financial and organisational fragmentation of the NHS works against integrated care. This is because there is inadequate financial integration between commissioners and providers which manifests itself in physical and organisational separation which works against delivering integrated care for patients. By contrast, under the Alzira model, there has been a reversal of the purchaser-provider split and a single organisation receives a capitation fee and is responsible for each stage of the patient's care.

Whereas the purchaser-provider split was introduced into the NHS to drive market based efficiency, the reversal of the split in Alzira has allowed the private sector to deliver more efficient and integrated care. This arrangement generates inbuilt incentives for preventative medicine and treating patients at the lowest level of care; the profit cap ensures a good deal for the public purse.

Kaiser's answer is the Multi-Speciality Group, which sees generalists and specialists working alongside each other in primary care under capitated budgets. These integrated groups perform well on a number of indicators since they have strong incentives both to meet the needs of patients – otherwise patients will leave and go elsewhere – and to use resources efficiently as they, the clinicians, directly benefit from any savings made.

Moreover integrated medical groups which have been successful in delivering high-quality integrated care to patients tend to combine responsibility for commissioning and provision. That is, there has been a reversal of the purchaser-provider split in limited circumstances where clinical and financial responsibilities are aligned beyond just primary care. Commissioning of healthcare services takes place at a higher level; the capitation payment is made subject to certain guidelines and monitoring, but all the other functions around the organisation and delivery of healthcare rest within a responsible provider organization.



We believe that integration and a move towards care which keeps patients out of hospital can only usefully be achieved at a national level by developing integrated tariffs – essentially a micro-capitation fee – for specific illnesses. For example, focussing on diabetes and cardiovascular disease which together account for 8.8% of the NHS budget each year.<sup>105</sup> The year of care pilot programme for diabetes has shown how services can be integrated to improve the quality of care at no increased cost.<sup>106</sup>

This move to considering the total cost of diseases or treatment pathways is already happening to some extent with personal budgets, which give the patient a budget to cover the care they will need, and allows them freedom in commissioning it, in consultation with clinical advisors.<sup>107</sup> We have previously recommended this approach in earlier work, and believe that the Department of Health should commission academic work in this area to facilitate Clinical Commissioning Groups in commissioning services for disease populations.<sup>108</sup>

The pooling of funds as a necessary step in delivering integrated care is well-recognised in the academic and policy literature.<sup>109, 110, 111</sup> However, while some believe that reversing the purchaser-provider split should be adopted on a widespread basis,<sup>112</sup> we believe that it should only be introduced in limited circumstances, for high-cost long-term conditions, rather than as a national programme.

Where adopted we foresee risk sharing structures sitting amongst the existing architecture of clinically-led commissioning groups and NHS hospital trusts. This arrangement would allow the efficiencies; clinical pathways and focus on patient-centeredness in the integrated care model to drive improvements and greater collaboration in neighbouring organisations, in the same way that the introduction of Independent Sector Treatment Centres helped raise standards and reduce waiting lists.

**Recommendation:** We recommend that the Department of Health commission academic work to calculate the current healthcare-related costs of the most common long-term conditions, including asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease. This should be accompanied by a framework to enable financial pooling arrangements between commissioners and providers to engage in delivering integrated care for patients. The intention is to encourage provider organisations to take over the running of certain long-term conditions.

## Information technology

Integrated care requires professionals across different organisations to have to work together in a coordinated way to provide high-quality care for a patient. This requires that healthcare professionals share information about, and indeed with, patients at all appropriate points in the care or treatment process. It is virtually impossible to imagine vertical integration succeeding in the NHS without a strong information management and technology component.

As most people will be aware, the NHS has been engaged in purchasing the largest civilian IT programme in Europe through the NHS National Programme for Information Technology (NPFIT). On most measures this project has been a failure and the centrally run NPFIT was neither designed to deliver the functionality needed, nor capable of delivering it.

105 Programme Budget Data 2010–11. Department of Health

106 NHS Diabetes. Year of Care. Report of findings from the pilot programme. 2011

107 Irani M, Dixon M, Drinkwater C, Reader P. Specialist Doctors in Community Health Services: opportunities and challenges in the modern NHS. NHS Alliance 2005. [www.networks.nhs.uk/nhs-networks/nhs-alliance-specialists-network/documents/Specialist%20Doctors%20in%20Community%20Health%20Services.pdf](http://www.networks.nhs.uk/nhs-networks/nhs-alliance-specialists-network/documents/Specialist%20Doctors%20in%20Community%20Health%20Services.pdf)

108 Featherstone H, Whitham L, Chambers M. Incentivising wellness: improving the treatment of long-term conditions. Policy Exchange 2010

109 Kodner D. All together now. A conceptual exploration of integrated care. Healthcare Quarterly Vol. 13 2009

110 Ham C, et al. Where next for the NHS reforms? The case for integrated care. Kings Fund 2011

111 Lewis CL, et al. Where next for integrated care organisations in the English NHS? Nuffield Trust 2010

112 Commissioning and the impact of the purchaser-provider split on the NHS in England. British Medical Association. Available at: <http://lookafterournhs.org.uk/wp-content/uploads/commissioning-and-purchaser-provider-split-with-links-03062.pdf>

Launched in 2002, its stated aim was to reform the way that the NHS in England uses information, and hence to improve services and the quality of patient care. By 31 March 2011, total expenditure on the Programme totalled some £6.4 billion, of this £1.7 billion has been spent on the maintenance of national systems by local NHS organisations and on central programme management by the Department of Health.<sup>113</sup>

One of the aims of the project was for detailed care records systems to be delivered to all NHS trusts and GP practices by the end of 2007, with full implementation by 2010. However, delays in software development and delivery, difficulties in implementing standard systems across the NHS, and contractual issues means that delivery has fallen well below expectations. As a result care records systems are no longer being delivered in every NHS organisation and the aim of creating an electronic record for every NHS patient will not be achieved this way. The cost is expected to be £11.4 billion.<sup>114</sup>

One of the key points about utilising IT to support integration is that there should be a focus on patient access to information through an interactive web portal.<sup>60</sup> The personal health record allows a patient to look at their own health data, and begin to understand it, and so work with the specialist to manage their care. There are wider applications too; it can be used to support healthy lifestyle and fitness plans, and there are potential social networking possibilities for patients who want them. All this serves to increase patient self-management, and thus to integrate care.

Although NPfIT has belatedly added HealthSpace, a web-portal for patients to access their summary care record and store information about their dietary habits and weight, take up has been low. The problem is that patient access to their records was never considered part of the original NHS IT plan. As a result, patients have been disappointed with the amount and type of data available, the need to enter data themselves, and the limited options for sharing this data with their clinician. Overall, patients perceived HealthSpace as neither useful nor easy to use and its functionality aligned poorly with their expectations and self-management practices.<sup>116</sup> Only 0.13% of patients invited opened an advanced account, compared with 5–10% of the population anticipated in the original NHS business case. In contrast, Kaiser expects around 80% of its patients to self-manage much of their care and the ability for the patient to gain access to their data, and discuss it via email with their doctor where necessary, is key to this model.

### Box 5.1: NHS electronic health records

The creation of a fully integrated electronic care records system is part of the £11.4 billion investment in NHS IT. It is designed to reduce reliance on paper files, make accurate patient records available at all times, and enable the rapid transmission of information between different parts of the NHS and comprises two parts:

- Summary Care Record containing medical information, such as allergies, made available to all NHS staff involved in treating the patient.
- Detailed Care Record containing full details of the patient's medical history and treatment, that is accessible to a patient's GP and local community and hospital care settings, for example, in the event that the patient is referred for hospital treatment.

113 The National Programme for IT in the NHS: an update on the delivery of detailed care records systems. National Audit Office. HC 888 Session 2010–2012. 18 May 2011

114 At 2004–05 prices. Ibid.

115 Rosen R, Ham C. Integrated Care: Lessons from Evidence and Experience. Nuffield Trust 2008

116 Greenhalgh T, et al. Adoption, non-adoption, and abandonment of a personal electronic health record: case study of HealthSpace. *BMJ* 2010; 341:c5814

About 8% of the UK population (4.4 million people) has an electronic Summary Care Record, although figures are increasing slowly.<sup>117</sup> This only carries essential information such as medicines the patient is on, and any allergies or previous bad reactions to medicines. It is not an electronic version of doctors' notes in any sense. Initial aspirations for the Summary Care Record would have seen it store referral letters, discharge summaries, and other data from acute care systems as well as primary care systems. But the scope has been narrowed due to pressures around privacy, and the technical and cost problems faced by the programme. For the purposes of integrated care, only access to the Detailed Care Record and records held in prescriptions, referrals and other local systems will make for a useful electronic record. This is now beyond the scope of the current programme.

The structural failings of the programme have been widely explored, not least its lack of focus and its inhibition of competition. The National Programme for Information Technology (NPfIT) has now revised its strategy and instead of a centrally mandated Patient Administration System (PAS) each hospital trust is now allowed to build on their existing electronic system where this is possible. Despite this welcome change we believe that activity should now be concentrated on delivering integration; that is connectivity between primary and secondary care through focusing on interoperability of existing systems. The Department estimates that achieving interoperability will cost at least £220 million and we see this as good investment to help deliver the £20 billion of required efficiency savings by 2015.<sup>118</sup>

It seems likely that the contracts for the National Programme for IT in the NHS are too tightly wound for significant renegotiation to take place. It is therefore interesting to note that in responses to the NHS Information Strategy consultation, some players are recommending opening up the market.<sup>119</sup> Cerner, for example, suggest that the Department of Health could require all healthcare providers to provide a standardised data set when patients leave their care, thereby allowing simple interoperability with primary care. Procurement for such systems could be left to local Trusts; with a benchmark of standards vendors have to meet. Where integration is most likely to be between discrete bodies – as in the NHS – interoperability criteria are the system wide requirement, with local development of suitable IT.

In retrospect it is not surprising to discover that the Electronic Record Development and Implementation Programme (ERDIP) Pilots which took place in the late nineties found that traditional procurement processes for large scale systems were “not likely to build on the integrated working philosophy, but result in procurement of large, predominantly organisationally based (‘silo-ed’) systems”.<sup>120</sup> That has proven to be the case. Local development of IT systems had driven integration because it had brought clinicians and work streams together to think about what was needed. If (and this is a tough challenge) it could open up the NHS IT contracts, the Department of Health could release the capital tied up in them. If that capital was siphoned through healthcare organisations for the purpose of procuring IT, a functioning, competitive and thus more effective market would appear overnight. We recommend that significant financial incentives should be created for delivering interconnectivity between primary, secondary, community and social care.

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117 [www.ehi.co.uk/news/EHI/6593/patchy\\_scr\\_roll\\_out\\_nears\\_10\\_per\\_cent](http://www.ehi.co.uk/news/EHI/6593/patchy_scr_roll_out_nears_10_per_cent)

118 The National Programme for IT in the NHS: an update on the delivery of detailed care records systems. National Audit Office. HC 888 Session 2010–2012. 18 May 2011

119 Response to the Consultation on the Information Revolution. NHS Information Centre 2011

120 ERDIP, Core National Evaluation: final report, 31st January 2003

Local development is also likely to be a technical reality. Experiences from Denmark, presented at a Wellcome Trust conference in 2007, suggested that a population of perhaps five million marks an upper limit of what is technically manageable – 10% of the English NHS population. By building local systems and databases with national language and interoperability criteria is much more likely to be successful than an attempt to build one huge database.

**Recommendation:** Integration care for patients cannot happen without efficient information technology linking professionals and systems across the complexity of the healthcare landscape. What remains of the National Programme for IT should focus on connecting local health economies – primary, community and secondary care – and the government should introduce substantial financial incentives to achieve this objective. Patient access to health records, as a mechanism for involving the patient in their own care, should be prioritised.

### Organisational leadership

Although information technology is an important condition to drive improved care; it is not sufficient on its own to achieve integrated care. This requires change and new ways of working by both clinicians and managers. Implementation and operation of an integrated health organisation requires leadership and vision, as well as an organisational culture that is aligned with that vision.

The NHS is becoming an increasingly complex people-management organisation. Yet in the last decade, there has been relatively little emphasis on the motivation of its people or the need to develop, attract and retain the very best management talent for such a demanding task. The introduction of general management in the 1980's was supposed to deliver better results for patients. However, its use by the previous government as a lever for achieving political targets through top-down performance management has eroded both managerial and medical professional autonomy. The process led management culture which developed didn't deliver proportionate gains in productivity.<sup>121</sup>

In recent years we have seen attacks on NHS management as an easy political target. The coalition government came to power committed to substantially reducing NHS management costs. However, the focus on reducing the quantity of managers could be seen as being misplaced, as management is essentially a co-ordinating and integrating function. A different perspective, and one which would be consistent with driving integrated care, would be a focus on the qualities of NHS managers, rather the quantity per se. Leaders capable of driving and delivering integrated care organisations need the powers to manage and freedom from central control.

Successive initiatives in the Department of Health have tried drawing in management talent from outside the NHS, yet there remains little information on the background and qualifications of the 400+ chief executives of NHS trusts. The background of the NHS's leaders and their standing among peers has a vital bearing on their ability to exercise effective leadership, and to bring about change. Currently, doctors in managerial roles face a difficult task. There are scant resources or rewards for medical leadership and only a handful of NHS Chief Executives are medically qualified. These clinical leaders span the managerial/clinical cultural divide with no professional recognition of their unique expertise as a distinct medical speciality.

121 Office for National Statistics.  
Public Service Output, Inputs  
and Productivity – Healthcare.  
March 2011.

The coalition government has, thankfully, abandoned the centralised approach embodied in the NHS National Programme for IT. However, its ambitions for the NHS will require considerable investment in IT, but also radical changes in the way that managers and clinicians work. With the policy shift to local ownership, NHS trusts will depend increasingly on their own clinical leadership to deliver IT-enabled transformation and integration. If the NHS is serious about informatics driving quality and increasing the drive towards clinicians becoming management leaders then the Chief Clinical Information Officer (CCIO) should be one of the key stepping stones in leadership development.

In the United States the CCIO role has developed over many years with evaluations finding that these officers had been able to recruit other champions for IT enabled clinical projects thereby contributing to training programmes and direct deployments.<sup>122</sup> In the UK, the British Computer Society and a number of the Royal Colleges are supporting the e-health insider campaign for the development of a new role – Chief Clinical Information Officer – to provide clear clinical leadership on IT projects and the use of information in NHS organisations.<sup>123</sup> We endorse this approach and recommend that the Department of Health promote the role of Chief Medical Information Officer at NHS trust level.

**Recommendation:** High-performing integrated care systems such as the Veteran’s Health Administration have long-recognised the pivotal role of IT and the Chief Clinical Information Officer (CCIO) in order to drive integrated care for patients. We believe that this role should be extended throughout the NHS as a necessary pre-cursor to delivering integrated IT systems for healthcare organisations.

### Rationalising the NHS estate

The benefits of integrated care come from substantial reductions in admissions to hospital which either won’t happen or will have no economic benefit if NHS organisations continued to be required to pay for fixed costs of care. Only by reducing overheads do the savings from integrated care become real.

The National Audit Office has published the breakdown of the fixed costs of care: staff costs are the largest section, responsible for 65%. Goods and services comprising clinical and general supplies are responsible for 17%, premises for 9%, and 9% on other costs such as consultancy, transport and clinical negligence costs.<sup>124</sup>

But the process of reducing hospital usage becomes all the more difficult in health economies with hospitals built under the Private Finance Initiative (PFI) scheme, as costs accrue irrespective of the number of hospital beds in use.<sup>125</sup> This means that savings from integrated care with reduced numbers of bed days cannot be realised. Currently hospitals pay an index-linked fixed sum, so it is difficult for them to make savings without cutting back on services.<sup>126</sup> At crude level; hospitals are forced to admit patients simply to pay off PFI contracts.

The PFI model can be very constraining and has long been considered too inflexible to respond to longer-term healthcare estate strategy and developments phased in over time. However, the workings of PFI are increasingly coming under the spotlight, including the failure of the Department of Health to secure savings from refinancing or economies of scale with major investors.<sup>127</sup> At the time of

122 Levis J, Kremsdorf R, Mohaideen MF. The CMIO – a new leader for health systems. *J Am Med Inform Assoc* 2006;13:573–8

123 <http://www.ehi.co.uk/campaign/ccio>

124 National Audit Office. Management of NHS Hospital Productivity. HC 491. Session 2010–2011

125 The performance and management of hospital PFI contracts. National Audit Office. 2010 HC: 68, 2010–2011

126 BMA response to Treasury Select Committee inquiry on the Private Finance Initiative. April 2011 [http://www.bma.org.uk/healthcare\\_policy/responses\\_consultations/treasurypfiavid.jsp#ref\\_5](http://www.bma.org.uk/healthcare_policy/responses_consultations/treasurypfiavid.jsp#ref_5)

127 PFI in Housing and Hospitals. House of Commons Public Accounts Committee. Fourteenth Report of Session 2010–11. 2011

writing HM Treasury is considering responses to its call for evidence on “Reform of the Private Finance Initiative”.<sup>128</sup>

Reducing unnecessary admissions to hospital and length of stay is one thing, but simply reducing the number of people in hospital doesn’t yield savings until the fixed costs of care can be taken out of the system. So why do individual hospital trusts need to waste scarce NHS resources monitoring PFI contracts, or even directly own property themselves?

Specialist investment funds already have interests in large numbers of PFI projects, including a substantial portfolio of hospital projects. We believe that the Department of Health and HM Treasury should extend the review of surplus NHS land into a full audit of all property assets, with the aim of the NHS becoming a

“Forward thinking hospital trusts are developing strategic estates partnerships with the private sector and using the land to develop services required to implement the integrated care model such as step down, patient hotels and care villages”

service provider renting buildings rather than owning them.<sup>129</sup> This is not a new concept and we believe it would deliver a much more flexible approach to the healthcare estate thereby facilitating the drive towards integrated care.<sup>130</sup>

Industry experts explained to us that using an integrated care model it is perfectly possible to remodel hospital usage and reduce the footprint of buildings by a quarter and land use by two thirds. For a typical NHS acute hospital operating out of 60 acres of land with 68,000 m<sup>2</sup> of buildings this equates to freeing up 40 acres, of which approximately 25 acres could be developable. Typical disposal values of between £600,000 and £900,000 per acre (depending on a range of planning factors) means that the traditional approach of disposing of surplus land could yield £19 million per hospital to be re-invested in patient services. Forward thinking hospital trusts are developing strategic estates partnerships with the private sector and using the land to develop services required to implement the integrated care model such as step down, patient hotels and care villages.

Our proposed scheme could operate whereby one or more NHS hospital trusts and clinical commissioning groups operate as a single integrated organisation that delivers services with buildings provided by a property management organisation. This would be on the larger side of our proposed organisational integration model described earlier, but could be trialled as part of the NHS ICO pilot scheme. The pace of change in medicine seen with the development of new technology and changes in society has meant that the design and function of acute hospitals is changing rapidly. It would be foolish to think that PFI hospitals built today will still be used in the same way in 25 years’ time – the length of a typical PFI contract – without being subject to major changes. Flexibility in the healthcare estate facilitates the development of new ways of working and the drive towards integrated care, and care closer to home.

Such a bold move is not without precedent. In April 1998 the vast majority of the Department for Work and Pensions (DWP) Estate was handed over to a private property company, Telereal Trillium, under the Private Sector Resource Initiative for Management of the Estate (PRIME) contract. The deal was worth £1.2 billion at the time, and the contract runs for 20 years. The property company, through DWP Estates, is responsible for the provision of fully serviced accommodation for most of DWP including Jobcentre Plus, The Pension Service and the corporate

128 HM Treasury. Reform of the Private Finance Initiative. December 2011

129 There are, of course, complexities with selling parts of the NHS estate, for example there are a number of War Memorial Hospitals erected by public subscription

130 Edwards N, Darch R. Do hospitals need to own their own buildings? Social Market Foundation. 2007



centre. This responsibility also extends to most of the estate occupied by the Child Maintenance and Enforcement Commission.

Under the terms of the contract the Department has transferred almost all its portfolio to the property company. In return for the payment of a single charge, the property company is responsible for providing a full facilities management service across the estate including: all building, landscape and site maintenance and refurbishment; internal and external cleaning; mechanical and electrical equipment maintenance; appliance testing and security; catering and portage services.<sup>131</sup> Since the initial deal, the amount of land managed has been expanded, and both the original deal and the expansion have been judged by the National Audit Office to offer value for money to the public sector.<sup>132</sup>

Under the PRIME contract, the property company makes money not so much on the facilities management they provide to the DWP offices, but by leasing out the unused DWP estate. Of course it could be argued that such a contract only works because the DWP estate is generic office space: in the health context, specialist estate is required, but that is not necessarily the case as decant away from secondary care into primary care requires much less specialisation. Newer primary care facilities with diagnostics and other services are being provided in former office buildings.<sup>133</sup>

A longer-term objective for the NHS Estate could be a full-scale sale and leaseback. The property management and development industry in the UK is well developed, with significant levels of expertise. Many sectors in the UK economy have seen the value of releasing assets to be managed by joint ventures or private sector partners who focus on delivering value from property, leaving firms to focus on their core business. Why should public healthcare be any different?

An alternative arrangement for NHS property would see combined primary care, community care and secondary care property assets held in a mutual model of private and public interests, with NHS staff taking on ownership on behalf of the public.

Currently, the decant of services from hospitals to primary and community care is limited by the fixed costs of capital whereby hospitals need to admit patients in order to service PFI debt. Removing this impediment would facilitate the development of integrated care both where the purchaser-provider split has been reversed with the introduction of integrated care organisations and where the traditional division of Clinical Commissioning Groups and foundation hospitals remain.

As integrated care models become successful, hospital usage will be reduced and politicians will face the challenge of reducing the size of hospitals. Hospital beds, wards, departments and in some cases whole hospitals will need to be closed as care becomes integrated and patients with chronic conditions spend less time being admitted to hospital and more time in community based facilities, or even at home. However, by rationalising the NHS estate to facilitate integrated care the political room to reduce hospital size will be greatly expanded.

**Recommendation:** The NHS is wasting valuable resources monitoring and paying for PFI contracts; it does not need to directly own property in its current siloes of primary, secondary and community which is hampering the drive towards integrated care. We believe that the Department of Health and HM Treasury should conduct a full audit of all property assets, with the aim of the NHS becoming a service provider renting buildings and facilities rather than owning them.

131 Anecdote has it that the Treasury looked at the 'Railtrack' model for healthcare, separating the infrastructure provider from the service provider, when Alan Milburn was at the Department of Health. Seeing the Railtrack model run into problems, they got cold feet over doing something similar in health. This fails to recognise that health is a different system – if one hospital fails, healthcare can still be provided – if a signal fails, a whole route and timetable collapses.

132 Transfer of property to the private sector under the expansion of the PRIME Contract. National Audit Office Report HC 181. 26 January 2005

133 £3m transformation of town centre office into modern health facility complete. <http://assuragroup.co.uk/view/article/21--3m-transformation-of-town-centre-office-into-modern-health-facility-complete>

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# Appendix 1:

## Financial Fragmentation in the NHS

The division between purchasers of care (the commissioners) and providers of care – the purchaser-provider split – was introduced in 1990 following the 1988 Review of the NHS which resulted in two 1989 white papers: *Working for Patients*, and *Caring for People*.<sup>134, 135</sup>

As part of the split, the forerunners of Primary Care Trusts, District Health Authorities, became purchasers of care and were stripped of their hospital management responsibilities and left to concentrate on the assessment of needs and commissioning of services. The financial model created by the purchaser-provider split centres on the provision of episodic treatment to address the main burden of disease at the time – cardiovascular & respiratory diseases and cancer. Moreover the creating of the purchaser-provider split increases NHS transaction costs, with estimates commissioned but not published by the Department for Health that they constitute up to 14% of total NHS costs – a sum greater than the cost of providing the entire primary care service.<sup>136</sup>

In short, the organisational structure of the NHS does not help deliver seamless care for patients a point which was emphasised in Lord Darzi's Next Stage review and it was no coincidence that this report set forth a series of integrated care pilots in the NHS.<sup>137</sup> The NHS will remain a confusing picture of organisations from which to purchase care and despite the rhetoric and diktat that commissioning should drive integration there is no guarantee that services will become any less fragmented from a patient's point of view.

### Fee for service in the NHS: "Payment by Results" (payment for activity)

In July 2000, the NHS Plan introduced a direct link between the allocation of funds to hospitals and the actual amount of activity they undertake. This was a radical departure from the previous block contracting system and the system of Payment by Results (PbR) underpinned the NHS reform agenda as a new way of reimbursing hospitals for their work. There would also be differentiation between payments for routine surgery and those for emergency admissions.

The system of Payment by Results (PbR) is better understood as a system of payment by volume or activity, since it introduced a standard price for many procedures. This new financial system aimed to produce better incentives to reward efficiency, to support sustainable reductions in waiting times for patients and to make the best use of available capacity. Previously, hospitals were (and still are in some instances, specifically certain procedures such as chemotherapy) paid according to block contracts – a fixed sum of money for a broadly specified

134 Parliament. *Working for patients*. Cm 555. London: HMSO, 1989

135 Department of Health. *Caring for People: Community Care in the next Decade and Beyond*. 1989

136 Health Select Committee. *Fourth Report of 2009–10 – Commissioning*. Parliament 2010

137 Darzi A. *High quality care for all: NHS Next Stage Review final report*. Department of Health 2008.



service, with no incentive for providers to increase productivity, because they received no additional funding for additional work. The three main reasons stated for introducing a standard price tariff were to:

- enable Primary Care Trust commissioners to focus on the quality and volume of services provided;
- incentivise NHS Trusts to manage costs efficiently; and
- create greater transparency and planning certainty in the system.<sup>138</sup>

It should be noted that the first reason – that competition should focus on quality, not price – has proven to be correct following academic analysis.<sup>139</sup>

By 2005–06 the PbR system covered most inpatient, day patient and outpatient activity, including both elective and non-elective services in surgical and medical specialties. Implementation in areas such as services for patients with chronic illness and services with a strong community service component, such as mental health and learning disabilities, has proved particularly challenging.

PbR attaches a fixed tariff to a number of hospital procedures, using data gathered from all NHS hospitals. The prices for individual procedures – ‘reference costs’ – were originally set at the national average. From 2010–11 only 4 best practice tariffs have been introduced – hip replacements, cataracts, gall bladder removal, and stroke care – 5 years after the Tariff was introduced.<sup>140</sup> Payments for these treatments will now reflect the performance of the most efficient providers, in an attempt to drive more efficiency. Such a system, applied to all procedures, would allow provider trusts to specialise in particular procedures that they know they are able to provide at high quality and low price.

Before PbR came into force, financial flows between health authorities and the NHS were dominated by block contracts. Under the block contract hospitals received a flat payment to care for a patient population, based on the previous year’s spend and regardless of quantity or quality of care. Budget holders are incentivised to use their whole budget, or even to exceed it, in order to avoid budget reductions in the following year or to make spending subsequent reductions in spending a more achievable target. If PbR is to be understood as ‘activity-based’ commissioning, block contracts can be understood as ‘process-based commissioning’, whereby what is costed and sold is infrastructure and process, regardless of the quantity or quality of care provided.

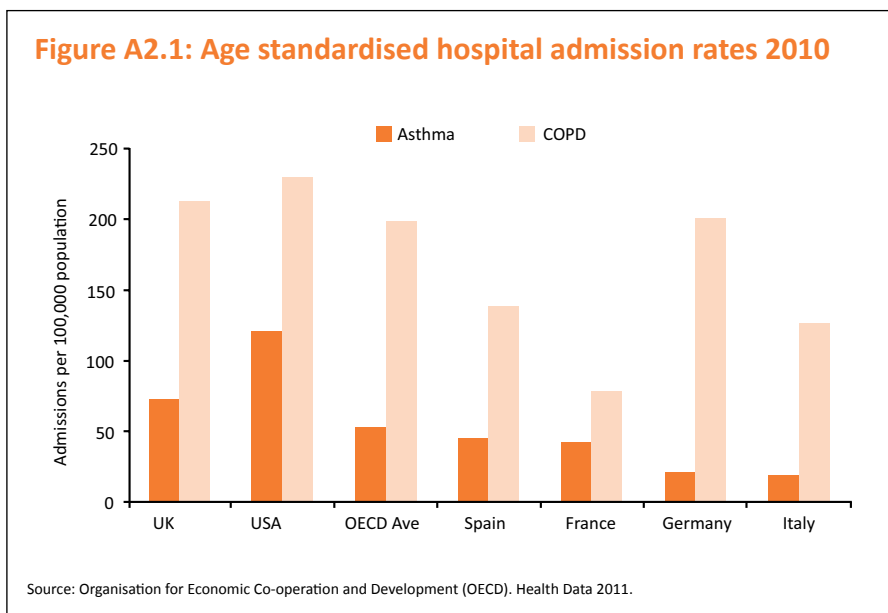
138 [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4005300](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005300)

139 Cooper Z, Gibbons S, Jones S, McGuire A. “Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms” LSE Health Working Paper No 16. 2010

140 The NHS operating framework for England for 2010/11. Department of Health 2009

## Appendix 2: Surplus Capacity in the NHS

The graph below gives a snapshot of admission rates for common chronic diseases such as asthma, chronic obstructive pulmonary disease (COPD). Although these measures are subject to many confounding factors they are valid to illustrate relative system performance. For asthma, the UK was amongst the worst for admission rates, with 73.7 per 100,000 against an OECD average of 51.8, and top performance of 19.2 in Italy. For COPD the UK was again higher than the OECD average (213 per 100,000), against an average of 198, and a top performance of 79 in France.



Although government spending on the NHS has substantially increased over the last decade, other countries have also spent more on public healthcare: the UK spends 9.8% of GDP on the NHS whereas the OECD average is 9.6.<sup>141</sup>

Lengths of inpatient stay are another measure of overall healthcare system performance. Since hospitals usually experience far more variation in patterns of patient discharge than in patterns of admission, this results in highly variable and unpredictable lengths of stay between hospitals and healthcare systems, which can be used as a useful benchmark for effective performance.

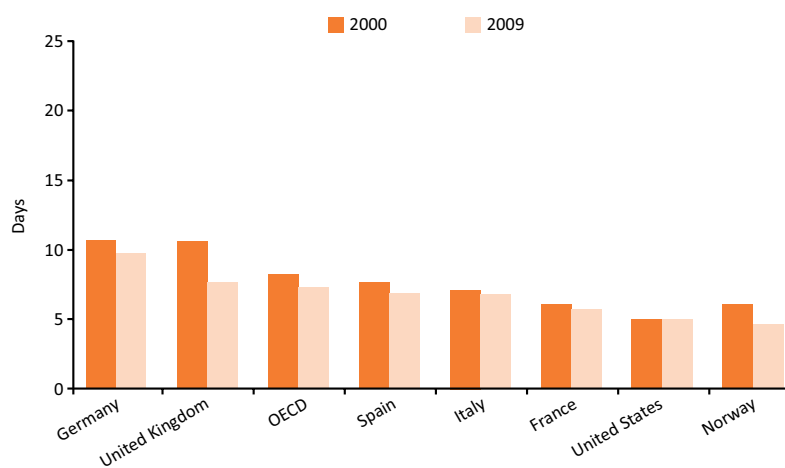
International comparisons suggest that the NHS has lengths of stay longer than they ought to be. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings

141 OECD Indicators. Healthcare at a Glance. 2011

improving patient outcomes. The average length of stay in the UK is 7.7 days, above the OECD average of 7.2 days, and double the best performer, Norway, at 4.6 days.

The OECD offers some explanation for the wide international variation in length of stay “the abundant supply of beds and the structure of hospital payments in Japan may provide hospitals with incentives to keep patients longer... Financial incentives inherent in hospital payment methods can also influence length of stay in other countries. For example, predominant bed-day payments in Switzerland have encouraged long stays in hospitals.”<sup>142</sup> In other words, it recognises the impact of tariff systems on lengths of stay.

**Figure A2.2: Average length of stay in hospital for all causes, 2000 and 2009 (or nearest year) OECD countries**



Source: Organisation for Economic Co-operation and Development (OECD) Health Data 2011.

Focusing on average length of stay for specific diseases or conditions can remove the effect of different mix and severity of conditions leading to hospitalisation across countries. Looking at length of stay for heart attack the UK has amongst the longest stays in the OECD following heart attack, at 8.1 days. The OECD average is 7.2 days, with USA among the best performers with 5.3 days.<sup>143</sup>

Previous analysis comparing lengths of stay between the NHS, and public and private systems in the USA for a number of specific procedures found lengths of stay in the NHS tend to be at least twice as long as some of the American equivalents.<sup>144</sup> For example, length of stay for stroke patients was over six times longer in the NHS than in Kaiser Permanente – an integrated care organisation.

Again, the NHS recognises that patients tend to spend too long in hospital and the NHS Institute has for many years offered a range of tools and teachings to help reduce lengths of stay. However, the wide range of performance on length of stay in hospitals across the NHS from 6.2 days (average) to 2.7 days (average) indicates room for continued improvement.<sup>145</sup>

142 Health at a Glance 2009, OECD indicators (p.98)

143 Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2011

144 Ham C, York N, Sutch S & Shaw R. *Hospital Bed Utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data*. BMJ 327:1257 (Sept 2003)

145 NHS Information Centre. *Hospital Episode Statistics HES Online*

**Table A2: Length of hospital stay (days) for people aged over 65**

Group	NHS	Kaiser		Medicare California		Medicare United States	
		Unstandardised	Standardised	Unstandardised	Standardised	Unstandardised	Standardised
Stroke	27.08	4.29	4.26	5.84	5.84	6.54	6.53
Chronic obstructive pulmonary disease	9.87	3.82	3.79	5.43	5.35	5.42	5.37
Bronchitis or asthma	11.73	3.11	3.09	4.05	4.22	4.41	4.41
Coronary bypass	13.27	9.82	9.60	8.86	8.63	10.37	9.98
Acute myocardial infarction	9.39	4.37	4.35	5.22	5.14	5.60	5.46
Heart failure or shock	12.42	3.72	3.70	5.29	5.28	5.39	5.37
Angina pectoris	5.88	2.22	2.21	2.66	2.58	2.62	2.56
Hip replacement	12.60	4.52	4.54	5.71	5.41	5.69	5.46
Knee replacement	11.32	4.16	4.17	4.52	4.54	4.39	4.40
Hip fracture	26.88	4.94	4.89	5.99	5.97	6.48	6.47
Kidney or urinary tract infection	15.19	3.78	3.80	5.14	5.11	5.31	5.32

Source: Hospital Bed Utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. BMJ 327:1257 (Sept 2003)



Often thought of as a single entity, the NHS should, in theory, be one of the most integrated organisations in the world. In practice, it is a confusing picture of separate organisations purchasing, providing and organising healthcare under a single NHS brand.

Over the last 20 years, successive governments have divided the NHS into smaller, ever more manageable pieces. Multiple organisations have been created, each with their own legal identity, culture, behaviours and incentives. These divisions mean that the patient experience is also fragmented and those with long-term conditions face a disjointed service which can lead to unnecessary and costly admissions to hospital.

In this report, the author considers some of the structural, organisational and contractual arrangements which have increased fragmentation in the NHS. Best practice examples from the USA and Spain are examined and a series of recommendations are made to help deliver integrated care for patients in the NHS.

£10.00  
ISBN: 978-1-907689-34-5

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