Bevan Commission

...promoting health and health services improvement in Wales

INCREASING THE PACE IN INTEGRATED CARE

Purpose

As part of its programme of work in 2012/13, the Bevan Commission has reviewed progress towards more integrated care in Wales. This is timely, as the health and social care system gears itself up to making progress in this vital area. This paper summarises the issues which have emerged, and offers advice to the Minister in relation to future progress in this important area:

Section A	What is 'integrated care'?
Section B	Critical success factors for integrating care
Section C	Recommendations

A. WHAT IS 'INTEGRATED CARE'?

Integrated care has become something of a nirvana for healthcare systems across the world, promising the most patient-centred, effective and efficient system of care. But what is it? One recent review of the literature[1] discovered a staggering 175 different definitions and concepts of 'integrated care', amounting to what has been described as an 'imprecise hodgepodge'.[2] The WHO define 'integrated service delivery' as 'the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money'[3], but for others that would merely be a definition of 'good' service delivery.

[1] Armitage GD, Suter E, Oelke ND, and Adair C (2009) 'Health systems integration: state of the evidence' *International journal of Integrated Care* 9(17) 1-11
[2] Kodner D (2009) 'Altogether now: a conceptual exploration of integrated care' *Healthcare Quarterly* 13(Sp) 6-15
[3] World Health Organisation (2008) *Integrated Health Services - what and why?* Technical Brief No.1

But some sort of working definition is essential. At least **five different 'types' of integration** can be observed[4] [5] and offer a potential framework for analysis of the progress in integrating care in Wales:

Table 1: Types of integration

Type	Description
1. Systemic	Coordinating and aligning policies, rules and regulatory frameworks
2. Normative	Developing shared values, culture and vision across organisations, professional groups and individuals
3. Organisational	Coordinating structures, governance systems and relationships across organisations
4. Administrative	Aligning back-office functions, budgets and financial systems
5. Clinical	Coordinating information and services and integrating patient care within a single process

So **what does integrated care look like**? In practice, it means some or all of the characteristics in Table 2[6]:

[4] Fulop N, Mowlem A and Edwards N (2005) *Building Integrated Care: Lessons from the UK and elsewhere* London: NHS Confederation
[5] Shaw S, Rosen R and Rumbold B (2011) *What is integrated care? An overview of integrated care in the NHS* London: Nuffield Trust
[6] RAND Europe and Ernst and Young (2012) *National Evaluation of the Department of Health's Integrated Care Pilots* Cambridge: RAND Corporation

Table 2: Some characteristics of integrated care

Characteristic	Which means...
Co-location	Staff work from the same bases and teamwork processes adapt
Integrated Teams	Multi agency/multi professional teams, with single lines of accountability working to common policies, protocols and pathways
IT-integrated healthcare	Care supported by integrated systems such as electronic medical records, personal digital assistants, remote patient monitoring etc
Patient-integrated healthcare	Patients are empowered and incentivised to coordinate their own health information and act as their own gatekeeper
Shared information among professionals from different sectors	Sharing of information, typically between health and social care staff and the third sector
Single assessment processes	Common approaches by different professionals and agencies
Single points of access	Common access points ensuring patients get the care they need with minimum effort

Perhaps most important is what matters to patients/clients – what **Integrated Care feels like** (Table 3):

Table 3: What integrated care means for patients/clients

No big gaps in care	'I am always kept informed and professionals talked to each other'
Co-ordination	'I always know the main person who is responsible for my care plan'
Shared and accurate information	'I don't need to repeat information constantly and I can see my health and social care record at any time'
Shared decision making	'I am always as involved in discussions and decisions about my care as I want to be'

B. CRITICAL SUCCESS FACTORS FOR INTEGRATING CARE

Several factors appear to be critical to any significant and sustained integration of care (Table 4):

Table 4: Some critical success factors

Critical factor	Why?
Leadership	Integration of care is often not so much a technical challenge as an exercise in change management, for organisational and clinical leaders and managers at all levels[7]
Organisational alignment	All agencies contributing to integrated care need to be enthusiastic and committed to the project. The existence of integrated health bodies in Wales should therefore be a significant advantage
Alignment of incentives	Organisations with different performance measurement systems and objectives, and clinicians and managers with conflicting objectives, are unlikely to find it easy to integrate services
Case management	Integrated care often depends upon effective case finding, assessment for targeting of care, care planning and coordination. The first of these has been a significant challenge in the parts of the UK
Evidence	The evidence that integration can improve clinical and care outcomes is strong, but evidence of improved efficiency is weaker.
Persistence	Integrated care typically takes 5 years or more to deliver its objectives and become self-sustaining

The influence of these success factors can be seen in the recent evaluation of the English integrated care pilots, which describes a typical development process[8]:

- Building governance and performance management systems, including shared key performance indicators and new lines of accountability
- Making and developing the local business case for integrated care, including describing the benefit for a 'typical' patient
- Changing attitudes and behaviours, through strong leadership and staff engagement and encouraging staff responsibility
- Developing the necessary infrastructure, including IT and 'soft' technologies such as multi-disciplinary working
- Establishing supportive financial systems and incentives, with aligned incentives, joint budgets and matching accountabilities.

More integration is not always the best option. There are choices to be made, for example:

[7] Robertson C, Baxter H, Mugglestone M and Maher L (2010) *Joined up care* NHS Institute for Innovation and Improvement

[8] RAND Europe and Ernst and Young (2012) *National Evaluation of the Department of Health's Integrated Care Pilots* Cambridge: RAND Corporation x-xi

- *System-wide or small-scale?*

The attractions of large-scale change are obvious, but so are the difficulties. The BMA, for example, argues that 'a series of smaller-scale efforts [at integration] can still make a significant-enough difference to patient care to make them worthwhile'[9].

- *More or less 'intense'?*

Walter Leutz[10] has characterised three levels of intensity in integration:

a. Linkage – taking place between existing organisational units with a view to referring patients to the right unit at the right time, and facilitating communication between professionals to promote continuity of care
b. Coordination – operating through existing operational units so as to coordinate different health services, share clinical information and manage patients' transition
c. Full integration – formally pooling resources, allowing a new organisation to be created alongside development of comprehensive services attuned to the needs of specific patient groups

The Nuffield Trust research report concludes with four key lessons[11]:

- Integrated care is best understood as a strategy for improving patient care
- The service user is the organising principle of integrated care
- One form of integration does not fit all
- It is only possible to improve what you measure.

C. RECOMMENDATIONS

The Bevan Commission is charged with offering advice to the Minister for Health and Social Services on issues of topical significance. Integrated care is clearly one such issue. It is encouraging that new initiatives and a new emphasis on integration are expected nationally, and that the topic is receiving new attention locally. But the challenge should not be underestimated. The WHO Technical Brief on integrated health services concludes with a warning which might resonate in Wales: 'There are many more examples of policies in favour of integrated services than there are of actual implementation'[12]

[9] BMA Health Policy and Economic Research Unit (2012) *Integrating Services without Structural Change* London: BMA
[10] Leutz WN (1999) 'Five laws for integrating medical and social services: lessons from the United States and United Kingdom' *Milbank Quarterly* 77(1) 77-110
[11] Shaw S, Rosen R and Rumbold B (2011) *What is integrated care? An overview of integrated care in the NHS* London: Nuffield Trust, 20
[12] World Health Organisation (2008) *Integrated Health Services - what and why?* Technical Brief No.1, 7

The aim

In future, people in Wales should have services from which:

- Their current and likely future needs are identified proactively, taking full account of their own wishes
- They receive tailored support to maintain their wellbeing and to mitigate the impact of any deterioration in their health or wellbeing – including information, signposting to services, practical support and training, and facilitated access to other people in similar situations – all under the control of the individual concerned
- They receive a comprehensive package of support to address their health and social care needs as required which, to them, appears 'seamless':
    - efficiently coordinated between agencies and professionals, with easy transitions between levels of generalism and specialism, and between individual services
    - supported by accurate, personalised information accessible to all who need it, and consistent information and advice
    - based on shared decision-making
    - with full support for those (family members and others) on whom they rely for day-to-day support.

Although most stakeholders would support this ideal, few people in Wales currently experience it, and much needs to be done to make it a reality for all. Not only is this a humanitarian priority, it is also a crucial element in making services sustainable, as the needs of society continue to change. The Commission identifies below seven areas which we think will be critical to success in Wales in the next few years, and which need to be addressed nationally and locally. We conclude with three specific suggestions which are both practical and have great immediate potential to improve integration.

Priority areas

1. Leadership	Integration of care is often not so much a technical challenge as an exercise in change management, for organisational and clinical leaders and managers at all levels

- the impact of a leader who really 'believes' in the importance of integration, and is determined to see it through, is evident in many parts of Wales
- leadership 'from the bottom up' is also important, and staff need to be empower to integrate services where they see the need: the coincidence of a very small number of people in a locality who trust each other and are passionate about integrated care can be very powerful
- The number of service providers potentially involved in integrated care in any locality is large, and the managerial task of ensuring their coordination is sometimes underestimated.

As a result, managers and clinicians sometimes find it easier not to try to integrate services: 'You don't do integration if you want an easy life' (senior manager)

- sufficient resources need to be allocated to integrated care – it is often not a cheap option, at least initially: 'You can't do Kaiser on a shoestring!' (senior joint manager)

2. Giving control to patients/clients and carers	Services should be designed to provide what patients/clients and carers need and want, and individuals should be given control over the detailed provision of their care. Carers are often a crucial element in supporting people with long-term and complex needs, and they should be treated as partners in the service

- Successful integration of services usually begins with a thorough understanding of what patients/clients and their carers would find useful and acceptable
- Enabling patients/clients genuinely to be 'partners' in their care often requires support for the client/patient, and changes to staff attitudes and expectations and to systems of care
- Carers are a major part of service provision, but often report being disempowered and excluded by professional staff. They need access to information about what services are available, influence over the care provided, and support for their own needs.
- All services should routinely find out about the experiences of their patients/clients, should report them publicly, and incorporate clients/patients in their performance management and continuous improvement

3. Organisational alignment	All agencies contributing to integrated care need to be enthusiastic and committed to the project. The existence of integrated health bodies in Wales should therefore be a significant advantage

- Co-location of staff is critical. This is often best achieved by having staff in the same offices and clinics, but 'virtual co-location' can also be an option, especially in rural areas where bringing staff together physically may not always be possible
- LHBs with several LAs need to find effective ways of coordinating their planning and delivery
- Integration *within* healthcare remains difficult because of the persistence of cultural differences between primary, community and secondary care, lack of mutual understanding, and the dominance of performance measures which are thought to relate exclusively to one sector or another
- Much of the support which people need is best provided by the 3rd sector, and should be commissioned as a core part of the integrated service
- common ICT platforms between agencies need to be adopted, but their absence should not be a reason for delay. Where a 'big bang' approach to this is unlikely in the near future, agencies should employ different approaches to reconciling their systems in the meantime.

4. Alignment of incentives	Organisations with different performance measurement systems and objectives, and clinicians and managers with conflicting priorities, are unlikely to find it easy to integrate services

- Individual citizens and service users should be empowered and supported to make real choices about what support they receive, and how it is provided, and systems should be effectively incentivised to respond to service users wishes and experience
- Practical ways must be found to circumvent the problems of 'cost shunting', which are significant in difficult financial times; this problem is often ignored or down-played. Continuing Health Care, for example, is often very inflexible for people whose needs go beyond 'health'
- Integration must be 'owned' by front line staff: this way of working should not be imposed from above. However, resistance to integration needs to be addressed and resolved
- The performance management of the different agencies should be aligned, so that, for example, health and social services bodies are expected to aim for the same objectives. This requires not just formal alignment (the same written goals) but also the 'organisational body language' needs to be aligned: each chief officer having the same 'P45 issues'
- Private provision (for example, nursing homes) is not always matched to need, or resourced realistically

5. Case management	Integrated care often depends upon effective case finding, assessment for targeting of care, care planning and coordination. The first of these has been a significant challenge in the parts of the UK

- Very few parts of Wales have yet identified those individuals in their communities who are on the brink of becoming major service users ('case finding'), and for whom they could provide targeted support to maintain their wellbeing and independence
- Case managers who coordinate all the support for an individual can be a simple and effective way of integrating care
- serious gaps in ICT (e.g. tools or approaches for risk stratifying populations) need to be plugged
- pragmatic approaches to tackling these problems are need now, before new all-Wales approaches are available
- telecare is currently under-utilised and its potential unevenly understood

6. Evidence	The evidence that integration can improve clinical and care outcomes is strong, but evidence of improved efficiency is weaker.

- Arrangements are not always in place to track the impact of integrated care, especially on clients' experience, unplanned hospital admission, and length of hospital stay. These are indicators of impact, and should always be considered in context: for example, a reducing length of stay is not progress if achieved at the expense of increased, unplanned re-admission

- Leaders and managers are often not sufficiently aware of how others' are addressing the same problems, or experience resistance in adopting solutions developed elsewhere

7. Persistence	Integrated care typically takes 5 years or more to deliver its objectives and become self-sustaining

- In some parts of Wales, services are reluctant to embrace integrated working, often because either they are nervous about the ability of other services to deliver for their clients, or because they are worried about the possible reduction in their own resources. Persuading them of the desirability of change takes a long time
- Medium-term planning is often undermined by staff turnover, short-termism from above, or the overwhelming impact of annual financial targets
- Brokerage, invest-to-save and other mechanisms can help people focus on the slightly longer term

Immediate measures

There are three measures which we believe could be introduced now, and which would make a big difference in integrating care:

1. *Clarify expectations and measure progress*

A small number of measures should now be adopted which would describe integrated care, and which should become 'must do' targets for both the NHS and local government. These should be supported by publication of annual assessments of the progress towards integrated care in each locality. For example, measures might include risk stratification of the population, so that effective support can be offered to those who will otherwise rapidly become depend dependent; guaranteed access to a wide range of different self-care support provision for those with long-term conditions, from the moment they are diagnosed; co-location and operational integration of NHS community and adult social services staff; and provision of case managers for all those in receipt of complex packages of care.

2. *Give people care managers*

People with complex needs should be given one professional who understands their needs, has sufficient clout to make things happen for them across all services, and who works with them to make sure that they get the support they need, in the way they want it. This will not usually be an additional member of staff: it is about clarifying local responsibilities amongst the existing team, and empowering that person to make things happen for the patient/client.

3. *Sort out immediate information systems and related problems*

Local teams and agencies should be given immediate pragmatic support in resolving practical problems such as lack of ICT integration, while they wait for the promised new, purpose-built systems: we should not allow the perfect to be the enemy of the good! At the national level, a

common approach to risk stratification of the population should now be agreed and implemented, because this is a basic building block of integrated care upon which so much else depends.

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