Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Integration' JSNA Chapter Summary Update '2014/15'

Contact: Abraham.George@kent.gov.uk

Website: www.kpho.org.uk

Kent & Medway Public Health Observatory

Kent County Council kent.gov.uk

Kent Integration (replacing QIPP) JSNA Chapter Update 2014

Introduction

Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved co-ordination. Integration is the combined set of methods, processes and models that seek to bring this about.

The current focus on integrated care reflects a long-standing concern in the NHS with the organisation of care across three sectors of the health service (primary, secondary and tertiary). However, the organisational separation of health and social care services has also been a further cause of service fragmentation. Concern about fragmentation typically focuses on a lack of service co-ordination for individual patients and, particularly, the structural and cultural isolation of generalist from specialist medicine, or adult social care from health care, which often results in patients experiencing discontinuity of care when they are transferred from home to hospital, or vice versa.

The focus on long term conditions and multiple morbidities

The Organisation for Economic Co-operation and Development (OECD) report (2011) on multi morbidity states that chronic and degenerative diseases (particularly dementia) are responsible for over 75% of the burden of disease in industrialised countries. Over half of hospital and physician encounters are represented by people with multiple chronic conditions and this is increasing. This has been caused by a significant demographic change/epidemiological transition over the last 50 years and is still continuing across many countries - increasing life expectancy, falling birth rates, migration leading to a growing older population. A whole systems change approach is needed to move from a 'see and treat' system we have currently (the foundation upon which the NHS was built) towards a preventive integrated system.

The 15 million people in England with long-term conditions have high health service use (55% of all GP appointments, 68% of outpatient, 58% of A&E appointments and 72% of inpatient bed days) and therefore around 70% of the total health and care spend. This means that 30% of the population account for 70% of the spend. Doing nothing adds at least £4bn in extra cost over the next seven years, 2008-15. Each year, 170,000 people die prematurely of long-term conditions. Only a small fraction of patients receive optimum care.

National context

Spending on the NHS is increasing each year; but at the same time demand for health services is rising, and expectations of the NHS are constantly changing as society changes, for example as people live longer and as new drugs and treatments become available. In 2009, the NHS was tasked with finding £15 – 20 billion in savings and improved productivity by 2014. If the NHS was to be sustainable for future generations radical culture change needed to be enacted. The Department of Health (DH) initiated the Quality, Innovation, Productivity and Prevention (QIPP) workstreams of which the Long Term Conditions (LTCs) workstream was the focus where the majority of the efficiency savings could be realised. It was tasked with improving the quality and productivity of services for the 15 million people who had a

Long Term Condition in England so they could access higher quality, local, comprehensive community and primary care services to improve clinical outcomes and experiences and reduce their need for unscheduled acute care by helping them manage their condition better and slow its progression.

The desire for better integration of care has been expressed in different ways. For example, multidisciplinary care was a particular concern in the 1960s, partnership working in the 1970s, and shared care and disease management in the 1980s and 1990s (see Table 1).

Table 1: Trends in integration initiatives

1980s	1990s	2000s
• coordinated working • shared planning • coordinated care • care programmes • case/care management	• inter-agency working • intermediate care • shared protocols • managed care • disease management	• inter-professional working • whole systems working • integrated delivery networks • patient-centred care • shared decision-making • integrated care pathways

'Integrated care' is an umbrella term, encompassing diverse initiatives that seek to address fragmentation, but that differ in underlying scope and values. From 1997 to 2010, the Labour Government emphasised a need for greater integration as part of the drive for improved quality, efficiency and patient outcomes. Initiatives such as 'integrated care pathways', 'patient-centred care' and 'shared decision-making' are examples of attempts to align clinical, managerial and service user interests, and to improve coordination of care for patients, in particular those with long-term conditions. New forms of health care organisation such as care trusts, managed clinical networks, accountable care organisations in the US and local clinical partnerships are all examples of different attempts to reshape the way in which combinations of primary, secondary, community and adult social care services are organised and delivered.

In 2009 a programme of Integrated Care Pilots was launched, a two-year Department of Health initiative that aimed to explore different ways of providing integrated care to help drive improvements in care and wellbeing (Department of Health 2009). Organisations across England were invited to put forward approaches and interventions that reflected local needs and priorities, and 16 were chosen for participation. In 2012 an evaluation was carried out, (Rand 2012), followed by an announcement in May 2013 of a framework document on integration: 'Integrated care: our shared commitment' (Department of Health 2013), signed by 12 national partners, setting out how local areas could use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration. In November 2013, 14 integration pioneers leading the way for health and care reform, one of which is Kent, were announced, showcasing innovative ways of creating change which the Government and national partners

want to see spread across the country (Department of Health 2013a, Kent County Council 2013).

Integration vs integrated care

A recent review of the literature on integrated care revealed some 175 definitions and concepts. Such diversity reflects what one commentator refers to as 'the imprecise hodgepodge of integrated care'. When considering integrated care, it is important at the outset to distinguish between integration and integrated care (see Table 2).

Table 2: Perspectives on integration and integrated care

What is integrated care?	What is integration?
Description The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to 'impose the **patient perspective as the organising principle** of service delivery' (Lloyd and Wait, 2005: p7).	**Description** It is the **processes, methods and tools** of integration that facilitate integrated care. Integration involves connecting the health care system (acute, community and primary medical) with other service systems (such as long-term care, education or housing services) (Leutz, 1999: p77–78).
Example Take the example of Torbay, an area with a high proportion of over-65s. Discussions driving integrated care have been characterised by "Mrs Smith", a fictitious 85-year-old with a range of care needs and requiring coordinated support across health and social care. Mrs Smith has come to **represent vulnerable local residents at risk of falling between gaps in the service.** By focusing on Mrs Smith, care has been reorganised – and better integrated – around needs such as hers. The patient perspective provided the foundation for restructuring services. Supply-driven models of care provision are now out-of-date. The result is **local health and social care provision that is flexible, personalised and seamless.**	**Example** In Torbay, the concern to deliver better and more coordinated outcomes for patients led to the **establishment of a care trust** in 2005. The development of five integrated health and social care teams aligned to general practice, single assessment processes, and shared health and social care electronic records are processes that have facilitated integration. The focus is on **improving clinical, satisfaction and efficiency outcomes** (Leutz, 1999). The result of integration includes a reduction in delayed transfers of care in acute hospitals, improved social services' ratings and enhanced access to intermediate care services. For Torbay this not only means improved outcomes, but also integrated care.

National Voices
More recently, NHS England have adopted the definition derived by *National Voices* (See figure 1).

Figure 1

A focus on integrated care can help policy-makers, managers and practitioners decide on the model of care they wish to develop. They can draw upon a combination of processes and mechanisms that enable integrated care to develop. The term 'integrative processes' provides a link between the concept of integrated care (in terms of the ambition to deliver services across providers with minimal duplication and disruption, and with high-quality outcomes and patient experience) and the concept of integration (in terms of the methods and approaches used to align goals across professional groups, teams and organisations). In the literature five main types of integration are typically described (see Table 3). Each type of integration is enabled through a range of integrative processes, some of which focus on systems and structures; others on less tangible aspects such as professional behaviour and teamwork. Commentators, however, tend to use diverse terms and, in some cases, focus on areas and processes of specific relevance to the integration project under consideration. For instance, recent government policy has encouraged health and care providers to consider integration in terms of aligned organisational structures and shared governance arrangements.

Table 3: Description of the five main types of integration and allied integrative processes	
1. Systemic	**Coordinating and aligning policies, rules and regulatory frameworks** for example, policy levers emphasising better coordinated care outside of hospitals, central impetus for diversity of providers, development of national incentive schemes (for example the Quality and Outcomes Framework) or financial incentives to promote downward substitution.
2. Normative	**Developing shared values, culture and vision across organisations, professional groups and individuals** for example, developing common integration goals, identifying and addressing communication gaps, building clinical relationships and trust through local events, or involving service users and the wider community.
3. Organisational	**Coordinating structures, governance systems and relationships across organisations** for example, developing formal and informal contractual or cooperative arrangements such as pooled budgets or practice-based commissioning; or developing umbrella organisational structures such as primary care federations or local clinical partnerships.
4. Administrative	**Aligning back-office functions, budgets and financial systems across integrating units** for example, developing shared accountability mechanisms, funding processes or information systems.
5. Clinical	**Coordinating information and services and integrating patient care within a single process** for example, developing extended clinical roles, guidelines and inter-professional education, or facilitating the role of patients in shared decision-making.

The King's Fund (2010) have defined integration at three levels with examples to illustrate:

a The *macro level* is one at which providers, either together or with commissioners, seek to deliver integrated care to the populations that they serve. Examples include health maintenance organisations such as Kaiser Permanente and Geisinger Health System, and integrated medical groups.

b The *meso level* is one at which providers, either together or with commissioners, seek to deliver integrated care for a particular care group or populations with the same disease or conditions, through the redesign of care pathways and other approaches. Examples include initiatives to integrate care for older people in North America and Europe, disease management programmes, chains of care and managed clinical networks.

c The *micro level* is one at which providers, either together or with commissioners, seek to deliver integrated care for individual service users and their carers through care co-ordination, care planning, use of technology and other approaches.

Although these three levels are distinguished for the sake of analysis, in practice they are often used in combination. This is in recognition of the fact that changes at the macro level, on their own, are limited in their ability to make a difference for

service users and also to address the weaknesses of care fragmentation. For example, organisations such as Kaiser Permanente and the US Veterans Health Administration seek to leverage the benefits of organisational integration by focusing on population management and care co-ordination. Integration is unlikely to deliver on its promise of improving outcomes **unless there is action at all levels**. There are a multitude of difficulties associated with measuring the impact of efforts to achieve closer integration.

References

Department of Health (2009) Integrated care pilots. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/IntegratedCare/Integratedcarepilots/index.htm

Department of Health (2013) Integrated Care: Our Shared Commitment. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

Department of Health (2013a) Integration pioneers leading the way for health and care reform. Available at:https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2

Kent County Council (2013) News item: Kent becomes pioneer if integrated health and social care. Available at: http://www.kent.gov.uk/news_and_events/news/2013/november/kent_becomes_pioneer_of_integr.aspx

Kent County Council (2013a) Delivering better healthcare for Kent: a discussion document: how health reform can lead to better use of public sector money and better outcomes for people. Available at: https://democracy.kent.gov.uk/documents/s38978/Appendix%20C%20-%20Delivering%20Better%20Healthcare%20for%20Kent.pdf

Nuffield Trust (2011) What is integrated care? Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/what_is_integrated_care_research_report_june11_0.pdf

RAND Europe, Ernst & Young LLP for the Department of Health (2012) National Evaluation of the Department of Health's Integrated Care Pilots. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215103/dh_133127.pdf

Smith, S. (2012) QIPP Programme (Quality, Innovation, Productivity and Prevention). Available at: http://ukpolicymatters.thelancet.com/qipp-programme-quality-innovation-productivity-and-prevention/