An overview of recent policy reform and reorganisation in the English NHS

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The idea is not new

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

(Rumbold and Shaw

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

(Guilleband Report, 1955)
A short history of integration in the NHS…..

recent milestones

• 2001 Health and Social Care Act
  • *Structural integration* between health and social care - Care Trusts formed

• 2003/2006 Health Acts
  • *Financial integration/alignment of financial incentives*: pooled health (NHS) and social care (local government) budgets

• 2006 Policy paper *Our Health Our care Ourselves*
  • *Cultural integration*: ‘Duty of partnership’ between health & social care

• 2009 National pilots of integrated care
  • *Varied interventions – no proven impact on service use*
  • *No evidence of improved patient experience*
NHS reforms: 2010 - 2012

• Coalition (Conservative /Liberal) Government elected 2010

• Health plans announced within 6 weeks – July 2010
  • Major structural reorganisation
  • GPs to lead payer side of NHS – clinical commissioning
  • New role for local government through ‘health and wellbeing boards’
  • Introduction of an economic regulator to promote competition - Monitor
  • Greater patient sovereignty ‘no decision about we without me’

• The ‘outcry’ – privatisation by stealth

• ‘The Pause’ – need to balance competition and integration

• Health and Social Care Act 2012
  • Creation of a health specific economic regulator (Monitor) to ensure that ‘choice and competition operate in the best interests of patients’
Integration in a cold climate: system change in the NHS

NHS: 2009

NHS: 2013
Additional layers of management and accountability

The NHS in England before the reforms

NHS April 2013 onwards

Department of Health

10 strategic health authorities (SHAs)

415 primary care trusts (PCTs)

Health services: NHS trusts and primary care services

Department of Health

NHS England

4 NHS England regional commissioning offices

19 commissioning support units

27 NHS England Area Teams

211 clinical commissioning groups

Health services: NHS trusts and primary care services
Multiple, complex lines of accountability
• **Competition regulator (Monitor)** polices the rules on choice and competition and acts to prevent anti-competitive behaviour by commissioners or providers where it is against patients’ interests.

• Monitor also has a duty to consider how it can enable or facilitate the delivery of integrated care for patients where this would improve quality of care or improve efficiency

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

‘It is our view that competition and integration are not mutually exclusive and competition does not and should not have to come at the expense of beneficial coordination.’
Diversity in integrated care:
Four case studies from the NHS
Case study 1: Lead contracting for cardiology and the use of financial incentives for integration:

**Integration type** – Vertical, speciality-specific service integration

- Integrated CHD/Stroke services based in the community
- ‘One stop’ assessment & management incl. prevention, treatment and rehab

**Main driver of integration** – payer led: focus on ‘integrated commissioning for outputs/ outcomes and efficiency

**Mechanism for promoting integration**
Financial integration: lead provider contract linked to specified outcomes
Financial incentives for integration

- Open competitive tender
- ‘Lead provider’ was the specialist hospital: sub-contracting services from other providers
- Performance based contract: 80/20% year 1; 60/40% year 2
- All outputs/outcomes delivered
- Estimated £600K savings to the payer

Knowsley metrics

**Diagnostic/management service**
- 95% seen within 10 working days
- 90% receive a one-stop service

**Cardiac rehab**
- 98% of eligible patients receive an invitation to attend
- 95% can access within three weeks of discharge
- 90% of eligible patients take up invitation
- 85% complete the programme

**Whole-service**
- 90% of patients have a positive experience and feel they have been treated courteously and with respect
- Reduction in number of outpatient appointments at acute trusts:
  - Year 1: 30%
  - Year 2: 60%
  - Year 3: 70%

Case study 2: North West London whole system integration

Integration type: Whole system (600K population) health and social integration

- Care planning and MDT working in patches of 50K pop. targeting people with diabetes and frail elders > 75 years

Driver – hospital £ problems. Support from CEOs in payer, hospital, social care (and from some GPs)

Mechanisms for integration:
- Whole system governance
- Shared IT system
- Care planning & protocols
- Incentives for MDT working
NW London whole system integration

- 100 GP practices participating in care planning
- Monthly MDT meeting to review complex patients
- 23,000 care plans completed
- **BUT** –
- Diff in diff evaluation; No significant reduction in hospital admissions or ED attends
- Small sample of pts report easier contact and less duplication of info provision
- Patient panel to co-design the next phase of the project and the evaluation

Exhibit M: Indicative targets for reduction in emergency care: Ramp-up during IC pilot year
Pennine MSK partnership: integrated planned care pathways

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

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

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

Identified a ‘programme budget’ for MSK (approx. £23m) and took on a ‘lead provider’ contract for all MSK activity including in-patient
Drivers and impact of integration

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

Impact of integration
- Reduced waiting times for assessment and treatment
- High patient satisfaction
- Reduced costs
- No significant incentive on hospital providers (paid FFS by Pennine MSK) to increase efficiency
Case study 4: Whole system health and care integration with virtual wards in Torbay and Devon

**Integration type:** Organisational merger – ‘Care Trust’ providing health and social care. Recently added in virtual wards

- 2005 – 2012 five locality integrated health & social care teams for populations of approximately 30,000
- 2012 – merged with neighbour and introduced Devon’s virtual wards

**Main Driver:** Applying learning from Kaiser Perm integrated system to NHS setting. Professionally driven vision for better care

**Mechanisms for integration:**
- Risk stratification to target intervention
- Care planning
- New professional roles (eg navigator)
- Pooled health and care budgets
- 2012-13: virtual wards

For more see Kings Fund: Integrating health & social care in Torbay,
Case study 4: Whole system health and care integration with virtual wards. Impact to date

Torbay care trust

- 24% fall in emergency bed day use by over 75s
- Fewer people delayed in transfer from hospital
- Less delay from referral to first assessment
- Change in staff perceptions of role and relationships
- Less people in residential care – savings to social care

Virtual wards

- Reduced emergency admission rates and length of stay in virtual ward patients compared to matched non-ward patients 2009/10 and 2011/12

2012/13 after merger between Devon and Torbay CCGs

EAs increased for the top 5% of patients at risk but fell for the top 0.5%

NB: Torbay under pressure to re-procure community nursing services through competitive tender:

In discussion with monitor about whether they can roll over integrated contract in best interest of patients
Implications for future integration initiatives
Supporting integration: applying evidence and experience

For policy makers:

• Minimise organisational disruption
• Avoid policy paradoxes
• Support payment innovation to align financial incentives
Supporting integration: applying evidence and experience

For Implementers:

- Map the context in which you are planning integration
  - Macro, meso and micro level support?
  - Payment systems to support integration (pooled funds, micro incentives or lead contracts)
  - ? Enough support to continue?
- Clarity of aims – what is the initiative trying to achieve for individuals and for the health system

For individuals

- Involvement in governance and design of integrated care
- Shaping the outcomes
Case study 3: Greenwich Coordinated Care Programme

Integration type: Horizontal community primary & social care integration

- Existing integrated health & social care teams ‘wrapped around’ GP clusters
- Targeted to patients with chronic complex problems

Main driver: health: managing hospital costs & throughput; Social: controlling spend on long term care

Mechanism for integration
- Professional leadership/normative integration – transforming business as usual
- MDT working
Greenwich Coordinated Care Programme

**Core team:** district nurses, social workers, care navigator

**Extended ‘menu of services’:** clinical, social care, housing, rehab NGOs

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

**Navigator** as contact point and facilitator for patients

**Impact to date:**
- Reduced EA & LOS
- £1m pa recurrent saving on care homes
- Ability to manage frail elderly/complex patients in own homes
Australian coordinated care trials; Evaluation framework

Figure 1 Overview of the National Evaluation Framework

Legacy Interviews with key stakeholders – lessons learned and policy insights
Implications for evaluation

Comparative, observational studies using large data sets; careful matching of controls and a ‘difference in differences’ methodology for comparison

Need to develop quantitative measures of patient satisfaction

The ‘I statements’ developed by National Voices provide a helpful framework for qualitative evaluation of patient and carer experience

Involve patients and carers in designing services and evaluations
Integrated care for patients

Provider
Coordinate services, tasks and patient care across professional, organisational and system boundaries

Care professional
Advocate for service users; provide and coordinate health (and social) care

Policy-maker
Design integration-friendly policies, regulations and financing arrangements; develop appropriate care systems, processes and quality standards; support holistic evaluation of integrated systems and programmes

Manager
Build and sustain shared culture and values; maintain oversight of pooled resources and funding streams; coordinate joint targets; supervise diverse staff; manage complex organisational structures and relationships

Regulator
Register integrated providers; assess care provision; monitor joined-up care; eliminate poor quality and safety

Service user/carer
Experience improved access and navigation across elements of care, including information-sharing

Evaluator
Measure integration against national standards

Community
Help to shape local services