REMOVING THE POLICY BARRIERS TO INTEGRATED CARE

THINKING THROUGH AN INTEGRATED CARE SYSTEM IN THE NHS: THE TRAFFORD EXPERIENCE

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Background

Trafford is a borough of approximately 213,000 people within the conurbation of Greater Manchester in the North West of England. Its demographic profile is very close to the national average in England. While it has its share of poverty and the associated health inequalities it fits well in the category of 'prosperous small town'.

The acute programme is delivered predominantly by two hospital trusts – Trafford Healthcare Trust (THT) in the north of the borough and University Hospitals South Manchester Foundation Trust in the southern end. Central Manchester Foundation Trust also has a key role in delivering networked services with THT, including major support to the consultant rotation in A&E. During the last few years, strategic changes have combined to produce significant financial pressures within THT and this has been both a constraint and an opportunity in developing the integrated care strategy. It has been a constraint because it has meant there has been less capital to invest in change (although the lack of capital can itself encourage innovation). It has been an opportunity because the trust has demonstrated a strong willingness to consider a completely new form and mode of operation in an attempt within the strategy to position itself to become an integrated care foundation trust.

The desire to develop an integrated care system (ICS)

Following an important series of clinical engagement events, NHS organisations in Trafford have come together to try and seek a 'win-win' solution for both commissioners and providers of care. The 'burning platform' of unsustainable local services, both from a clinical and financial perspective, has led the local PCT, provider trusts, and general practice colleagues to work together to try and develop an integrated health system based on new models of care, and that enables safe, effective, and accessible healthcare and prevention services. There are six design principles that have been used throughout the process of scoping the new integrated health system:

- general practice should be the 'locus of integration'
- consultant opinion is an essential component of effective integrated services

- the delivery of integrated services will primarily rest on extended roles for nursing and allied health professionals
- integrated services will be enhanced by the involvement of social care
- the voluntary sector and carers need a strong voice in the design and delivery of services
- future integrated services would bring together the full range of primary care services.

The approach that has been developed in Trafford has the scope of integrating across primary care, social care, community services and acute care in a way that enables significant improvement in quality and the introduction of new models of care using new technologies. There is also an intention to include some elements of mental health services within the 'integrated domain' in the future. The shift from the current service configuration to a new and integrated local health system is shown in Figures 1 and 2.

Central to this approach is the concept of 'office medicine' – community-based and -focused primary/secondary and outpatient specialist and diagnostic care. This is driven by a desire to meet the challenge of long-term conditions, and will necessitate a new relationship between doctors who are currently based in hospitals, and local GPs. As a first step towards this, community-based physicians are being appointed to nine or ten local practices, with a brief to focus on caring for those people identified as being at high risk of hospital admission, oversee the implementation of telehealth and develop the approach to population risk management.

Figure 1: Present service sectors in Trafford

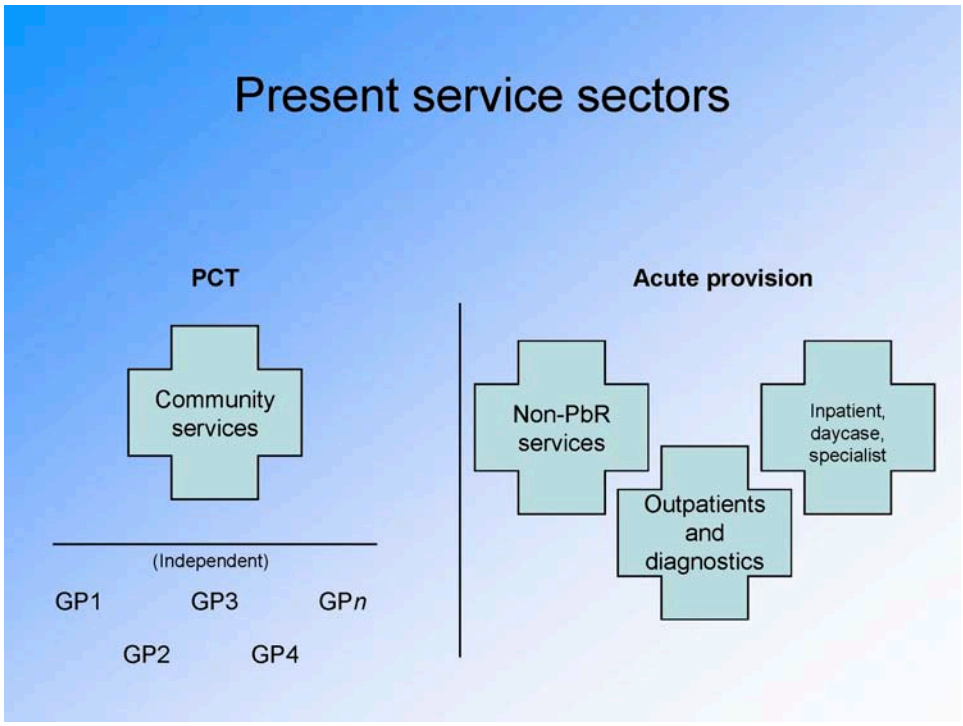
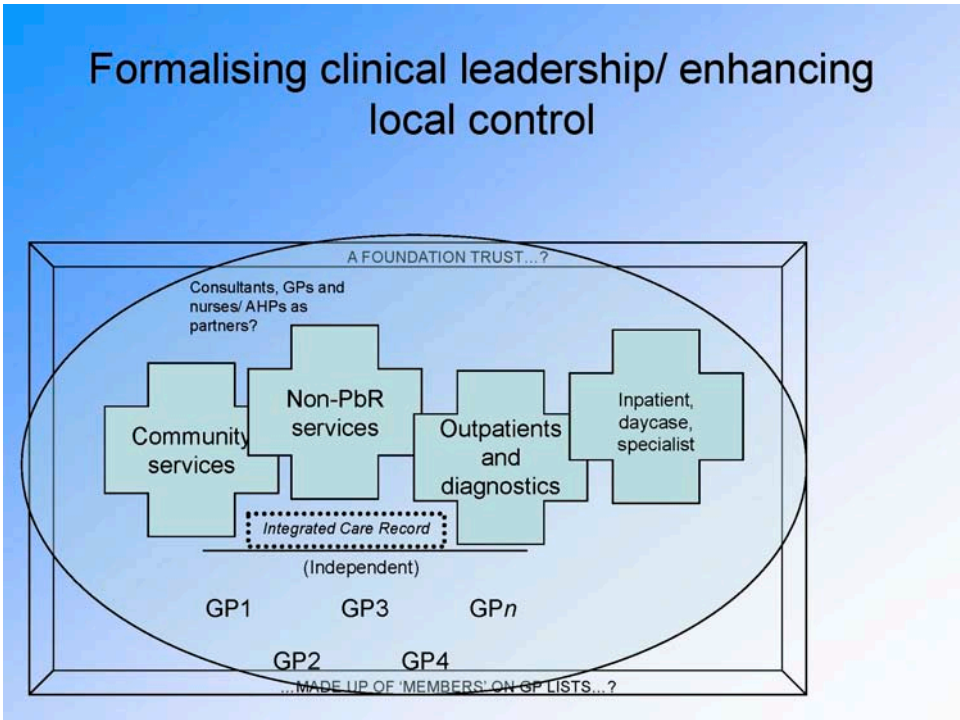


Figure 2: Proposed new integrated health system in Trafford



For surgery, there are plans for Trafford Healthcare Trust to enter into closer cooperation with other trusts in the area – particularly South and Central Manchester. This cooperation has its first expression in plans to jointly utilise the Greater Manchester Surgical Centre, which is presently a Wave One independent sector treatment centre (ISTC) but reverts to NHS control in May. This cooperation over inpatient surgery is accompanied by structured work to define clear pre- and post-operative surgical pathways focused on continuity of patient care and process control. The economy is developing this approach with ENT in 2010/11. Taken together, the development of office medicine and a new look at surgery offers the possibility of significant estates rationalisation and renewal.

Those clinicians and managers who are planning the Trafford ICS have discussed the possibility that 'maybe medicine and surgery are different in kind', with surgery requiring increased horizontal integration, through the networking or merging of a number of services into larger units, whilst medicine needs vertical integration between family medicine as delivered through general practice, office medicine, and acute medicine.

Clinical leadership is central to the development of the new integration plans, and a number of 'clinical congress' meetings have been held, at which clinicians from across primary, community health and secondary care have come together to explore how a different service model might work. Twenty-four disease areas or specialties have been identified as having the potential to benefit from integration, and six areas have been identified as the focus for 2010/11. Each of these areas will establish multidisciplinary

clinical panels, responsible for identifying models of care and quality measures. These panels will be accountable to an overall clinical board which is intended to become the most powerful body within the new ICS, undertaking evaluation and answering the fundamental question of whether integration is making things better. It is intended that the panels will oversee the move from an outpatient to 'office medicine' approach and that in due course, they may hold a programme budget to fund services for their particular specialty or service and oversee standards of provision.

Key agreements

As part of the process of developing the ICS concept, a number of key agreements have been forged, these being regarded as critical building blocks towards major and sustainable clinical and managerial change within the Trafford health economy. The agreements include:

- an integrated services strategy, used as the basis for developing a formal business case for the ICO
- the establishment of a clinical board to oversee the development of the integrated system
- the agreement by the Trafford Clinical Congress to develop panel-based integrated care
- a decision by local GPs to incorporate – forming a GP company (GPCo)
- local GPs agreeing to share data and develop a system that uses general practice clinical systems as the foundation of an integrated care record
- to aim for foundation status for the merged Trafford Healthcare Trust and Trafford Provider Services, the community services provider.

One of the main drivers of the above agreements has been a desire to have effective clinical leadership and engagement as the bedrock of the plans for the future of the system. Evaluation feedback from workshops held with local clinicians indicates strong support for building a negotiated view about how to develop integrated services for Trafford.

The GP list and information

The organisational partners developing the Trafford ICS are clear that a new integrated health system will have the GP registered list as its cornerstone. This reflects the desire for the ICS to be focused on population risk management and through this the systematic tackling of health inequalities, using real-time clinical data from primary care, public health and out-of-hours services to assess people's health risk at an individual level, and to use that assessment as a basis for providing tailored health and disease

prevention activities. A general practice-based holistic and integrated care record is regarded as central to the ICS, and there are ambitions to extend the integration of patient-level information to community health and acute hospital services.

New professional roles and perspectives

In the clinical congress meetings, and the panels representing specific clinical specialties, extensive work has been carried out to determine potential service models for patients and carers within a more integrated local health system. This has included the modelling of how an integrated system might work from four different professional perspectives:

- GP
- Consultant specialist
- Nursing/allied health professional
- Social care.

GP

The intention is that each general practice will have shared access to a new neighbourhood-based medical and nursing team which will include diagnostic services and equipment, specialist supervision and consultations, allied health professionals, community nursing staff, and shared urgent/rapid access care services. Over time, all practices will be offered the opportunity to co-design the service array necessary to best meet the distinct needs of their populations. A network of local neighbourhood centres had been considered as bases for the new infrastructure but these will probably now prove to be unaffordable. It is intended that each GP will have a named lead community nurse who is the care coordinator for their patients, a named specialist physician for advice on patients presenting with urgent care needs, and a series of named 'office consultants' for the main clinical specialties used on a regular basis by general practice (e.g. gynaecology, paediatrics, diabetology, cardiology, rheumatology).

Consultant specialist

A specialist consultant within the new ICO will have a set of core relationships that differ from the current situation where they are largely focused on the hospital organisation. They will relate to a number of GPs in a locality, providing rapid specialist advice to those GPs, and similarly to the associated neighbourhood nursing team. The specialist consultant will continue to relate to their hospital colleagues in other specialties, and will probably carry out some specialist clinics in primary care settings – such clinics will replace much of current hospital outpatient activity.

A new role for most specialists will be to take on a population health role whereby they assess and plan care for people identified as high risk of developing chronic disease, and undertake periodic reviews of identified cohorts of the population to agree how the most effective support can be given to the local primary care and community health teams. In

this way, specialists will have a role in supervising clinical practice standards across new and more integrated clinical care pathways within the locality and wider ICS.

Nursing and allied health professional perspective

A new cadre of community matrons will provide each practice with a named lead nurse to co-ordinate the formation and focusing of community services (both nursing and allied health professionals [AHPs]) onto a neighbourhood model and the overall relationship between practices, neighbourhoods and the specialist teams including consultants. Along with GPs and specialist consultants, lead nurses and AHPs will take part in an ICO-wide training and education programme.

Social care

Social care is committed to work from the outset to bring teams together wherever possible to deliver the best care for individuals and populations. As the new view of the GP registered list becomes available, the social care information team will attempt to combine this with available data on patients also receiving social care, thus enabling local integrated care that reaches beyond the NHS into local government-funded and provided services. There is an intention that there will be a lead social worker for each general practice or group of practices, and each lead social worker would also relate directly to the neighbourhood community health team (nurses and AHPs), and to the lead specialist consultants for the locality. Social care colleagues would also take part in the ICO training and education programme.

Governance

Trafford PCT is in final negotiations with the North West Strategic Health Authority about an accountability framework for the ICS development. The local Trafford Healthcare Trust that runs Trafford Hospital now has GPs on its board as 'medical directors', as an initial step towards planning the move towards office medicine. In a similar vein, a number of 'vanguard' practices have been selected (covering 90,000 of the Trafford PCT population), these being practices committed to developing and implementing new models of care within the ICS in the short to medium term and acting as the 'laboratory' for the development of the new population risk management system.

The PCT has agreed £2m of investment funding for the year 2010/11 in order to lay the foundations of the integrated care system, and has agreed a 'whole health economy' approach to delivering cost improvement programmes associated with new models of care and closer working across primary, community and acute care. A formal partnership with the local authority has been discussed but is not being pursued during the initial phase. The local authority is very supportive of the development and has indicated that it will consider the possibility of encompassing social care within the ICS, once some of the vertical integration across primary, community and acute care is starting to become embedded.

Work is also going on to develop 'mobilisation governance', namely a governance framework that can accommodate the shifts in models of care, arrangements for clinical and financial governance, and relationships between different current and planned organisations. In other words, how to ensure that 'business as usual' can be assured, whilst enabling the radical changes to care arrangements that are envisaged in the service and business strategies for the ICS. Central to this is the establishment of a stakeholder board that brings together the PCT, practice-based commissioners, community health services, general practice representatives, the local acute trust, the local council, and the two main foundation trusts that deliver care to Trafford residents.

Policy issues

Colleagues in Trafford are aware that whilst they started their ambitious integrated health system planning at the end of an era of financial growth in the NHS, they have arrived at the point of implementation at the start of an era of austerity. The nine policy enablers and barriers put forward and discussed at the seminar were nested in this particular context.

1) *The commissioner–provider split*
   In a fully realised integrated care system, there is a need to bring commissioner and provider functions together into a single organisation, though a funder (PCT) would still need to act as the systems manager of the integrated health system, allocating a population health budget to that system and holding it to account for health and service outcomes.

2) *Payment by Results (PbR)*
   It was argued that PbR creates the wrong activity incentives (encouraging more acute hospital admissions and consultant-to-consultant referrals) at a time when there is a desire for more out-of-hospital care. It was acknowledged that the new NHS operating framework proposals about PbR would start to help mitigate these incentives, but PbR remained too blunt for 'true cost' accounting, and it is difficult to understand the potentially significant variation in how coding is carried out in different hospitals – which is almost impossible to audit effectively. PbR did not provide a foundation for detailed comparative analysis of costs across hospitals, which would be beneficial in developing an ICS based on population-based risk contracts.

3) *Practice based commissioning*
   It had been challenging locally to reconcile how GPs viewed practice-based commissioning (PBC) in its current form, compared with the strategic contribution that *could* be made by PBC if it were differently conceived and incentivised. More needed to be done at a national and policy level to articulate a more radical future for PBC.

4) *World Class Commissioning (WCC)*

The way in which the eleven WCC competencies have been implemented as an 'assurance test' has become bureaucratic and distracting for local commissioners, especially when seeking major redesign of the health economy and service models. It has however enabled more rigorous audit and assurance of PCT practice, something that is viewed as contributing to PCT board governance.

5) *Choice*

In relation to the application of national policy on choice, it was noted that GP advocacy would always be paramount in patient decisions, hence the importance of having them central to the ICS and in an active service planning/commissioning capacity. Questions remained as to where the 'choice points' should be, across elective, emergency and chronic disease care, and as to whether there were other ways of 'keeping the system honest' that should be used in parallel to choice.

6) *Competition and contestability*

A key issue for the Trafford ICS is how acceptable it will be in respect of its actual or potential impact on competition and contestability, and this has been complicated to think through, given the many and sometimes conflicting voices in this area (e.g. transactions manual vs guidelines for competition, Cooperation and Competition panel vs DH authorisation of mergers). A question remains about whether it makes sense to have simultaneously competing providers over different parts of a care pathway if there is a concern to deliver integrated population-based care.

7) *Policy on the future of community health services*

The policy on the future of community health services has been at times contradictory, with encouragement towards social enterprise options at times, and merger with local foundation trusts at others. The Trafford experience points to a need for critical mass, and hence fewer, stronger providers and vertical integration (within the concept of office medicine) makes sense locally.

8) *Care Quality Commission*

As the overall arbiter of quality, it is as yet unclear as to how their role would operate across *systems* rather than organisations. At present, the response is to ensure that all activity preserves and enhances high quality within each reporting organisation, but some thought could usefully be given to how networks and whole systems should be regulated in the future.

9) *Insurance*

As Trafford colleagues have explored the implications of bringing together GPs and consultants within a single ICS, they have discovered a significant issue about the difference in approaches to liability between the Clinical Negligence Scheme for Trusts (CNST) and the Medical Defence Union (MDU).

Next steps

Partners in the Trafford Integrated Health System plans are convinced that a great deal can be achieved through strong clinical engagement within the present policy framework. Some changes to local financial systems (e.g. budgets for whole care programmes) and the monitoring of quality (new metrics focused on population health outcomes) will be required as more integrated care approaches are developed. In order to deliver a more extensive transformation in how services are delivered, a more consistent policy framework will be needed, to encourage the behaviours appropriate to service integration.

In the longer term, the ICS concept may be extended beyond Trafford to encompass services delivered by other providers. Another possibility might be to bring general practice within the ICS, aligning incentive structures with those of other providers. There is also the potential of a network of competing ICSs across a wider region, but for now, Trafford colleagues want to focus on having the local relationships, plans and commitment in place to deliver better integrated services in a manner that can assure quality and safety, improve services for patients and deal with the forthcoming financial challenges.

Judith Smith, March 2010.

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