

# Where next for the NHS reforms?

## The case for integrated care



### Summary

This paper sets out the challenges facing the English NHS now and in the future and identifies the reforms we believe are needed to meet these challenges. It has been written as a contribution to the listening exercise initiated by the coalition government following the announcement at the beginning of April of a pause in the parliamentary passage of the Health and Social Care Bill. It builds on The King's Fund's response to the health White Paper published in July 2010 (Dixon and Ham 2010), our briefing for the second reading debate on the Bill in the House of Commons (The King's Fund 2011a), and our extensive programme of policy analysis and research.

The main argument of the paper is that reforms to the NHS must be clearly focused on, and proportionate to, the challenges it faces. One of the reasons the coalition government has run into difficulty is that it moved very rapidly to set out radical changes to the NHS without having first clarified the problems that these reforms were meant to address. The King's Fund is in no doubt that in some areas there is scope to improve performance and to move closer to the standards of care achieved in other countries, but we suggest that a clear diagnosis of the state of the NHS today is needed to inform the design of future reforms.

The NHS is faced with the major challenges of using resources more efficiently and of meeting the needs of an ageing population in which chronic medical conditions are increasingly prevalent. The key task therefore is to implement a new model of care in which clinicians work together more closely to meet the needs of patients and to co-ordinate services. This model of integrated care would focus much more on preventing ill health, supporting self-care, enhancing primary care, providing care in people's homes and the community, and increasing co-ordination between primary care teams and specialists and between health and social care.

There are many barriers to the implementation of integrated care, including organisational complexity, divisions between GPs and specialists, perverse financial incentives, and the absence of a single electronic medical record available throughout the NHS. The coalition government's proposed reforms have the potential to help overcome some of these barriers but they could also make it more difficult to achieve closer integration of care unless they are modified in a number of areas. Our paper *Liberating the NHS: The right prescription in a cold climate?* proposed a series of modifications centred on the argument that well-designed reforms must strike a balance between collaboration in some areas of care and competition in others (Dixon and Ham 2010).

In this paper, we offer suggestions for revisions to the current Bill and future policy development but we also lay out a more radical model that we believe holds the prospect of greater progress towards the vision of integrated care and a health system sustainable in the longer term.

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### *Proposed legislation and future policy: summary of recommendations*

Many of the changes we outline do not require legislation and should be taken forward as a matter of urgency through established policy-making processes. The main implication for the Bill is to ensure that its centrepiece proposals for economic regulation do not promote the wrong kind of competition or create further barriers to collaboration and the development of integrated care where this will bring benefits. Monitor must adopt a nuanced and proportionate approach that encourages both collaboration and competition where appropriate.

In our view, the Bill needs to create a regulatory framework that supports the development of more integrated models of care and multi-professional collaboration at all levels within the NHS. The framework should enable local innovation and allow the continuing adaptation of service models as medicine advances and the needs of patients change. While we support the need to promote patient choice, and competition where appropriate, we believe that all organisations engaged in regulating, commissioning or providing NHS care should have the goal of integration 'hard-wired' into their corporate objectives.

The key changes that could facilitate integrated include the following.

- Alternatives to the tariff are needed for non-elective, long-term and complex care. These alternatives may include bundled payments, pooled or delegated budgets and capitated budgets. Any payment mechanism adopted needs to ensure that financial rewards are linked to the quality and outcomes of care.
- There is a need for system leadership at a regional level and this should be provided by multi-professional clinically led groups or clinical cabinets working with the NHS Commissioning Board.
- Joint working between health and social care needs to be facilitated in order to ensure population health issues are addressed, including tackling health inequalities and the needs of unregistered patients. GP commissioning boundaries should, as far as possible, be aligned to local authority boundaries to support this.

- At a local level, multi-professional health and social care teams that support the needs of high-risk patients such as frail older people should be a core element of service provision, as is already the case for patients with chronic mental health problems and learning disabilities.
- To support clinical integration and patient-focused care, anyone providing or commissioning NHS care should be required as part of their licensing agreement or statutory function to share relevant information with patients and professionals.

The reforms and the legislation should also allow the evolution of new approaches. At the end of this paper we lay out one such approach - the integrated care partnership - that The King's Fund and others have long advocated should be piloted (Curry *et al* 2008; Lewis *et al* 2010). Under this approach the commissioning function is split between a strategic commissioner and budget-holding, not-for-profit, integrated care partnerships. These integrated care partnerships might include GPs and relevant health and social care specialists forming organisations that take on a capitated, risk-bearing budget for a defined population while also being charged with the provision of care where appropriate.

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## Introduction

Throughout the debate on the White Paper and the Health and Social Care Bill, The King's Fund has argued that the real choice is not between stability and change but between reforms that are well designed and effectively implemented and those that are poorly planned and risk undermining NHS performance. Our concerns with the coalition government's proposals have centred on a view that they are moving too far and too fast and that this will make it difficult to achieve the productivity improvements required to deliver the so-called 'Nicholson challenge'. This paper describes how to design and implement the right reforms for the NHS, starting from where it is now and adopting an evolutionary path of change.

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## How good is the NHS?

The NHS has made significant progress over the past decade. Our review of NHS performance since 1997, published a year ago (Thorlby and Maybin 2010), identified a number of notable achievements:

- hospital waiting times have been transformed, with more than 90 per cent of patients waiting less than 18 weeks for treatment, with improvements in access to GP services too
- infant mortality has fallen and life expectancy is increasing for all social groups
- smoking rates have fallen, and deaths from cancer and cardiovascular diseases have been steadily declining
- infection rates for MRSA and *C difficile* have been significantly reduced, and there are now robust systems for collecting and analysing information on adverse events
- in mental health services, access to specialist early intervention and crisis resolution teams is considered among the best in Europe and has led to reductions in acute admissions
- there is now far more information available to patients, professionals and the public about how services perform.

This analysis is reflected in national and international surveys.

- According to the British Social Attitudes Survey, 64 per cent of people report that they are satisfied with the NHS, a record high (Appleby *et al* 2010a).
- The UK was ranked second in an assessment of health systems in seven countries published by the Commonwealth Fund in June 2010 (Davis *et al* 2010).
- In November 2010, a Commonwealth Fund survey of 11 leading nations found that people in the UK have the highest levels of confidence in the effectiveness and affordability of health treatment (Schoen *et al* 2010).

However, while good progress has been made, there are a number of areas where performance needs to improve before the NHS can be deemed truly world class. For example:

- although cancer survival rates have improved, international comparisons suggest we still lag behind other countries in survival rates for several types of cancer
- while infant mortality has fallen, recent analysis published by the *BMJ* suggests that child mortality rates in the United Kingdom are higher than in many other European countries (Wolfe *et al* 2011)
- NHS productivity has declined by an average of 0.2 per cent a year since 1995, according to estimates by the Office for National Statistics (National Audit Office 2011)
- while progress has been made in reducing smoking, alcohol consumption and related hospital admissions are increasing, and obesity rates have risen significantly
- inequalities in life expectancy between rich and poor have widened, even though life expectancy is increasing for all groups
- support for people with long-term conditions is inconsistent, and people continue to be admitted to hospital for conditions that could be managed in the community
- variations in the quality of general practice and in the treatment provided in hospitals remain persistent and widespread (The King's Fund 2011b; Appleby *et al* 2011).

Against this background of substantial progress, albeit with more work to do, the case for reform is clear, but the nature of reform needs to be focused on and

proportionate to the problems to be addressed.

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### What are the main challenges for the future?

As well as focusing on the areas where the performance of the NHS needs to improve, any reforms must address the future challenges it faces. The most immediate and pressing challenge for the NHS is to continue to improve patient care in a very difficult financial climate.

NHS spending now stands at more than £100 billion a year. Although the coalition government's pledge to protect the health budget meant it fared well compared to other Whitehall departments in the Spending Review, expenditure will be flat in real terms in the years up to 2015. To put this into perspective, the NHS has averaged real-terms increases of 4 per cent a year since it was established and 7 per cent since the turn of the century. The only similar period of near-zero real-terms growth was in the early 1950s.

In order to maintain the quality of care and meet rising demand for services, the Spending Review also committed the NHS to finding £20 billion in productivity improvements by 2015 - the so-called 'Nicholson challenge'. This requires it to deliver efficiency savings of at least 4 per cent a year, unprecedented in its history. Finding these savings must be the overriding priority for the NHS over the next few years, and any reforms must support it in meeting this challenge. The major organisational changes already under way, including the planned abolition of strategic health authorities, the clustering of PCTs, and reductions in management costs, risk distracting leaders from the task of improving financial performance and the quality of care.

The NHS faces other key challenges.

**Demographic change:** people are living longer and the population is ageing. While many people live both long and healthy lives, increasing numbers are affected by conditions such as dementia that affect their quality of life and place demands on families, carers and the health and social care systems.

**Social change:** more people are living in single-person households and further from their extended family. There will therefore be less marital and family support

for people as they get older and increased demand on paid/statutory support.

**The shifting burden of disease:** premature death rates from cardiovascular diseases and cancer have declined but chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia have become more prevalent. As the population ages, a high proportion of NHS funds will be spent on meeting the needs of increasing numbers of older frail people with multiple conditions and co-morbidities.

**Public expectations:** increased levels of per capita income and educational attainment have contributed to rising public expectations of the NHS. The NHS of the future will need to deliver more personalised, patient-centred services that give people genuine choice and control.

**Medical advances:** new forms of diagnosis and treatment have contributed to long-term improvements in population health, and developments in genomics, stem cell research and other fields hold out promise for the future but have significant implications for future spending on health care.

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### A new model of care

Current models of care reflect the legacy of decisions taken during the lifetime of the NHS. These models are centred on the provision of episodic treatment to address the main burden of disease in the second half of the twentieth century, namely cardiovascular diseases and cancer. Acute hospitals have come to play an increasingly prominent part in the NHS as successive governments have sought to make available effective treatment for people affected by these life-threatening conditions.

Demographic changes and the shifting burden of disease require a re-assessment of the hospital-based model of care. Meeting the health needs of the increasing numbers of older people should be a high priority. While many of these people will live long and for the most part healthy lives, others will require support from both the NHS and social care. This includes services for people with dementia and other chronic conditions to enable them to live independently in the community for as long as possible.

A new model of care is needed, less oriented to treating people when they become ill and more focused on prevention, accompanied by a progressive shift in resources away from acute hospitals to providing care in and closer to people's homes. This should seek to achieve the triple aim of improved patient experiences, better health outcomes and more cost-effective care. Moving to the new model requires a comprehensive approach that improves the co-ordination of services for patients and promotes integration in the delivery of care.

### *Key elements in the new model*

**Prevention of ill health:** action at the population/ community level and targeted at individuals to identify people at risk, address risk factors and fully engage the population in bringing about further improvement in life expectancy and in the quality of life. This includes action to reduce the health gap between more and less affluent groups.

**Supported self-care:** action to enable individuals, carers and families to make healthy choices and to continue to play a key role in looking after themselves when they become ill or are diagnosed with a chronic condition. This includes the use of assistive technologies in the home and training programmes to provide people with the confidence and skills to manage their conditions.

**Enhanced primary care:** action to reduce variations in the quality of primary care and to provide additional services that help to keep people out of hospital. This requires a network of primary care providers that promote and maintain continuity of care with local people and act as hubs not only for the provision of generalist care but also for access to diagnostics and chronic disease management. Increased collaboration between general practices in federated arrangements would enable patients to access services closer to home.

**Co-ordination of care:** action to link primary care teams more closely with specialists and with health and social care professionals to ensure patients and service users receive care that is effectively co-ordinated. This is likely to be facilitated by the development of the electronic care record and of IT systems that connect different parts of the care system. Responsibility for the co-ordination of patient care, regardless of where that is provided in the system, needs to be taken by the

organisation with whom they register.

**High-quality, safe specialist care:** action to rationalise acute care in fewer hospitals and to concentrate specialist services in centres of excellence able to deliver the best outcomes, supported by networks that link together expertise in different settings. Some services currently provided in acute hospitals will be increasingly unbundled, with more diagnostic and outpatient services provided in primary care, and many inpatient services delivered in step-down facilities such as community hospitals and nursing homes. In some cases, patients currently cared for in hospitals will be looked after in their own homes with support from nurses and others.

**Consistent standards of care:** action to reduce unwarranted variations in health care through systematic and routine collection and publication of data, the development of incentives to encourage action to tackle unwarranted variation and an emphasis on shared decision-making to establish the right level of variation based on patients' own assessments of their needs and attitudes to risk.

The approach we advocate requires a shift in the way care is delivered, with much less reliance on clinicians practising autonomously in a 'cottage industry' model and greater emphasis on standardising care around best practice guidelines supported by routine monitoring of performance and transparent reporting (Swensen *et al* 2010). This approach means moving beyond fragmentation between providers and services to effective co-ordination around the needs of patients. Choice and competition have a part to play in the health care system of the future, but applying market principles in health care needs to be done in a way that improves the value and outcomes of care.

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## **Towards integrated care**

At the heart of the new model of care is the need to better integrate services between providers around the individual needs of patients and service users. As The King's Fund's review of the evidence for integrated care concluded, significant benefits can arise from the integration of services (Curry and Ham 2010), particularly when these are targeted at those client groups for whom care is currently poorly co-ordinated.

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The integration of care can take on many different forms. A distinction can be drawn between *real* integration, in which organisations merge their services, and *virtual* or *contractual* integration, in which providers work together through networks and alliances. Studies have shown that organisational mergers do not deliver benefits without clinical and service integration. Virtual integration based on networks and alliances may therefore offer greater potential to deliver a new model of care if it facilitates clinical teams to come together to co-ordinate services around the needs of patients.

In some cases integration may entail bringing together responsibility for commissioning and provision. This form of integration is important because it allows clinicians to use budgets either to provide services more directly or to commission these services from others through 'make or buy' decisions. Many integrated medical groups in the United States work in this way, and research has highlighted the beneficial impact on both service utilisation (for example, reduced use of hospital beds) and quality of care. One of the challenges for the proposed reforms is how to facilitate the emergence of integrated medical groups able to take 'make or buy' decisions and we discuss this in more detail below.

Examples of integration can be found at the micro level in the use of multidisciplinary teams to meet the needs of individual service users and carers. They can also be found at the meso level when providers collaborate or merge to meet the needs of particular care groups like older people or populations with the same diseases or conditions. The most ambitious forms of integration are those that provide the full range of care to the populations they serve.

Kaiser Permanente in the United States is a well-known example, and it exhibits many of the elements of the new model of care described above. It is a virtually integrated system in which hospitals, the medical group and the health plan (or 'commissioner' to use NHS terminology) remain distinct organisations and collaborate closely. Kaiser Permanente delivers good outcomes for its members, with studies showing that it makes much less use of hospital beds than the NHS. It achieves this result because of its focus on prevention, supported self-care, and pro-active care co-ordination (Feachem *et al* 2002; Ham *et al* 2003).

## Integrated care in the NHS

In the NHS, integrated care is particularly important in meeting the needs of people with chronic diseases like diabetes and chronic obstructive pulmonary disease; frail older people who may have several chronic diseases and be in contact with a range of health and social care professionals; and people using specialist services – for example, those involved in cardiac and cancer care – where networks linking hospitals that provide these services have contributed to improved outcomes. The following box illustrates examples of each.

### Diabetes care in Bolton

The Bolton Diabetes Centre was set up in 1995 and is the base for a team of community-based specialists. The team reaches into the local hospital for inpatient care, and out to general practices to provide support and undertake shared consultations. The vision is of care that is patient centred and delivered in the appropriate place at the appropriate time by the appropriately trained professional. Bolton aspires to develop a fully integrated diabetes service without gaps or duplication and with smooth and quick referral from primary care to specialist advice. Patients and staff have reported high levels of satisfaction with the service, and in 2005/6 Bolton reported the lowest number of hospital bed days per person with diabetes in the Greater Manchester area (Irani *et al* 2007).

### Care for older people in Torbay

Health and social care for older people in Torbay is delivered through integrated teams, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and are used flexibly by integrated teams who are involved in micro commissioning to meet patients' needs. A major priority has been to increase spending on intermediate care services that enable patients to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care (Thistlethwaite 2011).

### Stroke care in Manchester and London

Stroke care in London and Manchester has been improved by planning the provision of these services across networks linking hospitals. Manchester uses an integrated hub-and-spoke model that provides one comprehensive, two primary and six district stroke centres. Results include increasing the number of eligible patients receiving thrombolysis within the metropolitan area from 10 to 69 between 2006 and 2009 (NAO 2010). In London implementation of a pan-London stroke care pathway and the development of eight hyper-acute stroke units has improved access and reduced length of stay in hospitals: 85 per cent of high-risk patients who have had a transient ischaemic attack are treated within 24 hours, compared with a national average of 56 per cent, and 84 per cent of patients spend at least 90 per cent of their time in a dedicated stroke unit, compared to a national average of 68 per cent. Five of the top six performing hospitals in the National Sentinel Audit for Stroke are now London hyper-acute stroke units (Intercollegiate Stroke Working Party 2011).

## The ingredients of effective integrated care

As the above examples illustrate, many different approaches can be taken to achieving integrated care. While mergers to create organisations that take full responsibility for commissioning and providing services for the populations they serve have been pursued in Scotland and Wales, this option is not on the agenda in England, and in any case the benefits of this kind of organisational integration remain a matter of dispute. A more promising route for the NHS in England is therefore to encourage virtual or contractual integration between providers, learning from experience in other sectors where strategic partnering and integration through supply chains and networks are widely used. In our view, the main priority should be to support clinicians to work together to deliver co-ordinated care by engaging them effectively in commissioning.

A number of ingredients can be identified that together contribute to the outcomes that integrated systems achieve almost regardless of the particular organisational form adopted.

### The core ingredients of integrated care

**Defined populations** that enable health care teams to develop a relationship over time with a 'registered' population or local community, and so to target individuals who would most benefit from a more co-ordinated approach to the management of their care

**Aligned financial incentives** that support providers to work collaboratively by avoiding any perverse effects of activity-based payments; promote joint responsibility for the prudent management of financial resources; and encourage the management of ill-health in primary care settings in order to prevent admissions to hospitals and nursing homes

**Shared accountability for performance** through the use of data to improve quality and account to stakeholders through public reporting

**Information technology** that supports the delivery of integrated care, especially via the electronic medical record and the use of clinical decision support systems, and through the ability to identify and target 'at risk' patients

**The use of guidelines** to promote best practice, support care co-ordination across care pathways, and reduce unwarranted variations or gaps in care

A **physician-management partnership** that links the clinical skills of health care professionals with the organisational skills of executives, sometimes bringing together the skills of purchasers and providers 'under one roof'

**Effective leadership** at all levels with a focus on continuous quality improvement

A **collaborative culture** that emphasises team working and the delivery of highly co-ordinated and patient-centred care

**Multi-specialty groups** of health and social care professionals in which, for example, generalists work alongside specialists to deliver integrated care

**Patient engagement** in taking decisions about their own care and support in enabling them to self-care

(Source: adapted from Curry and Ham 2010)

There is evidence to suggest that approaches to integrated care work best when some of the responsibilities for commissioning services are given to those responsible for delivery (Christensen *et al* 2008). Giving providers freedom to take 'make or buy' decisions means that the redesign of care and services is clinically led. Importantly, it promotes collective accountability among providers for the quality, costs and outcomes of care as incentives to integrate services are aligned and this approach becomes more culturally and systematically embedded.

We would also emphasise that integrated care does not appear to evolve as a natural response to emerging care needs in any system of care whether this be planned or market-driven. Achieving the benefits of integrated care requires strong system leadership, for example, from policy-makers and other system architects, to provide a platform to support it. Systemic barriers to integrated care in England must be addressed if patient-centred integrated care is to become a reality. It is to this issue that we now turn.

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### The barriers to integrated care and the implications of the proposed reforms

The NHS today contains many barriers to integrated care. Examples of how they have been overcome, such as those described in the previous section, are few and far between. As a result, the NHS ranks poorly in international comparisons examining patient-centred care where surveys demonstrate comparative weaknesses in its ability to support care co-ordination (Schoen *et al* 2008). What then are the main barriers to developing a new model of care?

#### *Organisational complexity and restructuring*

The NHS in England is made up of a large number of organisations, each with responsibility for different aspects of commissioning and service provision. These organisations include strategic health authorities, primary care trusts and NHS trusts (most of which are now foundation trusts) responsible for acute services, specialist services, mental health services, community services, and ambulance services. Complexity has been increased by the move to enable NHS services to be run

as social enterprises and by the encouragement given to independent sector and voluntary sector providers to deliver care to patients. Alongside the NHS, local authorities are responsible for social care, on which many of the most vulnerable users depend.

As well as organisational complexity, the NHS has been affected by frequent restructuring. This has had the effect of taking managers' time and attention away from the core business of improving patient care and addressing weaknesses in performance. In some cases, restructuring has resulted in increased fragmentation. Examples include the separation of responsibility for commissioning health care and providing services, introduced in 1991, and the requirement that primary care trusts divest themselves of responsibility for directly providing services under the transforming community services policy.

The latter policy has resulted in increased integration in areas where community services have been taken on by NHS trusts providing acute services and mental health services. Paradoxically, in other areas, such as Torbay, progress in integrating care has been adversely affected by this policy, in part because of the instability caused by restructuring, and in part because of the requirement that there should be a clear separation between commissioning and service provision in the care trust. Similar challenges have been encountered in areas like the Cumbria, the Isle of Wight and Knowsley where the requirement that primary care trusts should divest themselves of responsibility for directly providing services has put barriers in the way of closer integration.

#### **The impact of the proposed reforms**

The proposed reforms to the NHS could increase organisational complexity as encouragement is given to any willing provider to deliver care to patients and renewed efforts are made to encourage NHS staff to establish social enterprises. Also, the proposed abolition of strategic health authorities and primary care trusts may help in reducing the number and type of organisations in the NHS, but it will also have the effect of removing the two bodies that have the potential to support partnership working and provide local system leadership. On the other hand, the proposed health and wellbeing boards will have a duty to promote integrated care, although their powers to make this happen are weak under current plans.



### *Professional divisions*

One of the characteristics of British medicine is the historical separation between general practitioners (GPs) and specialists. This separation is in part organisational – GPs work mainly in the community as self-employed contractors and specialists mainly in hospitals as salaried employees – and in part cultural. Although the status and remuneration of GPs has steadily increased during the lifetime of the NHS, and the quality of primary care in the UK is widely admired, there remains a perception in some quarters that a career in general practice is not as prestigious as a career in hospital medicine. As a consequence, it can be difficult for GPs to work on equal terms with specialists.

An unintended consequence of the increasing trend towards specialisation and professionalisation in the roles and tasks performed by health and social care professionals has been fragmentation at a clinical and service level (Ahgren 2010). There is a need to promote the role of generalist physicians in the workforce – for example, in care of older people – to counter the unintended consequences of sub-specialisation.

This becomes more urgent with the increasing numbers of older people in the population, some of whom have multiple and complex chronic conditions that require the expertise of GPs and a range of specialists and their team. Integrated delivery systems in other countries, such as Kaiser Permanente, embrace a model of multi-specialty medical practice in which GPs work alongside specialists, often in the same facilities.

Multi-specialty medical practice (also referred to as integrated medical groups) is a form of integration that has been shown to deliver better results compared with arrangements in which doctors work in isolated practices (Curry and Ham 2010). It is relevant to the NHS because of the need for specialists and GPs to work together much more closely to help patients remain independent for as long as possible and to reduce avoidable hospital admissions. While there are some examples of specialists who work in the community alongside GPs (as in the Bolton diabetes service described above), these remain the exception rather than the rule.

One reason for this is that the organisation of general practice in relatively small units makes it difficult for

specialists to work outside hospitals in a way that is both efficient and supports the delivery of high-quality care. Also, the lack of appropriate buildings and equipment for diagnosis and treatment in primary care means that the hospital becomes the default setting for the delivery of most forms of specialist care. Proposals such as those put forward in London for the development of polyclinics were intended to address these challenges, but progress in implementation has been slow.

### **The impact of the proposed reforms**

The proposed reforms to the NHS could reinforce divisions between GPs and specialists if current plans for GP commissioning proceed without modification. They emphasise that GPs will take the lead on commissioning and are silent on the role of specialists and the part they will be expected to play in future.

### *Financial incentives*

The main way of paying hospitals for the work they do, Payment by Results, was introduced in 2003/4 to support the aim of cutting waiting lists and waiting times for planned hospital care, at a time when the NHS budget was increasing rapidly. The incentives contained within Payment by Results have contributed to the improvements in access to care in the past decade but also make it difficult to develop integrated care. This is because hospitals may experience a reduction in demand for their services and therefore income if greater emphasis is given to prevention and to care closer to home.

By setting up hospitals as profit centres seeking to generate surpluses for investment under the regulatory regime established by Monitor, recent health reforms have put significant barriers in the way of necessary changes in clinical practice. Anecdotal evidence of specialists being instructed not to undertake work that reduces hospital activity and income, or that is not remunerated under the Payment by Results tariff, such as telephone consultations with GPs, offer powerful evidence of this. In effect, financial incentives serve to lock in an outmoded model of care and provide no reward for the integrated models we have argued should be at the centre of the health care system of the future.

In theory, world class commissioning and practice-based commissioning were intended to act as a countervailing force to Payment by Results and the establishment of

foundation trusts, with the aim of moving to the new model of care we have outlined. In practice, neither primary care trusts nor practice-based commissioners in most parts of the NHS found it easy to challenge the power of acute hospitals, with the result that activity levels in hospitals have continued to increase and progress in developing care in alternative settings has been slow and uneven. The reasons for this can be found in the inherent difficulties involved in commissioning health care services, not just in the NHS but in other health care systems (Ham 2008), and the relatively weak incentives available to commissioners.

### **The impact of the proposed reforms**

The financial pressures facing the NHS require an urgent review of current incentives and how they should be modified, not least because commissioners will not be able to fund ever-increasing levels of hospital activity. Payment by Results makes sense for planned care as a way of supporting choice and competition in the market, and it may also have a role in other areas of care where there is a case for encouraging new providers to deliver services to NHS patients. In the case of unplanned care, where the aim is to reduce avoidable admissions and provide care outside hospitals wherever appropriate, alternative payment systems are needed. These alternatives should create incentives for high-quality co-ordinated care for people with chronic diseases. The experience of integrated systems that have incentives aligned with their objectives should be used to develop these alternatives.

### **Competition and regulation**

Successive governments over the past 20 years have used competition as a means of improving performance in the NHS. Studies have pointed to mixed results from the use of competition in the NHS, and there are strongly held views on how appropriate it is to apply market principles in a publicly funded health care system. One of the concerns of critics of competition is that it will result in increased fragmentation and inefficient duplication of services that may have adverse effects on the quality and outcomes of care.

Market principles have been applied most extensively in the United States. The analysis undertaken by Porter and Teisberg highlights the challenges that

arise when the 'wrong kind of competition' is used in health care (Porter and Teisberg 2006). These challenges include cost-shifting, attempts to capture patients and restrict choice, efforts to reduce costs by limiting services, and competition to increase bargaining power. The alternative proposed by Porter and Teisberg is value-based competition centred on integrated practice units defined around medical conditions rather than medical specialties.

The rationale behind this approach - echoing the arguments of this paper - is the need to move beyond fragmented care to an integrated approach in which patients receive high-quality co-ordinated services. The implication is that competition itself need not be a barrier to collaboration provided that the risks of the wrong kind of competition are addressed. This means ensuring appropriate regulation of the market to support the emergence of value-based competition. Porter and Teisberg's argument is related to the analysis of Christensen and colleagues (Christensen *et al* 2009), who see the solution to the problems of health care in the United States as lying in competition between integrated systems.

This analysis indicates that there is no inherent contradiction between competition and integration provided that the complexities of health care are understood. The well-known risks of market failure need to be addressed in the design of the NHS reforms to support the implementation of the new model of integrated care we have described.

### **The impact of the proposed reforms**

The proposed reforms to the NHS, and in particular the Health and Social Care Bill, include provisions for an economic regulator (Monitor) with a duty to promote competition where appropriate. Monitor will be expected to work with the Office of Fair Trading, the Competition Commission and the NHS Commissioning Board in discharging its responsibilities. If these proposals are taken forward, it will be essential that Monitor recognises the challenges of applying market principles in a way that avoids the problems identified by Porter and Teisberg. As we discuss in the final section of this paper, this means supporting both competition in the market and competition for the market. It also means ensuring that Monitor's duty

to promote competition where appropriate does not create further barriers to collaboration and integrated care where this will bring benefits.

### *Functional separation between commissioner and provider*

The concept of 'commissioning' as developed in England encompasses a broad range of activities, including analysing the health needs of the population, identifying commissioning priorities, planning and designing services, procuring and then monitoring and evaluating the services provided. Despite attempts to strengthen the commissioning function in England through the world class commissioning programme, commissioning has yet to deliver the ambitions set out for it (HCSC 2010). Commissioners have struggled in the face of large and powerful providers and a major asymmetry of information between commissioner and provider.

Even before the general election, there was discussion about whether PCTs were operating at sufficient scale to undertake commissioning effectively and challenge large providers. PCTs were also criticised for lacking clinical involvement despite the existence of a Professional Executive Committee as part of the governance arrangements. In many areas, they struggled to find ways to influence the quality of primary care, encourage the shift to develop more services in the community, and manage the volume of care.

Practice-based commissioning - that is, the delegation of budgets to groups of practices - was seen as the solution. However, these were soft or nominal budgets, small in size and scope, and the process for obtaining these delegated budgets was often cumbersome and lacking transparency. One of the key lessons from the experience of practice-based commissioning and its predecessors was that more progress in service redesign and delivery is made when 'real' budgets are devolved to commissioner-provider groups so they have autonomy in decision-making (Curry *et al* 2008).

### **Impact of the proposed reforms**

We have noted already the opportunities and threats to integrated care posed by the transforming community services policy. Similar issues arise in relation to the coalition government's proposed reforms, especially those relating to GP commissioning consortia.

While the proposed GP consortia would introduce valuable clinical insight to the commissioning process, the proposal that consortia should be statutory bodies that will only commission care continues the previous government's emphasis on the separation of commissioner and provider responsibilities. Public procurement rules are likely to make it difficult for GP consortia to implement the new model of care described in this paper because GPs will have to decide whether to be involved in commissioning or to focus mainly on developing new approaches to service provision to overcome concerns about conflicts of interest.

Our experience is that many GPs involved in the pathfinder programme see themselves first and foremost as providers and they are enthusiastic about commissioning because of the opportunities it offers to develop new models of provision in which they and other practices will play a part. If regulatory barriers are placed in the way of GPs and other clinicians using commissioning as a lever to innovate in service provision, then the current interest in commissioning may rapidly dissipate as has been the case in the past. This will severely attenuate the potential benefits of engaging clinicians more directly in commissioning, and underpins our argument for a more radical option set out at the end of the paper.

### *Information technology*

The final barrier to integrated care is information technology. Progress has been made in hospitals and, especially, in primary care in the use of information technology; however, delays in the Connecting for Health programme mean that the vision of a single system that links hospitals and primary care remains unfulfilled. The consequence is that patients may be assessed repeatedly, communication between clinicians is inhibited, co-ordination of care may suffer, and quality failures may occur.

High-performing integrated systems in other countries have made a major commitment to information technology and have been early and effective implementers of the electronic medical record and clinical decision support systems. The electronic medical record is itself an important means of supporting integration by enabling clinicians to access information about patients

wherever they are treated. Likewise, clinical decision support systems facilitate the adoption of best practice guidelines and the delivery of high-quality, safe health care. Patients are able to access their own records remotely, communicate with doctors and other clinicians through secure email channels, make appointments online and order repeat prescriptions.

The data captured through information technology can also be used to support comparisons of performance among clinicians and hospitals and as a tool for continuous quality improvement. This is fundamentally important in moving away from the cottage industry model of health care, reducing unwarranted variations in care and promoting greater consistency with recognised standards of care. Measurement and benchmarking can also be used to support informed patient choice and transparent reporting of performance.

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### What needs to be done to support integrated care?

Based on this analysis, what actions do we believe are now needed in relation to the legislation before parliament and to current health policies to make integrated care a reality? In this final section of our paper, we set out a range of proposals designed to inform the work going on during the listening exercise and the decisions the government will take on modifications to the Health and Social Care Bill when the listening exercise is completed. The discussion is organised around the ways of overcoming the barriers discussed in the previous section. We offer suggestions for revisions to the current Bill but also lay out an evolutionary path to a more radical model, based on a different approach to commissioning that we believe will help move towards the vision of integrated care and a sustainable health system.

As we have shown, the NHS does need to change to build on recent improvements in performance, and proposals to strengthen choice and competition have a part to play in this process. The imperative now must be to ensure that future reforms are well designed, appropriate to the challenges that lie ahead, proportionate to these challenges, and effectively implemented. In our view, the top priority for the current legislation is to adopt a nuanced

approach to economic regulation that avoids promoting the wrong kind of competition and does not create further barriers to collaboration and the development of integrated care where this will bring benefits. Such an approach needs to rebalance the system towards a more collaborative model while retaining a strong focus on clinical leadership and outcomes.

We would also reiterate the need to phase the implementation of the reforms in a way that supports delivery of the Nicholson challenge. As we have argued elsewhere, integrated care that is focused on the needs of older people and people with chronic conditions has a major contribution to make in enabling the NHS to rise to this challenge (Appleby *et al* 2010b). Migration from the current system should be calibrated on the basis of an assessment of the readiness of clinicians to take on the responsibilities being offered them and in a way that ensures the retention of experienced NHS leaders during and beyond the transition. This evolutionary path applies equally to current proposals and our more radical model.

#### *Organisational complexity and restructuring: the need for system leadership and coherence*

At a time when organisational complexity is likely to increase as a consequence of the government's any willing provider policy, the key question is how to achieve co-ordination around the needs of patients among an increasingly diverse range of providers? The answer to this question is unlikely to be through further restructuring to reduce the number and variety of NHS organisations, not least because of the negative effects of constant changes to the organisation of the NHS. An alternative is to recognise the need for effective system leadership in support of clinical commissioning, in anticipation of the eventual demise of strategic health authorities and primary care trusts.

By system leadership we mean the ability to take an overview of the needs of the population in an area and of the role of different organisations in responding to these needs. In our response to the White Paper, we argued that commissioning consortia were unlikely to be able to undertake this task and to address complex issues such as the organisation of specialised care and the reconfiguration of acute hospitals (Dixon and Ham 2010). Recent work by The King's Fund on the reorganisation

of hospital services in south-east London has reinforced us in this view (Palmer 2011). In the context of this paper, system leadership encompasses responsibility for promoting integrated care where this will bring benefits.

The government's plans envisage that health and wellbeing boards will have a duty to promote integrated care, and we welcome this. However, their powers are weak under current plans, and the future of health care services will be decided by commissioning consortia and the NHS Commissioning Board. It is likely that consortia will choose to work with each other to deal with issues that demand expertise unlikely to be available in every consortium, helping to fill the gap that will be left when strategic health authorities and primary care trusts are abolished.

Collaboration between consortia is, however, unlikely to be sufficient to take forward integrated care for specialist services such as cardiac care and cancer care or to ensure that existing networks are sustained where they are functioning well. As the examples of stroke services in Manchester and London show (see page 7), system leadership is needed to agree how some specialist services should be concentrated in fewer centres able to deliver better outcomes where progress has not already been made on these issues. For these reasons, we propose that the NHS Commissioning Board should be given an explicit role to work with commissioning consortia to provide system leadership and promote integrated care for specialist services.

A case can be made for the establishment of clinical cabinets at a regional level to provide support to consortia and to ensure that this system leadership role has at its heart the best available clinical advice. These clinical cabinets would have a major part to play in promoting integrated care for specialist services and in helping to overcome the historical divisions in British medicine that create barriers to integration. And by ensuring that clinicians are at the heart of this regional role of the NHS Commissioning Board, it should be possible to avoid the reinvention of strategic health authorities.

Under current arrangements, PCTs and local authorities have developed numerous ways of working in partnership, resulting in better co-ordination of services. The loss of co-terminosity achieved between many authorities and PCTs may create practical barriers to

joint working, particularly to support public health initiatives. It will also make accountability for outcomes more problematic as it will be significantly harder to link demographic and epidemiological data to commissioners' registered populations. There are strong arguments for seeking co-terminosity between commissioners and defined geographical areas.

### Recommendations

- System leadership is needed at the regional level and this should be provided by multi-professional clinically led groups or clinical cabinets.
- As far as possible GP commissioning boundaries should be aligned to geographical and local authority boundaries in order to address population health issues including tackling health inequalities, promoting public health and serving the needs of hard-to-reach groups.

### *Professional divisions: the need for clinical integration*

Demographic changes and the shifting burden of disease mean that the sharp division between primary care and secondary care is increasingly unhelpful. Patients who are the most intensive users of care need to access expertise from generalists as well as specialists and from different members of the health and social care team.

The implication is that at all levels of the NHS and social care there should be a commitment to clinically integrated care. The use of integrated health and social care teams aligned with GP practices to meet the needs of older people in Torbay illustrates what this means at a local level. The example of the integrated diabetes service in Bolton in which community-based specialists work closely with GPs and nurses demonstrates how barriers between professionals can be broken down across a health community.

Building on these examples, commissioning consortia should include involvement from specialists and other clinicians. This will help to facilitate the redesign of care pathways and to overcome the fragmentation and lack of co-ordination that prevents the NHS becoming truly world class in the delivery of care.



### Recommendations

- Multi-professional collaboration needs to be supported at all levels within the NHS.
- GP consortia should have a 'duty' to engage and collaborate with the other clinicians responsible for the care of their patients.
- Opportunities to develop multi-professional teams to support the needs of high-risk patients such as frail older people should be a core element of services at local level, as is already the case for patients with chronic mental health problems.

### *Financial incentives: the need to align incentives to support integrated care*

The financial pressures on the NHS and the need to reorient the provision of care towards prevention and care outside hospitals make it imperative that financial incentives are modified to support integrated care. Payment by Results has a continuing role in relation to planned care, including diagnostic services, outpatient appointments and elective surgery, where the emphasis needs to be on competition in the market. In the case of unplanned care, the provision of specialist services, and particularly the needs of older people and people with complex needs, the priority should be to develop ways of paying for care that reward good outcomes and avoid perverse incentives to increase hospital activity.

Experience in the United States of new forms of payment that go beyond fee-for-service and case-based reimbursement contains pointers on possible options (Shih *et al* 2008). These new forms of payment include episode-based payments that bundle together payments for a range of services relating to a particular episode of care. An example from Geisinger Health System is the use of a global fee that covers the entire cost of cardiac care from pre-admission through surgery to follow-up for 90 days after the operation.

There are various ways of adapting the current mechanisms to better support integrated care; for example (Ham *et al* 2011):

- combining payments to cover an episode of care or care pathway
- exploring the idea of the 'year of care' that has been tested in three national pilots for diabetes

- contracting with local clinical networks (of primary, secondary, or primary and secondary care clinicians) or foundation trusts to deliver integrated care for a specific population
- using personal health budgets to enable patients with support from carers and families themselves to commission care packages
- using CQUIN payments across pathways of care to incentivise best practice models and collaborative working
- increasing use of pooled budgets.

A further approach is for commissioners to place a contract with a lead or prime contractor to provide services for patients with a specific condition or disease like diabetes. Such an approach is being piloted in the East of England through work on commissioning integrated pathway hubs where the chosen provider will work under an agreed budget. While this work offers the potential to help move beyond fragmented and episodic care, there is a risk of creating new silos centred on conditions and diseases in place of existing silos.

An alternative would be for commissioners to contract for the provision of care to populations such as frail older people with complex needs who account for a high proportion of utilisation and expenditure. This would draw on the experience of areas like Torbay and might encompass social care as well as health care. An added attraction of this approach is that commissioners could use their leverage to promote integration of health and social care rather than this being achieved through structural change. Integrated care focused on populations would most likely be funded through capitated budgets that reflect the needs of these populations.

Whatever approach is adopted, it will be important to ensure that incentives are put in place to reward improvements in the quality of care and to avoid patients being under-served. Again, experience from the United States is relevant, as in the Alternative Quality Contract being tested by Blue Cross Blue Shield Massachusetts (Chernew *et al* 2011). Under this contract, which has some similarities with the quality and outcomes framework in general practice, medical groups are able to earn extra income based on their performance against a range of measures of quality relating to primary and secondary care.

## Recommendations

- Alternatives to the tariff are needed for non-elective, long-term and complex care.
- These alternatives may include bundled payments, pooled or delegated budgets and capitated budgets.
- Any payment mechanism adopted needs to ensure that financial rewards are linked to the quality and outcomes of care.

### *Competition and regulation: the need for a nuanced approach that recognises the complexity of health care*

Competition and collaboration are means not ends. Ministers must ensure that Monitor adopts a nuanced and proportionate approach that encourages both collaboration and competition where appropriate. All organisations involved in commissioning and providing care should be required to collaborate where this will bring benefits to ensure that the integration is 'hard wired' into the NHS of the future. The primary and sole duty of Monitor should be the protection and promotion of the interests of patients and the public.

In promoting competition where appropriate, Monitor must recognise the complexity of health care and the risk of encouraging the wrong kind of competition. Different services lend themselves to different approaches with competition in the market likely to work best for planned and elective care and competition for the market being appropriate for unplanned care and specialist services. Competition for the market can encourage co-operation and information-sharing among providers along a patient pathway as well as for patients with complex needs who do not fit easily into disease-based pathways.

It will be important to determine the most appropriate unit of competition. In some cases this might be the hospital or provider of community services and in others it could be a provider or co-ordinator of integrated care. In many cases, services will need to be planned and delivered across networks, with patients and their clinicians able to select a provider who can deliver high-quality packages of care over time, if necessary in collaboration with other providers.

The example of stroke services illustrates this point. [Evidence from Manchester and London summarised](#)

earlier demonstrates the benefits that arise when hospitals work in networks and specialist stroke services are concentrated in fewer centres to deliver better outcomes. Monitor should support developments of this kind and not see them as anti-competitive.

Monitor and the NHS Commissioning Board should also ensure that there is neither a proliferation of specialist services nor inefficient duplication as providers compete for market share. The NHS Commissioning Board can offer guidance on how to commission integrated services in different areas of care and provide advice and support on contractual routes, currencies and incentive schemes, and outcome indicators for assessment of progress. Equally, Monitor should guard against the wrong kind of integration and the risk that collaboration fails to deliver the improvements in performance that are needed.

Monitor needs to draw on experience in other sectors as it takes on its new responsibilities. While there are no direct parallels to the health sector, the experience of regulation of the railways has some relevance, especially in the award of long-term franchises to rail operating companies and in the emphasis placed on networks of provision (Walker 2011). Monitor and the NHS Commissioning Board can also support yardstick competition by the transparent reporting of performance in the market.

## Recommendations

- Monitor and the supporting regulations for NHS procurement need to promote both competition and collaboration.
- A duty to collaborate should be a requirement for all organisations providing or commissioning NHS care.
- The NHS Commissioning Board should provide guidance to support the commissioning of integrated care and should hold commissioning bodies to account against a transparent outcomes framework.

### *Information management and technology*

Like financial incentives, information can be a major enabler or barrier to integrated care. Policy needs to support the effective sharing of meaningful information for patients, providers and commissioners. The use of patient-held records should be actively encouraged.

### Recommendations

- Anyone providing or commissioning NHS care should be required as part of their licensing agreement or statutory function to share relevant information with patients and professionals.
- Monitor should include common protocols, data protection policies, data definitions and technology standards to facilitate the sharing of information in its licence.

### *Functional separation between commissioner and provider*

Proposals for commissioning consortia will help to ensure that commissioning decisions are led by clinicians and this is likely to bring benefits. As discussed earlier, consortia will need to collaborate to undertake some functions effectively and they will require excellent management support. There is a need to be clear about where in the system some of the strategic functions of commissioning will take place as not all of these are appropriately done at the level of consortia or consortia working together.

The development of clinical cabinets at a regional level as part of the NHS Commissioning Board as proposed earlier will assist in ensuring that these strategic functions are carried out effectively. This includes leading improvements in specialist services such as stroke and trauma care where reconfiguration of services across large populations may be needed. The combination of commissioning consortia and clinical cabinets at a regional level will go some way to overcoming the separation between commissioners and providers and in the final section of this paper we outline an evolutionary path that could go much further.

### Recommendations

- The NHS Commissioning Board should establish clinical cabinets at regional level to take on some of the strategic commissioning functions from consortia.
- The Bill must retain the flexibilities to allow consortia to cluster together and pool budgets as appropriate to undertake those aspects of commissioning better done at a more strategic level.

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## Beyond the current reforms: the case for radical evolution

The outstanding question is how far will the proposed reforms with the modifications we have outlined help to facilitate the new model of integrated care focused on the needs of patients required in the future? Our view is that while there is potential for commissioning consortia that involve clinicians from a range of backgrounds to support the emergence of new models of provision including federated networks of general practices and integrated care for people with chronic diseases and complex needs, the insistence on there being a continuing separation between commissioning and provision could inhibit development in this direction. This is because commissioning consortia as statutory bodies will not have the flexibilities to take the decisions to either provide services directly or commission them from others that are needed to implement integrated care. If the outcome of the listening exercise is to proceed with consortia, and to make modifications to their design along the lines we have proposed, then what more could be done to support evolution in the direction towards the new model of care?

The answer can be found by returning to the experience of integrated medical groups in the United States working under capitated budgets as well as the achievements of long-established integrated systems like Kaiser Permanente. Integrated medical groups that have been successful in delivering high-quality integrated care to patients combine responsibility for commissioning and provision (Curry and Ham 2010). One of the characteristics of these organisations is that they enable groups of GPs and specialists to take 'make or buy' decisions by linking clinical and financial responsibilities. In this way, they create a platform on which doctors who control budgets are able to provide care directly where this is appropriate and to commission from other providers where it is not.

Integrated medical groups working under capitated budgets perform well on a number of indicators and they have strong incentives both to meet the needs of patients (because they compete with other groups) and to use resources efficiently (because they benefit from any savings made). Evidence from the 1990s onwards shows that groups were successful in reducing the use of hospital beds, and more recent studies indicate that

larger groups are able to provide higher-quality care to patients at lower cost than other types of practices. Integrated medical groups deliver these results because they are both providers and commissioners and are able to use the clinical expertise of doctors to deliver improvements in care.

The King's Fund has recently studied experience in Massachusetts, where integrated medical groups ranging in size and scope have a long tradition of working in this way. These groups work closely with health plans, which monitor the use of resources by medical groups to ensure that the financial incentives under which they operate do not result in patients being denied access to necessary care or receiving care of poor quality. Groups are also rewarded by the plans based on their financial performance and ability to improve the quality of care. Some of the health plans have adopted incentive schemes that encourage medical groups to work closely with hospitals to improve quality through closer integration of care.

As this example shows, commissioning involves two distinct functions: clinical commissioning (or what we referred to earlier as micro commissioning) in which integrated medical groups use their control of budgets to improve the provision of care; and strategic commissioning in which a health plan takes responsibility for funding for a large population and supports clinical commissioners to undertake their functions effectively. GPs and other clinicians in the NHS are in our view much more strongly motivated to engage in clinical commissioning than strategic commissioning not least because this will enable them to make rapid improvements in how services are delivered. The requirement that commissioning consortia should only commission care and not be involved in providing services is likely to deter some of the most innovative clinicians from playing a full part in commissioning because these clinicians are interested mainly in improving service provision by developing new models of care.

One way of addressing this challenge would be through evolution from the reforms currently proposed to what we would call integrated care partnerships that involve a wider range of health and social care professionals that both commission and provide services. Integrated care

partnerships might evolve from federations of general practices working in partnership with relevant health and social care professionals to form organisations that take on a capitated risk-bearing budget to deliver services for a defined population. These organisations would be in a position to take 'make or buy' decisions, including developing networks of providers in which the co-ordination of care to meet the needs of patients is actively encouraged.

We would envisage these organisations being not for profit, for example, social enterprises or community interest companies. One of the advantages of this approach is that it would be easier to promote mergers and to forge alliances and partnerships than in the case of commissioning consortia that are statutory bodies. This would help to avoid the destabilising effects of organisational restructuring that we referred to earlier.

The NHS Commissioning Board and its clinically led regional offices could over time take on the higher level strategic commissioning functions from consortia and be accountable for the use of resources. The Board and the clinically led regional offices would retain a strong population and geographical focus. They would lead significant service change, for example, around the reconfiguration of hospitals and set commissioning priorities and goals. A critical role would be to oversee how integrated care partnerships use their resources and to provide the appropriate regulatory assurance in association with Monitor and professional regulators. They would also have strong relationships with health and wellbeing boards. In urban areas, where there might be more than one integrated care partnership, patients would be able to choose which partnership they register with.

Patients who register with a practice that is part of an integrated care partnership would be able to exercise choice of provider within the partnership as well as choosing to use services outside the partnership where these are not provided by the partnership itself. The point to emphasise is that integrated care partnerships would lever the benefits of collaboration among GPs, specialists and other care professionals and they would be stimulated to provide responsive and high-quality services through the knowledge that patients in urban areas would be able to join another partnership, say on an annual basis, if they were dissatisfied with their care.

In this way, choice and competition would go hand in hand with collaboration.

Moving in this direction beyond the current reforms would be a radical step. Many of our proposals have been set out at a high level and more work is needed on the detail. It is for these reasons that we have emphasised the need for an evolutionary approach that starts from the reforms currently proposed, modifies these reforms in the way we have suggested, and creates a basis for further changes in the light of experience. This kind of approach would help to avoid further top-down restructurings and would encourage experimentation from within the NHS led by innovative clinicians and managers. In our view, there would be merit in testing the radical option in one or two regions to explore the risks and benefits of such an approach.

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## Summary and conclusion

The proposals set out in this paper are offered as a constructive contribution to the listening exercise with the aim of building on recent progress in improving the performance of the NHS in England and creating the foundations on which the NHS can rise to future challenges. The proposals are intended to be a co-ordinated package of ideas for improving the government's current plans that need to be acted on together. If the government's response to this paper is to take forward some proposals and ignore others, then it is unlikely that the plans will be strong enough to address the concerns we have expressed in recent months. It is also important to emphasise the need to evolve in the direction we have proposed rather than to embark on a rapid process of change, and in doing so to retain experienced leaders whose involvement is essential to delivery of the Nicholson challenge.

We would argue that the proposals are both appropriate and proportionate to the issues that need to be addressed and that, if executed well, they should enable the NHS to meet the Nicholson challenge and above all to improve outcomes for patients. Some of our proposals, such as those on economic regulation, require modifications to the Bill, but most can and should be dealt with through established policy-making processes. The agenda set out here must be taken forward as a matter of urgency to remove barriers to the delivery of integrated care and to tackle the core challenge of an ageing population in which chronic medical conditions represent a threat to the sustainability of a universal, comprehensive, tax-funded health care system.



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