JOINED UP THINKING

The government hopes that integration of services will improve care, but as **Nigel Hawkes** reports the pilot schemes have a lot to prove

Sixteen organisations have been chosen to pilot new models of integrated care in the English National Health Service. The scheme, announced in the Darzi review last July, aims to improve services for defined groups of patients by integrating health and social care, or primary and secondary care, or both.

The pilots announced on 1 April include seven that will focus on long term conditions or chronic diseases, three on elderly people and end of life care, two on dementia, and one each on falls, mental health, delivery of rural health care, and substance misuse. Geographically the pilots are unevenly spread, with four in the North East Strategic Health Authority, four in the South West, but none in South Central, South East Coast, or West Midlands (box). The 16 were chosen from 100 applications.

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Integration has long been an article of faith among NHS commentators, and the new Care Quality Commission expresses that faith by combining the regulation of health and social care in a single organisation. But previous efforts to achieve integration have a mixed record. Since 2000 it has been possible to achieve integration through creating care trusts, but only 10 have been set up. UnitedHealth's Evercare scheme, which sought to achieve seamless care through better case management, was piloted in nine primary care trusts (PCTs) in 2003-4 and achieved some improvements but no significant effect on admissions, bed days, or mortality.

This uncertain background explains why integrated care is being piloted, rather than launched nationally. The pilots will run for two years before being evaluated for a further three years. They will, says the Department of Health, "allow communities to take a fresh look at how to deliver health and social care, based solely around the needs of the local population." The successful bidders have been urged "to look beyond traditional boundaries (such as between primary and secondary care) to explore whether new, integrated models can improve health and social care services."

Rebecca Rosen of the Nuffield Trust, a general practitioner and an expert on integrated care, says that the challenge will be to show that the extra costs of integrated care are outweighed by savings from fewer hospital admissions. "The evidence base is not very strong," she admits. "There is very little robust evidence that integrated care can reduce admissions."

She says that the pilots cover a diverse range and will be evaluated by experienced researchers. "They will be looking for two things," she says, "better experience of care for the patients and greater cost effectiveness.

"Integrated care isn't new—there are papers in the literature going right back to the 1970s. Generally, patients appreciate it and rate their care as better, but the cost can go up because of better medication. Both prescribing and compliance increase overall, so spending increases."

Some pilots have a head start. Torbay is already a care trust and will be piloting integrated care for elderly people across primary, secondary, social care, and mental health services. Chris Ham, professor of health policy and management at the University of Birmingham, writes in a recent report for the Nuffield Trust that Torbay has achieved some improvements in care, including quicker assessment and delivery of intermediate care and an improved rating from the Commission for Social Care Inspection, the predecessor of the Care Quality Commission.

Will integration work?

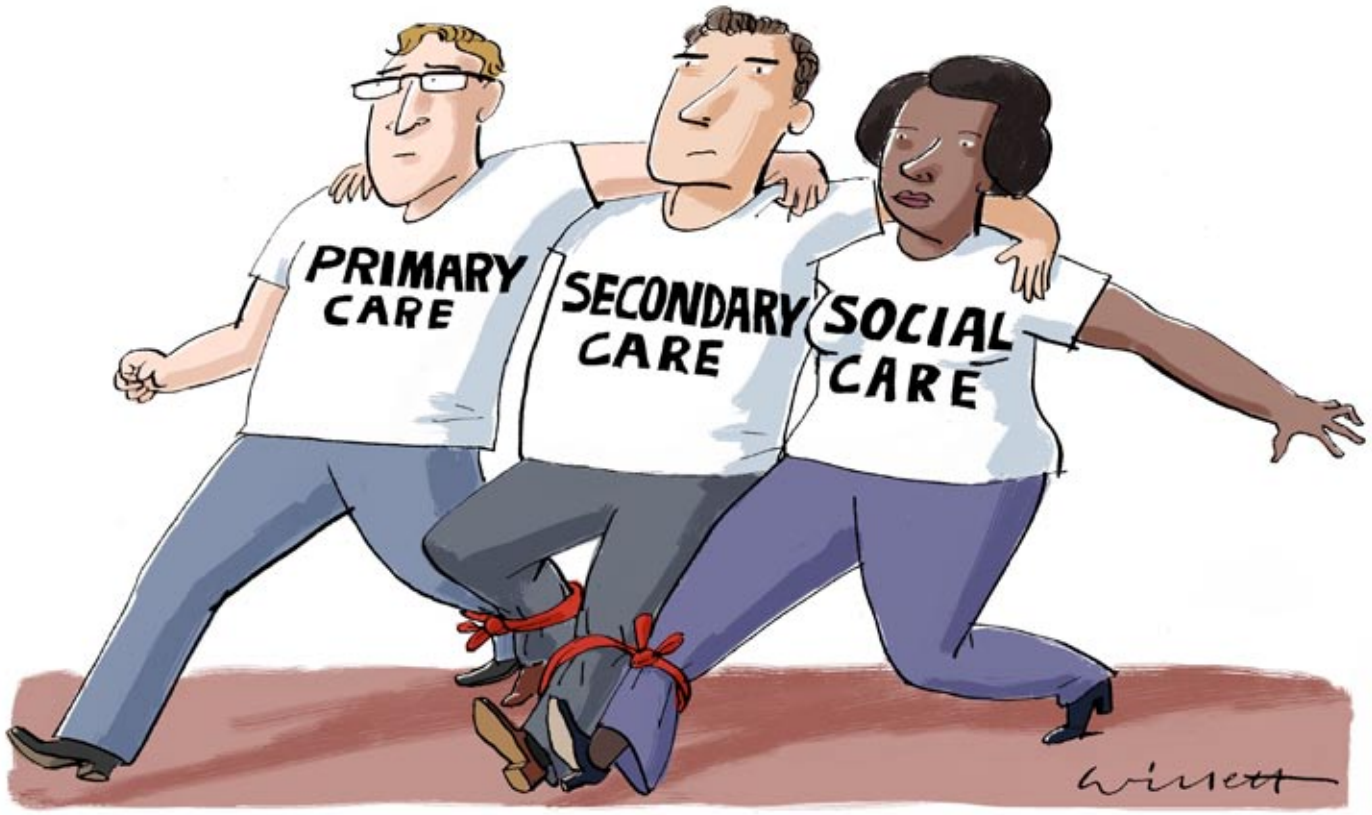
Integration means different things to different people. In the past, it has often consisted of ramming together organisations with different histories and cultures and expecting economies of scale and improved services to follow. "New and better types of care cannot be delivered by housing different professionals under one roof or merging multiple organisations," said Niall Dickson, chief executive of the King's Fund.

"It requires bringing teams together, integrating the way staff work, and creating new relationships between organisations. It is also important that we do not create new monopoly organisations around the NHS which deny patients choice—we need services that are responsive and understand that either patients or commissioners may decide to go elsewhere."

US experience also suggests that integration is easier in organisations that are both commissioners and providers of care. PCTs are now under strong pressure to get out of provision altogether, which could work against integration, warns Minoo Irani, a consultant paediatrician who represents the interests of consultants working in primary care in the NHS Alliance. Without clarity about the basics, he says, integrated care

Winning pilots

- Bournemouth and Poole Teaching PCT—Dementia care
- Cambridge Assura—End of life care
- Church View Medical Practice, Sunderland—Long term conditions
- NHS Cumbria—Chronic diseases
- Durham Dales Integrated Care Organisation—Rural health care
- Nene Commissioning Community Interest Company—Long term conditions
- Newcastle Hospitals NHS Foundation Trust—Reducing falls among old people
- Cornwall and Isles of Scilly PCT—Dementia
- NHS Norfolk and Norfolk County Council—Care of elderly people
- Northumbria Healthcare NHS Foundation Trust—Chronic obstructive pulmonary disease
- North Cornwall Practice Based Commissioning Group—Mental health
- Principia Partners in Care (Rushcliffe, Nottinghamshire)— Chronic obstructive pulmonary disease
- NHS Tameside and Glossop—Cardiovascular disease
- Torbay Care Trust—Care of elderly people
- Tower Hamlets PCT—Long term conditions
- Wakefield Integrated Substance Misuse Service—Drug misuse



pilots risk perpetuating fragmented health care, while still appearing integrated. "Confused enthusiasm is never a good thing on which to base health policy," he warns.

The Audit Commission has also expressed doubts about partnership working in the public sector, warning that it can generate confusion and weaken accountability. "Local public bodies should be much more constructively critical about this form of working," it said in 2005. "It may not be the best solution in every case. They need to be clear about what they are trying to achieve and how they will achieve it by working in partnership."

The only London project to make the cut believes it has met these criteria. Tower Hamlets in East London, one of the poorest parts of the capital, is aiming to improve the health and wellbeing of patients with long term conditions, delay the progress of disease, and increase the uptake of services by hard to reach groups.

Anwara Ali, lead member for health and wellbeing at Tower Hamlets Council, says: "It's all about putting local people's needs to the forefront of everything we do and structuring how we work around that. In Tower Hamlets we have a very strong partnership in place with our health colleagues which will support us in this work." Alwen Williams, chief executive of NHS Tower Hamlets, says it is one of the trust's major priorities to improve care for people with conditions such as stroke, diabetes, and cardiovascular disease.

The evidence for integration, as summarised by the Department of Health, does not inspire huge confidence. It can be a successful way of breaking down barriers between primary and secondary care (vertical integration) and between health and social care (horizontal integration). But the evidence of vertical integration on costs, outcomes, and patient experience remains weak.

Context is important, the department's summary says. Supportive leadership, strong local partnerships, and effective information technology and administrative systems are vital. It concludes on a gloomy note: "Integration has seldom increased efficiency. This is due to such factors as significantly different practices existent in the organisations that are to be integrated; and the steep learning curve inherent in joining with another organisation. Longstanding power imbalances between acute and community care makes such integration a challenge."

Dr Rosen believes there are several elements that need to be right to make the integrated care pilots work. "They have to be smart about the way they use data. If you are going to achieve real integration, the challenge is to use available data to the full, and you have to invest effort and resources to achieve that. In successful US systems, a lot of what is achieved is down to the clinical information systems, providing prompts or protocols on screen, for example, or risk stratifying patients.

"Second, you need high quality clinical leadership and governance arrangements that make it clear what you are aiming to achieve. The challenge of good integrated care is to ensure that patients don't fall between the cracks. You need to build a shared understanding and invest a lot in team development.

"Finally, my other big question is whether financial incentives can be aligned to make it work. There are other NHS policies, such as patient choice, that can disrupt it."

If the pilots fail, at least the time and money wasted will be limited—assuming the department heeds Niall Dickson's warning not to roll them out before lessons have been learnt, as has happened in the past. If they succeed, they could transform the way health care is delivered, according to enthusiasts such as Peter Reader, medical director of Islington PCT. But past experience teaches caution. Many NHS reforms, heralded as revolutionary when launched, have gone out of fashion and been abandoned before they have had time to show either success or failure.

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Competing interests: None declared.
Cite this as: BMJ 2009;338:b1484