PROVIDERS DISTRICTS AND BOROUGHS NHS CHILDREN'S CENTRES WELLBEING COUNCILS LEISURE POLICE AND CRIME COMMISSIONER COMMUNITY SAFETY COMMUNITY COMMISSIONERS RESIDENTIAL SCHOOL NURSES HOSPITALS CHILDREN FIRE AND RESCUE SERVICE PROBATION ADVICE SERVICES NURSING HOMES GENERAL PRACTICE SOCIAL CARE OLDER PEOPLE POLICE HEALTH HOUSING JSNA FIRE COUNCILLORS PHARMACY AMBULANCE EDUCATION TRADING STANDARDS ENVIRONMENTAL HEALTH INDIVIDUALS HEALTH AND WELLBEING BOARD SERVICES VOLUNTARY PARISH COUNCILS HEALTH VISITORS SCHOOLS TRANSPORT PLANNING LICENSING LOCAL ENTERPRISE PARTNERSHIP LIBRARY SERVICES

WARWICKSHIRE HEALTH AND WELLBEING STRATEGY 2014 - 2018

EVIDENCE REVIEW – INTEGRATION AND WORKING TOGETHER

WARWICKSHIRE HEALTH AND WELLBEING BOARD

This evidence review supports the Integration and Working Together chapter of the Warwickshire Health & Wellbeing Strategy (2014-18)

Definitions of Integration and Integrated Care

The UK National Collaboration for Integrated Care and Support (NCICS) defines integrated care 'as the support built around the needs of the individual, their carers and family and that gets the most out of every penny spent'. The NCICS view is that if the illness is prevented, the condition properly managed, the fall avoided, that not only is that better care for the individual but it also means less pressure on the system (NCICS, 2013). Person-centred coordinated care and support is promoted as being key to improving outcomes for individuals who use health and social care services (NCICS, 2013). National Voices (NCICS, 2013) define integrated care and support as being able to plan one's own care with people who work together to understand the individual and carer(s), allow control, and bring together services to achieve the outcomes important to the individual.

Care coordination like integrated care does not have a universally recognised definition. Other terms are frequently used to describe this, such as case management, disease management or multidisciplinary teams (McDonald et al 2007). The terms coordination and integration are frequently used interchangeably, though the former tends to refer to patient focused or clinical interventions while the latter focusses on organisational or managerial issues (Kodner, 2009) (Kings Fund, 2013)

Policy Context of Integrated Care

Integration and working together has been a long standing ambition for government and organisations responsible for delivering care for many years. Better partnership working between health and social care services has been a source of considerable aspiration, application (in terms of new initiatives, directives and incentives) and frustration for national and local policy leaders for a considerable period (Glasby & Dickinson, 2008).

In the 1980s greater emphasis was placed on partnership working. Early policies focused on breaking down organisational barriers and getting the NHS to forge stronger links with local authorities (Department of Health, 1997). The need to achieve integrated care across health and social services to support people with multiple needs was given greater emphasis in The NHS Plan (Department of Health, 2000). Over the next decade, this policy direction continued and various White Papers such as Our Health, Our Care, Our Say (Department of Health, 2006) and the Next Stage Review report High Quality Care for All (Department for Health, 2008) set out how integrated care may be developed; but it was not until the Health and Social Care Act of 2012 that it became a statutory duty to promote integrated care (Kings Fund, 2014).

However, significant barriers to achieving integrated care in England remain. Budgets within the NHS (General Medical Services and Hospital and Community Health Service) and between the NHS and social services are separate. Institutional separation between primary care (independent small businesses – GP practices), hospital care and social care (commissioned or provided by local authorities) is a significant obstacle (Lewis RQ et al, 2010). Staff employed by these different institutions may work together but they can be separated through different cultures, and different terms and conditions. A lack of integrated data and information systems between care providers is another barrier (Goodwin et al, 2013). Some of these barriers have been successfully overcome in some parts of the country but generally can continue to hinder progress and prevent integrated care being delivered on a large scale (Kings Fund, 2014).

International and National Examples of Integration

The United States view on integrated care and working together has been focused around the development of accountable care organisations (ACOs). The basic concept of an ACO is that a group of providers agrees to take responsibility for providing all care for a given population for a defined period of time under a contractual arrangement with a commissioner. Providers are held accountable for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target (Kings Fund, 2014). Conversely Integrated Care Partnerships (ICP's) in Northern Ireland are described as a cooperative network between existing providers that design and deliver high quality services that will be clinically led. Much of the focus of ICP's is around improving key aspects of the way services are organised for older people and those with long term conditions. ICP's are aimed at preventing hospital admissions by identifying patients most at risk and will proactively develop strategies to manage health and social care needs. It has been suggested that working in this integrated way will reduce or prevent hospital admissions (Kings Fund, 2013). Oversight of Integrated Care

The Case for Integration and Working Together

The rationale of integration is based on the premise that there are efficiencies and savings to be made through improved co-ordination and coproduction (Kings Fund, 2014). Overall the belief is that integrated care and support can help to remove gaps and reduce duplication in existing service provision, improve effectiveness, safety, and the experience of patients and people who use services. Integrated care is also expected to promote equality and improve access for all (NCICS, 2013).

The need to coordinate and tackle the rising demands placed on health systems by ageing populations with complex needs has become central to national strategies (Kings Fund, 2013).

Cost pressures associated with those ageing populations and an increase in the numbers of people with chronic illness create a need for more accountable and integrated forms of delivering health services. People seeking care frequently require support from a range of different settings – hospitals, primary care, clinics, nursing homes and home care agencies. Each organisational silo faces a different set of constraints and incentives, and consequently each part works to optimise its own performance with little, if any, consideration for other parts in the care delivery system. There is duplication and gaps in information and communication, resulting in variable quality of care and high costs. More integrated approaches to care delivery are required to improve the quality and patient experience of care, as well as the overall health of the population, and to reduce the rate at which costs are rising (Kings Fund, 2014).

As a result of the ageing population and increased prevalence of chronic diseases, this requires a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated (Kings Fund, 2013).

Integrated care is necessary for any individual for whom a lack of care co-ordination leads to an adverse impact on care experiences and outcomes. It is an approach best suited to frail older people, children and adults with disabilities, people with addictions, and those with multiple chronic and mental health illnesses, for whom care quality is often poor and who consume the highest proportion of resources. It is also important for those requiring urgent care, such as for strokes and cancers, where a fast and well-co-ordinated care response can significantly improve care outcomes (Goodwin et al, 2012).

The aim of integrated care is to support improved outcomes and experiences for individuals and communities through (NCICS, 2013):

- Individual experience of integrated care and support that is personalised and coordinated.
- Population based public health, preventative and early integration strategies.
- Shift away from over reliance on acute care towards focus on primary care.

Oversight of Integrated Care

The role of Health and Wellbeing Boards, convened by local authorities following the Health and Social Care Act 2012, are focused around playing a key role in coordinating the activities of the different groups of commissioners (Kings Fund, 2013). Collectively, the task of this set of commissioners is to deliver a sustainable health care system in the face of one of the most challenging financial and organisational environments the NHS has ever experienced. The task is especially challenging in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing else changes in the NHS, will be significant unmet need and threats to the quality of care (Kings Fund, 2013).

Organisational barriers to integrated care Health and Wellbeing Boards may face include (Goodwin et al, 2012):

- NHS management culture talking about innovation but demonstrating a 'permission based' and 'risk averse' approach.
- The divide between primary, secondary, health and social care.
- Lack of time and sustained project management support accorded to demonstration sites.
- The absence of robust shared electronic patient records.
- Weaknesses in commissioning, focusing on individual organisations rather than a partnership approach.

Policy barriers to integrated care include (Goodwin et al, 2012):

- Payment by results approach to funding hospital activity – leading to increased activity and decreased lengths of stay.
- Choice and competition of policy – sometimes contrary to the desire for integrated care.
- NHS regulation focusing too much on organisational performance and not enough across organisations and systems.
- Multiple outcomes frameworks with few shared objectives with a need to develop a single outcomes framework to promote joint accountability for delivering services that are joined up for patients, service users and their carers.

Recommendations for Successful Integration

By concentrating on components of care rather than specifying where care should be provided or who should provide it, the aim should be around focusing on older people and their needs rather than service structures. To achieve this, Oliver (2014) uses nine components to describe how this should be achieved:

1. Age well and stay well.
2. Living well with one or more long term condition.
3. Support for complex co morbidities.
4. Accessible effective support in a crisis.
5. High quality person centred acute care.
6. Good discharge planning and post discharge support.
7. Effective rehabilitation and reablement.
8. Person centred, dignified long term care.
9. Support, control and choice at the end of life.

Commissioners should be supported to be able to use their leverage to support the development of integrated care through innovations in payment systems and contracting (Kings Fund, 2014). There is rationale to focus on the small proportion of people who account for a high proportion of use and cost through risk stratification (Kings Fund, 2014). A case management and care co-ordinated approach is recommended to support these high cost/use people (Kings Fund, 2014).

There is a need to support the development of integrated care through information sharing and investment in information technology (Kings Fund, 2014). The need to engage patients and to support them to play a bigger part in managing their health and well-being with support from information technology is integral to integration and ensuring people access services upstream as opposed to inappropriate use of emergency care (Kings Fund, 2014).

If the vision for a more integrated health and social care system is to be realised in scale and pace, organisations must adopt an enabling framework to guide integrated care over the coming years, to include (Goodwin et al, 2012):

- Provision of a compelling and supporting narrative for integrated care.
- Allow innovations in integrated care to embed.
- Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies.
- Support commissioners in the development of new types of contracts with providers.
- Allow providers to take on financial risks and innovate.
- Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework.
- Ensure clarity on the interpretation of competition and integration rules.
- Set out more nuanced interpretation of patient choice.
- Support programmes for leadership and organisational development.
- Evaluate the impact of integrated care.

If the Better Care Fund is going to prevent people from being admitted to hospital and result in improved care, the role of the voluntary sector in delivering it needs to be strengthened. It is recommended to request Health and Wellbeing Boards be mandated to engage with the voluntary sector as an equal and active partner in planning and delivering the Better Care Fund (McNicoll, 2014).

Conclusion – Integration in Warwickshire

Many organisations have a role to play to ensure successfully integrated services. It is imperative to consider the needs of the individual and ensure they are at the heart of services working together. Desired outcomes from successful integration of service delivery in Warwickshire should include, person centred coordinated care using a case management approach, co-production, improved outcomes for individuals, reduced pressure on the system by preventing illness, managing conditions effectively, appropriate use of primary care, appropriate discharge and reablement (NICS, 2013). All of these outcomes should be underpinned by best practice, support from the community and voluntary sector, national evidence and work towards achieving a positive impact against the priorities in the JSNA.

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