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Building integrated care

Lessons from the UK and elsewhere



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Registered Charity no. 1090329
Published by the NHS Confederation
ISBN 1 85947 122 6
Ref: BOK56101

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Introduction

For many years health policy development in the UK has been constrained by an artificial divide between primary and secondary care. This division is largely historical and seems to reflect ancient divisions within medicine rather than how patients use services. Integration has great potential to redesign care around the needs of patients rather than NHS structures, particularly for patients with long-term conditions. Whilst integration is a desirable objective for many services, and the launch of *Commissioning a patient-led NHS* has increased interest in it, the evidence suggests that there are a number of pitfalls that must be avoided if successful integrated organisations are to be created.

This report reviews the evidence about integration, provides a conceptual framework and focuses on some of the pitfalls that await the unwary. It is intended to contribute to the debate about the future of out-of-hospital services and help NHS Confederation members and policy makers in their discussions and plans for the future.

A full version of the literature review is available at www.nhsconfed.org/docs/vertical_integration_lit_review

Integrating services

Vertical integration is one of the potential strategies for integration. It is the process of extending the scope of an organisation's activities by moving up or down the 'value chain'. For example, a supermarket might buy up its suppliers or a brewery purchase pubs. Economic theory suggests that for this to be an appropriate strategy the advantages of reduced uncertainty and improved economies of scope and scale must be greater than the increased costs of co-ordination and the loss of flexibility delivered by outsourcing parts of the process.

In healthcare there are two types of vertical integration:

- where agencies involved with patients at different stages of the care pathway are part of a single organisation – for example, the structural integration of primary, community and secondary care achieved by hospitals expanding their scope
- where the payer function is integrated with provision – integrated commissioner–providers – as in the 'pre-paid group practice' models such as Kaiser Permanente.

There are three routes towards integrated services:

- hospitals expanding outwards and downwards
- primary care expanding outwards and upwards
- through the formation of new organisations of healthcare delivery.¹

There is also a choice about how to do this:

- by creating formal organisational structures through diversification, takeover or acquisition; or
- by developing virtual organisations and networks held together through contracts.

There has been much interest in the first variety of integration – structural integration – and there is both UK and international experience of hospital-focused integration. The GMS contract has now stimulated the development of alternative providers of medical services (APMS), which offer opportunities for primary care to run a range of new services, including some previously provided by hospitals. More radically, practice-based commissioning could give rise to the second variety of integration – integrated commissioner–providers based around clinical groups.

Dimensions of integration

Much of the focus on integration has tended to be on structures and governance. This is, however, only one aspect; process and cultural changes are likely to be at least as important. The following typology builds on an existing body of work and identifies the key requirements for effective integration.^{2,3,4,5,6}

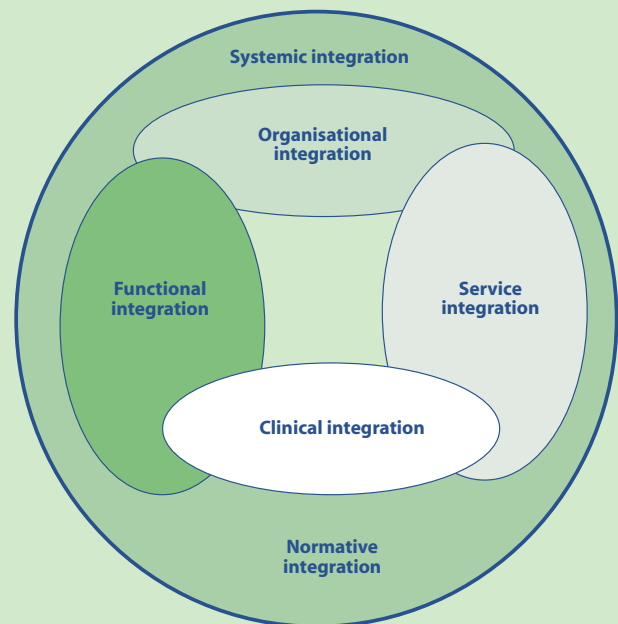
- 1 **Organisational integration** (or how the organisation is formally structured) – for example, by mergers and/or structural change or virtually through contracts between separate organisations.
- 2 **Functional integration** – how are non-clinical support and back-office functions integrated?
- 3 **Service integration** – at the organisational level, how are the clinical services offered by the organisation integrated with each other?
- 4 **Clinical integration** – at the clinical team level, is care for patients integrated in a single process both intra and inter-professionally through, for example, the use of shared guidelines along the whole pathway of care?

In addition, two factors are crucial in determining how successful integration is:

- 5 **Normative integration** – the role of shared values in co-ordinating work and securing collaboration in the delivery of healthcare.
- 6 **Systemic integration** – the coherence of rules and policies at the various levels of organisation.

A summary of this typology is shown in Figure 1.

Figure 1. Typology of healthcare integration



Source: Mowlam and Fulop (2005), adapted from Contandriopoulos and Denis (2001)

Real and virtual vertical integration: the evidence

Vertical integration – the US experience

Burns and Pauly reviewed the research evidence relating to vertical integration of hospitals in the US. The research points to some successful systems, such as Carle and Marshfield Clinics; these offer some valuable lessons, but Burns and Pauly argue that the health maintenance organisations (HMOs) launched had some significant and specific features of their environment which could be difficult to reproduce elsewhere⁷:

- The integrated system was focused around a well-established multidisciplinary team.
- Plenty of time was allowed to develop a coherent culture.
- When located within a rural area, there was less pressure from competitors (although in other settings it should be noted that competitive pressure was a trigger).
- An accumulation of managed care experience resulted from a well-established health plan.

Other attempts were not so successful where the drivers of this type of integration included:

- the need to lock-in referrals and increase bargaining power
- the need to improve the co-ordination of care
- the search for economies of scope and scale, leading to improvements in the quality and efficiency of care and cost reductions in running the business.

A strategic response to this was the acquisition of primary care practices and, in some cases, community and rehabilitation hospitals. The results were

unimpressive and the large majority of systems made significant financial losses for a number of reasons:

- high acquisition costs
- inappropriate choice of primary care practices
- insufficient cash flow at the practices
- lack of productivity and at-risk compensation incentives for clinicians
- expected increases in market share failing to materialise
- the organisation not having shared objectives with primary care clinicians and failing to engage either their hearts or minds
- economies of scope and scale not emerging, not least because of cultural differences between small businesses providing primary care and large, complex systems providing secondary care.

As a result, many hospitals downsized their networks of primary care clinicians before any of the intended benefits could be realised.

Strategic alliances between hospitals and specialist clinicians working outside the hospital setting had similarly poor outcomes. This seemed to be related to a lack of managed care infrastructure and problems in the relationship between clinicians and hospitals, with multiple conflicting objectives. Secondly, business and financial performance failed to improve.

Some hospitals moved into the insurance market and set up HMOs. These attempts, with the notable exceptions highlighted above, were on the whole unsuccessful due to: low capitalisation; conflicting capital needs between hospitals and health plans; poor pricing of risk; and inability to market effectively, so hindering successful entry into competitive health markets.

Vertical integration – the UK experience

Evidence from the UK shows that formal **organisational** integration of acute and community care trusts which took place during the 1990s did not necessarily result in the delivery of more integrated care.⁸ The research demonstrated that effective forms of both formal and informal **clinical** integration could develop

regardless of the organisational configuration of the trust. Both formal and informal networks remained significant factors in the provision of child health services, and the authors argue that organisational structures did not create incentives to develop these networks. It may be that organisational integration led to an, often incorrect, assumption that the service was integrated at other levels. As a result, less effort was dedicated to creating more effective clinical integration.

Casestudies: Integrated emergency care

London Ambulance Service

The London Ambulance Service (LAS) is playing a pivotal role at the 'front end' of the NHS by managing access into the health system and influencing bed capacity across London. The LAS has redesigned its response to GP out-of-hours calls by placing more patients on pathways at or near home and integrating the tasking of all emergency and urgent responses.

All urgent and unscheduled calls are received by one call-handling centre. This includes calls to 999, urgent requests from GPs, GP out-of-hours calls and those transferred from the Metropolitan Police. NHS Direct also transfers urgent calls to the centre.

An integral part of the service is the use of emergency care practitioners (ECPs) who are able to straddle the boundaries between the emergency/acute system and primary/community care. ECPs are often a better initial response for most 999 patients than a traditional ambulance. They are familiar with all the local care pathways available in their area and can, therefore, refer or transfer patients to the most appropriate service. As a result, ECPs take fewer patients to A&E and offer better patient care at lower cost.

Essex Ambulance Service

The Essex Ambulance Service also has ambitious plans to create an emergency care trust. Rather than viewing non-emergency calls into the urgent care system as inappropriate, it is

redesigning the system to provide the most appropriate service for the patient.

The trust has estimated that less than 20 per cent of patients require immediate transport to A&E. The remaining 80 per cent can be dealt with effectively in the community using pathways and services closer to home and which respond more appropriately to their condition. The urgent care system is being redesigned by integrating 999 services, NHS Direct, GP out-of-hours and primary care.

The ambulance service is the biggest out-of-hours provider in Essex. The GP-led service operates out of eight primary care centres, three of which are co-located with an emergency department in an acute hospital. It is possible to make an appointment to see the doctor or to request a home visit from the GP or emergency care practitioner. The service is linked into district nurses, social services duty teams, mental health workers and palliative care. In the longer term, a redesigned emergency care system could become responsible for the management of A&E and all unscheduled and urgent care in the county.

The model is based on building partnerships with other service providers to give maximum coherence for the patient. This is of key importance as emergency care practitioners must have a very clear understanding of how to use out-of-hospital support to keep the patient out of hospital. Integrated pathways and assessment criteria are essential.

Casestudy: Brent Emergency Care and Diagnostic Centre (BECaD)

BECaD is the result of the joint endeavours of North West London Hospitals NHS Trust and Brent Teaching PCT. Their aim is to create “true clinical integration across the borough to ensure seamless high-quality services regardless of site of delivery.”¹¹ Whilst the project encompasses major redesign of the facilities at Central Middlesex Hospital, the key objectives centre on ease of access for the local population to high-quality primary care and disincentives to use hospital care.

Central Middlesex needed to radically redesign its clinical model as, although the traditional district general hospital (DGH) model was becoming unviable, the centralisation of acute hospital services was not an acceptable option. The response has been to develop a new model of delivering care – particularly urgent care. The service has the following components, which are shown in Figure 2:

- An urgent care service consisting of a personal medical service (PMS) primary care service is staffed by GPs and nurse practitioners. As well as providing treatment, the service can register patients with other practices in the primary care trust.
- An acute care centre with 100 beds is able to offer diagnosis and treatment for a wide range of acute conditions. From these beds, patients have access to a specialist who will visit them at the centre, whilst their day care is still delivered by the A&E medical team. Once the acute phase of

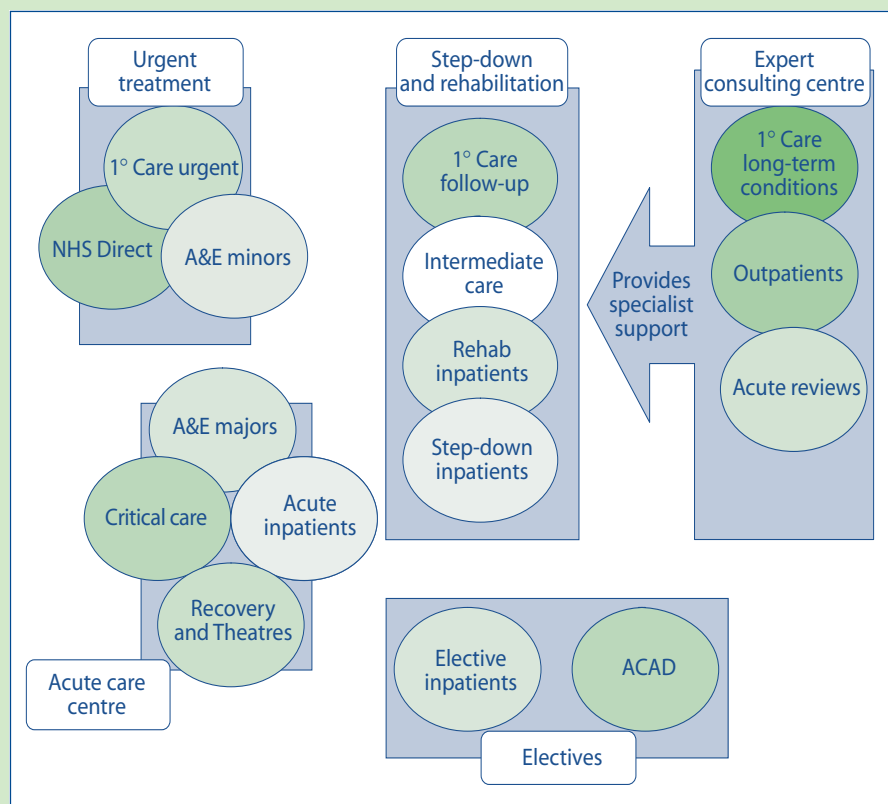
illness has been dealt with, patients will be moved to step-down and rehabilitation closely linked to home care services.

- An expert consulting centre replaces outpatients and provides specialist support to the step-down and rehabilitation services and to primary care, particularly in the management of long-term conditions.

Seven main concepts underpin the BECaD philosophy: integration of hospital and community services; rapid response; case management; empowered local teams; rapid throughput; local provision of care; harmonisation of approach.

The BECaD model is the result of many years of detailed clinical work which is still continuing. It is hoped it could provide one possible answer to the question of how to keep hospital services sustainable.

Figure 2. The BECaD model



Much of the residual concern about vertical integration was caused by the widespread ‘asset stripping’ of community services by the acute part of some integrated trusts. This arose from a combination of weak commissioning, which was a major feature of the healthcare system in the 1990s; an inequality in bargaining power between the different parts of the organisation; and the higher political profile given to acute hospital work, with an increasing focus on waiting lists as a proxy for high performance within the health service. Consequently, at least one integrated trust was compelled to de-merge and applications were discouraged in applicants for NHS trust status in waves 3 and beyond. The experience was not universal and conditions have now changed, so this problem may not reoccur.

Evidence on virtual integration

The study by King et al demonstrates the potential effectiveness of virtual integration.⁸ One important

model of virtual integration within healthcare has been clinical networks. In their review, Goodwin et al looked at the evidence for what makes clinical networks function effectively.² While these examples refer to networks, they also apply to more formal types of integration. They are:

- central co-ordination (if possible, by someone neutral)
- clear goals and reasonable boundaries
- inclusiveness in design and development
- not being too large – smaller groups work better
- cohesion increased through the development of ‘boundary spanning individuals’, and by using IT and shared guidelines and protocols
- professional leadership
- avoiding over-regulation and instruction
- avoiding ‘network capture’ by one professional group or institution
- having a clear business plan and mandate for management

Casestudy: Mid Hampshire Partnership

In January 2005 Winchester and Eastleigh Healthcare NHS Trust and Mid Hampshire Primary Care Trust came together as Mid Hampshire Partnership. They share a single chief executive, and other key staff are increasingly developing their roles to span both organisations.

The partnership took its lead from health plan models in the USA, particularly the model in Arizona and the model used by Kaiser Permanente in northern California, recognising that a patient focus pays dividends but achieving a sustainable financial balance was also critical for the partnership. Hence, integration took on two forms: integrated provision and a single executive team covering both provider and commissioner functions, minimising the impact of organisational boundaries.

The focus on managed, integrated care means that GPs and consultants work together on the care pathway and are slowly re-aligning work from secondary to primary care. The recent star

ratings would suggest that this approach is having a significant and successful effect. The partnership scored highly on rapid treatment of heart attack patients and they have hit the ‘four hour’ A&E target. Contrary to evidence that integration leads to neglect of community services, the partnership maintained their high score in these areas and is confident that it can sustain excellent prevention and promotion and community services as well as high-quality hospital care.

The partnership is confident that the new ways of working are making the system simpler for everyone. It feels that the time and money saved frees up staff to concentrate on further improvement. Locally, the management integration means financial problems are not simply pushed from commissioner to provider but managed together; incentives are now aligned across the partnership and there is a holistic approach to achieve optimal efficiency.

- engagement and connectivity
- adding value to members and others.

Managed clinical networks in Scotland

A number of pressures, such as quality of emergency care, workforce and the challenge of providing specialist care to a dispersed population, led to the development of managed clinical networks in Scotland. Multi-disciplinary teams of healthcare providers work together to provide appropriate and high-quality care irrespective of their organisational and professional boundaries.²

Although evaluations of these networks are on-going, early results show that while involving patients, sharing information, mapping patient pathways and constructing protocols, standards and guidelines have been relatively successful aspects of the network development, changes aimed at clinical and service improvement are not evident. A lack of involvement and commitment from the professionals involved were identified as two of the key reasons for this.⁹

The development of trust, goodwill, respect, communication and clinical interest are key parts of network building and need to be in place prior to the implementation of any structural changes. However, as managed clinical networks become more established in Scotland, there is a view that their development is being driven in an increasingly top-down manner, resulting in less effective outcomes.¹⁰ In such an atmosphere the importance of 'clinical champions' on the ground becomes increasingly important. Sustainability is, however, threatened if these champions leave.²

'Chains of care' in Sweden

The 'chains of care' model consists of a network of providers aiming to deliver high-quality, co-ordinated healthcare to patients. It differs from the Scottish networks in that there is a system of contractual relationships between purchasers and providers. Thus, a purchaser would set up a contract using a chains of care-based agreement

specifying volumes, costs and quality, with delivery overseen by a dedicated manager. One of the advantages of the Swedish model is that payments are based on the healthcare provided across a system. Therefore, incentives exist to develop integrated care and care pathways for patients.²

Although there is purported support among clinicians for the intended goals and outcomes of the chains of care, there have in fact been no significant changes in management systems and few changes to clinical services.¹¹ One of the key issues has been the difficulty of getting staff, both clinical and managerial, to embrace change by actually undertaking different roles and implementing new work practices. Ahgren argues that resistance is stronger among doctors than other healthcare professionals.¹¹

Chronic disease management

The chronic disease model developed in the US via the Group Health Co-operative of Puget Sound identifies six core components required to deliver effective care of chronic conditions: community resources and policies; healthcare organisation; self-management support; delivery system design; decision support; and clinical information systems.¹² It also recognises that chronic care takes place in three overlapping arenas: the community; the healthcare system; and the provider organisation.^{12,13}

A review of care delivered using this chronic care model, carried out in the US, demonstrated that whilst not all outcomes were positive, the majority of care did result in reduced healthcare use, costs or both.¹⁴ Ouwens et al examined the evidence from systematic reviews on the effectiveness of integrated care programmes and found that, despite the heterogeneity of interventions, there was a commonality of objectives – namely to reduce fragmentation and increase continuity and co-ordination of care.¹⁵ The wide variety of definitions and components of integrated care programmes made it difficult for the authors to be conclusive in their review, although the outcomes from the reviews they examined did seem to be positive. Integration with primary care is a key part of the successful implementation of this model.

Lessons for policy and practice

Lesson 1: Don't start by integrating organisations

Integration that focuses mainly on bringing organisations together is unlikely to create improvements in care for patients. It may not create integration at all without significant additional work. As with horizontal mergers, the danger is that the task of bringing quite different organisations together is at best a distraction from other tasks and at worst may create very significant problems.

All six aspects of integration – organisational, functional, service, clinical, systemic, normative – need **sustained** and **simultaneous** attention. Many attempts at integration have started at the organisational level. A more profitable approach might be to start at the level of the front-line team and the patient journey and then consider the most appropriate organisational form to deliver the required level of integration.

Whilst pursuing integration based on the pathway of care is attractive, some caution is required with models of disease management that 'carve out' a particular condition such as diabetes. These models run significant risks of fragmenting care and losing the benefits that come from co-ordination by primary care – particularly the management of co-morbidities. US experience suggests that outsourcing disease management may also increase the costs of co-ordination.¹⁶

Lesson 2: Economies of scope and scale are hard to achieve

Quality of care improvements for patients could be significant if integration leads to more co-ordination between formerly fragmented service providers. The potential economies of scope and scale from integration are likely, however, to take a considerable time to realise and are unlikely to justify integration on these grounds alone.

The US experience suggests that whilst there was an expectation that merging out-of-hospital services with hospitals would lead to economies of scope and scale, hence improving efficiency, there is very little evidence that this has been the case. The reasons for this are, in retrospect, quite obvious:

- Burns and Pauly point out that nothing in economic theory says economies of scale are inherent in vertical integration.⁷
- Many of the activities and the way that work is arranged in the organisations coming together are quite different and, therefore, the scope for improved efficiency is hard to realise.
- Substantial learning curves are involved in taking over a new business. These produce costs that may outweigh any economies of scope and scale from elsewhere.
- The increasing regulation of anti-competitive behaviour meant that hoped-for improvements in market position were not realisable.

Lesson 3: Cultural differences between sectors are a major issue

Overcoming cultural differences is a considerable challenge for all the organisations and clinicians involved in integration, whether real or virtual. This appears to have been underestimated in many of the studied cases. The organisation and culture of hospitals and the nature of hospital medicine are very different from out-of-hospital care – particularly primary care. The US experience suggests that cultural differences present very significant obstacles to creating alignment between different groups of clinicians and between clinicians and the integrated organisation. In particular, US hospitals which acquired small independent family practices did not understand them and tried to apply the management techniques, IT systems and approaches that worked in the hospital rather than tailoring them to the different culture of family practice.

Lesson 4: The right incentives

Providing appropriate incentives is an important consideration. Shortell argues that in order to achieve buy-in to integrated systems of care, clinicians not only have to be convinced of the clinical argument for changing service provision, but also need to have financial incentives.⁴ Evidence shows that where this is the case, as with the Permanente medical group within Kaiser Permanente, for example, then the critically important changes in clinical practice required to maximise benefits, as discussed above, are more likely to take place.^{17,18}

Lesson 5: Be patient

The time required to undertake and implement effective integration is a recurrent theme of studies in this area and is confirmed by the experience of NHS Confederation members. The tendency is to underestimate the time needed to deliver the desired benefits. This is unsurprising given the scope of changes needed to achieve integration as illustrated in the typology on page 4.

Lesson 6: Ensure that community services don't lose out

Any experiment with vertical integration needs to address this issue and develop active strategies to avoid problems. The reported weaknesses of community services in integrated NHS trusts may have been the result of commissioners failing to be sufficiently vigilant or specific about what they required from them, and also the obvious power imbalances between acute specialties and community services.⁸ This was compounded by cultural differences, particularly as community and other 'priority services' were often lumped together under one director, whereas hospital services were usually heavily represented on the trust board. Whilst practice-based commissioning may improve commissioning of community services it is not clear that there is an easy answer to the second, which is the result of wider power politics in healthcare and clinical practice. Corporate boards in integrated

organisations need clear strategies to deal with the power imbalance.

Lesson 7: Integrate for the right reasons

The US experience is that whilst integrated systems such as Kaiser have grown organically, attempts to create integration from scratch through take-over, merger and acquisition tend to have considerably less happy outcomes.¹⁹ This seems to have been related to some over-enthusiasm and a pursuit of integration for what, in retrospect, turned out to be mistaken reasons.

Questions to be answered when considering service integration

The following should be considered:

Are the new services related to the core business?

Burns and Pauly point out a key insight from the empirical and theoretical literature: unrelated diversification rarely creates real value.⁷

Can the objectives be achieved in other ways?

Although many patients have pathways that run between primary and secondary care, many do not. Even for those who do, integration may be achieved more effectively through contracts or networks. This would mean hospitals would be well positioned to provide early discharge, community rehabilitation, urgent care or some long-term condition management (see BECaD casestudy on page 7), but might be cautious about other less related services.

Is the 'make or buy' decision correctly balanced?

There are costs to internalising services, particularly if economies of scope and scale are not immediately obvious, the services are difficult to co-ordinate or the state of the market is very uncertain and prone to sudden downturns or technological change. The latter is clearly more of a problem for primary care services taking over hospitals or secondary care providers acquiring high technology or tertiary services than it is for integration from hospital to out-of-hospital care.

Is offsetting high hospital costs the objective?

Organisational integration may appear to offer the opportunity for hospitals with relatively high costs to spread their overheads over a wider cost base. The absence of evidence in the literature of significant economies from this sort of integration (apart from some limited back-office savings) means that this may not be a legitimate reason and could lead to all the services provided suffering. However, where hospitals can develop out-of-hospital services (either through direct provision or sub-contracting) that allow the redesign of their services, this may have a beneficial impact on costs (for example, by reducing length of stay) and on patients (by providing care in a better setting).

Does the proposed change create a monopoly?

If the answer is yes, it is likely this solution will be vulnerable to challenge by regulators or other future changes in policy.

Two hypotheses about integration

The following hypotheses seem to be plausible extrapolations of the evidence. They require further investigation.

1. Integration should lead to a reduction in hospital care

This has been one of the obstacles to its adoption in the US where admission is a major source of income.²⁰ However, if this is not an explicit objective of integration plans, then the question arises – what are the expected benefits? The US experience suggests that if hospital care is to be reduced, payment systems need to discourage admission and create incentives which ensure that beds are treated as a cost to the system rather than a source of income and profit. From this, two possible conclusions follow:

- Capitation may be more conducive to the integration of services for long-term care than a simple payment by results system – capitation provides a payment for a year of high-quality care rather than for individual episodes.

- The ownership of a large fixed asset base may be an obstacle to integration as it creates a strong pressure to generate income to cover overheads. This may discourage integration models that effectively reduce hospital use.

2. Integration from primary care upwards into hospitals may be beneficial

The viability of small and medium-sized general hospitals might be strengthened through integration as this may increase their ability to create a critical mass of clinical staff. This is the case with small hospitals in continental Europe where specialists work in primary care settings and provide support to the local hospital on a part-time basis. New models of physician employment may offer significant benefits in supporting this.

This approach also changes the dynamic of how services are provided. Primary care has a different approach to risk and patient management and the development of a joint approach can have significant benefits for patients.

Integration and system reform

The development of payment by results may produce some obstacles to integration by creating a 'zero-sum game' between primary care and hospitals. To achieve the benefits of integration, new mechanisms to deal with the potentially perverse impact of payment by results, particularly on the management of long-term conditions, may be needed. These mechanisms could include:

- pooled budgets with risk and benefit sharing between primary care and hospitals
- joint-venture arrangements between hospitals, practices and other providers
- a lead provider with sub-contracted commissioning, in which the lead provider takes responsibility for developing a network of providers. This is explored in an NHS Confederation consultation on mental health commissioning.²¹

Any separation of commissioning and providing caused by *Creating a patient-led NHS*²² will only extend as far as practices or localities. Consequently, localities could start to look like a combined payer and provider HMO. Localities will not have the pressure to improve that comes from competition for members and there is, therefore, potential for complacency. Other mechanisms would be required to correct this and might include patients having a choice of commissioner. This will be the subject of a future NHS Confederation *Briefing*.

Conclusion

There is strong evidence that integrated care can be an effective way of delivering healthcare and that it offers opportunities to break free from the stranglehold of the division between primary and secondary care that has constrained innovative thinking in the past. The evidence suggests that approaches which focus on integration around the patient pathway are more likely to be successful than those which involve the wholesale transfer of functions from other organisations. There is also good evidence that carving out particular disease groups and contracting care out to specialist providers should also be avoided, except for very specialist conditions, and close collaboration with primary care is important in all cases.

The unwary face a number of pitfalls, of which the most common are over-optimism about timescales and potential results, misjudging the dangers of unrelated diversification, and under-estimating the importance and difficulty of the cultural issues and management of change. Structural change is not a substitute for direct conversations with clinicians about changing the way the organisation delivers care.

As with much of the reform agenda, the importance of high-quality commissioning to hold integrated organisations to account is paramount.

The idea of integration based on capitated groups of clinicians with responsibility and accountability for the care of their population is interesting and deserves further exploration.

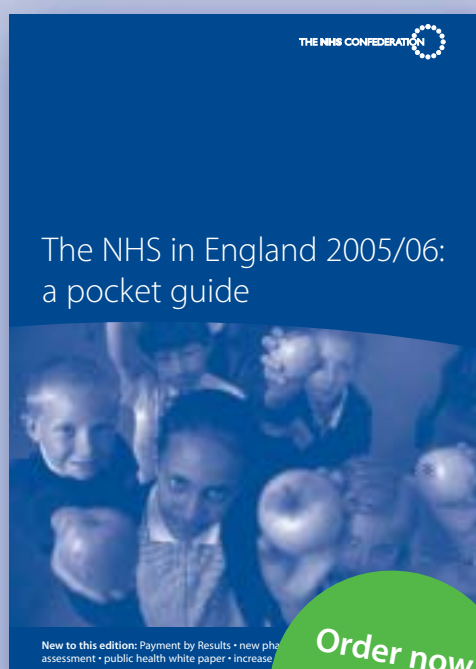
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References

- 1 Feachem, RG. and Sekhri, NK. 2005: 'Moving towards true integration', *BMJ*, 330, pp787–778
- 2 Goodwin, N., Peck, E., Freeman T. and Posaner, R. 2004: *Managing across diverse networks of care: lessons from other sectors*. Health Services Management Centre, Birmingham
- 3 Shortell, SM. 1996: *Remaking health care in America: building organised delivery systems*. San Francisco: Jossey Bass
- 4 Shortell, SM. 2000: *Remaking health care in America: the evolution of organised delivery systems*. San Francisco: Jossey Bass
- 5 Warner, W. and Gould, N. 2003: 'Integrated care networks and quality of life: linking research and practice', *International Journal of Integrated Care*, 3
- 6 Denis, JL. 2004: *Governing change and changing governance in health care systems and organisations*. Research proposal funded by Canadian Institute of Health Research
- 7 Burns, LR. and Pauly, MV. 2002: 'Integrated delivery networks: a detour on the road to integrated health care?', *Health Aff* 21(4), pp128–143
- 8 King, A., Fulop, N., Edwards, N. and Street, A. 2001: 'Integrating acute and community health care: integration versus cooperation? The case of child health services' in Asburner, L. (ed), *Organisational behaviour and organisational studies in health care: reflections on the future*. Palgrave
- 9 Hamilton, K., Taylor, R., Wyke, S., Baker, C., Scott, A. and Sullivan, F. 2002: *Evaluation of the pilot of a local managed clinical network for cardiac services in Dumfries and Galloway*. University of Glasgow
- 10 Hudson, B. 2003: 'The net worth of networks', *Health Service Journal* 113: 16
- 11 Ahgren, B. 2003: *Chain of care development in Sweden: results of a national study*. WHO/IJIC International Conference on New Research and Developments in Integrated Care. (Notes: www.ijic.org)
- 12 Robert Wood Johnson Foundation. 22 June 2005. Chronic care model
- 13 Bodenheimer, T., Wagner, EH. and Grumbach, K. 2002: 'Improving primary care for patients with chronic illness', *JAMA* 288(14), pp1775–1779
- 14 Bodenheimer, T., Wagner, EH. and Grumbach, K. 2002: 'Improving primary care for patients with chronic illness: the chronic care model, Part 2', *JAMA* 288(15), pp1909–1914
- 15 Ouwens, M., Wollersheim H., Hermens, R., Hulscher, M. and Grol, R. 2005: 'Integrated care programmes for chronically ill patients: a review of systematic reviews', *International Journal for Quality in Health Care* 17(2)
- 16 Bodenheimer, T. 2000: 'Disease management in the American market', *BMJ* 320 (7234), pp563–566
- 17 Light, D. and Dixon, M. 2004: 'Making the NHS more like Kaiser Permanente', *BMJ* 328, pp763–5
- 18 Shapiro, J. and Smith, S. 2003: 'Lessons for the NHS from Kaiser Permanente', *BMJ* 327, pp1241–2
- 19 Enthoven, A. and Tollen, C. 2004: *Toward a 21st century health system*. San Francisco: Jossey Bass
- 20 Professor Harold Luft UCSF, personal communication
- 21 *Mental health – the commissioning challenge*. NHS Confederation Consultation 21 September 2005
- 22 *Creating a patient-led NHS – delivering the NHS Improvement Plan*. DH 2005

Acknowledgements

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Building integrated care

For many years health policy development in the UK has been constrained by an artificial divide between primary and secondary care. The division is largely historical and seems to reflect ancient divisions within medicine rather than how patients use services. Integration has great potential to redesign care around the needs of patients rather than NHS structures, particularly for patients with long-term conditions.

Building integrated care reviews the evidence about integration, provides a conceptual framework and focuses on some of the pitfalls that must be avoided if successful integrated organisations are to be created.

This report is intended to contribute to the debate about the future of out-of-hospital services and to help NHS Confederation members and policy makers in their discussions and plans for the future.

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