

## Lessons from experience

# Making integrated care happen at scale and pace

March 2013

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**Why integrated care matters**

The King's Fund has been instrumental in making the case for integrated care (Ham and Curry 2011; Ham *et al* 2011; Goodwin *et al* 2012). Our argument is that the current fragmented services fail to meet the needs of the population and that greater integration can improve the patient experience and the outcomes and efficiency of care. This case was accepted by the NHS Future Forum, and the government in its response made commitments to promote integration. The challenge now is to convert policy intentions into meaningful and widespread change on the ground.

The aim of this paper is to support the process of 'making it happen' by summarising the steps that need to be taken to make integrated care a reality; we have drawn on our own work and that of others in areas where local leaders have identified integrated care as a core strategy. At the end of the paper we acknowledge that changes to national policy and to the regulatory and financial frameworks are needed for local leaders to fully realise a vision of integration.

The case for integrated care is reinforced by the need to develop whole-system working to address the demands arising from an ageing population and increases in the number of people with multiple long-term conditions. The evidence of the benefits, in particular to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be co-ordinated around the needs of people and populations. Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place.

We start from the assumption that the unprecedented financial and service pressures facing health and social care cannot be tackled by making incremental adjustments to existing services and ways of working. A step-change is needed given the prospect that public services face a decade of austerity in which budgets will either not increase (in the case of the NHS) or face further cuts (in the case

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of social care). This requires a commitment to whole-system working involving not only health and social care but also other services that influence the health and wellbeing of communities.

What needs to be done to make a reality of whole-system working, and where should we start? The answers will, of course, depend on the context in which public service leaders are working and the specific local challenges they face. There are no universal solutions or approaches that will work everywhere and the steps set out in this paper need to be read and interpreted with this in mind. There is also no 'best way' of integrating care, hence our emphasis on discovery rather than design when developing policy and practice.

Accepting all of these caveats, we offer these important lessons from the experience we have gained over the years about what is now required at a local level to develop integrated care at scale and pace.

## **1: Find common cause with partners and be prepared to share sovereignty**

During our work in England and other parts of the United Kingdom, we often meet public service leaders who recognise the seriousness of the challenges they face and understand that by working together they will be better placed to meet these challenges. This means finding common cause in overcoming fragmentation between services and developing more integrated models of care that are better suited to meet the needs of the population and are able to deliver better value for money. An early example of integrated care in north-west England expressed this common cause in terms of a desire to make best use of the 'Knowsley pound' through leaders of different public services sitting round the same table to agree how to achieve improved value for the local population from all of the public funding available in that borough (Ham 2009). The challenge this presents is that organisations may have to share some of their sovereignty in pursuit of the greater good of the population they serve – and this is not always easy.

## **2: Develop a shared narrative to explain why integrated care matters**

Our experience shows that public service leaders need to develop a shared narrative or story to explain to staff and users why integrated care matters. One example of this approach is the way in which a fictional ageing local resident – Mrs Smith – has been used to guide work in Torbay. Torbay Council and its NHS partners drew on the experiences of people like Mrs Smith to illustrate the problems that arise when services are fragmented and they tested changes in care by asking whether these changes would bring improvements for her (Thistlethwaite 2011). The power of this example was its ability to express in simple language the outcomes integrated care is seeking to achieve using the experience of a person everyone can recognise as someone who needs well co-ordinated care.

## **3: Develop a persuasive vision to describe what integrated care will achieve**

Progress on the journey to integrated care will be slow unless it is possible to describe an alternative and better future that motivates and inspires care providers to work differently. This includes developing a clear understanding of what integrated care means and how it will help to overcome the challenges faced by public services. In Buckinghamshire, leaders from across health and social care have not only committed to a shared vision of more integrated care, they have also described what such a system will feel like for all involved: those commissioning services; those delivering services (for example, a sense of belonging to one system, and being empowered to do the right thing); and those living in the community. In future, under the integrated system, residents of Buckinghamshire will be supported to stay healthy and when they use health and social care services they will know what to expect and will be kept informed. The experience will be as easy and seamless as possible.

## **4: Establish shared leadership**

Whole-system working needs to be based on sound governance arrangements with clarity around decision-making and accountability. These arrangements must bring together the leaders of NHS organisations and local authorities with, in some cases, leaders of other public bodies and the third sector. In Cornwall and the Isles of Scilly, NHS and social care organisations, the private sector and the voluntary sector have established a joint leadership summit. They are working together to drive more integrated care in close collaboration with the local health and wellbeing board (see [www.kernowcc.org.uk](http://www.kernowcc.org.uk)). In other areas where organisations are coming together for the first time, health and wellbeing boards may also act as the focus for collective action or may replace existing system leadership arrangements. Whatever the chosen mechanism, effective governance arrangements need to be underpinned by senior executive support and dedicated programme management to turn high-level commitments into action. There is likely to be a gap between intentions and impact unless sufficient resources are identified to support implementation and execution.

## **5: Create time and space to develop understanding and new ways of working**

The effectiveness of whole-system working depends on the skills of public service leaders and their ability to develop new ways of working. The familiar 'pace-setting' style that predominates among top NHS leaders needs to be complemented by a willingness to facilitate change by working with others to deliver improvements in outcomes and care through influence, persuasion and the use of 'soft' skills. This, in turn, hinges on the ability of leaders in different organisations to establish the trusting relationships on which successful partnerships depend. Often this requires willingness on the part of leaders to create time and space to understand each other's priorities and styles and to work together to develop shared and collective leadership. One way of doing this is to commit to a development programme to support new ways of working, as in the Fund's whole-system leadership development programme (see [www.kingsfund.org.uk/leadership/leadership-development-clinicians/whole-system-leadership](http://www.kingsfund.org.uk/leadership/leadership-development-clinicians/whole-system-leadership)). Clinical leaders are central to this programme and act as powerful change agents. This approach underlines the importance of shared leadership at all levels – not just at the top of organisations. Time invested in developing trust and understanding is often an important prerequisite to agreeing governance arrangements and shared leadership.

## **6: Identify services and user groups where the potential benefits from integrated care are greatest**

Deciding where to focus attention is critical, given that it is difficult to tackle the needs of all services and user groups at the same time. In the Fund's experience, the needs of older people are often given high priority because these people are intensive users of health and social care and account for a high proportion of care costs. There are many opportunities to improve outcomes and efficiency for older people by recognising the interdependencies of services and the importance of integrating all aspects of care from prevention through to specialist treatment. In South Warwickshire, a holistic assessment system combining health, social

care and the third sector has been developed to identify the needs of an older person around seven domains in which early intervention can counter threats to health, independence and wellbeing. Following assessment, the service response is based on the priorities of the older person (Philp 2012).

Integrated care and whole-system working also offer potential benefits in the case of children, tackling health inequalities, and meeting the needs of other user groups where fragmentation results in gaps in care and wastes scarce public resources. Integrating care around the needs of people with single diseases or conditions, such as diabetes or dementia, is also important but this needs to follow on from a focus on the whole population if it is to avoid the creation of new silos. The biggest opportunities for improvement are often found among people with multi-morbidities for whom excellent care focused on a single disease is not sufficient.

## **7: Build integrated care from the bottom up as well as the top down**

The main benefits of integrated care occur when barriers between services and clinicians are broken down, not when organisations are merged. A fundamental building block is the creation of integrated or multidisciplinary teams comprising all the professionals and clinicians involved with the service or user group around which care is being integrated. Experience indicates the importance of a single point of access to this team, a single assessment process, and close alignment between the work of the team and that of other providers of care, such as general practices. In north-west London, multidisciplinary teams in an integrated care pilot have found weekly case review meetings extremely valuable (see Harris *et al* 2012). Co-location of teams and a unified management structure are important, but critically it is about team members aligning goals and working together. In some instances a new style of working will be needed to support more collaborative behaviours between professionals belonging to different organisations. A key function of teams is to know the population they serve by making use of registries and other data sources, and to stratify the needs of this population in order to target expertise effectively. Teams also need to implement care planning systematically to

ensure that people most at risk have a plan developed and agreed with the team responsible for their care. Risk stratification and case finding need to avoid the trap of focusing only on people currently vulnerable and seek opportunities to intervene early to support those who may become vulnerable in future.

### **8: Pool resources to enable commissioners and integrated teams to use resources flexibly**

The ability to look at overall expenditure for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care. This is important in enabling commissioners and integrated or multidisciplinary teams to allocate resources efficiently and ensure that needs are met in the most appropriate and cost-effective way. The experience of areas such as Torbay is that pooling resources may result in funds that are nominally allocated to one service (the NHS) being used to increase investment in another service (social care), which supports the development of new models of care closer to home. In this case, increased investment in rapid response intermediate care, including the use of a range of health and social care professionals, contributed to measurable changes in the location of care over a period of years, including reduced use of hospitals and care homes. A useful starting point for work to pool resources is to understand how different organisations currently use their funding through resource mapping, as has been done in Essex as part of the work on integrated health and social care commissioning for older people and the Whole Essex Community Budgets Programme (Mitchell-Baker and Greene 2011).

### **9: Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector**

There is growing interest in innovations in contracting mechanisms, such as lead providers, alliance contracting and capitated and outcome-based incentivised contracts and recognition of the need for new payment mechanisms, such as the year-of-care tariff and capitated budgets. The opportunities and risks of these

innovations are not fully understood and there is a need to assess how they work in practice by testing and evaluating alternative approaches. This includes being open to the role that third and independent-sector providers can play in providing integrated care alongside existing public sector providers. Work is currently under way in Cambridgeshire to explore an outcomes-based contract for frail older people. A critical requirement for success is the willingness of different commissioners to work together to support the emergence of integrated care, a task that has been made more difficult by the fragmentation of the population-based budgets, formerly controlled by primary care trusts, to clinical commissioning groups, the NHS Commissioning Board and local authorities.

### **10: Recognise that there is no 'best way' of integrating care**

Evidence from across the world illustrates the many different ways of integrating care. In some cases the emphasis has been placed on 'real' integration by merging organisations. In others, priority has been given to supporting organisations to work more closely through 'virtual' integration in the form of networks and alliances. The scope of integrated care varies from initiatives that seek to cover the whole population to those that focus on particular groups within the population. There is no evidence that any one form of integration is superior to others, and many of the same ingredients (such as those we have described in this paper) are found in different forms (Curry and Ham 2010). As we have argued, the main benefits of integrated care derive from clinical and service integration not from organisational integration. We would add that small-scale pilots focused on the needs of people with single diseases and conditions are unlikely to deliver benefits on the scale needed at the present time. It is important to reflect this when deciding where to focus effort in order to avoid 'the wrong kind of integration' (Ham 2011).

## 11: Support and empower users to take more control over their health and wellbeing

The use of direct payments and personal health budgets has brought benefits for some service users, and politicians of all parties advocate their more widespread adoption. There is also scope to support and empower users through approaches such as care planning; the use of case managers; care navigators and advocates to support people with complex needs; support for self-care; and the use of telecare and telehealth where these approaches have been shown to be cost-effective (for information about NHS North Yorkshire and York large-scale telehealth project for people with long-term conditions see [www.nyytelehealth.co.uk](http://www.nyytelehealth.co.uk)). The key point is to ensure that care is well co-ordinated around the needs of people like Mrs Smith by using interventions that have been shown to offer value. Evidence indicates that a range of interventions used together is likely to make a bigger impact than single interventions. Users also need comprehensive and easily accessible information about the services that are available, and to be involved in co-designing new models of integrated care.

## 12: Share information about users with the support of appropriate information governance

Innovations in integrated care in the NHS and other systems are underpinned by a commitment to sharing information about users. Outside the NHS this is facilitated by a substantial investment in information technology, including the use of a single electronic health care record that is available wherever a patient is seen. NHS organisations are making progress in this direction by finding local solutions to information-sharing, often with the involvement of local authorities. In South Warwickshire, the electronic shared-assessment system has replaced a collection of locally developed assessment instruments, and information is stored on a shared database, which also makes data available to support population needs assessment (Philp 2012).

One of the lessons from experience is the need to ensure that information-sharing is supported by appropriate information governance and equally is not hindered by

overly zealous interpretation of the rules on information governance. Areas such as north-west London have made significant progress on these issues with valuable learning for the rest of the NHS (see Harris *et al* 2012) including board-level commitment to information governance and seeking the consent of patients to the sharing of their data in care planning.

## 13: Use the workforce effectively and be open to innovations in skill-mix and staff substitution

High-quality integrated care depends on team-working that makes full use of the skills of a range of health and social care professionals. Team-working creates opportunities to vary skill-mix and use staff substitution, eg, nurses and pharmacists taking on roles previously performed by doctors. There are also opportunities to establish new roles, such as the health and social care co-ordinators employed in Torbay's integrated teams. These co-ordinators have no professional training, but are skilled in acting as the point of access in teams and knowing how best to use the skills of other health and social care professionals. Another example is the development of hybrid roles spanning social care and community nursing in jointly commissioned re-ablement services.

## 14: Set specific objectives and measure and evaluate progress towards these objectives

A common weakness in the Fund's experience is the failure to move beyond high-level aspirations to agree specific objectives for integrated care. In practice, these objectives need to encompass a variety of dimensions of care including user experience, service utilisation, staff experience and the costs of delivering care. Progress towards these goals must be measured frequently to support learning and to inform implementation. This needs to be part of an evaluation strategy designed to strengthen the evidence base for integrated care and to understand the relationship between inputs, process and outcomes. The example of the Veterans Health Administration (VA) in United States in the 1990s illustrates how setting specific objectives and measuring progress towards them formed a core element



in the transformation of that organisation (see [www.kingsfund.org.uk/audio-video/kenneth-kizer-achieving-integrated-care-highlights](http://www.kingsfund.org.uk/audio-video/kenneth-kizer-achieving-integrated-care-highlights)).

## 15: Be realistic about the costs of integrated care

One of the so-called laws of integrated care is that it 'costs before it pays' (Leutz 1999). Put differently, there may be a need to invest in new models of care before resources can be released from existing models - as was the case in the 1970s and 1980s with the shift from hospital-based to community-based care for people with mental health needs. At a time when there are no additional resources to invest in new services, it may be necessary to top-slice allocations to create the funding needed to pump-prime innovations in integrated care. Work currently under way in the NHS, such as the integrated care pilot in north-west London, has modelled substantial potential savings from the extension of current work to integrate care for older people and people with diabetes, but whether these can be delivered in practice remains to be seen. The experience of health care organisations in other countries is that while there is considerable scope to reduce waste and inefficiency by tackling duplication and fragmentation, there is little if any evidence that integrated care can be delivered more cheaply. However, there is evidence that integrated care can enhance the quality of services as demonstrated by the transformation of the VA (as above, see [www.kingsfund.org.uk/audio-video/kenneth-kizer-achieving-integrated-care-highlights](http://www.kingsfund.org.uk/audio-video/kenneth-kizer-achieving-integrated-care-highlights)).

## 16: Act on all these lessons together as part of a coherent strategy

The experience of organisations that have made the transition from fragmentation to integration demonstrates that the work is long and arduous. Leaders need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy that acknowledges the importance of all the lessons outlined here. Public services involve complex adaptive systems in which change is rarely linear and where the effect of different actions is hard to predict. Much hinges on the skills of leaders in acting on the evidence we have distilled in this paper and their ability to adjust direction during implementation.

## Moving forward

Many of the issues we have outlined above are being tackled simultaneously in different parts of the country, and it is important that those taking integrated care forward share their experience, success and failures with others. For example, the pace of development can be accelerated if innovators and leaders are supported to work together in learning networks through which information and intelligence can be shared. This helps to avoid unnecessary duplication of effort and can help build commitment and support by enabling leaders to work together in a community of practice, as in work the Fund has done with the Advancing Quality Alliance (AQuA) in north-west England. It is also important to make it easy for those leading integrated care to access outside expertise, eg, in identifying what best practice looks like when developing integrated care for older people, or learning how best to share information about users across organisations and services. Creating a hub to support learning and development is likely to be critical, as is accessing skills in service improvement to support rapid cycles of learning.

We know that local leaders' capacity for action will be greatly enhanced if they are supported by some key policy changes. These include:

- active encouragement of innovations in payment systems to move beyond Payment by Results and to test the year-of-care tariff, capitated budgets and pooling of resources (as in the Whole Place Community Budget pilots) in order to put in place the right financial incentives
- regulation by Monitor, the Co-operation and Competition Panel and the Office of Fair Trading must support integrated care by avoiding inappropriate application of competition policy to health and social care
- regulation of financial performance and the quality of care by Monitor and the Care Quality Commission must focus on system performance not just organisational performance
- alignment of the outcomes frameworks for public health, health, and social care.

### Further support and resources

The King's Fund will be launching a range of new initiatives to support the development of integrated care at scale and pace. Full details of these, and a wide range of resources on integrated care, can be found at: [www.kingsfund.org.uk/topics/integrated-care](http://www.kingsfund.org.uk/topics/integrated-care).

To find out more about our programme of integrated care, contact Dr Nicola Walsh, Integrated Care Programme Lead and Assistant Director of Leadership ([n.walsh@kingsfund.org.uk](mailto:n.walsh@kingsfund.org.uk)), or Beatrice Brooke, Policy and Research Adviser to the Chief Executive ([b.brooke@kingsfund.org.uk](mailto:b.brooke@kingsfund.org.uk)).

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