A stitch in time – the future is integration
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Key points
• Developing integrated health and social care is critical to keep pace with today’s changing needs.
• Integration and competition are not mutually exclusive. They can, and do, support each other.
• Successful integration is dependent on good commissioning and strong contracts that result from a clear and open tendering process.
• The more pluralist systems of Western Europe provide helpful examples of how to develop more effective integration than we currently have in the UK.
• Robust integration drives up the quality of care, encourages innovation and development, benefits the individual organisations and delivers cost savings to the public purse.

This Briefing looks at integration and collaboration in health and social care and highlights the benefits that an inclusive approach brings to the delivery of care in both sectors. It includes examples of successful models of integration from within the UK, where NHS organisations are now working more effectively with other public sector providers as well as independent providers, and from Western Europe, where integration between the public and independent sectors is more widely accepted.

Home and away
For many health economies developing and delivering integrated care is a priority to enable health and social care to keep pace with the changing demographics of national populations.

The UK is no exception and in order to meet the increasing demands on our health and social care systems a more inclusive approach to collaborative partnerships needs to become a commonplace, and standard, model of delivery. However, integration has never been a key feature in the traditional UK NHS model where silo working is still too prevalent.

Good integrated services bring enormous advantages to a healthcare system. They drive up the quality of patient care, encourage innovation and development, benefit the different organisations involved and deliver cost savings to the public purse.

Integration and competition
One of the key levers to successful health and social care in the future is going to be integration and cooperation between different types of organisations from both the NHS and the independent sector.

Integration and competition are not mutually exclusive. In fact, they can, and do, support each other. Close collaboration enables partnerships to benefit from the strengths of the individual organisations while also being able to streamline the care that they are able to deliver.
The concept is not new and a range of successful collaborations already exists in the UK and across Europe. Within the UK it is primary care that is often leading the way, with a number of primary care providers creating commercial and service partnerships that support better integrated care.

This includes a number of innovative partnerships with foundation trusts that provide significant benefits to the NHS and its staff, patients and the public purse. In one example, a partnership produced an estimated saving for the primary care trust of between £300,000 and £400,000 over the contract term when compared to the previous service.

Innovative partnership models include:

- partnerships between the independent sector and third sector providers, such as Age UK, for end-of-life care
- independent sector providers in collaboration with foundation trusts, such as the Recovery at Home Service between Healthcare at Home and University Hospital Southampton NHS Foundation Trust
- independent sector providers in partnership with GP practices to improve end-of-life care and provide integrated GP and nursing support to nursing homes
- independent sector providers in partnership with specialist NHS services, such as Barchester Healthcare’s model of joint working with Nottinghamshire Healthcare NHS Trust
- integration between health and social care. For example, in the UK, the Torbay and Southern Devon Health and Care NHS Trust model and in Finland the Eksote model
- a single integrated model delivered through a public-private partnership, such as the Alzira model in Valencia, Spain
- partnerships with GP practices that deliver both improvements to end-of-life care and integrated nursing support to nursing homes.

New opportunities

The architecture and landscape of the NHS has gone through fundamental change as a result of the Health and Social Care Act. This provides a unique opportunity across all health and social care sectors.

The newly formed clinical commissioning groups (CCGs) are in a strong position to explore and develop innovative new partnerships that bring together the best services and deliver the highest quality care possible while helping organisations meet the financial challenges that both health and social care currently face.

The power of commissioning

Integration is not dependent on having single providers, or on the type of provider, but instead on good commissioning and contracting arrangements. These in turn are usually stronger if they are a result of initial competition through a clear and open tendering process.

To achieve effective integration the focus must be on how commissioners and CCGs buy their services. As in all successful markets, the final product is largely driven by market forces. The seller produces what the buyer demands, so in health and social care the emphasis must be on the commissioner. If commissioners request integrated multi-provider services, or bundled services, this is what providers will deliver. But if they continue to demand individually priced and provided services, the pattern of silo working will remain in health and social care.

Looking to other industries

Integration is not a concept unique to health. There are numerous examples of complex and highly competitive industries where effective integration and partnership has driven quality and success, while appropriate, tailored regulation ensures sensible application of competition principles. Health and social care have many particular characteristics but there are useful lessons to be learned from elsewhere.

One such example is the aviation industry, where the emphasis on safety and reducing risk is paramount. The sector has developed networks of integrated organisations that enable the industry to keep pace with the travel needs of today’s consumers and the widening choice available to them, while at the same time helping airlines to survive in a harsh economic environment.

Major airline alliances such as one world bring together leading international airlines in partnerships that enable them to deliver high-quality, value and safety to customers, and efficiencies, innovation and benefits to organisations that no individual airline is able to provide alone.

They also compete fiercely with each other, helping to drive quality and innovation, demonstrating that competition and integration can be effectively combined to the benefit of the consumer.
It is, however, also true that much of the best innovation comes from providers. Therefore, effective communication from providers to commissioners about the available service options is vital to informing innovative integrated commissioning. Commissioners will continue to buy their tried and tested services if they are not made aware of new provider models and the advantages that they bring to their patients and their budgets.

Strong collaborations and partnerships work best with clear guidelines, clarity over objectives and strong contractual arrangements. Dependence on arrangements firmed up with a handshake, or assumptions about cooperation, that have been relied on in the past no longer work in today’s complex landscape and can result in misunderstanding and gaps in service.

**Health and wellbeing boards**
The separation of the health and social care budgets can make it more difficult to achieve a common approach to buying integrated services across the two sectors. However, it is hoped that the new health and wellbeing boards will play a major role in enabling a more cohesive approach to commissioning and delivering services.

**International comparisons**
Discussion on international comparisons usually focuses on the North American health and social care system and few will disagree that the famous Kaiser Permanente model provides one of the most outstanding examples of integrated care today. However, it is to the social democracies of Western Europe that we should look when examining how to develop better integration within the UK, utilising the advantages of pluralism, the strengths of different types of provider and the broader contexts of the European social democracies.

Making comparisons between different systems is problematic because of the societal and historical differences. However, the main indicators from the World Health Organization (WHO) and Eurostat suggest that the more pluralist systems, such as those in Spain, France and the Netherlands, show better results on a number of criteria than countries, like the UK and Denmark, where an overwhelmingly state-funded and provided system dominates. One factor in this is the growing ability in some European health economies to develop integrated models comfortably within a framework of EU competition and procurement law.

At a time when all health and social care systems face similar economic and systematic concerns it is critical that we examine the benefits of the different ways of achieving effective integration. The demographic and financial imperatives mean we simply do not have the time nor the luxury of either reinventing everything for ourselves or burying our heads in the sand and ignoring the overwhelming benefits of a truly collaborative approach.
Collaboration delivers three key wins

Steph Palmerone, director of strategic initiatives at Barchester Healthcare, describes how a new way of joint working with NHS organisations delivers benefits to patients, staff and the public purse.

Barchester Healthcare embarked on a number of collaborative projects in 2008, largely based in England, arising both opportunistically and from strategic discussions.

As a result we now manage successful models of integrated healthcare with foundation trusts, other trusts, primary care trusts and social enterprises, as well as with councils and charities.

Solid building blocks

We worked through a number of key learning points with different NHS partners, building ways of working to support successful collaborations and tackle blocks to integrating services.

Project planning explicitly acknowledged that the NHS does not traditionally work with the care home sector directly to support people with complex needs, but strong and effective collaborations make the best use of the capacity and competency available within Barchester.

Collaboration is often supported through QIPP (quality, innovation, productivity and prevention) and goals are based on evidencing three key wins:

- for the people using services
- for the organisations
- for the public purse.

Cost savings

The basic engine for financial benefits is that Barchester’s 24-hour service is less expensive than NHS mental health and acute services. Savings are initially achieved through NHS assessment processes being shortened or reduced as Barchester is able to make the best use of its skilled staff teams.

Practical examples of Barchester’s collaborative working include:

- enabling people with complex mental health requiring placement out of area to return home through reablement programmes
- cutting long-term use of NHS beds. The latest evaluated project supports capacity flow in an acute hospital through discharge to a home for up to three weeks when individuals are medically stable.

Projects are continually evolving and developing. Although many began with time-limited goals, they have broadened following the success of the collaboration. A number of new projects are also just starting.

Contact

For more information about Barchester’s collaborative working, visit www.barchester.com or contact Steph Palmerone at Steph.Palmerone@barchester.com

<table>
<thead>
<tr>
<th>Three key wins and the rationale behind them</th>
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<tbody>
<tr>
<td><strong>The key win</strong></td>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td>A benefit for people who use the services</td>
<td>The two organisations must have at the heart of what they do a commitment to delivering the best services possible to the people who need them.</td>
</tr>
<tr>
<td>A benefit for the organisations and the people who are employed by them</td>
<td>The most important asset to both organisations is their staff, and investment is key. At the same time, the venture must support the business plans and aims of both organisations and show that the joint venture helps progress the plans of each equally.</td>
</tr>
<tr>
<td>A benefit for the public purse</td>
<td>The joint venture must be accountable to the public, elected members and the local community, and show that services funded through public sector commissioning processes offer high quality, high value and high productivity.</td>
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Collaboration with Nottinghamshire Healthcare Trust

Our long-term collaboration with Nottinghamshire Healthcare Trust includes redevelopment of existing Barchester services for managing higher needs, work to build links between people living with dementia and community nursing teams, shared facilities for early onset dementia, and joint work on leadership development and learning.
Zone teams give patients clear and accountable care

Mandy Seymour, chief operating officer at Torbay and Southern Devon Health and Care NHS Trust, outlines the key benefits of their integrated health and social care model.

Torbay and Southern Devon Health and Care NHS Trust provides healthcare across Torbay and Southern Devon, including 11 community hospitals, and provides and commissions adult social care services in Torbay.

The integrated trust, which employs 2,000 staff across the health and social care sectors, manages and delivers care to around 375,000 people and is built upon the foundations of health and social care integration that were laid down by Torbay Care Trust in 2005. It is currently the only integrated health and social care trust in the South West of England.

**Patient benefits**

The integration of health and social care services ensures that both patients and service users only need to tell their story once. The streamlined system also means that each patient and service user has a single contact that remains the same throughout their interaction with the health and social care services.

This collaborative approach to care has created clear lines of responsibility and accountability. It has also reduced duplication, improved communication between professionals and has simplified the decision-making process.

**In the zone**

Multi-disciplinary teams, which include occupational therapists, district nurses, physiotherapists, social workers, community care workers, mental health workers and community matrons, are co-located in zone teams. There are ten zone teams in the locality. Health and social care coordinators bring together members of each team to provide a more coordinated and faster response to people’s needs.

The zone teams provide a single contact point for referrals making transitions between health and social care a much smoother journey for users. They also provide packages of care that are designed to meet both health and social care needs.

The wider impact on the local health community has been impressive and has included:

- some of the lowest occupied bed days for patients over 75 with two or more admissions
- minimal delayed discharge from the district general hospital
- some of the lowest rates of hospital deaths in England.

**Single community care record**

While the organisation has been integrated for some time, it is now exploring ways of using technology to further support the working relationship.

As part of this, we are liaising with IT systems integrator Simpl to develop a single community care record (SCCR) for patient information. This can accommodate both health and social care structures and information to help ensure that staff working in either sector have access to all the relevant information.

**Contact**

For more information about the model of integration in Torbay, visit [www.tsdhc.nhs.uk](http://www.tsdhc.nhs.uk) or contact the trust on 01803 219700.

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**The integrated health and social care model has simplified care pathway for users**

**From seven steps:**

1. **GP/district nurse**
2. **Social services**
3. **Referral coordinator**
4. **Service manager**
5. **Care manager**
6. **Service manager**
7. **Home care manager**
8. **Broker**

**To two simple steps:**

1. **GP/district nurse**
2. **Health and social care coordinator**
3. **Broker**
A single integrated provider keeps Valencia healthy

Alberto de Rosa, general manager of Ribera Salud Grupo, describes a pioneering public-private partnership that delivers impressive care, achieves high patient satisfaction levels and retains staff.

The Alzira model, from the Valencia region of Spain, takes a ground-breaking approach to healthcare that is delivered through public-private partnership between the healthcare provider, Ribera Salud Grupo, and the local government.

The model, which was developed in 1997, is based on a single integrated provider responsible for almost all care to the local population. Although the service is privately provided, the fundamental principles are that it remains under public ownership and control and is paid for through public financing.

The capitation system

One of the most innovative aspects of this model is the payment by capitation system. An annual budget is assigned to the private contractor in each area based on the population size and the range of services provided. This has to cover all expenses required to provide the service and rises each year in line with the region’s public health budget increase.

In return, the private contractor is responsible for running the health department and must offer universal access to its range of health services. One of the main advantages of this arrangement is that the annual cost of healthcare is fixed and can be forecast with reasonable precision.

Ribera Salud Grupo offers a high-quality, efficient public healthcare service. It was originally designed for secondary care but was extended to cover primary care in 2003. Full integration of healthcare provision was dependent on aligning three key pillars across all services:

• clinical management
• business directorates, including HR
• IT.

Shared patient record

A shared patient record between GPs and other providers is also vital to the success of the model, which depends on clinical integration between primary and secondary care, supported by a strong information system and a management culture that relies on compliance with procedures and guidelines.

The model also uses staff incentives and ensures that the incentives for primary care clinicians, and for other parts of the system, are aligned to ensure that work is carried out in the most appropriate place.

Overcoming obstacles

The change towards the single management of primary and specialised healthcare, and the provision of healthcare through functional, professional and clinical integration, were both initial obstacles.

We also had to establish the validity of the system and deliver greater efficiency at a lower cost without affecting results or quality.

Benefits of the Alzira model

For patients

• greater level of perceived quality
• higher level of dignity, privacy and comfort, resulting in more personalised care
• greater accessibility and faster response time
• choice of hospital and doctor
• availability of technology

For staff

• job security
• innovative salary system
• opportunity for development and pursuing a professional career
• opportunities for teaching and research
• a strong commitment to technology

For local government

• offloading of the public budgets
• lower-than-average and relatively predictable cost for the public management of a public service
• investments are the concessionaire’s responsibility during the management period
• capitated payment with transfer of financial risk
• innovation in management technologies and systems
• contribution of complementary HR
In addition, we inherited outstanding challenges that had to be managed. These included those around sharing healthcare services, multi-hospital management models and efficiency improvement.

**Finance and figures**
The Valencia area has more than five million inhabitants and 20 per cent of these are within the health areas covered by the Alzira model.

The Ribera Salud Grupo has three hospitals and 2,931 members of staff (of whom 86 per cent are clinical). In total, the organisations run over 100 health facilities.

The cost of providing health services to the population is lower for the regional administration under the Alzira model. The capitation fee paid per inhabitant by the local authority to the private contractor is around 25 per cent lower than under the previous model. In addition, it is currently 15–25 per cent lower than that of other areas of Spain that do not have this model of management in place.

**Further information**
The Alzira model was the subject of an NHS Confederation study visit in 2011. The resulting report, *The search for low-cost integrated healthcare: the Alzira model*, examines the model in more detail. For a copy, visit [www.nhsconfed.org/publications](http://www.nhsconfed.org/publications).

**Contact**
For more information about the Alzira model, visit [www.riberasalud.com](http://www.riberasalud.com) or contact Alberto de Rosa at arosa@riberasalud.es

**Comparison between Ribera Salud Hospitals and other hospitals in the Valencia region**

<table>
<thead>
<tr>
<th>Rate</th>
<th>Ribera Salud Hospitals</th>
<th>Other hospitals in Valencia region</th>
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</thead>
<tbody>
<tr>
<td>Outpatient major surgery</td>
<td>56%</td>
<td>43%</td>
</tr>
<tr>
<td>Outpatient surgery rate</td>
<td>79%</td>
<td>52%</td>
</tr>
<tr>
<td>Cesarean section rate</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Average hospital stay</td>
<td>4.5 days</td>
<td>5.8 days</td>
</tr>
<tr>
<td>Minor emergency</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency waiting times</td>
<td>Under 60 minutes</td>
<td>131 minutes</td>
</tr>
<tr>
<td>Emergency response times</td>
<td>4 hours</td>
<td>Not available</td>
</tr>
<tr>
<td>External consultation delay</td>
<td>25 days</td>
<td>51 days</td>
</tr>
<tr>
<td>Average surgery delay</td>
<td>34 days</td>
<td>60–90 days</td>
</tr>
<tr>
<td>CT scan delay</td>
<td>12 days</td>
<td>90–120 days</td>
</tr>
<tr>
<td>MRI delay</td>
<td>15 days</td>
<td>90–120 days</td>
</tr>
<tr>
<td>Readmission within three days</td>
<td>4.05</td>
<td>6.1</td>
</tr>
<tr>
<td>(per 1,000 discharges)</td>
<td></td>
<td></td>
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<tr>
<td>Patients’ satisfaction (0–10)</td>
<td>9.1</td>
<td>7.2</td>
</tr>
<tr>
<td>Electronic medical history use (hospital)</td>
<td>100%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**The key features of the Alzira model**

- **Public control**
The contractor has to comply with clauses of the contract. The government has the power to control and inspect it, and to establish regulations and impose sanctions.

- **Public funding**
The system of payment is based on a per capita payment. The government pays the contractor an annual fixed and pre-established sum for each of the inhabitants ascribed to it.

- **Public provision**
The contract for providing the health service is awarded for a pre-established period to a company that commits itself to ensuring the proper operation and management of the public service.

- **Public ownership**
The public nature of the health service is guaranteed at all times. The health centre that has been contracted out is a public hospital built on public land and belongs to the network of public hospitals.

Source: Ribera Salud
Streamlined care in Finland gives residents the best quality of life

Dr Tuula Karhula, acting director of elderly services in the Eksote district of Finland, outlines a health and social care integration model that ensures patients and clients receive high-quality joined-up care.

The South Karelia Social and Health Care District of Finland, called Eksote, provides healthcare, family and social welfare services and elderly care services that promote the health and wellbeing of local residents and enable them to have the best possible quality of life.

At the start of 2010, Eksote entered into a service contract with nine participating districts based on the needs of those areas. Of these, only one district currently participates in the provision of special healthcare and services for disabled residents within the district. The total population of the participating districts is approximately 133,000.

Home but not alone
Part of the family and social welfare services are provided as local services in the client’s own home, while the delivery of less frequently required services or services that need special expertise is centralised.

Services for the elderly aim to promote their wellbeing, health, ability to function and working capacity with high-quality, cost-effective and flexible services that are able to adapt to the service needs and age structure of the population.

Independent living
The staff at Eksote have a rehabilitative approach to developing the care of the elderly, and also make good use of modern technology.

Their care particularly emphasises the importance of enhancing the existing capabilities of each person and supporting them in being able to live independently where possible.

While integrating services in a new way we realised how important it was to have the correct processes in place. But it is the way that each carer treats their patient/client as an individual that is the most important aspect of our care and counts for more than anything else.

Customer care
In Eksote our vision is to be the best at:
• pioneering increased health and wellbeing across the district
• helping people to live independently where possible
• distributing technology effectively to our staff as well as into the homes of our patients/clients
• working as cost effectively as possible

• providing the most enjoyable and inspiring work environment.

Our values are reflected across all our work and include emphasis on customer orientation, personal responsibility, fairness, openness and productivity.

Our main goal is to provide services that meet the needs of clients and patients while encouraging them to use the available services in an appropriate and timely manner. We respect the individuality and dignity of each person, and seek to continuously develop our services based on customer feedback.

Contact
For more information about the Eksote model, visit www.eksote.fi or contact Dr Tuula Karhula at tuula.karhula@eksote.fi

Services provided by Eksote

The healthcare services delivered by Eksote include:
• outpatient care and oral healthcare
• mental healthcare and substance abuse services
• medical support services, including laboratory and imaging examination services
• acute hospitals, including A&E.

Family and social welfare services consist of:
• family services
• social services for adults
• special services for the disabled.

The elderly care services consist of:
• home care, including preventive care
• living in elderly care homes and sheltered houses
• hospital care of the rehabilitation and chronic diseases.
Eksote’s mission: quality and productivity – together

<table>
<thead>
<tr>
<th>Models and processes</th>
<th>Finance and productivity</th>
<th>Customers and services</th>
<th>People and skills</th>
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</thead>
<tbody>
<tr>
<td>Renew service production and distribution</td>
<td>Financial capability of the district is adapted to meet the financial capabilities of participating municipalities</td>
<td>The service is designed to recognise clients’ and patients’ needs</td>
<td>Shared values-based organisation culture</td>
</tr>
<tr>
<td>Reduce institution-based care</td>
<td>Continuous improvement of financial aspects and productivity</td>
<td>Utilise partners for promoting services to customers</td>
<td>Professional and sufficient staff</td>
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Critical success factors

| e-services are used in all areas | Correct and sufficient information about operations and finances | Supporting clients’ and patients’ views and choosing service providers openly | Governance that endorses staff motivation and satisfaction |
| The development of mobile services and self services | Responsibility-based contract negotiations between district and municipalities | Influential and first-rate services | Staff are offered opportunity to develop and advance their career |

NHS Partners Network

NHS Partners Network (NHSPN) was established in 2005 and incorporated into the broader NHS Confederation in June 2007. The network represents a wide range of independent sector providers of NHS services, ranging through acute, diagnostic, primary and community care. Its members are drawn from both the ‘for profit’ and ‘not for profit’ sectors and include large international hospital groups and small, specialist providers. All members are committed to working in partnership with the NHS and to the values set out in the NHS Constitution.

For further details about the work of NHSPN, visit www.nhsconfed.org/nhspn or email NHSPartnersNetwork@nhsconfed.org