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Making integrated out-of-hospital care a reality

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Executive summary

The current set of financial and demographic challenges faced across health and social care mean that integration is undoubtedly a necessity.

This paper provides a set of principles to lay the foundations for delivering effective integrated out-of-hospital care, each underpinned by a range of drivers and enablers.

At the heart of an integrated model for out-of-hospital care must be the provision of better care for all, not merely those meeting ever stricter eligibility criteria.

Steps should be taken to enable better patient experience of integrated care year-on-year, while also empowering communities to pilot elements of a new approach.

Organisations can utilise risk profiling systems to help to ascertain those who should gain the most from an integrated system.

Alongside robust risk sharing, there is undeniably a need to ensure shared gains, to enable any savings to be appropriately reinvested, provided desired outcomes are being delivered.

Design of new tariffs to incentivise integrated care can be supported with more widespread information sharing.

The impact of integrated care upon staff, both on their ways of working and care of patients, will need to be demonstrated, with staff engaged throughout the transition.

Making integrated out-of-hospital care a reality

At a time when the NHS is embarking on the most substantial reforms in its history, during a period of flat funding in real terms and increasing demographic pressures, the effective delivery of integrated care is vital.

This report discusses the foundations for integrated care for adults, children and young people, with a focus on implementing out-of-hospital care, and connecting primary, community and social care. It highlights key evidence and draws on learning from partners across health and social care.

Background

A set of principles, each underpinned by a range of drivers and enablers at primary and secondary levels, can support the effective delivery of integrated out-of-hospital care.

This report outlines the issues raised at a round-table event convened by the NHS Confederation and the Royal College of General Practitioners (RCGP) in April 2012, involving stakeholders from across health and care. Participants endorsed a range of principles and drivers. Discussions were informed by learning from an integrated care model being developed in Southampton by Dr David Paynton, national clinical lead at the RCGP Centre for Commissioning. The principles and drivers build on previous work by the Association of Directors of Adult Social Services (ADASS) and the NHS Confederation.[1] Their further development was also informed by the findings of an RCGP report on integrated care, published in June 2012.[2]

Integration: "The organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."
World Health Organization

The themes discussed included:

- improving patient experience and care
- ensuring fewer and less incapacitating years of ill health and improving quality of life
- ensuring more streamlined patient pathways
- affordability.

Learning from the evidence

Looking at recent evidence, an assessment of 16 integrated care pilots (ICPs) found there was no consistent approach to integration.[3] However, the majority of pilots involved "integration of practitioners working in different organisations" and examples of horizontal integration, such as that between community services and social care.

A survey of NHS Confederation members, published in June 2012, underlines the importance of the role that needs to be played by integrated care to ensure financial sustainability and improved quality across the service.[4] Seventy-seven per cent of respondents overall (81 per cent of trust chairs and 73 per cent of chief executives) identified integration as an essential reform, the most commonly cited area.

Shifting care away from the acute setting into the community was the second most frequently chosen area by Confederation survey respondents, at 63 per cent.

The public also recognises the positive impact such service redesign can have. In a recent survey for the Department of Health, also published in June, 66 per cent of those polled agreed that moving services into the community can raise standards.[5]

Moreover, when NHS Confederation survey respondents were asked to choose their key priorities for increasing quality in the year ahead, integration of care was again the clear winner. Thirty-nine per cent chose it as the top priority (compared to 15 per cent for innovation and 14 per cent for leadership), with an additional 34 per cent placing it second or third. NHS trusts were the organisation type who most definitively identified integration as a priority (82 per cent).

What is the ultimate system of integrated care?

At the round-table event there was universal agreement among the participants that the current set of financial and demographic challenges faced across health and social care mean that integration is unequivocally a necessity, as part of a new overarching approach to improving service delivery and efficiency. However, it was highlighted that there is a need to comprehend the scale and complexity of the issues to be addressed.

The ethical underpinning provided by NHS values within the NHS Constitution must be retained and the current revision of the Constitution provides an opportunity to strengthen it. Delegates discussed whether a uniform set of values specific to integrated care could apply across all organisations, due to the different contexts within which people live and organisations work. Whilst a set of underlying values may stay constant, the way in which they are applied is likely to vary.

Investment is required

A number of myths around this agenda will need to be dispelled to ensure changes are given the requisite time to bed in. For example, it is crucial to address the misperception that integrated out-of-hospital care can be delivered without up-front investment. Furthermore, any savings accrued from shifting care into the community are normally only realised in the medium to long-term and not necessarily by the organisations that deliver the initial resources.

Removing barriers

Discussions highlighted that there are a number of barriers to integrating care. Organisations must focus on improving care for patients in order to deliver system redesign. There is concern that the levers in the current system, such as tariff for episodic acute care, work against shifting resources to the community, hindering potential progress elsewhere. The need to address the potential risk of 'cost shunting' between health and social care was also raised, alongside ensuring that the use of pooled budgets is firmly linked to the delivery of agreed outcomes.

Encouraging a transparent, 'open book' approach to accounting could help overcome such barriers.

Effective integration of out-of-hospital care will require buy-in from across the health and social care system. The necessary levers will need to be established, and everyone involved will need to sign up to 'what good would look like.' The prompts suggested in this report for each of the principles may help in this regard.

Barriers that currently make it too complicated to integrate services locally need to be tackled. For example, more widespread alignment of health and social care funding streams needs to be enabled, with a focus on minimising use of the more expensive forms of care (acute, care homes), offering the potential to inspire innovative, integrated solutions.[6]

Other barriers include demarcations between workforces, sharing risks (relating to both finance and quality) and information sharing.

Issues such as decommissioning and contracting expertise are also important. Commissioners need to act as enablers for innovative approaches, as part of an effort to end the 'us and them' culture between commissioners and providers.

The NHS Confederation has recommended that Monitor prioritises more widespread evaluation of alternative tariffs and the production of guidance and best practice around competition rules. We have advocated that Monitor factor in a number of issues in its next phase of work, including: commissioner support; health and social care integration mechanisms; and the different requirements for integrated care between urban and rural areas. This underpinning would be welcome if integrated care is to become a reality.

Turning rhetoric into reality – key principles

A set of principles to act as foundations for delivering integrated out-of-hospital care were agreed at the round-table event. Each principle is underpinned by drivers, at both a primary and secondary level, as well as potential enabling projects to support their implementation in practice. On the following pages prompts are given for local leaders to check whether they are implementing the principles. Case studies show how elements of the principles are being carried out in practice.

Many of the drivers and enabling projects overlap and apply across more than one of the principles. Therefore, all of the identified drivers and enablers for each principle are listed, and those deemed to be of most relevance in each case are discussed.

'More widespread alignment of health and social care funding streams needs to be enabled, with a focus on minimising use of the more expensive forms of care'

Principle 1: Making best use of resources to improve health and wellbeing outcomes for the whole population

It is essential to ensure both the best outcomes and best use of resources. The provision of better care for all, not just those meeting ever stricter eligibility criteria, must be at the heart of an integrated model for out-of-hospital care that encompasses treatment of both adults and children.

Current procedures need to be challenged to ensure that proven care pathways are scaled and that effective management for those with multiple morbidities is delivered. While primary care has attempted to address the latter, it must be able to do more and be sufficiently supported towards this end by the wider system. This would be underpinned by an integrated model, with any metrics designed in order to address co-morbidities. The NHS Commissioning Board's mandate, published in November, may provide an opportunity to focus on this agenda.

Measuring integrated care

While it is appropriate to have different approaches in different localities, it is also necessary to agree a common set of desired outcomes. The focus of commissioners in relation to integrated out-of-hospital care should be on quality across a bundle of services through outcomes measurement, with any potential metrics that may be employed as part of this work sharing that emphasis.

At a time when resources are tightly constrained across health and social care, it is necessary to show that any investment is delivering improved outcomes. While participants endorsed the principle of targeting particular services at those who would benefit most, there remains a commitment to ensuring continued enhancement of health and wellbeing outcomes for local populations as a whole.

Choice of provider should be offered to patients in the right circumstances and where it can be of clear benefit, with the emphasis placed on enabling choice of care options. It was suggested that choice may need to be restricted, where appropriate, within a framework of available resources.

Utilisation of a single point of access (SPA) system can help organisations to manage all referrals for particular conditions, such as diabetes, more effectively, by acting as the first point of call for both patients and health professionals. SPA enables those with a diagnosed health and social care need to access the most appropriate services.

Principle 1: Making best use of resources to improve health and wellbeing outcomes for the whole population

Prompts to assist with putting the principle into practice

- Are patients from right across the age range being cared for appropriately through your integrated model?
- Have your proven models of delivery been sufficiently scaled to provide the widest possible benefit to your local community?
- Have commissioners ensured their focus is on measuring outcomes and reflected this approach in any metrics adopted?
- Are patients and service users always able to exercise choice within those pathways where it is has been found to be of greatest benefit?
- What impact has integrated delivery had upon demand for health and care services?

Primary drivers to support actions

- Self-management programmes – enabling patients to take more control and responsibility for their care.
- Integrated community teams working with primary care.
- Agreed patient pathways with monitoring – demand management can be more effective within an integrated model.
- Shared objectives with local authorities – one possibility is to expand the Quality, Innovation, Productivity and Prevention (QIPP) programme to encompass social care services.
- Shared information to support design of national and local tariffs that incentivise integrated care within the NHS and across health and social care.
- Developed outcomes measures to demonstrate the value of out-of-hospital care.

Secondary drivers focusing on specific actions to fulfil the aims of this principle

- A reliable, accepted tool used by primary care and potentially others.
- Clinical review of high-risk patients with care planning.
- Services integrated around clusters to support practices in managing high-risk patients.
- Local authority involvement in care planning and care in the community.

Enabling projects/interventions to facilitate system-wide integration

- Roll-out and action recalibration of risk stratification tools, such as adjusted clinical groups (ACG).
- Clinical dashboard and care planning part of organisational development programme for practices – the NHS Institute's Productive General Practice.
- Organisational development programme for community prior to writing specification in partnership with practices and service.
- Contracting strategy for providers with shared risk/incentives.
- Single 111 number and single point of access linked by enabling IT. (To note: this is early in implementation and needs ongoing evaluation of pilot sites.)

Principle 2: Empowering patients to have more control over their care packages, strengthen prevention, self-care and wellbeing

What might be done to involve people in finding solutions to the detailed variations in service provision? Any efforts would have to ensure engagement from a range of sources, not merely patients and service users, but also carers, families and, in the case of children, their schools, to raise awareness.

Engagement in decision-making

Shared decision-making is key to ensuring patients are empowered to have more control over their care packages. A range of tools can be provided to support patients in their efforts to improve their knowledge and confidence regarding their conditions. The NHS Confederation has argued that greater shared decision-making is a prerequisite to deliver a truly patient-centred NHS.[7]

Ethical issues will need to be considered, as well as the burgeoning expectations of patients and public around public services in general.

It is essential that the agreed set of principles be comprehensible to patients. The objective should be to ensure better patient experience of integrated care year-on-year, while also empowering communities to pilot elements of a new approach.

Case management

Case management should be used, where appropriate, for those with long-term conditions. The system highlights individuals at particular risk of hospital admission and ensures they have a personalised, coordinated plan, fully in keeping with their care and support needs. This must also incorporate administrative coordination and ensure the right care for the right person at all times.

Development of case management would enable increased 'health literacy' and self-management, with case managers bringing the various pieces together. However, concern was expressed that self-management may not be the right approach for children. Staff will need to be able to ascertain the views of, and engage with, younger patients, whether using case management or another appropriate engagement approach. The roles to be played by parents, schools and children's centres must also be considered. This issue is particularly acute among children in vulnerable circumstances and for those with learning disabilities.

Care planning[8] (utilised in health and social care, encompassing patients' full range of needs) and support plans (how individual budgets will be used to drive desired changes) both offer some important lessons and can act as foundation stones for future initiatives. The former was an important feature of the NHS Institute's Productive General Practice and Productive Community Services programmes, aimed at driving greater efficiency while also freeing up time for health professionals to care for patients. Technologically-driven solutions can help to ease pressure on staff, provided effective training is given. However, both an evidence base and investment will be required.

All organisations should sign up to ensure a whole-system approach, driven by personal plans and aspirations, not just health indicators. Primary care has a part to play as an element within integrated community teams.

Case study: Integrated transition from paediatric to adult services

An integrated paediatric to adult clinic service in Oxford has improved outcomes for young adults with kidney failure.[9] It has done so by supporting patients to transition successfully from one service to another and enabling them to have more control over their care and treatment.

Typically in the UK, around a third of kidney transplant recipients who transfer from paediatric to adult services lose their kidney within three years. Communication is one of the biggest factors that empowers and supports patients. To address these issues and improve outcomes, Dr Paul Harden from Oxford University Hospitals NHS Trust, and colleagues, designed an integrated care pathway for the transition of paediatric patients with end-stage kidney disease to care in an adult renal unit.

A cornerstone of the programme was listening to the needs and wishes of patients and providing opportunities for different types of care and support, with peers, youth workers and clinicians in different settings: cafes, sports clubs, youth centres as well as hospitals. This approach resulted in zero transplant losses in patients who were transferred as part of the integrated care pathway. These findings demonstrate the significant benefits for integrating care, working more closely with patients, and are applicable to other chronic diseases.

NHS Kidney Care has also supported other projects to develop new approaches to supporting young adults. These have centred on the role of a key worker to work across adult and paediatric kidney services as well as primary care, social care and other settings using the 'You're Welcome' criteria to develop holistic patient care, supporting patients to have more control over their care packages.

Principle 2: Empowering patients to have more control over their care packages, strengthen prevention, self-care and wellbeing

Prompts to assist with putting the principle into practice

- Have you ensured that engagement has been undertaken with as wide a range of stakeholders as possible, not only patients and service users?
- Can you demonstrate that patient experience of integrated care is improving year-on-year?
- Are patients and service users being provided with all of the resources they need to enable truly shared decision-making?
- Is a case management model available for all patients with long-term conditions, where appropriate?
- Have all local health and care organisations agreed a whole-system approach to the delivery of services and patient empowerment?

Primary drivers to support actions

- Self-management programmes – enabling patients to take more control and responsibility for their care.
- Agreed patient pathways with monitoring – demand management can be more effective within an integrated model.

Secondary drivers focusing on specific actions to fulfil the aims of this principle

- A reliable, accepted tool used by primary care and potentially others.

Enabling projects/interventions to facilitate system-wide integration

- Roll-out and action recalibration of risk stratification tools, such as adjusted clinical groups (ACG).
- Clinical dashboard and care planning part of organisational development programme for practices – the NHS Institute's Productive General Practice.

Principle 3: Targeting services – focusing integrated services on those patient groups most likely to derive the most benefit

Organisations can use risk profiling systems to help identify those who should gain the most from an integrated care system. In times of scarce resources, it is important to target investment in such a way to derive greatest return.

The adjusted clinical groups (ACG) tool was identified as a possible enabling project for this principle. This case-mix system has already been implemented in some primary care trusts and enables risk profiles to be developed for entire populations, not just service users. Furthermore, it can bring together all available data across primary and secondary care and is centred around the patient.

Case study: Integrating delivery, the softer side

NHS Barking and Dagenham has integrated teams across primary and social care. The set-up was prompted by a number of challenges, including chronic obstructive pulmonary disease mortality, population turnover and the low number of GPs in the area.

Risk modelling helped to ensure the most effective approaches were targeted, with case conferences and a coordinator employed to manage the process. Integrated teams were co-located, which enhanced 'softer' skills that are essential for integrated care: improved communication; sharing of risk; and greater ownership. Solutions were developed and owned across health and social care. Named professionals are now in place to help patients navigate their way through the system and patient advocates support patients and carers.

Three boroughs utilise the same information system, which makes it much easier for hospitals to see and share data. In 2011, social care was reorganised to focus more on personalising services, which provided an opportunity to implement several of the changes. Each cluster serves six to seven GP practices, with a hub and spoke model employed to ensure a balanced workload across the clusters.

Principle 3: Targeting services – focusing integrated services on those patient groups most likely to derive the most benefit

Prompts to assist with putting the principle into practice

- Can you be confident that investment has been targeted at those most at risk?
- Have risk profiles been produced for local populations, not just those currently accessing services?
- Is there proactive management of high-risk patients?

Primary drivers to support actions

- Risk profiling – for the circa 5 per cent of patients deemed to be most at risk.

Secondary drivers focusing on specific actions to fulfil the aims of this principle

- A reliable, accepted tool used by primary care and potentially others.
- Clinical review of high-risk patients with care planning.
- Proactive management of high-risk patients by practices and community.
- Services integrated around clusters to support practices in managing high-risk patients.

Enabling projects/interventions to facilitate action across the system

- Roll-out and action recalibration of risk stratification tools, such as adjusted clinical groups (ACG).
- Clinical dashboard and care planning part of organisational development programme for practices – the NHS Institute's Productive General Practice.
- Organisational development programme for community prior to writing specification in partnership with practices and service.

Principle 4: Collective leadership and joint working – health and social care leaders jointly deliver solutions appropriate to their own communities

Risk sharing

A robust system of risk sharing could help to alleviate some of the anxieties held by the workforce around this agenda. However, while the sharing of risks is important, there is also a need to ensure shared gains, both at the micro and macro levels. This could enable savings to be reinvested, provided that desired outcomes are being delivered.

Technological solutions

Home and social care providers have already begun to examine risk and reward for both telecare and telehealth, although this has yet to happen at sufficient scale to initiate significant change.

Education and training

There is a challenge to ensure the necessary expertise is available. An example relates to the lack of paediatric training within primary care, with only around 40 per cent of GP trainees thought to have undertaken such specialist training. The RCGP has proposed that GP training be extended and enhanced (from three to four years) to reflect the changing needs of patients: this represents a significant opportunity to enhance patient care and should be implemented.[10]

Networks should be established between GPs and paediatricians, psychiatrists and geriatricians as appropriate to ensure that knowledge and advice can be shared frequently and with confidence. Furthermore, multi-agency working is needed to ensure health and social care professionals are knowledgeable about how different services work to improve the integration of care.

Professional bodies have a key role to play in the facilitation of more flexible working arrangements as organisations adapt to a more integrated system and the recognition of qualifications.

Collaboration and sharing

Appropriate information and communication infrastructure are needed to take this work forward, providing one place to access all available resources and a network of case studies. Round-table event participants agreed that we need to make the most of the different approaches utilised across sectors, ensuring shared learning from projects that have been both successful or otherwise.

Case study: Leading the way on telecare and telehealth

NHS North Yorkshire and York was the first commissioner to implement a long-term condition pathway redesign around a telehealth system. By the end of last year, more than 600 patients were using the service. In the first phase of evaluation, a 28 per cent decline in A&E attendances and a 40 per cent decrease in emergency hospital admissions was noted.[11]

NHS leaders were following in the footsteps of their counterparts at North Yorkshire County Council, who have been implementing telecare services across the county since 2005/06. Council analysis has shown that telecare services resulted in average savings of 38 per cent. Moreover, service users were overwhelmingly satisfied with the new approach, with 95 per cent reporting that telecare had enabled them to feel both safer and more confident and 91 per cent rating the service overall as either excellent or good.[12]

Principle 4: Collective leadership and joint working – health and social care leaders jointly deliver solutions appropriate to their own communities

Prompts to assist with putting the principle into practice

- Are commissioners and providers sharing risks and gains in integrated care?
- Are there developments in telehealth and telecare that join up services locally?
- Are there multi-agency training arrangements for health and social care professionals?
- Are lessons learnt in one part of the system being shared with other parts of the system?
- Is best practice being measured and shared and are lessons being learned from poor practice?

Primary drivers to support actions

- Integrated community teams working with primary care.
- Agreed patient pathways with monitoring – demand management can be more effective within an integrated model.
- Shared objectives with local authorities – one possibility is to expand the Quality, Innovation, Productivity and Prevention (QIPP) programme to encompass social care services.

Secondary drivers focusing on specific actions to fulfil the aims of this principle

- Services integrated around clusters to support practices in managing high-risk patients.
- A&E and minor injuries unit (MIU) pathways.
- South Central Ambulance Service (SCAS) pathways.[13]
- Local authority involvement in care planning and care in the community.
- Virtual wards, including end-of-life care – this scheme should ideally be mainstreamed to between 5 and 10 per cent of patients, focusing on those suffering from more than one long-term condition.

Enabling projects/interventions to facilitate action across the system

- Organisational development programme for community prior to writing specification in partnership with practices and services.
- Contracting strategy for providers with shared risk/incentives.
- Single 111 number and single point of access (SPA) linked by enabling IT. (To note: this is early in implementation and needs ongoing evaluation of pilot sites.)
- Shared objectives for use of reablement funding.

Principle 5: Incentivising integrated care – develop mechanisms to reward organisations and staff to deliver integrated care

There was agreement that the current tariff system puts incentives in the wrong place, with changes required to support greater personalisation of pathways. Design of new tariffs that can incentivise integrated care, both locally and nationally, can be supported with more widespread information sharing.

The Year of Care Programme for those with long-term conditions offers a potential solution. Its funding model is based around annual risk-adjusted and needs-based budgets for care delivery, as opposed to episodic activity payments. Having been successfully piloted for diabetic patients, the Department of Health is now testing and evaluating the model further, with Year of Care currencies and prices currently planned for national implementation from April 2014 and April 2015 respectively.

Alongside an acknowledgement that such reform would necessitate investment, a principle around trust, openness and an open-book approach was advocated (see principle 6).

Concerns remain that any savings generated from integration would be used subsequently to bail out other parts of the system – this would ensure a key incentive for reform is lost.

Workforce and training issues

Changes to workforce and education providers were deemed necessary to ensure a move towards integrating care within community settings. A more flexible approach is required, with in-service training provided, to enable staff to assume new approaches and responsibilities with confidence.

National frameworks and organisations should facilitate new ways of utilising staff, resources and information. An example that can also act as an underpinning driver is the use of outcomes measures across the various outcomes frameworks. The Government hopes that integration can be enhanced through the alignment of such measures across the NHS, social care and public health. Moreover, they can act as an incentive for staff to deliver integrated care out-of-hospital with proven value.

Case study: A successful integrated care programme

The coalition of organisations involved in Lambeth and Southwark's integrated care programme has been working on the integration of physical, mental health and social care for the past 18 months. A tailored model of care was developed following an extensive design process involving representatives from across health and social care.

Patient information from a three-year period was examined in order to identify potentially avoidable admissions and whether there were clear patterns of care at weekends. Clinical engagement and buy-in was secured. A rigorous business case was developed and financial flows over the same three-year period were mapped to help alleviate concerns around hidden costs. Shared governance arrangements are in place, which not only ensure regular monitoring of outcomes and costs but also that any significant changes are scrutinised appropriately.

Benefits realised by the programme include:

- fifty per cent of GPs are signed up to deliver holistic health assessments, *en route* to a longer-term objective to assess half of the over-65s every year
- a majority of the multi-disciplinary teams are now in place to support case management, with the remainder expected to be in place by January 2013
- GPs are able to access same-day or next-day appointments with geriatricians
- same-day rapid response packages are available in homes.

Principle 5: Incentivising integrated care – develop mechanisms to reward organisations and staff to deliver integrated care

Prompts to assist with putting the principle into practice

- How has your organisation ensured it is sharing information more widely to support new tariff development?
- Has staff training been reformed to enable greater flexibility and in-service training?
- What changes in practice have been driven by the various outcomes measures contained within the new outcomes frameworks?

Primary drivers to support actions

- Shared information to support design of national and local tariffs that incentivise integrated care within the NHS and across health and social care.
- Developed outcomes measures to demonstrate the value of out-of-hospital care.

Secondary drivers focusing on specific actions to fulfil the aims of this principle

- Use outcomes measures to incentivise staff to improve integrated care.

Enabling projects/interventions to facilitate action across the system

- Contracting strategy for providers with shared risk/incentives.

Principle 6: Ensuring openness and transparency – using an open-book approach towards all aspects of integrated care development

Assurances around transparency and competency must be sought for staffing, as well as finances. The impact of integrated care on staff, both on their ways of working and the care of patients, will need to be demonstrated. Clear articulation of the need for quality measures for integrated care will help to motivate staff to be innovative in their approach to driving improvement in outcomes.

Case study: Award-winning staff engagement

NHS Greenwich has driven the development of integrated community teams, as well as integration of intermediate and adult social care, through a recognition of the importance of people management. This was born out of an acknowledgement that the performance of an integrated model will be heightened through a range of bespoke approaches including: talent management; engagement; skills development; enabling employees to assume ownership of programmes; and widespread participation.

In December 2011, 61 per cent of service users who completed their reablement needed no additional support. There has also been a 19 per cent decline in intensive care packages. This work won the trust two awards in the 2011 *Health Service Journal* awards.[14]

Principle 6: Ensuring openness and transparency – using an open-book approach towards all aspects of integrated care development

Prompts to assist with putting the principle into practice

- Have staff felt engaged and supported throughout the transition to an integrated care model?
- What quality measures have been developed to facilitate innovative approaches from staff to drive integration?

Primary drivers to support actions

- Shared information to support design of national and local tariffs that incentivise integrated care within the NHS and across health and social care.

Enabling projects/interventions to facilitate action across the system

- Contracting strategy for providers with shared risk/incentives.

Conclusion

We hope the principles and drivers discussed above act as an invaluable tool for organisations planning to implement integrated out-of-hospital care. It must be stressed that the examples used are only a starting point and are by no means exhaustive. There are many drivers and enablers that can help to make this all-important agenda a reality in the years to come, as the benefits of developing integrated, innovative models of care outside of the hospital setting are unequivocal.

For more information on the issues covered in this *report,* please contact Sam Hunt, Senior Policy & Research Officer, at **sam.hunt@nhsconfed.org**

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Making integrated out-of-hospital care a reality

At a time when the NHS is embarking on the most substantial reforms in its history, during a period of flat funding in real terms and increasing demographic pressures, the effective delivery of integrated care is vital.

This report presents a set of principles to act as foundations for delivering integrated out-of-hospital care. It provides local leaders with prompts to check whether they are implementing the principles, and gives case studies showing how the principles are already being applied in practice.

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