# HealthInvestor round table

## Integrated care: Crossing the divide...

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If the political parties' health teams could agree on anything during the election period, it was that integration of health and social care budgets and services was a must.

However, it is still early days and the implementation of the vision set out in Simon Stevens' 'Five Year Forward View' (FYFV) has so far been led by NHS commissioners, NHS providers, and local authorities. The independent sector, including the third sector, has been mostly kept at arms-length when it comes to breaking the barriers between health and social care.

This lack of engagement with private and third sector providers – who deliver the vast majority of social care – is a major stumbling block to developing new models of care that drive quality and efficiency in the market.

So what can the health and social care community do to fully engage all of the stakeholders required for successful integration?

**Vernon Baxter:** At a recent Health Select Committee meeting, Jeremy Hunt talked at length about difficulties caused by the ageing population, financial pressures, and raised expectations from users. In this climate, how likely is it policy goals such as integration will be pursued?

**Stephen Dorrell:** The triple whammy, as it has become fashionable to call it, is not at all a new concept – in reality, it is as old as the health service. There was an American commentator a few years ago who said we must be careful not to waste a crisis, and the key issue is not to shave bits off here and there and continue as before, but to recognise integration is about changing the ways health and care services are delivered. We have inherited a whole system of silos and institutions. In so far as they were designed at all, they were designed for a different era, different demand pattern, different technologies. They are massively out of date and they need rethinking. The important thing is not to go to the Treasury and ask for money to save the system, it is to insist that we mustn't waste the crisis.

**Vernon Baxter:** Steve – it's been a bit of time now since the election. Do you see movement in the system?

**Steve Melton:** We need to see leadership in terms of how we adopt new models for care. I would be a real advocate of empowering organisations like CCGs or providers to bring forward new models, because I think that is tried and tested in every industry as a means of generating innovation. The vanguards are out there but, as an observer, I still don't see it. In particular we don't understand yet what role the government would like the independent sector to take in that journey, if any. We are very happy to contribute. But only if there is a stable commercial environment in which one can contribute and get a return on investment for it.

**Vernon Baxter:** Neil, do you feel the NHS environment is currently conducive to reform?

**Sir Neil McKay:** First of all, I agree absolutely with Stephen's view that we shouldn't waste a crisis. In all of my years as a chief executive at different levels of the NHS, the greatest catalyst

for change has been a good old problem. We have not always got the results that we wanted, but it has certainly forced people to think about how to do things differently. The notion of achieving financial salvation by salami slicing is just hopeless. One of the biggest issues we have is leadership capacity. We have got some brilliant leaders in the NHS but there aren't enough of them. The view that we should wait for the government to declare its hand about how the independent sector should play into integrated care, would probably result in us sitting around for years waiting for it. The confident leaders locally will find ways of working with the independent sector.

**Ian Baxter:** The independent sector in that sense can be a catalyst because I think part of the issue is it is not just a lack of leadership but there is also just a lack of leveraged resource as well. People will try and work their way through the crisis with their heads down, rather than looking out. When you are looking at new models of integrated health and social care, it requires capabilities that haven't pre-existed in the NHS, or even local authorities.

**Stephen Dorrell:** People often used to come to me when I chaired the health committee and say 'we have got this wonderful idea about how care could be improved. Will you introduce us to somebody in Richmond House?' I always used to say, 'don't go anywhere near Richmond House'. If you have got a good idea don't wait for it to be blessed as the new programme, just go and find a problem and solve it. We will never make progress with integration if we try and do it everywhere all at once. Find somewhere where that solution works, and apply it.

**Clare Auty:** I think there are missed opportunities at the moment, because we have Devo Manc and, as far as I'm aware, there is no independent sector or third sector provider involved. That would be the perfect opportunity. I know people have asked to be involved – and I've been in meetings where they have said 'please can you be involved, please can we have a chance to work together to try and come up with a solution'. So there is an appetite there but the door is still not fully open.

**Steve Melton:** Perhaps if I could just jump in on Stephen's point there. We have probably demonstrated by our actions that we are keen to get stuck in. But there comes a point where you actually do have to have a degree of permission or enablement that supports these things scaling. We are also hitting some fundamental issues like if you are an integrator you can't get access to patient level data. The system resists us doing the very thing we are there commissioned to do. My fear at the moment, if I look at a lot of the vanguards and integration conversations going on, is that integration is being seen as an invitation to close ranks between providers and commissioners locally to the exclusion of choice for patients and participation by the independent sector.

**Leanne Wareham:** There is real nervousness as well about sharing information between providers. One of the projects I've been involved in involves an alliance of the acute sector, ambulance services, community services, mental health and the independent sector. If you are going to be the lead provider, you need to share information on performance, on finances, and contract management. There is suddenly a bit of a nervousness about that because people think these partners are still effectively our competitors. We need a really open culture but I don't think we are quite there yet.

**David Torbet:** You can differentiate between the philosophical barriers that we are talking about here, as in nervousness around the private sector, or fear of profit, but actually the biggest issue may be the practical barrier. How do you actually share data? I also think different timescales are at play. Stephen, Circle are a great example of a company that tries to think outside of the box. ▶

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But if you are ramping up to deal with those challenges, you are recruiting, training and planning, and then if the other side is not responding in the timescales that you ultimately need them to, then it is very difficult to keep that running. There is a total mis-match of timetable there.

**Clare Auty:** The timescales within the NHS are sometimes different as well. On the commissioning side, the time that you are actually given to put in your bid for your contract work is very short. So you might have a service that you are asked to provide, but it doesn't give you enough time to identify suitable partners, go through the pricing and put that together. If you are bidding for a one-year contract you are not going to do that. If you have got a three or a five-year contract you would invest the time to do that and come up with innovative models.

**Vernon Baxter:** Contract length is one aspect – but delivering a care pathway can be complex. Rebecca, how difficult is this for a regulator?

**Rebecca Lloyds-Jones:** To some extent there is a structural challenge for us, in that we are established to regulate per provider who is registered with us. We have begun to try and do some more strategic thinking about this more integrated model. We do have the ability to conduct reviews, and I think that is probably how we will do it for now. That might be quite a helpful way of being able to step back and take a holistic view of a particular model of care from an end-to-end user perspective, which I think could be a more constructive approach than trying to regulate in parallel 15 providers all grouped together. But I think at some point the government will have to take a view on whether the powers that we have got and the way that they are established, will need something additional to make us a bit more flexible.

**Steve Melton:** As a provider, actually risk management isn't that difficult. We simply have taken on the risk and then shared it appropriately. We are not frightened to take on risk, including demand risk and other pretty substantial risk, because we have the levers to manage it. That is the crucial bit, and that is the distinction from our experience of running an acute hospital where you take the consequences but you can't actually control some of the phenomenon that are influencing your ability to be a success.

**Stephen Dorrell:** Can I bring us back to something Steve said about data systems. What we are seeking to do this morning is to explore the obstacles for the development of new models of care. Every other sector has been reinvented around the capacity of IT systems to change the relationship between users and providers and different parts of the supply chain. That is the thing that marks out health and care services from other sectors – we haven't changed our business model to realise the potential which information systems provide. Unless, and until we do that, we shall continue to run into the kind of problems that Steve has identified. We pay multiple times to gather the information and we don't use it because the structures don't exist to allow us to do so. That is actually a scandal.

**Ian Baxter:** Integration has to change the nature of provision but it also has to change behaviours by having different modes of communication.

**David Torbet:** The other big barrier that has been swept away in most other sectors is professional demarcation. 'I

am a doctor I do this', 'I am a nurse I do this'. And because of commercial pressures that is typically an argument that gets addressed in other sectors. We shouldn't underestimate the challenge of that in health and care.

**Sir Neil McKay:** There is another major obstacle to progress – the disparate nature of the organisations involved. There is one patch that I was looking at recently that was thinking about integrated care, and I counted 23 different organisations, all of whom had a legitimate claim to being involved in a process of trying to design an integrated out-of-hospital care system.

**Stephen Dorrell:** I completely agree with what Neil has said, but there is a default instinct that we should be wary of, which is to say therefore we must have it all in one large organisation. This is about connecting organisations, it is not about reinventing the statutory bodies.

**Steve Melton:** I passionately believe you are right, but there are a number of individuals and organisations who believe that integration is all about creating one big monolithic organisation. Our experience in Bedford proves the opposite. You can actually use integration to promote managed competition.

**David Torbet:** Integrated care and the overall concept should deliver cost savings, it should be a benefit, but I do worry that if you are commissioning on that basis the unit you are commissioning may well cost you more due to unmet demand coming through. Your savings will be in five years' time when the incident that would have occurred, doesn't occur.

**Leanne Wareham:** There needs to be a really long-term view to financial savings. They are not going to be seen until possibly 10 years' time if you are dealing with preventative care, particularly. If a provider is only getting a contract for year or two years, with very limited scope for extension, they are really not encouraged to invest upfront in the long term structure of the integrated care system. Not just financially but also in terms of time and energy as well, and bringing staff on board.

**Clare Auty:** You need a holistic approach from both the commissioner and the provider because you have got to have a way of transmitting the benefit and savings across organisations, otherwise people will just see it as a great idea. It could improve a patient outcome but 'if there is no fiscal or reputational benefit I'm not going to do it'.

**Stephen Dorrell:** 25 years ago we used to fund institutions. Progressively, and very messily, we have emerged from that to a position where provision is to some degree separated from the commissioning process. And it is an imperfect world but there is recognised to be a commissioning process which is separate from provision. This links to Devo Manc because it allows the Howard Bernstein's of the world to come forward and say stop funding the health service in Manchester, stop funding social care in Manchester, just fund Manchester and let us use pounds in Manchester in a way that delivers better services for Mancunians, and let us work out whether it is an NHS pound or a social care pound or an independent sector pound or a private equity pound.

**Vernon Baxter:** Looking at it from the point of view of social care providers – is there a risk that they would simply be overwhelmed by larger NHS providers in an integrated system?


**Ian Baxter:** Whether you are in a local authority or in a healthcare organisation, your focus should be on the patient improving the outcome for the patient. But the point is that people have worked in their silos for years and years, so people have never worked together and don't trust each other as if we all worked together in a room side by side.

**Leanne Wareham:** The distrust comes in part from concerns in the acute system that any sort of integrated care model that is designed to keep people out of hospital will lead to a decline in activity and a decline in financial resources. My view is that is not an argument against integration, it is a problem we will have to deal with.

**Sir Neil McKay:** You are absolutely right Leanne, but it is a real issue. There will be lots of fixed costs that will need to be covered somehow or other. It is the system's responsibility to think about that consequence and consider how to plan your way through it. I find it fascinating that when I spend time with integrated care teams, they are feverishly enthusiastic about the work that they do. It is hard to spot any demarcation because they are thinking about a patient, and what is best for them.

**Stephen Dorrell:** Any integrated care team, virtually by definition, will have people from the independent sector in it because if it is

engaged in community services it will almost certainly have the local social care people who are overwhelmingly from the private or independent sector. We also should remind ourselves that it will quite often have a primary care representative, which is also in the private sector. There is a lazy tendency to think even the NHS is a Stalinist central state owned system. That is just not true and never has been.

**David Torbet:** It is valid to question how the culture of social care needs to change as well. It is a very well understood model. You are a provider, there is a commissioner, there are targets, you get regulated this way, you get paid in this way. It has worked. But we are, as the private sector and social care providers, somewhat institutionalised. The business model is for good providers to build the capability to meet that demand. But that is not really what we need.

**Steve Melton:** We have great experiences working with NHS colleagues in integrated pathways and inside hospitals and outside and so on. I have no issue ideologically with that at all. But where we have a challenge is that if commissioners do not seek to bring procurements to market, then you can't as an independent provider take part or offer your alternative to them for consideration. That is where people need to be open to ideas. ■

*The above is an edited transcript and is not reported verbatim. The panel met in central London on 17 September 2015. For more information on HealthInvestor roundtables, please call 020 7451 7067 or email mark.harper@investorpublishing.co.uk*

Integrating health and social care is something of a Holy Grail for the UK's health system but as our discussion made very clear, it's a quest that is unlikely to be complete anytime soon. What is vital, however – as Stephen Dorrell emphasised through the debate – is that our health and social care systems do not 'waste the crisis'. In other words, the triple pressures of our ageing demographic, increased expectations from service users and patients and a very challenging financial environment have to be a catalyst for change.

Breaking down silos between health and social care – and within both existing systems – is complicated by a number of factors. Technically, legally and culturally, integrating care pathways across the NHS and social care is going to require an enormous amount of effort, thought and leadership. Our panel agreed that our approach to information and technology was perhaps the greatest enabler for achieving integration – but in many ways it is currently acting as the biggest block to progress. Providers have learnt already that even if the stakeholders, patients and leadership are willing, often information is missing, duplicated or inaccessible to providers in a care pathway.

There are many very compelling reasons for pursuing integration across the system – and pioneering initiatives such as Devo Manc represent a significant opportunity to move the debate forward. What is apparent from many of these pilots, however, is that integration will require significant investment and there will be few 'early wins'. There needs to be a long term commitment of time and resources to make progress with integration, and in a system where resources are scarce making the case for care pathways will require strong leadership. ■

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