Vertical integration: who should join up primary and secondary care?

Summary of IPPR seminar 27th February, 2006

A discussion note by IPPR was distributed to participants, along with Monitor’s paper on Foundation Trust provision of primary and community services. These, and other papers related to the Foundations and Fundamentals seminar series, are available online at: http://www.ippr.org/research/teams/project.asp?id=1754&pid=1754 and http://www.monitor-nhsft.gov.uk/publications.php

These notes summarise key themes from the discussion. These notes represent IPPR’s interpretation of the discussions, but not necessarily IPPR’s position. The seminar was held under the Chatham house rule and the notes have been structured to reflect this.

The seminar opened with three presentations. Slides are available on the IPPR website above.

Vertical integration and the NHS reforms – the missing link?

Prof Chris Ham, Health Services Management Centre, University of Birmingham

Prof Ham contextualised the debate in the wider trends in health, with advanced societies moving from infectious to acute and increasingly to long-term conditions. Hospitals are no longer so central to health services, with primary care, continuity and self-care greater priorities for the future.

Prof Ham emphasised that integration should not only be considered at the organisational level. Clinical or service integration should be higher priorities that vertical organisational integration. Service integration can be ‘virtual’ – i.e. collaboration between different providers and commissioners to provide continuity of care for patients or particular disease pathways.

The challenge in the current reform agenda is combining collaboration and competition. There is a risk that competitive incentives will crowd out collaboration. For example, Choice and Payment by Results concentrate on electives rather than emergencies and Long Term Conditions. However collaboration and competition are not exclusive – there are elements of both in the private sector. In the future, different organisations provide different services – e.g. primary care, outpatients, diagnostics and day surgery in integrated medical offices, acute inpatient facilities and ICU at a streamlined hospital, community hospital for intermediate care.

Kaiser Permanente has achieved more integrated care with greater efficiency. NHS Kaiser pilots in Birmingham, Northumbria and Torbay are trying to implement these lessons, requiring strong leadership to maintain the model in the face of policy disincentives.
In order to provide more integrated care, we need to go beyond thinking about primary and secondary care as oppositional and exclusive. However, current reforms are a risk. For example, choice and PbR ignore the 2/3 of bed days that derive from emergency admissions.

**Vertical integration – you know it makes sense!**

**John Coakley, Medical Director, Homerton University Hospitals NHS Foundation Trust**

Dr Coakley described the characteristics of Homerton Hospital treatment and admissions. Homerton’s admissions are largely emergency-driven, with attendances at A&E increasing often due to under-provision of primary care.

Dr Coakley pointed to the cultural barriers between primary and secondary care, with antagonistic relationships and a frequent lack of mutual understanding. He challenged assumptions about hospital-inflated demand, and emphasised that hospitals were part of the solution rather than the problem of integration.

For example, Homerton runs a growing number of community services, including a significant primary care component in A&E.

Hospital professionals want to be able to run more preventive chronic disease management programmes with GPs with Special Interests, etc. At present FTs are not commissioned for this preventive primary care work. Meanwhile, Primary Care Trusts and Practice Based Commissioners will continue to commission and provide.

Dr Coakley concluded that there will be no service integration while we are arguing about money and structures. He therefore called for a pragmatic approach, allowing FTs to work in collaboration with community services to provide more integrated care. He also argued that integration should focus on relationship building between acute and primary care as this has been a major barrier to providing integrated care.

**Primary care-led commissioning**

**Dr Pete Smith, National Association for Primary Care**

Dr Smith also stressed the need to look at integration from a pragmatic perspective. Practical benefits of vertical integration include FTs managing patients upstream. Integrated providers could be particularly valuable for small communities. However, there are also possible disadvantages of vertical integration would be going against the process of creating a market and patient choice.

Practice Based Commissioning consortia will be doing ‘total purchasing.’ They will need to manage demand by working with secondary providers, not against them.

The creation of a market in primary care will be useful to drive up standards. In this context it would be good to have FTs in the bidding process as one option. Difficulties of market management would be managed by commissioners.
Discussion
The presentations were followed by a discussion chaired by Dr Jessica Allen, senior research fellow in health and social care, ippr. These notes reflect some of the key themes and points made in the discussion.

Role of commissioners
PCT and practice based commissioners are tasked with shifting care out of hospitals into the community and managing provider markets. Intelligent commissioning will be key in ensuring that care pathways are joined-up.
PCTs will be commissioning primary care, and there may be a lack of people, skills and seniority to oversee contract performance. There may be a temptation for commissioners to favour vertically integrated providers as an easier option, rather than proactively managing the market and commissioning appropriate pathways.
There is a risk that commissioners – particularly in practices – will lack the capacity to commission integrated, quality, planned and innovative care based on outcomes and partnerships. Commissioners are likely to put out contracts based on cost and volume.
There is a continuing question about whether PCTs can and should continue to provide services as well as their core commissioning function. However, it was also argued that commissioners would see the benefit of separating commissioning and providing interests to ensure best value.
There could be positive case studies within the UK of integrated services in mental health.
Overall there may be a disproportionate burden being placed on commissioning as the panacea for potential problems with system reform, and a risk that commissioners will lack the capacity.

Role of primary care
Access to primary care, particularly in poor areas, is crucial to enabling more integration. Lack of GPs puts extra pressure on hospitals that are reduced to emergency-led provision, and prevents the development of more integrated care pathways. It was suggested that more provision of primary care alternatives in the A&E setting could be a solution and offer real choice. Co-located walk-in centres are valuable, but often are not open out of hours.

Role of Foundation Trusts
There are differences between FTs, so their relative integration with community and primary services should reflect these. For example, an international specialist hospital may do better by concentrating on secondary care; whereas a smaller, community-based hospital with stronger links with primary and community services could be better placed to be more integrated.
It was argued that FTs want to keep people out of hospital as well. The rigours of Foundation status and Payment by Results will ensure that they are motivated to make relationships locally, co-operating to
reduce costs. FTs will mainly want to slim down and focus on their area of expertise, rather than empire-build or create monopolies.

It was questioned more generally whether it would be desirable to keep FTs out of the primary care market. FTs have better community links and greater transparency than many independent sector providers so should be encouraged to enter the market, in particular in challenging locations where vertically integrated providers may be the only way of getting services off the ground.

Payment by Results
Tariff-based competition is intended to ensure competition on quality and satisfaction rather than on costs. Movement towards best-practice pathways as the basis for tariff-setting could provide additional incentives to provide more integrated pathways. However, this also carries more risks for acute providers, who currently have required minimum staffing levels to maintain services within Working Time regulations and rota and on-call standards. If tariffs mean that services become unsustainable, will FTs be subsidised, or will they exit from those services?

Regulation
Oversight of commissioners also remains unresolved. It is not clear who will be performance managing commissioning, and who will be responsible for managing the market. Will Strategic Health Authorities, Monitor or Healthcare Commission hold the ring in market management?

Integration from the patient’s perspective
It should not be assumed that integration – and moving care out of hospitals – is always what patients want. Quality of care is more important. Co-location of specialties in District General Hospitals can offer more convenience and less travel between more specialist community hospitals. It may not be integrated from the patients’ perspective to be discharged from an acute hospital therapy team to a different community hospital team. Patients could deal with more teams in more locations.

It was asked what the incentives were for long term conditions, with the current policies focused on choice and PbR. Patient pressure on commissioners could be one form of incentive.

From a patient’s perspective, organisational barriers are less important than communication and co-operation. Barriers within organisations may be more significant than barriers between organisations.

Communication and engagement
Cultural and communication barriers between primary and secondary care are a significant problem. It was suggested that all hospital doctors are exposed to general practice in training so they understand and respect primary care.

US providers have made massive investments in communications, aiming for long-term benefits of integration. Connecting for Health should be the answer to many of the perceived barriers.
Foundations and fundamentals

This was the fourth in a series of seminars addressing five key challenges for health system reform: regulation, commissioning, governance, integration and financial frameworks. For further information please see the website at http://www.ippr.org/policyareas/?id=1226.

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