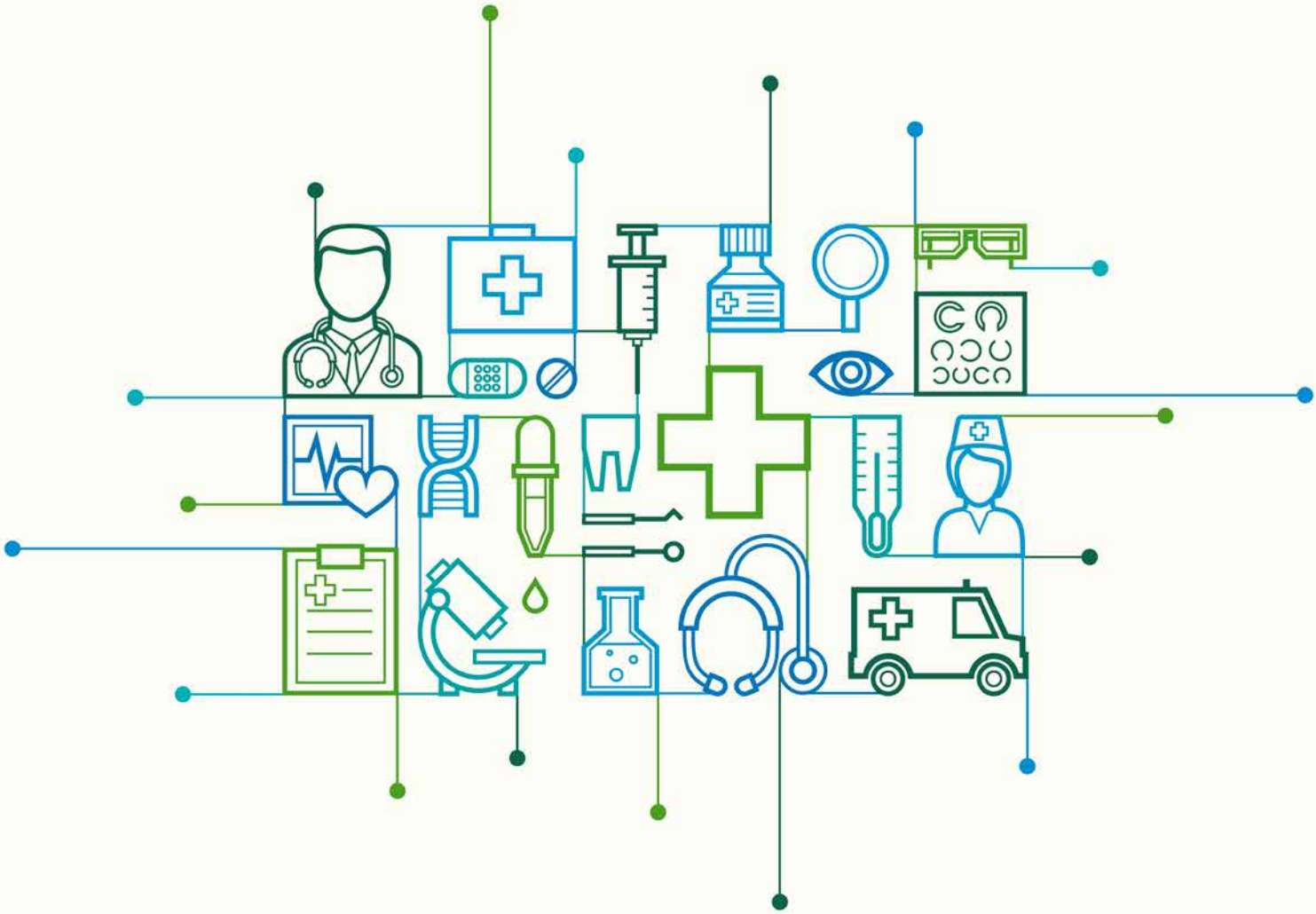
Integrated Care Roundtable

Co-Chaired by Rt. Hon. Stephen Dorrell and Lord Ara Darzi

This report has been created by PPP with input and financial support from MSD



Public Policy Projects

Introduction

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Constraints on NHS funding growth combined with increasing demand for healthcare as well as technological advances have resulted in a 'black hole' in NHS funding of around £30bn by 2020/2021[1], which is only expected to grow. In order to close this gap, new ways of providing services need to be explored. The NHS England Five Year Forward View (FYFV) set out concisely the challenge and the direction of travel towards tackling this fragmentation:

> *'The traditional divide between primary care, community services and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. Long term conditions are now a central task of the NHS; caring for those needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. Increasingly we need to manage systems – networks of care – not just organisations. Out-of-hospital care needs to become a much larger part of what the NHS does. And the services need to be integrated around the patient.'* [2]

Following on from this, the NHS released its Long Term Plan[3] setting out the vision of how the health service will be transformed over the next decade, to better meet patient and staff needs. Included within this was the aspiration to boost out-of-hospital care, prevent health inequalities, offer more digital solutions, upgrade technology and improve care quality and outcomes.

From these aspirations we have seen the growth of 44 Sustainability and Transformation Plans (STPs) which evolved into Integrated Care Systems (ICS) in some areas. This journey is expected to continue, with Next Steps on the FYFV setting the goal:

> *'Our aim is to use the next several years to make the biggest national move to integrated care of any major western country.'* [4]

But how – and whether – Integrated Care Systems will work, and whether they are alternatives remains a topic for significant discussion. Public Policy Projects, supported by MSD, recently bought together experts from across primary and secondary care, as well as NHS England and local government to discuss the topic, chaired by Rt Hon Stephen Dorrell.

We are grateful to the following for their contribution:

Lord Ara Darzi	Professor of Surgery	**Imperial College London**
Bob Alexander	Associate Director, Health and Integration	**CIPFA**
Chris Harrison	Medical Director	**The Christie NHS Foundation Trust**
Mike Morgan	National Clinical Director for Respiratory Services	**NHS England**
Matthew Swindells	Deputy CEO	**NHS England**
Ian Dodge	National Director Strategy and Innovation	**NHS England**
Harry Quilter Pinner	Research Fellow	**IPPR**
Dr Karen Kirkham	National Clinical Advisor Primary Care and Clinical Lead	**Dorset ICS**
Sally Gainsbury	Senior Policy Analyst	**The Nuffield Trust**

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The Challenge

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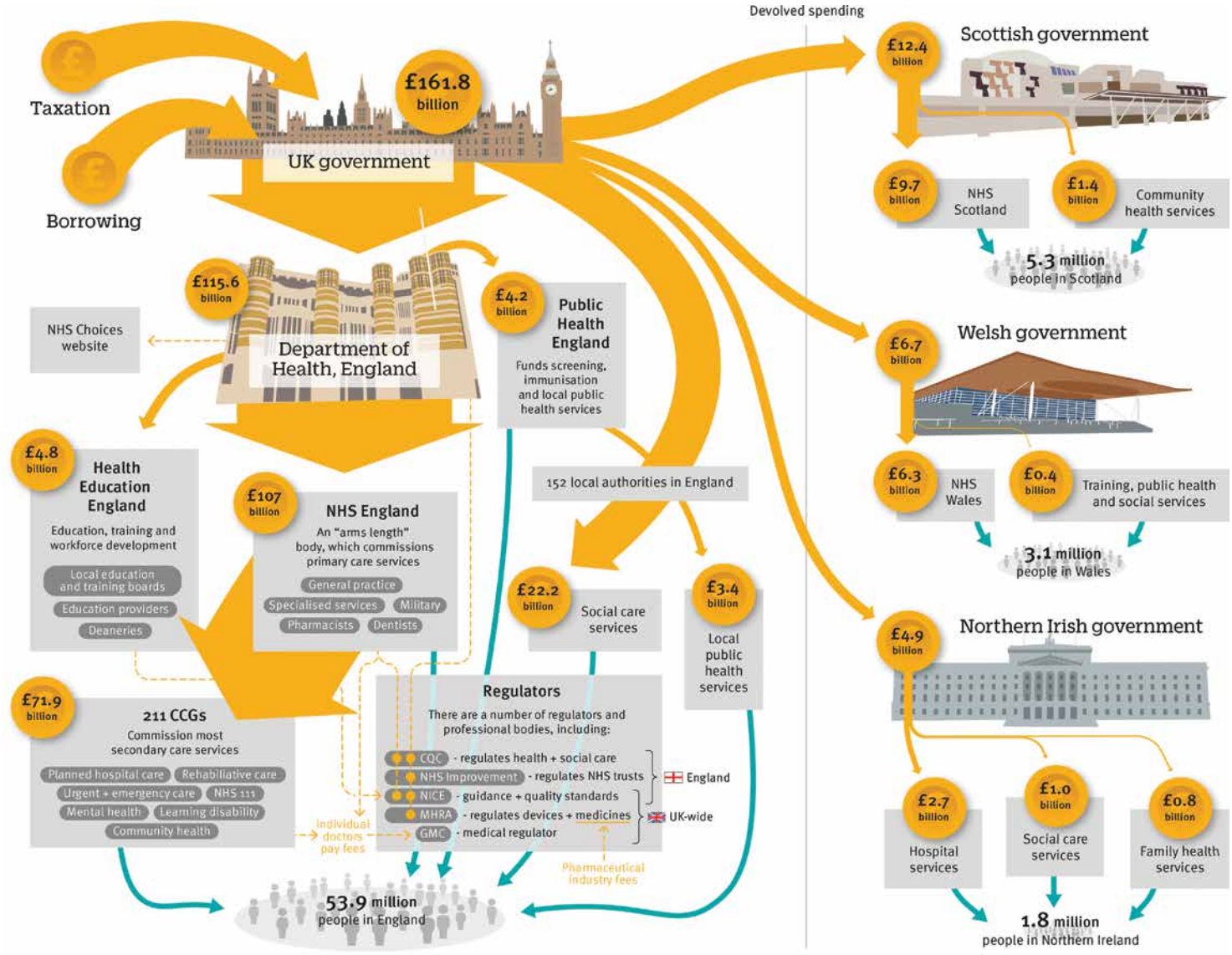
Public support for the NHS is almost universal, with 90 per cent of the population supporting the founding principles of the NHS.[5] However there remains some confusion between support for the principle of universal healthcare, and the institutions of the NHS in their current form. Changing demographics, demand and treatment options mean that how we are cared for has changed, and yet the institutions in which we are cared for are largely unchanged since 1940s.

This is the challenge faced by those responsible for leading the NHS into the next 70 years; how to change the institutions to meet the realities of modern life, without departing from the principle of universal healthcare.

We often refer to the NHS as one institution, but in reality it is very fragmented, with 195 Clinical Commissioning Groups (CCGs), 135 acute non-specialist trusts, 17 acute specialist trusts, 54 mental health trusts, 35 community providers and over 7,000 GP practices.[6] Encouraging them to work together, as well as with Local Authorities, Local Education Authorities and social and third party providers is essential if we are to have an NHS fit for the twenty first century.

NHS Structure [7]



Alongside the challenge of fragmentation is the most significant challenge the NHS faces, that of affordability. The UK currently spends 9.8 per cent per cent of GDP on healthcare[8], compared with 17 per cent in the United States, and between 9 and 12 per cent on average across Europe.

Layer on this the country's changing demographics and increasing technological advancement gives a clear burning platform for action.

Integrated Care Systems & Primary Care Networks

To address the growing affordability challenge of the health service, NHS England announced plans for Integrated Care Systems in the NHS Long Term Plan. Integrated Care Systems (ICS) are expected to cover the whole country by April 2021. Their objective is to be a partnership between the NHS and other stakeholders including local government, the independent sector and the third sector. The commitment of NHS leadership to build a more collaborative approach at local level is key; it reflects recent developments in the structure of local government, and it offers the prospect of developing a focus on outcomes and away from the excessively transactional approach which has grown up in recent years.

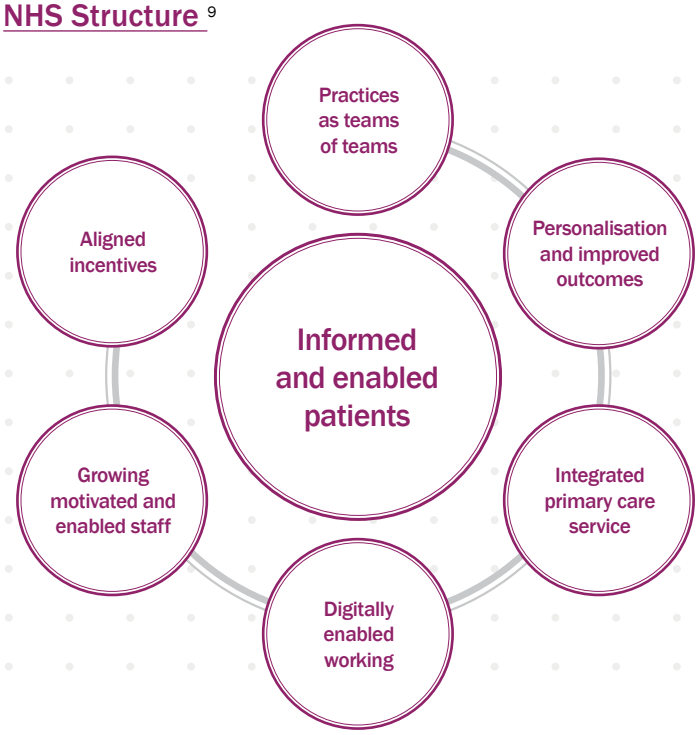
Alongside this, NHS England has committed that every GP practice will be part of a Primary Care Network (PCN) and that PCN territories will be the basic building blocks of each ICS. Most PCNs will be GP led networks of existing GP practices contracted under a nationally mandated formula by slimmed down CCGs, working within the ICS framework.

The Building Blocks

Universal Primary Care Networks: There is a benefit to the national agreement for Primary Care Networks, with supportive Local Medical Committees (LMCs) in order that there will be universal coverage across the country, which will require all GPs to engage. PCNs will result in a named clinical lead in each area, who will be responsible for working with community teams and other specialists, such as geriatricians, specialist nurses etc on care redesign. The commitment to ICS and PCNs must be retained – to prevent people going back into their vested interests - whilst looking at overlaps and geographies. In some areas there is a PCN, an ICS, a Cancer Network and multiple local authorities with differing geographies and participants. These new networks need to fit alongside – or be integrated with - existing, successful organisations.

Vertical and Horizontal Integration: It will be impossible to stem the tide of patients into acute care without changing the interaction between primary and secondary care. This is not simply about GPs working together, or working with other primary providers, there also needs to be vertical integration, with the secondary care clinicians becoming involved in

NHS Structure [9]



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primary care and taking greater responsibility for the local community. Primary and secondary care providers need a shared purpose and objectives. Integrated care organisations are the right vehicles to deliver vertical integration, but they need to start off on the right track. Too many people have the wrong diagnosis, diagnosis too late or never had a diagnosis made. In order to address this, clinicians need to get out of secondary care settings – either physically or virtually – and work alongside primary providers to improve diagnostics and care.

Data: PCNs are a good size from an information perspective; as they allow data to be analysed and conclusions drawn about the local community. The aspiration must be to set the population health outcomes an area wants to achieve and use data to assess whether new models of care are speeding progress towards those goals. This will require all organisations to participate in data collection, data sharing and data analysis so that decisions about cost and clinical effectiveness, as well as outcomes, can be taken.

Widen the Network: The PCNs and ICSs are good building blocks, as they bring together many of the key participants in delivering local healthcare. But alongside traditional NHS providers, the ICSs must work with non-NHS providers, such as local education authorities, third parties and the independent sector to strengthen the networks and set common objectives.

Secondary Care Pathways: Just as we want aggregation at primary care level, we also need good referral flow, based on standardised pathways using best practice. ICSs need to be designing standard secondary care pathways which are adhered to. This should cut out duplication, improve inefficiency and result in consultants seeing the right patients. There needs to be a clear focus on evidence-based pathways and whilst there might need to be some local variation, there should be a standard basis of care and diagnostics a patient should have received before they reach secondary care.

Preventative Healthcare: There is no doubt we are on the cusp of a technological revolution, with digital and wearable technology which has the potential to move us towards personalised health support. But how does a system which is built around bricks and mortar adapt to the technological challenge? However, questions remain about whether the NHS is ready to embrace it, and whether patients would accept the intrusion into their lives such advancements could bring. Easy to give someone the device, but who collects and analyses the data? Is it possible that a future version of NHS 111 could involve a link between kite-marked wearable technology and the 111 call centre, so that the devises can alert the 111 operators to any concerning readings?

Engaging Local Government: Since the foundation of the NHS questions have been asked about where the responsibility for public health rests and how local authorities and NHS institutions should work together. Historically it has taken a long time to get some local authorities and the NHS to collaborate; they are worlds that should collide, but the language can be very different. Within the last eighteen months there has been some progress, with some areas convening local boards along the lines of Health and Wellbeing Boards. Building on this partnership and setting common objectives between local authorities and ICSs will be vital to their overall success.

Transparency: Do we need to name and shame local authorities or NHS organisations who don't fulfil their responsibilities? How do we highlight poor use of public resources? Do we need a national commitment to transparency to reveal health inequalities, bad decisions or ineffective use of resources? Is there a role for Government in highlighting the opportunity cost of bad behaviour and poor decisions?

Role of the employer: Is there a role of employers in providing healthcare, working in partnership for the benefit of the population? Evidence from the United States shows that this can benefit employers by resulting in a healthier workplace and fewer lost days due to ill-health. If we are going to engage employers it needs to be on the basis of contributing to universal healthcare, and not moving towards an insurance-style model. If we ask employers to engage with health, and give them an incentive to do so, what is it that we would ask them to measure, accounting for the reality that workforces start from different baselines.

Role of other third parties: How do we bring in other non-traditional players, such as house-builders. There is evidence to link poor quality housing to poor healthcare, so would it be possible connect housing expenditure with health outcomes? Many developers would want to be part of a healthy community initiative, and simple improvements to house design could have a significant impact on population health.

Recommendations

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1) The Government must commit to the ICS and PCN structure, in order that organisations have time to adapt and embed structural changes.

2) Steps must be taken to vertically integrate secondary care, as well as horizontally integrate at primary and community level.

3) Clear data standards need to be established, so data is comparable between localities, and can be used to improve services and patient outcomes.

4) Networks must go wider than healthcare and include education providers and other community and independent partners.

5) Standardised secondary care pathways should be developed.

6) The ICSs must embrace preventative healthcare technology and integrate it into healthcare networks.

7) Local Government must be integrated as a true partner with the ICSs.

8) The Government should use data to highlight poor performing Local Authorities or NHS organisations.

9) The role for the employer must be explored, to engage employers in the health of their workforce.

10) Non-traditional players, such as housebuilders, must be included with the ICS plans, to help improve overall population health.

About our speakers

About Lord Darzi

Professor Darzi holds the Paul Hamlyn Chair of Surgery at Imperial College London, the Royal Marsden Hospital and the Institute of Cancer Research. He is Director of the Institute of Global Health Innovation at Imperial College London and Chair of Imperial College Health Partners. He is an Honorary Consultant Surgeon at Imperial College Hospital NHS Trust.

Research led by Professor Darzi is directed towards achieving best surgical practice through innovation in surgery and enhancing patient safety and the quality of healthcare. His contribution within these research fields has been outstanding, publishing over 800 peer-reviewed research papers to date. In recognition of his achievements in the research and development of surgical technologies, Professor Darzi has been elected as an Honorary Fellow of the Royal Academy of Engineering; a Fellow of the Academy of Medical Sciences and in 2013 was elected as a Fellow of the Royal Society.

He was knighted for his services in medicine and surgery in 2002. In 2007, he was introduced to the United Kingdom's House of Lords as Professor the Lord Darzi of Denham and appointed Parliamentary Under-Secretary of State at the Department of Health. Upon relinquishing this role within central government in 2009, Professor Darzi sat as the United Kingdom's Global Ambassador for Health and Life Sciences until March 2013. During this appointment and beyond Professor Darzi has developed his status as a leading voice in the field of global health policy and innovation. Professor Darzi was appointed and remains a member of Her Majesty's Most Honourable Privy Council since June 2009.

About Rt. Hon. Stephen Dorrell

Stephen is currently Chair of the NHS Confederation. He stepped down as a Member of Parliament in May 2015.

In May 1979 Stephen was elected as the first Conservative Member of Parliament for Loughborough. From June 1983 to June 1987, Stephen served as Parliamentary Private Secretary to the Secretary of State for Energy, the Rt Hon Peter Walker MP. In June 1987, he was appointed an Assistant Government Whip and became a Lord Commissioner of HM Treasury (a senior Government Whip) in December 1988. From May 1990 to April 1992, he was Parliamentary Under-Secretary of State at the Department of Health. In April 1992, he was appointed Financial Secretary to the Treasury. Stephen was Secretary of State for National Heritage from July 1994 until July 1995 and Secretary of State for Health from July 1995 - March 1997.

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In the 1997 General Election, he won the new seat of Charnwood with a majority of 5,900, and subsequently served as Shadow Secretary of State for Education and Employment. In June 1998, he left the Shadow Cabinet to return to the backbenches. From 2006-07 he was Co-Chair of the Public Service Improvement Group, established by David Cameron to review policy in education, health, social care and housing. From 2010 to early 2014, Stephen was Chair of the Health Select Committee. He became a Place2Be trustee in 2012.

Stephen brings a wealth of knowledge around senior government and the Department of Health. His business interests include chairing LaingBuisson, Public Policy Projects, Dorson Group and The Network Group.

About Public Policy Projects

Public Policy Projects (PPP) has a 20-year history of delivering events in the health, care and local government sectors. Public Policy Projects (PPP), chaired by Rt Hon Stephen Dorrell, offers practical policy analysis and development. PPP has hosted speakers including Rt Hon Matt Hancock MP, Rt Hon Jeremy Hunt MP, Andrew Gwynne MP, Simon Stevens, Lord Carter, Professor Dame Sally Davies and many other senior thought leaders. The network consists of senior leaders across the health, care, life sciences and local government sectors. PPP also advises on policy development in health, care, life sciences and local government. The parent company of PPP is Dorson West Ltd.

About Simon Nicholson

Simon Nicholson is the Market Access Director for MSD UK having taken up this role in December 2015. Prior to his current role, Simon was the General Medicine Director and responsible for the sales and marketing teams aligned to the Diabetes and Cardiovascular business. Simon is passionate about improving patient experience and outcomes through innovative partnership working with the NHS.

Simon built an innovative healthcare service business within MSD UK. This differentiated service portfolio included healthcare analytics, clinical pathway design, patient engagement and coaching and telehealth services.

Simon has a wealth of experience developing and implementing market access strategy in the pharmaceutical industry and has represented the industry on a variety of strategic initiatives in the NHS including Innovation Health and Wealth.

About MSD

For more than a century, MSD, a leading global biopharmaceutical company, has been inventing for life, bringing forward medicines and vaccines for the world's most challenging diseases. MSD is a trade name of Merck & Co., Inc., with headquarters in Kenilworth, N.J., U.S.A. Through our prescription medicines, vaccines, biologic therapies and animal health products, we work with customers and operate in more than 140 countries to deliver innovative health solutions. We also demonstrate our commitment to increasing access to health care through far-reaching policies, programmes and partnerships. Today, MSD continues to be at the forefront of research to advance the prevention and treatment of diseases that threaten people and communities around the world.

MSD is investing in the UK and continues to drive forward innovative partnerships and solutions to meet some of the most significant challenges facing the NHS. Building new partnerships and programmes (e.g. the Early Access to Medicines Scheme or NHS Test Beds initiative) can help ensure patients access the treatments and care they need. MSD is determined to be part of the solution to the future of the NHS, offering innovative, yet affordable medicines and new partnership approaches.

For more information, visit www.msd-UK.com and connect with us on Twitter @MSDintheUK.

References

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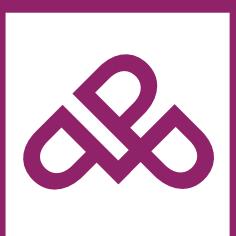

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