Integration of care: the salvation of the NHS?

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The performance of the NHS continues to be a focus for national media attention and concern regarding its welfare was the first priority of the public in pre-election polls. Although the scientific rigour of national targets as arbiters of efficiency and quality in healthcare provision is open to question, there is little debate that hospitals are struggling to cope with the demand placed upon them and that the quality of care they deliver can fall below acceptable standards. Is the NHS failing, manifesting declining performance as it slides steadily into frail old age, or is the explanation more complex? More importantly, are there potential opportunities for rejuvenating our largest public institution?

Factors contributing to poor NHS performance have been catalogued many times. People are living longer and developing increasingly complex medical and social problems. A younger population is presenting prematurely with medical conditions fostered by the alarming prevalence of obesity and the influence of adverse lifestyle factors, including alcohol, tobacco and other drug usage. Our patients and their families have higher expectations of the health service, attributable partly to advances in medical technology and the publicity that surrounds it, and partly through promises made by politicians, particularly in the run up to general elections. Moreover, in recent decades we have witnessed a changing social structure in which family support is no longer the backbone of care delivery for aged relatives while, at the same time, investment in community support services has declined. These observations suggest that, rather than tired old age being responsible for declining performance, the NHS has a consistent historical record of failing to recognise evolving population health needs, and of not responding to them punctually.

Radical change is essential. Proactive preservation of health and wellbeing must be pursued rather than the traditional response of reacting to illness as it develops. In the future, emphasis should be on prevention rather than cure – or amelioration, which is often a far more realistic clinical outcome in many chronic illnesses. The public must be convinced that hospitals aren't the only successful retailers of healthcare; that they offer sub-optimal environments for many with complex medical problems and prove positively harmful to some. Furthermore, hospitals will inevitably fail efficiency and quality targets if they continue to be used as the default repository for other elements of the provider system that underperform. There are other, potentially better, ways of managing patients, either exclusively in the community or, more likely, through a combination of primary, community and secondary care health providers – a collaboration that has been seen only rarely to date.

For several decades, the prevalent belief has been that centralisation of secondary care services is the route to achieving the highest quality standards. While economies of scale argue convincingly that 'big is better' in the realms of specialist medical and surgical treatment, the evidence is far less compelling for the clinical needs which generate the biggest demand for hospital intervention. There is therefore a balance to be struck between centralisation of specialised services and retention of appropriately comprehensive local health provision. Underpinning this is the non-negotiable element of supplying safe clinical care to all members of the population, regardless of post code or proximity to 'centres of excellence'. Responding to public and patient opinion is a vital component of this adjustment and providing hospital care closer to home and loved ones is afforded consistently high priority in relevant surveys. Older patients in particular prefer not to travel long distances for hospital treatment and may be willing to accept differences in clinical outcome as an inevitable consequence of this choice. A major challenge for the future, therefore, is to achieve an optimum provider balance of the traditional district general hospital with tertiary centres, ensuring an efficient interchange of clinical expertise and resource allocation that is currently all too often lacking. Shared clinical pathways, easy referral and repatriation systems and workforce networks are the building blocks for such improved collaboration, with zero toleration for any solipsistic mindset in tertiary centres.

The concept of 'integrated care' has been embraced for some years as offering potential for addressing many of these issues, and recent government publications, including the NHS 'Five-year forward view' and the RCP's 'Future hospital: caring for medical patients' espouse the benefits that integration of care brings.[1,2] This edition of *Future Hospital Journal* concentrates on the aspirations of integrated care and explores the evidence supporting the clinical value and cost-effectiveness of projects that have been tested to date. Two papers offer timely and comprehensive reviews of projects carried out in the UK and a third describes the efforts undertaken by an 'alliance' of health and social care providers in a rural part of England where the demographic is even more challenging than the national norm. A fourth describes interesting approaches to integration that

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move away from the position of the district general hospital as the 'provider of last resort'.

The ingredients in the mix of challenges to secondary care have been rehearsed many times in numerous environments and are a ubiquitous phenomenon of the developed world. Strenuous efforts have been made internationally over decades to confront and control the rapid growth in demand for healthcare in general and for hospital services in particular. We are therefore delighted to offer insights into Australasian innovations in this field with four key contributions. The first is from north New South Wales where several integration initiatives are being tested. The second is from a geographically isolated part of the West Coast, South Island, New Zealand where staffing a small regional hospital has been especially challenging. Formal liaison with the nearest tertiary centre (Christchurch), including outreach and telemedicine services, has been combined with creative approaches to training programmes for local secondary care practitioners. From the Canterbury health district itself, pioneering work was tragically put to the ultimate test following the devastating earthquake in Christchurch in 2011, which claimed 185 lives, destroyed many of the City's buildings and disrupted vital infrastructure. The author's view that without an integrated way of working the Canterbury health system would have failed to meet the needs of their population is especially compelling. Finally, a paper from Singapore shows how an integrated healthcare system can be designed from scratch when appropriate leadership and impetus are provided.

Innovation in integrated care must be accompanied by rigorous 'benefit analysis' and balanced by an acceptance of certain salient principles. These include an awareness that any clinical initiative must be allowed reasonable time for positive outcomes to be realised. Second, analysis of benefit is crucially linked to the range of clinical outcomes measured and these should include arbiters of quality. Specifically, we know that 'targets' are fragile indicators of quality in healthcare and also that scientifically and quantitatively assessed clinical outcomes are not the only parameters that matter to patients. A good example is hospital admission avoidance, which, although not the holy grail of clinical outcomes, does seem to be one of those most commonly measured. Other criteria have sounder claims to quality improvement, such as patient experience and comfort, control of pain and anxiety and avoidance of physical isolation from friends and loved ones at times of ill health. Quantitating quality is a huge challenge in the scientific analysis of medical innovation but has to be a priority in the overall assessment of care integration.

Most pertinently, should financial benefit be a pivotal assessment criterion for the success of integrated care? Purdy and Hazarika comment here that 'evidence for the economic benefits of integrated care is equivocal, although many of its components have clear benefits for the quality of services received by patients'. In other words, we must separate financial success from those outcome criteria that reflect quality, safety and efficiency improvement for patients. If these latter result, and care integration is found to be clinically sustainable, then we have sufficient justification for continuing to move in the strategic direction of integrating healthcare services. ■

References

1 NHS England. *The Five Year Forward View.* London: NHS, 2014. Available online at www.england.nhs.uk/ourwork/futurenhs/ [Accessed 10 April 2015].

2 Future Hospital Commission. *Future hospital: caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013.

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