Vertical Integration

In early 2008 I interviewed leaders in Trusts in England, Northern Ireland and Wales, on behalf of the NHS Confederation. I was looking at the existing practical examples of Vertical Integration of services to inform a forthcoming policy paper.

This paper is produced as a consequence of that work and of representing those findings to a policy seminar at the DH. It does not represent the views of the Confederation (or DH) and the Confederation will produce its own policy paper in due course.

What is 'Vertical Integration'?

Vertical Integration was re-introduced to the NHS lexicon in the Commissioning Framework of late 2007, although the concept is hardly new. In essence it can be seen as some form of alignment of the management or organisation of services between sectors. For example, provision of services by a Primary Care provider of services which have traditionally been the preserve of Secondary Care, and vice versa. Indeed one of the newer aspects of the debate has been the interest of Foundation Trusts in using their 'freedoms' for the provision of services. Some commentators regard integration between health and social services as horizontal integration. While it is not clear this generates a significantly different understanding, it is clear the nature of the available examples of current integration is qualitatively different in the field of health and social care integration. The examples were also easier to find, perhaps indicating there are more examples.

Why is it back on the agenda?

Because it represents a natural extension of some existing policy strands – but interestingly, it also conflicts with some others, as I hope will become clear below.

It is a natural onward step from the mode of thought of Care Pathways. So often these deal with issues between and within organisations. Patient-centredness means we attempt to address issues of hand-overs, along pathways, within and between organisations. And it often seems that no-one, (including especially GPs who often still see this as their role) has an oversight of the whole pathway. The possible exception here is the patient ('possibly' because too often their views and insight into the nature of that pathway have so little impact on its 'design' or its navigation).

So, why not reduce the number of organisations in a pathway, and reduce those hand-offs?

Why does this generate new issues?

Apart from the apparently natural tendency of organisations to become defensive, when the need for their separate existence is questioned? (Let's not forget that creation of 'Community Foundation Trusts' generates new organisations and new boundaries, potentially increasing the hand-offs).

I don't think it is necessarily so, but some would have it that World Class Commissioning invites us to believe Commissioners can become all knowing, and all powerful. There is plenty to be done to improve the quality of Commissioning, and putting good data and the power to use it at the heart of the process is surely no bad thing. But can Commissioners, even with the help of PBCs, really ensure that the best available, most dignified, flexible and clinically appropriate response is readily available all of the time? If not, why not use some

of the Kaiser experience to formulate different relationships with patients and clinicians, co-creation if you like, and forget about existing organisations as the vehicle through which to drive change? We know NHS staff so often don't see their organisation (let alone the NHS itself) as something they can advocate, despite this being a critical factor in influencing how the public perceive the quality of services they receive[1]. But they do see their team as something they can advocate, in other words the people they actually work with, are good or OK, but those others....? This challenges us all to think carefully about the nature and composition of teams in today's NHS.

Vertical Integration also challenges those who commission to think about how to generate contestability in a Vertically Integrated world – so often this is seen as a contest between primary and secondary provision of a service at the interface, or competition in secondary care between a range of NHS and non-NHS providers, of just one part of the pathway, not the whole. In a Vertically Integrated world, the competition must be along the whole pathway, meaning that whole pathways could be commissioned, as single entities. And, examples from abroad are of Vertical Integration that includes the commissioner.

And Vertical Integration challenges us to think again about the role of intermediary services, such as Community Hospitals and Intermediate Care. How should these services be managed, what do they provide that secondary care or top-quality care at home can provide (especially when that is well-integrated with social care, in ways which are often only dreamed of, but are a reality in small pockets of provision)?

How does this relate to Vertical Integration?

Because it (Vertical Integration) changes 'who I work with'. Vertical Integration offers an opportunity to work beyond existing boundaries. It would require Commissioners not to try to 'unbundle' the tariff in an attempt to secure more control and more flexible use of the cash, but instead to bundle the cash to fit a vertically integrated pathway (probably requiring some form of sub-contracting, or internal procurement by a lead provider for a Pathway). It also requires Commissioners to commission for outcomes on the whole of that pathway (beyond organisational responsibilities), and start to see the patient as a whole.

Why doesn't this happen already?

One of my personal learnings from the work was there is no real impediment to this way of thinking in existing national policy. In particular, the Care Trust experiment, born of the Kaiser influences of a few years ago, shows that mature organisations can have real influence on the operation of the pathway. But experience in other services, for example in Wales and Northern Ireland showed similar results.

Practical issues raised by Vertical Integration include:

- The need to align how staff in new, integrated units of management are paid, incentivised and managed. Agenda for Change helps but doesn't prevent you having to deal with a variety of issues which are traditionally difficult to resolve.

- The 'Power issue'. This way of thinking means Commissioners (and others) have to give up forms of power and control, just as these appear to be coming to fruition. But if you're in this game for power and control, are you sure this is the right game....?

[1] See Ben Page's work for IPSOS MORI as presented to the NHS Confederation Conference 2008.

- It requires us to tackles issues of organisational identity and to allow clinical teams to address the questions 'who do I need to work with'? and 'which organisation do I most need to provide the best service to patients'? And we may not always be comfortable with the answers!

- There is a danger this becomes a merry-go-round of organisational change, rather than clinically driven and organic development, just at a time when we surely don't need more 're-structuring'.

- Governance is key. English Care Trusts gave shown a way forward that crosses not just organisational boundaries but care sectors too, so solutions **are possible.**

- The area of greatest potential change (the middle ground) is the community services which have been struggling to re-focus their role and identity since PCTs have become focussed on Commissioning.

- This is also the area where our understanding of the costs and the application of the Tariff has had most difficulty (some would say, as a direct consequence of the uncertainty over its role and contribution). It remains an open question whether integration of these services would see either a successful managing down of the cost variations or the loss of benefits which sometimes go unrecognised. Perhaps it is inappropriate to buy such unintended consequences or perhaps such benefits (if real) should be properly commissioned within the pathway. If the latter is the case this could be regarded as a potential benefit of a 'bundled' approach to pathway commissioning and lay a long-standing ghost to rest.

All these are issues in the normal management domain, and there is no explicit dictat preventing this type of change, albeit that these are hardly the areas of comfort and choice for many of us, even as the service recovers from the demands of the last few years.

Rather the issue, I concluded, was leadership and will – to get beyond the perspective of what the (real) problems are, and to focus differently on shaping organisations to meet the need of those we serve. Now there's a real challenge!

My learning

Some common themes emerged from my work. In particular, the work demonstrated

- the value of and potential for **leadership** and **will** to get beyond organisational boundaries and loyalties; where progress had already been made this was a clear requisite. In fact the differences in Wales, in English Care Trusts and in Northern Ireland didn't come about **because** of different organisational structures, but **because** of very personal leadership – often, as was openly acknowledged in Northern Ireland, the emphasis on structures was a very real inhibitor of change.

- so, despite a permissive or liberal policy regime this remains a difficult process requiring **time, commitment, mind sets and skills sets** which are not in abundant supply.

- there are many **opportunities.**

- there is real value in **sharing successes and learning** from others' experiences, for example in relation to;

    - **Governance** issues, on issues of clinical governance and risk assurance,
    - in the case of integration involving PCTs and/or Social Care, **demonstrable separation of functions** (for example in Commissioning in examining the **benefits and dis-benefits** from such separation).

- The process of Vertical Integration **challenges Commissioners to think innovatively;**
    - about Commissioning for **whole pathways** (eg concepts of bundling rather than unbundling).
    - about the role of **much valued services** in Intermediate Care and Community Hospitals.
    - about their **preferred relationship** to their own provider services, and
    - about the balance between **generalist and specialist** services, especially in community settings, and the balance between hospital and community services.

- It therefore also **challenges the Commissioners role** in determining these balances!

Food for thought!

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If you'd like to know more about the practical applications of this thinking, or learn about specific examples of Vertical Integration in practice do please contact me on 0772 505 3480 or graham@grahamenglishconsultancy.co.uk