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Integrating healthcare through design

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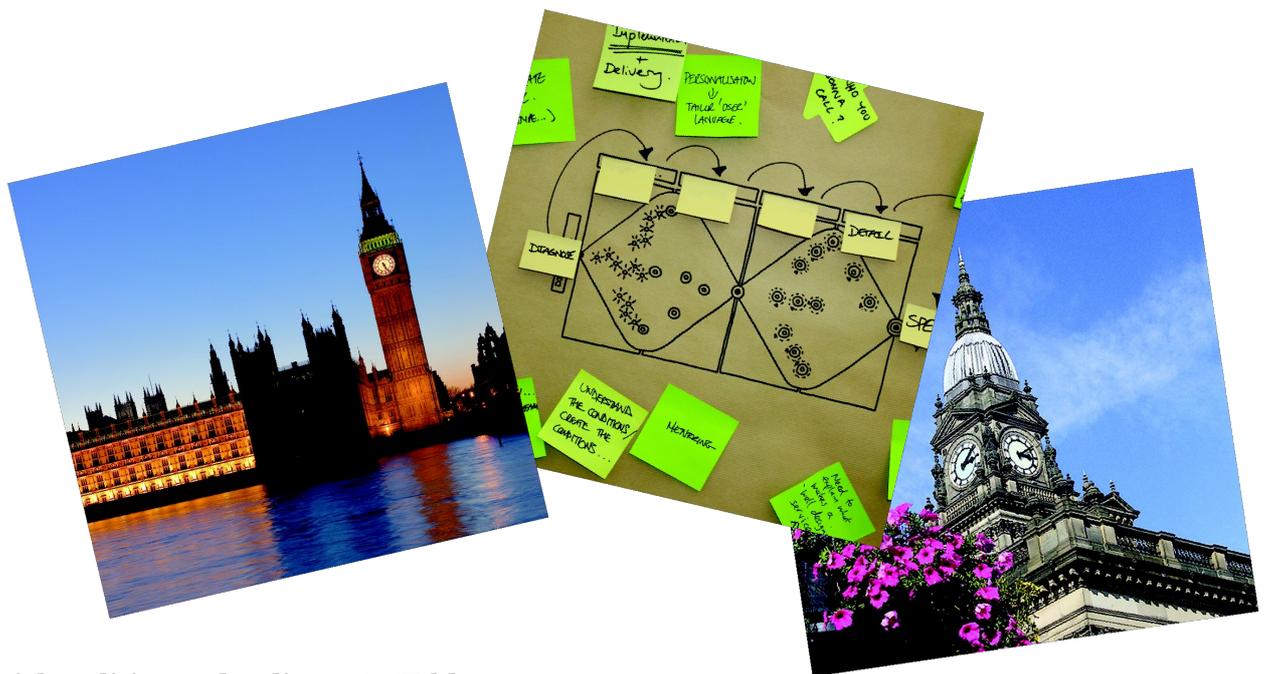
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Integrating Healthcare through Design

Paul Rainford and Jane Tinkler

Introduction

The NHS is about to undergo another bout of structural reform. The proposals are outlined in the Health and Social Care Bill and have been amongst the most controversial of all those put forward by the new Coalition government. Reforms proposed involve the abolition of Strategic Health Authorities and Primary Care Trusts and replacing them with GP consortia who will handle commissioning with a much increased budget. NHS services will be opened out to greater competition from 'any willing provider'.

The impact assessment for the Health and Social Care Bill estimates that the overall reduction in management costs proposed will save the NHS over £5 billion by 2014-15 and then £1.7 billion year on year after that (Wise, 2011). Unlike other parts of the public sector, health needs to accommodate two principal sets of changes: the first is to meet changing social needs and consumer demands; the second is to adapt to rapid advances in medical science, necessitating a change in both the pattern and delivery of healthcare. Where once a patient may have been hospitalized for several days post-surgery, it can now mean a short stay or even day surgery. The key focus therefore becomes moving from a health service defined by structure to one which is defined by the patient's journey through the system.

Joining-Up in the Public Sector

UK public services are delivered in different and complex ways that create confusion for citizens. It is estimated that that there are at least forty different and substantively important ways of organising the inter-relations across tiers of government in most areas in the UK, each of them with their own distinctive peculiarities, institutional histories and characteristic ways of working (Dunleavy and Hancock, 2010).

With regard to healthcare, services can already be delivered by a range of providers, some central services mediated by central government, others delivered purely by regional

administrations. There is little indication that the health secretary's proposed reforms will do much to simplify the landscape. They may even, after the estimated £1 to £3 billion spending on the reorganisation, leave the landscape very much the same. Jacqui Wise (2011) in the British Medical Journal noted that: 'there are 140 GP led commissioning consortiums signed up to the pilot pathfinder scheme covering 28 million patients — more than half the population. This indicates the final number of consortiums could be around 300—similar to the number of existing PCTs'.

The costs of this complexity are difficult to estimate. It seems undeniable that the luxuriant proliferation of public service delivery chains entails extra costs for citizens in coping with duplication across service provision. On the local level there has been a push toward thinking about public services in a more joined-up way, resulting in the growth of local partnerships that bring different delivery chains together to focus more effectively on many health and social care related issues (Dunleavy and Hancock, 2010). These local-level partnerships have achieved some advances in co-ordinating provision, and will be given further impetus with the Coalition's reforms on increasing the focus on public health.

The Figure below shows how joining-up delivery can evolve through seven stages – although it is possible to skip levels as the intermediate forms of partnership are often costly to operate. In some cases too they can add to institutional complexity in the public sector rather than simplify it. Yet there is a fairly broad practitioner consensus in favour of fostering greater joining-up (Dunleavy and Hancock, 2010).

Stages in the development of joined-up services

Stage 1: Free-standing services and all cooperation is 'foreign affairs' diplomacy at the top. Lots of cases and issues fall between the cracks

Stage 2: Agency co-operation to avoid gaps in provision and achieve some basic client-focus or area-focus

Stage 3: Active inter-agency collaboration so that co-working becomes more fluent and grass roots staff understand how partners work

Stage 4: Basic cross-agency coordination achieved with agreed common goals and joint planning, and ICT systems at least communicating

Stage 5: Equal coordination partnership, genuinely shared provision with joint teams working on problems towards consensual programmes

Difficult next stage – maybe one of these alternatives

Stage 6a: Lead agency coordination of some roles and other organizations bow out

Stage 6b: Pooled budgets at partnership level, and each organization must deliver on partnership goals

Stage 6c: Common leaders across two organisations

Stage 7: Mergers, take-overs or permanent integration of services into one or fewer organisations

However in the public sector generally, there are problems inherent within the process of joining up services. These are similar issues to those that are facing health bodies looking to undertake the proposed healthcare reforms. We will look at these problems grouped into three themes:

- Governance, accountability and service standards
- User involvement and new providers
- Information and technology

These are interlocking issues and cannot therefore be looked at in isolation. Therefore solutions will need to cover all three areas.

Governance, Accountability and Service Standards

The ease of the transition to integrated healthcare will be linked to the governance processes that underpin the reforms. As discussed in previous seminars, authors have argued that there has been a shift across the public sector away from the 'new public management' approach that dominated the period from 1985 to 2005 and moved towards what can be termed new 'digital-era governance' practices (Dunleavy et al, 2006). These focus on:

- *reintegration*, by de-siloing and 're-governmentalising' processes to achieve radical simplification,
- *needs-based holism*, which creates client-focused structures for departments and agencies that can respond in real-time to problems, and
- *digitalization*, which covers the adaptation of the public sector to imbed electronic delivery at the heart of government.

A seemingly dominant contention has held that efficient digital era governance may be generated by firstly cutting management. Indeed disintermediation – which means the stripping out or slimming down or simplification of intermediaries in the process of delivering public services - achieves 'joining-up' by significantly and visibly reducing the complexity of the institutional landscape that citizens confront in trying to access, draw on and improve public services (Dunleavy, 2010)

However, recent LSE research has suggested that instilling and investing in better management within health bodies 'provides a highly efficient way of increasing quality of care, even, and perhaps especially, in times of budget constraints... Managers will be the key instruments of the performance transformations being called for in the NHS.' The research team clearly linked management with increased quality: 'boosting the proportion of [NHS] managers with clinical skills... is the key to better performance' (Homkes, 2011).

This is clearly not a 'quick fix'. Serious consideration also needs to be given as to how performance and service standards can be maintained throughout the transition. Key targets, such as being seen within four hours in Accident and Emergency, have been dropped by the Government. Will this mean that waiting times and waiting lists will once

again be growing? Health groups such as the King's Fund in a recent report have argued that it is essential that performance measurements are kept in place in order for new delivery mechanisms to be compared, and the organisations held to account by their local communities: 'standards are required to ensure the quality and completeness of data recorded and reported by general practice', and 'standardised methods for defining and applying indicators are also needed, to ensure compatibility between indicators in different areas or reported by different agencies... These measures will need to be supported by transparent and robust mechanisms by which GP consortia (and PCT clusters) can account to local people for the quality and performance of local health services'. (Goodwin, Dixon, Poole, and Raleigh, 2011)

Increasingly there is an expectation of uniform standards in healthcare delivery, especially in an area the size of England. If the structural pattern will no longer be there to provide assurance, then alternative models will need to be created and new methods of regulation, standards and accreditation should be adopted.

It has been proposed that 'clear and simple guidance on what are basic acceptable governance and structural arrangements for the emerging GP commissioning organisations' should be established, and it needs to be made clear as to 'what body (or bodies) will assume overall responsibility for assessing performance... during the period of transition' (Smith and Charlesworth, 2011). There are a number of bodies that will be involved in assessing performance but most controversial is that of Monitor. Currently Monitor is responsible for the regulation of Foundation Trusts. There are plans for it instead to become an economic regulator with a responsibility to set prices, promote competition and safeguard continuity of services across the NHS. This competition role is one that Nick Clegg, the Deputy Prime Minister, has singled out as needing the 'most substantial changes' in order for the Lib Dems to give the Conservatives their full support on the Bill (Guardian, 2011).

The Care Quality Commission will continue in its role of regulating the quality of services provided, and licensing health and social care providers of whom there may be considerably more. The Government have outlined that CQC will undertake more inspections and rely less on self-reporting by providers however the resourcing available to them for this has not

yet been clarified. Also, in order to ensure a greater say from the public in how NHS services are delivered, the reform proposals include Local Involvement Networks (LINKs) becoming local HealthWatch bodies, commissioned by local authorities, to provide local intelligence for a national level body, HealthWatch England. These bodies will be charged with being local consumer champions for health and social care. Their roles will include encouraging patient and public involvement in decision making, and being able to comment on changes to local services.

Additionally, local authorities will be able to choose how to use their health scrutiny powers, in ways they think most suitable for their local communities. So, once the Audit Commission is abolished, they are able to continue with the present arrangements or set up completely new structures. The Government is proposing that Health and Well-Being boards should be set up in every upper tier local authority that will have representatives from GP consortia, Directors of Public Health, Directors of Adult Social Services, Directors of Children's Services, local HealthWatch plus at least one local elected representative.

User Involvement and New Providers

Integrating healthcare and designing higher quality services will require greater user involvement and a more active engagement with making decision making processes. Services should be re-designed to look across the full range of interactions with groups of citizens, and individual customer journeys can be analysed in an 'end to end' way rather than the siloed view of how healthcare provision currently operates. A report by Henry Featherstone and Carol Storey for Policy Exchange (2009) noted that genuine reform

can only be driven by putting patients in control of their NHS. Currently, the default position in primary care is no choice at all; patients are just not used to it. As a result the primary care market is largely unresponsive to patient needs. Therefore, we propose that registration with a GP should become an active process repeated every 2-5 years. However, so that this mechanism does not entrench inequalities we suggest that Health Trainers should be used to support patient choice. Health Trainers are already being successfully used to encourage people in disadvantaged communities to adopt healthy lifestyle.

Complementing choice for patients with competition between providers is, in some quarters, seen as the key to raising standards, increasing efficiency and innovation, and lowering costs across the health sector in the UK. In this vein, Andrew Lansley has encouraged 'doctors, nurses and other healthcare staff' to form their own mutuals which will 'contract with the NHS to provide care for patients'. Initially, 'mutuals will be able to offer services without tendering and competing for a contract – but as time goes on, that is likely to change and competition will be allowed' (Guardian, 2011b)

By way of response, Dr Mark Porter, Chairman of the British Medical Association's Consultants Committee, warned that:

doctors and other healthcare professionals are qualified to provide excellent care, but we believe the NHS should remain in the hands of the public. It is hard to see how the NHS can operate effectively if lots of bits of it are in private hands – even if they are those of former employees. New mutuals could quickly find themselves in conflict with each other, and at risk of being out-competed by private healthcare giants. The consequence could be financial and operational chaos'.

The key aspect here is the possibility of alternative providers profiting from undercutting others in terms of costs and taking these profits out of the NHS. Similar to other joining up government projects, savings are often made away from the those bodies who are putting the most resources into the reorganising process.

Information and Technology

An important stimulus for joining-up public services stems from the need to adapt to the digital era to keep pace with the private sector and civil. Modern ICT changes cannot be divorced from equally necessary organisational and service-design changes. The centralising effects of networking allow for more and more data points to be systemised and analysed by fewer decision makers in real time. Concomitantly the decentralising effects of modern databases mean that workers have far more access to information and can make decisions further down the organisational hierarchy. The two dialectically linked trends have dominated the evolution of private industry and are increasingly evident in the public sector (Dunleavy and Hancock, 2010).

Technology is the enabler to provide information to patients, enabling them to have more control over their healthcare and a voice in the decision-making process affecting their health. Moving from a patient service to a people service where the focus is on both illness prevention and / or the management of long-term or chronic conditions will require people to have access to high quality information. This in turn will impact on an individual's journey through the health system: whilst structure in itself will not facilitate personalisation, technology can enable an integrated health system designed around the needs of the individual.

Here a better handle on information is key to joining up services, both in terms of aiding managers in decided how services should be delivered and altered, and also to empower patients in ensuring the quality of their own care. The largest civilian government IT programme was launched under the Labour Government in 2002 under the title National Programme for IT. Its aim was to join up the complex and fragmented landscape of ICT systems to improve the IT infrastructure and services of the NHS. Its four key components were the setting up of a National Care Records Service to handle a single set of information for all UK patients; a single NHS email system; an online appointment booking system called Choose and Book; and a national broadband IT network to upgrade the current infrastructure. A recent NAO report on the programme found that the latest deadline for joining up care records will be missed with the NAO stating that the £2.7 billion that has been spent on it was not value for money: 'the rate at which electronic care records systems are being put in place across the NHS under the National Programme for IT is falling far below expectations and the core aim that every patient should have an electronic care record under the Programme will not now be achieved' (NAO, 2011).

A similar situation exists in relation to helping patients get the information they need to choose and assess services. Currently, however, there is still 'a lack of high-quality comparable information in primary care. It is extremely difficult for patients to find out how one GP practice is different or better than another - 30% of patients say they don't know where to look for any information that might be available' (Featherstone and Storey, 2009). In this context there needs to be a renewed focus on how to improve the quality and

content of information on healthcare across the board. Featherstone and Storey suggest that:

the NHS should focus on producing standardised, meaningful and accurate information on quality of care and outcomes, whereas personal experience and informal information should be independent and free from the appearance of threat of manipulation or bias. We believe that the NHS Choices website should be run by an independent organisation such as the Consumer Association or I Want Great Care, which already offers a way to rate doctors in the UK.

Interestingly in relation to health information, a more extensive role has been given to NHS Information Centre. It will take over data collection responsibilities from all other NHS bodies including the Department of Health. It will be charged with ensuring that information is provided quickly and accurately to local decision-makers and the public and health regulators.

Conclusions

The NHS is a large and complex organisation. Any restructuring of the scale proposed by the Government will inevitably cause both political and structural problems. These problems are similar to those uncovered by organisations attempting to design the joining up of heavily siloed services around health and social care. The key issues are around governance arrangements and accountability, user involvement and new providers, and information and technology.

The focus will be on whether primary care bodies can be encouraged to support the coordination of health and social care and to promote continuity of care. GPs will need to see themselves at the hub of a wider system of care and can take additional responsibility for coordination and signposting to services beyond their boundaries such as social care, housing and benefits. The regulatory systems would need to be more flexibly designed to take account of this, and technology would need to be vastly improved in order for it to work.

At a fundamental level, the problem with the NHS is that it is currently structured to the benefit of the producer, but in future it needs to be designed around the consumer.

Further Reading

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