Education and leadership

Integrated Cancer System: a perspective on developing an integrated system for cancer services in London

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Key messages

• Integrated cancer systems have the potential to transform the current model of cancer care to one which is designed around the needs of the patient
• Evidence suggests that better integrated delivery can improve quality and reduce the cost of healthcare, and ultimately improve health outcomes

• Involvement of all the organisations involved in the cancer care pathway is essential for true integration to enhance quality
• Commissioners and providers will be required to work more closely together to achieve effective integration of services and improved patient outcomes

ABSTRACT

This article explores the potential for integrated cancer systems to improve the quality of care and deliver cost efficiencies and improve outcomes for cancer patients. Currently, patients in the UK still have poorer survival rates than comparable countries such as Canada, Sweden, Norway and Australia. Improving the quality of cancer services is a key policy objective and cancer is a priority outcome measure in both the NHS and Public Health Outcomes Framework.

Evidence suggests that better integrated delivery has the potential to improve the quality and reduce the cost of healthcare, and ultimately improve health outcomes. One of the key themes from the Model of Care for Cancer Services was that cancer services should be commissioned along pathways and that provider networks should be established to deliver care. London has two integrated cancer systems; one covering north central and east London (London Cancer) and the other covering west and south London (London Cancer Alliance).

There a number of areas in cancer care that the current model of service provision has failed to adequately address and which have the potential to improve significantly though implementation of integrated services. These include improving early
Introduction

Integration of cancer services has the potential to change the traditional model of service provision moving away from the clear demarcations between primary, secondary and tertiary care to one which is designed around the needs of the patient. This is of particular importance for patients with long-term conditions and multiple co-morbidities where health service provision may become increasingly fragmented, as care tends to straddle the interfaces between sectors.

What is integrated care?

There is no single concept of integrated care and a wide variation in the scope of integration. The World Health Organization definition states the following:

"Integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency".

There are widely agreed definitions on the methods of integration. Horizontal integration refers to the affiliation of organisations which provide a similar level of care, for example networks of providers. Vertical integration (Figure 1), involves the affiliation of organisations that provide different levels of care, for example developing pathways across primary and secondary care or health and social care. Either of these methods of integration can be real or virtual depending whether organisations merge services or whether organisations work through a network or alliance to deliver services.

Evidence suggests that better integrated delivery has the potential to improve the quality and reduce the cost of health care, and ultimately improve health outcomes. Currently, there are 2 million patients living with cancer with the UK. Developing greater integration in cancer care should improve the quality of care for patients and lead to cost efficiencies.

Integrated Cancer Systems

Improving the quality of cancer services is a key policy objective and cancer is a priority outcome measure in both the NHS and Public Health Outcomes Framework. However, across the UK, patients still have poorer survival rates than comparable countries such as Canada, Sweden, Norway and Australia. In London in particular, the patient experience is reported as being less satisfactory. Important contributory factors are delays in diagnosis and treatment and variations in access to and quality of treatment. These factors may be
ameldiorated by facilitating an integrated system and have the potential to transform care provided.10

In 2009, NHS London published Cancer Services: Case for Change.11 This set out the need to improve the commissioning and provision of cancer services to ensure the future availability of world class cancer services in London and more specifically to address the inequalities that exist in health and access to health services. This was followed by the Model of Care for Cancer Services which provided the framework to deliver the recommendations. One of the key themes from the Model of Care was that cancer services should be commissioned along pathways and that provider networks should be established to deliver care. Two networks, termed integrated cancer systems (ICSs) have been designated in London where:

“An integrated cancer system is defined as a group of providers that come together in a formal, governed way to provide comprehensive, seamless cancer patient pathways. Integrated cancer systems will be commissioned to provide cancer care based on defined care pathways to meet patients’ needs”.12

This description concentrates on the development of a provider network and as such is most closely aligned with horizontal integration. However, the cancer pathway is not confined to the acute healthcare setting but extends from awareness and prevention through to survivorship or end of life care. In order to effectively address the needs of cancer patients at all stages of the care pathway it will be necessary to focus on vertical integration to enable a seamless transition between all stages of the cancer pathway. Primary care has a pivotal role to play in the pathway to co-ordination of services for the areas of the cancer pathway outside the acute treatment stage, especially around early diagnosis, screening and survivorship

How the integrated cancer system developed

London has two integrated cancer systems: one covering north central and east London (London Cancer) and the other covering north west, south London (London Cancer Alliance). The plans of the two proposed integrated cancer systems were subject to an assurance process by NHS London and were authorised in September 2011.

The initial work has been to implement governance arrangements and management systems to promote integration. Pathway groups for different tumour types are being implemented in a phased approach with each pathway bringing together partners from across the cancer community, including primary care. In addition, a number of cross-cutting pathways on survivorship, acute oncology and palliative care have been established. To date the work focus has been on the implementation of the recommendations in the Model of Care for Cancer Services.1

This initial focus is on horizontal integration and better care co-ordination and addresses variations in access to and quality of treatment. However, this is unlikely to significantly impact on some of the other factors contributing to lower survival rates such as late presentation. In order to address these wider issues a more radical and ambitious redesign of cancer services is needed one which maximises the potential for integration by aiming for vertical and horizontal integration.

Learning from integrated care

Approaches to integrated care are more likely to be successful when they cover large populations and address populations with a specific condition.10 The population of London is close to 8 million, but specialised cancer services are provided over a wider geographical population of around 12 million. This should provide the ideal context in which to develop integrated services.

There a number of areas in cancer care that the current model of service provision has failed to adequately address and which have the potential to improve significantly though implementation of integrated services.

- Improving early diagnosis of cancers: Late presentation of cancers is one of the main contributory factors for low survival rates. Cancer Services: Case for Change13 stated that that if UK cancer survival equalled Europe’s best, there would be an estimated 1000 fewer deaths a year in London.
- Inequity in access to and outcomes of cancer services: Currently there is significant variation in the incidence and mortality rates of cancer patients across London with inequalities in access and outcomes. The demographic profile for London shows wide variations in socioeconomic inequalities which is strongly associated with the incidence and mortality of many cancers. Understanding the key drivers of local health inequalities through the better use of data will enable identification of where and how to intervene to improve patient outcomes and reduce inequalities.
- Unmet need of cancer patients: Current services focus on the clinical needs of cancer patients. However, many patients have unmet emotional, psychological and practical needs that requires a more holistic approach. These needs may often be better met by services outside the hospital setting.13
Drivers for integration

Several factors are central to driving integration of cancer services.

**Clinical Leadership**

Research shows that leadership across systems requires an ability to work across different cultures and priorities. More specifically, this requires leaders who are able to develop a compelling vision, are not constrained by the current systems and draw on a wide range of perspectives. Integrated Cancer Systems should be clinically led. One of the key successes of integrated systems to date has been strong collective leadership demonstrated by clinicians who have a clear and ambitious view of how to provide high quality, patient-centred, integrated services and who are able to engage and motivate their colleagues and wider stakeholders in the work to implement this model. This has centred on multi-disciplinary groups drawn from across the provider networks, primary care, public health, users and the third sector.

**Informatics**

Lack of access to shared electronic patient information across organisations is recognised as a major barrier to successfully integrating care, as this is one of the key drivers of better care co-ordination. Integrated Cancer Systems should allocate significant resources to establishing an informatics system which will enable sharing of patient information across the provider network and will be linked with the National Cancer Registry to provide information on outcomes. In the longer term, a key aim must be to develop a system to share information between primary, secondary care and patients.

**Quality & service improvement**

The ultimate aim of integrating services is to produce the best outcomes for patients, in terms of care and experience. Currently, there is variation in access to and quality of cancer services across London. Initial work should focus on auditing services across the provider network and producing standardised evidence-based guidelines and protocols. This should be in conjunction with the development of metrics on clinical outcomes and patient experience. These metrics will provide a set of indicators against which the performance of the integrated cancer systems can be evaluated.

**Patient Experience**

Results of the National Cancer Patient Experience Survey indicate the need to improve patient experience, particularly around co-ordination and integration. National Voices, a coalition of health and social care charities in England, describe the lack of joined up care as the biggest frustration for patients and carers. Patients and service users want services that are organised around, and responsive to, our human needs. We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void.

National Voices stresses that to achieve effective integrated services the focus must be on the needs of and outcomes for, the people who use services, and should include the important contributions made by the third sector. From the patient and clinician perspective, issues identified as important include:

- Patient registry
- Risk stratification (co-morbidities, holistic health needs)
- A single set of evidence-based, clinical protocols shared across the care system
- Care plans with clear pathways for each patient
- Easy access to care within the system
- Seamless care demonstrating a truly integrated care system
- Proactive delivery of care – patient taking more ownership and responsibility
- Professional case conferences
- Communication between healthcare professionals and with the patient
- Clinical audit
Emerging needs and future challenges

Increasing involvement of Primary Care, Public Health, the Third Sector and users

Involvement of all organisations involved in the cancer care pathway is essential for true integration to enhance quality. Primary care, public health and third sector involvement hold key roles in the process particularly in early diagnosis and post treatment care. Primary care and public health have an important role to play in this wider health agenda, with more people surviving cancer, in particular for work around health improvement, early diagnosis, screening and survivorship. The holistic needs of the patient, including psychosocial issues and the side effects of treatment, must be considered at all stages of the care pathway with additional support from the third sector.

Developing clear channels of communication and engagement both within the integrated cancer systems and with external stakeholders is complex and requires culture change. Ensuring that all parties keep the patient’s needs at the heart of the discussion and meet as equal partners will enable the creation of the right environment for discussion and development.

Capacity in primary care:

Examples of successful integrated care projects have all required additional and improved services outside hospital. A King’s Fund report highlighted the need to increase investment in primary and community care services, “There is a need for general practice to adapt rapidly so that it operates at a scale that can provide the platform for integrated care”. This will not only support the patient experience and quality of care, but also support the increasing demand for services due to an ageing population, improved treatment and survivorship.

Cancer patients significantly increase their visits to the GP following a diagnosis of cancer and this has increased by 30 per cent over the last 10 years and will continue to increase. Integrated cancer systems will have a major impact on the work of general practice in managing patients with cancer and cancer survivors. This raises the question of whether there is sufficient capacity, expertise and resources in primary care.

How do we commission an integrated cancer care system?

Commissioners and providers will be required to work more closely together to achieve effective integration of services and improved patient outcomes. One of the potential benefits of integrating services is around delivering cost efficiencies. This is highly significant in the current climate when the NHS is facing the most serious financial challenge in its history with an increasing demand for services.

The aim of a health care system must be to improve the value to patients where value is defined as patient outcomes achieved per unit price. Porter proposes that the most effective way to develop a value based health system is to commission integrated care delivery across separate facilities, imposing minimum thresholds on volume of patients and also developing geographical centres of excellence. Costing and activity data can then be used to develop a bundled tariff to allow reimbursement of costs through bundles of care and not individual treatments.

The use of financial incentives can be a powerful lever to advance the development of integrated care. Moving to cost based pathways with bundled prices for care cycles, based on actual costs has huge potential for commissioning to deliver value and so improve outcomes. There remain a number of caveats around the implementation of these principles and a key barrier is around the availability of accurate costing information. This will be a significant obstacle to developing bundle tariffs which include the early diagnosis and survivorship stages of the pathway but is one which must be addressed to improve outcomes.

Conclusion

Vertical integration presents an enormous challenge but presents an exciting opportunity to radically transform the provision of cancer services through creating a holistic model spanning organisational boundaries and placing the patient at the heart of the system. P D James, the author, states that “to become a patient was to relinquish oneself, to be received into a system which, however benign, subtly robbed one of initiative, almost of will”. The challenge is to produce integrated cancer systems that promote an active and involved response by patients and their carers.
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