GENERAL PRACTICE AND THE INTEGRATION OF CARE:
AN RCGP POLICY REPORT
Integration of Care

Authors:
Nigel Mathers
Vanita Patel
Mark Thomas

Acknowledgements:
Helena McKeown
Scott Brown
Richard Vautrey
Executive Summary

The Royal College of General Practitioners champions integration of care as crucial to patient-centred practice, seeking approaches that improve patient care and experience as well as being efficient and effective.

Integration of care is about placing patients at the centre of the design and delivery of care. It leads to better outcomes for patients, safer services and improved patient experience, and can also act as an enabler of more cost effective care. As such, it is an urgent priority for the NHS, particularly at a time when the number of patients with long term and complex conditions is rising, and when services are under growing financial strain.

There is a natural affinity between the principles that underpin integrated care and general practice. This report draws on the experience of the RCGP’s members to make the case for integrated care; sets out the leading role that general practice can play in implementing it; and asks what needs to be done by policy makers and professionals to support this.

For general practice, the integration of care should be ‘Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes.’

Important models through which better co-ordination of care can be delivered for patients include:

- Care planning and co-ordination, particularly for patients with complex conditions;
- Redesign of services to provide more services in the community, provided by generalist and specialists working together as part of multi-disciplinary teams;
- The establishment of GP Federations.

Despite the benefits of integrated care, evidence suggests that its implementation in the NHS is at best patchy. This reflects a number of barriers that exist to its implementation. These include the need for cultural change and education and support to staff to develop new skills; the lack of effective systems for sharing patient information; the need for greater investment in general practice; the threatened abolition of practice boundaries; and the potential for service fragmentation as a result of competition and the perverse consequences of the NHS financial framework in England.

The external policy framework can play a crucial role in either stimulating or impeding progress in integrating care. In order to support integration, the following measures are needed:
• Resolution in England of the tensions between competition, choice and integration left unresolved by the Health and Social Care Act;
• Urgent action by Government to facilitate the sharing of electronic patient records, supported by appropriate patient safeguards;
• Action to increase the scope and capacity of general practice as a provider of care and to allow GPs to spend longer with patients alongside other members of the multidisciplinary team, focusing in particular on those with complex needs;
• Commissioning of additional services around general practice to help provide better care coordination and support for patients with complex and long term needs;
• An urgent review of the payment by results system in England to identify ways of strengthening incentives to provide high-quality, integrated care;
• An extension in the length of GP training to at least four years, and action to promote cultural change and the development of leadership and communication skills;
• A clear commitment to uphold the principle of area based commissioning, through the retention of practice boundaries, and by ensuring co-terminosity between CCGs, local authorities and other public service agencies.

The RCGP vision for Integrated Care

In our view, successful integration care would ensure:

- Patients are much less aware of the organisational boundaries between services;
- Patients feel in control of their care and empowered to share decisions about it;
- Patients are fully aware of their care plan and where they are at every step of the process;
- They experience transfer from one service to another as straightforward and timely, within both health and social care;
- Clinicians and other staff at all stages have the necessary information about the patient and care is therefore tailored to the patient’s precise needs;
- The patient experience is better and patient safety and health outcomes are also improved;
- Better outcomes and quality of care for patients with multi-morbidity;
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.

Integrated care would also be assessed on its more cost-effective use of resources, since:

- Patients would be far less likely to be referred for unnecessary treatment;
- Better use of information would ensure that conditions could be managed with fewer visits to secondary care;
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- Resources would used more efficiently with less duplication;
- Patient care would be delivered in the community, or even at home, wherever possible, and there would not be incentives in the system to stop this happening;
- Care would be delivered by the most appropriate person in the most appropriate setting at all times.

We would expect that this would result in greater satisfaction for clinicians and other care staff, as:

- They would waste less time in duplication of information and chasing referrals;
- They would have better communication with colleagues in other areas, so that there are shared goals rather than a silo mentality as so often at present;
- There would be greater opportunities for shared learning and development.
1. Introduction

The Royal College of General Practitioners (RCGP) has been a champion of integrated care throughout its history. The College’s vision is ‘A world where excellent person centred care in general practice is at the heart of healthcare’. We strongly believe that the delivery of integrated care is central to this ethos, and has a critical role to play in delivering higher quality patient care that is more effective and leads to better health outcomes.

The issue of integration of care has recently risen in profile. This has in part been driven by concerns about the potential for the fragmentation of services as a result of the application of competitive market forces in the English NHS. At the same time, growing numbers of patients with complex and long term conditions have stimulated a recognition across all of the UK’s health systems that the integration of services is vital to both improving patient outcomes and helping to deliver more cost effective care.

In October 2011, the RCGP launched a consultation with members and other organisations on what integration means for general practice and general practitioners. Responses received were by online survey and written responses. Our consultation asked for views on specific aspects of integration of care, in particular focussing on the role of general practice in integrating care.

This policy paper sets out our findings, highlighting the central role of general practice in the successful integration of care. Drawing on the evidence from our consultation, we address the barriers to, and make recommendations for, the successful transition to delivering integrated care.
2. Integrated care – what is it and why does it matter?

*Integrated care* is care that places patients at the centre of its design and delivery, meeting their needs in a co-ordinated and individually tailored way. It is associated with a number of beneficial outcomes, most notably better health and improved patient experience. Integrated care is especially relevant in an environment in which finances are constrained and the number of people with multiple morbidities and long term conditions is rising.

A central feature of integrated care is partnership working between patients, carers and the teams of professionals around them, in which patients are encouraged to be active participants in their care, and provided with the information and support to do so.

*Integration* is the range of processes, methods and tools that, if used correctly, can help to achieve the goal of integrated care. The term “integration” can be applied to a number of different aspects of healthcare provision. For example, it can refer to:

- Integration of care across different conditions – treating the whole person in a joined up way, not just focussing on a specific disease;
- Integration of care over time (also described as continuity of care);
- Integration between the working practices of different professional groups;
- Integration between the services provided by different providers;
- Integration of the way in which care is accessed (e.g. through co-location of services under one roof);
- Integration in the way healthcare needs are identified and commissioned for.

There is no one “right” model of integration: different approaches will be appropriate depending for example on patient needs, geographical factors and organisational characteristics. The RCGP’s preferred definition of integration describes the approach general practice should take in leading the integration of care. This can be summarized as “patient centred, primary care led shared working, with multi-professional teams, where each profession retains their autonomy but works across professional boundaries, ideally with a shared electronic GP record.”

**Benefits of integration**

Significant benefits can arise from the development of well functioning integrated services. Our consultation highlighted that such benefits include better health outcomes, improved patient experience, more cost effective care, reduced health inequalities, and enhanced job satisfaction.
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Better health outcomes and an improved patient experience

The most important potential benefit of integration is higher quality care, leading to better health outcomes and an improved patient experience\(^1\).

Virtually all of the respondents to the RCGP's consultation talked about the positive impacts that integration can have on patient care, referring for example to the joining up of services and a more patient focussed approach.

Integrated care leads to:

- Improved patient experience: Patients do not have to repeat the same information on multiple occasions, find it easier to access the services they need, and are clear about who is accountable for different aspects of their care.
- Better health outcomes: through a greater focus on prevention, faster diagnosis and treatment, increased patient empowerment, and better follow up.
- Better patient safety: care providers have the right patient information to ensure safe treatment and operate to consistent standards.

As those with multiple conditions access a greater range of services more frequently, integration of care is likely to have the greatest impact on improving their health outcomes. For example one recent research study\(^2\) based on patients from across 182 general practices in England found that 16 per cent of patients had more than one chronic condition included in the Quality and Outcomes Framework, but that this group accounted for 32 per cent of all consultations. It also found that people with multi-morbidities receive less continuity of care.

In their response to the RCGP’s consultation, the **Patients’ Association** set out key benefits of integration as:

- Providing those patients who need to access health and social care frequently (i.e. those suffering from long term conditions or with complex needs) with a co-ordinated and joined up service;
- Addressing poor communication between different care providers;
- Easing the transition between care settings, particularly for patients moving between hospital and care homes.

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\(^1\) Curry N, Ham (2010) *Clinical and service integration: the route to improved outcomes*. The King’s Fund.

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More cost effective care

A second benefit of better integration is the opportunity it brings to improve the cost effectiveness of care. However, it is important to acknowledge that any savings from integration of care will be dependent on its form and how well it is implemented, and the transfer of resources from secondary to primary care. Even then, any savings may not be immediately apparent.

Respondents to the RCGP’s consultation identified a number of ways in which integration could lead to more cost effective care. These include:

- Less duplication, saving time for patients and professionals alike and cutting waste;
- More efficient systems, particularly in relation to information sharing;
- Better health as a result of an increased focus on prevention, and earlier intervention to prevent the escalation of problems to the point where they become more expensive to treat;
- Reduced need for hospital care, as a result of fewer unnecessary hospital admissions, more efficient discharge, and better provision of community based services.

The College of Occupational Therapists told us how integrated services can lead to lower costs by reducing the time wasted determining people’s entitlement to resources based on differing criteria for health, social care, access to work and education. This can also lead to the better use of staffing resources, for example meaning that clients only have to see one occupational therapist rather than two.

The growth in the prevalence of long term conditions and multi-morbidity mean that the NHS’s success in integrating care will play an increasingly important role in shaping the future trajectory of healthcare expenditure. Currently, people with long term conditions account for more than 50% of general practice appointments, 65% of all outpatient appointments and over 70% of all inpatient bed days, as well as 70% of the total health and social care spend in England.

The highest potential cost gains lie with those patients with multi-morbidity. While the total number of people in England with one or more long term conditions is expected to remain stable over the next ten years at around 15.4 million, the number with two or more long term conditions is projected to increase from 5 million today to about 6.5 million. A recently published study of data from 314 practices in Scotland revealed that 23.2% of the population had multi-morbidity, with the number of multi-morbidities and the proportion of

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4 Department of Health (2010) Improving the health and well-being of people with long term conditions. World class services for people with long term conditions: information tool for commissioners.
5 Ibid.
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people with multi-morbidity increasing substantially with age\textsuperscript{6}. Those with multi-morbidity are also the people who are most expensive to treat: on average someone with three or more long term conditions in England costs £8000 a year, compared to £3000 a year for someone with one\textsuperscript{7}.

One of the key drivers through which the integration of care can help reduce expenditure is its role in supporting patients to actively engage in taking decisions about their care. There is strong evidence, for example, that shared decision making by well-informed, engaged patients together with their clinicians, can lead to lower rates of surgical intervention and fewer unscheduled hospital admissions\textsuperscript{8}.

**Reducing health inequalities**

Integration of care can have a significant role in tackling health inequalities and ensuring those who are already disadvantaged are not doubly disadvantaged through by the way care is provided.

Such individuals stand to gain the most from integrated care, as they are more likely to have complex health needs and may be less well equipped to overcome the barriers posed by poor co-ordination. By ensuring that care is tailored to the needs of those who are commonly excluded, such as those with learning disabilities, integrated services can also help to ensure that they are able to access services on an equal basis.

As evidenced in the Marmot Review, health inequalities arise from a complex interaction of factors including housing, income, education, social isolation and disability.\textsuperscript{9} The multi-facetted causes of health inequalities mean that an integrated approach between different bodies and agencies at both national and local level is vital. As well as helping individuals who already receive services, this must involve proactively identifying those most at risk so that their health needs can be met at an earlier stage and they can be supported to achieve better health outcomes.

**Enhanced job satisfaction**

Respondents to the RCGP’s consultation emphasised the enhanced job satisfaction for professionals that the integration of care could lead to. This reflects increased opportunities for shared learning and innovation; fewer

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\textsuperscript{7} Department of Health (2010) Improving the health and well-being of people with long term conditions. World class services for people with long term conditions: information tool for commissioners.


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frustrations as a result of organisational inefficiencies; more satisfied patients; shared goals and a more collaborative working culture.

**Vertical and horizontal integration**

The integration of care may take place in either a vertical or a horizontal direction:

- **Vertical integration** is concerned with the coordination of services providing care at differing levels of intensity according to the severity and complexity of healthcare need. Its main benefit is in ensuring that services are provided at the right time and in the right place, as close to the patients' home as possible. Although it is often associated with the concept of a single patient pathway, the challenge is to ensure that patients with multiple conditions receive appropriate referral and management.

- **Horizontal integration** concerns the co-ordination of care across the whole range of a person's health conditions and the services they receive, spanning both primary and secondary care and beyond this to social care. The most important benefit of horizontal integration is its ability to take a whole person approach and to deal effectively with multi-morbidity.

Both types of integration require primary care to play a leading role in order to be successful. While vertical integration is important, primacy lies with horizontal integration, as it is only through this that it is possible to bring together care across multiple disease pathways.

**Integration and the role of general practice**

General practice by definition entails a high degree of integration, offering as it does a comprehensive service that deals with the health of the whole person in the context of their socio-economic environment. In recent years, some GP practices have also broadened the range of their services to offer treatments and diagnostic procedures previously only available in a hospital setting, for example minor surgery and imaging.

An increasingly important part of general practice is the treatment and management of long term conditions. This often involves GPs working as part of multidisciplinary teams to monitor patients and to support them in planning their care. In particular, GPs play a crucial role in integrating and co-ordinating care for patients with multiple morbidities.

Beyond the direct provision of care, GPs’ role as the gateway to more specialised treatment means that they play a crucial role in facilitating the smooth transition for patients across organisational boundaries. The ability of GPs to make appropriate referrals and assist patients and carers in navigating their way around the system, is vital. Increasingly, GPs are also being looked to for the provision of advice to patients on the options open to them under the Government’s policy in England of choice of healthcare provider.
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The role of GPs gives them a unique understanding of the effects that poor co-ordination of care can have on patients and carers and how the integration of services can be improved. The diagram below illustrates some of the main service interfaces that patients and their GPs, may encounter. Key aspects include:

- The division between the provision of care in the community (for example at home, at the GP surgery, in a local pharmacy or community health centre) and in a hospital based setting;
- The divisions between general practice, other parts of primary care such as pharmacy, and - critically - the provision of community health services;
- The organisational and funding divisions between the NHS and social care;
- Especially within the acute sector, the separation between mental health and other health services.

Service Interfaces in the NHS
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In addition, there exists a further set of disconnects between health and social care and the whole range of other services that patients come into contact with, and which help to shape the context of their lives. These include, for example, schools, housing services, the voluntary sector, public transport, criminal justice and the welfare benefit system.

The practical insight into these interfaces that GPs bring to bear places them in an excellent position to contribute towards the process of reshaping and redesigning services to provide a more integrated service to patients. This looks likely to become an increasingly important component of GPs’ role in future, both in England as commissioners, and across all four countries of the UK as local clinical leaders.

Principles of Integration

While different forms of integration are appropriate to different circumstances, it is possible to articulate common principles that underpin successful attempts at integration. The following list is informed by the results of the RCGP’s consultation, the available research and also the principles developed by other organisations such as National Voices.

A person-centred approach

The overarching goal of integration must be to improve the quality of patient care and the patient experience. Care should be tailored to the individual and should respond to the needs of the whole person. In particular, it is vital that services provided to those suffering from multi-morbidity are joined up, and not organised around the constraints of disease-specific care pathways.

Care when and where it is needed

Care must be provided when it is needed, and in the setting that is most appropriate. For many patients this will mean the identification of need and provision of services earlier on, within the community, to promote good health and prevent the escalation of problems to crisis stage. At the same time, it is important to preserve the ability of general practitioners to continue to refer patients to specialist hospital based services where this is the most appropriate option for them.

Involving patients in their care

Integration must reinforce the principle that patients (and, where appropriate carers) should be fully involved in all aspects of their care. Systems, processes and culture must be developed in a way that encourages patients to share in decisions concerning their treatment, and support provided to them to allow them to make informed choices and become active participants in their care.

Building on the strengths of general practice

Moves to improve integration in the NHS must build on the unique strengths of general practice. These include the ongoing nature of the GP patient relationship; the existence of a registered list of patients focussed within a
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particular geographical area; the patient information that practices hold; and the knowledge that GPs have of their local communities. The aim should be to take steps to support general practice to realise its full potential, by providing more services to more patients, reaching out to high risk groups and playing a greater role in the proactive management of those with long term conditions.

Multidisciplinary working
Attempts at integration where one professional group or sector dominates are unlikely to succeed. Integration should be founded upon the development of strong multidisciplinary working, drawing both on generalist and specialist skills. In particular, this means pioneering new ways of joint working between GPs and consultants, and strengthening primary care teams and the links between general practice, community health services, and social care.

Patient and public voice
Successful service reform requires the input of service users and the support of both patients and the wider public. Mechanisms must be put in place at every stage of the change process to engage patients, carers and the public in the process of change and to ensure accountability and transparency.

Clinical leadership and support
The process of change must be underpinned by strong clinical leadership and engagement. For service redesign to work, it must be shaped by a strong clinical input, and must have the support of a broad base of local clinicians.

Continuous evaluation and improvement
The integration of care should be an ongoing process that is subject to continuous evaluation and improvement in the light of the lessons learnt and changing needs. The current evidence base on the impact of integration is limited and the opportunity should be taken to carry out research on the impact of new initiatives, to improve knowledge of what works.
3. Putting integration into practice: models of implementation

Existing models of integrated care vary widely. Although initiatives to integrate care have been a feature of the NHS for a long time, many of these have been small scale in nature and research into them has been limited. As a result, it can be difficult in some cases to draw firm conclusions regarding their efficacy and the implications for future policy.

This chapter sets out some of the main models of integrated care, illustrated by reference to case study examples, and reviews the evidence concerning their outcomes. It shows how the different aspects of integration - clinical, service, cultural, financial, administrative, and organisational - can be combined together in a range of ways. The approaches are ordered according to level of activity to which they apply, starting with the care provided to individual patients, followed by service and process level redesign and finally organisational level reform.

The role of commissioners and clinical leaders in developing integrated models of care is key. Arrangements for specifying and designing services are different across the four nations of the UK, and are in a state of flux in England, with the transfer of commissioning to Clinical Commissioning Groups (CCGs) and the National Commissioning Board. Regardless of these structures, those responsible must work with patients and communities to place integration at the heart of their thinking. In addition, there is a growing recognition of the benefits that can be realised through better joining up between health and other services such as social care. In England, Health and Well Being Boards are now providing a forum for the development of joint high level principles for the commissioning of health and social care. Similarly, in Wales, Local Service Boards have enabled constructive dialogue between public service providers, helping to stimulate the development of local integrated projects for the benefit of public health and well being.
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Improving the integration of individual level care

Care planning and co-ordination

Care planning is the process of agreeing a plan to improve an individual’s health and well-being, and co-ordinating across a range of health, social care and other professionals to ensure the provision of support and services to address the patient’s needs.

An early example was the introduction of the Care Programme Approach\(^{10}\), under which a multi-professional group including GPs, psychiatric social workers and nurses, psychiatrists and others developed an intensive but flexible shared care plan for people with significant mental health needs. More recently, similar approaches have been developed for people with long term conditions, elderly patients with complex needs and for end of life care\(^{11}\).

There is considerable evidence to suggest that a care planning approach leads to improved patient experience and outcomes, while some (but not all) studies have found an association with lower levels of hospital utilisation\(^{12}\). In 2011, the RCGP produced guidance for GPs on care planning for people with long term conditions, which can be accessed at http://www.rcgp.org.uk/PDF/CIRC_Care_Planning.pdf.

A central requirement of successful care planning and co-ordination is a designated care co-ordinator with sufficient authority to exert influence across a range of different providers. While this may be a GP, it may also be another professional, for example an advanced nurse practitioner. In either case, the role of the GP in agreeing the care planning objectives and evaluating the outcomes will be crucial to successful implementation.

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\(^{11}\) Ross S, Curry N, Goodwin N (2011) Case Management: what it is and how it can best be implemented? The King’s Fund.

**Virtual Wards**
This model is now in place in a number of areas of the NHS, including Croydon, Wandsworth and Devon\(^\text{13}\). It provides support to high risk patients by replicating the structure of a hospital ward on a virtual basis within the community, with the aim of providing as much care as possible within the home. A community matron or GP acts as case manager, assessing the patient's needs and drawing up a care plan, and regular virtual ward rounds are held, at which each patient is reviewed by a multidisciplinary team. A ward clerk provides a central point of contact and facilitates the timely exchange of information.

**Personal health budgets**
Personal health budgets are a way of allowing people to exercise more choice, flexibility and control over their care. Under this approach, patients are allocated a budget which they use to fund services and treatment to meet their health needs, tailored around their own individual preferences. The budget is structured around an agreed care plan, detailing the individual’s care needs, the amount of money available, and the services on which it will be spent.

Personal health budgets can facilitate the provision of better integrated care, as they allow greater flexibility to tailor services around the specific needs of the individual\(^\text{14}\). A key feature is that individuals can use their personal health budget to undertake activities that fall outside the scope of conventional treatment, or which cross the boundary between health and social care. The care plan is drawn up by a ‘care broker’ who is specially trained to work with the patient, and agree treatments to suit the individual’s needs.

Once a care plan has been agreed, the money in a personal health budget can be managed in a number of different ways:

- A notional budget: in which the NHS holds the money, and buys or provides the goods and services chosen.
- A third party arrangement: in which the same function is undertaken by an organisation that is legally independent of the NHS (for example, an Independent User Trust or a voluntary organisation)
- A health care direct payment: the money is transferred to the patient, and they buy the goods and services chosen. Some support organisations act as agents and can help patients manage the direct payment.

\(^{13}\) Curry N, Ham C (2010) *Clinical and Service Integration, the route to improved outcomes*. The King’s Fund. p 36.
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While there is reasonably good evidence that personal health budgets are associated with increased patient satisfaction and empowerment, the evidence for a direct positive impact on health outcomes is currently sparse. In addition, the implementation of personal health budgets poses a number of risks, for example of increased health inequalities and in terms of the clinical effectiveness of non traditional treatments. One key challenge from the point of view of ensuring integration is how to ensure that services purchased using a personal health budget are effectively co-ordinated with the other aspects of the patient’s care. Involving GPs in decisions about the use of personal health budgets, and sharing information with them, will be crucial to this.

Service level redesign

The RCGP’s joint paper Teams without Walls\textsuperscript{15} set out a vision of an integrated health system in which clinicians would work together to commission and provide services in ways that transcended the traditional boundaries between primary and secondary care. Under this model:

- Services would be designed around patient pathways, with the right balance between prevention, early identification, assessment, and long term support;
- Generalists and specialists would work together in new ways as part of multi-professional teams, establishing clinical networks;
- The emphasis would be on keeping patients out of hospital and managing outpatient care and minor complications in the community, but teams would also have the skills to enable them to support patients during hospital admissions if required.

A good illustration of how this approach can be developed is the in design of integrated diabetes services. This entails patients and clinicians working together to develop locally defined care pathways encompassing components such as diagnosis, care planning, medicines review and treatment of complications including inpatient care. Specialist diabetes teams, often with extended roles, already work in primary care through community consultants and GPs with a special interest to enable delivery of the services required.

While the redesign of care pathways can deliver real benefits, there is a danger that, if limited to a disease specific focus, this approach will create new silos and will fail to deliver integrated care for those with multi-morbidity. Such patients frequently receive care from multiple sets of providers, and decision making concerning their treatment is often complicated by the potential for interaction between conditions\textsuperscript{16}. The expertise of GPs in managing multi-morbidity in these cases is vital, and there is an urgent need for further


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research on how to capitalise on this strength to design services that are flexible around the needs of the whole person.

A further issue concerns the shift from hospital based to community based services. Research evidence\textsuperscript{17} shows that simply relocating hospital services does not lead to savings, particularly if it is not accompanied by decommissioning of acute capacity. There are also questions concerning how reconfiguration will affect accessibility\textsuperscript{18} and patient behaviour\textsuperscript{19}, including levels and patterns of service utilisation. Much will depend on the specifics of the service model proposed, including structures of multi-professional working. Overall, the indications are that better access, higher quality, and lower costs are most likely to result where reconfiguration is linked to genuine redesign of care pathways, supported by changes in working practices and skill mix.

A number of features frequently characterise the design and delivery of new services to provide more integrated care. These include:

- Shared electronic patient record systems;
- The development of new community based and intermediate services, such as outpatient clinics, hospital at home and reablement schemes;
- Employment of generic care workers who can undertake basic health and social care tasks;
- Initiatives to promote more timely hospital discharge, for example proactive discharge planning by hospital discharge co-ordinators;
- The use of best practice clinical guidelines and the development of clinical protocols to spell out who has responsibility for different elements of the care pathway;
- Establishment of common intervention thresholds and needs assessment frameworks;
- The introduction of new structures for clinical governance and leadership;
- Systems to allow GPs to obtain easier access to specialist advice, including through the use of online technology;
- The development of disease registers and the employment of risk stratification techniques to identify those most likely to benefit from proactive intervention.

While knowledge of clinical guidelines and the measurement of clinical performance are both essential, it is important that these tools are applied in the right way. Guidelines to inform the management of single chronic conditions often fail to offer clear direction on the management of co-morbidities\textsuperscript{20}. Variation in the management of patients can also be entirely warranted in nature, reflecting differences in patient preferences and clinical

\textsuperscript{17} The Health Foundation (2011) Evidence in brief: Getting out of hospital?


\textsuperscript{19} Ibid p35.

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condition. One of the inherent drawbacks of the HMO model, for example, is the difficulties it has in taking this into account. It follows that integrated services must be designed to build in flexibility, so that GPs are able to make the best use of their skills to tailor care around the individual needs of their patients.

Developing a whole system approach to urgent and emergency care

The RCGP’s Guidance for commissioning integrated urgent and emergency care sets out a “whole system” approach to looking at the patient journey across the whole of the urgent and emergency care pathway, encompassing health and social care, and community based and acute services.

It highlights evidence that the public are confused about how to access emergency and urgent care, and that poor sharing of information by providers is leading to significant failures of care. It also points out that because of system “gearing”, a small percentage increase in the number of cases dealt with by primary care could result in a much bigger fall in the secondary care caseload, helping to stem the rise in the number of A&E presentations.

The guidance sets out a number of initiatives that commissioners can take to improve the commissioning and provision of urgent and emergency care, for example:

- Implementation of NHS 111 and access to live, up to date directory services to direct the patient to the right professional in the right service;
- Signposting pharmacy provision, with greater use of pharmacists’ skills and training;
- A 24/7 integrated health and social care rapid response team in every locality;
- Greater use of anticipatory care pathways, e.g. Met office health forecasting for COPD patients, and fall assessments.

Organisational level integration

It is clear that structural change is by no means a guarantee of integrated care, and indeed can detract from it. Nonetheless, implemented rightly, it can play an important part in supporting the changes to service design and working relationships needed to deliver integrated care.

21 Mulley A, Learning from variations to increase value for money in the NHS. King’s Fund [Online] Available at http://www.kingsfund.org.uk/blog/health_variations.html [accessed 9/2/2012]
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GP Federations

Primary Care Federations are associations of GP practices and community primary care teams that come together with the goal of sharing responsibility for developing high quality, patient focussed services for their local communities. By drawing on a broader range of expertise and encouraging innovation, Federations are able to offer patients access to a wider range of services outside the hospital setting. These might include:

- Community clinics run by specialist consultants, GPs with a special interest or other specialist practitioners;
- Longer opening hours;
- Diagnostic services such as echocardiograms;
- More effective support for those with long term conditions;
- A more proactive approach to tackling health inequalities and promoting healthier lifestyles.

At the same time, Federations retain the generalist skills and continuity of care that are so important to patients.

An important feature of GP Federations is the formation of strong multi-disciplinary relationships across community health, primary, secondary and social care. This could involve, for example, developing new ways of working with community matrons to co-ordinate the care of patients with complex conditions, and with community pharmacists to manage the medication of patients with long term prescriptions.

The adoption of GP Federation style arrangements has proved an important driver of more integrated care in a number of locations, for example Redbridge and Cumbria. For example, some PCTs have devolved a portion of their commissioning budgets to Federations to enable them to reshape services and deliver more care closer to home.

The RCGP has developed a toolkit on Federations, available at http://www.rcgp.org.uk/federations_toolkit.aspx

Organisational integration

Organisational integration can take a number of forms, including:

- Networks of provider organisations, with a lead provider who then sub-contracts elements of the service;

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- Organisational mergers to form single provider organisations;
- Integrated commissioner-provider organisations\(^{25}\), with budget holders taking “make or buy” decisions on the provision of services.

In all models, an important component is the establishment of mutual financial arrangements such as pooled budgets and gain sharing agreements, in which costs and savings are shared.

The 2008 NHS Next Stage Review\(^{26}\) introduced the concept of Integrated Care Organisations (ICOs), under which care providers come together to jointly take responsibility for the design and delivery of integrated clinical services. Prior to this, the 1999 Health Act introduced the power to establish joint budgeting and commissioning across health and social care.

While competition to sign up patients between integrated commissioner-provider organisations is a feature of the US healthcare landscape, there is no reason why they cannot be set up to serve a geographically defined population. Although the development of such models in England has been constrained as a result of the purchaser provider split, a few examples nonetheless exist. One such is in Cumbria, where budgets for the commissioning and provision of many services have been devolved by the PCT to six locality based ICOs. In addition, the introduction of Care Trusts in 2000 provided a vehicle to bring together health and social care within a single provider/commissioning organisations, as in the case of Torbay Care Trust (see box). However, the ability for Care Trusts to act as commissioners as well as providers has recently been removed as a result of the Health and Social Care Act.

In the Scottish and Welsh health systems, the purchaser provider split no longer exists. In Wales, there is already integration in theory with the shift to single health provider organisations across primary and secondary care, including Directors of Public Health. There are local authority representatives on Local Health Boards and co-terminosity between Local Health Board and local authority areas but no sharing of health and social care budgets. In Scotland, the Scottish Executive has set out plans to integrate health and social care through the formation of Health and Social Care Partnerships which will be the joint responsibility of the NHS and local authorities, working in partnership with the independent and third sectors\(^{27}\). These will be required to produce joint budgets for older people’s services and are aimed at reducing cost shunting and shifting the balance of resources away from institutional care and towards community provision.


## Provider integration in Torbay and Cumbria

Torbay Care Trust was formed in 2005 with the goal of delivering better integrated care for older people by bringing together responsibility for the commissioning and provision of health and social care services. The Trust is formed of five locality based health and social care teams, working in close partnership with GPs. Using health and social care coordinators, the teams target high risk cases, covering all types of condition including chronic disease, palliative care and people with disabilities. Through budget pooling, intermediate care services have been developed in each locality, accessible via a single contact point, and this has contributed towards an impressive reduction in the level of hospital admissions.

More recently, the Torbay Care Trust joined the local Foundation Trust, the local authority and mental health services to become an ICO pilot. This was intended to explore the use of pooled budgets across all four providers, focussing on goals including an increased emphasis on prevention and bringing expertise into the care of older people in accident and emergency.

In Cumbria, the PCT has devolved budgets for the commissioning and provision of many services to six locality based ICOs. These have brought together community health and primary care, with integration supported by the roll out of EMIS web to allow the sharing of information from primary care, community health diagnostic services, and intermediate care and specialist outpatients.
4. Overcoming the barriers to integration

Although integration in health services and social care services is currently happening in some places, evidence suggests that progress is patchy and there is a long way to go in making the delivery of fully integrated care the norm. For example:

- On average only 54% of patients in England with a long-standing health condition or conditions feel that they had enough support from local health services to help them this\textsuperscript{28};
- Only 11% of patients in England report that they have been told they have a care plan\textsuperscript{29};
- Between 2004/05 and 2010/11, the number of people aged 75 or more in England with two or more emergency hospital admissions in a year, increased by 33%\textsuperscript{30}.

Leadership, clinical and management skills

Integrating care requires the application and development of skills across a number of key areas, such as leadership, management and clinical practice. Without these in place, the cultural, organisational, and service changes needed for integration are unlikely to be delivered.

Evidence suggests that successful integration of care requires sustained and effective leadership\textsuperscript{31,32}, a point that was strongly emphasised in the responses to the RCGP’s consultation exercise. Structures and resources need to be put in place to support this at all levels, not only to ensure that senior management buy-in is secured, but also to nurture strong front line clinical leadership.

The development of a greater range and complexity of services in the community will also require new clinical and commissioning skills. The role of GPs, with their breadth of knowledge, and their experience of working with a wide range of disciplines, will be vital to this. At the same time, it will be important to provide support to staff used to working in a hospital setting to develop the skills needed to provide care in a community environment.

\textsuperscript{29} Goodwin N, Dixon A, Poole T, Raleigh V (2011) Improving the Quality of Care in General Practice, King’s Fund.
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Public and political support

Changes to local health services can cause considerable tension and anxiety, particularly where they involve the closure or replacement of hospital services. If not handled correctly, this can swiftly spread and act as a stimulus for political opposition.

Widespread engagement of patients, the public and staff from the start of the process is vital. Before decisions are announced regarding the closure or decommissioning of existing services, patients will want to know what alternatives are proposed and to be convinced that these will meet their needs. Securing the buy-in and involvement of local politicians is also important: something with which the role in England of local Health and Wellbeing Boards will increasingly be key.

Information sharing systems

The lack of efficient, effective and compatible systems for the sharing of patient information is one of the biggest barriers to the integration of care.

Without this key infrastructure in place, professionals providing care will be unable to access patient information, hindering a fluid and easy transition for patients and potentially compromising the safety, continuity and quality of patient care. GPs and community nurses frequently have a completely different set of notes, and out-of-hours services often have no notes at all, resulting in clear inefficiencies and risks to patient care. In addition, patients and their GPs often have to wait for a long time to receive hospital discharge letters.

A big gap is the lack of a comprehensive system of shared electronic care records. The NHS Future Forum’s report on Information identified that the best way of achieving this is the development of interoperability between computer systems, rather than seeking to implement a single IT solution. Modifying general practices’ existing electronic patient record systems may however involved additional costs, while many hospitals continue to rely on paper based systems to record patient information.

The impact of competition and any qualified provider

The increased use of competitive market forces in the delivery of NHS care in England is likely to make the integration of services more difficult by introducing greater organisational complexity and undermining the collaborative working on which its success depends.

The Health and Social Care Act establishes Monitor as an economic regulator, tasked with applying the Principles and Rules for cooperation and

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competition, and with upholding patient interests by preventing anti-
competitive behaviour and enabling integration. Under the policy of Any
Qualified Provider, the Government is already expanding the number of
services in England exposed to competition, with an initial focus on
community health. The NHS Commissioning Board will consult with Monitor
to establish the parameters for choice and competition in all parts of the
English NHS, including guidance on which services can be bundled and
integrated. This will reflect the “Choice Mandate” set by the Secretary of
State.

The NHS Future Forum has identified the need to clarify as a matter of
urgency how competition, choice and integration will work together, and how
this will fit with the principles and rules for cooperation and competition, and
with UK and EU competition law. Unless this is satisfactorily resolved, there
is a real risk that the system will act as a block to integration, by forcing
commissioners to put services out to tender where this would lead to greater
fragmentation. It addition, it may have the effect of undermining initiatives to
better integrate care, for instance by preventing organisational mergers or the
tendering of integrated pathways of care.

Financial barriers

Respondents highlighted the significant role that the financial framework for
health and social care can play in inhibiting the integration of care.

One of the most important barriers is the system of payment by results used
by the English NHS for the reimbursement of secondary providers. Introduced in 2003 to help drive down waiting lists and facilitate the
implementation of competition and choice, this runs counter to the provision of
integrated care in the following ways:

- Payment is structured around single episodes of care, discouraging the
development of integrated services around long term conditions and
care pathways;
- Reimbursement is based on activity (and to a certain extent quality),
rather than health outcomes;
- By making the income of secondary care providers dependent on the
volume of patients they treat, it pits their interests against those of
commissioners and undermines efforts to provide more services in the
community;
- There is also anecdotal evidence of specialists being told not to
undertake work that is not remunerated under Payment by Results,

34 Department of Health (2011) *Any qualified provider: your questions answered*. [Online]
available at [http://healthandcare.dh.gov.uk/aqp-answers/#How will AQP deliver integrated
health care?](http://healthandcare.dh.gov.uk/aqp-answers/#How will AQP deliver integrated
care?) [accessed 10/2/2012]

35 NHS Future Forum (2012) *Integration: a report from the NHS Future Forum*, Department of
Health, p28.
such as undertaking telephone consultations with GPs and helping to establish community based clinics.

By contrast, the financial incentives experienced in primary care pull in largely the opposite direction. So, in general practice the large majority of income is not based on levels of service provision, but represents a combination of capitation payments and money linked to achievement under the Quality and Outcomes Framework. On top of this, practices receive some activity related payments for the provision of additional services, for example through enhanced service payments. However, it is not clear what the future of these will be.

Finally, the separate funding streams and eligibility criteria for health and social care present a major impediment to the integration of health and social care. As a result of the squeeze on social care funding, service provision is increasingly being restricted to those assessed as being in highest need\(^{36}\), and problems with affordability may mean that options are limited for individuals who do not qualify for state funded social care. While the pooling of health and social care is an option that has delivered tangible benefits in a number of places, safeguards are needed to ensure that this does not result in cost shifting between organisations to the detriment of health outcomes.

**Multi-disciplinary working**

While respondents to the RCGP’s consultation recognised importance of multi-disciplinary working in delivering integrated care, many also highlighted the challenges that it can present.

Common concerns raised were potential confusion about roles and responsibilities, a failure to take decisions and a lack of accountability. Other issues mentioned included vested interests; the need for backfill for meetings; different approaches to risk management; different line management and administrative requirements; and the possibility of professional tensions, especially if pooled budgets were being used. Addressing these challenges requires both time and investment to develop a common vision and trusting relationships.

For GPs, a key issue is finding new ways of joint working between generalists and specialists, particularly in community settings. In addition, the establishment of strong relationships between GPs and those working in social care is likely to be increasingly important.

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The need for investment

Delivering integrated care requires time and resources to build relationships, acquire new skills and invest in the design and provision of new services.

General practice has a critical role to play in the design and provision of new forms of service as part of the provision of integrated care. However, it suffers from a variety of constraints that inhibit its ability to do so.

These include:

- Insufficient consultation time, particularly for patients with the most complex needs;
- The time and resource implications of attending multiple meetings;
- Lack of diagnostic facilities; and
- Outdated and cramped premises.

In addition, where services are moved out of hospital settings and into the community, there is likely to be a need for up-front investment in new services prior to existing services being decommissioned. This means that costs may increase, rather than decrease in the short term.

The commissioning framework

The application in England of the principle of the purchaser provider split has imposed constraints that can act as barrier to the integration of care. An important example of this is in the provision of community health services. Under the policy of Transforming Community Services instigated by the previous Government, PCTs were required to divest themselves of responsibility for community health provision, transferring this function to other bodies such as acute trusts. This has had the effect in many places of creating a block to attempts to integrate community health services with primary care, forcing their integration with acute trusts or establishment as stand-alone social enterprises.

A further issue concerns the role of GPs as both providers of care and, through CCGs, as commissioners. General practice has a central role to play in the provision of new forms of integrated care, but it is not clear if, as commissioners of services, they will have the freedom to fulfil this role, and how any perceived conflicts of interest will be managed.

A more fundamental question concerns the extent to which the operation of a purchaser provider split is conductive to the integration of care. As noted by

the King’s Fund\textsuperscript{38}, there is evidence to suggest that integration works best when some of the responsibilities for commissioning services are given to those responsible for delivery. Amongst the respondents to the RCGP’s consultation, there was a strong feeling that providers had an important contribution to make to the design of services, bringing valuable knowledge of patient needs and a practically based knowledge of the opportunities for better integration. Some respondents went further, suggesting that rather than being either provider or commissioner led, the approach taken should be one in which providers, commissioners and service users work together on a mutual basis to define the outcomes against which services should be held to account.

It should be noted that while the abolition of the purchaser provider split in Scotland and Wales may have been helpful in some respects, it has not led to automatic gains in the integration of care, and there are still significant challenges that remain.

\textbf{Systems of regulation and performance measurement}

Instead of assessing how the elements of the system interact to affect patients, regulation has tended to be designed around the activities and sustainability of particular categories of organisation within it. For example, until recently the question of how to redesign the provision of urgent care in order to achieve better continuity and patient experience has received relatively little attention compared to organisational measures such as time waited in A&E. Likewise, the regulatory requirement on foundation trusts to turn a surplus encourages them to increase their levels of activity even if this is at the expense of new models of service provision to provide more care within the community.

The College’s consultation exercise revealed broad support for greater weight to be given to the measurement of health outcomes, especially for patients with long term conditions. There was also strong recognition of the need to reflect patient experience, and support for the measurement of adverse indicators such as the number of hospital admissions.

\textbf{Potential shift away from an area based approach}

Although a key plank of successful integration is a focus on a defined, geographically based population, current “patch-based” working (such as many health visitor arrangements) presents a particular challenge. It is essential that co-ordination with other agencies takes place to address the whole range of determinants of health, and to proactively reach out to high risk groups. The ability to do this could however be jeopardised if certain recent policy developments are allowed to go ahead.

\textsuperscript{38} Ham C, Imison C, Goodwin N, Dixon A, South P (2011) \textit{Where next for the NHS reforms? The case for integrated care}, King’s Fund
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One such threat is the proposal that practice boundaries could be abolished or substantially relaxed, allowing patients from multiple areas to register with a practice. Our consultation showed that there is strong feeling amongst GPs that this would have a negative effect on integrating care. Reasons for this include difficulty in coordinating services over large geographical areas, and also the complexity of commissioning services without oversight of the demography and epidemiology of the population they are intended to cover.

A further area of concern relates to the continuity between NHS boundaries and those of local government and other agencies with whom a co-ordinated approach is key. The Government has now changed its position to state that Clinical Commissioning Group boundaries should ordinarily be coterminous with those of local authorities. Deviations from this principle will still be possible, but will need to be agreed by the NHS Commissioning Board to demonstrate that they would benefit patients while also preserving the ability to integrate health and social care services.

5. Identifying policy solutions: creating a pro-integration policy framework

In order to tackle the barriers to the integration of care identified in the previous chapter, a supportive policy framework is needed. This chapter examines what this should look like.

A policy framework that supports the integration of care will:

- Provide sufficient flexibility to allow the adoption of local models in the light of the circumstances on the ground;
- Put in place mechanisms to incentivise the wider adoption of good practice;
- Measure success in achieving integration against agreed benchmarks.

Above all, policymakers must sign up to the idea that integration is vital to the delivery of better quality, more effective patient care, and that as such it must be a top priority.

Specific areas in which policy action is required are set out below:

**Putting patients at the heart of integrated care**

- Patients, carers and communities must be fully involved at all stages when decisions are being made about the design of more integrated services;
- The integration of care should be organised around the needs of the whole person, including those with multi-morbidity, and should not be limited to single disease pathways;
- GPs must take the lead in ensuring that individuals with complex needs receive a planned and co-ordinated service and the support and education required to navigate the system and manage their health;
- The regulatory system should be reviewed to focus more on how the system as a whole affects patients, and less on the activities of individual organisations;
- The advent of personal health budgets in England poses both opportunities and challenges for the design of integrated services. Information sharing must be central to the delivery of personal health budgets so that appropriate menus of choice for patients can be developed and planned provision of care ensured. Effective information sharing systems must also be put in place.
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Increasing the scope and capacity of general practice as a provider of care

Delivering integrated care means a bigger role for general practice as a provider of community based services and in offering support to those with complex needs. This requires:

- Extra investment in the number of GPs, to free them up to spend more time with patients with complex needs, focussing in particular on under-doctored areas;
- Use of financial incentives to encourage the development of an increased range of new community based services, drawing on the expertise of multidisciplinary teams;
- Measures to encourage the wider roll out of GP Federations;
- Additional help for practices that would like to develop extra services but are prevented from doing so due to the constraints imposed by their premises;
- Extension of GP training to at least four years, to provide new GPs with the confidence and skills to treat patients with a range of complex needs.

Shared patient records

- Governments across the UK should bring forward practical proposals to facilitate the sharing of electronic patient records as a matter of urgency. This must include details of how any costs to general practices will be met;
- The maintenance of adequate safeguards regarding who patient information is shared with and how it is used, is key. Protocols to ensure this, whilst at the same time allowing the efficient exchange of information, need to be incorporated into any new system.

Developing a pro-integration approach to commissioning

It is essential that commissioning works in a way that supports the provision of integrated care. This requires:

- A joined up commissioning approach in England between the National Commissioning Board and CCGs, to support the movement of more care into the community and better integration of services across the primary/secondary care divide;
- The commissioning of additional services around general practice to help provide better care coordination and support for patients with complex and long term needs;
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- Recognition by commissioners that some variation in the management of patients can be positive in nature, reflecting patient preferences and differences in clinical condition;
- Commissioning of additional social care for older people at high risk of emergency admission, with referral pathways from general practice;
- Removal in England of the policy requirement for community health services to be separated from the commissioning function, in order to allow closer integration between community health and general practice;
- Exploration of the use of pooled health and social care budgets, supported by safeguards to prevent cost shifting across organisational boundaries. These could include, for example, tying the use of funds to jointly agreed health outcomes, and the application of open book procedures;
- The avoidance of policy developments such as the abolition of practice boundaries that would erode the principle that commissioning should be carried out for geographically defined populations.

Shifting the balance from competition to collaboration

Despite changes to the healthcare reforms in England to emphasise more strongly the importance of collaboration in promoting integrated care, the final legislation still leaves significant issues unresolved:

- The legislation does not guarantee that decisions on whether to expose services to competition will rest ultimately with CCGs, as the best and most appropriate arbiters what is in the interests of their patients and communities. This point must be clarified as a matter of urgency within the CCG commissioning regulations, the principles and rules for cooperation and competition, and NCB guidance;
- It must also be established beyond doubt that commissioners will not be prevented from bundling up single episodes of care into integrated service packages;
- All providers of NHS care should be subject to a duty to collaborate where this is in the interests of patients and there should be a requirement on providers to share relevant information as part of their licence conditions.

Improving financial incentives

The Government is already in the process of introducing a number of changes to the payment by results system in England, for instance the development of tariffs for long term conditions. However, there is a need to go beyond this:

- An urgent review of the payment by results system is required, to identify ways of strengthening incentives to provide high-quality, integrated care;
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- Financial mechanisms must be found to encourage acute providers to provide specialist support to GPs and to work alongside them to move more services out of hospital and into the community;
- The regulatory framework for Foundation Trusts should be reviewed to tackle the financial incentive it creates for acute providers to increase the volume of patients they treat.