Department of Health Future Forum Workstream: How can we create a more integrated service?

1. I write with regard to the Future Forum workstream on integrated services.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The RCGP 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. For example, the College has show-cased models of mixed generalist and specialist teams working across the primary and secondary care divide\(^1\), made recommendations for improved collaboration between general practitioners and other professionals working in General Practice.

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practitioners and community pharmacists\textsuperscript{2}, and developed a model for Primary Care Federations\textsuperscript{3} of GP practices, providers and other services working in partnership to meet the local needs.

4. The College recently launched a major piece of work on Integration of Care, the report of which should be published early in 2012. As part of this project we have produced a consultation document\textsuperscript{4} and invited comments from College members across the UK. The suggestions below are drawn from these early comments. We will send the Future Forum the complete paper when it is published, as this will provide a fully developed discussion of the College’s position in this area.

5. We have addressed below the questions on Integration of Care as specified when this workstream was launched in August, using these as a framework but aware that there may be overlap between many of the answers.

**What does good look like?**

The RCGP has in the past defined the ideal model of integrated care as involving \textit{‘primary care led, multi-professional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with a shared electronic (GP) record.’}\textsuperscript{5}

From a service user perspective, the World Health Organisation\textsuperscript{6} definition is also helpful:

\textit{‘For the user, integration means health care that is seamless, smooth and easy to navigate. Users want a co-ordinated service which minimizes both the number of stages in an appointment and the number of separate visits required to a health facility. They want health workers to be aware of their health as a whole (not just one...’}


\textsuperscript{5} House of Commons Public Bill Committee on the Health and Social Care Bill 2010-11. Health and Social Care (Re-committed) Bill. Memorandum submitted by the Royal College of General Practitioners. (HSR 33).

clinical aspect) and for health workers from different levels of a system to communicate well. In short, clients want continuity of care.’

We also note the definition provided by the King’s Fund7, which encourages us to think about integration as working at three different levels – that of the whole population, that of specific local contexts (pathways or services), and that of the coordination of care plans for individuals.

In our view, integrated care would be adjudged successful if it meant that:-

- patients were much less aware of the organisational boundaries between services;
- they experienced transfer from one service to another as straightforward and timely, within both health and social care;
- clinicians and other staff at all stages had the necessary information about the patient and care was therefore tailored to the patient’s precise needs;
- the patient experience was better and patient safety and health outcomes were also be improved
- patient care was patient-centred, not service-centred, with patients and their carers involved in meaningful decisions about their 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
- 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.

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7 Curry, N. and Ham, C. Clinical and service Integration. The route to improved outcomes. London: King’s Fund, 2010.
We should 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.

In particular, GPs will recognise success if they are able, through their practice, to oversee and coordinate holistic care for their patients, without the risk of losing track of them as they are admitted to secondary care management, or looked after by other agencies. GPs need to continue to have oversight of the patient’s care to ensure both greater efficiency (as they do not have the instinct or incentive to over-refer) and to check that outcomes for patients are positive.

On the same basis, alternative models of integration, in which secondary care organisations such as foundation trusts in England are allowed to be the dominant partners, even taking over general practices, should be carefully avoided – since, as payment by results incentivises foundation trusts to increase activity, this is likely to lead to over-treatment and increased cost, along with skimping on investment in primary care services and training.

Integrated care must not be about pathways into which patients can be slotted, but about services providing holistic care, built around the patient’s individual situation – which is why primary care, which has traditionally had this focus, must be enabled to take the lead.

If integrated care were successfully implemented, with barriers between organisations removed, it would be much easier for innovative practices to be shared, so that quality would improve across the NHS as a whole. Services would be dynamic and not static, responding to patient needs, new service opportunities or technologies and assessments of local population needs.

**Where should services be better integrated around patients, service users and carers – both within the NHS, and between the NHS and local government services?** We are particularly thinking of social care – for example, better management of long term conditions, better care of older people, more effective handover of a person’s care from one part of the system to another, etc.
Integration of care can have a significant role in tackling health inequalities and ensuring those who are already disadvantaged are not doubly disadvantaged through the provision of care, particularly if integrated services are planned with whole populations in mind, and not just registered practice populations.

Greater integration in the planning of out-of-hours services in England should be addressed as a priority – there are currently issues in places with the lack of access to patient records, and with education for out-of-hours care, so that in some cases the continuity of care is not ideal. The RCGP and partners have done much work in this area, but it will be crucial for success going forward that GPs are enabled to support and develop their relationship with nursing staff who may take on a good deal of responsibility in these settings.

Plans for integration must give particular consideration to patients suffering from multiple co-morbidities. There is a risk that integration of disease-specific care pathways will have a less than optimal effect for such patients – precisely the sort of circumstance in which the coordinating role of general practice will be critical.

Services for ex-offenders would also benefit from much greater integration, since at the moment there is often a radical disconnect between services they receive in prison and how they are treated on release, with failures of information transfer heightening difficulties for this already disadvantaged group.

One of our respondents praised examples of good services in Oxfordshire, for example the ability to arrange social care through a single phone call; excellent primary-secondary care arrangements for patients with COPD to avoid hospital admissions; excellent GP services with integrated drugs treatment/mental health and social services for homeless patients; and strong outreach services such as palliative care services and a TB nurse.

How can integrated services achieve better health, better care and better value for money?

Our members are sceptical that integrated services can make major savings, though there may be opportunities for better outcomes. The most cost-effective intervention, as in Barbara Starfield’s work, is likely to be maintained by basing a comprehensive team of doctors, nurses, health visitors and healthcare assistants in each community, working

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8 RCGP, Urgent and Emergency Care Clinical Audit Toolkit (RCGP/RCPCH/College of Emergency Medicine 2011)
closely together to deliver patient care for a registered population across all needs – from health-promoting social support to end-of-life care, as in modern U.K. general practice.

Initiatives must be evidence-based, rather than based on personal preference – that is, assessed against patient care outcomes to establish best practice before being applied regionally or nationally. Integration should be built into outcome measures, so that clinicians and social care staff are obligated to work together and encouraged to pursue integrated solutions. Outcome measures must be developed that assess the success or failure of the integrated service as a whole, and not just individual parts.

Assessing new integrated service developments may take time, however – it will be vital that new integrated services have a chance to show their success and are not subject to short-term commissioning priorities. This will clearly be a challenge with multiple budget-holders and a system set up to encourage competition.

Effective input, management and use of information will be critical to ensure that these goals are achieved – only with this will we maximise effective planning, ensure that best practice is recognised, measured and disseminated, enable efficient communication between clinicians, and encourage patient self-care. General practice leads the way in this respect, and it is vital for integrated care that secondary care services and others be brought up to speed. Currently GPs and community nurses frequently have a completely different set of notes, and out-of-hours services no notes at all, resulting in clear inefficiencies and risks to patient care. The College has long been a champion of better use of information, shared records and patient access to records, and we refer the reader to the publications of the RCGP Health Informatics Group\(^9\). Interoperable IT systems are an essential basis for truly integrated services.

**What, if any, barriers to integration should be removed, and how can we incentivise better integration of services at all levels?**

We have discussed previously, in our responses to the 2010 Health White Paper\(^10\) and the 2011 Health and Social Care Bill\(^11\), concerns that the greater degree of choice and competition envisaged in the current health reforms may impede, rather than encourage,

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\(^9\) RCGP Health Informatics Group - [http://www.rcgp.org.uk/health_informatics_group.aspx](http://www.rcgp.org.uk/health_informatics_group.aspx)


better integration of services. It is our view that service commissioners must be free to develop evidence-based integrated services without the worry that they will fall foul of competition law. Services in open competition with one another are likely, we think, to be constrained from the open dialogue which would be vital for integration.

Also, whilst fully supportive of patients being able to exercise choice about their care, we would be concerned that unlimited choice, for example of services outside of area, might undermine the ability of commissioners to plan integrated services in the most efficient and cost-effective manner. That said, commissioners, should they see it as beneficial in their locality, ought to be enabled to plan integrated services with a range of local providers, so that potential benefits of choice and competition can be realised. We would hope that Monitor will be encouraged to see its role in supporting these kinds of developments.

The tendency to ‘silo-working’ amongst professionals will be challenging to overcome – it was noted that this is often reflected in administrative systems, where for example, in one area, the ambulance, community and hospital services each used a separate Do Not Resuscitate (DNR) form. The evidence shows that collaborating around tasks for the patient often breaks down inter-professional barriers. The opportunity to communicate with and get to know other staff as people is known to reduce fragmentation: commissioners should endeavour to create consistent teams to deliver care, and specify routine good practice in communication, in order to ensure that professionals do not repeatedly have to re-create collaborative routines of working together for patients under their care. Generalists at the front line of services are also often important to integration as they have an effective overview of clinical needs and management options – this is discussed in detail in the report of the Commission on Generalism12.

In developing integrated services, clinicians will need to be careful to ensure that there are no unforeseen disadvantages for the most vulnerable members of the public. For example, geographical changes in services may have potential for cost-savings, but this must always be pursued with sensitivity to local needs, particularly in widely dispersed communities where access to and affordability of transport may already be an issue.

Medical education needs must also be considered when planning and commissioning integrated services. We have not yet seen the Government’s revised proposals on the future structures of education and training but if, as previously intended, these are to be locally directed, it will be vital to build provider pathways that facilitate training and allow space for middle grade trainees to work alongside consultants. We need to ensure that all integrated services provide educational placements and undergo rigorous evaluation, so that health professionals learn to work in new models, and we all learn from these developments.

Short term contracts for service providers are also potentially a barrier to integration, since they discourage the development of innovative strategies and, at the very least, impede the development of effective cross-organisational relationships. Long-term contracts, subject of course to quality assurance, will be better to incentivise integration.

Current payment structures in England were identified by many of our respondents as impediments to integration. They incentivise increased activity by Foundation Trusts, when precisely what is most needed for greater efficiency and improved care overall is fewer episodes of secondary care. There is also a huge opportunity to tackle the issue of delayed discharge by giving both health and social care services the incentive to ensure that patients are moved to the most appropriate (and cost-effective) setting.

We would encourage evaluation of pilots of pooled budgets between primary and secondary care, but this must on no account draw resources away from primary care services, which are usually very cost effective. Payment by pathway or by outcome must also be very carefully tested to avoid perverse incentives.

On a related note, we believe it is crucial that, unless there are exceptional circumstances, clinical commissioning groups have coterminous boundaries with local authorities, to ensure that incentives to cooperation between health services and local authority provided services including social care are fully evident. Government plans to abolish practice boundaries could have created a real barrier in this area, in addition to the clear barrier to planning care pathways for individuals and the increase in health inequalities generated by measures so clearly disproportionately accessible to wealthier and more mobile patients. We are hopeful that they are moving away from this position, and this is something that the Future Forum should emphasise.

As mentioned above, the design and implementation of outcome measures that explicitly reward integrated services could be a strong incentive to service development. Outcomes should be shared between services wherever possible, so that no service is
encouraged to ‘pass the buck’. One example might be for GPs and health visitors both to be charged with achieving immunisation targets – but there will be dozens of similar, specific changes that could incentivise integrated care.

**Who needs to do what next to enable integration to be progressed in a pragmatic and achievable way?**

We would argue that this is a complex picture and will necessarily vary from locality to locality. Health commissioners, alone and in conjunction with local authority Health and Wellbeing Boards, should have access to the information about their local populations that enables them to make strategic decisions about where and when to integrate services. However, it may be that providers, with close relationships with patients on the ground and experience with specific areas of treatment, will be better placed to develop ideas about how specific service integrations might work. There are obvious tensions about involving providers in discussions about service developments for which those same providers may later be tendering – but on the whole our respondents felt that, whilst clinician-led commissioning groups must have a leadership role, it would be essential to success to involve providers in discussions.

What is clear is that service integration should, for the most part and excepting those elements within the remit of the National Commissioning Board, be developed at locality level, without excessive central direction, to take advantage of local expertise and resources. A primary role for central expertise would be the compilation and dissemination of evidence of best practice, so that the current situation, where examples of excellent integrated services exist in many places but are rarely disseminated or replicated elsewhere, cannot prevail.

Additionally and as discussed already, there is a need for central leadership in setting outcome measures that are supportive and not inhibiting of integration, and pricing structures that do not provide a perverse incentive for unnecessary activity but support the development of efficient patient-centred care. These are measures that can be taken now, and will be of value whatever the precise future form of the NHS.

Integrating services will not be easy. Implementing such a plan will be likely to tread on the toes of many vested interests, and there will be many barriers to change, both obvious and hidden. Local leadership will therefore be a vital component, particularly the clinical leadership of CCGs, and we should be doing as much as possible, as early as possible, to develop this. The RCGP is playing a part through its Centre for
Commissioning\textsuperscript{13}, but more is clearly required if we are to realise the vision of better patient care through integrated services.

In fact, it will be vital to consider the drive to integrated care in workforce planning across health and social care services. The urgent need for greater numbers of GPs\textsuperscript{14}, trained for longer so as to be equipped sooner in their careers to meet the challenges of delivering clinical care, particularly in areas of social deprivation\textsuperscript{15}, as well as supporting service commissioning, is well known. It is also a concern that the current push for efficiency savings – the so-called Nicholson challenge – by, for example, reducing the number of specialist nurses, may impede the development of integrated services before they even get off the ground.

**How can innovation in integrated care be identified and nurtured?**

As discussed above, we would see this as a collaboration between central bodies, such as government, Monitor, the National Commissioning Board and organisations such as Royal Colleges, who will be in a position to evaluate and disseminate successful innovative models of integration, and local leadership in CCGs and local authorities who will be better placed to apply these new approaches to specific localities. Research evaluations are essential to ensure that we understand which factors ensure quality: this will allow evidence-based commissioning. The ability to access, good, up-to-date information about what is working will be a critical element in ensuring that we invest in the right projects and maximise the benefits nationally.

\textsuperscript{13} RCGP, Centre for Commissioning - \url{http://commissioning.rcgp.org.uk/}

\textsuperscript{14} See OECD Health at a Glance report (November 2011) - \url{http://www.oecd-ilibrary.org/sites/health_glance-2011-en/03/02/index.html?contentType=ns/Book./ns/StatisticalPublication&itemId=/content/book/health_glance-2011-en&containerItemId=/content/serial/19991312&accessItemIds=&mimeType=text/html}

\textsuperscript{15} Mercer, Stewart et al, ‘More time for complex consultations in a high-deprivation practice is associated with increased patient enablement’. British Journal of General Practice, 57(545), December 2007, pp 960-966
6. We gratefully acknowledge the many contributions of College members and members of College Council in formulating this response.

Yours sincerely

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