Integration of health and social care

Royal College of General Practitioners

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 with an aging population 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. 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;
- Establishment of GP Clusters where GP practices come together with the goal of providing more integrated services for their communities.

Despite the clear 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 need to adequately finance new integrated care arrangements it they are to operate effectively.
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:

- Commissioning of additional services around general practice to help provide better care-coordination and support for patients with complex and long term needs;
- Action to increase the scope and capacity of general practice as a provider of care and to allow GPs to spend longer with patients, focusing in particular on those with complex needs;
- Urgent action by Government to bring forward proposals to allow the sharing of electronic patient records, supported by appropriate patient safeguards;
- Better structured discharge planning from secondary care;
- A realisation that what may work in one area may not in another. Local solutions should be sought for local problems;
- 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 in part to move this agenda forward.

1. Introduction

1.1 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 deliver higher quality patient care that is more effective and leads to better health outcomes.

1.2 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 recognition that the integration of services will be vital to both improving patient outcomes and to helping to deliver more cost effective care.

1.3 In November 2011, the RCGP produced a consultation paper and engaged 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.
1.4 This policy paper explores our findings, highlighting the key role of general practice as central to the successful integration of care. Drawing on the evidence from our consultation, we address the barriers to and recommendations for the successful transition to delivering integrated care.

2. Integrated care – what is it and why does it matter?

2.1 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.

2.2 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 over time (also described as continuity of care);
- Integration of care across different conditions – treating the whole person in a joined up way, not just focussing on a specific disease;
- 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.

2.3 There is no “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 we believe is appropriate in the context of general practice. This is that integration should be “patient centred, and primary care led with multi-professional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with a shared electronic GP record.”

3. Benefits of integration

3.1 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.

**Better health outcomes and an improved patient experience**

3.2 The most important potential benefit of integration is higher quality care, leading to better health outcomes and an improved patient experience.

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.

**More cost effective care**

3.3 A second benefit of better integration is the opportunity it brings to improve the cost effectiveness of care.

Respondents to the RCGP’s consultation identified a number of ways in which integration could potentially do this. 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.

**Reducing health inequalities**

3.4 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.

3.5 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 their needs of the 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.

3.6 The multi-faceted nature and causes of health inequalities mean that an integrated approach between different bodies and agencies at both national and local levels is vital. As well as helping individuals who already receive services, this must also involve identifying those most at risk and reaching out to them proactively to meet their needs at an earlier stage and provide support to achieve better health outcomes.

**Enhanced job satisfaction**

3.7 Respondents to the RCGP’s consultation emphasised that greater job satisfaction for professionals could transpire as a result of the integration of services. This reflects increased opportunities for shared learning and innovation, fewer frustrations as a result of organisational inefficiencies, more satisfied patients, shared goals, and a more collaborative working culture.

**4. Integration and the role of general practice**

4.1 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. As the population ages and chronic conditions become more common, an increasingly important part of GPs’ work is the treatment and management of patients with multi-morbidities. 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.

4.2 Beyond the direct provision of care, the GPs’ role as the gateway to more specialised care means that they play a crucial role in facilitating the smooth transition for patients across organisational boundaries, helping them to navigate their way around the system and co-ordinating care. The ability of GPs to make appropriate referrals and assist patients in navigating their way around the system and co-ordinate care is vital.

4.3 The position of the GP and the nature of their relationship with the patient gives them both a unique understanding of the effects that poor co-ordination can have on patients and means that general practice is ideally placed to lead the integration process.
4.4 The diagram overleaf illustrates some of the structural fault lines in the Scottish NHS, viewed from the perspective of the GP. The main dimensions of the diagram are:

- The divisions 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;
- The boundary between in-hours and out-of-hours urgent and emergency care.

The Divisions in the Provision of Care in Scotland
5. Principles of Integration

5.1 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.

5.2 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-morbidities are joined up, and not organised around the constraints of disease-specific care pathways.

5.3 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.

5.4 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.

5.5 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 patient list; 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.
5.6 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 the links between general practice, community health services, and social care.

5.7 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 and the public in the process of change and to ensure accountability and transparency.

5.8 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.

5.9 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.

6. Successful integration

6.1 In our view, successful integration care would ensure:

- Patients were much less aware of the organisational boundaries between services;
- Patients felt in control of their care and empowered to make decisions about their own care and choices.
- Patients are fully aware of their care plan and where they are at every step of the process.
- Patients 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;

• A reduction in health inequalities, as patients are treated in a timely manner, in an appropriate setting, and a location close to their home.

6.2 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;

• Resources were 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.

6.3 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.

7. Overcoming the barriers to integration

7.1 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 with a long-standing health condition or conditions feel that they had enough support from local health services to
help them this\textsuperscript{1}

- Only 11\% of patients on average report that they have been told they have a care plan\textsuperscript{2}

**Leadership, clinical and management skills**

7.2 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.

7.3 Evidence suggests that successful integrated care requires sustained and effective leadership\textsuperscript{3} - 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.

7.4 The development of a greater range and complexity of services in the community will also require the development of new clinical and organisational 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.

**Public and political support**

7.8 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 level opposition.

7.9 Widespread engagement of patients and the public 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 will also be important if changes to community integration of care are to be successfully achieved.

\textsuperscript{1} GP Patient Survey January – December 20010 [http://www.gp-patient.co.uk/surveyresults/][Accessed on 6/01/2012]
\textsuperscript{2} Goodwin. N, Dixon. A, Poole. T, Raleigh. V (2011) Improving the Quality of Care in General Practice, King’s Fund
Information sharing systems

7.10 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.

7.11 Without this key infrastructure in place, primary and secondary health professionals will be unable to access patient information, hindering a fluid and easy transition for patients and potentially compromising patient safety and quality of 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 although the emergency care summary should bring improvements.

Multi-disciplinary working

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

7.14 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; 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.

7.15 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.

7.16 There will be a need to create a culture and enthusiasm to deliver change especially across organisational boundaries.

The need for investment

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

7.18 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;
• Outdated and cramped premises.

7.19 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.

Workforce Planning

7.20 If full integration of care is to be realised in communities there will be a need for a highly trained workforce that will require taking on many new tasks. There is likely to be an increase demand on services in the community. There has not been the growth in doctor numbers in primary care that has been seen in the hospital service for instance to deal with this. Therefore, in order to maintain and improve the provision of a quality service, the required capability and capacity to meet demand and provide a quality service will need to be planned for and managed. A sufficient increase in general practitioners, primary care and social care staff to cope with the additional workload will likely be needed as integration of care develops.

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

8.1 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.

8.2 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.

8.3 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:

8.4 Putting patients at the heart of integrated care

• The integration of care should be organised around the needs of the whole person, including those with multi-morbidities, not just around 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.

8.5 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, focussed in particularly in 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 Clusters;

- 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.

8.6 Shared patient records

- The Government should bring forward practical proposals to allow 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 need to be incorporated into any new system whilst at the same time allowing the efficient exchange of information.

8.7 Developing a pro-integration approach to patient care

It is essential that commissioning works in a way that supports the provision of integrated care. This requires:
• Support of the movement of more care into the community and better integration of services across the primary/secondary care divide. This includes better structured discharge planning for patients from secondary care back into the community.

• The commissioning of additional services around general practice to help provide better care-coordination and support for patients with complex and long term needs; for instance intermediate care beds and community hospitals.

• Provide additional social care for older people at high risk of emergency admission, with referral pathways from general practice.

8.8 The emphasis should be on collaboration

• A greater emphasis should be placed on the need for providers to collaborate in the interests of integration. 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.

9. Putting integration into practice: models of implementation

9.1 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. What may work in one area may not in another. Local solutions should be sought for local problems.

9.2 This chapter sets out some of the main models of integrated care, illustrated by reference to examples from the UK and beyond, 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 models are grouped according to the level at which they are focussed, starting with individual patient, progressing through to service and process redesign, and ending with organisation level reform.
Improving the integration of individual level care

Care planning and co-ordination

9.3 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.

9.4 An early example was the introduction of the Care Programme Approach\(^4\) in 1991, 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\(^5\).

9.5 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\(^6\). 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.

9.6 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 such as, for example, an advanced nurse practitioner. In either case, a strong connection with general practice is vital, in order to identify patients for whom this approach is likely to be most beneficial, and to ensure good communication.


Virtual wards
This model is in use in some general practices, such as Maryhill Health Centre in Elgin. 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. The patient’s needs are assessed and a care plan drawn up for them, 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
9.7 Personal health budgets are a way of allowing people to exercise more choice, flexibility and control. Under this approach, people 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.

9.8 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. A key feature is that individuals can use their personal health budget to undertake activities such as singing lessons that fall outside the scope of conventional treatment, or which cross the boundary between health and social care.

9.9 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); or
- 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.

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Service level redesign

9.10 The RCGP joint paper *Teams without Walls*\(^8\) set out a vision of 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 in 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.

9.11 A good illustration of how this approach can be developed is the 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, work in primary care through community consultants and GPs with a special interest to enable delivery of the services required.

9.12 A review of examples of integrated service design indicates that many of these are characterised by a number of common features and processes. These include:

- The implementation of joint electronic patient record systems;
- Development of new community based and intermediate services, such as outpatient clinics and rehabilitation schemes;
- 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;

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• Systems to enable easier access to specialist advice for GPs;
• The development of disease registers and the employment of risk stratification techniques to identify those most likely to benefit from proactive intervention.

9.13 While the redesign of services around disease-specific care pathways can deliver real benefits, there is a danger that if pursued alone this could result in parallel integrated services, creating barriers to effective treatment for people with multiple health problems. This is where the skills of GPs in managing multi-morbidities are likely to prove especially vital, and there is an urgent need for further research how to capitalise on this strength when designing strategies to create health services that are integrated across the health needs of the whole person, and not just a particular disease. In addition, it is important that guidelines and protocols are applied with sufficient flexibility to allow GPs to make best use of their expertise in dealing with undifferentiated disease and managing clinical risk.

9.14 A further issue concerns the shift from hospital-based to community-based services. Research evidence\(^9\) shows that simply relocating hospital services does not always lead to savings, particularly if it is not accompanied by decommissioning of acute capacity. There are also questions concerning how reconfiguration will affect accessibility\(^10\) and patient behaviour\(^11\), 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.

Organisation level integration

9.15 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.

GP Clusters

9.16 GP Clusters are associations of GP practices that come together with the goal of providing more integrated services for their local communities\(^12\). They range in structure from loose alliances to highly managed models, and are characterised by new ways of working and the development of stronger multi-

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\(^9\) Evidence in brief: Getting out of hospital? June 2011 The Health Foundation
\(^11\) Ibid pp35
disciplinary relationships across community health, primary, secondary and social care.

9.17 By drawing on a broader range of expertise and encouraging innovation, GP Clusters are able to offer patients access to a broader 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;
- Diagnostic services such as MRI or echocardiograms;
- More effective support for those with long term conditions;
- A more proactive approach to tackling health inequalities and promoting healthier lifestyles.

9.18 The adoption of GP federation style arrangements has proved an important driver of more integrated care in a number of locations in England, for example Redbridge, Nottingham and Cumbria. In many of these locations, PCTs have devolved a portion of their commissioning budgets to Federations to enable them to reshape services and deliver more care closer to home. Another important feature of many models is the establishment of much closer links with community health services and pharmacy. GP Clusters are only just beginning to be experimented with in Scotland in, for instance, Moray and Highland health board areas.

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

**Provider integration**

9.19 The 2008 NHS *Next Stage Review* introduced the concept of Integrated Care Organisations, 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, and in 2000, Care Trusts were introduced, uniting health and social care within a single provider and commissioning organisation.

9.20 Provider integration can take a number of forms, including:

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

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13 See for example Ham C and Smith J, September 2010, *Removing the policy barriers to integrated care in England*, Nuffield Trust
14 Department of Health (2008) *High Quality Care For All*, NHS Next Stage Review Final Report
• Integrated commissioner-provider organisations\textsuperscript{15}, with budget holders taking “make or buy” decisions on the provision of services

9.21 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.

9.22 While integrated commissioner-provider organisations (ICO) that compete to sign up patients are a feature of the US healthcare landscape, there is no reason why they cannot be set up to serve a geographically defined population. The development of such models in England has largely been constrained due to the purchaser-provider split, but a few examples nonetheless exist, for example, in the Torbay Care Trust and (on a more limited scale) the development of locality based ICOs in Cumbria (see box overleaf). In Scotland, interesting projects are being developed in the Highland Health Board area and have taken place successfully in Nairn.

9.23 The Scottish Government 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\textsuperscript{16}. These will be required to produce joint budgets for older people’s services and will aim to reduce cost shunting and to shift 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 co-ordinators, 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 is intended to explore the use of pooled budgets across all four providers, and will focus 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 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.

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