



Royal College of
General Practitioners

RESPONSE TO INTEGRATION OF ADULT HEALTH AND SOCIAL CARE IN SCOTLAND PROPOSALS

The Royal College of General Practitioners (RCGP) is the academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the 'voice' of general practitioners on education, training and issues around standards of care for patients.

The College in Scotland came into existence in 1953 (one year after the UK College), when a Scottish Council was created to take forward the College's interests within the Scottish Health Service. We currently represent over 4600 GP members and Associates in Training throughout Scotland. In addition to a base in Edinburgh, the College in Scotland is represented through five regional faculty offices in Edinburgh, Aberdeen, Inverness, Dundee and Glasgow.

THE ROLE OF GENERAL PRACTICE IN THE INTEGRATION OF CARE

Growing numbers of patients with complex and long term conditions have stimulated recognition that the integration of services will be necessary to both improving patient outcomes and to helping to deliver more cost effective care. 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 integrated care is central to this ethos, and has a critical role to play in delivering higher quality patient care.

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. Integrated care is especially relevant in an environment where finances are constrained and the number of people with multiple morbidities and long term conditions is rising. The Royal College of General Practitioners seeks approaches that improve patient care and experience as well as being efficient and effective. We must identify those most at risk and ensure that those who are already receiving services have their needs met more quickly.

For general practice, we believe 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, sharing appropriate information, to deliver the best possible health outcomes*.

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. This is the essence of generalism, described

in the recently published RCGP document.¹ 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, such as ultrasound, CT and MRI scanning.

Beyond the direct provision of care, the GPs' role as the gateway to more specialised care means that they play a pivotal role in facilitating the smooth transition for patients across organisational boundaries, helping them to navigate their way around the system and coordinating care. The close relationship between GP and patient offers a unique understanding of the effects that poor co-ordination can have, we therefore believe that general practice is ideally placed to lead the integration process.

Issues important to consider in developing the integration of adult health and social care

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 organisational, cultural, and service changes needed for integration are unlikely to be delivered.

Evidence suggests that successful integration of care requires sustained and effective leadership² - 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 NHS management buy-in is secured, but also to nurture strong front line clinical leadership. The joint RCGP/NES programme '[Developing leadership](#)', has a major focus on looking at how best to ensure that the new roles for primary care professionals in HSCPs are filled by individuals with the skills and commitment necessary.

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

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.

¹ Medical generalism; why expertise in whole person medicine matters. RCGP Publications; June 2012 (www.rcgp.org.uk/pdf/Medical%20Generalism%20-%20Why%20expertise%20in%20whole%20person%20medicine%20matters.pdf)

² Shaw. S, Levenson. R, (2011) Towards Integrated Care in Trafford. The Nuffield Trust. p17 & Ham. C, Smith. J, (2010) Removing the policy barriers to integrated care in England. The Nuffield Trust.p11

Widespread engagement of patients and the public from the start of the process is an imperative to success. 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.

Information sharing systems

It is essential that efficient, effective and compatible systems for the sharing of patient information are put in practice as this is one of the biggest barriers to the integration of care.

Patient safety and quality of care could potentially suffer without this key infrastructure in place. Primary and secondary health professionals and social care will need to access the same patient information, where appropriate.

Multi-disciplinary working

General Practitioners recognise the 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; and the possibility of professional tensions, especially if pooled budgets were being used. Addressing these challenges is crucial but requires both time and investment to develop a common vision and to nurture constructive behaviors and trusting relationships. In particular we are disappointed not to see more mention in the consultation of the importance of pharmacy input into integrating services.

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.

There will be a need to facilitate a culture and enthusiasm to deliver these changes, especially across organisational boundaries. The culture required will be one of good professional relationships, collaboration and effective leadership to bring about improved care for patients.

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. Capacity within primary care is currently limited and upfront investment is likely to be required to overcome these constraints, which 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.

Workforce Planning

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 increased demand on services within communities. Growth in primary care doctor numbers should be matched with levels seen in the hospital service in order to deal with this. To maintain and improve the provision of a quality service, the required capability and capacity to meet demand 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.

The Royal College of General practitioners believes a policy framework that supports the integration of care will:

- Provide sufficient flexibility to allow the adoption of local models;
- put in place mechanisms to incentivize the wider adoption of good practice;
- Measure success in achieving integration against agreed benchmarks.

Above all, policymakers must invest in the idea that integration is integral to the delivery of quality, more effective patient care.

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

Putting patients at the heart of integrated care

- the integration of care should be organised around the holistic needs of the patient, especially those with multi-morbidities. The generalist approach that GPs have to offer is crucial here.
- GPs can take the lead in ensuring that individuals with complex needs receive a planned, coordinated service, and the support and education required to navigate the system and manage their own 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. There is a risk that these gaps will be where problems arise.

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 and deprived 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;
- Mechanisms to encourage and support 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 inadequate premises, currently a growing problem.
- Extension of GP training to four years, to provide new GPs with the clinical, generalist and leadership skills to treat patients with a range of complex needs.³

Shared patient records

³ Enhanced Training for General Practice : the educational case. RCGP Publications 2012.
http://www.rcgp.org.uk/pdf/Case_for_enhanced_GP_training.pdf

- The Government should bring forward practical proposals to allow the sharing of electronic patient records as a matter of urgency. This should include details of how any costs to general practices will be met.
- Protocols to ensure the maintenance of adequate safeguards regarding the flow of patient information should be incorporated into any new system. This is an imperative for patient confidentiality ensuring the efficient exchange

SUMMARY

RCGP Scotland believes that better co-ordination of care can be delivered for patients through:

- 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 to effective 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** if 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, we believe that the following measures are needed:

- 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;
- The development of additional services focusing around general practice to help provide better care-coordination and support for patients with complex and long term 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 to improve clinically effective care and improve patient safety;
- A realisation that what may work in one area may not in another. Local solutions should be sought for local problems. There is no “right” model for integration; different approaches will be appropriate depending, for example, on patient needs, geographical factors and organisational characteristics;
- An extension in the length of GP training to at least four years (see above), and action to promote cultural change and the development of leadership and communication skills in part to move this agenda forward.

This is the RCGP Scotland position on the Integration of Health and Social Care influencing our response to the directed questions of the Consultation which are mapped out below.

RESPONSE TO THE CONSULTATION QUESTIONS

Q1

We welcome the focus on shared outcomes rather than centrally-driven structural change. We agree that there is a need to focus on improving care for older people as we have outlined above. However, GPs from the top 100 most deprived practices in Scotland have a large number of patients who are physiologically 'elderly' from their mid to late 50s. There are also many such patients scattered throughout Scotland in many practices, as well described in the recent CSO (Scotland) funded research from the Scottish School of Primary Care⁴. The focus on older people may discriminate against many patients living in deprived areas, as well as many other in areas of mixed/ pocket deprivation. You have pointed out in section 1.12 that conditions associated with old age and frailty are often experienced much earlier than 65, particularly but not exclusively in areas with high levels of deprivation. People with disabilities also have requirements for care across all age groups. We would not wish to see an artificial divide created within adult services where older people are given preferential treatment. National outcomes could still be achieved, if locality areas are allowed to focus on patients with greatest need regardless of age. RCGP Scotland therefore feel that robust measures other than chronological age need to be included to avoid potentially harmful incentive being legislated for. We also support the recommendation made by the Deep End Steering Group though their report on Integrated Care⁵.

Q2

The proposed reforms are based on nationally agreed outcomes to be achieved by all HSCPs which will depend on an appropriately allocated integrated budget. Much will depend, therefore, on clearly defined outcomes that can be measured appropriately and in a meaningful way. It is hard to overstate the importance of this. The quality outcomes outlined in ANNEX A are currently too vague and will need further development. Budget allocation between HBs and local authorities will need to be sufficient to bring about meaningful development at locality level. Which aspects of the acute sector budget might be included is not clear and we would like further clarification.

It remains ambiguous from a GP point of view by what mechanisms this could result in a transfer of resources to the community to provide care – as far as we can see, this would mean transfer of resources from the acute sector into community nursing and general practice care. For a variety of (very good) reasons there is enormous pressure against this from the acute sector, and we are not clear from the proposals how this will be achieved. If there is no additional time provided for GPs, community nurses, social work staff etc to address people's needs then this will be an empty exercise. Simply moving resources around within the community does not address

⁴ Barnett K, Mercer S, Norbury M, Watt G, Wyle S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research and education. *Lancet* 2012; **380**:37-43

⁵ Deep End Report 18 on Integrated Care September 2012 http://www.gla.ac.uk/media/media_238713_en.pdf

these fundamental issues.

Q3&4

It will be vital that health boards and local authorities deliver a budget that will allow for the development of services that will achieve the outcomes intended by the bill. Single Outcome agreements are probably only of value between boards, local authorities and the new HSCPs. In order for localities to achieve success, they will need clear and simple targets. We wish to avoid increased bureaucracy and unnecessary organizational complexity. How these targets will be integrated into the work of frontline staff is important. For instance, GPs already have a great many differing objectives with QOF, QIP, and local enhanced and direct enhanced services. It is unlikely that general practice will be able to continue to function effectively if further targets are added on in a piecemeal way. This may be a timely opportunity for the Scottish Government to look at the way in which general practice is currently operating. Many GPs already feel overstretched in contractually based work that, at times, does not appear to be well coordinated.

In addition, the increasing pressure on GP prescribing budgets requires that robust governance arrangements are in place and that there is professional input from both GPs and pharmacists at strategic level within HSCPs.

Q5-14

Our understanding of the new proposed structure is that health boards and relevant local authorities will come together to agree a joint budget for health and social care which will then be allocated to the HSCPs. It will then be up to the partnerships to achieve the national outcomes set out in the bill. In order to do this effectively, HSCPs will form localities to allow frontline community staff to work together to achieve best care for patients. Accountability will therefore rest jointly with Health boards and local authorities to ensure HSCPs deliver on the outcomes.

To allow flexibility in the delivery of outcomes, HSCPs should be given the opportunity to decide for themselves how localities should be formed and operated. We believe that it is not necessary for SG to legislate for localities but is sufficient to provide guidance on how they might be structured and how they might function. So long as HSCPs are held accountable for outcomes, how these outcomes are achieved should be a matter that is left to HSCPs and localities to decide. We would however expect HSCPs to allocate budgets to localities based on their individual circumstances, taking into account deprivation levels, health inequalities and rurality for example.

While we realise there will be possible budgetary tensions between HSCPs, health boards and local authorities, we are not clear how the described Joint Accountable Officer would resolve that in practice. Further clarification on this pivotal role would be welcomed. Performance management arrangements will need to be sufficiently strong to afford public confidence that effective action will be taken if local services are failing to deliver appropriately.

Q15-20

On the whole we believe that locality planning should be left to local determination. Remote and rural areas in particular should be allowed a certain degree of flexibility. However, principles and guidance underpinning the development of localities

would be extremely useful. In order for the localities to be effective they will require analytical data in relation to their locality to help them plan services. Consideration should be given to integrating IT systems to enable the appropriate sharing of patient records between professionals. Budget allocation should be appropriate as discussed above. Clearly, availability of time to participate in locality planning, particularly in areas of high deprivation will be important if GPs are to be engaged in the process. Certainly workload issues will also have to be taken into account (we have outlined this in our opening statement).

It should be further stressed that building successful partnerships goes beyond commissioning and budgetary planning, and the role of front line staff is far more than just being consulted on how to commission services. Locality planning is about organically growing trust, developing behaviours and relationships and local systems that make integrated working and smoother decision making possible. Front line staff and volunteers are the people who will or will not work as partners to make services more integrated and seamless for patients. However, they need the resources to be able to do this, and not loaded with endless targets developed remotely. This legislation is an opportunity to create the kind of organisational environment which makes it possible to grow this kind of trust and people-based system of care that patients expect and deserve. To this end, we welcome the suggestion of provision in a new Scottish focused GMS contract that considers time required for locality planning.

Primary care teams, as the universal providers of care and the recognized point of contact for 95% of the population should be given a hub role, with support given from a strong mesh of connections within the community. To this end, RCGP Scotland support the suggestion of locality planning around GP clusters, organised around small to medium sized population groups as proposed in the document. However, if the legislation arranges GP as a hub from which care is to be organised then GP representation should *be obligatory* on HSCP committees – the current “requirement” to put engagement arrangements in place is not strong enough. We believe that if integration of health and social care is to work at a local level, then GP involvement is vital to every HSCP.

FURTHER COMMENTS

Risk

RCGP Scotland supports the following points made by a colleague at the BMA:
“As a society we need to be a lot more open and explicit about the risks associated with trying to keep many thousands of very old frail and dementia sufferers in their own homes for as long as practically possible. There are considerable risks associated with this and if we are to avoid rising litigation, complaints and critical incident investigations we need to be open and transparent about this. We think there also needs to be a public debate about the balance of responsibility between the state statutory services and families when it comes to the health and social care needs of vulnerable, frail, mentally and/or physically unwell older people”.

We are also concerned that it is unrealistic to suggest in documents talking about the integration of health and social care that community services will be built up to the level required to prevent a high percentage of truly avoidable admissions being achieved by disinvesting in hospital services. This is equally true of nursing home provision. If the aim is to keep people in the community, what we need is investment in intermediate care beds, increase in personal care staff, closer collaboration with

pharmacy services and an increase in allied health professionals to provide such services as occupational therapy and physiotherapy. Furthermore, all of these additional measures would need to be available at weekends as well as weekdays.

Housing

If the main aim of Integrated Health and Social Care is to keep people as healthy as possible in their own homes, then it is an imperative that their homes are suitably equipped for the care to be administered. Some patients may even need alternative housing to allow care to be administered properly. It seems important, therefore, that we include housing authorities, and local housing associations in the planning of appropriate services for patients. Investment in energy efficiency and better insulation and heating systems will be important in improving housing stock, which in turn makes it easier to keep elderly or vulnerable people at home.

Carer support

Carer support is alluded to in the document, but we feel the proposals need stronger provision. We need to continue to identify carers so that we can provide the best possible support, we need to involve them in care planning, and we need to consider funding for breaks in carer responsibilities.

Third sector involvement

The RCGP supports third sector involvement wherever possible to provide support services for patients. However there needs to be an enabling culture not a dependency culture to make sure resource is not wasted. We would welcome further discussion on how the third sector might contribute.

The need for research based in general practice to support integration

Current guidelines from SIGN and NIHCE are often flawed and inappropriate for many elderly patients and those with multi-morbidities. NHS Scotland with support from the medical and pharmacy professions needs to build on the current polypharmacy work and develop powerful statements with detailed guidance about not prescribing and avoiding polypharmacy—founded on research based in general practice to reduce the risk of iatrogenic harm, which currently leads to many hospital admissions.