Consultation response

Integration of Care

4 November 2011

General comments:

We welcome the opportunity to respond to this consultation. Good integrated care will improve the quality of care patients receive and ensure they receive care from the most appropriate provider (for the patient) in an accessible and timely way leading to improved health outcomes. The ideal of fully integrated health and social care which focuses on preventive health care will lead to healthier people and populations and reduced costs to the country.

When considering integration of care all patient interfaces need to be considered together particularly between secondary and primary care and across health and social care in order to truly develop person centred integrated services. If any one of these is taken in isolation gaps will develop and care will not be integrated. Previous initiatives focused on integration of care have not been particularly successful, for example, in April 2000 section 31 of the Health Act introduced partnership arrangements and the ability to share budgets, however, this has been very difficult to manage in practice.

In order to address the challenges faced when patients move between the various health and social care settings the Royal Pharmaceutical Society (RPS) recently led a piece of work with the other Royal Colleges, focusing on the transfer of medicines information when patients move across care providers. This guidance is now being implemented in practice via an Early Adopter Programme and assists with integration of care. More information can be found at www.rpharms.com/toc.

From a pharmacy perspective our main comment would be about the lack of integration in the use and optimisation of medicines in the system at the present time and what could be done to improve

this. Medicines are the second highest cost within the NHS and the biggest intervention made in relation to healthcare. We believe that the integration of medicines optimisation is key to a safe and effective NHS.

We have several points to make relating to this:

- Without integrated systems allowing access to healthcare records showing either prescribed medicines from GP practices or dispensed medicines from community pharmacies medicines reconciliation in secondary care is both time consuming and more importantly carries serious patient safety risks;
- Similar patient safety risks occur at hospital discharge where systems are not well integrated with the many organisations involved to allow transfer of care from secondary to primary care settings in an accurate or timely manner, although the RPS are working with other royal colleges to address this issue (see www.rpharms.com/toc);
- Hospital pharmacy is poorly integrated with local pharmacy services and the ability to coordinate what needs to happen with the medicines between the various parts of the pharmacy profession is difficult. Discharge Medicines Use Review (MURs) have recently been introduced as an advanced service in the community pharmacy contractual framework in England to improve medicines optimisation between secondary and primary care;
- Clinical specialist integrated care pharmacists should be routinely involved in the review of medicines for people with complex medication to liaise between secondary and primary care at discharge;
- Patients taking medicines receive advice about their medicines from a number of sources but this could be improved to ensure patients are well and consistently informed about their medicines. The introduction of the New Medicines Service and targeted MURs in England will also assist with this in the community;
- Patients in care homes have been the subject of much concern and medicines optimisation for such patients has been shown to be poorly integrated into the overall system; and
- There is little integration of medicines management between the GP and community pharmacists. The care record service could be enhanced and used more fully.

What would an integrated system of medicines optimisation look like?

The first requirement for integration is common and compatible systems for every healthcare sector. If, in the future, the NHS system is going to have even more providers then there will be even greater numbers of IT systems involved and integration will become even more difficult. There then needs to be a place where the master patient records are stored and from where they can be accessed appropriately at all stages of the patient journey. If this continues to be the GP practice then that needs to clearly be the GP's responsibility and they need the infrastructure to enable it to happen in an efficient and timely manner. The GP systems then need to provide ways in which other providers can both access and input to the system. It may be that for some aspects of care (particularly those centred around 'wellness') the pivot could be moved to the community pharmacy. If that is to occur there would need to be a greater investment in improving the IT systems in pharmacy and also how that input is integrated into the rest of the NHS system. Currently both pharmacy and GP systems are all different and the roll out of even the most basic systems is proving problematic.

Questions:

1. **What in your view are the three main benefits of integrated care?**
    - A seamless pathway for the patient and patient centred approach that proactively promotes "wellness" as opposed to "illness" with a reduction in errors of omission and misunderstanding
    - The right professional expertise being used at the right point in the care pathway with increased inter-professional communication (leading to improved understanding and working between health and social care providers and primary and secondary care) to deliver improved patient outcomes
    - Improved integration of public health and social care to support the commissioning of patient-centred care

2. **What are the risks of integrated care?**
   We believe that the main risks of integrated care will be due to lack of leadership and inadequate IT or sharing of information. We have outlined some risks below:
    - That it won't work due to barriers and competition, the current primary care contracting arrangements in England have introduced competition for services and do not lend themselves to an integrated system approach
    - That there would be an inadequate funding system that doesn't encourage investment in integration
    - The system would need to be comprehensive to avoid fragmentation in other areas
    - That there would be inadequate IT systems to support shared access to patient records and transfer of information
    - That no one would take ownership or responsibility of the patient's care, believing that other professionals would be looking after the patient. Integration tends to be led by individuals (champions)
    - If communication and working across sectors, both vertically and horizontally, are poor, this would lead to inadequate patient care
    - That there would continue to be too great an emphasis on the bio-medical model which would prevent true integration of care
    - It would be more difficult to manage the information

3. **What definition of integrated care do you believe should be used to inform policy decisions?**
   Ideally an amalgamation of all 3 suggested definitions would be preferable as the WHO definition lacks detail of budget pooling which may be important and the RCGP definition does not place patients at the core, nor imply that such a system will be user friendly or value for money. However, the RCGP definition does mentions the need for a shared electronic record which we believe is vital for integrated care to work effectively.

   None of the definitions mention social care which also needs to be integrated into care pathways to maximise benefit to patients and commissioners

4. **How can competition and choice of provider be reconciled with integrated care services?**
   There needs to be a flexible approach and patients must be at the centre of service provision and the pathway must follow the patient journey. The service has to demonstrate quality and value for money and this could be enhanced by having pooled budgets. There needs to be

multidisciplinary agreement of the design and delivery of care pathways. Most importantly it has to be about the patient, viewed holistically, and not the provider.

5. **Who should make decisions about what integrated care services are required in a given area?**
All areas will the need the majority of services; the numbers needing individual services will depend on demographics and areas of deprivation are likely to have a greater demand for certain services.

The Joint Strategic Needs Assessment (and the Pharmaceutical Needs Assessment) should be the starting point to determine what services are required in a given area. The Joint Health and Wellbeing Strategy should make informed decisions about integrated services.

The local field forces with input from Local Professional Networks, Local Representative Committees and Clinical Commissioning Groups could make overall suggestions on what integrated services are required and it is essential that there is also secondary care input.

The NHS Commissioning Board and clinical networks should provide overarching care pathways which can be adapted for local need. In order for this to happen, key stakeholder discussions are needed and the patients and the public must play a central role. In Scotland, Community Health and Care Partnerships will make local decisions on service requirements.

The consultation document asks if commissioning led integration is preferred over provider led commissioning. We would suggest a joint approach but this will be restricted in certain areas by how proactive the commissioners are and how many providers there are.

6. **What role should providers take in developing integrated care services?**
We believe that the role that providers should take includes:
    - Clarifying the unique contribution that each provider can make to the whole system and to improved patient care
    - Seek partners to assist in provision of integrated services
    - Develop tenders to bid for services
    - Provide knowledge of the needs of the population e.g. community pharmacists have a good knowledge and understanding of their local population and often see those members of the public who are not registered with a GP
    - Feedback on issues that prevent them from developing integrated care services

We would recommend that one of the roles of the multidisciplinary clinical senates would be to champion and encourage integration of care.

7. **How can models of payments be reformed to support integrated care?**
The Quality and Outcomes Framework (QOF) could be one mechanism to provide a reward for integration of care. There has recently been a move in the QOF to require GPs to work jointly with others in order to receive payments.

We believe that pooled budgets including health and social care will assist in the provision of integrated care. Payments should be developed along care pathways rather than individual services. Although, the provision of wider choice and more personalised services may often mean there is less ability to integrate.

We are concerned about how personalised budgets fit into the model of integrated care and wonder how this is being considered.

8. **What leadership and management skills are required to develop integrated care services?**
We believe that the following leadership and management skills are required to develop integrated care services:

- Development and communication of a vision
- Use of the NHS Leadership framework to demonstrate competency as a leader
- An understanding of the needs of patients and communities
- A robust understanding of what different professionals can bring to the table
- Good links and communications with all health and social care providers
- Excellent project management skills
- An ability to build on existing best practice and local networks

It is crucial to take the public with us when developing integrated care systems and they need to be involved at all stages - 'no decision about me without me'.

9. **What are the risks and opportunities of involving nurses, specialists and Allied Health Professionals from providers in the commissioning of integrated care?**
The opportunities of involving nurses, specialist and AHPs in the commissioning of integrated care include:

- An integrated approach would mean that the patient will get the maximum benefits from the NHS as all providers can demonstrate their role in the patient care pathway
- It will provide a real opportunity to improve care, making it more accessible to patients so they can receive care at a time and place that suits them, and ensuring the best professional delivers the right aspect of the care pathway
- It will provide and enable services to be developed and delivered in a different way, ensuring best use of NHS resources
- It will provide an opportunity to build up local relationships between health care professionals and promote joined up working rather than a silo approach
- It will enable the skills and locations of other provider groups to be maximised, for example, pharmacists are experts in medicines use and optimisation and are often the healthcare professional who sees the patient most frequently. There could be more effective use of their clinical skills around medicines and the management of long term conditions, particularly making use of pharmacist prescribers.

The risks associated with this could include:

- The current model encouraging competition between providers, rather than best use of skill mix across all healthcare professional may be a barrier to integrated care
- Not including all relevant health professionals in the development of integrated services. There is a need to involve multiprofessional teams as the issues are often in the detail.
- Real integration of medicine care is not possible without pharmacist input and we believe that the issues of continuity of formulation and unlicensed medicines must be addressed

It should not be about the individual professional or profession but about working together for the benefit of the patient

10. **What impact will the abolition of GP practice boundaries have on the commissioning and provision of integrated care? How might these problems be resolved?**
We are unable to provide much comment on this question as it would depend on financial models used, the level of patient choice available and how care is packaged
However, we do believe that shared electronic patient records would enable better access to care for patients.

11. **What do you need from information systems to support integrated care, and how should they be funded?**
In order for information systems to support integrated care the following will be required:
    - All health care professionals need to have appropriate access to a shared electronic patient record and be able to input into it so everyone has the relevant information when providing care to the patient. Community pharmacists should have appropriate access to the electronic patient record so that they can record interventions made and also any relevant purchases of 'over the counter' medicines which could potentially affect another clinician's decision making
    - There should either be one system to cover primary and secondary care or fully integrated systems that enable appropriate information to be shared. This would benefit patients as well as health and social care professionals
    - All those involved in a person's care would be required to be responsible for ensuring records are kept up to date and accurate

    We believe that integrated records should be funded at a local level as most of the NHS budget will now sit at such a level. However, there needs to be equity amongst all professionals when integrated systems are developed. Whilst funding should be at a local level systems should not be developed in isolation so that providers in one part of the country cannot access the records of a patient from a different area.

12. **How might outcomes measures be used to support integrated care?**
Outcomes could be measured in the following ways:
    - Process outcomes to demonstrate that the systems work
    - Patient experience (PROMs) outcomes
    - Local audits to demonstrate both process and patient outcomes
    - The affect on other related services such as admissions / re-admissions into secondary care
    - Surrogate markers such as the number of people from certain demographic groups accessing services to help reduce health inequalities

    However, we would need to be realistic and realise that not everything can be measured so some proxy measures should be identified such as reduced hospitalisations and better outcomes around the metabolic syndrome.

13. **How can integrated care help to reduce health inequalities?**
Integrated care can help to reduce health inequalities by:
    - Increasing access to services
    - Ensuring services are delivered in more convenient locations and closer to home
    - Providing a multifaceted approach with both health and social care professionals involved which could be very successful for hard to reach groups

- Using of a range of providers
- Providing holistic management of patients conditions incorporating prevention, patient education, planning, social care with generalist and specialist care at primary and secondary care levels which should improve patient outcomes and reduce overlap and costs

14. How can integrated care services prevent silo working?

Integrated care can prevent silo working in the following ways:

- Involving all professions in the development of pathways
- A better understanding of roles and responsibilities and services provided by all health and social care providers
- Ensuring real engagement to make services work best for the patient
- Providing better communications across the pathway

We would encourage the adoption of an information prescription system for all patients to ensure that not only delivered interventions but also information provision is consistent, evidence based, individualised and appropriate

15. Are there any other important issues not identified above?

There are some important issues that have not been identified and these include:

- Governance issues. Who will make the decisions about what providers are included in integrated care and who provides what part of the patient's acre pathway?
- The NHS culture tends to be paternalistic and this would need to change in order for integrated care to become a reality
- Patients need to be at the centre of care, good integrated health and social care programmes should lead to improvements in health and welfare and reduce costs for both patients and the NHS
- Packages of care across communities could be offered by more than one provider to ensure equality of access for those in areas of depravation or who may not like traditional sources of health care
- The skill mix within primary care needs to be recognised and valued, with GPs working as part of enhanced primary care teams comprising of specialists and generalists
- Integrated care should start with health promotion and health prevention and the services which support this

16. How can the RCGP help to ensure that integrated care services are developed in the future?

The RCGP could help in the following ways:

- Ensure support and engament with the other professions via the Royal Colleges
- Work with the NHS commissioning board and clinical networks as well as other Royal Colleges to develop national template pathways involving all relevant professionals, if appropriate develop competency frameworks and potentially set national tariffs
- Start to progress the recommendations in the joint RCGP / PRS statement 'Breaking down the barriers', particularly around the development of joint standards for the professions

- Work closely with the Kings Fund and Nuffield Trust on work they are carrying out on behalf of the Department of Health and the NHS Future Forum[1]

The pharmacy profession would welcome the opportunity to work with RCGP on integrated care pathways, particularly as most pathways will contain medicines and pharmacists are experts in medicines use and optimisation.

Finally, we would like to draw attention to the principles of integrated care recently published by National Voices which we fully support. They can be found at http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/principles_for_integrated_care_final_20111021.pdf

[1] http://www.nelm.nhs.uk/en/NeLM-Area/News/2011---October/21/Think-tanks-work-together-to-support-integrated-care-for-patients/

Organisational profiles:

Pharmacy Voice (PV) represents community pharmacy owners in the UK. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists' Association (CCA) and the National Pharmacy Association (NPA). The principal aim of Pharmacy Voice is to enable community pharmacy to fulfil its potential and play an expanded role as a healthcare provider of choice in the new NHS, offering unrivalled accessibility, value and quality for patients and driving forward the medicines optimisation, public health and long term conditions agendas.

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. PSNC are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors and work closely with Local Pharmaceutical Committees to support their role as the local NHS representative organisations.

PSNC's goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

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