Royal College of Physicians

Royal College of General Practitioners

Patient care: a unified approach

A case study report

Introduction

The integration of services is vital if patients are to receive the best care possible. This means that care should be planned with healthcare professionals who work together with patients to understand a patient's needs. Care must be delivered in a way that is safe, effective and accessible, and provides the best possible outcome to the patient.

This report highlights case studies that exemplify how integration between GPs and physicians can be achieved. The case studies span a wide range of services in England and Wales, and cover a variety of learning points involving different specialties, different population groups and different ways of addressing complex issues. This report has been compiled to share learning from successful examples of integration, and to encourage GPs and physicians to reflect on their own practice.

Many of the examples provided are disease specific, owing to the way in which secondary care is organised; however, around the country there are many innovative examples of more holistic treatment, for example GPs working with geriatricians to enable older patients to be treated at home or within primary care. Further integration will support a move towards these approaches. The NHS vanguards programme has not been included in this report; however, the Royal College of General Practitioners (RCGP) is currently undertaking a piece of work looking at new models of care, which will include a discussion of how the vanguards programme is producing innovation in the way that GPs and physicians work together to provide care. The Royal College of Physicians (RCP), through its Future Hospital Programme, is exploring further new and innovative ways of delivering care.

Our commitment to integrated care

Both the RCP and the RCGP have produced seminal reports that consider the need for greater integration: the report of the Future Hospital Commission[1] and *An inquiry into patient centred care in the 21st century*,[2] respectively.

In 2014 the RCP and the RCGP released a joint statement on integrated care,[3] which outlined our commitment to making the integration between primary and secondary care a reality.

The RCP and the RCGP want a health and care system in which:

1 everyone is supported to lead a healthier life

2 people's basic care needs are always met

3 people's experience of care is valued

4 people:

> know who is responsible for their care

> are actively involved in decisions about their care, and their families and carers are supported as partners in care

> are supported to self-care and self-manage

> have timely access to safe, appropriate and effective care, 7 days a week

> receive coordinated services tailored to their needs and preferences

> receive care in settings that best their meet their medical and support needs

> have an individual care plan focused on recovery or wishes at end of life

5 staff are supported to care, collaborate, improve and lead.

Working together at national level to promote person-centred care, integrated care and collaboration, we will:

> recognise integrated care as a priority

> embed the principles of this statement in all our work

> deliver specific projects focused on achieving integrated care.

Working with our memberships to promote integrated working in practice, we will:

> share and promote examples of good and innovative practice

> support our members to overcome barriers to integrated care

> identify local barriers to integrated working in order to inform and influence national policy.

Involving patients, carers and service users across the breadth of our work, we will:

> ensure that our activities and recommendations are patient centred

> work directly and meaningfully with patients, carers and service users

> review, share and learn from good practice in patient involvement.[3]

What will integration look like for GPs and physicians?

The collated case studies in this report give examples of how integration can be achieved and developed, and provide learning about how physicians and GPs can work more closely together. Themes include:

> there are many approaches to integration, which will vary depending on the patient population

> improved communication and the establishment of an ongoing dialogue between GPs and physicians are vital to successful integration

> empowering the workforce to make change, and providing an educational environment that encourages innovation

> a supportive external environment, including commissioning and funding that are fit for purpose, and information and technology systems that support primary and secondary care working together.

What does integration look like in practice?

Types of integration

The RCGP and the RCP have long been supportive of closer working, where professionals from primary and secondary care work together in teams, across traditional health boundaries.[4] The case studies in this report demonstrate that integration can take many forms, and show different ways of integrating to suit different circumstances. A key theme of all case studies is the difference that can be made to patients if GPs and physicians are part of a multidisciplinary team (MDT) and work across the whole health economy. Where services are integrated, patients are more likely to be able to access care and support at the right time and in the right place for them.

Integration between primary and secondary care cannot occur without the engagement and support of other professions involved in the care pathway. This is demonstrated through the involvement of a range of healthcare professionals, such as the use of wellbeing coordinators and a community resource team model by Cardiff and Vale University Health Board (UHB), and Sunderland's dermatology service with specialist nurses and healthcare assistants.

When care is integrated, patients and the system benefit because timely care is provided in the right place and avoiding duplication. However, funding must be provided to support services regardless of their setting. Moving activity out of hospital settings and into the community without adequate additional funding is unlikely to deliver improved patient care.

The exemplars of integration in this report include GPs and physicians working together to found and develop new partnerships. This can be seen in the Northamptonshire cardiology service, where a GP and a cardiologist collaborated to develop a new way of working for primary care, and in the North Bristol Lung Clinic, where the secondary care service has developed a telephone advice line as a way to better support primary care. This collaborative way of working means that patients are less likely to experience a fragmented system.

'The ability to work across geographical boundaries and locations is a vital aspect of integrated working.'

The ability to work across geographical boundaries and locations is a vital aspect of integrated working. In Tower Hamlets, to provide multidisciplinary diabetes support, 35 GP practices are grouped geographically into eight networks of four or five practices. Six times per year, a consultant attends each network to undertake a 2-hour MDT meeting with GPs, practice nurses, dieticians, diabetes specialist nurses and a diabetes psychologist. This has resulted in more improvements in blood pressure and cholesterol control in Tower Hamlets than in any other clinical commissioning group (CCG) in England over a 2-year period.

More than just physical integration is required; many of the case studies demonstrate success using virtual platforms. Highly rated services feature innovative ways of connecting GPs and physicians for advice, and virtual clinics can help to build relationships and make subsequent collaboration more straightforward. An example is the Whittington Health Integrated Community Ageing Team (ICAT), which established a telephone advice line for GPs to discuss the health needs of care home residents and a community geriatric service for the wider population.

However services are integrated, it is of vital importance that the pressures on services and professionals do not unwittingly conspire to leave patients without information, unaware of who (if anyone) is leading the coordination of their care, with unnecessarily long delays, or unaware of what happens next. All forms of integration must be centred on the needs of patients, including support for self-management and involving patients as partners in service design.

Learning

Integration should be driven by the needs of patients; it is often complex and needs to work across whole health economies. Funding needs to reflect service provision; it is clear that there is a role for both GPs and physicians to play in leading the development of integrated working. However, successful integration also requires close working with other health and care professionals.

Building and developing relationships

All case studies featured in this report have one central theme: the importance of strong relationships between GPs and physicians as a foundation for integrated working. Where a dialogue is formed, there is likely to be improved access for patients to services and an improved experience, with fewer delays caused by lack of communication. However, the ability for all healthcare professionals to take the time to develop these relationships is being constricted, and staff morale is at an all-time low.

The RCP's fellows and members have found that it is not always possible to take the time out to develop relationships across their local health economy. Over 50% of physicians feel that they do not have the time to build relationships with GP colleagues, and six out of 10 feel that their hospital does not support GP and physician teams working together.[5] At the same time, GPs are under unprecedented pressure as primary care struggles to provide the care needed by an increasing patient population. Ballooning workloads, declining resources and an overstretched workforce are placing a huge strain on services that remain the first point of contact with the health service for most of the UK public.

However, this does not mean that there are no opportunities to develop relationships; there are a whole range of approaches and techniques that have been successful in these difficult circumstances.

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A recent survey of RCP members and fellows[5] asked for examples of how GP–physician working has been successful in their local area. The majority of responses emphasised the need for face-to-face interaction as a way of starting to build relationships, from joint social events to using existing opportunities such as educational sessions. Examples included:

- 'We have an active book club and walking group that allows strong relationships to develop and a free dialogue.'
- 'Our medical director and chair of the local medical committee chair a bimonthly meeting with primary and secondary care practitioners from a range of specialties.'
- 'I ran educational sessions that were very effective and mutually educational. I try to ring GPs to discuss patients but it is often hard to find them (and vice versa). There needs to be recognition of the importance of this in job planning and commissioning.'
- 'I have been linked with a GP practice in my area and visit them twice a year to talk about issues – most consultants have been part of this scheme in my hospital.'[5]

The case studies in this report demonstrate how relationships can be developed through formal process such as service planning and design. In Cardiff and Vale UHB, relationships were developed through the impetus of the 'pacesetter primary care schemes'. In Oxfordshire CCG, GPs and physicians were part of the initial clinical advisory group to analyse current musculoskeletal care (MSK) provision in the area, and had a role in developing transformation plans for services.

Established working relationships between GPs and physicians can also be the driver for service change and integration. In Northamptonshire, a cardiologist and a GP proactively led service change to improve care for patients by identifying a need and developing the service to address it.

Learning

Closer working between GPs and physicians is often predicated on the development of relationships. Closer relationships between professions can lead to a dialogue around specific patients or patient groups, as well as the development and redesign of services. Physicians and GPs should ensure that they exploit every opportunity to break down barriers between primary and secondary care.

Workforce and education

Leadership

GPs and physicians have a clear role as leaders of their respective professions. As the Nuffield Trust has identified, strong leadership is a key driver of integration; this is needed both from senior management in primary and secondary care organisations, and from clinical leadership from the front line.[6]

Barriers being broken down between services and clinicians, not just the merging of services, has been identified as another key driver for integration.[7] Leadership from GPs and physicians can play a key role in this. Historically there has been a lack of investment in leadership identification, development and support in general practice and primary care. Both the RCP and the RCGP are supportive of a greater focus of this aspect within the NHS.

Leadership in primary care has been demonstrated by developing specialist services to be delivered in primary care, as seen in the Sunderland dermatology and minor surgery service. Integration can also mean secondary care taking the lead on a specific condition, as seen in the integrated respiratory service of King's Health Partners and Lambeth and Southwark CCGs, where the service operates from a hospital base but has GPs embedded as part of the leadership.

Education and training

The case studies demonstrate the value of formal education and training opportunities to share knowledge and experience. This can involve GPs being trained in the management of specific conditions using the knowledge and experience of specialists; this skill transfer breaks down the barriers between primary and secondary care, and also improves patient care.

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Where there is closer integration between GPs and physicians, there are also learning opportunities for these physicians to learn more about the specific expertise developed by GPs, especially in relation to low-resource clinical risk management and primary care consultation skills. Another theme of the case studies concerns the opportunities, through continuing professional development, to share success and to reflect on difficult experiences; this has been an outcome of the King's Health Partners' and Lambeth and Southwark CCGs' integrated respiratory service.

The Tower Hamlets diabetes MDT service runs shared educational sessions between consultants, GPs, practice nurses, dieticians, diabetes specialist nurses and a diabetes psychologist. The consultant in the Sunderland dermatology service provides quarterly education sessions for GPs and other primary care staff in common dermatological ailments and treatments, as a means to ensure proper referral into both this service and hospital care.

Integrated working can also lead to career opportunities; the Northamptonshire cardiology service provides cardiology education training sessions, run by two GPs with a specialist interest (GPwSIs) in cardiology, and a consultant cardiologist.

Learning

Both GPs and physicians can take the lead in integrating services; integration could be a GP lead in a secondary care service, or a secondary care lead in a GP service. Where GPs and physicians show leadership in integration, this can have a positive impact across the rest of the health economy. Education and training initiatives provide not only an environment to build relationships, but also opportunities for GPs and physicians to be leaders in integration and to improve patient care by sharing knowledge and expertise, as well as career development.

External environment

Commissioning, contracting and payment system

An often-cited barrier to new ways of working is the current commissioning, contracting and payment system. Where barriers to joined-up care exist, they should be dismantled, and commissioning should be based on whole pathways of care. Long-term planning is also essential so that initiatives like those outlined in this report can operate in a secure environment.[8] A move away from commissioning for activity to a payment system that rewards added value and shared, desirable patient outcomes is likely to drive the process of professional integration.

Involving both commissioners and healthcare professionals in the early stages of planning and development is a way of overcoming any potential barriers. Oxfordshire CCG's new MSK service has been developed with a costed business plan, followed by joint commissioning with local providers to refine the details. A delivery plan is currently being developed, which will then be implemented. By integrating care, pressure on the whole system will be relieved; however, funding must be provided to support services, irrespective of the setting in which they are provided.

Supportive local health economy

From the case studies analysed for this report, a key theme of successful integration is support from commissioning organisations, providers and the rest of the local health economy. This includes CCGs committing to supporting services established by GPs and physicians. For physicians, this would require supportive job planning to allow time to work in a different way.

The King's Health Partners' and Lambeth and Southwark CCGs' integrated respiratory service has benefited from engagement, support and long-term commitment by the local CCGs. Whittington Health ICAT was directly commissioned by Islington CCG in March 2014 to provide two main services: specialist support into care homes in Islington, and a community geriatric service for the wider population.

'Involving both commissioners and healthcare professionals in the early stages of planning and development is a way of overcoming any potential barriers.'

Supportive local health economies are seen for Cardiff and Vale UHB, where local health leaders came together under the local health board to create a new service, and for the Tower Hamlets MDT diabetes support service, where the grouping of GP practices led to a supportive network that was the basis of a new way of working.

An important aspect of a supportive local health economy is strong patient engagement. Designing services where healthcare professionals, patients and commissioners are involved from the outset leads to services that reflect patient needs and prioritisation of the things that are most important to patients. Cardiff and Vale UHB demonstrated this by holding a workshop with patients and carers to prioritise the areas for improvement in their diabetes community care model.

Information and technology

Some of the greatest opportunities for integrating care involve technological developments and the integration of health records. However, it is often hard to share health records between different aspects of the health service, or to integrate separate operating systems. King's Health Partners and Lambeth and Southwark CCGs found communication barriers a constant challenge, with IT systems that are not fully joined up across the health and social care sectors. Whittington Health ICAT also found that multiple operating systems and structures posed a difficulty in integrating care, but was successful in securing access to GP systems.

The RCP and the RCGP are committed to working together to recognise that medical informatics is of growing importance in healthcare, and that there is a strong case for establishing the infrastructure required to professionalise and support the discipline.

Learning

There are many external barriers to integrating services but, as the case studies in this report prove, key drivers for success include working closely with stakeholders across the health economy (which must include patients and service users), ensuring early involvement of CCGs, and working to ensure that information and technology systems support integrated working.

Case study

Cardiff and Vale University Health Board: Shaping our future wellbeing

Challenge faced

People should be able to maintain or recover their health as close to home as possible. This can only be achieved by closer integration between physicians and GPs.

Solution

Cardiff and Vale UHB launched *Shaping our future wellbeing*, setting out how it plans to achieve its vision that a person's chance of leading a healthy life is the same, wherever they live. A guiding principle of this approach was that the UHB should enable people to recover or maintain their health as close to home as possible. This is, and can only continue to be, possible through closer integration between GPs and physicians.

The programme of work includes a range of schemes that involve the whole local health economy as well as collaboration between primary and secondary care, including:

Maximise the community asset potential – wellbeing coordinators / system navigators

> Aim: to improve the interface between GPs and the community to deliver public health priorities, embed public health principles and enhance the social model of care through their use of community networks and experience of co-production.

Expansion of the community resource team model

> Aim: the current 'reach' of the multidisciplinary community resource team, in terms of extending the service to operate 7 days a week (currently a 5-day service), broadening the skillsets within the teams and extending the portfolio of support that can be offered.

Expand community nursing to improve responsiveness to primary care and secondary care

> Aim: to expand the capacity of community nursing teams by establishing a phlebotomy-only service, thus enabling time to be released back into core community nursing.

How GPs and physicians worked together

GPs and physicians are involved indirectly or directly in all the schemes outlined opposite. Specific examples of integrated primary and secondary care working are outlined below.

Project summary

Diabetes community care model

Role of consultant diabetologists:

> named consultant for each of 69 GP practices

> twice-yearly practice visits for case-note review, treatment discussion and review of guidelines

> GPs and practice nurse have email access to consultant for treatment advice.

Role of diabetes specialist nurses:

> support combined oral therapy

> support injectable therapy to start in primary care

> support dose titration of all therapies

> disseminate good practice and provide mentorship.

Role of GPs:

> local leads have championed the model and helped in its implementation

> GPs have actively engaged in developing leads for diabetes within practices and sought the inclusion of practice nurses

> GPs have taken on additional roles in managing diabetes, such as titration of oral agents and initiating injectables (other than insulin)

> additional workload tolerated, in spite of multiple pressures on practice staff and time from other disease areas

> practices have developed enhanced capability to manage their own patients and engaged with prescribing advisers to implement guidelines.

Outcomes

Rollout of the programme is still ongoing and its results have yet to be fully evaluated. However, preliminary indications suggest that its benefits may include:

- primary care staff feel more confident in managing diabetes, especially in initiating non-insulin injectables and titrating therapies
- there are fewer referrals to secondary care
- more focused and appropriate referrals
- positive feedback around timely email advice and access to secondary care opinion / decision making.

Outcomes for patients

Patients are able to access diabetes support in their GP surgery. Management of diabetes in primary care means that GPs can take a more holistic approach and ensure that care is delivered in a way which reflects patient priorities.

The approach taken has also led to greater patient engagement, with a workshop held to identify how the community model could have a more holistic approach. The top four action areas prioritised by participants were: peer and professional support/ community organising; a range of education and support; stronger access to physical activity opportunities; and an information pathway. We are currently looking at how we take forward a set of actions to meet these priorities.

End-of-life care

Working across primary care, secondary care and the third sector, Cardiff and Vale UHB is putting in place a new model of care within Cardiff and the Vale of Glamorgan for 'hospice at home'. When assessing the various options, they considered the principles of prudent healthcare, which is underpinned by a commitment to strengthen community-based care, including placing greater value on patient outcomes and creating a patient-centred system. The new collaborative model of care will include:

- central coordination of available resources by dedicated postholders
- greater flexibility to move support staff around the localities in response to patient need
- a multi-visit system with short-burst and long-burst care
- needs-based services
- integrated workforce
- integrated communication systems
- holistic support
- responsive services that respond to changing patient needs.

Outcomes

Work has begun with a third-sector partner (Marie Curie Cancer Care) to develop and initiate the commissioning process. The primary outcomes will be:

- more patients achieving their preferred place of care at the end of their lives
- an increase in the number of bed days saved by more efficient discharges
- an increase in the number of people supported to die at home if that is their wish
- a reduction in hospital readmissions in the last weeks of life
- a reduction in strain and anxiety for patients and family.

Case study

Whittington Health Integrated Community Ageing Team (ICAT): A specialist geriatric service into care homes, Islington, north London[9]

Challenge faced

To ensure that older patients, who often have complex comorbidities, can spend as much time as possible at home with their conditions managed in the community.

Solution

Development of the Integrated Community Ageing Team (ICAT) in March 2014, run by Whittington Health to provide specialist support into care homes in Islington and a community geriatric service for the wider population.

How GPs and physicians worked together

The team is made up of community geriatricians, a GPwSI in geriatrics, a Darzi fellow and two community pharmacists.

Consultant geriatrician sessions are provided by three consultants: two from Whittington Health and one from University College London Hospital. The GPwSI is a local Islington GP, who provides two sessions a week for the service.

Project summary

ICAT was commissioned by Islington CCG in March 2014 to provide two main services: specialist support into care homes in Islington and a community geriatric service for the wider population. The service is currently focused on the 10 care homes in Islington, north London, which house approximately 500 residents.

ICAT aims to:

- work alongside GPs and other community services to provide high-quality, integrated care for patients from care homes in the most appropriate setting according to their wishes and needs
- improve communication between secondary care and primary care for patients in care homes
- maximise the number of days spent within the care home through comprehensive geriatric assessments and treatment escalation planning
- work closely with care home staff and support their education and development
- work closely with allied GP practices to support ongoing professional development in complex geriatric case management.

In setting up the service, it was felt that it was very important to work closely with the care home staff and the GPs to provide the best care to the residents. The service therefore spent the first couple of months meeting staff, understanding their challenges and building relationships so as to be able to develop a service that worked for everyone.

Based on the concerns and needs of the nurses, carers and GPs who look after care home residents, the ICAT service was developed with four components:

1. monthly MDT visits to the care homes to review residents who meet specified criteria and to provide comprehensive geriatric assessments
2. in-reach service to review all care home residents who have been admitted to hospital
3. telephone advice line, available Monday–Friday from 9am to 5pm, for GPs to discuss residents of concern with a consultant geriatrician or GPwSI
4. weekly teleconferences with all the allied health professionals working into care homes, as well as the care home staff and GP, to discuss patients.

A number of different services work into the care homes and they are often from different organisations. This presented challenges in terms of integrating multiple operating systems and governance structures. To overcome these barriers, the service worked closely with Islington CCG and secured access to the GP information technology systems within the care homes. This system is still being developed to ensure coordinated and safe patient care.

Collaboration remains central to the delivery of ICAT and it continues to work closely with other services that work into the care homes, in particular the mental health and palliative care teams, to provide the best possible outcomes for patients.

Outcomes

Since ICAT started its service, the average number of admissions to Whittington Health from care homes in Islington has decreased by 26% (8.8 admissions) and the number of bed days has reduced by 18% (87 bed days) per month.

Outcomes for patients

A qualitative analysis of the service undertaken by Healthwatch revealed positive outcomes from the perspectives of patients and their relatives, who commented on improved continuity of care and an enhanced feeling of shared decision making.

Case study

North Bristol Lung Centre, Southmead Hospital: Respiratory HOT clinic

Challenge faced

To ensure that patients can be treated in the community or close to home, rather than being admitted to hospital.

Solution

The establishment of a respiratory HOT clinic, staffed by the respiratory consultant of the week and a respiratory nurse.

This service is available for GPs to refer patients between 9am and 5pm Monday–Friday. It is intended to prevent the admission of patients with acute respiratory problems and is suitable for referral of adult patients threatening admission with a respiratory problem. Patients are discharged from the clinic with a management plan drawn up by a respiratory consultant and a typed and faxed letter to the GP on the same day / within 24 hours.

The service also offers a respiratory advice baton mobile phone, manned by the respiratory consultants between 9am and 5pm, for GP or community matron advice calls.

There is also a pleural HOT clinic, run by the pleural team (consisting of a pleural fellow / specialist registrar / consultant and a pleural nurse), for patients with undiagnosed effusions to prevent hospital admission, but to allow speedy investigation and pleural intervention using pleural ultrasound (eg aspiration, CT-guided biopsy, thoracoscopy, indwelling pleural catheters).

Project summary

Patients are seen within 24 hours of receipt of a fax (criteria include chronic obstructive pulmonary disease (COPD) exacerbation, mild asthma flare, mild pneumonia but good social support). The service consists of a receptionist, respiratory nurse and respiratory consultant with access to rapid diagnostics including bloods, radiology and lung function.

When fully staffed, the service can see up to eight patients per day, assuming a steady flow of patients throughout the day. Referrals usually come from GPs, but patients can be seen from the acute admissions unit (AAU) or A&E if suitable and vetted by colleagues there to improve flow and avoid admission.

Only <10% of referred patients are admitted and the service is underpinned by an early supported discharge, with respiratory nurses and a physiotherapist to manage COPD exacerbations with temporary oxygen and nebulisers at home.

How GPs and physicians worked together

Referrals usually come from GPs. The service also offers a respiratory advice phone line, manned by the respiratory consultants on a dedicated mobile phone between 9am and 5pm for GP advice calls, such as choice of antibiotic therapy, how to investigate, chest X-ray queries, fitness to fly queries, and palliation of symptoms in advanced lung disease.

Outcomes

The clinic has significantly reduced referrals to AAU and A&E, and admission. A recent audit of the effectiveness of this clinic showed that 72% of referrals were successfully treated in the community following attendance at the clinic, thus avoiding hospitalisation.

Feedback from GPs is that they value the service very much, including the advice phone number (especially for patients who are unable/unwilling to come to the HOT clinic), which cuts down a lot of referrals and provides useful dialogue between primary and secondary care.

Outcomes for patients

The service enables patients to be treated closer to home, and the development of management plans offers opportunities for the facilitation of self-management and shared decision making.

Case study

King's Health Partners: Integrated respiratory service[10]

Challenge faced

To improve the respiratory health of an inner London population with high deprivation and smoking rates, and high premature mortality due to respiratory disease.

Solution

A multidisciplinary integrated respiratory team (IRT) working across two acute hospitals and the community, delivering COPD, oxygen, pulmonary rehabilitation and supported discharge services. Specialist care comes closer to the patient through a 'team without walls' working in an integrated way across primary, secondary and community care.

How GPs and physicians worked together

The team is led by an integrated respiratory consultant and two locality GP respiratory leads. A team of specialist respiratory nurses, physiotherapists and a smoking-cessation adviser works 7 days a week across two acute hospital sites. There are seven staff members on each site, of whom a minimum of two from each team are based in the community on a rotational basis.

Project summary

The integrated respiratory team has a vision of 'teams without walls' and aims to bring specialist care closer to the patient. The purpose of the service is to ensure that local patients living with a long-term lung condition, and their carers, experience high-value, collaborative and coordinated care wherever they need it. The guiding principles are right care and value-based healthcare.

The multidisciplinary IRT consists of specialist respiratory nurses, physiotherapists, a respiratory pharmacist and a smoking-cessation adviser working across primary, community and secondary care. The team is led by an integrated respiratory consultant (Dr Irem Patel) and two local GPs (Dr Noel Baxter and Dr Azhar Saleem). The integrated team operates 7 days a week within the two teaching hospitals making up the Academic Health Science Centre of King's Health Partners (King's College Hospital, Guy's and St Thomas' hospitals and King's College London). There are close links with the emergency department, smoking-cessation services, hospital and community pharmacy, clinical psychology, community mental health, dietetics and palliative care. The service is funded jointly by the acute trusts and Lambeth and Southwark CCGs.

The 7-day working of the team aims to ensure that every bed day counts for patients admitted to hospital with exacerbations of airway disease. The IRT reviews patients to promote accurate diagnosis and acute management, and to prioritise inpatients for a respiratory bed. Supporting and treating tobacco dependence is a key priority for the team, and all staff are appropriately trained. They ensure that every patient has a person-centred specialist review, focused on collaborative care planning, and that patients have a supported discharge including the use of the COPD discharge care bundle. The IRT works with community rapid response and hospital at home services on admission avoidance and early supported discharge where appropriate. They follow patients up by telephone and see them at home post discharge, working with other agencies to coordinate onward care, as patients are often older, breathless and have complex comorbidities or social issues. There is a 7-day telephone advice line for patients and local GPs. On leaving hospital, the IRT ensures that a patient's primary care team has a detailed summary of their care and ongoing plan, including goals agreed with the patient to follow up. Hospital- and community-based pulmonary rehabilitation runs across six local venues in Lambeth and Southwark, and the IRT also links with the local Breathe Easy patient-led support groups.

In the community, a single point of referral means that referral to any of the IRT services from primary care comes first to one of the two locality GP leads, enabling peer-to-peer support and ensuring that patients receive the right care, in the right place, first time. The team works with GP, practice nurse and community colleagues to assess patients with complex breathlessness in their own home. A home oxygen assessment and review service supports patients in respiratory failure. The integrated respiratory consultant undertakes regular joint domiciliary visits with GPs or palliative care teams for patients with advance care planning needs.

Respiratory 'virtual clinics', supported by a respiratory pharmacist and the local CCG medicines management teams, run twice a week in primary care in Lambeth and Southwark. These are underpinned by jointly agreed priorities of care and prescribing guidance. The focus of virtual clinics is joint working between primary care teams and the IRT, and to systematically review the diagnosis and long-term management of the respiratory patient caseload. These clinical sessions enable skill transfer, strengthen referral processes, and build closer working relationships across traditional boundaries of care. The IRT also runs regular study days for community colleagues. A major initiative within the virtual clinics has been to support responsible respiratory prescribing and to reduce harm and waste through inappropriate use of inhaled therapies. Over a 2-year period, this has resulted in significant financial savings for the local health economy and a shift in resource allocation towards higher-value treatments, such as pulmonary rehabilitation for the local population.

Outcomes

Focus on high-value and 'right' care for a population; coordinated care; making every bed day count; re-ablement after acute admission; supported discharge and smoother transitions of care; patients supported at home; reduced prescription of inappropriate medicines, financial savings and reinvestment in high-value care to deliver outcomes that matter to patients; supporting patients at the end of life.

Outcomes for patients

Specialist care is available to patients where they need it; a single point of access ensures that patients are able to access support with the right person, in the right place and at the right time for them. Primary and secondary care are working together toward the goals that are most important to the patient, rather than the practicalities of delivering a service.

Case study

Oxfordshire CCG: Integrating MSK services

Challenge faced

To transform the current services for patients with musculoskeletal (MSK) problems across all the sectors of health and social care locally, to produce a high-quality, patient-centred, locally focused and innovative service. Redesign the MSK patient pathway in the Oxfordshire CCG area to improve areas of identified weakness, including patient satisfaction, high levels of expenditure and 18-week referral-to-treatment targets.

Solution

The project aims to transform the current services for patients with MSK problems across local health and social care sectors to produce a high-quality, patient-centred, locally focused and innovative service. The service will also produce data to assist in primary prevention and direct patients into secondary prevention.

How GPs and physicians worked together

GPs, physicians, allied healthcare professionals, surgeons, academics and charity sector representatives formed a clinical advisory group for the project, to analyse the current processes for patients with MSK problems and to help refine areas for further discussion to improve the quality of clinical services.

GPs and physicians were present at several larger stakeholder engagement sessions to inform the focus and larger groups. GPs and physicians also worked with the final focus group to define the proposed future service. GPs and physicians were also part of the board used to scrutinise the proposed service specification.

Project summary

After widespread engagement with stakeholders, there were focused discussions on important areas identified, including shared decision making and care planning for patients with long-term MSK conditions.

A service description was developed and a costed business plan was produced. This was followed by joint commissioning with local providers to refine the details. A delivery plan is currently being developed, which will then be implemented.

Outcomes

The service will deliver patient-centred, timely, locally focused treatment of both long-term and limited-term MSK conditions.

Outcomes for patients

Services will be planned in a way that reflects patients' priorities, with an emphasis on shared decision making and care planning.

Case study

Northamptonshire: Cardiology service

Challenge faced

To ensure that unwell or vulnerable patients are able to have cardiology services delivered closer to home and ensure that they are not unnecessarily admitted to hospital.

Solution

As a means to avoid unnecessary hospital admissions and deliver more care within the community in Northamptonshire, a local NHS consultant cardiologist and a GPwSI in cardiology set out to develop a new extended role for GPs working in cardiology. The extended role was developed to enable GPs to diagnose and manage patients with mild to moderate heart failure and patients with atrial fibrillation within primary care, through their participation in a brief training course and by providing ongoing clinical support.

How GPs and physicians worked together

In early 2010, Dr Jonathan Shribman (GPwSI in cardiology) and Dr David Sprigings (consultant cardiologist, Northampton General Hospital (NGH)) approached a number of GPs within the NGH catchment area with a pilot scheme for recruiting and training GPs from local GP surgeries for a GP extended cardiology role (ECR), which it was envisaged would provide an enhanced level of cardiology care within general practice and a practice-based service for patients who might otherwise have been referred to hospital.

GP practices were briefed at locality meetings, inviting them to participate in the pilot. The recruited practices were selected through consultation with the (now defunct) primary care trust. A GP from each recruited practice was then nominated to undertake the new extended role.

Project summary

10 GP practices within the area are currently signed up to this service, each having one GP within the practice who is trained to undertake cardiology care within general practice. The participating GPs attend cardiology education training sessions, run by two GPwSIs in cardiology and an NHS consultant cardiologist. These sessions provide education in elements of clinical triage, use of cardiology investigations and management of heart conditions. At the end of the training process, the GPs sit an assessment written by the GPwSIs and the consultant cardiologist.

Under the new system, when a patient presents with cardiac symptoms at one of the surgeries with a GP working in this extended role, rather than referring the patient to secondary care, they will be referred to, investigated by and managed by the ECR GP within the GP surgery, with referral to secondary care only when judged necessary.

This management includes access to basic cardiology tests to assess the urgency of a condition. In addition, ECR clinical interventions within general practice are supported by a consultant cardiologist and GPwSI in cardiology, with whom the ECR GPs will be in close contact to ensure that they are supported in their decision whether to refer the patient to secondary care.

By embracing this system, not only has general practice within the NGH catchment area been able to change the pathway for cardiac patients to ensure that people who can be treated within the community are, but ERC GPs have also made themselves the focus of cardiology care within their practice by providing clinical leadership and clinical support to their own colleagues.

Outcomes

- Fewer referrals to secondary care: during the pilot for this programme, the pilot practices observed a 66% decrease in referrals to secondary care.
- An audit of all the patients assessed by the ECR GPs confirmed that there was no spillover into secondary care cardiology by other means, eg emergency admissions or non-extended role GP referrals.
- Clinical satisfaction: 97% of cases reviewed were within the remit of the pilot scheme and were considered to meet the ECR GP guidance for the new in-practice cardiology service. The review was led by a local public health consultant.

Outcomes for patients

There was high patient satisfaction with the service. The initiative also provided greater information to patients, with 72% of the patients stating that they understood their condition better and 61% who felt better able to cope with it. 47% of patients reported that it had helped them to keep themselves healthy. The service demonstrates that closer working between GPs and physicians can support patients to self-manage through the provision of information.

Case study

Sunderland dermatology and minor surgery service

Challenge faced

To provide services that are delivered in accordance with patient need. This meant diverting patients away from secondary care into primary care, where they could be better served.

Solution

The Sunderland dermatology and minor surgery service diagnoses and manages patients with a range of skin conditions whose treatment does not require a hospital setting. The service is run by South Tyneside NHS Foundation Trust and is delivered in a purpose-built primary care centre co-owned by Sunderland CCG and Sunderland City Council.

The service originated in 2002 when a nurse and a healthcare assistant were recruited to support GPs in managing patients with chronic conditions and carrying out minor surgery in primary care within the area. In 2005, it moved to a new primary care centre built locally with £1 million Department of Health funding. A consultant dermatologist was appointed on a half-time basis to provide leadership on clinical governance and training, and to enable delivery of treatments only available under specialist supervision. In 2010, an advanced nurse practitioner was appointed to provide full-time senior clinical management and leadership.

How GPs and physicians worked together

The Sunderland dermatology and minor surgery service developed over a period of 12 years from a situation where GPs were supported by healthcare assistants to provide care for chronic dermatological conditions within general practice, to a specially designed service employing a wide range of specialist practitioners, including a GPwSI in dermatology and a consultant dermatologist, within a designated primary care centre.

Project summary

The Sunderland Dermatology Centre provides routine care to patients suffering from non-urgent and non-life-threatening dermatological conditions. Care is provided within a dedicated primary care centre, by a wide variety of specialised staff including a part-time consultant dermatologist and a full-time GPwSI in dermatology, as well as specialist nurses and a healthcare assistant.

The diversified team allows the service to provide a number of different treatments and services, such as:

- diagnosis of a range of skin conditions through general dermatology clinics run by a consultant dermatologist and GPwSI
- nurse-led clinics that monitor prescribed management plans and deliver a range of treatments such as steroid injections
- healthcare assistant-run clinics that provide patient education
- advice, education and support for patients with chronic conditions, who can access a telephone advice line or a rapid access clinic when experiencing a flare-up
- a dedicated nurse-led clinic for people with severe acne
- minor skin surgery – generally performed by the nurse surgeon or by one of two GPs who run minor surgery sessions in the centre; patients can be assessed, treated and discharged on the same day
- telephone advice on diagnosis and treatment for GPs, practice nurses and other healthcare professionals (such as school nurses, district nurses, staff from minor injury units and chiropodists) provided by the consultant dermatologist, GPwSI and senior nursing staff.

In addition, the consultant dermatologist provides quarterly education sessions for GPs and other primary care staff in common dermatological ailments and treatments, as a means to ensure proper referral into both this service and hospital care.

Patients are referred into the service by staff in a number of different disciplines, including GPs, nurses, health visitors, district nurses and minor injury units. In addition hospital consultants can, in some circumstances, refer patients into the service for follow-up appointments following hospital admission, or for education and self-management advice.

Once a patient has been referred to the service, the administrative staff (with clinical support from the nurse practitioner and consultant dermatologist) will triage the patient into the correct team within the health centre.

Patients with a confirmed diagnosis by their GP may be referred directly to the nurse-led acne clinic or to the minor surgery service. Patients without a confirmed diagnosis have an initial consultation with the consultant dermatologist or part-time GPwSI, and are then referred to nurse-led clinics for follow-up appointments and treatment.

The consultant dermatologist and GPwSI provide ongoing management only for patients with complex needs, with all other patients directed towards the nursing service. If a patient is suspected to have a more serious condition, such as skin cancer, or requires urgent treatment, they will be referred into secondary care.

The service does not provide a walk-in service; however, patients suffering from a small number of chronic conditions or acne can self-refer back into the service within either 6 months or 1 year of their original appointment.

Outcomes

- Patient experience surveys (covering two quarters in 2013, and a total of 42 patients) found that 100% of patients would recommend the service to others.
- Waiting times were lower than in the hospital-based dermatology service: median wait for first appointment was 4.8 weeks, compared with 6.7 weeks at the acute trust.

Patient outcomes

Patients report high levels of satisfaction with the services. Access has improved and waiting times are reduced, with patients being quickly directed to the most appropriate service. Patients are also able to self-refer to the service.

Case study

Community Independence Service and Medicine for the elderly services at Imperial College Healthcare NHS Trust: A continuum of services supporting complex older patient care via multiple providers[11]

The Community Independence Service (CIS) is a multidisciplinary health and social care team that provides coordinated nursing, therapy, psychiatric liaison and social care input to local residents. The aim is to enable people to be supported in their own homes and remain independent.

The 'virtual ward' is a morning MDT meeting at which a geriatrician and a local GP based in the community hub support the CIS team to discuss patients identified as being at high or escalating risk of hospital admission. If needed, patients are then seen at home by the most appropriate team members. The 'virtual ward' communicates directly with the patient's own GP and liaises with the hospital's acute geriatric team.

This service also links closely with other older persons' services, such as the Older Persons Rapid Access Clinic (OPRAC), 5 days a week and a GP direct phone line to a consultant geriatrician for advice or referral to OPRAC. Patients who are felt to be at high risk of hospital admission can then be seen within a few days in this one-stop, all-day centre, by an MDT team with access to full diagnostics, therapy assessment and secondary care expertise.

Case study

Tower Hamlets diabetes MDT support and meetings[12]

In Tower Hamlets, 35 GP practices are geographically grouped into eight networks of four or five practices. Six times per year, a consultant attends each network to undertake a 2-hour MDT with GPs, practice nurses, dieticians, diabetic specialist nurses and a diabetes psychologist. This provides an opportunity for shared education, review of the key performance indicators for the diabetes care package, and communication on local diabetes care initiatives, including updates on guidelines and the drug formulary etc. This model has resulted in Tower Hamlets having better improvements for blood pressure and cholesterol control than any other CCG in England over a 2-year period. In Tower Hamlets, the consultants also offer actual or virtual community-based MDT clinics to review the management of challenging patients, eg frequent non-attenders, housebound patients.

References

1 Future Hospital Commission. *Future hospital: Caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: RCP, 2013. www.rcplondon.ac.uk/projects/outputs/future-hospital-commission [Accessed 28 January 2016].

2 Royal College of General Practitioners. *An inquiry into patient centred care in the 21st century: Implications for general practice and primary care.* London: RCGP, 2014. www.rcgp.org.uk/policy/rcgp-policy-areas/inquiry-into-patient-centred-care-in-the-21st-century.aspx [Accessed 28 January 2016].

3 Royal College of Physicians and Royal College of General Practitioners. *Joint statement on integrated care.* London: RCP/RCGP, 2014. www.rcplondon.ac.uk/news/gps-and-physicians-want-care-based-patients-needs-rather-buildings [Accessed 28 January 2016].

4 Royal College of General Practitioners, Royal College of Physicians and Royal College of Paediatrics and Child Heath: *Teams without walls: The value of medical innovation and leadership.* Report of a working party. London: RCP/RCGP/RCPCH, 2008. www.rcplondon.ac.uk/projects/outputs/teams-without-walls-value-medical-innovation-and-leadership [Accessed 28 January 2016].

5 Royal College of Physicians. Research panel survey May 2015 – results (unpublished).

6 Ham C, Smith J. *Removing the policy barriers to integrated care in England.* London: Nuffield Trust, 2010. www.nuffieldtrust.org.uk/publications/removing-policy-barriers-integrated-care-england [Accessed 28 January 2016].

7 Ham C, Walsh N. *Making integrated care happen at scale and pace.* London: The King's Fund, 2013. www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace [Accessed 28 January 2016].

8 Royal College of Physicians. *Putting the pieces together: Removing the barriers to excellent patient care.* London: RCP, 2015. www.rcplondon.ac.uk/guidelines-policy/commissioning-system-payment-and-structures-nhs [Accessed 28 January 2016].

9 Royal College of Physicians. *Your story – Specialist geriatric service integrated into care homes.* www.rcplondon.ac.uk/projects/outputs/your-story-specialist-geriatric-service-integrated-care-homes [Accessed 28 January 2016].

10 Royal College of Physicians. *Your story – Integrated respiratory services: hospitals without walls.* www.rcplondon.ac.uk/projects/outputs/your-story-integrated-respiratory-services-hospitals-without-walls [Accessed 28 January 2016].

11 Royal College of Physicians: *Integrated care: taking specialist medical care beyond hospital walls.* London: RCP, 2016.

12 Hull S, Chowdhury TA, Mathur R, Robson J. Improving outcomes for patients with type 2 diabetes using general practice networks: a quality improvement project in east London. *BMJ Qual Saf* 2014;23:171–6.

Royal College of Physicians

Royal College of General Practitioners