

INTRODUCTION

Fragmentation and poor communication among different parts of the health service are seen as some of the causes of the problems that the NHS is now facing. Front-line services are under greater pressure than ever, hospitals are severely stretched, support in the community is often flimsy and uneven, and patients with complex needs often get lost in the system. Much has been written about integrated care, although there is not yet a real consensus about exactly what this means in different settings and how it will contribute to the improvement of services and better use of resources. To generate further debate and discussion we asked five experts for their vision of what integrated care should look like for five important groups of patients: children, older people, people with cancer, those with mental health problems, and patients with multimorbidity.

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... FOR ACUTELY ILL CHILDREN



Ann Van den Bruel

Acute illness in children is very common, predominantly infectious, and self-limiting, although a small number of children experience a serious condition that requires appropriate and timely management, such as sepsis or diabetes.

Most of the episodes are managed at home, but acutely ill children also represent a large proportion of the primary care workload. Additionally, pressure on secondary care increases consistently: unplanned hospital admissions of children have risen by 15–22% over the past decade, and admissions for acute

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respiratory tract infections alone rose by 18%. In addition to the obvious resource consequences, hospital admissions for self-limiting illnesses reinforce hospital-centric health-seeking behaviour, exacerbating the problem in the future.

In contrast, childhood mortality is substantially higher in the UK than in other European countries: children with chronic conditions and from a deprived background are at higher risk. Difficulty in recognising serious illness in children both in primary care and in hospital has been identified as one factor contributing to childhood mortality.

This problem could be solved by better integration of the care provided by parents and clinicians across the health system. Integrated care for acutely ill children is defined in terms of evidence-based functions rather than structure. The three core elements are access, assessment, and self-care.

- Access should be easy, responsive to acute problems, and unrestrained by financial barriers. This involves care being available at short notice during and after regular surgery hours, especially for children at higher risk. All NHS access points should be part of an established pathway for acutely ill children.
- Assessment should be standardised and based on the best available evidence to stratify risk, with the potential for rapid exchange of advice and transfer between ambulatory and hospital settings. Importantly, a proper diagnostic

assessment also includes ‘softer’ contextual information such as a sudden change in health-seeking behaviour or parental anxiety.

- Self-care focuses on enabling parents or carers to look after themselves and their children with close support, and providing clear and unambiguous advice on how and when to re-consult. In addition, integrated care takes responsibility for liaising with the parents and coordinates the healthcare response until the urgent problem is resolved.

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... FOR FRAIL OLDER PEOPLE



Clare Gerada

Frail older people have complex health and social care needs. New diseases, old

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diseases behaving differently, difficulties brought about by polypharmacy, and problems faced by loneliness and poverty make managing this group of patients challenging.

The physical environment and care processes of hospitals are geared to acute illness, making it difficult to manage patients with multiple comorbidities, who experience fragmented care and delays between episodes of intervention or assessments.

Caring for frail older patients requires generalists, with specific competence in managing this patient group, working with a dedicated multidisciplinary team providing care in and out of hours, in and out of hospital, and, if possible, access to intermediate community facilities.

Fifteen years ago, before the terms 'frail elderly' or 'integrated care' were used, we almost had such a service.

Our practice, together with others in the area had access to a GP-run intermediate 'hospital' called the Lambeth Community Care Centre (LCCC). GPs and district nurses had direct admitting rights, and the LCCC, which along with two dozen in-patient (GP-run) beds (for respite, acute, and rehabilitation needs), had a day centre with drop-in facilities and on-site social worker, occupational health, nursing team, dentistry, and physiotherapy.

Once a week, a team meeting, involving nurses, a GP lead, a physiotherapist, a social worker, and a local geriatrician would help deal with complex issues.

Patients who were in-patients at the local acute hospital could be transferred directly to the LCCC ward (although most admissions and day care patients came directly from the community — day or night) using the LCCC's own transport and avoiding an acute hospital stay.

An outreach team would help patients with any transition (for example, from in-patient stay to home), which could be staged according to their needs. GP records were directly accessed via a remote terminal.

This was true integration: joint care, going beyond the simple exchange of letters, with professionals working together and using a single electronic (GP) record, and providing holistic care to patients. Maybe we need to go back to the past, and learn from it.

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"Patients in a diagnostic (or treatment) pathway should not have to worry about what comes next: it should just happen."

... FOR PEOPLE WITH SUSPECTED CANCER



William Hamilton

Do you remember the 'grandmother test' we used as medical students? This translated to 'what care would I want to offer this woman if she were my gran?' As we aged, this became the 'mother test', and I'm already thinking about the 'me test'. Once we start thinking as patients, integrated care models make more sense. The word 'integrated' really means 'seamless'. Patients in a diagnostic (or treatment) pathway should not have to worry about what comes next: it should just happen.

Examples of fragmented care in cancer diagnosis abound. The most egregious is the 'ping-pong patient'. The patient with pancreatic cancer with loss of weight and abdominal pain will frequently have a negative colonoscopy, then a negative gastroscopy, eventually having an abnormal CT. They probably had an ultrasound somewhere along the way too. That's four trips to hospital, probably four specialists, and at least four times the anxiety. No one seems to be in charge and care appears haphazard.

Seamless care can happen. Breast clinics work; arguably entry criteria are too liberal, but patients get a slick, quick service. Possible bladder cancer similarly has integrated care, with patients with haematuria receiving ultrasound, cystoscopy, and a diagnosis in a well-ordered fashion. These services are expensive though, with diagnostic costs exceeding treatment costs once you count all the patients in diagnostic clinics.

How can we extend that to other

cancers, without breaking the NHS budget? Increased diagnostic access for GPs can help. Brain CT/MRI can, and should, be open access. Colonoscopy can be performed as open access (will someone please redesign bowel preparation packaging so it fits through a letterbox?). A few innovative trusts have their biochemistry labs reporting abnormal Ca125 test results direct to the radiology department, and, if the transvaginal ultrasound is abnormal, a 2-week gynaecological referral is made. This process averts delays that can arise if the GP has to authorise each step. Similar processes can work with follow-up imaging for a vague abnormality on a chest X-ray. Our ping-pong patient probably needs a generalist-specialist who can access appropriate testing, although, unfortunately, these have largely vanished in the era of super-specialism. In theory, the GP has this overall responsibility; in practice, seamless care is unworkable if the GP cannot access the necessary tests directly.

Other examples of integrated cancer diagnostic pathways can be designed by thinking of, or asking, Granny.

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... FOR PEOPLE WITH MENTAL HEALTH PROBLEMS



Tony Kendrick

Integration of care is especially important for people with psychoses and other severe mental illnesses, who often have life-

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shortening cardiovascular and respiratory problems due to inactivity, smoking, and obesity, and require support from a range of health and social care providers. Integration should be both vertically across primary, community, and hospital services, and horizontally, between health services, social services, and other care providers.

Vertical integration should include agreed written criteria for referral from primary care to psychological and psychiatric services; arrangements for initial assessment; signposting to required services according to patients and/or service users' needs; arrangements for planned discharge back to primary care; and ongoing care management. Initial needs assessment in specialist mental health care should include, in addition to mental health problems and treatments, personal, family, and social circumstances; social functioning; substance misuse, physical health problems, and interventions; and capacity to consent to care.

A single care plan should be completed by a named care manager who has been agreed with the various agencies, and meets with them all regularly, ideally in cross-boundary multidisciplinary meetings but if not then with individual providers; for example, with GPs between patients in their practices. A shared care record should be actively used by all health and social care providers involved in the person's care, using language mutually understood by the care providers, the person, and their carer. It should also include regularly updated information about statutory and voluntary organisations involved in the person's care.

The shared care record should show that physical health needs have been assessed at least annually and list cardiovascular risk factors; review of physical and mental health medication and side-effects; health promotion and its effectiveness; and who is specifically responsible for responding to the person's various health needs. Assessment of physical health needs should lead logically to the provision and monitoring of appropriate evidence-based interventions including lifestyle advice on smoking, diet, and physical activity; nicotine replacement therapy; statins; and

appropriate antihypertensive and diabetes medication. The locus of provision of health promotion and physical health care could be in primary and/or secondary care, but should be appropriate to the individual person's circumstances.

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... FOR PEOPLE WITH MULTIMORBIDITY



Graham Watt

Like Molière's *Bourgeois Gentleman*, who discovered at age 70 that he'd been speaking prose all his life, GPs do not have much to learn about 'integrated care'. Providing unconditional, personalised continuity of care for all patients, whatever problems or combinations of problems they present, is 'integrated care' in anybody's language. However, the barriers to such care are many.

Every general practice is a compendium of patient stories. They are the currency of health care, but how do we know if the local currency is strong, or weak? When patients' serial encounters with health professionals are added up, what is being achieved, and is it 'good enough'? Unlike the management of

high blood pressure and similar conditions, where definition, measurement, audit, and research are simple, we have no similar information system for integrated care. It needs to be invented.

The patient struggling to cope with dysfunctional, fragmented, local systems has become commonplace. Too often in the distribution of resources and arrangement of services, professional interest trumps patient need. Health professionals should ask themselves not only 'What do I do?', but also 'What am I part of?'. The question is relevant to general practice.

With their patient contact, population coverage, continuity, flexibility, long-term relationships, and trust, general practices are the natural hubs of local health systems, but need better connections with almost everybody: hospitals, area-based services, community care, the third sector, and local communities.

In the 19th century, Britain's industrial revolution was led not by scientists, inventors or investors, but by a cadre of entrepreneurs who knew how to combine new knowledge, scientific inventions, raw materials, and local people in productive local systems. For the social revolution required to help people with multimorbidity live long and well in the community, similar leadership is required, to produce not goods and profits, but the multiple productive relationships, based on mutuality and trust, that make strong local health systems.

Human energy, passion, and capacity are the last great natural resources. Societies can be resource poor, but people rich, as in Cuba, or resource rich and people poor, as in the US. The health outcomes are similar. Yet it is US ideas and companies that are being imported.

Local health systems need local leadership and are unlikely to develop in any other way. Lead or be led, that is the future.

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"When patients' serial encounters with health professionals are added up, what is being achieved, and is it 'good enough'?"
