Vertical integration of GP practices with acute hospitals in England and Wales

GP practices are usually run separately from hospitals. Yet, in some places in England and Wales, the NHS organisations responsible for managing hospitals are now also running local GP practices.

What is vertical integration?

Vertical integration is integration between organisations operating at different stages along the patient pathway.

What did we investigate?

1. What is the rationale behind vertical integration?
2. What arrangements exist for acute hospital organisations to manage GP pratices?
3. What is the experience of impementing this vertical integration?
4. How has it affected primary care provision?

Methods

- Rapid literature review
- 52 interviews with GPs, NHS managers and other staff
- Stakeholder workshop
- Three comparative case study sites

What did we find?

The main driver behind vertical integration is to **sustain primary care provision locally** by avoiding closure of GP practices.

Vertical integration has developed further where there were good pre-existing relationships between primary and secondary care, and where **key individuals were active in providing leadership, energy and focus** for the integration.

The net impact of vertical integration on **health system costs appears either to be neutral or beneficial**. The main benefit to efficiency is the scope for better management of emergency patient flows to acute hospitals. Centralisation of back office functions may also offer modest savings.

Governance and contractual arrangements differed between the case studies. In one place the contracts are run directly by the local health board. In another place the practices are part of the NHS hospital trust. In the third case study, a separate company has been created, which is wholly owned by the local NHS hospital trust, to run GP services.

Improving care pathways, and the efficiency of the local health economy, for patients who are high users of emergency secondary care and/or living with complex or multiple morbidities was a particular focus at two of the three sites.

The different operational practicalities and cultures of primary care and secondary care have required effort to bridge. The **main impact on ways of working has been in primary care**.

Overall theory of change

Rationale

To sustain primary care by supporting local practices

To protect patient access and better manage patient demand

Priorities

Improve recruitment and retention in primary care and address growing workload

Existing GP partner model is unsustainable

Inputs

Financial investment to recruit locums and improve estates management

Reorganisation of back office and data sharing functions

Development of MDT (multi-disciplinary team) models

Processes

Development of common back office functions

Integrated governance

Transfer existing primary care staff

Development of training opportunities

Outcomes

Better recruitment and retention of primary care staff

Flexible, upskilled primary care workforce

GP practices remain open

Impact

Sustained patient access to primary care and managing demand in secondary care

Improving patient management and care through MDT model

Increased opportunities for innovative care

The key takeaways:

1. Vertical integration is a **valuable option to consider when GP practices look likely to fail**.
2. It is **not an option that should be imposed from the top down**.
3. Vertical integration may be a route to better integration of patient care, at least in some areas, but **it is not the only route**.

BRACE Rapid Evaluation Centre

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