Good Governance Institute

Goldberg III:
Can the NHS deliver integration? Lessons from around the world

David Goldberg
December 2014

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Document name:	Goldberg III: Can the NHS deliver integration? Lessons from around the world
Version:	Final Report
Date:	December 2014
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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisations.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services, services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

ISBN: 978-1-907610-29-5

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Foreword by Dr. John Bullivant, Chair, Good Governance Institute

'What rests, rusts' [1]

Our thanks again to David Goldberg for both an authoritative canter around UK and international efforts to both commission and deliver integrated health and social care. David has provided both an insightful and personal view based on his vast experience of cajoling complex systems in the US, UK and Pacific regions into joined up coherent patient focused delivery of care. This is not just another resume of what should or could be done but a practical call to arms from those in authority in commissioner and provider boards, governing bodies and cabinets, in regulators and from those in policy-making or holding-to-account delivery positions. We all want you to up your game to stop delivering in isolation and to recognise the very obvious expectations of patients, service users and *navigators* (those carers and professional supports to patients), to provide integrated, aligned, joined-up health and social care services focused not just on central targets but on individuals hopes and needs.

The Good Governance Institute prides itself on basing all its work on two simple beliefs:

1. The board (or governing body) is important; it has authority; it can make a difference and the best of boards add value not only to the population they serve but to the management and clinical teams they oversee. They exercise authority through vision, an appetite for risk, unrelenting scrutiny and a worldliness, which extends beyond today's compliance to tomorrow's expectations.

2. The NHS, local authorities and partners have the ability and agility to operate jointly in a complex, changeable world, engaging with stakeholders to focus on improved delivery across institutional boundaries in spite of a range of cultural, financial and regulatory barriers. It can be done.

None of this is easy but we hope and believe the text here identifies not only a series of impediments to progress but examples and a prescription for success. There is of course a major resourcing issue in the face of increasing demand, cutbacks and an apparent loss of motivation but there is also the obvious driving challenge to be met. We are good at this and can deliver.

GGI have tried to support this agenda through a number of publications, all freely available from our website www.good-governance.org.uk. They are useful, but history. We hope this new call to arms will inspire boards and others to action. *Can the NHS Deliver Integration taking lessons from around the World? Yes we can.*

Dr John Bullivant FCQI
Chairman, Good Governance Institute

December 2014

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Introduction

'We need to move beyond arguing for integration to making it happen, whilst exploring the barriers' [2]

Over the past two years I have written about strategy in the NHS. This new report is focused on what has become called "integrated care". Integrated care has many definitions. Basically, it can be surmised as the coordination of all elements of health and social care around a patient or group of patients. To date, efforts to apply this emerging model have mostly been focused on patient populations where the need is greatest – safeguarding children and caring for the frail elderly, and those with a single or multiple long-term and mental health conditions. Experience in the United Kingdom (UK) and internationally has clearly shown that improving the integration of care for our most vulnerable citizens can directly reduce their utilisation of expensive secondary care services. In this report, I will present my personal views on the lessons I believe the NHS in England can learn from experiences with integrated care in the UK and beyond.

The recent work of the King's Fund, "Providing integrated care for older people with complex needs; lessons from seven international case studies[3]," provides a compelling introduction and prescription for the NHS. This report builds on the work of the King's Fund and others to encourage practical actions, in particular by boards and governing bodies, to advance an integrated approach to caring for our most vulnerable citizens in the safest and most cost-effective manner possible.

Integration has been approached in many ways. One is the integration of providers (often referred to as vertical or horizontal organisational integration) to enable better coordination of care. Whilst there has been considerable activity integrating organisations – large hospitals absorbing smaller ones; community trusts merging into acute and mental health trusts; the federation of general practitioner (GP) practices, etc. – *there is little evidence to date that patients have received better co-ordinated – integrated care.*

Another is a more patient-centric approach looking at the specific needs of an individual, involving the individual and their carers in the discussion and fashioning of a co-ordinated, proactive "integrated" approach to on-going care. To be successful, the patient and their journey must be at the centre of care design and delivery and there must be a "high touch" personal approach. The Good Governance Institute (GGI) and the Institute of Healthcare Management encouraged commissioner and provider boards to expand their horizons beyond the single institutions to demand assurance that service delivery at the boundary is joined up in a joint paper as long ago as 2008[4].

This report will explore why patient-centric integrated care is so important to improving the quality and efficiency of care delivered to some of our most vulnerable and needy patients; what barriers exist to improving the integration of care in the NHS and between the NHS and social care; and what models within the UK and internationally provide insight and direction to the successful integration of care. The discussion will then shift to practical lessons and recommendations to better integrated care within and beyond the NHS.

Most health care systems are not organised to provide integrated care. In England, care is provided by a multiplicity of organisations – privately run GP practices, community trusts, acute care trusts, mental health trusts, community pharmacies, third sector organisations, independent providers and local government. Each of these organisations is incentivised by regulators and commissioners to develop rules, policies, and in some cases bureaucracies to be able to deliver care efficiently and with consistently high quality within their own locus of care. Less attention is paid to how each of these providers interact with one another. Each are "organisation-centric", not patient-centric, in their history and design. Consequently, patients and their carers are often faced with confusing and disconnected components of a health and social care system that is intended to meet their individual needs – but consistently fails to do so.

The present system provides comparably high-quality care for those who have limited interaction with the health and social care system, those, for example, who see their GP once or twice each year or who take their child to an acute an emergency (A&E) department to get a simple fracture set[5]. However, the bulk of NHS resource allocation is on patients with multiple long-term conditions, mental health conditions and the frail elderly who require services from some or all of the various components of the health and social care system. This is, of course, by no means a new phenomenon, nor one that is not recognised politically. Indeed, the recent publication of the Royal College of Physicians' Five Point Plan for the next UK government identifies the need to "remove the financial and structural barriers to joined-up care for patients". [6]

2) NHS Future Forum, 2011
3) Goodwin, N. et al., 2014
4) Bullivant, J., Deighan, M., Stolen, B. and Corbett-Nolan, A. (2008) 'Integrated Governance II: Governance between organisations'
5) http://www.nhsconfed.org/resources/key-statistics-on-the-nhs
6) Dacre, 2014, 'The RCP's five-point plan for the next UK government'

The demographic imperative

As noted in my previous reports, the population of the UK is growing and ageing. People over the age of 65 constitute 23% of the population and this will increase to 29% in 2034[7]. Regardless of any other factor, we know that as individuals age they utilise more health and social care services. Furthermore, successful medical technology has had a way of converting acute illness to long-term conditions (e.g. HIV/AIDS). As we age we inevitably develop one or more long-term conditions that, as life is extended, add years of care to our collective demand for services.

According to NHS England, more than 70% of the NHS expenditure on primary care and hospital care is estimated to be spent on individuals with one or more long-term conditions. This is further exacerbated if one of these long-term conditions is a mental health diagnosis.

As reported by NHS England[8]:

- There are more than 15 million people living with long-term conditions in England
- The number of people with three or more long-term conditions is expected to increase from 1.9 million in 2008 to 2.9 million in 2018
- Half of all GP visits are with people with one or more long-term conditions
- 70% of acute care bed days can be attributed to individuals with one or more long-term condition

There has been much research on the increased cost and complexity of medical care for patients identified with a mental health problem. In their February 2012 report, "Long-term conditions and mental health. The cost of co-morbidities," the King's Fund Centre for Mental Health authors concluded: "Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions[9]".

Mental and physical health are deeply inter-connected and the potential of integrating the care for both, whilst widely acknowledged, remains largely untapped due to a lack of information sharing, shared protocols, aligned funding and commissioning, cross-organisational liaison as well as cultural barriers between professions.

Investing in prevention and better treatment of mental health conditions among children, teenagers and young adults is particularly imperative, given that 50% of adult mental illnesses start before the age of 15, and 75% before the age of 18[10]. In this area many organisations are starting to look at joint commissioning, particularly in the field of Children and Adolescent Mental Health Services (CAHMS). CAHMS services require a fundamental integration between health, social care and the education sector to create complete service for the younger members of our society – yet achieving success here is problematic.

Diagnosing and treating more of them effectively would constitute not only a huge potential for reducing the costs of long-term mental and other health conditions to the NHS and the economy, but most importantly to enable more people to live healthier, happier lives.

At present, 75% of people with treatable mental illnesses in Britain receive no treatment at all, a new report by Dame Sally Davies[11] reveals. The shame and stigma that holds many affected people back from seeking help, is only exacerbated by health and social care professionals often lacking the training and understanding necessary to detect and treat mental health conditions. Engaging multi-disciplinary teams and/or locating more mental health professionals in GP practices is an important element to improving the accessibility of mental healthcare in the community.

7) Age UK, 2014
8) https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/
9) Naylor, C. and Galea, A., 2012
10) Davies, S. C., 2014, 'Annual Report of the Chief Medical Officer 2013. Public mental health priorities: investing in the evidence'.
11) Davies, S. C., 2014, 'Annual Report of the Chief Medical Officer 2013. Public mental health priorities: investing in the evidence'.

An interesting example to illustrate this point is the lack of co-ordinated support for people leaving prison given that the majority of prisoners in England suffer from mental health issues. They suffer disproportionately from conditions like drug and alcohol dependence, depression, personality disorders, post-traumatic stress disorders (PTSD), and psychosis . Among young offenders, the Centre for Mental Health claims[12], as much as 95% of 16 to 20 year-olds suffer from at least one diagnosed mental health condition. The transition from prison to care arrangements in the community is often problematic due to the unsteady living situation of many clients and the reluctance of many community care organisations to take on the responsibility for their care. This contributes to the high suicide rates (especially among women) and high re-offending rates among released prisoners[13].

The demographics of GPs in England

The demographic realities coupled with the growth of the number of people with one or more long-term condition is further impacted by a growing shortage of GPs.

GP services have been the bedrock of the NHS, since its formation in 1948. They remain the predominant first port of call for thousands of people every day, the advisor, the listener, the gatekeeper, and more importantly, have not fundamentally changed since the NHS inception. In fact, you could argue that actually they are the only real remaining structure from those expectant post-war health policies.

In a health setting the GP knows where you should, could and can go to get further treatment and specialised support – this is not a taught skill – this is an experience-driven skill and one of the key tenets as to why the NHS stands out internationally as a remarkable healthcare system. Yet there is a significant problem: these experienced professionals are beginning to mirror the population at large – in short GPs are aging. This presents a major challenge for NHS Boards and governing bodies, and the workforce governance of the system as a whole.

Official data analysed by the House of Commons Library shows that at a time of ever increasing demand for their services, the number of GPs has dropped by 356 compared with its level in 2009/10. The proportion of family doctors serving every 100,000 people has also dropped, from 70 in 2009/10 to 66.5 in 2013/14[14]. Further, changes in the pension rules have resulted in having caps on pension contributions reached by age 55 for GPs. This too will result in earlier retirements.

Pulse, a leading medical publication addressing GP issues, revealed earlier this year that the number of graduates applying for training positions decreased by 15% from last year[15]. Dr Richard Vautrey, deputy chair of the General Practitioner Committee (GPC), said: 'These figures are deeply concerning and represent a serious threat to the delivery of effective GP services to patients. They show that we are experiencing serious shortfalls in the number of doctors choosing to train to become GPs, which will ultimately mean fewer GPs entering the workforce across large parts of the UK, most worryingly in already under-doctored areas such as the North and the Midlands.' In 2014, only 87.64% of the GP training posts were filled. This means that 379 posts were unfilled. This masks the geographic disparity in posts filled. In the East Midlands only 70.5% of GP training posts were filled, and in Yorkshire and Humber only 74.77% were filled.

Further, GP partner net income has decreased continuously over the past decade. Fewer and fewer new GP graduates are interested in becoming practice partners. GP partners take all of the financial risk of owning or leasing surgery facilities, employing and retaining staff, insurance, etc. Young GPs, many of whom are women, seem less interested in ownership and more in having a steady salary and being able to have better life/work balance than their older generation colleagues. In our work at GGI we find that GP partners have expressed frustration with their younger

12) Sainsbury Centre for Mental Health, 2014, 'Mental health care and the criminal justice system'
13) Fazel, S. and Baillargeon, J., 2011, 'The health of prisoners
14) Helm, T. and Campbell, D., 'GP numbers tumble in England as recruitment crisis bites'. The Observer, 14 June 2014
15) http://www.pulsetoday.co.uk/your-practice/practice-topics/practice-income/gps-predicting-8-decrease-in-drawings-this-year/20006961.article

colleagues as they report that the productivity (patients seen per session) of young GPs is far less than that of an experienced GP partner.

Consequently, taking into account the salaries paid (together with the additional costs, such as insurance and time off for education and normal practice overheads), in many cases, partners claim they are actually subsidising the costs of salaried GPs. I believe the "partnership" model for GPs is in terminal decline. **It is time to re-visit who can hold an NHS patient list and consider the options for allowing qualified organisations to be list holders.** Indeed, the devil will be in the detail.

We see a range of interesting and provocative options for list holding. Clearly, one can foresee allowing a federation of GPs, organised as an LLP, to hold NHS patient lists. But, could this model be extended to an acute care trust, mental health trust or community trust? Indeed, could a social enterprise, a third sector or private organisation, a local authority, corporation or university providing support for students, staff and families (and possibly even customers) become new models?

Each of these options opens up opportunities, in addition to practical and political challenges such as the issue of "privatisation". Nonetheless, the present model is failing and will be in crisis in many parts of the country over the coming 2-10 years, as critical GP shortages impact adversely upon the ability to delivery primary care services.

One change that appears to be coming is the opportunity of co-commissioning wherein CCGs will be delegated the responsibility and authority to commission and manage primary care, including GP contracts. Whilst this offers much promise for CCGs to develop a bespoke and appropriate primary care delivery system to meet local needs and challenges, it is fraught with risks and challenges. Unless co-commissioning provides real flexibility and additional financial resources, CCGs will become the harbingers of bad news for GPs and will be identified as the body that says 'no'. Whilst I support CCGs taking on primary care commissioning, I am worried that the added issues around conflicts of interest and performance management will be very difficult to balance and manage. It is critical that CCG membership fully understand the implications of co-commissioning and are supportive of the new responsibilities that their CCG will be taking on. GGI is coming into touch with many of these emerging sensitivities with our work with CCGs around the country.

Organisational integration

By "organisational integration," I am referring to the combination of NHS organisations by merger, acquisition or simply by adding organisational elements to existing NHS organisations. The presumed benefit of such organisational integration is to reduce duplicative costs and to make the patient experience streamlined and therefore more effective. There has been much study of organisational integration, particularly in the US, where the motivations are more about market protection and market share gains than about improving the patient experience. I observe similar activity increasing in England, particularly around London where the growth of large university hospital-centric systems, is increasingly competing for access to patients for research, training and service delivery.

Over the past few years there have been a number of organisational mergers and acquisitions and more are in the planning stages. By and large these involved large successful hospital trusts taking over smaller failing hospital trusts. Examples include The Royal Free London NHS Foundation Trust acquiring Chase Farm Hospital and Barnet Hospital; Kings Health Partners taking over Princess Royal University Hospital; Lewisham and Greenwich Healthcare NHS Trust taking over Queen Elizabeth Hospital in Woolwich; Frimley Park Hospital NHS Foundation Trust merging with Heatherwood and Wexham Park Hospitals. All of these developments or rationalisations were strongly influenced by Monitor, the NHS Trust Development Authority (TDA) and the Competitions and Market Authority. GGI has been involved in buddying arrangements between hospitals too, and we sense that some of these have the potential to end as mergers or acquisitions.

In addition, a number of NHS acute hospital trusts and mental health trusts are diversifying and integrating with community care. Examples include Guy's and St. Thomas' NHS Foundation Trust providing community care in Lambeth and Southwark; and Barnet, Enfield and Haringey Mental Health NHS Trust providing community services in Enfield. There are numerous examples around England of this.

There are also some interesting developments where NHS acute care trusts are beginning to employ GPs directly – in their A&E departments and in their respective communities. Indeed, there have been examples of this going back 20 years in one form or another – but the potential is there to dramatically and imaginatively extend this from simple triage and primary care in A&E. Presently, only licensed GPs can hold NHS patient lists – it would be interesting to see if large acute care trusts will develop mechanisms to work with or directly employ GPs who are list holders. Later in this report, I will address some anticipated, and in my opinion welcome changes in the organisation and delivery of GP services.

One example of integration development in primary care that will be interesting to monitor is the newly-formed limited liability partnership (LLP) among 100% of the GP practices in Hackney. The purpose of this federation is to reduce back-office operating costs and to form a provider organisation that can tender for local services. Since the GPs are members of the City and Hackney Clinical Commissioning Group (CCG), there are substantive concerns about potential conflicts of interest and competition. Yet, I regard this new provider model of integration as being very positive.

So we have the emergence of a perfect storm for the boards, governing bodies and cabinets of health and social care organisations to consider – increasing population, increased aging of the population, increased number of people with one or more long-term conditions including mental health issues, a failing GP organisational model and a growing shortage and increasing workload of GPs. This at a time when the NHS is trying to reduce the national health expense by £20bn by 2015 and there has been at least a 15% reduction in funding for social care for the elderly since 2010[16].

16) ADASS, 2014, 'Better Care Fund changes make a bad situation worse for social care'

Barriers to integration in England, and domestic and overseas examples of what can be done

'You can't depend on your eyes when your imagination is out of focus' [17]

Why has providing a better connected and 'integrated' service to the frail elderly and those with one or more long-term conditions and those with mental health diagnoses been so challenging all across the industrialised world including within the NHS? As with any large bureaucracy, the NHS is burdened by significant siloing. Whenever a patient leaves their GP for consultant, community, mental health, hospital care or social services they have to cross one or multiple organisational boundaries. Here is where the challenge to integrated care begins. Presently, there are many barriers to seamless integrated care within the NHS and between health and social care:

- Organisations, by definition, try to maintain their own integrity as an organisation. Boards of directors tend to focus on ensuring their organisation can continue into the future
- NHS and social care organisations are accountable to different regulatory agencies (in part), regimes, politics and legal bodies
- Each component of health and social care acts according to how they are paid and financially incentivised. These are often at variance with those of other organisations in the broader local NHS/social care system. Co-payments and own payments are a significant feature for social care services but not in health
- Relationships between GPs and secondary care consultants are very variable. Furthermore, there is a significant cultural divide between primary and secondary care clinicians
- With CCGs as the main local commissioning organisations, GPs are, by definition, conflicted as they are at once referrers to secondary, community and mental health services and also commissioners of many of these same services and they are even, at times, contracted providers of some types of extended primary or secondary care
- Health and social care services are managed by completely different organisations, cultures, leaderships, budgets and legal frameworks
- Data about individual patients is disintegrated and exists in multiple databases that are not inter-connected. Yet, interested patients and the public believe their medical data is transparent across the NHS
- Regulatory and fiscal pressures have forced more focus on cost improvement plans (CIPs) and hitting targets, rather than on delivering patient-centred integrated care
- There is little, if any, personal reward for championing integrated care. Why should people change? The benefits to patients and the benefits to providers need to be aligned to facilitate a sustainable delivery model
- Much of the work to develop integration programmes has been conducted outside of normal working hours, in addition to the "day-job" and this is not sustainable over time
- The voice of the patient/carer is often not heard or is ignored
- At present only GPs can hold NHS patient lists
- The exisiting model of delivery of primary care, (within very brief encounters), in GP surgeries is not fit for purpose for caring for our most vulnerable patients

In spite of all of these barriers, brave and creative GPs, local NHS trust leaders and local leaders of social care have attempted to better integrate care, and we will highlight some of their efforts later in this report. But, much of these efforts require extra funding or are layered on top of already hectic and demanding work schedules. Unless the effort to improve integration is rewarded fairly and incorporated in the normal day-to-day care of patients (particularly those with on-going complicated care needs), pilot efforts and innovations will not be sustainable.

GPs are choking on current patient demand and expecting to them to add work to their hectic schedules is unrealistic and unsustainable. In the hundreds of conversations I have had with GPs over the past several years, most sheepishly admit that their session schedules are not suitable to care properly for the frail elderly and those with complex long-term and mental health conditions. They tell me that they can really only be reactive rather than proactive and as such are becoming just focused on preventing further decline. As mentioned above, the next generation of GPs are not willing to see the number of patients per session that many of today's GP partners presently see.

At the core of any change must be an alignment of incentives – financial, cultural, reputational, etc. Unless there are very clear lines of authority and accountability there will be little real change. Presently, there are no consequences,

17) Mark Twain

financial or otherwise, to GPs who over-refer to secondary care or who over-prescribe. There are neither barriers nor consequences to over or misuse of A&E departments for the patient.

I have often asked groups of GPs whether their behaviour would change if they were charged a fee every time a patient on their list inappropriately utilises an A&E department. Most are astonished, but I am certain better control would be asserted if there were financial consequences. While I am not advocating having financial penalties for patients or GPs I raise the question to challenge us to re-think how we would organise care to improve the patient and clinician experience and deliver the highest quality care in the most efficient location. In reality of course there are financial consequences to the NHS that are hidden and consequently very difficult to manage. Every time a patient presents inappropriately at A&E, there is a direct unnecessary cost to the NHS and it further exacerbates the current inexplicable surge of demand on A&Es across the country.

The Better Care Fund (BCF):

A major tool introduced to push integration of health and social care is the £3.8bn BCF, more than half of which has been re-allocated from NHS commissioners' budgets with the rest from local government[18]. Local BCF plans have been jointly submitted by NHS commissioners and local authorities to ensure proper coordination in planning and delivering services between health and social care organisations. The success of BCF plans will be evaluated against criteria such as a reduction in admissions to residential and care homes, speedier transfer of care, reduction in avoidable emergency admissions and improved service user experience.

However, there is a risk that the BCF is not used to fund joint projects focused on prevention, telehealth/telecare pilots, falls prevention, community interventions in schools, mental health, or making housing more adequate for home care, all of which require additional investment. While the BCF requires co-operation and joint planning between commissioners of health and social care, concerns have been raised about the impact of recent cuts to social care budgets.

> The Association of Directors of Adult Social Services in England (ADASS) emphasises that social care departments have had to cope with a 26% budget cut since the Coalition Government came to power in 2010. Although measures such as better data and IT systems provide some space for efficiency and productivity gains, this drastic reduction of public funding has left many providers in a difficult position and incentivises them to divert as much funding from the BCF as possible to backfill funding for essential social care services. Many CCGs worry that the pooled BCF budgets might lead to them having to subsidise basic social care and other local government services while having to cope with smaller acute care budgets[19].

Moreover, the National Audit Office (NAO) criticises NHS England and the Department for Communities and Local Government for having done "no analysis of local planning capacity, capability, or where local areas would need additional support"[20], and therefore underestimated the challenge at hand. They also concluded that the savings potential of the BCF has been greatly overestimated. A survey by the Foundation Trust Network (FTN) conducted earlier this year[21], showed that the majority of respondents from acute, ambulance and community trusts, do not believe that the BCF will lead to better and/or more integrated health and social care service. Almost half of them reported that they were not involved in the planning process by commissioners or local authorities. Reduced funding was a central concern, leaving an overwhelming majority of respondents pessimistic about the BCF's impact on their financial situation.

While it is too early to evaluate the potential impact of the BCF, it is likely to be made ineffective by the lack of adequate social care funding. In fact, at the moment it appears that health and social care providers feel that they are in competition for BCF resources. This may be hindering the establishment of better cross-sector relationships. One need only look at the way some of the funding shifts, (public health etc.), from the NHS to social care that has, in some communities, been raided for other pressing social needs. The level of recent cuts to social care has caused councillors and local authority executives to make difficult decisions regarding delivery of much needed social care services.

18) Bennett, L. and Humphries, R., 2014, 'Making best use of the Better Care Fund'
19 The Association of Directors of Adult Social Services (ADASS) (2013) 'Effective integration needs top-level leadership and the right tools, say care and health leaders'
20) NAO, 2014
21) Foundation Trust Network (2014) 'The Better Care Fund – The NHS Foundation Trust and Trust view on the impact of the Better Care Fund'. http://www.foundationtrustnetwork.org/resource-library/better-care-fund-member-briefing/

North West London Whole System Integrated Care programme

There are, however, examples where the pooled budgets under the BCF is being used positively. The North West London Whole System Integrated Care programme, one of the 14 national pioneers pilots, regard the BCF as "an important short term step on our longer journey that our Whole Systems Plans will align to and build on"[22]. Health and social care providers and commissioners from the eight North West London boroughs are working together to set local strategic aims, jointly conduct risk stratification and financial impact assessments, and empower service users and their families and carers. GPs, supported by a wide range of health and social care professionals, are at the centre of the programme. Patients have a single contact – similar to the Kaiser navigator as you will see below – who coordinates the different elements of their physical, mental and social care. The primary aim is to help people to remain independent and to keep them out of hospital.

The Whole Systems Integrated Care programme has been implemented with remarkable enthusiasm and against a number of substantial challenges familiar to many localities in England. Healthcare demand is rising while commissioners face a £1bn funding gap for this financial year. Moreover, half of all GPs in North West London will retire in the next 10 years[23]. Changing the entrenched 'siloed approach' that was accompanied by poor professional relationships across sectors and organisations and often limited awareness of services available from other providers, is a long-term endeavour. The establishment of multi-disciplinary teams across all stages of planning, commissioning and delivering services, and a greater focus on integration in workforce training are key components of North West London's strategy to bring about this cultural change.

Key lessons:

- Care-coordinator as a single point of contact for the client
- Multi-disciplinary teams key to cultural change
- BCF used to support the transition to integrated care model

Hertfordshire

Hertfordshire has pioneered health and social care integration in England for years with close co-operation between the Council and healthcare providers. Several organisations in Hertfordshire have placed integrated patient-centred care at the heart of their strategy and the joint effort has resulted in an inspiring example for other communities.

Hertfordshire Community NHS Trust is planning, together with CCGs and the County Council, to use the BCF to foster integration with GPs, mental health, social service, voluntary and community organisations, and to promote self-care. In 2014/15, the Trust made long-term conditions and improved patient and community-centred service coordination a strategic priority.

The Community Nursing Service in Hertfordshire supports patients at home as long as possible. Community nurses assess not only patients' physiological but also psychological and social needs and develop care plans together with the patients and their families and carers. They also work closely with other providers of formal and informal health and social care.

The HomeFirst approach in Hertfordshire focuses on keeping patients at home and out of hospital wherever possible. Identifying 'high risk' patients early using risk stratification tools and cooperation between GPs, carers and patients, is key to preventing escalation and hospital admission. Providers have created a 'virtual ward' entailing proactive case management as well as rapid response. This enables data sharing and communication across organisations and professionals with a first contact professional being identified for each service user. In the patient feedback questionnaire, 89% of respondents reported to feel actively involved in decisions about their care, and 99% had

22) North West London Whole Systems Integrated Care, 2014, 'Our Journey'
23) http://integration.healthiernorthwestlondon.nhs.uk/section/what-is-the-case-for-change-for-gp-networks-

confidence in the HomeFirst team[24].

GPs echoed this positive feedback in the GP Experience survey. 89% of respondents said they would recommend the service to friends or family and felt that the multi-professional team working had a positive impact on local community services.

Key lessons:

- Early identification of 'high-risk' clients
- 'Virtual ward' enabling data sharing and communication between organisations
- Central role of community nurses as care coordinators

Scotland

With the Public Bodies (Joint Working) (Scotland) Bill, the Scottish Government set a framework in 2013 to fully integrate the commissioning and delivery of adult health and social care with a single governance structure, a single budget, and common guidance and objectives. New 'integrated authorities' are being set up by councils and health boards that will manage the integrated budgets and that are accountable to both partners. While England has encouraged independent NHS Foundation Trusts and new commissioning structures to decentralise commissioning and provision, Scotland has gone the other way and remains one of the most centralised healthcare systems in the world. The focus on fostering co-operation rather than competition is a key difference, although the challenge of overcoming cultural and organisational barriers and the dominance of acute healthcare in pubic and political attention and funding are similar.

The new Bill contains an essential ingredient for successful integration: flexibility. The challenges and opportunities for integrated care are different in every local area, and the integrated budgets in Scotland can be either allocated by an 'integration joint board' to existing health and social care providers, or in restructured services, allowing, for instance, social workers to be employed by the NHS like the 1,500 social care staff who have been transferred to NHS Highland in 2012[25]. On the downside, this flexible arrangement might risk producing a situation – confusing for service users at best, leaving them with an inequitable provision at worst – where the degree and nature of integration between health and social care would vary from council to council.

> Responding to the challenge of the Scottish geography the Government is also investing in the expansion of home health monitoring for conditions such as diabetes and heart problems. NHS Scotland has recently started to set up a telephone advice service as well as telehealth tools for smartphones, tablets and digital TV. With the leading provider of telehealthcare in the market, Tunstall Healthcare UK, leading the implementation of the telehealthcare system, Scotland has a strong strategy in place to reduce hospital admissions, support earlier discharges and enable clients with chronic conditions to live more independently. This is complemented by the aim to introduce personalised electronic patient records for the whole of Scotland by 2020, which is intended to allow individuals to access and review their health and social care information online.

It is too early to draw any conclusions yet about the impact that the new Bill might have and what lessons England could learn from the Scottish experience. Strong leadership and good cooperation between the Government, NHS, local councils and the third sector in a relatively small country certainly appears to impact positively on the development and implementation of the long-term integration strategy.

Beyond that, the King's Fund[26] identifies the unified NHS boards as key enablers of integration in Scotland. The now 10-year old boards are made up of representatives of acute, primary and community services, and local government, have

24) Hertfordshire Community NHS Trust, 2014, 'Hertfordshire Presentation'
25) Ham, C. et al, 2013, 'Integrated care in Northern Ireland, Scotland and Wales – Lessons for England'
26) Ham, C. et al., 2013

proven effective in joint planning of care services and provide a robust set-up upon which the new integrated authorities can build. Health Boards already produce an annual commissioning plan, which could form the basis of integrated planning, but Health Boards and local councils need a more robust system of holding themselves to account for the delivery of these commissioning plans and might well learn from the Welsh system of Integrated Medium Term Plans. The Health and Wellbeing Boards (HWBs) established in England in 2012/13 could also have the potential to take on a similar role if under-pinned by sufficient resources. However and as an aside, during 2014 GGI has been looking at the work of HWBs, especially in connection with the development of services for people living with diabetes, and has found very significant variation in the capacity and imagination of leadership by HWBs.

Key lessons:

- Flexibility key to enabling innovation and adaptation to local circumstances
- Leadership and continuity key to good co-operation between government, the NHS, local councils and the third sector
- Cross-sector boards key to developing a joint vision and strategy

Wales

Similar to Scotland, consecutive governments in Wales have resisted the introduction of quasi-markets and competition seen in the NHS in England. Better coordination between different pubic services facilitated through the 22 local health boards (LHBs) working with the 22 local authorities, has been at the heart of social policy since devolution. Consistency in political leadership has also resulted in consistency in health policy, avoiding frequent politically motivated restructuring of the NHS as experienced in England.

In the poorest nation of the UK with the Gross Value Added per head 29.8% below that of England[27], reducing health inequalities has been a key strategic aim together with improvements in quality, IT systems and information governance, and service modernisation. While there is no explicit integration policy, the introduction of the LHBs was a key element of bringing the funding, commissioning and delivery of health and social care services into alignment. In 'Setting the Direction' (2010), the Welsh Assembly outlined further steps towards better integration, including integrated community services linking primary care and acute hospitals, an emphasis on prevention, and multi-sector locality leadership teams that are jointly funded and led.

Quality improvement and key performance targets focus on delivering prudent patient-centred healthcare with strong collaboration between health, social and third sector providers. Furthermore, the Welsh Government has laid out clear expectations for more aligned planning and integrated delivery of health and social care that Health Boards and Trusts must address in their 2015/16 Integrated Medium Term Plans.

Like Scotland, Wales has started to promote the extension of self-care tools, embracing assistive technology devices as well as self-care support networks in the community and online, and better provision of information and training for patients, carers and the public. Surprisingly, pooled funding for health and social care remains a rarity in Wales. Compared to England, cuts to social care funding in Wales have been less severe, while NHS funding has not been ring-fenced. Funding constraints are a huge challenge for both health and social services in Wales, yet cost-sharing tools, such as charges for prescription drugs, have almost all been abolished by the Labour government.

While LHBs, like the unified NHS boards in Scotland, are ideally placed to deliver better integration, a recent King's Fund report[28] emphasises the lack of integration within the healthcare sector, largely due to cultural and organisational barriers and slow progress in improving shared IT systems. Furthermore, involvement of the third sector, though often better placed to deliver patient-centred care in the community, is very low compared with England.

The main lesson to be learnt from the Welsh example is perhaps that a change in culture is, at least, as important for successful integration as organisational and structural reforms. Changing attitudes, fostering mutual understanding and

27) Office for National Statistics, 2014
28) Ham, C. et al (2013) 'Integrated care in Northern Ireland, Scotland and Wales – Lessons for England'

better cross-professional and cross-organisational team working is a process that requires time, commitment and clear leadership in government and the NHS. Such commitment is apparent in the Welsh Planning Framework for 2015/16, which provides a clinical value-based framework to foster the integration of health and social care through regional and national approaches. GGI is currently working with all NHS organisations in Wales to support the peer review of these plans.

Key lessons:

- Consistency in leadership and policy
- Cultural change needed to ensure the success of organisational and structural reforms
- Aligning funding, commissioning and delivery of health and social care through joint planning institutions (like the LHBs)

Northern Ireland

Health and social care in Northern Ireland have been structurally integrated at the local level since 1973, even though little attention was paid to how this system performed, in practice, during the period of Direct Rule. With the health and social care reforms in 2009, a single commissioning body, the Health and Social Care Board, was created overseeing five Health and Social Care Trusts across the country. Hence, funding, planning, commissioning and delivery for health and social care are joined up. The integrated trusts are, for instance, responsible for both hospital discharge and the arrangement of the proceeding community care, which eases this critical transition significantly. The leadership of the multi-disciplinary teams delivering health and social care is open to a range of professionals including nurses and social workers. The multi-professional training approach that seeks to value all professions equally, is a significant strength of the system. However, the degree of integration varies greatly across disciplines with mental health and learning disability being the most integrated areas. In others, such as acute care, the dominance of the health agenda is reflected in targets, the make-up of executive teams and allocation of financial and staff resources.

Mental health is of particular concern in Northern Ireland, given that demand for mental health services is 44% higher than in England[29], while spending has been considerably lower. Post-traumatic stress disorder, as well as anxiety and depression are major public health issues. Fortunately, the integration of mental health services with physical and social care services has progressed over recent years with some organisations having developed innovative, holistic approaches in this area. One of them is the Belfast Health and Social Care Trust, the largest provider of health and social care in Northern Ireland. Not only does the Trust provide a variety of health and social care services itself (acute services, cancer and specialist services including rehabilitation and therapeutic services, adult social and primary care including learning and physical disability and mental health, specialist hospitals, and children's community services including childcare and social work), it also collaborates on projects such as the Ethnic Minority Mental Health Awareness Programme or the Family Nurse Partnership with community organisations, consultants and third sector organisations. The Trust is a prime example of organisational integration, established in 2007 as a result of a merger between six health and social care trusts.

An outstanding feature is the Trust's Arts in Health Strategy that aims to involve arts in the health and social care of all of its clients in order to improve staff-patient relationships and care outcomes. In partnership with Arts Care NI, Artists-in-Residence and Clown Doctors the Trust has developed a unique health and social care services delivery model. The approach shows a deep understanding of the inter-connectedness of the psychological, emotional, physical and social dimensions of well-being, particularly important to the treatment of long-term conditions, cancer, dementia, learning disabilities and neurological disorders such as Parkinson's disease.

A variety of projects involving music, dance, drama, photography/film-making, visual and clowning are offered across the Trust's primary and secondary health facilities and its social care settings. It is a great example of an impressively integrated and innovative patient-focused project, locally driven with well-established partnerships across sectors and organisations. Serving some of the most deprived areas in the UK, the Belfast Health and Social Care Trust has

29) http://www.nicva.org/sites/default/files/d7content/attachments-articles/mmh_policybriefing_summary_final_8-2014.pdf

embraced this challenging long-term project whole-heartedly and has in addition to that developed initiatives to engage hard-to-reach groups in particular, such as the Roma community and children in foster care.

Key lessons:

- Integrated Trusts responsible for primary and secondary healthcare as well as social care, mental health, and community services
- Multi-professional training approach and interdisciplinary teams
- Holistic approach encompassing clients' physical, psychological, emotional and social needs

The Buurtzorg model in the Netherlands

In 2006 a group of district nurses in the Netherlands designed a model of integrated home care provision that has grown to an organisation with 4,000 employees across the country, 70% of whom are nurses. The local multi-disciplinary teams with no more than 12 professionals care for 40-60 chronically ill, functionally disabled, and elderly clients as well as providing end-of-life care. Supported by local GPs, the teams are led by nurses and one team member is the single point of contact for a client.

> The success of the not-for-profit Buurtzorg ('neighbourhood care') model is not only apparent in its rapid expansion, but also in the national quality of care assessment where it has received the best user satisfaction rating of all home care organisations in the Netherlands. On top of that, the model also makes good economic sense, having decreased the costs to less than half those for conventional home care. Like conventional care, Buurtzorg is largely funded through the universal social insurance system AWBZ.

There are six components of Buurtzorg's service model: assessment, mapping the network of formal and informal carers, the actual care delivery, supporting the service user in their social roles, and the promotion of self-care and independence. A robust and comprehensive IT system, Buurtzorgweb, is central to the organisational effectiveness and coordination between the different providers involved. It facilitates the storage of employees' and service users' data, storing and sharing documents, the administration required to ensure accountability to commissioners.

The immense savings open up funds for investment, which Buurtzorg uses amongst other things to fund its new Bachelor programme in nursing at the Buurtzorg Academy, and the collection and analysis of big data with the Omaha system to improve the evidence-base for approaches to problem solving, and improving interventions and outcomes. It even leaves room for a weekly Buurtzorg radio show where nurses give practical health advice! Buurtzorg has just been awarded the title 'best employer of the Netherlands' with exceptionally high scores for inspiration and staff involvement.[30]

The central aim of Buurtzorg is to support clients to live independently at home and to respond to their needs and wishes by creating more caring communities. The local teams work closely with local hospitals to coordinate the transfer of patients from the latter back into the community care. Despite the size of the organisation, Buurtzorg has preserved its informal relationships, eschewing central management or control of the local teams. Instead, trust and an unwavering belief in the positive motivation of every employee are at the heart of the model. Each week, the local team reflects with the client on their care to discuss possible improvements and make sure that the clients' wishes are at the centre of their care.

Buurtzorg is an inspiring example of how the competencies and skills of different health and social care professionals can be used to their full potential and how holistic patient-centred care in the community can produce better and more cost-effective care. It also shows how quickly and relatively effortlessly a radically different model of integrated care can

30) http://www.beste-werkgevers.nl/beste-werkgevers/plus1000/stichting-buurtzorg/

be implemented locally, even in a highly fragmented system like the Dutch one. The success of the Buurtzorg model is somewhat contingent on the relatively free care market in the Netherlands that allows for much greater patient choice than the NHS in England. Still, there is no reason why a similar community-based model could not be equally successful in England. In fact, the model's simple structure has proven to be very transferable as it has recently been established in the Minnesota, Sweden and Japan. [31]

The main lesson to be learnt from Buurtzorg is that trust in employees, strong relationships, small community-based teams, and a holistic approach to understanding patients' needs are absolutely central to good integrated care. With no central deployment, Buurtzorg leaves the local teams the freedom to self-organise. High performance is a key value of Buurtzorg, yet the model really strives on its focus on inter-personal relationships and trust. Implementation of this approach in England would take a very grown-up discussion with CQC.

Key lessons:

- Strong relationships build on trust and respect between staff members and with clients is key
- Giving small local teams the freedom to self-organise
- Community-centred care
- Importance of taking time to "reflect" on each case

Kaiser Permanente in Portland, Oregon, USA (Kaiser):

Kaiser Permanente is a staff model Health Maintenance Organisation (HMO). It is actually the combined effort of an insurance company, "Kaiser", and a separate legal professional corporation, the Permanente Medical Group that employs all of the physicians. An HMO is a combination of a care delivery organisation with a risk-taking insurance organisation. Kaiser contracts with employers and the U.S. government (Medicare for the elderly and Medicaid for the poor) under a fully capitated programme.

Kaiser accepts a set amount of money each month to manage all of the health care needs of their contracted membership. They are at risk for all of the health needs of their membership for this "Per Member Per Month" (PM/PM) financial payment. If their members require care that exceeds the amount paid, then Kaiser is liable for the additional financial resource required. If members utilise fewer or less expensive services then Kaiser recognises savings. The idea is to have a balance of those who have more need and those who have less so that the financial math works. There is no government rescue if utilisation exceeds the financial resource!

What is clear, and what permeates the culture at Kaiser, is that there are aligned financial incentives to keep members healthy and away from expensive secondary and tertiary care.

Yet, Kaiser is a large complex organisation and in many ways looks like a mini-NHS. Leaders at Kaiser in Portland, Oregon have recognised that the complexity of their organisation is often a barrier for better integrated care.

Kaiser already has many of the elements required to integrate care:

- All clinicians are employed by the same entity – Permanente Medical Group
- Financial rewards are enhanced (bonuses) when the organisation has surplus – e.g. provides more efficient care at lower cost
- There is a single electronic data system, EPIC, across every Kaiser locus of care (primary, secondary, tertiary, mental health and social care)
- There is an aligned management system

Why, therefore, is there still concern to better integrate care? As a complex organisation, Kaiser faces some of the same siloing of interest that bedevils the NHS. In 2013 Kaiser primary care leaders recognised the benefits and necessity

31) de Blok, J. and Kimball, M., 2013, 'Buurtzorg Nederland: nurses leading the way!'

of better integration of care, particularly for patients who were high users of services (the frail elderly and those with single or multiple long-term conditions). They designed and began to pilot a programme to improve integration. The programme began by engaging high-user patients and their carers to listen to how they encounter Kaiser and their care needs. They quickly discovered that patients and carers had very limited relationships with identified people in Kaiser. Kaiser was seen as a complex and anonymous large organisation. One of the lessons was that personal relationships were important in how individual patients accessed care – the more anonymous services were delivered, the more utilisation there was. So, one component of their programme was to personalise care – to provide patients, particularly high utilising patients, with a clear and named personal connection within Kaiser.

Their programme currently involves inviting GPs and other primary care clinicians to refer complex frail elderly and those with long-term conditions to a team of co-ordinated clinicians. Each team consists of a primary care physician, a pharmacist, one or more nurses, a social worker and a newly created role – a navigator. When a patient is referred, if they agree to participate, and virtually all do, they are evaluated by various members of the team. Their record is reviewed, their medications are scrutinised and they are effectively risk assessed and placed on an agreed care plan. Each patient (and their carers) is given a unique telephone access number that connects them directly with a dedicated navigator.

> The navigator is a person who is a member of the care team and whose job is to be the personal single point of contact between the patient (and their carers) and the Kaiser system. The navigator serves as a friend, advocate and concierge to address the needs of patients and to access the most appropriate services available within Kaiser and in the greater community. The navigator has already identified the importance of leaders within the faith-based community as important advocates and collaborators to address more appropriately individual patient needs and desires.

Each clinical team meets weekly (during dedicated and paid time) to review up to twenty cases of patients in the programme. The single electronic record is coded to identify patients in the programme so that if there is, for example, an unexpected emergency centre visit or an unplanned hospitalisation, the navigator is informed by the system and the care team quickly becomes involved in managing the patient's care.

Whilst it is still early days and the numbers of patients in the programme are still relatively small, the results in terms of emergency centre visit reductions, hospital admission reductions, length of stay reductions and patient satisfaction improvements have been marked.

Key lessons:

- Aligned financial incentives to keep patients out of hospital
- A single electronic data system for primary, secondary, tertiary, mental health and social care
- The navigator as the personal single point of contact for the patient
- All clinicians employed by same organisation

MCCI Medical Group in Miami, USA

MCCI is a provider of integrated care in Miami, Florida. They are organised as a group practice of general internists (GPs for adults) and manage a Medicare Advantage (risk) Contract. Medicare is a non-means tested public insurance for all Americans over the age of sixty-five. Medicare Advantage (Risk) Plans were formed to improve the integration of care under a capitation method. The public Medicare programme pays the provider organisation (MCCI) an amount each month based on a risk assessment of each of the patient/member.

Eligible Medicare beneficiaries can choose to become members of a number of Medicare Advantage programmes. Within this monthly payment, the provider is at full financial risk to provide care to the member. MCCI is a very

interesting provider. Their Medicare Advantage patient membership are mostly poor, elderly Cuban-Americans.

When a patient chooses to be part of the MCCI Medicare Advantage Plan, they are invited to two clinical/social assessments. The first is typically with a nurse practitioner and a pharmacist. Members are asked to visit the clinic and to bring all of their medications. Typically the medications are reduced by 15-30%. Members are then scheduled for a two-hour complete history and physical by one of the employed internists. Based on this initial assessment, the internist places the member into a risk category. Each risk category proscribes proactive care into the future. The more risk (e.g. sicker patients) the more frequent the proscribed visits. MCCI believes that compliance to these risk-based courses of care and visits is so important that they actually collect patients from their domiciles in vans.

> The MCCI surgery facilities provide many primary care services under one roof. In addition to physician consultation rooms, there is a dispensing pharmacy, phlebotomy service, basic radiography services, physiotherapy capabilities and a set of consultation rooms where visiting consultants hold scheduled sessions. They added a social hall where members can get a meal and spend time in a social setting therein reducing social isolation.

MCCI contracts with hospital and ancillary service providers in the community. There is a robust and mature "market" tendering with providers competing for business. I have seen tenders for ancillary services. So, for example, MCCI might go to market to purchase 1,000 MRIs. In addition to price, they have very detailed key performance indicators covering patient access, hours of operation, speed of receiving electronic study reports etc.

One very different aspect is that hospitalist consultants are direct employees of MCCI – these consultants are actually accountable to the MCCI primary care internists. Patient data are connected and these hospital consultants have personal direct communication with MCCI internists about the care of their patients. In addition, MCCI employs hospital-based care and discharge coordinators to ensure efficient care within the hospital and safe efficient discharge home, nursing home or to intermediate care facilities.

The MCCI outcomes are impressive. MCCI has some of the lowest hospital admission and re-admission rates, lowest lengths of stay, lowest A&E utilisation and highest patient and provider satisfaction rates I have ever seen

Key lessons:

- Preventative measures based on a comprehensive risk assessment for each patient
- Many primary and secondary healthcare, specialist services and social space under one roof
- Hospitalist physician employed by primary care
- Hospital-based coordinators ensure efficient hospital stay and smooth transition from hospital to community care, nursing home or intermediate care facilities

A way forward

"We keep moving forward, opening new doors, and doing new things, because we're curious and curiosity keeps leading us down new paths" [32]

When we examine the barriers to integration in England and the successful examples of integration in England, the UK and abroad, two approaches to making integration more effective for the frail elderly and those with one or multiple long-term and mental health conditions emerge. One is a large-scale experiment, the other is more incrementally-focused set of activities.

A radical experiment:

The first is a wholesale, radical experiment where a large patch with a population of at least 200,000 (perhaps selected in a competitive tender process) becomes fully capitated – or prepaid to manage and deliver all needed health and social care services within an at-risk fixed budget. Ideally, all health and social services budgets would be combined to calculate the appropriate population based capitation. However, social care, currently funded through local councils, involves complex qualification and means testing – often resulting in shared costs between the social care agency and the patient. This would be very difficult to accommodate under full capitation so I would suggest that social care funding remains as it is, but better co-ordinated with healthcare.

Such a large-scale experiment would require a protected period of 3-5 years of operation in order to effectively evaluate its success. Applicant patches for the experiment must show how financial risk and reward will be shared among the providers and agree on an organisation that will legally hold the capitation and risk.

Issues that will need to be considered and agreed during include:

- Agreement on a population and risk-based rate per list member/per month based on existing historical utilisation and cost data and development of an agreed monthly capitation amount
- Creation of nominal budgets for each aspect of care (GP, community, acute and mental health).
- Agreement on a way that any losses are covered and any surpluses are distributed
- How the NHS (or commercial reinsurer) guarantee outliers (e.g. any single patient whose annual expense exceeds an agreed amount and an aggregate spend threshold) this protects the capitated organisation(s) from unexpected surprises such as epidemics or an unusual and unanticipated number of expensive individual cases such as serious neonatal problems
- Evaluation of pre and post-capitation utilisation, patient and provider satisfaction, performance against indicators and delivery of quality

Such an experiment would be insightful and could serve to see how care is organised and delivered when the financial incentives are better aligned. It is very difficult for the NHS to carve out a patch or population to deliver care in a different way to the norm. Capitation requires tight management of providers and provider choice that can encounter problems with the rights of patients to choose where they receive care.

To realistically develop and implement a fair capitation system, excellent historical data must be available and real time integrated data must be readily available. Finally, there needs to be agreement by the Government to allow the experiment to run without interference even if it crosses a national election and the government changes. This is asking a great deal and is difficult to see it being approved[33].

To have immediate and direct impact on improving integrated care for the frail elderly, and those with long-term and mental health conditions, one must look to the many "transitions" that patients must go through in the NHS.

32) Walt Disney
33) One thought is whether current arrangements such as section 75 of the National health Service Act 2006 is in accordance with section 1 of the Localism Act 2011 could provide the enabling mechanism to fund and account for such an experiment or whether new legislation would be required.

The step by step approach

A more incremental approach could focus on four loci of care:

1. prevention
2. movement from primary into secondary care (via referrals and use of the A&E)
3. movement from acute care and mental health trusts back to primary care (post hospitalisation)
4. end-of-life care.

1. Prevention

Prevention is still the most effective approach to avoiding or delaying the onset of debilitating and expensive long-term conditions. Many long-term conditions can be prevented or delayed by improved individual behaviours. We cannot take our eye off of the challenge of reducing/eliminating smoking (particularly in teens); better controlling alcohol consumption; increasing physical activity and improving the diet of youth to prevent childhood obesity, supporting safe sexual practices to reduce disease and prevent unwanted pregnancies, actively addressing mental health conditions among youth and enhancing social opportunities for our elderly to reduce isolation and depression. *Joined up processes to safeguard vulnerable children and adolescents from grooming and elderly confused people from financial as well as emotional and physical abuse are very important.*

Impacting upon these is not easy and yet there have been great strides over the years. Concerted, focused local and national campaigns need to be strengthened so that the health, public health, social care and education worlds are aligned around consistent messages about personal responsibility and behaviours. Further, though politically dangerous, increasing "sin taxes" (specific added taxes to cigarettes, alcohol, speeding tickets etc.) could be considered as a dedicated funding mechanism for public education, expansion of healthy activity alternatives for youth and teens and for care of the frail elderly. Prevention is obviously not in any one domain of health or social care but involves a concerted effort across all aspects of living in society and is therefore a perfect place for co-ordinated health and social care activity.

In addition to population-based prevention, GPs have a particular role in managing and preventing the decline of their patients, particularly those at risk (frail elderly and those with long-term and mental health conditions). These conditions are ultimately the most costly to the NHS and are quite difficult to manage – particularly given the average twelve minutes per visit that we encounter with GPs. The care of these high-risk and high-cost patients must be improved and NHS England should budget for GPs and care teams to take the time to improve care planning and delivery.

The frail elderly and those with long-term and mental health conditions must be cared for in primary care with greater focus on keeping them out of hospital. As is illustrated above in the exemplars of good care in the Buurtzorg model, the Community Nursing Service in Hertfordshire, this entails establishing strong personal links with patients and their carers, proper risk assessment and establishment of clear and transparent care plans for each of these patients and the on-going proactive monitoring and support of patients and their carers. Only some of these services can reasonably be provided by GPs. This is where a community-based focused integrated approach makes sense. Patients who are identified as "frequent flyers", those with frailty and those with long-term and mental health condition care plans should be identified and nominated to participate in a more intense management of their care.

The role of "*navigator*" or care coordinator as outlined in the Kaiser exemplar above comes to mind. Imagine a person on a GP care team who makes frequent contact with high-utiliser and high-risk patients – who provides an additional point of contact and lifeline to the NHS. The navigator can counsel patients and carers as to how best to access services, can prevent unnecessary A&E visits, can alert their GP when they are in need of care, can mobilise NHS and community resources to better support these patients to ensure that they are in receipt of all their pension credits as well as care and attendance allowances they are entitled to.

When these patients enter hospital the navigator can liaise with hospital consultants and discharge staff to enable a more rapid and co-ordinated transfer out of hospital back to the care of the GP and/or community-based care. There will indeed be issues of information security and credibility with the role of navigator or care coordinator that will require time and persistence.

The make-up of these care teams could include: a GP, a pharmacist, a nurse, a social worker, a navigator or care coordinator and a mental health provider. Care teams must be commissioned to have the time to effectively manage their caseloads.

2. Transitions from GPs to secondary care:

It is in the transitions of care between NHS and social care organisations where inefficiencies and the barriers identified above come into play.

A hospital-based geriatrician in one of the urban hospitals in England recently complained how she was often compromised when a frail elderly patient is admitted to her geriatric ward. "If it is a Wednesday afternoon, the evening or at the weekend, I cannot get a current medication list from a GP surgery. The lack of connectivity to the primary medical record causes delays and mistakes. I cannot get a GP to email me a medication list. Instead, I have to ring the surgery, get transferred to a records person or nurse, then if I am lucky I get a fax within a reasonable time". *Who knew there were still functioning fax machines…*

Getting timely (read *instant*) patient medical record information from primary care to secondary care should be a priority. For pregnant women the problem has been addressed wherein the women themselves carry their paper records with them. Elsewhere, around the world, we have seen innovation where there are separate, disconnected data systems between primary and secondary care. In New Zealand, for example, a company called DrInfo has connected more than 80% of GP electronic medical records systems to hospital A&E systems. DrInfo has recently provided apps for smart phones giving patients the ability – in real time – to access summaries (prescriptions, allergies and summaries of recent diagnoses and visits) directly on their phones which they can then show (therein giving their consent) to A&E consultants, ambulance attendants or secondary care consultants.

Identifying the "frequent flyer" users of A&E and developing an approach to re-directing their care to GPs or community-based providers (urgent care or after hours care). Here is where a community navigator (much like the role identified above in the Kaiser example) could be very useful. A navigator can be the first point of contact for those patients who mis-utilise or over-utilise the A&E centre.

It is critically important to understand why patients inappropriately access services from the A&E and to address their concerns. Without a financial penalty or co-payment for misuse of the A&E, creative approaches must be undertaken based on what one learns from these surveys. Solutions elsewhere have included:

- Increasing the hours of GP surgeries or urgent care centres
- Locating urgent and after hour care centres more convenient to patients
- Providing frequent flyer utilisers of A&E special dedicated phone numbers (perhaps directly to the navigators) that get them priority appointments with their GP
- Providing GP services at the A&E for patients who do not need emergency care
- Providing a navigator who can counsel and advise patients to decrease their use of A&E.
- A&E Senior Nurse who has 24/7 hot line to facilitate return to a place of safety and support.

3. Transitions from acute care back to GPs:

One of the most dangerous times for the frail elderly and those with long-term and mental health conditions is immediately following hospitalisation when care is transitioned to a nursing home or the patient's home and back to the care of the patient's GP. Often there are delays and patients tend to occupy acute hospital beds longer then their medical conditions require. This is both expensive and in many situations unsafe for the patient.

These patients who are awaiting placement into a nursing home, rehabilitation facility or back to their homes are congesting hospital flow resulting in delays all the way back to the A&E. The discharge of frail elderly and patients with long-term and mental health conditions must become a more organised and critical function in care planning for these vulnerable patients. According to the Royal Voluntary Service[34]", in the last five years almost 200,000 people aged over 75 returned home from hospital without the support they needed to look after themselves".

34) http://www.royalvoluntaryservice.org.uk/news-and-events/news/lack-of-support-after-hospital-doubles-readmissions-for-older-people

Geriatricians have reported that they are much less comfortable having their frail elderly patients transferred post-hospitalisation to a nursing home if they are not under the immediate care of a community geriatrician. The hand-off of care back to a GP is slow, cumbersome and often misses the critical first weeks of post hospital care where these patients are most at risk and where re-hospitalisation is frequently required. Discharge summaries, sometimes poorly hand written by junior doctors, are frequently delayed and GPs often are not even aware that their patients have been in a hospital. Medication charges often occur that are not reflected in the patient's GP medical record.

Here again the navigator role could play an important function as a coordinator of care, liaison between the NHS, social care, nursing home and the patient and their carers. Weekly care coordinating team meetings could focus on these particularly vulnerable patients.

4. The final transition - end-of-life care

A personal story. Twenty years ago I received a phone call from my mum. She had just come from her GP and said that he told her that she had ninety days to live. My mum was 69 at the time and had smoked her entire life. She was diagnosed with metastatic hepatic and pancreatic cancer. We chatted and I said I would see her the next day and asked that she book a second opinion visit with an oncologist – that meant flying five hours across the U.S. I booked the flight and rang an oncologist friend who confirmed the likely prognosis if the diagnosis was correct. I then went to the medical school library and read all that I could. The literature was pretty clear that the cancer my mum had was indeed incurable at that time.

I arrived at her home the next day following an all night flight and we commiserated and as her designated medical power of attorney we chatted about her wishes. The next day we saw a 35 year-old oncologist who straight faced attempted to give us hope of a cure. I questioned him and he suggested there was an experimental chemotherapy that was promising – though the literature indicated that its only success to date was to extend life briefly and the treatment was very toxic and could only be administered in hospital.

We went home to discuss our options. At that moment I realised that my mum and I had the power to commit between $500,000 and $1,000,000 of U.S. taxpayers resources searching for a miracle cure. There were considerable feelings by members of my family wishing her to undergo any treatment that had even a slight possibility of success.

She opted to stay at home and we contacted a third sector hospice provider who took care of everything from installing a hospital bed in her home to getting all of the palliative drugs prescribed to implanting a morphine pump.

After ten wonderful weeks together mum lapsed into coma and on the sixtieth day she died in my arms – never having to endure any pain. It was sad but a dignified death – one that she chose.

Planning for your end-of-life care

Much attention is being paid to the amount and locus of money spent on medical and social care in the last months of an individual's life. Much of this spending appears to be on autopilot and is directed as a result of how an individual presents to the health care system and whether or not there are any living wills in place. Advanced directives are legal documents where an individual considers the type of care she/he desires as they approach the end of their life. These

documents provide subjective guidance for those family members who may be faced with making life-extending/terminating decisions. Advanced directives also provide some objective cover for clinicians faced with the withdrawal of services or technology the results of which may speed an individual's death.

Having conversations regarding end-of-life care wishes is very difficult and not many consider these issues prior to being faced with them under duress. However, they are critical to supporting a dignified death in concord with the wishes of the person facing the end of their life. As illustrated above, the difference in public spending is enormous depending on whether life ends in a hospital setting or at home or in a hospice setting – so there are public policy implications.

It has been suggested that the number of people dying in any one year will rise by 17% between 2012 and 2030[35]. According to the Demos report 'Dying for Change' by Charles Leadbeater and Jake Garber (2010), 'out of the half a million people who die in Britain each year, sixty per cent die in hospital, even though only eight per cent would chose to die in hospital'.

> Another personal story. Last year, my wife and I were notified by our attorney that due to some changes in federal and state law, we needed to review our estate plan. Following a consultation with our attorney we agreed to the changes she recommended and received a redraft of our wills etc. In addition we each received a half-inch sheet of paper related to advanced directives. Each page posed a possible scenario where we might be unconscious or mentally incompetent to make choices for ourselves. They were there to provide guidance to our loved ones and to the person who held a medical power of attorney and who would be turned to if/when decisions about the end of our lives needed to be made. Though not easy to consider we found these very helpful as we considered our role as the possible decision maker over the end of life of our spouse.

Most people have not communicated their end-of-life preferences. Many cultural and religious barriers deter these conversations. The goal must be to enable individuals to have the most dignified death possible and to hear and honour their wishes as they face the end of their lives. Many resources exist to facilitate conversations regarding end of life. The "Conversation Project," an American charity, provides very helpful guidance for addressing these difficult conversations (theconversationproject.org). There are many excellent resources in the UK (search "end of life conversations UK"). Every GP surgery and NHS organisation should have packets of guidance for patients and families.

35) Gomes and Higginson, 2008

Conclusion

'Overcome the routine in order to do the essential' [36]

We, as many others before, champion integrated care for our vulnerable citizens; the frail elderly and those with long-term and mental health conditions. But talk is cheap and it is now time to focus commissioning intentions and priorities on advancing integrated care at the coal-face. This will take the redirection of limited financial resources but the return on investment is compelling. The shortage is bold leadership. As Chris Ham, Chief Executive of the King's Fund so aptly stated, "the essential ingredient in making integrated care a reality more widely is leadership at all levels – from frontline teams through to NHS boards and in national bodies such as NHS England, Monitor and the Care Quality Commission[37]".

It is time for leadership to be BOLD! I have organised my recommendations for different key players in the NHS, in local communities and for my colleagues at GGI:

I. To politicians:

As we approach the 2015 national elections I reiterate my entreaties to politicians in all parties from my last report (Goldberg II Delivering on Strategy in the NHS – April 2014)[38]

- It is critical for the next UK Government to not undo the most recent re-organisation of the NHS. Doing so would dampen the fire of commitment and enthusiasm that GP leaders of CCGs have shown across the country. Progress is being made and stability is critical now
- There should be a clear countenance of an overall direction that encourages and rewards integrating social and health care, whilst keeping healthcare funding ring-fenced
- Co-ordinated local and national prevention campaigns must be funded and promoted around personal responsibility, smoking cessation, moderate alcohol consumption, safe sexual behaviour, obesity and healthy diet and physical activity
- Look at tying together 'sin taxes' and the funding of health and social care. For example, consider a tax on 'couch potatoes', targeting sedentary activities such as television-watching and video games to fund recreational facilities or increased physical education in schools to address juvenile obesity
- Recognise mental health of children and teenagers as a major public health issue and put mental health education on the national curriculum
- Initiate public awareness campaigns about mental health concerns and ensure that support networks are adequately funded and embedded in integrated care networks
- Government needs to promote a well-publicised and co-ordinated campaign to raise the consciousness of the populace around thoughtful individual planning for end-of-life care
- Government should abandon the goal of reducing the cost of the NHS over the coming several years. This goal is dangerous at a time of increasing demand and an aging of the population. Please consider increasing NHS funding to better serve an aging populace with truly integrated high quality health and social care

II. To NHS England:

- Support co-commissioning wherein CCGs have the authority and responsibility over all primary care.
- Enable GP lists to be held by qualified organisations
- Recognise that the technology exists today to link patient data among GPs, secondary care, community and social care. Then invest and implement solutions now

36) Marlene Dietrich
37) Ham, 2013
38) http://www.good-governance.org.uk/goldberg-ii-delivering-on-strategy-in-the-nhs/

III. To the regulators (Monitor, CQC and the TDA):

- Re-focus efforts away from meeting targets and on to how to encourage and improve integration across health, community and social care. Make integration and requirement against which Trusts will be assessed
- Support the organisational integration of Trusts

IV. To GPs and CCGs:

- Whereby recognise and embrace the challenges to GPs today and in the future
- GP shortages will be increasing into the foreseeable future. Develop robust workforce plans to address these shortages before they overwhelm local resources
- Encourage and enable the combination of GP practices in order to develop primary care organisations with the critical mass of clinical and administrative leadership to plan and deliver a full range of primary care in larger one-stop primary care hubs
- Create an incentive scheme wherein GPs are rewarded for reducing A&E attendances by patients on their respective lists. This should involve establishment of baseline data on utilisation of A&E by GP patient lists and rewarding future reductions. This activity must be supported by enabling robust after-hour-care facilities and services promoted and co-ordinated with all local GPs, the 111 service , local A&Es and even the local ambulance service. We must reduce the glut of patients attending A&Es who can be more effectively and conveniently cared for in the community
- Enable and fund appropriate "social" prescribing where GPs write prescriptions for diet counselling and daily activity promotion (even gym membership) for at risk patients where the GP believes behavioural change can be enabled
- Locate more mental health professionals in GP practice
- Foster integration of Children and Adolescent Mental Health Services with health and social care as well as the education sector
- Create an atmosphere of learning rather than performance monitoring to address clinical variation among GP member practices of the CCG
- Recognise that acute care discharge planning cannot be only the responsibility of the local acute care trusts. It requires a focused co-ordinated effort of community care, social care, local care homes, GPs working together with consultants and staff at hospitals
- Organise primary care (particularly for the frail elderly and those with multiple long term and mental health conditions around the patient. Create listening fora where small groups of patients can provide guidance as to how to improve their care and lives
- Care for the frail elderly and for those with multiple long-term and mental health conditions can best be provided by local organised and funded multi-disciplinary teams where interested GPs have paid time to better manage these complex patients
- Create and fund the role of "Navigator" or "Care Coordinator" as key members of the care team and personal links to the frail elderly and for those with multiple long-term and mental health conditions.
- Support national and local campaigns to encourage individual patients and families to face and embrace choices for end-of-life care (provide opportunities for interested staff and their families to address these difficult issues)
- Recognise that the technology exists today to link patient data among GPs, secondary care, community and social care. Then invest and implement solutions now
- Increase the funding and coordination of self-care utilising new assisted technologies (e.g. telehealth and telecare)
- Explore "capitation" as an alternative funding mechanism to better align financial incentives with care planning and delivery

V. To NHS Trust:

- Ban smoking from your entire estate – not just from your buildings. It is disconcerting to see patients, visitors and indeed staff smoking a few metres from Trusts entrances
- As major local employers develop robust employee assistance programmes (for staff and their families) around health promotion (smoking succession, diet, physical activity etc.)
- Willingly work with CCGs and local GPs to move as much ambulatory care out of the hospital and into community primary care hubs
- Become resources for information and guidance for end-of-life planning for patients and families
- Instigate focused patient feedback to improve care. Trusts should bring together groups of patients who have received similar care into focus groups. For example, imagine the insights Trusts could gain by bringing together a representative group of patients who received hip replacements in the past six months. Enable them to discuss the outcomes of their care, failures of the care pathway, how the course of their care was perhaps different from what they expected. Gaining these insights could only improve the care of patients in future and better inform hospital clinicians

VI. To local Council leaders and Health and Wellbeing Boards:

- Work closely with CCGs to find all of the synergies that can support prevention efforts for the populace
- Seek ways to physically combine local recreational and social care services with GP services an community care into one-stop health and well being hubs
- Enable social care professionals to be part of primary care teams
- Use the LHBs in Wales and the unified NHS boards in Scotland as examples of joint governance, commissioning and planning with representatives of health and social care providers, local government and the third sector. With sufficient funding and embedded in clear governance structures, Health and Wellbeing Boards in England could fulfil an equally enabling role

VII. To GGI:

- Continue to develop tools and advise for boards around the challenges and opportunities of better integrated organisations and care pathways
- Build on the work GGI is doing with NHS England to provide guidance for improving leadership (particularly for clinical leaders) around integrating care across NHS and social care organisations
- Focus attention on improving ways boards can gain assurance or quality and efficiency across organisations
- Continue to explore approaches to better combining the governance of primary, community and social care
- Continuously bring to boards the importance and benefits of listening to patients to gain insight in how care can be improved

Next steps by Andrew Corbett-Nolan

'Circumstances are beyond human control, but our conduct is in our own power' [39]

We are just almost six months away from a general election, and in truth no one can call the result. Indeed, small parties with special interests may be the power brokers. As a result, though important in the election campaign itself, health will not be the core of any deal to grab the keys to Downing Street. But whoever is asked that fateful Friday morning to walk across Whitehall from Downing Street to Richmond House will have the toughest ministerial brief of them all.

As the politics of health and delivering healthcare have become more difficult and multi-faceted, politicians have sought to distance themselves from some of the really difficult issues that need dealing with. Instead, they have spent valuable time obsessing with structures on the one hand and, frankly, bullying those managing services on the other. One stable part of the system remains boards, and their new CCG incarnation of 'governing bodies'. Boards matter, and how the individuals on the board behave and work has significant effects on their local populations' healthcare opportunities over decades. The decisions boards and governing bodies take effect the very cohorts of people David Goldberg focuses on: the frail, the vulnerable, and those living testing lives with various long-term conditions as their long-term companions.

David's observations and recommendations are his own, and they are insightful and telling. He has seen patient-focused care work, and commends the NHS to seize the nettle and learn from these systems. These are not management models that can be neatly slotted into the present way we work here in England. Some find themselves out of context or too far ahead of the curve to be capable of easy implementation. Indeed and for example, in GGI's work this past year we have seen NHS organisations that have been 'too innovative' and their quality achievements don't fit the regulators' mould. These organisations have been manacled from making stepped changes in the way they work.

It is clear to me that several things need to happen at once. Firstly, there needs to be some political courage. Those steering local service transformation need to be less prey to central political manipulation. Secondly, boards and governing bodies need to exert leadership and be brave. They need to successful tactics that can enable them to 'push back' on the system. Thirdly, those leading and shaping services and the professionals that work in them need to think of the unit of service as being the patient and not a ward, community team, clinic, or surgery. It's all about Mrs. Jones and how she chooses to live her life.

Finally, both local and national politicians, and informal leaders at all levels and of all types need to be switched on to health and social care. There is a desperate need to frame realism in the public mind. The debate about end of life care that David talks of is predicated by many mis-beliefs and rituals that surround death – not religious in nature but beliefs such as 'I have a right to inherit Mum's house, and no Council is going to sell it and pay for a nursing home', to 'If Dad comes out of hospital then I'm going to need to look after him and, hang it, I've only seen him twice in the last three years, I don't know how I'm going to face doing that'. A similar range of myths surround the close of acute care provisions, the durability of the current model of general practice and technologically assisted health and social care (telehealth and telecare).

So we believe that it will be the folks that GGI spend their time with – the boards and governing bodies – that can and will always make the difference. Boards are a terrific resource to the NHS, and the calibre of executive and non-executives sitting around the board table has undoubtedly risen this past decade. Boards have been coping well under sustained stress, but are increasingly finding their organisations have been shackled into the wrong paradigm. Almost the most important focus for boards today is to be the midwife of tomorrow, rather than the apologist for yesterday.

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December 2014

39) Benjamin Disraeli

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