

The Value Case for Co-ordinated Health and Social Care



Contents

Executive Summary	2
The Purpose of this Document	4
The Vision for Integrated Care	5
What does this mean for me, my family and carers?	6
What does this mean for my GP?	9
What does this mean for local health and care services?	12
What does this mean for Health and Wellbeing Boards?	16
The Enablers of Whole System Integrated Care	18
The Business Case for Whole System Integrated Care	23
Conclusion	27

Executive Summary

This overarching value case for co-ordinated health and social care promotes whole system integrated care as a solution towards creating sustainable public services that, crucially, ensure that the individual is at the heart of the system.

“Whole system” integrated care is important because only by delivering change at scale can we ensure that:

- people consistently experience the best possible care
- necessary investment occurs in a timely and effective way
- the improvements that result are sustained and built upon

NHS services that were set up to provide episodic care - to help sick people get well, often in a hospital setting - are now struggling to meet the changing nature of demand, including increasing numbers of people requiring long-term care. In many cases those individuals are the very same people requiring support from local authority social services to help them stay independent and well.

We know that around 15 million people in England have one or more long-term conditions, and that the number of people with multiple long-term conditions is predicted to rise by a third over the next ten years.¹

With pressures growing within both NHS and local government budgets, there is a growing urgency around adapting to meet the changing needs of individuals, families and communities today; and to put in place arrangements that will continue to meet those needs into the foreseeable future.

This value case, and the integrated care toolkit as a whole package, aims to provide specific support for Health and Wellbeing Board members in taking forward integrated care, specifically linking to the Better Care Fund (BCF).

It does so in three ways: by providing a structure for the visions and schemes sections of the BCF, including typical aims and objectives of person-centred, co-ordinated care; by providing indications of the type and scale of joint investments that underpin all current successful models of integrated care, linking to the overall financial implications; and finally by providing both narrative and quantitative support in relation to describing the outcomes of improved person-centred, co-ordinated care.

The value case is also intended to serve as a tool to support commissioners and providers and patients, people who use services and carers in moving from the ‘why’ of integrated care to considering how implementing whole system integrated care might be achieved on a practical level.

It starts with real people who interact with the current health and social care system on a regular basis, be that as service users or service providers. After reflecting on what whole system integrated care might mean for these individuals and their families or organisations, the value case identifies some of the common enablers required to achieve the changes necessary for making integrated care possible.

¹ *Ten things you need to know about long term conditions*, Department of Health, 2011

In particular, the value case focuses on winning the case for change in the context of the significant risk that such a radical transformation entails. This includes examining existing evidence to support the business case for whole system integrated care. Using the evidence base, the value case explores how leaders across the health and social care system might go about developing a business case for whole system integrated care in their own local area.

Attracting the requisite combination of bottom-up and top-down support, buy-in and ownership is vital for making whole system integrated care a reality. This value case aims to provide examples of some effective means of achieving this, in a way that is tangible and accessible for the breadth of Health and Wellbeing Board membership.

The Purpose of this Document

“Do the right thing, in the right place, with the right people and at the right time”
Gesundes Kinzigtal

The purpose of this document is to help Health and Wellbeing Boards and their local partners make the case for whole system integrated care, as a response to the increasing pressures on health and adult social services in England.

Any failure to provide the right care in the right place, at the right time carries significant risks of individual distress and harm; ultimately putting greater strain on individuals, families, communities, and the public services that support them. Many people with experience of health and care services in England speak to the excellent quality of care; but many also speak to the frustrations that arise when the ways in which that care is provided break down.

National Voices has shown the commitment of patient and service user organisations to supporting changes to the way in which services work today. The adoption of the National Voices narrative for better co-ordinated, person-centred care by NHS England, in collaboration with the Local Government Association, the Department of Health and a number of other national and local bodies, speaks to the overall priority being given to this as an agenda.

Making such change occur at scale – across a “whole system” of public service commissioning and provision – nonetheless involves significant complexity and risk. Most people today still experience fragmented care; and whilst our systems are struggling to cope with growing demands, there are real and understandable concerns around whether alternative models will work, and how we might manage the transition.

However, against such tests as the ability to promote health and wellbeing, to enable safe and independent living, and to provide a good quality of care, there is growing evidence that person-centred, co-ordinated care delivers.

Translating this into whole system improvement involves having a shared understanding of what good care looks like, from an individual’s perspective; and a parallel understanding of what change will mean in practice for local health and social care professionals, whole communities, and the organisations that are responsible for commissioning and delivering care on their behalf.

Developing person-centred, co-ordinated care in the face of long-standing fragmentation takes very strong leadership. Leaders from all parts of the existing system, including those receiving health and care services, need to build a consensus that there is a better way to operate, and be able to move resources where they are needed most, irrespective of traditional boundaries or ways of working.

This is what we mean by making the case for whole system integrated care.

It is about understanding the key “enablers” of better care and what it means to put these in place. It is about being able to describe and to deliver the benefits.

And it is about taking the first steps towards ensuring that the vision described by National Voices becomes a reality, underpinned by real and sustainable changes in the way in which health and care services are provided across England as a whole.

The Vision for Integrated Care

What does this mean for me, my family and carers?



“Patients get an opportunity to discuss their care as a whole, not just their medical care, but the social aspects, the psychological aspects, and also what the carers feel they need.” [WELC Integrated Care Programme](#)



“Mum trusted them and as the weeks progressed, she was encouraged and enabled to get ‘out and about’ again and resume her normal activities. They gave her great confidence and I am convinced that she would not have achieved so much without the team.” [North Devon Stroke Service](#)



“I was helped to regain my independence when I thought I would have to go into care.” [Greenwich Integrated Care](#)

Integrated Care is about achieving improved outcomes for individuals in need of health and social support, enabling them to live not just longer, but better lives.

Torbay and Southern Devon Health and Care NHS Trust demonstrates how the journey towards better co-ordinated health and care services across a whole locality can start with one individual, “Mrs Smith”. The basic expectations of, and for, Mrs Smith – that she should have:

- a single point of contact
- professionals who talk to each other
- quick and responsive services, and
- should only ever have to “tell her story just once”

reflects the priorities of those engaged in the National Voices narrative, and patients and people who use services across England. Such narratives are important not just in ensuring an improved experience of care, but because of increasing evidence that the principles that underpin them also produce the very best outcomes for individuals, their families and communities.

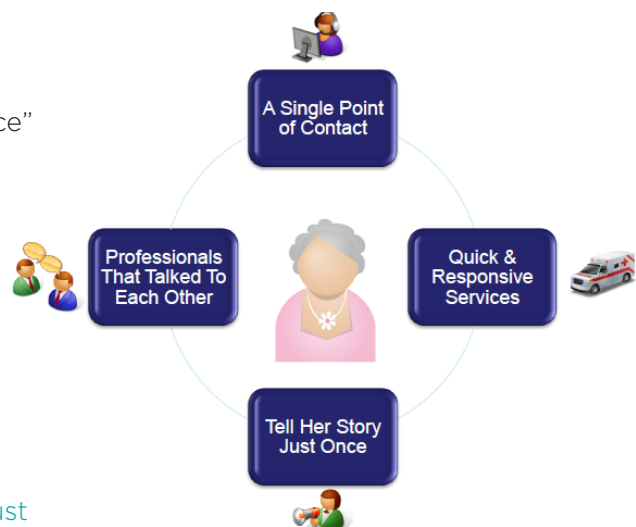


Figure 1: “Introducing Mrs Smith”, Torbay Care Trust

The National Voices narrative highlights the gap between what matters most to patients and service users, and many people’s daily experience of care. It shows the commitment of patient and user organisations to supporting changes to the way in which services work today. It provides evidence in people’s own words about the benefits of better co-ordinating care. It captures what matters to individuals, their carers and families. And it includes alongside their voices, the voices of frontline health and care professionals.

Figure 2: The National Voices narrative, NHS England

What it means to have a “better” life will be as individual as the people concerned, but there are a number of elements that help describe what patients, people who use services and professionals are working towards in terms of better care.

Within the **Triborough** of Kensington & Chelsea, Hammersmith & Fulham and Westminster, the process of developing new joint services has involved from the start building an understanding (across a diverse, urban population of 550,000 people) of the key challenges being faced by those receiving support from health and care services today.

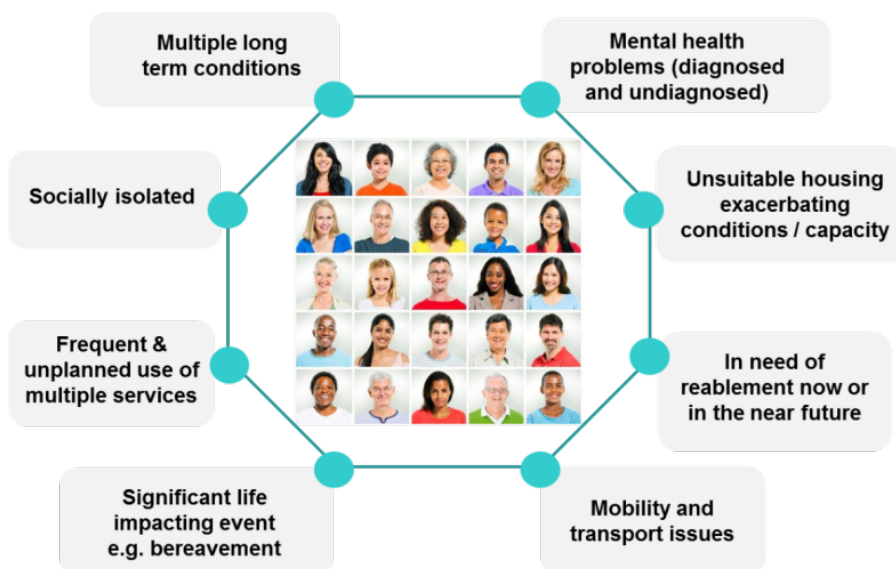
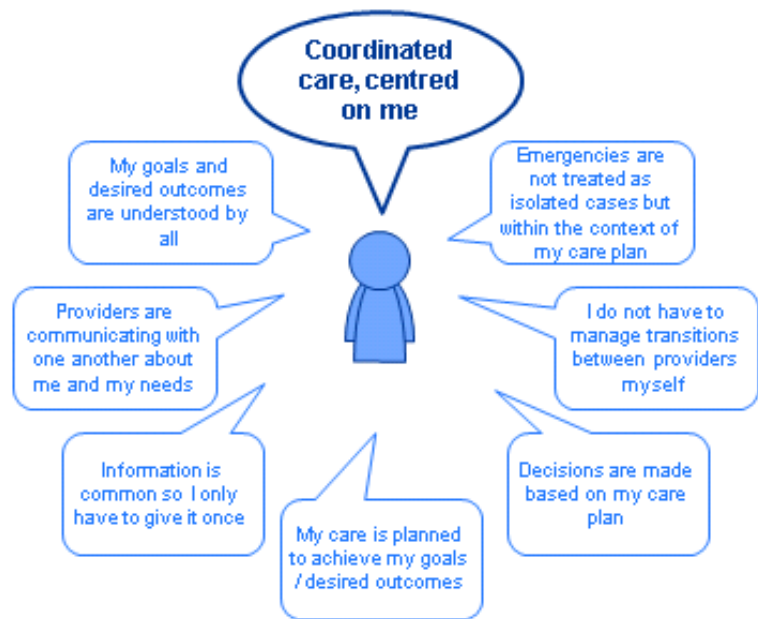


Figure 3: Challenges faced by people in the Triborough

As people live longer, so working to ensure they remain independent and well means an increasing focus on understanding the capabilities and needs of the whole person, and not just individual physical or mental health conditions.

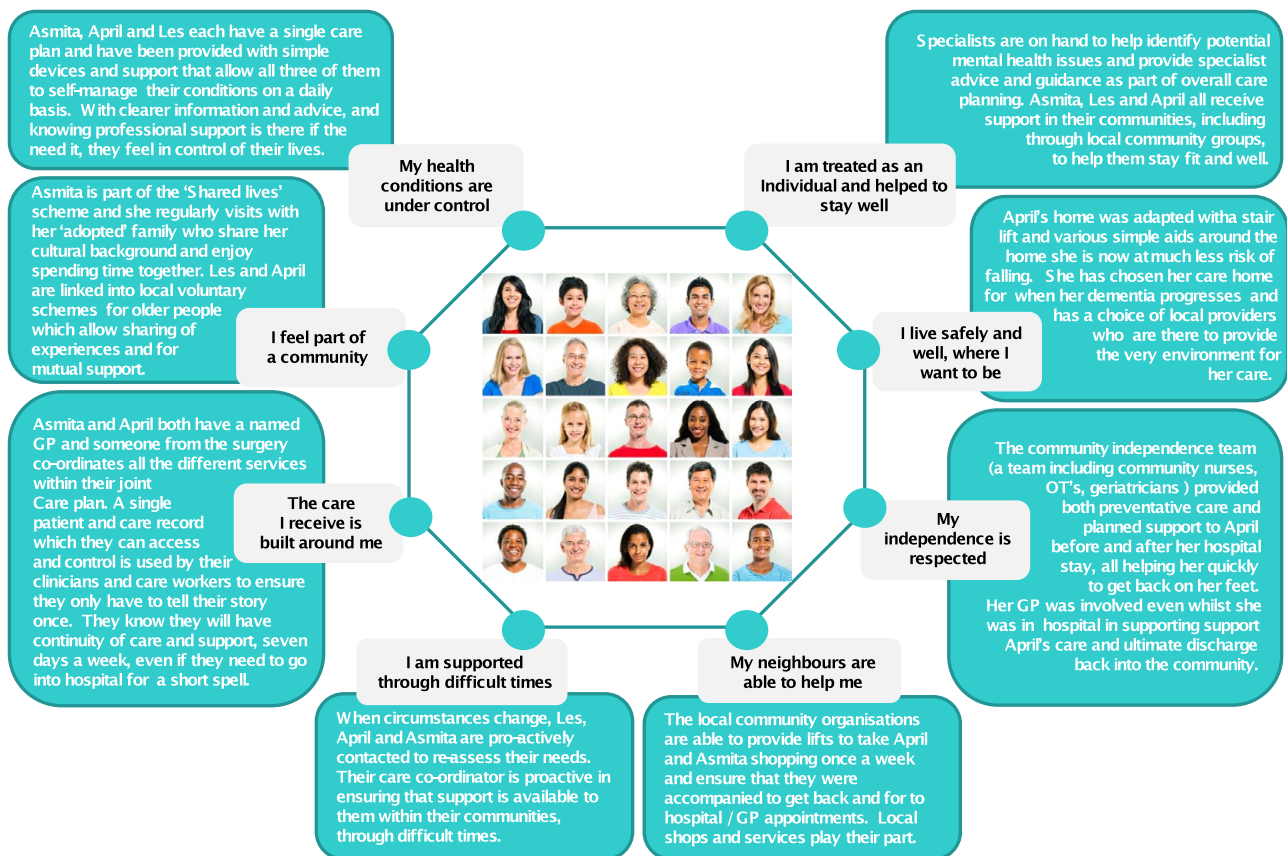


Figure 4: Vision for health and wellbeing outcomes in the Triborough

What individuals expect is a set of services that work in a co-ordinated way with them, to understand what matters most in their lives, and to build support around achieving the outcomes that are important to them.

Many of those outcomes will involve keeping them safe, physically and mentally well - out of hospital, in their homes and local communities, in the best possible health; but as important will be that the co-ordinated support people receive also enables them to live their lives the way they would like to live them, including in relation to their housing, mobility and social needs.

Whilst these objectives may not always all neatly align, building better relationships between individuals and the professionals working to support them is essential to ensuring that people are genuinely supported in living not just longer, but better lives.

Successful integrated care systems help people to help themselves.

Delivering better outcomes with limited resources means transforming the way in which health and care professionals work with individuals, carers and families. This starts with recognising the value that patients, people who use services, carers and communities bring.

For every minute of professional time spent with someone suffering from a long-term condition, many more hours and days will be spent with them coping on their own, or through informal networks of personal and local support. Equally, no amount of professional support and

investment will really help if it is not aligned with the broader priorities and goals of the individual concerned.

Through providing help and support to individuals, their carers and families better to manage their conditions on a day-to-day basis; investing in developing resilience and formalising networks within the community; and working with individuals as true partners, rather than just as patients or people who use services; there are significant opportunities to prevent people getting ill and to keep them living well.

Developing more equal and reciprocal relationships between health and social care professionals, people currently receiving help, and their families, neighbours and communities will not happen without specific commitment from both the individuals concerned and those professionals working to support them. However, when activities are “co-produced” in this way, the changes are much more likely to be both successful and sustained.²

This is a vision of better care where people should expect, for themselves and those they care for, to be listened to; to be involved not just in deciding upon the packages of care they receive, but as an active participant in how it is delivered; and to enjoy better health and wellbeing within their homes and communities as a result.

Summary

Whilst the way in which services are configured and developed will vary from area to area (and few areas are starting from scratch) the vision for individuals, their carers and families is of high-quality support based around:

- being respected as an individual
- being helped to stay fit and well
- being able to set and meet personal goals
- staying independent and active
- staying out of hospital, except for planned care best delivered in that setting
- having at all times high-quality, tailored support available where and when it is needed
- having care that is developed and joined-up around me, not the “system”
- having care that is provided in a proactive, consistent and sustainable way
- being able to live and die with dignity

² David Boyle & Michael Harris, *The Challenge of Co-production*, NESTA, London, 2009, p.11

What does this mean for my GP?

Joan's Story

The London Borough of Harrow has decided to implement capitated payments across the patch. In addition, Harrow's six multi-disciplinary groups (MDGs) have expanded to include more providers, and the GPs within them are beginning to specialise into different care pathways.

Joan is a GP who joins one of these MDGs. She consequently spends two hours each week in an MDG meeting with a group of other GPs and providers, where they discuss what is going on with their complex patients. Joan additionally decides that she can afford to specialise in her main interest, care of the elderly, now that capitation will allow her to maintain her current income with fewer patients. Joan focuses on elderly care, attends extra education courses once a month to hone her skills, and reduces her list size to only 500 people. She brings cases to the MDG working group once every two weeks so that she can collaborate with the group on their care.

Finally, the GPs within the MDG decide that they are going to co-locate with each other into a larger hub that will provide more services. Joan moves her practice to this hub, and subsequently has help with her extended hours services. While she used to do all extended services within her own practice, she now has a whole network of GPs who can take turns doing evenings and weekends.

Case study from North West London Whole Systems Integrated Care programme, 2013

GPs are the “gatekeepers” to the current healthcare system and their involvement is critical to making future models of care work.

Integrated care builds directly upon existing relationships and best practice within primary care; it will not function without these. GPs see the results of the failures of fragmented care every day in their surgeries.

Person-centred, co-ordinated health and social care empowers GPs to call directly upon specialist expertise, support and resources from across the health and care worlds to keep their patients well and as independent as possible.

The GP is often where individuals are first diagnosed and become aware that they are suffering from a long-term health condition.

It is usually the first call for subsequent advice, guidance and check-ups. The GP is the medical professional with whom individuals have an on-going relationship and who they trust to help keep them well. To carry out this task GPs are in turn reliant on a support system of acute (hospital) based consultants, of community nurses and other community based services, and of local social services, to help in understanding the best response to a patient's needs and ensuring that the assistance required to keep them well is delivered. It is therefore not surprising that GPs are amongst the first to experience the negative impact of breakdowns in communication and co-ordination across health and care services.

Many GPs can already identify the majority of their patients who are at risk of losing their independence and wellbeing – this is about enabling GPs to work with those individuals at the earliest possible stage to improve outcomes.

Whilst no system for identifying “at risk” individuals is without its challenges, the issues at the surgery level are rarely those requiring complex risk stratification systems or information sharing arrangements beyond the obvious to resolve.

Person-centred, co-ordinated care at general practice level often means simply being able to get someone on the phone to help, at the point where that help will have the greatest effect. It means being able to work efficiently and consistently with local social and community-based services to ensure proper support in the home, for an individual who otherwise will end up in hospital or residential care. It means having access to specialists when needed, with a view to understanding both individual and local community issues, and ensuring subsequent access to services which are co-ordinated to help support the whole person under the GP's care, not just one element of their needs.

Ultimately providing person-centred, co-ordinated care is about GPs being able to keep their patients well and as independent as possible, and to manage overall demands on the local health economy in a way which ensures that resources are used to maximum effect.

The role GPs play within local integrated care systems will vary according to how those systems are developed.

In some primary-care led models, the GP's role will become one of the patient advocate and navigator – helping to co-ordinate their patient's care across an increasingly complicated provider network.³

North West London Whole Systems Integrated Care Programme is an example of one that has GPs at the centre of their vision for organising and co-ordinating people's care.

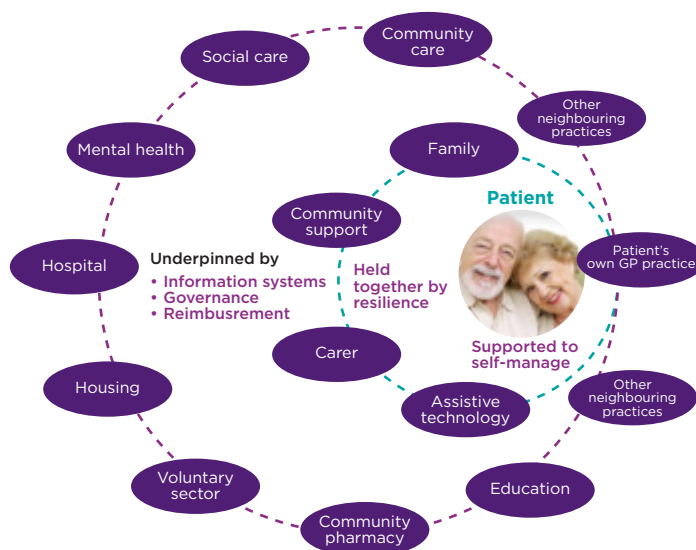


Figure 5: The North West London vision for Whole Systems Integrated Care

Care for Older People in Torbay achieves this with a new role of named care co-ordinators, who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey separately from the role of the GP. Torbay has established five integrated health and social care teams organised in localities aligned with general practices. Care co-ordinators support older people following an emergency hospitalisation, helping them to receive the intensive support required to enable them to live at home.⁴

Whilst there are a number of options around the day-to-day activities and responsibilities of a GP in an integrated system, there are many things that will not change.

The GP will still usually be the first port of call for patients and will take an active role in case management and care planning for their patients. The GP will be at the forefront of leading their patient's care – but this is not always the same thing as managing every aspect of care:

³ Clare Gerada, 'The Challenging Role of the General Practitioner' from *Together: A vision of whole person care for 21st century health and care service*, Fabian Society, London, 2013, p.71
⁴ The King's Fund, 'Care coordination through integrated health and social care teams'

the system as a whole needs to support GPs in achieving this. The GP will still have a responsibility to offer patients continuity of relationship where this is important, and access to primary care when it is required.⁵

There are also some common changes that will be evident across the profession.

These will be positive measures that support individual GP's capacity to effectively provide high-quality care, including access to holistic patient records, more integrated ways of working with other healthcare professionals, new forms of training and development, the potential for longer, less regimented consultation times, and working through new channels and technologies to support patients needing help.

GPs may encourage patients to access help remotely via telephone, email, text message and through social media, where and when this works better for both sides. This has the potential to extend to virtual examinations by doctors and practice nurses in settings outside the confines of the surgery and at more flexible times. GPs will be able to promote self-care by referring patients to e-health information systems. Shared decision-making between GPs, patients and carers will be a key part of this.⁶

Working in federations or networks of GP practices is one of the major opportunities for GPs in an integrated health and social care system.

Developing networks brings benefits to the GP profession as a collective, both in terms of supporting individual practices in meeting the demand for specialist services and out-of-hours provision, and strengthening the role that GPs play in the wider provider landscape – balancing the power levels between primary and secondary care.

Change will nonetheless be a difficult process, and one in which GPs will be balancing daily pressures against both longer-term opportunities and risks.

As the vision for better co-ordinated care is unlikely to ever be realised without the effective involvement at every stage of local patients and people who use services, so GPs and other health and care professionals are fundamental to managing and delivering this change.

For GP practices struggling to deal with daily demand, and frustrated by the difficulty of securing the right help and support for their patients at the right time, the opportunity of playing a central role in co-ordinating their care and providing a greater range of services is a significant one. GPs will nonetheless need to be confident that these changes represent a real improvement to their patients and to the way in which the system works now, and not simply an extra burden or bureaucracy for their practices.

Summary

Person-centred, co-ordinated care enables General Practice to:

- focus on delivering high-quality, holistic care
- know there is one care plan being owned by one team
- mobilise support and resources from across health and local government
- prevent and not just react to individual and community health problems
- manage demands on local surgeries
- get the best possible results for and feedback from patients

⁵ *Developing General Practice today: Providing healthcare solutions for the future, British Medical Association 2013*

⁶ *Clare Gerada, 'The Challenging Role of the General Practitioner' from Together: A vision of whole person care for 21st century health and care service, Fabian Society, London, 2013, p.73*

What does this mean for local health and care services?

Elsie's Story



Hello, I'm Elsie; I'll be 78 years old at my next birthday. I've had type 2 diabetes for over 20 years and now I'm registered blind and have had a heart attack. I found it difficult to manage at home so last year I moved into Sunshine View.

I like it here but I hadn't been here long when I ended up in hospital with sky-high blood glucose levels and pneumonia. I was very frightened and I hope it doesn't happen again.



Hello, I'm Ludmilla; I'm one of Elsie's carers at Sunshine View. We were all very upset when Elsie got so poorly that she needed to go to hospital. Fortunately for us, the local CCG has prioritised health care provision in care homes. The local diabetes specialist nurses, primary care team and HCA have been evaluating the care we provide to our residents and have also been educating the care home staff regarding how to look after the different aspects of diabetes care.

This has included treating hypoglycaemic attacks, medication management, monitoring blood glucose and, most importantly, ensuring people with diabetes undertake some physical activity and follow a healthy diet to reduce their chances of developing cardiovascular problems.

This work has been very valuable as we have local general practitioners, specialist nurses and educators working together with us and it is great to get the one common message in looking after residents who have diabetes. I have also completed a certificate in diabetes care and now I am the link worker for diabetes at Sunshine View.



Hello, I'm Betty; I've been a nurse on the Elderly Care Ward at the hospital for over thirty years. More and more of the older people I look after seem to have diabetes nowadays. I used to feel that I didn't know much about diabetes and its complications but I feel much more confident since I took some eLearning modules as part of my statutory and mandatory training. We also have Think Glucose™ in our hospital which has made people more aware of diabetes.

In addition, we have a protocol in place now so that anyone coming in with a diabetes problem gets referred to the diabetes specialist team straight away and seen by them within twenty four hours. This means that we can ensure the person is receiving the best care possible and also really helps us with discharge planning. We work with the specialist team and the older person to draw up a care plan for their diabetes. I made sure that Elsie's GP and the team at Sunshine View got a copy of this before she went home.

Taken from "Best Practice for Commissioning Diabetes Services: an Integrated Framework", Diabetes UK

We do not need to know "Mrs Smith" in Torbay, to know and care about someone like her.

That person may be widowed, living on his or her own and a few miles away from their nearest family. They may be an older person, still full of life but with long-term health conditions - breathing problems, high blood pressure and diabetes - that are gradually getting them down.

They have a carer to help them get out of bed and a different carer to help with lunch. Over a month they could be visited by one nurse focussing on their diabetes, and another nurse checking their oxygen.

They visit their GP once a month to have their blood pressure checked, but last year may have had to go to A&E multiple times, and on some of those occasions be admitted.

An admission to hospital can lead to a lengthy stay, because the hospital may not always recognise underlying conditions, such as diabetes, if the admission relates to another health issue - leading to those underlying conditions getting worse. Not surprisingly, once someone has been admitted to hospital, they and their families may be anxious about them being discharged home; and following hospital stays, twice a week visits from the district nurse could be required to deal with resulting leg ulcers.

In an average week this person could be visited by 4 different social care staff and 2 different nurses.

Over an average month (without an emergency visit) they may see 10 different professionals from the health and social care world, each of whom has a specific task. This increases during and after each exacerbation in one of their conditions.

They and their family recognise that each of these interventions are helpful and they try and make some sense of it all, but taken as a whole it is bewildering. Most days are spent waiting for someone to come and carry out specific parts of their care.

In basic economic terms, each intervention adds some value to their life, but the value is rarely helpful for much longer than the visit because no one is building these interventions in a way which focusses on the whole person and their long-term needs.

Each intervention does not link with the next to add value to each other. The failure to build a strong chain of support to help maintain health, wellbeing and independence means that each aspect of value added evaporates over time.

Another way of looking at this fragmentation is in terms of wasted patient time and days. In the above example 30 days were spent in hospital in emergency beds. Both spells came about because the individual's home was not made into a location where serious but long-term conditions could be dealt with on a day-to-day basis and this lack of safety led to hospital visits. One spell of 20 days was longer because, in diagnosing a breathing problem, they failed to recognise a comorbidity, diabetes. Both spells were protracted because the individual and their family did not feel their home was a safe place to be with a breathing problem.

The individual spends many days waiting for various strangers to come and visit at times that fit in with their own organisations and not with their life. Simple structural changes to put the person at the centre could make a big difference to that individual's experience. It would be beneficial, for example, if the same social carer was looking after them for most of the week. It would also be good if the nurses all came on the same day.

What is required is a joint approach from local health and social services, where providers are incentivised to look at the whole person, their needs, and how support can be best provided to keep them health and well.

Person-centred, co-ordinated care means having a care co-ordinator making sure that the GP and every other health and social care professional is working to the same personalised care plan. It includes potentially working with voluntary and community organisations that will come and stay with the individual at any hour of the day or night that they feel anxious about their breathing. And it means that every professional who goes into their home has a responsibility to provide both specific care, but also to place that care within the context of care that addresses all parts of that person's needs. Some care may be provided by people who can undertake both health and social care tasks, such as a social carer who can also change dressings, thus minimising the number of professionals that the individual needs to come into contact with and making the delivery of care much more efficient, flexible and immediately responsive.

In **Camden** Mrs. Foster is an 87 year old lady living alone in ground floor flat who has Parkinson's disease and osteoarthritis. She suffered from frequent attendance to A&E as a result of recurrent falls, urinary retention, multiple UTIs, and a L3 crush fracture. Mrs. Foster was identified as a frail patient by her GP working with secondary care. A district nurse matron undertook a joint assessment and a care plan was produced jointly with social care, a neighbour, Mrs. Foster's next of kin, the rapid response team, the GP and the district nurse service. Following care planning Mrs. Foster had no further non-elective admissions to hospital.⁷

Person-centred, co-ordinated care also means supporting an individual to take an active role in the co-delivery of their own care and services, removing tightly defined boundaries between professionals and recipients of care to develop partnerships working towards shared goals.

It means empowering patients and people who use services to manage their condition(s) by providing with the right education and the necessary access to data and equipment that they need in order to be able to do so. This involves knowledge sharing between both professionals and patients, and both being equally valued for their contribution. The new power balance by default demands a responsibility from the individual to make meaningful contributions to their own care – this could vary from monitoring their own blood pressure on a daily basis to setting a clearly articulated desired wellbeing outcome: “I would like to feel well enough to attend my grand-daughter's wedding in June.”

Being able to take an active role in decision-making about the type of care that you might want to receive is crucial. This may present in the form of a personal budget, where financial autonomy and flexibility lies in the hands of the patient or service user. Rather than choosing to spend money on regular visits from a social worker, a person might decide to spend that money on visiting a relative in another town, improving experiential outcomes for two people rather than just one. The shift towards proactive, preventative care is inevitable when individuals work with professionals to co-produce care. Early interventions are key to keeping people out of hospital, be that in the form of medication management or undertaking a programme of regular exercise.

Public health has a vital role to play in embedding the principles of person-centred, co-ordinated care into the day-to-day lives of members of the public.

When services are integrated across the nation, joined up provision of public services will become the norm: business as usual for health and social care professionals and an ordinary experience for people using services. How this might look and feel may vary in different local areas across the country, but the underlying principles of co-ordination, blurred organisational boundaries and individuals' responsibility will remain at the core of the new system.

⁷ Case study provided by London Borough of Camden

One vision is that of regular 'health and wellbeing days' held nationally in different cities and local areas across the country. For example, whilst participants are running in a Cancer Research-led 'Race for Life', spectators can enjoy the day out with opportunities to take their blood pressure and measure their blood sugar levels, undertake community support activities as part of a time-banking initiative, and test out the latest advances in telehealth and other technological devices at various different stalls. In this way health and wellbeing is incorporated into a family day out as a consistent experience for people all over the country.

Summary

Person-centred, co-ordinated care means health and care professionals:

- working together to identify those at greatest risk
- developing joint plans for supporting an individual's health and wellbeing
- working side-by-side to deliver those plans, in partnership with individuals and carers
- building capacity in the community, to provide early and effective support
- being able to focus on shared goals and outcomes

What does this mean for Health and Wellbeing Boards?

Understanding the benefits

For a population of 300,000 implementing a whole system model of integrated care targeted at the over 65s as planned in Greater Manchester, the Health and Wellbeing Board might expect to see savings of £1m in social care from reduced care dependency, £2m in reduction of non-elective admissions and £2m in reduction of non-elective bed days – totalling a cost saving of £5m across health and social care in year one.

Extend this model to include the whole adult population with a focus on preventive care such as “Gesundes Kinzigtal”, and the Health and Wellbeing Board could benefit from cost savings of £10m in social care from reduced care dependency and £19m in non-elective admissions – totalling a cost saving of over £29m in the first year.

Effective crisis response, improving transitional care and effective ongoing support are some of the key investments required to deliver integration at scale, driving outcomes at a community and locality level, with a disbenefit calculation value of £8m respectively should these not be implemented.

Winning the argument

“It doesn’t happen overnight! The Neighbourhood Care Programme in Cumbria is built on years of planning, good working relationships, clear leadership and a willingness to work together for the benefit of customers by health, social care and third sector organisations... Gaining the confidence of Council elected members and GPs was crucial to creating the programme.”

Nick Waterfield,
County Manager for Health and Wellbeing
Cumbria Adults and Local Services

Health and Wellbeing Boards are the strategic hub of local service development and delivery.

In the new organisational architecture of the NHS, Health and Wellbeing Boards are the principal vehicle to promote local integration, bringing together key players from the NHS, public health, adult social care and children’s services, including elected representatives and local Healthwatch, to plan jointly how they can best meet the needs of their local population⁸.

Within their core membership are the Cabinet Members and CCG Chairs who are responsible to local constituencies for explaining the impact of the changes to existing resources and practice. This includes addressing the impact on the acute sector in terms of the reduced need for hospital-based services, not only in financial terms but in relation to effective prevention of admissions and rapid enablement of those who do need acute-based care.

Working with both patients and people who use services, and the third sector will be crucial to the success of Health and Wellbeing Boards in facilitating the realisation of person-centred, co-ordinated care.

The great potential of Health and Wellbeing Boards as an organisational structure lies in the opportunity to work innovatively and outside of the current paradigm of health and social care hierarchies. Commissioners and providers alike (including those that may fall outside of the traditional spectrum of care services) will lead the integration movement for local areas, and this is a new way of working for many of Health and Wellbeing Board members.

There are lots of examples of effective co-ordination of care at a local level.

⁸ Neil Churchill, *Getting Started: Prospects for Health and Wellbeing Boards*, The Smith Institute, London, 2013

If better care is to have maximum effect for individuals and communities, there is a need to ensure that this is achievable at scale. At a locality level a number of other enablers become important including, but not limited to, the ability to identify and target resources to specific sets of the whole population through risk stratification, to share information and data between the organisations supporting that population, and overall to commission or buy health and social care services in a joined up way which promotes the outcomes described at the individual and practice level. This is about linking systemic solutions to the local level.

There is a clear business case for getting the enablers right to facilitate the scaling of person-centred, co-ordinated care.

There is no “one size fits all” model of integrated care, and tailoring integrated solutions to the local population’s requirements is the key to successful implementation. Health and Wellbeing Boards should look to integrate services that offer a logical fit and where the impact will be greatest based on the local population and geography. Hospital use and costs are not the only impact measures, for example better care planning has real potential to improve patients’ experience, in particular around reducing duplication and improving access. It is vital to be explicit about desired outcomes, how they will be achieved and to use interim markers of success.

Despite only 9 of the 70 respondents in a recent survey of Health and Wellbeing Boards across the UK citing the realisation of integration as a major priority at this stage, being able to articulate plans and outcomes for integrated care is more important now than ever. The Government has recently announced the creation of a Better Care Fund (BCF): “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”.

In 2014/15 £200m will transfer from the NHS to social care in addition to the £900m already planned to enable localities to prepare for the full BCF in 2015/16. In 2015/16 the BCF will pool £3.8 billion worth of funding to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In addition to the £1.1bn planned for 2014/15, the full BCF will consist of £1.9bn additionally transferred funding from the NHS, £300m CCG reablement funding, £130m Carer’s Breaks funding, £220m Disabled Facilities Grant (capital), and £134m ASC grant (capital).

The Chair of the Local Government Association, Sir Merrick Cockell, describes this fund as “an important catalyst for change, and moving more towards preventative, community-based care will help to keep people out of hospital and in community settings for longer.” Health and Wellbeing Boards are the structure through which BCF plans will be approved and signed off for local areas.

For Health and Wellbeing Boards, delivering person-centred, co-ordinated care is about coming together to provide cross-sector leadership and strategic direction, fostering new ways of working and overcoming organisational boundaries, and working collaboratively to find solutions to complex challenges and systemic barriers that will ultimately raise the health and wellbeing of their local population.

Summary

Being able to describe the outcomes of person-centred, co-ordinated care is about demonstrating clear improvements in areas such as:

- patient and service user experience
- effectiveness of enablement
- delayed transfers of care
- average length of hospital stay
- emergency admissions
- admissions to nursing and residential care

The Enablers of Whole System Integrated Care



Figure 6: "My Life, A Full Life" roadmap, Isle of Wight

Empowering people in relation to the care that they receive; co-ordinating support around their needs and those of their carers and families; channelling resources into keeping people independent and well, rather than reacting only when they become so ill they can no longer cope on their own.

All of this is what hundreds of thousands of health and social care professionals in England aspire to do, each and every day. The elements that make integrated care an attractive model for

delivering health and care services in the future are, in many ways, simply reflections of what we would describe as best practice in the way we provide care today.

There are nonetheless huge inconsistencies across the country in relation to an individual's experience and outcomes of care. There is both a moral and a practical argument that this level of inconsistency is unacceptable.

Systems that rely on joining up around the needs of individuals, to produce better outcomes, require all of those involved in the design and delivery of services – from policy makers at the very top through to professionals delivering care at the frontline – work towards the same vision and the same objectives. Many of the investments and benefits required can only be achieved by working together, at scale, to make change happen and to manage the implications of that change, for the health and care economy as a whole.

The “House of Care” metaphor illustrates a “whole system” approach, the interdependency of each part and components that need to be in place to hold it together.

NHS England is increasingly using the ‘House of Care’ model as a checklist and a metaphor for these building blocks of high quality person-centred co-ordinated care; it is useful for drawing together the building blocks of integrated care, incorporating the essential elements of continuity.

At the heart of this model, and many of the locally developed descriptions of integrated care, is an understanding that better care starts, and ends, with individuals. As such there is no one set of solutions which will work everywhere, or for everyone.

However, by looking at the evidence for what is and isn't working right now, it is possible to identify common areas for improvement; and in parallel, common enablers of those systems that are functioning today to achieve better outcomes.

Better co-ordinated, person-centred care means being able to identify those at greatest risk, both on an individual and population level, at the earliest possible stage. It means being able to co-ordinate across organisational boundaries to understand the capabilities and meet the needs of such individuals, their carers and families. It means having the right support, in the right place, at the right time to keep people healthy, and to safeguard their independence. And it means being able to shift and manage resources, across organisational boundaries, to where they will have the greatest short, medium and long-term effect.

This implies for each local area, the ability to:

- understand existing high users of health and care services, and those at risk of losing their independence in the near future.

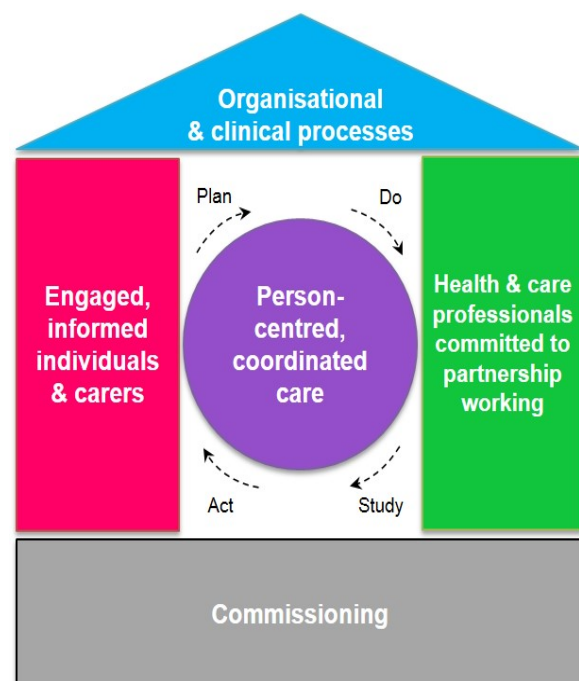


Figure 7: The “House of Care”, NHS England

The North West London Integrated Care Pilot (ICP) has created a patient registry that covers the population and used associated data from all settings of care. Initially diabetic and elderly care pathways were rolled out at inception of the pilot; COPD, and cardiac pathways were then developed. Currently the ICP focuses on segmenting individual patients by risk, enabling the planning of proactive care. The Outer ICP covers a potential population base of 1.2m registered patients, covering 223 GP practices; approximately 140,000 fall within the current criteria for receiving integrated care.

This includes consistent screening for common problems, improved detection and management of clinical and social issues, and proactive discussion with individuals of how their health will be managed in future. Undiagnosed clinical conditions were identified in 20% of participants. 12% were supported to initiate a significant change to their social situation. 88% of patients discussed their health related goals for the future and developed an action plan to reach these goals and 38% of patients began anticipatory care planning.

- **develop a joined-up plan** for ensuring individual physical, mental and social wellbeing, a plan which builds on the capabilities of the individuals concerned, develops with them a clear understanding of their goals and needs, and of the support required to keep them independent and well.

“Gesundes Kinzigtal” (GK) was formed in 2006 in the Rhine Valley of South West Germany and based around 20 preventive and health promotion programmes for specific conditions. The programme uses a “gain share” model between GK and the two sickness funds covering the total costs of care for the population.

The care management programmes are secondary-prevention focused on developing individual treatment plans and goal-setting agreements between doctor and patient, enhancing patient self-management and shared decision-making, a chronic care model and stepped care approach, together with investment in patient coaching and follow-up care.

GK currently serves 33,000 people. Life expectancy of GK patients has increased by 1.5 years relative to controls, with significantly less chance of hospitalisation (an increase of 10.2% compared to 33.1% in the control group) and a 15% reduction in nursing home admissions.

- **develop a joined-up workforce**, capable of working with individuals, their carers and families to put this plan into action: co-ordinating help and support across primary, community, acute health services; local voluntary, community and informal networks of support; and the full range of local government services, including housing, social care and public health.
- **have the ability to react** in a timely, co-ordinated and consistent way when emergencies arise, aligned with the long-term support and goals of the individuals concerned.
- **ensure that the right resources** are in the right place, at the right time, with joint responsibility for delivering high-quality, joined-up care; the ability to commission outcomes for the whole person; and to direct funding to ensure these outcomes are met in the most sustainable way possible.

Greenwich Integrated Care consists of 3 integrated teams – the Community Assessment & Rehabilitation Team (CAR), providing up to 6 week rehabilitation and social care linked to and working with home care reablement; the Joint Emergency Team (JET), providing fast immediate responses to prevent hospital admission and urgent social care referrals; and the Hospital Integrated Discharge Team (HID), supporting speedy discharge to intermediate and social care.

The teams have been responsible for overseeing reduction in A&E admissions, working with GPs to refer to JET rather than hospital; reduction in hospital admissions, maintaining a presence in A&E and AMU, 8am-8pm, 7 days a week; and a 7% reduction in admission to care homes per annum.

- **provide timely and appropriate access to information** for the health and social care professionals who are tasked with supporting people, with informed consent of the individuals themselves.

Putting Patients First (PPF) is a web portal that allows integrated care packages to be delivered virtually - increasing co-ordination and transparency between services, reducing duplication and allowing remote multi-disciplinary team meetings.

Already covering 3.5 million patients across 528 GP practices nationally, its recent implementation in the Isle of Wight is being accompanied by the introduction of Patient Passport – a handheld card owned by the patient providing access to their health data, which they can present at the point of need.

- **develop individual capabilities** to manage their own health and wellbeing, including through investing in self-management, care navigation, time-banking, personal budgets, and community support.

Cumbria Community Foundation is a jointly commissioned programme by Cumbria County Council and Cumbria CCG, with 6 locality partnerships of over 30 voluntary and community organisations. The emphasis is on developing community capacity and volunteering by building on local assets, harnessing the expertise of communities and the voluntary sector including Age UK, the Red Cross and others to develop local solutions to local needs.

Advice and access to equipment, small adaptations, handyperson schemes, and other practical help such as decorating and gardening are all key features of the programme. Trusted Assessors ensure that the right options are offered to customers in each locality. Support for people who return home from a spell in hospital is integral to the scheme. Older people and others are encouraged to keep active and healthy by participating in volunteering or offering their skills through time banking.

In 6 months over 3,000 people have received help and support through the Neighbourhood Care Programme, with plans to recruit 1,000 volunteers and undertake an external evaluation of outcomes through the Institute for Public Care at Oxford Brookes University.

- **provide the required technology and adaptations** to enable people to live independently for as long as possible, safe within their own homes or communities.

The Scottish Government reviewed the evidence on the cost effectiveness of preventative support services that assist older people with care and support needs to remain in their own homes, by contrasting the costs of these preventative support services with the costs of specialist housing options, such as sheltered and extra care housing and also with the costs of health services, as part of reviewing the value for money of preventative support services (PSS).

They estimate that 32% of older people whose housing has not been improved or adapted are at risk of a fall during the course of one year, which could result in hospital admission, community health service use and / or a need for social work department funded support. By contrast, the estimated annual rate of falls among those older people whose housing has been improved or adapted by care and repair / HIA services was 10%. On top of this they estimate that 9% of older people whose housing had not been improved or adapted would need to make a move to sheltered housing during the course of one year. This compared to a rate of 5% of those whose housing had been improved or adapted by care and repair services. They also estimated a 10% reduction in the number of older people requiring personal care funded by social services (i.e. social work service funded care).

Summary

It is difficult to reduce whole-system, integrated care to a simple “checklist” of enablers, but there are a number of components which appear across successful systems of co-ordinated person-centred care. These include being able to:

- identify those at greatest risk, within the total population
- develop a single assessment of a person’s physical, mental and social needs
- build a care plan, focussed on shared priorities with the individual concerned
- co-ordinate and share information across local health and care services
- invest in joined-up teams of health and care professionals to deliver planned care
- align funding around meeting the needs of individuals into the medium and long-term
- respond in a timely and joined up way to emergencies and the process of recovery
- develop a clear strategy for shifting resources from acute to community services
- govern this change, with clear local accountability and engagement
- invest in individuals and communities to maximise their ability to manage their own wellbeing

The Business Case for Whole System Integrated Care

“In five to seven years we get to the point where it starts to restrict our ability to do anything very much else. Over a 20-year period, unless there was really radical corrective action, adult social care and children’s services would need to take up the totality of our existing budget.”

Nick Walkley
Chief Executive
London Borough of Barnet
May 2012⁹

“Our analysis shows that if we continue with the current model of care and expected funding levels, we could have a funding gap of £30bn between 2013/14 and 2020/21, which will continue to grow and grow quickly if action isn’t taken.”

David Nicholson
Chief Executive
NHS England
July 2013¹⁰

PACE

The Programme for All-inclusive Care of the Elderly (PACE) in the USA has evidenced a 63% reduction in nurse visits, a 52% reduction in inpatient days, a 52% reduction in nursing home admissions, with high levels of staff and patient satisfaction.

Greenwich

In the first twelve months of implementing Greenwich Integrated Care, the re-design enabled an immediate 5.5% productivity saving on the health services in the borough, and a saving on the social care budget of £900,000.

The story of health and social care in England is often written as one of crisis, but it is important to remember how much of this is driven by another story – one of success.

Between 2001/02 and 2011/12 net NHS expenditure increased from £49 billion in to £104 billion.¹¹ That investment flowed into developing existing and new hospitals, primary and community care services.

In parallel, local authorities were empowered and committed by successive acts of parliament to develop systems of social care to provide practical care and support for those who need it, designed to enable people to retain their independence and dignity. Gross current expenditure by CASSRs (Councils with Adult Social Services Responsibilities) on adult social care in 2011/12 was £17 billion, an increase over the same ten year period of 33%.¹²

As a result of progress in medical science, public health, and the provision of associated health and care services, people in England can expect to live longer than ever before.

Expectations of the quality of life and care they can expect have also been, rightly, raised.

⁹ David Brindle, ‘Graph of Doom: a bleak future for social care services’ from *The Guardian Online*, London, 2013, <http://www.theguardian.com/society/2012/may/15/graph-doom-social-care-services-barnet>

¹⁰ Call to Action, NHS England, 2013, <http://www.england.nhs.uk/2013/07/11/call-to-action/>

¹¹ Key Statistics on the NHS, NHS Confederation, 2013, <http://www.nhsconfed.org/priorities/political-engagement/Pages/NHS-statistics.aspx>

¹² Personal Social Services: Expenditure and Unit Costs - England, 2011-12, Final Release, Health & Social Care Information Centre, 2013, <http://www.hscic.gov.uk/article/2021/Website-Search?productid=10667&q=social+care+expenditure&sort=Relevance&size=10&page=1&area=both#top>

The models of health and care that have developed in England over decades to support people to live well are now struggling to keep up with demand.

- The treatment and care of those with long-term conditions already accounts for 70% of the primary and acute care budget in England.¹³
- In a 1 year study of 133,055 people aged 75 and over, 71% of those receiving social care had also made use of one or more hospital service.¹⁴

Simply demonstrating that what we have now is no longer sustainable, does not make the case for specific models in the future - not least because millions of people rely every day on what we have now.

If new ways of providing health and social care are to become the norm, then there is a need to demonstrate that they are better for individuals, and affordable for society as a whole.

As with any major change, better care will require investment.

However, one of the strengths of an integrated approach is the potential to convert a negative cycle of growing demand, limited resources and deteriorating outcomes into a positive one - with the value created when individuals work together in a co-ordinated way being “locked in”, and the benefits reinvested into better services and better outcomes for the future.

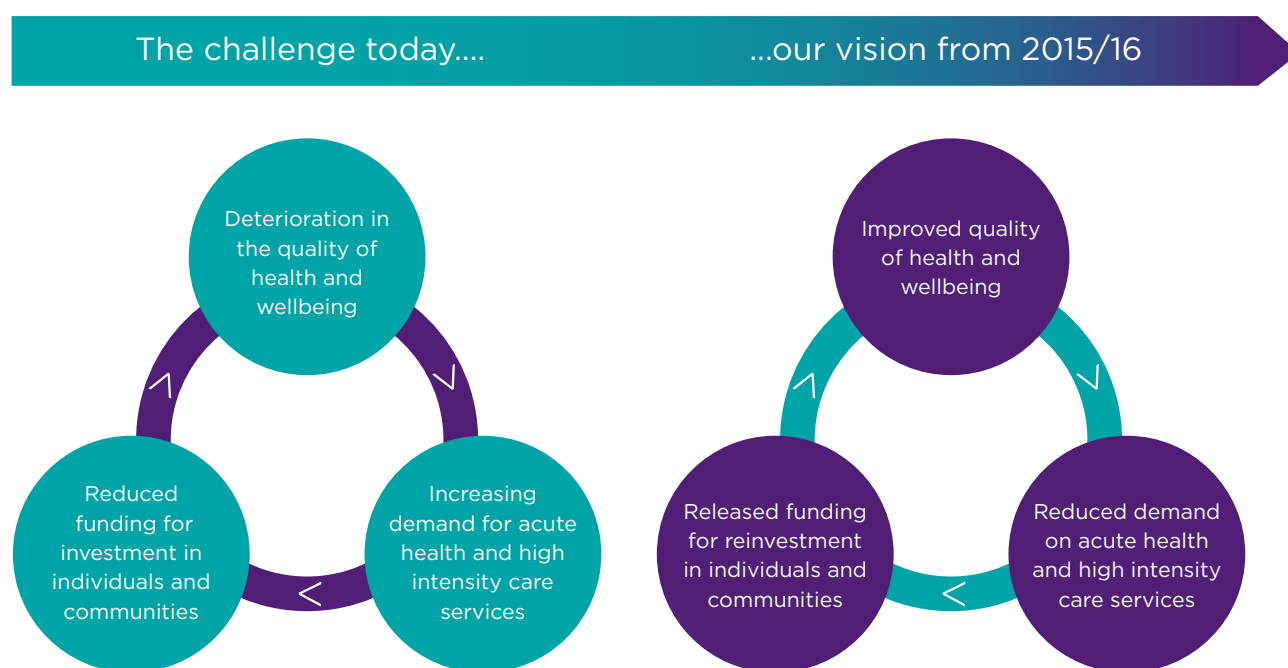


Figure 8: The value cycle

¹³ 'Ten things you need to know about long term conditions'; Department of Health, 2011

¹⁴ Bardsley, Georgioui, Chassin, Lewis, Steventon, Dixon, 'Overlap of hospital use and social care in older people in England', from Journal of Health Services Research & Policy, 2012

Rolling out person-centred, co-ordinated care at scale across regional populations and across the country as a whole has the potential for enormous impact on the way we live our lives and the way that our public services operate.

The national and regional context for integration is important: initiatives are likely to have a greater impact if they are part of a larger scale scheme that is clearly thought out and provides a framework within which local changes can be developed and assessed. Many successful initiatives have depended on financial incentives, for example providing extra funding for providers to develop new services or to re-organise services, which if meaningful are likely to have significant consequences for existing models of health and care provision and funding.

The investments required to scale integrated care are significant, but are more than matched by the returns.

The Partnership for Older People Projects (POPP), which received £60 million funding from the Department of Health and involved over 250,000 people found that for every extra £1 spent on the POPP services, there was approximately £1.20 saving on emergency bed days. Overnight hospital stays were reduced by 47%, the use of A&E departments by 29%, and therapy and clinic / OPD appointment reductions saved £2,166 per person .

The national Telecare Development Programme (TDP) for Scotland is estimated during the period 2006-2010 to have delivered a very significant gross financial benefit of some £48 million, from an investment in telecare of some £12.6 million nationally (including match funding). The collective impacts of telecare included avoidance of some 6,600 unplanned hospital admissions, avoidance of some 2,650 residential care and nursing home admissions, and avoidance of some 411,000 home check visits to monitor the wellbeing of older people and other groups .

Reconfiguring services which often transcend local boundaries will require co-ordination across different Health and Wellbeing areas, but will remain grounded in securing local clinical, professional, patient and service user, and community support.

There is general consensus that person-centred, population-based care with both vertical and horizontal integration of health and social services, with a single point of entry and one assessment process, offers the greatest benefit. Greater Manchester, North West London and other regional collaborations across the country (including Wales) provide the basis for mapping out the potential impact of combining local co-ordination of care planning and delivery with targeting resources across a broader population area.

For a region with a population of 1,000,000 implementing a Whole Systems approach such as that in Waltham Forest, East London and City (WELC), an expected reduction of 34,804 in non-elective admissions might save up to £71m in one year.

The impact of applying a Whole Systems model similar to that in Kinzigtal, Germany could result in £32m social care savings and £82m in savings through reduced non-elective admissions in one year.

The impact at a national level for England is similarly significant. A £5.1bn saving, comprising of £1.7bn savings from social care and £3.4bn savings from non-elective admissions in one year, figures which are particularly pertinent in the context of current financial and demand pressures on local government and on the country's hospitals.

On top of financial and activity impact, there is real evidence that highly integrated systems that emphasise continuity and co-ordination of care are associated with better patient experience.

Summary

The business case for person-centred, co-ordinated care is about:

- transcending boundaries to target resources where needed across a population
- providing high-quality care, which is fit for purpose and sustainable into the long-term
- relieving pressure on acute providers across the country
- increasing efficiency of public services, creating added value for every pound invested
- proactively managing the increase of an ageing population by developing social capital
- delivering care that is based on the involvement of those who receive services as much as those who provide and commission them

Conclusion

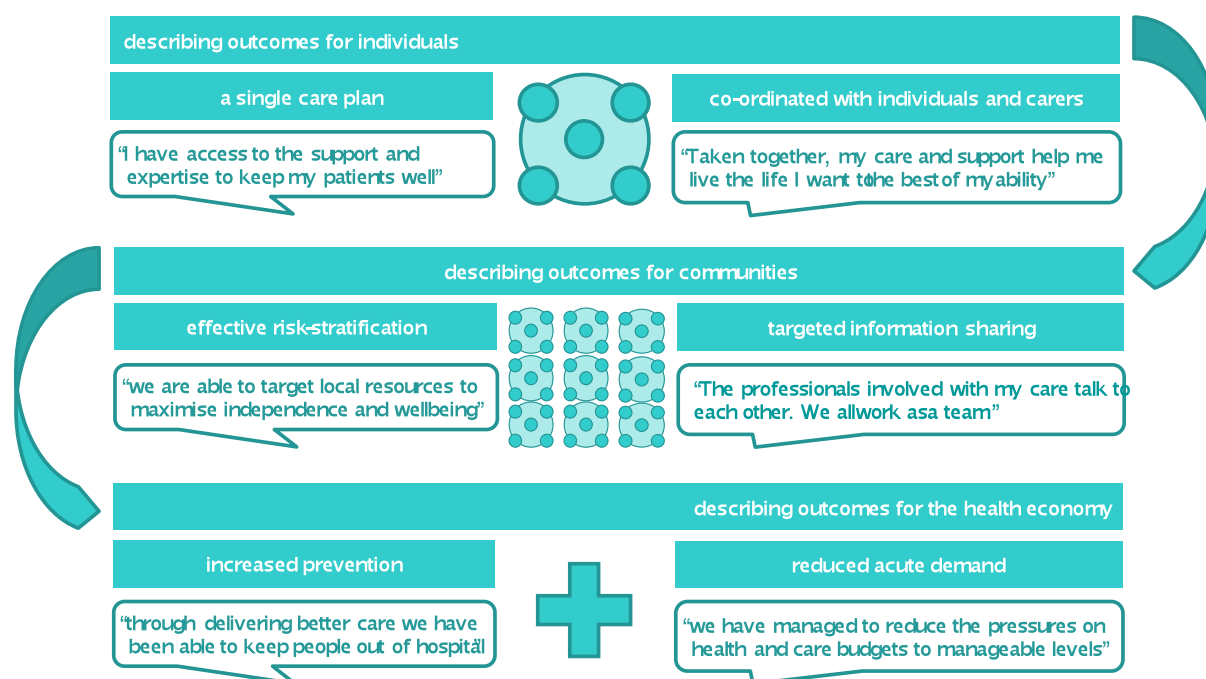


Figure 9: From individual to whole economy outcomes

Returning to Mrs Smith in Torbay and the millions like her nationwide provides the drive to do things differently at an ambitious scale, as well as the mechanism for understanding the complexity of the way in which services are delivered today, and describing how they can be improved.

Many localities have developed their own "Mrs Smith" personas as an instrument to ground complex transformation in the experience of the patient or service user at all times.

One of the key lessons learned by those involved in developing the Integrated Care Trust in Torbay was to continue to base any strategy on the vision for and benefits being sought for patients and people who use services (i.e. Mrs Smith) to create a compelling narrative. Their tips for success are to specify these in advance, communicate them constantly, invest in improving them, and monitor improvement.

The Isle of Wight credit their ability to capture their roadmap towards a person-centred, co-ordinated vision of care in a way which is understandable to many audiences and clearly demonstrates the positives of the change for all those involved as central to the success of their integrated care programme "My Life, A Full Life".

Communicating a business case, or a case for change, in language that is relevant and meaningful to the particular audience – patient, NHS manager, or third sector care provider to name but a few – cannot be underestimated. **Effective communication is key to securing genuine partners as opposed to stakeholders on the journey towards delivering whole system integrated care**, and cementing these new relationships is crucial to achieve effective joint working.

Overall, person-centred, co-ordinated care will deliver significantly greater individual and collective value for less resource, but only by equipping key stakeholder groups with both the narratives and numbers to make this case locally will the benefits be delivered.

This value case is the beginning of a narrative that can be adopted and developed by patients, people who use services, carers, GPs, health and social care commissioners and providers, local and national politicians.

The next step is for local areas to jointly shape and take ownership of the narrative and leverage the wealth of resources on integrated care that are already in existence. By doing so, we can harness the potential for ground-breaking system change over the coming few years, improving the quality and experience of care for individuals whilst creating a sustainable legacy of public services for generations to come.