Rethinking the integration agenda

A discussion report from the Good Governance Institute

Giving people a life, not a service

Rethinking the integration agenda: a discussion report from the Good Governance Institute

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Creating sustainable care for the future will require an integrated approach that embraces housing, health and social care. However, that approach remains an ideal, and one that shows few signs of becoming a reality. This paper draws on the experience and expertise of a range of commentators to understand what the obstacles to integration are, and offers practical ideas on next steps.

Integrated care as an aspiration is simple, and simplest if one begins with the needs of the patient or user. Unfortunately, the ideal of patient-centred care all too often remains just that – an ideal, and not a reality. Failures in leadership, management and organisational systems dog our care services, often at great expense and more importantly at an unacceptable cost to patient safety.

This papers identifies some of the reasons why care services have not developed further and faster than they have, including:

1. **Organisational Obstacles**: Frontline staff live with the day-to-day consequences of a failure to integrate. At the top of organisations, however, we often find not just a lack of exposure to the effects of poor integration, but perverse incentives to resist it. Doing a good job too often does not favour collaboration across departments, and being a champion for the needs of patients rather than services and organisation is generally not the easy option.

2. **Systemic Obstacles**: When we move out of the institution into the world of partnerships and systems, we discover a key obstacle to integration. We can talk about the boundaries between health, housing and social care, but the reality is that housing is generally so far removed from the other two that there is no boundary; it is sadly to be found on a separate map. Although safe homes, community networks and other supports for good living are often cited as essential to good care solutions, these sectors seldom make it around the table.

3. **Public Engagement**: Integration has been linked strongly with empowerment and enablement of patients, users and carers. The public, as patients, clients or carers, might be expected to be strong advocates and supporters of new style services. Too often, in practice, strategies that have been designed to improve care fail to take account of public and patient views, creating powerful opposition regardless of the actual merits of the plan.

4. **Politics and Policy**: It is difficult for politicians to champion longer-term changes that may prove contentious in the short term. A powerful example is the regular controversy over closures of beds and even hospitals, forcing local MPs into defending short-term expediency over longer-term improvement. Politicians, it was felt, should be included in changes in care and given support to engage their constituents in real consultation.

The report identifies three key pathways to addressing these issues:

A. *Good living pathways* should inform how we think about care services.

This demands that we include housing and community supports, as well as health and social care professional services. The omission of housing and community-based assets from the current debate needs to be corrected immediately. Locally designed, but nationally mandated, this new broader approach to integration will lead to the outcomes the public themselves want.

B. New cultures of care

Current organisational cultures constrain real-time integration. We need to refocus our work in line with the cultures of care we aspire to. Co-production of care with service users needs to be developed. Collaboration across boundaries by staff needs to be incentivised and prepared for, from basic training onwards.

Alignment of organisations around shared outcomes is essential. Health and Wellbeing Boards are best placed to lead this, but as yet lack capacity.

C. Investing in new enabling technologies

Technology now offers new and cost effective solutions. These range from personal care navigators, new budgeting systems, digital information resources through to assistive technologies.

Of course, new technology creates teething troubles for most industries. Care services that deal in empathy, relationships, knowledge of conditions and many other complex human factors have understandably found this more difficult.

Leaders now need to benchmark service planning in line with new models of support, and to focus on public entitlement. Failure to pave the way for gains in the future from emerging technologies is a dereliction by local leadership. Investing in and unlocking the potential of information technologies, engagement strategies and assistive technologies should be the norm and not the exception.

Next Steps

With this in mind, we have devised a series of eleven principles and proposals under five broad themes:

A.   Creating a new paradigm of care

B.   The role of central government

C.   The role of local leadership

D.   The role of economics

E.   The role of the organisation

1 Introduction

Creating sustainable care for the future will require an integrated approach that embraces housing, health and social care. However, that approach remains an ideal, and one that shows few signs of becoming a reality. This paper draws on the experience and expertise of a range of commentators to understand what the obstacles to integration are, and offers practical ideas on next steps.

The Good Governance Institute (GGI) convened an expert group in April 2013, bringing together leading experts from health, housing and social care, including clinicians, nursing representatives and NHS commissioners. The group agreed the clear imperative for action to achieve integrated care, explored the current landscape and considered the best ways forward. That meeting generated an initial paper and GGI has since undertaken a further round of consultation that has enabled us to develop our thinking into this report.

Integrated care as an aspiration is simple, and simplest if one begins with the needs of the patient or user. Starting from here, the care response is determined and shaped to meet the user's needs – to treat them if needed, to support their recovery and to help them regain and maintain the best possible quality of life. Those providing different elements of the response required to achieve those outcomes work together to ensure the overall outcome of the user's general safety, health and wellbeing. A reasonable aspiration that would not seem to require much rocket science.

Unfortunately, failures in leadership, management and organisational systems dog our care services, often at great expense and more importantly at an unacceptable cost to patient safety. These failures are serious and, if not addressed, threaten the very sustainability of public care. To quote a statement given ringing endorsement in our consultation: "It's not whether but when. If we don't sort out the care system, it *will* collapse. And the debris will be a national crisis."

So how has this crisis been allowed to develop, and why do the various services charged with addressing the problem seem so incapable of decisive action? This report considers these questions, explores a variety of solutions, and sets out the case for radical change. In particular, we identify three key shifts that are needed across all care services. Shifts that need to start happening now.

2 An informed view of the current landscape

We first need to dig deeper into why we find ourselves in this situation. This report draws on the views and expertise of a group of people from across care services with decades of experience in delivering, managing and leading services. All have one thing in common: they are all advocates for integration. However, despite best efforts and some successes, they recognise that they failed to make that breakthrough across the system. Their accounts describe the terrain, and give a glimpse of the challenges ahead.

2.1 Inside Organisations

On the front line, the effects of poor integration are often easy to see: lack of coordination of care, staff not sharing information, duplication of effort and brick walls separating one part of the system from another. At the top of organisations, meanwhile, we often find not just a lack of exposure to the effects of poor integration, but perverse incentives to resist it. Doing a good job too often does not favour collaboration across departments, or building care around ones individual's needs. Being a champion for the needs of patients rather than services and organisation is generally not the easy option.

Leading organisations rely on promoting the needs of that organisation, focusing staff on internal performance and reporting on *your* success, not that of another organisation. Leading organisations through change also means making hard choices; learning how to do things in new ways is relatively easy, stopping doing things in old ways is more difficult. A common fudge is to run new approaches as "projects" and then fail to mainstream them.

What we can see from the different pressures and experiences encountered at different levels of the organisation, is that integration creates winners and losers. Some of the factors at play here include entrenchment over staff conditions, protectionism by professionals, resistance over role changes and perceived threats to individual careers. At organisational level the loss can be more dramatic, with potential loss of resources in terms of budgets, beds and staff.

When proven models and case studies become available, experience shows that these regularly fail to be adopted. Of course, change often involves investment and redirection of resources, and public services have a very low risk appetite. But the greater risk lies in not changing.

2.2 Within the System of Care Organisations

When we move out of the institution into the world of partnerships and systems, another set of challenges arise.

For the elderly, integrated care will stretch into a wide range of care needs. With the early work on care pathways (often disease specific) we see great energy and creativity to work collaboratively, and there have been many successes. Each initiative in its own way has had to overcome common themes and problems.

We can talk about the boundaries between health, housing and social care, but the reality is that housing is generally so far removed from the other two that there is no boundary; it is sadly to be found on a separate map. Although safe homes, community networks and other supports for good living are often cited as essential to good care solutions, these sectors seldom make it around the table.

It was unanimously agreed by our group that the real challenge to joint working lies in cultural barriers not structural ones. Lack of familiarity between professions, different attitudes, standards, management styles and of course patterns of working were the most dramatic influences in integration projects.

The problem starts in the very way we think about services. Integrated care has the hallmark of systems that are designed around outcomes and where the person is at the centre of all decision making. These new approaches are of course found in parts in many services. Experience suggests again that this entails a radical overhaul of how we deliver services.

Then there is how to resource and fund new integrated ways of working? As a general rule, funding was and is a major impediment to radical transformation and, without national direction, a tough nut to crack. The way through may involve aligning rather than pooling budgets while at the same time reshaping teams and incentives in line with a 'mutual benefit' system. Other ideas included integrating authorities, co-location, linking people and budgets, funding managed by the citizen (with corresponding tax incentives) and changing funding at service level.

Healthcare is free at the point of delivery while social care is not. Reforms to funding regimes are therefore essential. There are signs the debates are changing, with proposals such as 'year of care' tariff for patients and an overhaul of current payment systems.

Organisational structures of many types lead to disintegration but perhaps the primary culprit is a lack of information-sharing, resulting in a painful process for the patient or user navigating care. There are areas where there have been real achievements, but investing in mechanisms to draw information together and work around patient-owned data is essential.

2.3 The Public and Integration

Integration has been linked strongly with empowerment and enablement of patients, users and carers. The latter has for some time been seen to be a good thing. In practice, however, the demands of professionals, systems, organisations and established cultures get in the way, and distort priorities.

The public, as patients, clients or carers, might be expected to be strong advocates and supporters of new style services. Too often, in practice, strategies that have been designed to improve care fail to take account of public and patient views, creating powerful opposition regardless of the actual merits of the plan. This highlights a demanding task in itself – that of wholescale and meaningful public engagement. This involves changing expectations, providing information and ceding the power to demand change.

Given the existing barriers within health and social care, drawing housing into the mix will need an even higher level of intervention, in terms of policy as well as practice. However, a broader care debate will platform and promote new ideas on positive living. One example is the growth in *older people villages*, where home becomes a core part of the care agenda and a lever for change.

Despite a growing number of new approaches to care, the systems we use to measure effectiveness have not been recalibrated to work for these approaches, resulting in a lack of hard and compelling evidence to drive integration forward.

The priority becomes how to empower individuals. This might involve direct support, perhaps from a new type of care role, which might be termed *care navigator*. Care navigators would advise users, broker discussions with professionals, and ensure co-ordination across different services. This will involve changes in the role of the citizen, from passive recipient of care to active partner – a transition that may be supported by connecting patients and costs, delivery charges on outcomes, but some sanctions too at individual and organisational levels.

We already have access to tools that can support and even lead integration initiatives. Three major tools are telecare, informatics and care brokerage. Telecare has created security and support for patients and professionals and allowed high quality care to be developed. The absence of strong co-ordination with housing has seriously delayed the take up of telecare over the last three decades, though what is referred to as professional technophobia has also contributed. These examples however highlight the need for commissioners to understand and use such resources.

Finally, policy to unlock resources to provide care in later-life from the assets of the service-user and their family are perceived as punitive rather than supportive of those who have saved for their old age. To get the public onside the tax and care benefits systems will need better alignment.

2.4 Politics and Policy

There was disagreement over the role politicians can and should play in leading these changes. Our group recognised that it is difficult for politicians to champion longer term changes that may prove contentious in the short term. A powerful example is the regular controversy over closures of beds and even hospitals, forcing local MPs into defending short term expediency over longer term improvement. Politicians, it was felt, should be included in changes in care and given support to engage their constituents in real consultation.

A further tension is between central dictat and local determination. Some of our group proposed that these changes could not be achieved without strong national prescription, albeit leaving implementation to local control. This, we have to conclude, is an area for further discussion, and consideration of national and international evidence relating to the type of policy that supports sustainable longer term outcomes.

At a local level, GPs, CCGs and Health & Wellbeing Boards are now the key leadership groups. The change programme, whatever it is, needs to start with them. However, there were concerns that HWBs, while a critical group, lack visibility and capacity.

3 Highlighting the Barriers

If the care system presents innovators with a rather hostile environment, what can be done? GGI feels there are lessons to be learned from our own experience over the past ten years of leading the integrated governance movement. Organisations have perpetuated siloed thinking, and this disadvantages both the organisations concerned and those using the services that the organisations provide. From our experience there is a clear menu of issues that local leaders need to address, and national policy makers need to insist on. The findings that emerged from the summit very much echo our work to date published under the Governance Between Organisations (GBO) banner.

3.1 Culture

Cultural divides within and between organisations are at the heart of problems of ownership and implementation. The issues of culture cover attitudes, understanding between groups, alternative priority setting, risk appetite and willingness to embrace changes in roles, responsibilities and practice.

Quote: "We know that our biggest challenge is cultural change, while much of what we actually work towards is structural change. There has to be a new culture around outcomes not process."

3.2 Organisational structures

Across all three sectors there are barriers that actively work against integration, in accountability, decision-making, priority setting and incentives. A key issue is where the power and control over budgets lie. The emergence of new bodies such as CCGs and HWBs in themselves do not facilitate integration; it is the links, when supported by constructive behaviours, that are critical. What is required is clear collaboration on overarching goals, efficient coordination of systems and support for front-line co-operation.

Quote: "Money follows the patient, but patients just follow the well-beaten path to the hospital."

3.3 Risk management

Shared management of risk is an important conduit to integration. Nevertheless there are blocks to this approach which counteract the willingness to accept accountability for decisions. At present our understanding and management of risk is largely embedded within individual organisations, and while risk can be managed, the default position is often for collaboration to be undermined by traditional risk management practices.

Quote: "Resolving the systemic problems demands we work as if one organisation. If we are serving the same population, then we need person-focused outcomes as our mutual aims."

3.4 Resources

Across health and social care, as well as housing, incentives and funding streams act as deterrents rather than enablers of integration. Funding at a time of declining resources can be the primary barrier, limiting the access to 'bridging' resources that are needed to facilitate change and introduce new models of service. While funds were critical there was an important dimension of time needed to implement changes that again can limit the uptake of proven models of integration.

Quote: "What we have always underestimated is the length of time these root changes take. You spend two years in planning, two years in implementation – then just as you are nearly there, people and organisations change again!"

3.5 Policy drivers

Varied opinions emerged from our summit about whether policy should be prescriptive or left to local determination. Some felt that without strong direction, integration would fail to be a priority or would simply not be implemented. Localism was viewed as both an opportunity and a hurdle, and this issue remained contentious in the discussions. The overall experience of GGI in other fields is that central direction can be a useful, if somewhat blunt, instrument. However, if not supported by concerted efforts to win hearts and minds locally then change simply will not happen.

Quotes: "If you want to make a sea change you have to be prescriptive. Don't say you should, say you will!" "If you want the changes to stick, they need to be owned by the people."

3.6 Politics

Given the length of time that integration has been on the agenda, many see a lack of political leadership in the important role of public engagement. Poorly presented hospital closures and unexplained changes to services, which mobilise public resistance, are symptomatic of politicians unwilling to lead. Public and politicians need a clear vision of care that firmly implants integration within public expectations. The trend for politicians to reorganise has been highly damaging, as integration developments can become the victim of stalling while new bodies are created and new roles established.

Quote: "There is no avoiding the politics in this. I would argue for more politics at a local level – they have to go out and engage, where Westminster perhaps feels that need less."

3.7 Best practice models

There are many models and many success stories. Where these have been nurtured by senior clinicians and managers, they offer evidence of the added value and improvement in quality of care. However, despite the successes, case studies on their own fail to drive mainstream change and often the level of proof needed is disproportionate. Individual leadership can create change in local settings, but still face problems in generating broader adoption and cross fertilisation of ideas.

Quote: "There are some really good models of integration around, demonstrating effective sharing of resources, good leadership, and people letting go of power. But they don't get taken up by others in the area. This shows that leadership is vital to making this happen."

3.8 Change Management Costs

Change takes time and energy. Culture change, a key part of any successful integration, is by its nature a long-term task. Where services fail to set aside the resources for this transition, leaving it as an addition to the day job, real change is much more difficult to achieve. Funding the engagement, training and development work that goes hand in hand with successful culture change is a priority. Pooling resources can ease the burden of enabling culture change, while a failure to change affects both service users and the overall public purse.

Quote: "We need to accept that integration will take time and investment, and each locality will have its own issues to manage. We also need to encourage some quick wins."

3.9 Public understanding

This is critical if integration is to become core practice, as both a driver of change and to support shifts in resources. Patient-centred care is now an accepted part of the conversation, but until it drives a broader range of decision-making and patients themselves play a more significant role, the previous nine barriers will not be overcome.

Quote: "People have to believe what happens on their patch. We need to get the service user to deliver the argument for you"

4 Seismic Shifts: Three Key Ways To Effect Change

At the heart of our proposals is an overarching principle of "giving people a life, not a service" and, despite the challenges detailed above, there is cause for optimism that this can be achieved.

The time of tinkering has to be over; root and branch changes are now the only way forward. The essence of what is needed is captured by the short phrase above and, to achieve this shift, the narrative around our care services needs to be simple and clear to drive real transformation.

Important though the money is, the major challenge is in the style and culture of our care givers and services. We can be optimistic that political parties, the public and many professionals now recognise the importance of these changes. We are also entering a time when rapid advances in behavioural and other sciences offer us new approaches to care. Last but not least, the threats to sustainability of traditional care services are now more visible and demanding of action.

Our group was able to come up with three key policy steps that would foster the changes needed:

4.1 Whole person care defined through *good living pathways* should inform how we think about care services.

This demands that we include housing and community supports, as well as health and social care professional services. The omission of housing and community-based assets from the current debate needs to be corrected immediately. Locally designed, but nationally mandated, this new broader approach to integration will lead to the outcomes the public themselves want.

These good living pathways need to translate into funding, audit, performance management and staff development. A new positive public debate, focused on what care services do well rather than chasing wrongdoing can help release the innovation needed. Introducing a common care agenda across commissioners, providers and upheld by regulators, government and funders will help leap the hurdles.

4.2 New cultures of care

Current organisational cultures constrain real-time integration. We need to refocus our work in line with the cultures of care we aspire to. Care is not a production line process, and we now need to invest in the skills, attitudes and supports that recognise that. This marks a new era for our public services and needs a highly public and transparent Care Conversation.

Co-production of care with service users needs to be developed. Collaboration across boundaries by staff needs to be incentivised and prepared for, from basic training onwards. Co-location and sharing good practice needs to become the way we work here.

Cultures are maintained and shaped by organisations and their leadership, but structural change will not change culture. Alignment of organisations around shared outcomes is essential. Health and Wellbeing Boards are best placed to lead this, but as yet lack capacity.

Cultural divisions are especially profound when we include housing and community-based staff, and the gap widens further when we give power to the users themselves. Dismantling old ways of working will need strong, indeed brave, leadership. However, the culture needed to create ownership among the public of their services is not unique to health or care – perhaps in that there lies the drive we need for real reform.

4.3 Investing in new enabling technologies

Re-routing resources and reducing barriers to the funding of new innovative technologies is essential. Technology now offers new and cost effective solutions. These range from personal care navigators, new budgeting systems, digital information resources through to assistive technologies.

Of course, new technology creates teething troubles for most industries. The finance sector adapted with speed, but they were dealing with a simple commodity – money. Care services that deal in empathy, relationships, knowledge of conditions and many other complex human factors have understandably found this more difficult. Yet slowly the benefits are beginning to come through.

Rebalancing investments to support positive living options rather than maintain disjointed services is a priority. New technologies and new care paradigms are coming on stream very fast. Our work with boards suggests many having only a limited understanding of the new possibilities that technology is opening up. Leaders now need to benchmark service planning in line with new models of support, and to focus on public entitlement.

Technology moves quickly. Auditors and regulators need to catch up, and to monitor what is not being made available to local populations. Whether agencies, associations, trade unions or others like it or not, this necessarily entails that Government provide direction to support transformation.

These three overarching principles need to be embedded across the public service. Horizontally, all sectors, providers and commissioners need to play their part. Vertically from Parliament down to front line teams, and from workload management to high level strategy, these now need to drive our futures.

5 Next Steps

Change does not happen overnight, and we recognise that significant change takes even longer. However, it is important that we do what we can today to stimulate integration, however long it takes to create an integrated care system in the end. With this in mind, we have devised a series of principles and proposals under five themes:

- **A. Creating a new paradigm of care**
- **B. The role of central government**
- **C. The role of local leadership**
- **D. The role of economics**
- **E. The role of the organisation**

We believe these must inform organisational and individual thinking throughout the sectors in question, as a matter of urgency.

A. Creating a new paradigm of care

People rather than systems must drive the debate. We must start with how people, whatever their age or health condition, can live well.

When this happens, integration emerges as a priority. Our proposal is to initiate a new conversation, drawing in the public, patients and families. This conversation will give individuals support through brokers or navigators to plan ahead early in their life and care journey. It will include communities, managers, local leaders and politicians charged with redistribution of resources across our society, for it is our society that is our care system, locally and nationally.

This demands that all services enact a new accountability, built around health and life outcomes and early action on need. This accountability will translate into new metrics on experience of care alongside clinical and care outcomes and resource efficiency.

Quote: "We are clear here that if we start to integrate current services, then we are unlikely to achieve real change. If we start by empowering users, giving them the power to shape their services, we can achieve better outcomes. If we empower the user, they then empower themselves."

Quote: "There are many examples of engagement and empowerment that deliver real change on the ground. It needs commitment, investment and follow through. We are awash with examples of failures to engage, from hospitals straining at the seams through to hospitals we do not need but stay open."

Housing needs to sit alongside health and social care as part of a wellbeing solution.

We believe that central direction is essential in this respect, and should not be seen as out of line with local solutions.

With our new *Living Well Pathways*, housing and life at home become part of the solution. We need to recognise the importance of owner-occupiers and how we include this large group, as well as housing associations and other voices. Although it is ultimately a question for the Treasury, we believe it is time to look at how our tax system can contribute to this new era of life planning.

Quote: "We could not have had the success we have without linking health and housing. We were able to set better outcomes at an early stage and then deliver them through effective social care interventions."

B. The role of central government

Politicians need to be brave about promoting new models of care. They need to move the debate on and help build care around individuals and communities, not institutions and buildings.

This is not a debate in the gift of professionals alone. It involves creating a broad consensus among the public on entitlement and responsibility. Current debates on funding are dominated by services and limited options of pooling or aligning budgets. With political will, integration of personal health and care budgets could liberate funds and ensure future sustainability of public services.

A greater attention to the potential of greater policy integration at government level is needed. We recognise there is a tension for politicians when dealing in longer term changes, but this can be mitigated by short term wins. A review and catalogue of existing examples of good care at nil cost increase would enable constituency MPs to champion applications in their patch.

Quote: "We desperately need something akin to a national marketing campaign. We can identify champions the public will trust and have politicians, nationally and locally out in communities walking the talk. That is the only way we can get a settled view on what our society needs and wants from its care services."

C. The role of local leadership

Local leadership needs to insist on new technologies such as telecare and ways of working.

Boards and Cabinets should be leading an audit of what is available against what is being delivered, with public transparency.

For leading professionals, such as GPs, we need further transparency on where across the system people in need are failing to receive integrated care. Healthwatch has a critical role in leading this process of review and action.

Quote: "Why do we always monitor and audit what is done rather than what is not being done? This needs a strong mandate, and we need to make organisations pay for failure."

Leadership must come from the top.

Health and Wellbeing Boards (HWBs) have potential, but we suspect do not currently have the capacity to lead integration across services and sectors. Enhancing their role and accountability is essential, as is investment in their capacity to operate in this role.

In part it is for these bodies to win investments from boards and cabinets, professional bodies and community leaders, but a little more encouragement and support from the centre would help.

A key element in culture change lies in the styles and skills of managerial classes across public services. Boards, Cabinets and third sector partners need to provide a much greater level of support for front line staff to work across boundaries.

Quote: "Let's be honest. As yet there are few examples where these health and well being boards are ready to take this ahead. They do sit at the best point in the system, and should be able to build an understanding of all sides. This will need strong direction from government and a drive to implement this enhanced role locally."

Quote: "Integration may not seem like an immediate priority, but real success comes from looking beyond the immediate. We need commitment from everyone – local leaders, royal colleges, central government – to take this on."

D. The role of economics

Incentives and funding mechanisms need to be aligned.

Policy needs to scrutinise and act against internal funding mechanisms that prevent integration.

Current payment regimes actively disintegrate care, are unsustainable and limit the uptake of cost effective innovations. As empowerment of users increases, there is a need to address the conflict at local authority level between advisory and provider roles. Current payment regimes need to be overhauled, with assessments of approaches such as 'Year of Care' tariffs.

Current funding systems need to be audited to remove false incentives. New metrics, audit and accountability measures need to reflect how organisations perform in integrating the care of their users. *Good Living Pathways* could help drive this. Nationally a benchmark of financial incentive mechanisms that support integrated working should be rolled out.

We could move towards a 'public budget' across a population. In this context, personal budgets could drive change, especially if they involved families.

Finally, the Treasury needs to think through ways of incentivising service users and their families to unlock personal assets to fund care packages themselves. Options might include providing some kind of amendment to inheritance tax thresholds, such as a pound-for-pound increase in the inheritance tax threshold allowance set against money spent on care services in the last five years of life.

Quote: "We can not continue to tinker, we need a more fundamental change. We need whole care packages, where costs and savings are allocated across the system. We all know where we waste money for lack of access to resources that provide better care. The obvious example is of course elderly patients, medically ready for discharge yet lying in expensive beds and going downhill rapidly."

Invest to save schemes should be prioritised.

Failure to pave the way for gains in the future from emerging technologies is a dereliction by local leadership. Investing in and unlocking the potential of information technologies, engagement strategies and assistive technologies should be the norm and not the exception. Mainstreaming projects is probably key, which means significant changes to mainstream services.

New technologies must include broadening the skills of staff to facilitate engagement with people in need. It is now important to translate planning on early intervention and prevention into new job descriptions, community team investment and tools to support front line staff.

Quote: "If you can focus and fund early intervention and prevention then you can release resources and improve practice. This can save councils millions but you need to be prescriptive across the whole system."

E. The role of the organisation

Resist further reorganisation

Structures can support or impede integration, but structural change cannot deliver these changes on the ground. Aligning organisations around accountabilities for care, mutual outcomes and shared financial incentives must be the new priority.

New organisations should be charged with assessing their own services' contributions to good living outcomes, especially in targeted groups such as frail elderly, early stage dementia sufferers and those living with long term conditions. Commissioning bodies should likewise be able to account for their contributions.

New regimes of accountability will open the door to our new ways of working. Few need to fast track the removal of existing restraints on staff working across organisations, introduce the use of new style support roles and invest in new technologies – not least in tackling backlogs in information sharing and enabling take up of innovative digital solutions.

Quote: "We now need to test our organisations, to the limit if necessary. We can build on what we have but most importantly the power and the money need to sit with those we can, and do, hold accountable."

There is an urgent need for accountability and transparency across sectors.

Changes to cultures, ways of working and empowerment are more likely to be delayed or distorted by restructuring. Aligning organisations can be achieved without the upheaval of change.

Quote: "We can be a catalyst to bring together a coalition of the willing, as there is no one solution for all organisations. We have been doing this by bringing together all sectors involved in making care work into a real consortium. Our remit is simple, to find practical solutions put them in place and show what can be done."

Commissioners need to account for local integration plans, and indeed lack of integration.

Local internal audit should identify wastage from non-integration. The internal audit focus should be across whole populations, rather than focusing on single organisations.

Quote: "We have to ensure that the control of budgets and the responsibility for risk sits in the place where those with the greatest control sit. Then we can start to pool budgets and collaborate, but most of all we can start to be transparent and accountable."

Quote: "We have shown it can be done. We have co-location of services, we use our good knowledge and understanding of our patch and the services, and we design what we do around that shared understanding and shared objectives."

Quote: "There is a problem with a lack of good metrics when we talk integration but it is imperative that we start to unpick all the costs, from grab rails to chiropody to surgery. A good place to start is with the community teams that we all have. Once we start to count it all up, the arguments for integration will mount."

Boards and cabinets need to update their skills.

Directors and leaders have a clear responsibility to understand the market within which they are working and individuals on boards need to quickly gain a much more sophisticated understanding of the potential of new service modalities and technologies.

Many are presiding over strategies to deliver this year's services to the populations of the future. Service users will be disadvantaged unless boards better understand how future care services can be created and maintained.

Quote: "Leadership across all organisations is needed now. This is a new type of leadership. It should be judged on delivery of transformation, with clear consequences for failure."

Next steps: conclusion

All these changes could be put into action within a single Parliament – indeed many within twenty-four months. Our work with boards through previous reforms draws us to conclude that the main structures and systems do not need significant change: the answer lies in policy and resourcing alignment, changing beliefs and behaviours and creating a new settlement with patients, service users and carers. Despite the apparent enormity of the challenge we face in managing future care, much can be achieved quickly.

Appendix I

Working group members

Nigel Appleton, Executive Chairman, Contact Consulting (Oxford) Ltd. He is a trustee of Help and Care, Bournemouth and has been an honorary research fellow at the Centre for Urban and Regional Studies, Birmingham University.

Steve Barwick, Senior Policy and Account Director, Connect Communications, working with clients that include RSPGB, London Luton Airport, Abbey National, UNISON.

Dr. Felix Burden, Secondary Care Consultant Board Member, Sandwell and West Birmingham CCG. Dr. Burden is a consultant physician specialising in diabetes, and is President of the Community Diabetologist Consultants nationally.

Elizabeth Butler, Chair, Lewisham Healthcare NHS Trust. A specialist in social housing and long experience as an NHS non-executive, including being Chair of Bromley PCT.

Andrew Corbett-Nolan, Chief Executive, Good Governance Institute and currently Director of the European Governance Office of the European Society for Quality in Healthcare and a non-executive director of the UK Public Health Register.

Stephanie Elsy, Associate, Good Governance Institute. Previously Leader of the London Borough of Southwark, non-executive director of Southwark PCT and Director of Corporate Affairs at Serco plc.

Dr. Simon Fradd, General Practitioner and Board Member, Southwark Clinical Commissioning Group. Managing Director of Concordia Health. Former BMA GP negotiator and Deputy Chair of the BMA GPs' Committee. Member of the GMC.

Professor Martin Green OBE, Chief Executive, English Community Care Association. Department of Health Independent Sector Dementia Champion, Vice-Chair of the International Longevity Centre and a trustee of the National AIDS Trust.

Dr. Adrian Heald, Consultant Diabetologist, East Cheshire Hospitals NHS Trust. Prospective Parliamentary Candidate.

Derek Law, Social Care Consultant and currently a non-executive director at an NHS Trust in the South West, Chair of a Housing Association and a non-executive of the Devon and Cornwall Probation Trust. He was the Director of Adult and Community Services at North Yorkshire County Council.

Hattie Llewelyn-Davies, Chair, Hertfordshire Partnership NHS Foundation Trust. Housing specialist, Vice Chair of a building society and a Governor of the Peabody Trust.

Maureen McEleney, Director of Housing and Neighbourhood Services, London Borough of Barking and Dagenham and a non-executive director of a Housing Association. Her professional background is as a social worker.

Ali Rogan, External Affairs Director, Tunstall Healthcare – 10 years of working within health, housing and social care fields. Prior to that, marketing within a range of sectors from the arts, construction, design and 10 years in telecommunications.

Sue Stirling, Associate, Good Governance Institute, with experience as a Regional Child Policy Champion and working at director level in several policy institutes.

Professor Bryan Stoten, Chair, Warwickshire Health and Wellbeing Board, with a long career as an NHS Chair, including NHS Warwickshire, Walsall Hospitals and Birmingham Health Authority. He is the Chair of the UK Public Health Register.

Dr. Amanda Thompsell, Consultant in Old Age Psychiatry at South London and the Maudsley NHS Foundation Trust and the Department of Health Dementia Clinical Champion for the Modernisation Initiative End of Life Care Programme.

Dr. Zoe Wyrko, Consultant in Old Age Medicine, University Hospitals Birmingham NHS Foundation Trust. Dr. Wyrko is the Hon Secretary of the British Geriatrics Association.

Rethinking the integration agenda

A discussion report from the Good Governance Institute

Giving people a life, not a service

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