Good Governance Institute

Making integration a reality

A reflection on the Health + Care Conference 2015

September 2015

Making integration a reality
A reflection on the Health + Care Conference 2015

Version: Final discussion paper
Date: September 2015
Authors: Dorothea Baltruks, Knowledge Management Analyst, Good Governance Institute;
Chris Smith, Team Leader Knowledge Management, Good Governance Institute.
Review by: David Cockayne, Managing Director, Good Governance Institute.

info@good-governance.org.uk

www.good-governance.org.uk

Introduction

Once a year, the Health + Care Conference, the biggest of its kind in the UK, brings together commissioners, providers, politicians, and others from all over the country and beyond to facilitate discussions around some of the pressing issues facing the sectors, and promote best practice. In this short paper, we want to capture some of the conference's main debates and share some of the examples of innovative approaches to health and social care that inspired GGI.

Starting with a reflection on the key debates of the conference, this paper will look at aspects of integration, including links between health and other social policies such as housing, the role of data and IT, and physical and mental health integration. Emphasising the prominence of localism, we will also describe a number of examples where these different aspects of integration have been incorporated into local action plans.

Money, people, and the long road to integrated care

The main focus of the conference was the question of how patient-centred integrated health and social care can, and should, be provided across the UK, particularly given the financial constraints within which the system has to operate.

As former Minister of State for Care and Support Norman Lamb MP pointed out, the UK spends considerably less on healthcare than other Western European countries. Whilst the UK spent 9.3% of GDP on healthcare in 2012, other Western countries spent significantly more (France 11.6%; Germany 11.3%; Canada 10.9%; United States 16.9%). The UK also spent significantly less per capita on health ($3,011) than Germany ($3,995), France ($3,476), Canada ($4,045) or the United States ($7,662).[1]

The discrepancies are even greater for social care spending. The King's Fund predicts the UK to spend 1.1% of GDP on long-term care in 2016/17.[2] France spent 1.8% of GDP on its universal social care system in 2013, whilst the Netherlands spent 3.7% and Sweden 3.6% of GDP on social care.

As Mr Lamb argued at second key note discussion of the Conference, funding pressures indicate that it is time for the UK to accept that if we want to maintain a high quality health and social care system, funding in both areas will need to be increased substantially, probably well beyond the £8bn quoted in the Five Year Forward review. It is unrealistic to expect that we can deliver the same quality as France, the Netherlands, or Sweden with significantly less funding. The disucssions picked up on recent polls that have shown that the majority of voters would consider paying higher income tax to increase funding for the NHS.[3]

Undoubtedly, the NHS' performance and quality of care remains very good by international comparison. Yet, stroke and cancer survival and mortality rates whilst improving remain worse than in other OECD countries.[4] Addressing these serious areas requires complex analysis of data, and learning from other countries with better outcomes could provide valuable lessons.

In critiquing the Conservative government's health plans, Lord Hunt, Shadow Spokesperson for Health, identified 'money and people', i.e. funding and staff shortages, as the two biggest issues facing the NHS. As GGI describe in more detail in our recent 'The Nursing Journey' white paper[5] nursing shortages, in particular, are a major problem for many NHS trusts, not helped by new migration rules which are forcing many nurses from oversees to leave the UK and which are making it more difficult for qualified health professionals from overseas bring their families with them.

Of course, the nebulous but in our post-Francis era omnipresent issue of 'culture' was also discussed within the first hour of the conference. The Secretary of State for Health called for a 'learning culture' where organisations, their leaders, and staff should learn from mistakes. Referring to the shocking revelation from the 2014 NHS staff survey in England that 24 per cent of NHS employees had experienced bullying, Mr Hunt called for 'leadership by values' to create a more open culture in the NHS. GGI has seen the seriousness of bullying in our recent investigation at Worcestershire Acute Hospitals NHS Trust, where we found the Dignity at Work Policy not fit for purpose, and the management of bullying and harassment concerns inconsistent and not transparent enough.[6] Staff in any NHS organisation need to be confident that the organisation they are working for is a listening organisation supportive of and valuing the expertise and hard work of its workforce.

A recent report by the Local Government Association and ADASS (Association of Directors of Adult Social Services) predicts a 28 per cent funding gap in the health budget by 2020 and a 29 per cent funding gap in the social care budget.[7] Dr Ray Jones, Professor of Social Work at Kingston University, emphasised the need for stability of local services as well as better trust between health and social care organisations in order

1. OECD (2015) Health spending (indicator). doi: 10.1787/8643de7e-en (Accessed on 03 July 2015)
2. The King's Fund (2013) Spending on health and social care over the next 50 years – Why think long term? p. 45
3. Neville, S. (2015) 'Voters back tax rise to fund the NHS, poll shows' http://www.ft.com/cms/s/0/ae50d886-ddce-11e4-9d29-00144feab7de.html#axzz3hHNyt6FO (last accessed 29th July 2015)
4. Qualitywatch (2015) 'Focus on: International comparisons of healthcare quality' p. 37
5. GGI (2015) 'The Nursing Journey'
6. Good Governance Institute (2015) 'Worcestershire Acute Hospitals NHS Trust – An independent investigation into how the Trust carries out reviews of allegations of bullying and harassment, under the Trust's Dignity at Work Policy', http://www.good-governance.org.uk/worcestershire-acute-hospitals-nhs-trust-investigation-report/ (last accessed 8th September 2015)
7. Local Government Association and ADASS (2014) 'Adult social care funding: 2014 state of the nation report', p. 25

to build shared agendas and work in partnership. The immense cuts to the social care budgets under the Coalition Government clearly undermined integration efforts intended to be enabled through the Better Care Fund (BCF). Moreover, as Lord Hunt argued, as long as social care is means-tested while healthcare is not, integrating the two will remain difficult. Integrating health and social care funding would resolve these issues but would required major structural, political and system changes.

In order to resolve these problems, we should perhaps follow the suggestions of Rob Webster, Chief Executive of the NHS Confederation, to start with patients and to focus on how to organise services better around their needs and wants rather than focusing on organisations and the architecture of the system.

Personal Care Budgets are one way to ensure that patient choice really is the driver of care plans. People with long-term conditions or disabilities should be able to determine their priorities and choose between different models of care, not just as a one-off decision but on an ongoing basis. Needs and preferences change, and we should encourage people to explore different models of care in order to better support their needs and enable them to live as independently as possible.

Self-determination should also be at the heart of an end-of-life care system fit for the 21st century. The vast majority of people do not want to die in hospital, yet the majority still do. We need to learn from the hospice movement to have more honest conversations with patients and their loved ones, and focus on how we can support them to spend the last stage of their life how they want. The new guidance on 'care of the dying adult', a draft of which is currently open to consultation[8] promises that much needed shift in focus and outlines a holistic approach focused on the complex needs and wishes of the individual.

8. National Clinical Guidance Centre (2015) 'Draft consultation: Care for the dying adult' https://www.nice.org.uk/guidance/gid-cgwave0694/resources/care-of-the-dying-adult-full-guideline2 (last accessed 29th July 2015)

Health in all policies

One of the most quoted figures at the Health + Care conference was that GPs are only responsible for 20% of the healthcare provided in the UK. Education, housing, and other areas of social policy play a major, though oft forgotten, part in preventing ill health. Social prescribing can play a key role in maintaining good physical and mental health and in supporting conventional treatment actions. It refers to 'non-medical tools and services that can support or improve people's wellbeing and are prescribed by GPs or other healthcare professionals. Often social prescribing promotes behavioural changes such the adoption of a healthier diet and more exercise, but it can also seek to combat loneliness and improve people's social wellbeing through group activities, befriending schemes, or peer support. More specific services such as debt counselling or benefit advise can also resolve sources of distress that may impact on someone's wellbeing.

The use of social prescribing is still minimal and data on its effectiveness still developing. Busy GPs may not know about community services available or may be unsure about how to refer patient to the latter. Yet, pilot schemes suggest that especially patients with long-term conditions, mental health problems, and those who show little response to conventional medical or drug treatments as well as socially isolated people, could benefit substantially from greater use of social prescribing.[9]

Other areas of policy such as taxation also have a crucial impact on public health by shaping financial incentives for people's behaviours and shopping patterns. The success of taxing tobacco and its strong correlation with the huge reduction in smoking, an area where the United Kingdom is regarded as an example of best practice by the WHO[10],is a classic example. Whilst the options discussed to tax foods and beverages high in sugar or to regulate the sugar content of certain foods are more complex and run the risk to be similarly regressive, their potential to improve public health is convincing. Even though a 20% tax on sugary drinks, for instance, would only add a few pence to the price of a can or a bottle, a study suggests that such a tax could reduce the amount of sugary drinks consumed by 15% and have a particularly strong impact on teenagers and younger adults who consume the most.[11] Of course, this is only a small contribution to a complex issue. Still, reducing the cost of healthy foods whilst increasing the price of unhealthy foods certainly finds the approval of many healthcare professionals.

Housing and health

Anyone who has ever thought about integrated, patient-centred care and the importance of prevention will have recognised that we have to look beyond the doors of our hospitals and practices and into people's homes. Several debates at the conference emphasised that we also need to look at people's homes. Concerns about housing are steadily climbing up the 'voters' top priorities list' in polls.[12]

When mentioning the 'health hub' on his organisation's website, David Orr, Chief Executive of the National Housing Association, suggested that healthcare organisation should have a 'housing hub' on their websites. Indeed, access to and quality of housing can have a significant influence on people's health and wellbeing. According to the National Housing Federation, people in social housing are significantly more likely to have a physical or mental health condition, and about a third are disabled.[13] Housing associations can play an important role in supporting residents to live as independently as possible, get back into work, and adapt their homes to their needs. However, many lack the resources to do this, and have seen their resources reduced further in recent years, and multidisciplinary working with health and social care services remains too often a desirable vision rather than a day-to-day reality.

9. Nesta (2013) 'More than medicine: new services for people powered health' https://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf (last accessed 29th July 2015)
10. World Health Organization, Report on tobacco taxation in the United Kingdom http://www.who.int/tobacco/training/success_stories/en/best_practices_united_kingdom_taxation.pdf (last accessed 28th July 2015)
11. BBC Health (2013) 'Sugary drinks tax 'effective public health measure' http://www.bbc.co.uk/news/health-24759517 (last accessed 30th July 2015)
12. Jackson, G. (2015) 'Datawatch: shift in priorities for UK voters since 2010', Financial Times Online, http://blogs.ft.com/ftdata/2015/05/06/datawatch-shift-in-priorities-for-uk-voters-since-2010/ (last accessed 9th September 2015)
13. National Housing Federation & the Centre for Economic and Social Inclusion (2015) 'Worklessness, welfare and social housing' http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/Worklessness_welfare_and_social_housing_-_Executive_summary.pdf (last accessed 28th July 2015)

Data and IT integration

As the Secretary of State for Health emphasised in his opening speech, good data analysed and used effectively can be the engine of improvement in health and social care. Mr Hunt further argued that the path to lowering the cost of healthcare is the same as the path to better care given the consequences of substandard care (complications, treatment of consequential symptoms and compensatory payments).

He introduced the idea of "intelligent transparency", i.e. publishing data in a way that is comprehensible and meaningful for stakeholders and the public and would help patients to make informed decisions about their care, an idea that the CQC have been promoting since November.

In the month since, Hunt has dubbed intelligent transparency "Patient Power 1.0"with the ultimate goal, "a radical permanent shift in power towards patients" through the use of technology and science, "Patient Power 2.0."[14] His claims that "within the next five years our electronic health records will be available seamlessly in every care setting", and "new medical devices will mean an ambulance arrives to pick us up not after a heart attack but before it – as they receive a signal sent from a mobile phone", whilst exciting, may seem slightly over-ambitious at this stage. However, myNHS,[15] a service which allows patients to see information about the quality of services NHS organisations are providing, as well as the increased number of GPs offering patients access to their summary medical record online have been lauded as real and promising success stories.

GGI has long promoted the use of technological solutions in the NHS and firmly believes that technology will be vital to achieving the goals set out in Simon Steven's Five Year Forward View. Indeed, we are already seeing the impact technology can have on services: a system used in care homes in Croydon can spot the onset of delirium, whilst wearable devices can now track and monitor the symptoms of Parkinson's 24/7.[16]

However, although advancements in technology and I.T. can support better patient care, inform policy decisions, and predict local and national healthcare trends, steps must be taken to ensure that data is appropriately collected and managed. Lessons must be learnt from the recent admission by the Health and Social Care Information Centre, that details from up to 700,000 patient records have been shared with a third party without prior consent, in order to provide reassurance to a data-nervous public.[17]

14. Department of Health (2015) 'Speech: Making healthcare more human-centred and not system-centred' https://www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred (last accessed 29th July 2015)
15. https://www.nhs.uk/service-search/performance/search
16. The Guardian (2015) 'NHS and the internet of things: The future of care is about the patient taking control'
17. Pulse Today (2015) 'GP records to be shared without patient permission to tackle 'high cost' patients

Invest to save – the imperative for better prevention

Long-term and mental health conditions take up a major share of health and social care resources. Many of these conditions and their consequences could be substantially reduced through prevention and better self care support.

The opportunities of fostering the prevention of mental ill health are potentially huge. We know that 75% of all mental health conditions manifest before the age of 24 yet prevention initiatives in schools are still rare and the recent spending cuts to CAMHS budgets in many councils can only be counterproductive. Overall expenditure on CAMHS has fallen by 6% since 2009/10.[18] Children's and adolescent mental health treatment options are not only very cost-effective, they are also the best prevention for long-term mental ill health of adults. Yet, only a fraction of children with diagnosable disorders (conduct disorder, anxiety, depression, and ADHD are the most common) receive treatment. More investment in improving the reach and quality of treatment options is urgently needed – as is more evidence for the effectiveness of prevention and intervention programmes for other common disorders such as self-harm and eating disorders.[19]

Many speakers openly disagreed with Jeremy Hunt's opposition to a 'sugar tax'. According to Public Health England (PHE), obesity costs the NHS at least £5bn a year, and type 2 diabetes £8.8bn.[20] Yet, efforts to prevent both and consequent conditions remain modest compared to other major public health concerns such as smoking and alcohol consumption. Especially, children's high sugar consumption calls for imaginative new approaches to change habits and incentives. The speakers agreed that the responsibility cannot be put solely on parents. It would be naïve to expect this hugely profitable industry to voluntarily reduce sugar contents, stop advertising sugary foods and drinks, and stop promoting them misleadingly as 'healthy'. A combination of health campaigns, stricter regulation, clear labelling, and a tax on sugary drinks (which are now the main source of children's overall sugar consumption) are urgently needed to combat what Simon Steven calls "a slow-motion car crash in terms of avoidable illness and rising health care costs."[21]

Integration is crucial for all areas of the health and social care sector, but the imperative is probably strongest for mental health given the complexity of its nature and consequences affecting potentially all areas of a person's life, and the longevity of many mental health conditions.

Postcode lottery or local prioritisation?

That a person's postcode can dictate the quality of healthcare they can receive has long been a cause for public consternation in the UK. But, re-branded at the Health + Care Expo 2015 as 'local prioritisation' where variances were described as being based on local demand and need, this same reality won widespread support.

In 2011, the NHS Atlas of Variation in Healthcare revealed broad regional disparities in the quality of patient care. Notably, the study found that there was a three-fold variation in the amount that the then commissioning bodies, Primary Care Trusts (PCTs), were spending on learning disabilities, a two-fold variance in spending on mental health and similar variations in spending on cancer care, issues that are at the forefront of healthcare today.[22] At the time Professor John Wennberg argued the need to reduce variation in order to maximise the value we can derive from healthcare.[23]

Does this argument still stand? Arguably not. In June the BBC reported that the interim metro-mayor for the new Greater Manchester 'supercouncil', Tony Lloyd, would "welcome a postcode lottery in the NHS where Greater Manchester provides better services for its residents than other parts of England", arguing that "We [Greater Manchester] are not having the Whitehall mandarins, a long way away, making decisions about

18. Price, C. (2015) 'Child mental health spending cut by £50 million since last Government' http://www.pulsetoday.co.uk/news/commissioning-news/child-mental-health-spending-cut-by-50-million-since-last-government/20008883.article#.Vbn2qGBRfdk (last accessed 29th July 2015)
19. Centre for Mental Health (2015) 'Investing in children's mental health: A review of evidence on the costs and benefits of increased service provision'
20. Public Health England (2015) 'PHE urges parents to cut sugary drinks from children's diets' https://www.gov.uk/government/news/phe-urges-parents-to-cut-sugary-drinks-from-childrens-diets (last accessed 23rd 2015)
21. NHS England (2014) 'Get serious about obesity or bankrupt the NHS – Simon Stevens' http://www.england.nhs.uk/2014/09/17/serious-about-obesity/ (last accessed 23rd 2015)
22. http://www.theguardian.com/society/2011/dec/09/nhs-lottery-survey-uk-disparities
23. RightCare (2011) 'The NHS Atlas of Variation in Healthcare'

communities they don't understand."[24] Similar arguments, in favour of devolved power and localism were rife at the Expo and it is likely that Cornwall will shortly follow Greater Manchester as NHS England's next great devolution experiment.

By devolving power to regions such as Greater Manchester, NHS England is allowing a degree of autonomy not before seen in the NHS. Regions will be able to allocate pooled health, care, and council budgets as they see fit and will undoubtedly tailor this to the needs of their population. If one region has higher rates of diabetes among its population, for example, and decides to devote more financial resource to awareness raising and treating those who live with this condition then it is likely to have a better diabetes service than an area with comparatively fewer diabetics and which decides to devote its resources to over illnesses.

Indeed, taking into consideration the current financial situation in the NHS, notably the need to achieve minimum efficiency savings of £8 billion by 2020, the prioritising of services is an inevitability. It makes sense to tailor the delivery of services to the needs of the local population in order to reduce inefficiencies and wasteful services, despite the potential of this resulting in worse health outcomes for the few.

Given this, is the term 'postcode lottery' misleading, or even sensationalist? The conference speakers pointed out that, whilst it is true that in this new devolved model your postcode can dictate the quality of care you may receive, a more accurate description is certainly 'local prioritisation', and a service which reflects the needs and demands of the majority of the population.

Localism

Localism rooted in best practice does not undermine the centralised NHS, rather it can complement the latter. It was encouraging to hear about a number of successful initiatives and programmes from across the UK that we want to mention here.

Healthy Liverpool

Under the motto 'how to be digital not just for digital's sake', Liverpool CCG described the Healthy Liverpool Programme, which seeks to improve public health and the integration between hospital and community services in the city.

Liverpool faces challenges that other places all over the country will recognise, yet due to above-average levels of deprivation and corresponding public health problems some are more pronounced than elsewhere. According to Public Health England, 32% of children grow up in poverty, which has a clear impact of their health and wellbeing. Childhood obesity, rates of alcohol-related hospital admissions for minors, teenage pregnancy levels, educational outcomes, and smoking are all worse than the average in England.[25]

Health inequalities are also significant. Liverpudlians in the wealthiest areas of the city can expect to live more than a decade longer than those in the poorest areas, where people are up to three times more likely to die from cancer alone. In 2021, the number of Liverpudlians over 65 is expected to be 9 per cent higher than it is now. About a quarter of Liverpool's population is obese and alcohol and tobacco-related health issues are worse than in England on average.

In light of these challenges, the Healthy Liverpool Programme is a holistic approach to improving residents' wellbeing as close to their homes as possible by fostering partnership working between the city, GPs, schools, care homes and other health and social care providers, as well as facilitating better self-care support. Prevention is a key priority, especially increasing physical activity – Liverpool aims to become "the most physically active city in the country by 2021"[26] – and reducing smoking and alcohol consumption.

24. BBC (2015) 'Greater Manchester's 'metro-mayor' welcomes NHS postcode lottery'
25. Public Health England (2015) 'Liverpool: Health Profile 2015'
26. Liverpool Clinical Commissioning Group (2014) 'Healthy Liverpool: Prospectus for change', p. 17 http://www.healthyliverpool.nhs.uk/files/Healthy_Liverpool_Prospectus.pdf (last accessed 30th July 2015)

Another key element of the programme is 'healthy ageing' which aims to improve home support services for older people, reduce the number of people dying in hospital by providing better support to those wishing to die at home, improve early diagnosis rates for dementia and cancer, and prevent falls.

The programme has six priority areas with dedicated community-based services and outpatient programmes:

- Mental health
- Healthy ageing
- Cancer
- Children
- Long-term conditions
- Learning disabilities

Placing empowered people at the heart of the system, Liverpool also plans to extend community services with more joined up working between health, social care and voluntary services, whilst reducing hospital admissions. To enable this joined-up cross-organisational working, the Merseyside iLinks strategy is being implemented, which will make shared electronic information available in real time which service users can access and contribute to.

Healthy Liverpool's plans are ambitious and far-reaching. It will be exciting to hear about their success in implementing these plans but we can be optimistic about the benefits the programme could bring to the city's residents.

Sheffield

Sheffield is moving towards a complete integration of health and social care budgets – beyond the Better Care Fund. The strong partnership between Sheffield City Council and the local CCGs enabled the agreement of a single budget of £270m and a single monitoring process for health and social care service, overseen by a single executive management group. They have started to align systems and data, include service user involvement and recognised that the leadership needs to be focused on outcomes.

Like in Liverpool, key aims in Sheffield include reducing hospital admissions by improving community services that support independent living at home, and reducing health inequalities by investing in supporting people with mental health problems and learning disabilities, and investing in children's services.

By integrating health and social care services, the CCG and the Council want to ease cross-sector team working focused on maintaining people's independence and care at home, as well as improving emergency response services to prevent long hospital stays. To achieve this, the integrated commissioning programme is planning to establish four core work-streams:[27]

- Keeping people well at home through clinical and non-clinical interventions
- Active support and recovery after hospital care
- Independent living solutions in community settings
- Long-term care and high support in residential care

Again, we look forward to seeing how the integration plans in Sheffield will be implemented and how they will change health and social care provision.

27. NHS Sheffield Clinical Commissioning Group, Integrated Commissioning Programme, http://www.sheffieldccg.nhs.uk/our-projects/integrated-commissioning-programme.htm (last accessed 31st July 2015)

Devo Manc

Throughout the conference Greater Manchester's health and social care devolution plans were trending as expected. Essential components of the 'Devo Manc' model are common outcomes and standards to which all 12 local CCGs and 15 NHS provider organisations are signed up. They are built into the ten local borough plans that will be delivered in the localities of Greater Manchester and have a combined budget of £6bn.[28]

The aims are ambitious: reduce the number of hospital emergency surgeries by 60 per cent, improve outcomes, better user experience, less waste and inefficiencies, close gaps and inconsistencies in patient pathways, and most of all improve the wellbeing of Mancunians. Health inequalities within Greater Manchester are a critical issue, as is the gap between health outcomes across all age groups in Greater Manchester and the rest of England.

It is much too early to pass judgement on the success of this programme. However, great things are expected with Simon Stevens calling the landmark agreement between NHS England, the local NHS, and local government leaders "the greatest integration and devolution of care funding since the creation of the NHS in 1948." We welcome NHS England's decision to devolve power in Manchester, and in Cornwall also where a £2 billion combined health, care, and welfare budget set to be pooled by 2020. However, from our perspective it is imperative that these new programmes are implemented with strong governance arrangements, ensuring public accountability and quality.

Mental health – a priority area for integration

GGI welcomes the current focus mental health and its integration with physical health is receiving and supports the objectives outlined in the previous government's mental health strategy from 2014.[29] The introduction of waiting time targets for mental health, the requirement of local partnerships to deliver the Mental Health Crisis Concordat, and new national guidelines are all important steps promising to improve the provision of mental health services. Yet, there is a worrying consensus that all too often lip service is being paid but actions remain insubstantial. We fully agree with the UK Council for Psychotherapy that "if the national commitment to parity of esteem for mental health is to mean something, then the mental health and wellbeing of our children and young people must be a priority, not an easy target for budget cuts."[30]

Sara Evans-Lacko who is currently working on her PhD at the London School of Economics and Political Science (LSE) outlined to the delegates the key points of a major report on the economic potential of mental health prevention[31] published in 2011. The report analyses the economic benefits of a number of specific mental health prevention programmes and shows that many can be assumed to be "outstandingly good value for money"[32], particularly in the medium to long term. Apart from direct savings to the NHS and other provider organisations in unutilised service provision, avoidable unemployment or underemployment, reduced sickness absence costs, and potential saving to the criminal justice system were major areas of predictable financial savings.

Moreover, many effective interventions are relatively low-cost and easy to implement, for instance suicide training courses for GPs or better screening for alcohol and substance misuse, depression, and psychosis. The medium to long-term potential benefits of bridge safety barriers for suicide prevention is also impressive, especially given the ease with which these could be put in place.[33]

According to the report, "30% of people with a long-term conditions have a mental health problem" and "46% of people with a mental health problem have a long-term condition." It is therefore absolutely imperative that better integrated services for people with both mental health and long-term conditions

28. Manchester City Council (2015) 'Major step forward for Devo Manc: shared plan for £6billion health and social care funding' http://www.manchester.gov.uk/info/200109/council_news/6894/manchester_people_-_march_2015 (last accessed 27th July 2015)
29. HM Government (2014) 'No health without mental health: A cross-government mental health outcomes strategy for people of all ages'
30. UK Council for Psychotherapy (2014) 'Health Committee inquiry into children's and adolescent mental health and CAMHS: Written evidence submitted by the UK Council for Psychotherapy'
31. Knapp, M, McDaid, D. and Parsonage, M. (eds.) (2011) 'Mental Health Promotion: The Economic Case', Personal Social Services Research Unit (London School of Economics and Political Science), Centre for Mental Health, Centre for the Economics of Mental Health, Institute of Psychiatry (King's College London)
32. ibid, p. 43
33. ibid, pp. 41-42

are developed. Treating these co-morbidities effectively also requires better data analysis and analysis to understand how they influence each other and what patients find helpful and effective in different treatment options.

The Centre for Mental Health[34] advocates for the alignment of payment mechanisms for physical and mental health services, particularly for people with co-morbidities and long-term conditions. Policy strategies and NICE guidelines should be redesigned to take the interconnectedness of physical and mental health conditions into account. Crucially, training of health and social care professionals needs to ensure that all health and social care professionals have at least a basic level of mental health skills. Closer liaison between mental health and other specialists in multidisciplinary teams and closer cooperation is imperative to ensure that patients with complex physical and mental health needs receive appropriate care.

Every patient with long-term conditions should be screened for mental health problems, which requires a general improvement of practitioners' psychological assessment and management training.[35]

As Dr Geraldine Strathdee, NHS England's National Clinical Director for Mental Health, pointed out in one of the sessions at the conference, meaningful outcome measures are very hard to identify in mental health, yet they are needed to ensure improve consistency of mental health services.

The poor access to mental health services for children, teenagers and young adults has the hallmarks of an emerging crisis, as a recent publication by the Health Committee illustrates.[36] It is a well-established fact that more than three in four adults with a mental health condition were diagnosed before the age of 18 and half before the age of 15.[37] Yet, according to the charity Youngminds, about two thirds of the top tier local authorities reduced their CAMHS budgets between 2010 and 2013,[38] some by more than 20 per cent. The potential financial savings of early identification, early intervention, prevention of mental illness, and the promotion of mental health initiatives are huge and could alleviate the strain on the NHS, social care budgets, and the criminal justice system substantially, not to mention the invaluable potential of reducing human suffering and the manifold social, economic, and emotional consequences of mental ill health.[39]

34. Centre for Mental Health, 'Co-morbidities: physical health and mental health problems together' http://www.centreformentalhealth.org.uk/co-morbidities (last accessed 24th July 2015)
35. Mental Health Network NHS Confederation (2012) 'Investing in emotional and psychological wellbeing for patients with long-term conditions' http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Investing%20in%20emotional%20and%20psychological%20wellbeing%20for%20patients%20with%20long-term%20condtions%2016%20April%20final%20for%20website.pdf (last accessed 28th July 2015)
36. Health Committee (2014) 'Children's and adolescents' mental health and CAMHS', http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34208.htm (last accessed 8th September 2015)
37. Jones, P. B. (2013) 'Adult mental health disorders and their age onset', the British Journal of Psychiatry 202(s54): 5-10
38. Youngminds (2013) 'Local authorities and CAMHS budgets 2012/2013'
39. Knapp, M., McDaid, D. and Parsonage, M. (editors) (2011) 'Mental health promotion: the economic case', Personal Social Services Research Unit, London School of Economics and Political Science

Mental and physical health integration in East London

Talking about change is always easier than actually doing something about it. Three CCGs in East London have embarked on a bold journey to actually do something, to integrate mental and physical health.

Newham CCG has undertaken a comprehensive transfer programme from outpatient departments back to their GPs for adults with a stable serious mental illness (SMI). Since the beginning of the programme, about 6,000 service users have been discharged back into the community and the feedback from them and their GPs is overwhelmingly positive. The possibility of a discharge would be discussed with the service user and their carer, and support teams consisting of Community Psychiatric Nurses working in GP surgeries would provide advice and support after the discharge. Dr Lise Hertel, Mental Health Lead for Newham, told us that the psychiatrists in the outpatient services were sceptical at the beginning. They were concerned that their patients would not receive adequate support in the community from their GPs.[40] Fortunately, due to the excellent work of the Community Psychiatric Nurses and the commitment of GPs, these concerns have largely vanished and it has become apparent that service users are well cared for in their communities and that their physical needs are better met than before due to regular meetings with their GPs.

In Hackney, a whole series of steps have been taken to improve the integration of physical and mental health. The enhanced primary care service combined GP services with psychological therapies and the support of peer mentors focused on recovery. Similarly, Primary Care Psychotherapy Consultation Services (PCPCS), essentially primary care services using a psychodynamic approach with complex patients, have proven effective with patients who often present with physical symptoms but have an underlying or accompanying mental health condition, through joint consultations. The logic of including a psychotherapist in the A&E team, for instance, is clear, and Hackney now has regular multidisciplinary team meetings in A&E departments to discuss 'frequent attenders' of their services and underlying psychosomatic causes. Other measures include a full depression screening for all diabetics and a mental health fact sheet being given to all 16-year olds in Hackney.

In Tower Hamlets, collaborative outcome-based commissioning has been at the heart of the borough's efforts to better integrate physical and mental health. Tower Hamlets' comparably high number of people suffering with mental health conditions, especially depression and depression, is fuelled by a high prevalence of mental health risk factors such as poverty at all ages, long-term unemployment, poor housing conditions and overcrowding, homelessness, and crime.[41] The borough's strategy focuses on a holistic approach to recovery and supporting the self-determination of service users. Third sector organisations have been given an equal role to public sector organisations and the CCG introduced financial incentives for achieving the outcomes set out in the borough's mental health strategy. Integrating the IT systems of mental and physical health care providers has proved tricky but crucial to avoid duplication and collect better data and improve recovery metrics.

40. Hertel, L. (2015) 'An Extended Primary Care Service for patients with serious mental illnesses' http://blog.good-governance.org.uk/an-extended-primary-care-service-for-patients-with-serious-mental-illnesses/ (last accessed 31st July 2015)
41. Tower Hamlets Health and Wellbeing Board (2014) 'Report of the London Borough of Tower Hamlets: Mental health strategy update' http://moderngov.towerhamlets.gov.uk/documents/s63828/3%202%202014%2011%2019%20Draft%20HWBB%20Mental%20Health%20Strategy%20update%20with%20CFO%20comments.pdf (last accessed 29th July 2015)

The future of care homes, home care, and people-centred social care

We are all aware of the remarkable effects medical advancement, better public health and living standards have had on our life expectancy. Yet, we are equally aware of how inadequately our services are meeting many people's needs and wishes in old age. Ageing is a normal process, not a disease – yet too often our health and social care system treats it like that, as Atul Gawande critiques in his latest book on the issue.[42]

Whilst quality of care is strictly regulated and monitored in healthcare organisations, it still receives surprisingly little attention in the home care sector. All too often, the financial challenges and often recruitment issues overshadow all else in the sector.

Again, people-centred support and care services closer to home can play a crucial role in reducing costs in the long-term, improving quality as well as meeting service users' need in old age.[43] At the same time, structural innovations and different approaches to how social care is commissioned and on what basis contract are awarded can have a big impact on the quality of care.

At the conference, we heard from Birmingham City Council how they have changed their commissioning of home care services in recent years by moving from block contracts and fixed prices to an 'Open Framework' agreement approach[44] focused on outcomes. The new approach has allowed the Council to better scrutinise providers' quality of care incorporating service users and carers' feedback. This has led to a number of changes with some providers being further and further driven out of the market due to poor quality, while a number of other providers offering better quality have flourished. Transparent information and close collaboration with partner organisations as well as service users and their families has been central to this transformation. According to the Council, "since the roll out of the micro procurement system, 93% of all care packages have been won by the best quality provider rather than the provider submitting the lowest price."[45]

42. Gawande, A. (2014) 'Being mortal: Medicine and what matters in the end'. London: Profile Books.
43. The Health Foundation (2014) 'Person-centred care made simple: What everyone should know about person-centred care' http://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf (last accessed 4th August 2015)
44. Birmingham City Council (2014) 'Birmingham City Council's micro-procurement process for adult social care services' http://www.matrix-sps.com/pdfs/BCC-Micro-procurement-leaflet.pdf (last accessed 4th August 2015)
45. ibid

Conclusion

Despite huge challenges and dire budgets, there are inspiring examples of new approaches, real integration and impressive collaborative working across the UK. We have to make sure that our health and social care system allows for the flexibility and freedom to try new approaches, and facilitate the means allowing others to learn from them.

Our biggest challenges looking ahead are clear. Integrating services in a patient-centred manner is a long complex journey that we have started but cannot expect to deliver miracles overnight. Given its prevalence and its immense impact on people's wellbeing, the NHS and our economy, mental ill health desperately needs to be addressed in a more holistic way than has been the case in the past. Again, positive examples of new approaches have emerged all over the country and should be shouted about loudly, but overall, we have a long way to go. In this area as in others where the UK has struggled for a while, cancer care in particular, looking beyond this island's shores can provide new ideas and perspectives.

Perhaps the greatest challenge of our time is to move away from a healthcare system that focuses on technical solutions to apparently technical problems of our bodies, to one that focuses more on informing patients about their conditions as well as treatment and care options, but putting their choices, wishes and goals in life at the heart of everything. From social prescribing to personal care budgets to hospice care, we have to embrace the complexity of people's wellbeing and put their self-determination first.

www.good-governance.org.uk