

Making best use of the Better Care Fund

Spending to save?

Authors

Laura Bennett

Richard Humphries

Introduction and purpose

As financial and service pressures facing the NHS and local government intensify, the need for integrated care to improve people's experience of health and care, the outcomes achieved and the efficient use of resources has never been greater. The pooling of resources across health and social care boundaries is an important ingredient of effective integrated care ([Ham and Walsh 2013](#)).

The June 2013 Spending Round announced the creation of a £3.8 billion Integration Transformation Fund – now referred to as the Better Care Fund – described as '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' ([Local Government Association and NHS England 2013](#)).

The Better Care Fund offers a substantial opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care delivered at scale and pace. But it will create risks as well as opportunities. The £3.8 billion is not new or additional money: £1.9 billion will come from clinical commissioning group (CCG) allocations (equivalent to around £10 million for an average CCG) in addition to NHS money already transferred to social care. For most CCGs finding money for the Better Care Fund will involve redeploying funds from existing NHS services. Guidance makes clear that the Better Care Fund will entail a substantial shift of activity and resource from hospitals to the community – 'hospital emergency activity will have to reduce by 15%' ([NHS England 2013](#)). This could place additional financial pressures on providers already facing the quandary of how to maintain and improve quality of care while achieving financial balance. In addition, the Better Care Fund does not address the financial pressures faced by local authorities and CCGs in 2015 which 'remain very challenging' ([Local Government Association and NHS England 2013](#)).

It is clear that although commissioners will lead local discussions about how the grant is used, the engagement of providers in discussions will be vital. Decisions will affect providers' existing activity and funding and the risks arising from this need to be assessed and managed; providers also have indispensable knowledge and capability to deliver innovative solutions. The most effective local plans will be those that arise from collaboration across the whole system of health, care and support, engaging all NHS and local authority partners, including acute and community health care organisations.

This paper summarises the evidence from work by The King's Fund and other research about which approaches are likely to offer commissioners maximum impact in a way that will benefit both the NHS and social care. Its purpose is to offer an evidence-based guide focusing on 'what works', to assist and support local discussions between CCGs, local authorities and health and wellbeing boards. The ambition must be to invest the Better Care Fund wisely in one part of the system to reduce pressure elsewhere – 'spending to save'.

Background

The Better Care Fund will comprise the following existing budgets, to create a pooled budget of £3.8 billion:

- £1.1 billion existing transfer from health to social care
- £130 million Carers' Breaks funding
- £300 million CCG re-ablement funding
- £350 million capital grant funding (including £220 million Disabled Facilities Grant)
- £1.9 billion from NHS allocations.

In preparation for the full Better Care Fund, which will come into effect in 2015/16, £200 million will be transferred from the NHS to social care in 2014/15, in addition to the £900 million transfer already planned. This pooled budget must be used to support adult social care services that have a health benefit, based on agreement between local authorities and CCGs, which are signed off by both parties and the local health and wellbeing boards.

Health and wellbeing boards are expected to provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans, by 14 February 2014. These two-year plans should sit in the context of a five-year strategic plan for 2014/15–18/19 setting out a broader vision for a transformed health and care system. Plans for spending from the Better Care Fund must detail how they will provide:

- protection for social care services
- seven-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number
- a joint approach to assessments and care planning and, where funding is used for integrated packages of care, an accountable professional
- agreement on the consequential impact of changes in the acute sector, with an analysis, provider-by-provider, of what the impact will be in their local area alongside public and patient and service user engagement in this planning, and plans for political buy-in.

The national metrics for how well the Better Care Fund is being used to develop integrated care will be:

- admissions to residential and care homes
- effectiveness of re-ablement
- delayed transfers of care
- avoidable emergency admissions
- patient/service user experience.

These measures will be important in allocating the £1 billion of the Fund that is related to performance against outcomes, though there is some scope to use locally developed measures.

Using this guide: evidence and approaches

The NHS planning guidance for 2014 (NHS England 2013b) requires commissioners to include in their plans a vision for how health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

It is important to note that the strength of evidence quoted in this paper varies and there are gaps in our knowledge of ‘what works’. Some admission avoidance and intermediate care schemes, for example, can be implemented using different service models and with different criteria that affect the results and outcomes achieved. Often very promising evidence from local integration programmes has yet to be replicated.

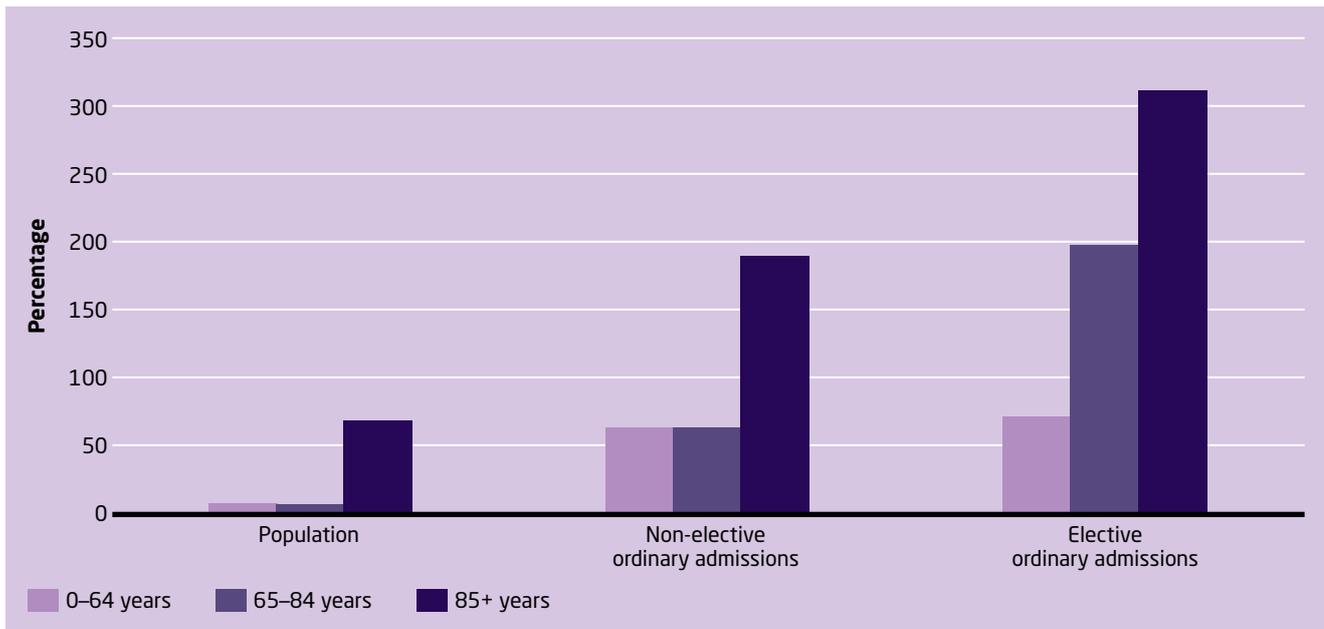
Despite these constraints, health and care leaders are faced with the necessity of making decisions about the use of the Better Care Fund based on the best available knowledge and evidence. This will require a sound understanding of the key local challenges and the underlying issues that need to be addressed, so that the evidence summarised here can be interpreted and used accordingly. Decision-makers must also balance evidence-based decision-making with a willingness to innovate and try out different approaches.

Understanding the sources of need and demand

The Better Care Fund has been implemented in the context of an ageing population and an increasing number of people who have one or more long-term conditions. These two factors mean that the needs of patients and service users increasingly cut across multiple health and social care services. Increasing demand and financial pressures mean there is a need to focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources. It is vital that clinical commissioning groups and local authorities understand the populations they serve and how the use of services is distributed within their populations in order to target interventions where they can have the most impact. Local Joint Strategic Needs Assessments may be a useful tool here.

Nationally, our population is growing, ageing and becoming more diverse (The King’s Fund 2013). Over the next 20 years the number of people aged over 85 is expected to increase by 106 per cent. By 2030, the number of older people with care needs, such as requiring help with washing or dressing, is predicted to rise by 61 per cent and by 2032, more than 40 per cent of households are expected to be people living on their own. The number of people with dementia is expected to more than double over the next 30 years. The graph overleaf indicates the growing pressure that an ageing population is placing on hospitals (The King’s Fund 2013).

Growth in activity over past 20 years, by age group, England, 1989/90–2009/10



Source: The King's Fund Time to Think Differently web page. Available at: www.kingsfund.org.uk/time-to-think-differently/trends/demography/ageing-population

In the next 20 years, the number of people with some diseases is expected to double. Currently, 58 per cent of people aged over 60 have a long-term condition and people in the poorest social class have a 60 per cent higher prevalence than those in the most affluent social class (Department of Health 2012). People in the most affluent socioeconomic class can expect to live on average seven years longer than those in the poorest socioeconomic class.

By 2018, the number of people with three or more long-term conditions is expected to rise to 2.9 million; in 2008 this figure stood at 1.9 million (Department of Health 2012). Our health and social care services increasingly need to be able to prevent and manage multi-morbidity rather than single diseases. The number of conditions a patient has can be a greater determinant of a patient's use of health service resources than the specific diseases (Barnett *et al* 2012) and a small number of patients can consume a large proportion of resources across acute, community, primary, mental health and social care. For example, in an analysis of North West London's population, it was found that 5 per cent of the population, who were identified as at high risk of emergency admission, accounted for 40 per cent of the total spend (McKinsey & Company 2013). Knowing who these people are is essential to being able to change how services and resources are used.

Further reading

The King's Fund Time to Think Differently web resources. Available at www.kingsfund.org.uk/time-to-think-differently

Primary prevention

Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system. The King's Fund has recently published a resource for local authorities that outlines the key priorities for prevention and improving the public's health (Buck and Gregory 2013). The paper highlights partnership working and systematic use of health impact assessments as key and highlights key areas that can improve public health and reduce inequalities.

Key pointers from evidence include:

- supporting individuals to change behaviours such as smoking, for example, through advice during a consultation
- community interventions in schools to reduce childhood obesity
- regulatory actions such as controlling the density of alcohol outlets (Campbell *et al* 2009)
- investing in winter preparedness to reduce excess winter deaths (The Eurowinter Group 1997)
- ensuring we get housing right to support people (especially older people) to stay in their own homes (Association of Directors of Adult Social Services and Housing Learning and Improvement Network 2012)
- preventing social isolation and loneliness to help to maintain independence (Allen and Glasby 2010; World Health Organization, Commission on the Social Determinants of Health 2008).

(Naylor *et al* 2013)

Further reading

Buck D, Gregory S (2013). *Improving the public's health: a resource for local authorities*. London: The King's Fund.

World Health Organization, Commission on the Social Determinants of Health (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf (accessed on 17 December 2013).

Self-care

People with long-term conditions account for 70 per cent of all inpatient bed days (Naylor *et al* 2013). Self-management programmes, which aim to support patients to manage their own condition, have been shown to reduce unplanned hospital admissions for some conditions such as chronic obstructive pulmonary disease (COPD) and asthma (Purdy 2010).

Evidence for resulting cost savings is more equivocal (Naylor *et al* 2013), but key pointers from evidence include the following:

- tailoring interventions to the condition (de Silva 2011); for example, for conditions such as diabetes structured patient education may be beneficial, while conditions such as depression may require behavioural interventions
- involving patients in co-creating a personalised self-management action plan, which could include education programmes, medicines management advice and support, telecare and telehealth for self-monitoring, psychological interventions and patient access to their own records (Richmond Group of Charities and The King's Fund 2012)
- telephone health coaching
- behavioural change programmes to encourage patient lifestyle change
- as the number of people who are unpaid carers for older people is expected to rise (House of Lords 2013), providing support for informal caregiving (WHO 2012).

Further reading

de Silva D (2011). *Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management*. London: The Health Foundation.

Managing ambulatory care-sensitive conditions

Conditions where the need for hospital admissions can be reduced through active management (known as ambulatory care-sensitive (ACS) conditions) accounted for 15.9 per cent of all emergency hospital admissions in England in 2009/10, with an estimated cost of £1.42 billion (Tian *et al* 2012). The rate of emergency admission for these conditions in the most deprived areas is more than twice the rate in the least deprived areas in England (Tian *et al* 2012). The annual Care Quality Commission (CQC) 'state of care' report (2013) found that 'older people are increasingly arriving in A&E with avoidable conditions' such as diabetes or respiratory diseases. The report found that some areas were more able to avoid these admissions and it highlights interaction between primary health care, secondary health care and social care as key (CQC 2013).

Key pointers from evidence include:

- early identification of ambulatory care-sensitive conditions, for example, through risk stratification (*see below*)
- increased continuity of care with a GP
- early senior review in A&E, and structured discharge planning.

(Purdy 2010)

Further reading

Purdy S (2010). *Avoiding hospital admissions: what does the research evidence say?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding-hospital-admissions (accessed on 19 December 2013).

Risk stratification or predictive modelling

Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions. In an evaluation of predictive modelling options, Billings *et al* (2013) suggest:

- choosing which predictive model should be based on a number of factors, including the intervention design and the data that it will analyse
- including GP data in predictive modelling is particularly important, and including all patients in an area rather than just those with prior hospital use was found to improve case-finding.

One example of a service model that uses risk stratification is 'virtual wards', which provide multidisciplinary case management to people in their own homes identified as high risk, as would be available in a hospital ward, in order to prevent emergency admissions.

Key pointers from evidence include:

- using an 'impactability model' to identify high-risk patients who are most likely to benefit from preventive care
- having catchment areas based on the distribution of high-risk patients, for example, smaller catchment areas in deprived neighbourhoods where there are likely to be more high-risk patients
- organising these around groups of GP practices or an equivalent
- considering the needs of the local area when developing the staff mix, for example, include a mental health professional in areas with high prevalence of mental illness.

(Lewis *et al* 2013)

Further reading

Lewis G, Georghiou T, Steventon A, Vaithianathan R, Chitnis X, Billings J, Blunt I, Wright L, Roberts A, Bardsley M (2013). *Impact of 'virtual wards' on hospital use: a research study using propensity matched controls and a cost analysis*. Final report. London: NIHR Service Delivery and Organisation programme. Available at: www.nets.nihr.ac.uk/__data/assets/pdf_file/0011/87923/FR-09-1816-1021.pdf (accessed on 20 December 2013).

Falls prevention

Older people who are frail are a key concern for health and social care services and are at risk of sudden functional decline including falling or becoming immobile (Clegg *et al* 2013). Identifying those at risk of falls and setting up fracture prevention services for older people have been found to reduce hospital admissions and the need for social care such as admission to a care home (Department of Health 2009). Older people who are at risk should be screened for frailty and receive a comprehensive geriatric assessment (Clegg *et al* 2013). National Institute for Health and Care Excellence (NICE) guidelines (2013) recommend that older people should be asked routinely whether they have fallen in the past year and that older people who report recurrent falls should be offered a multifactorial falls risk assessment and individualised intervention.

Key pointers from successful intervention programmes include:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal.

(NICE 2013)

Further reading

NICE (2013). *Falls: assessment and prevention of falls in older people*. NICE clinical guideline 161. London: NICE. Available at www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf (accessed on 17 December 2013).

Department of Health (2009). *Fracture prevention services: An economic evaluation*. London: The Stationery Office.

Care co-ordination

Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual's needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in recent changes to the GP contract.

Key pointers from evidence include:

- a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than a purely clinical focus on treating medical conditions
- a single entry point for care co-ordinators to provide personal continuity for patients and carers as well as enabling access to care through multidisciplinary teams
- shared electronic health records can support the process but a 'high-touch, low-tech' approach can promote face-to-face communication, foster collaboration and enable meaningful conversations about care for patients with complex needs

- co-ordinating care at the neighbourhood level ‘where the benefits of engagement with local communities sit alongside the need to have close working relationships within multi-disciplinary teams dealing with manageable caseloads’
- prioritising engagement with GPs and links with secondary care to ensure quality transitions, for example, from hospital to home.

(Goodwin *et al* 2013)

Further reading

Goodwin N, Sonola L, Thiel V, Kodner D (2013). *Co-ordinated care for people with complex chronic conditions*. London: The King’s Fund.

Case management

Case management exists in many different forms, but it is generally described as ‘a targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination’ (Ross *et al* 2011). Co-ordinated and integrated services for people with long-term conditions have potential to deliver better and more cost-effective care if they are well designed, involve professionally trained case managers and care teams, and are embedded in a wider system that supports co-ordinated care (Ross *et al* 2011). Evidence suggests that a significant proportion of admissions could be avoided if alternative forms of care were available (Health Foundation 2013).

Key pointers from evidence include:

- a focus on early action and prevention, targeted at particular communities to mobilise local people
- community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location
- a single point of access, single assessment and shared clinical records
- targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data
- the individual and their case manager co-producing a personal care plan, which brings together an individual’s personal circumstances (including housing, welfare and access to informal care) with their health and social care needs
- systems to enable all those involved in a patient’s care to access up-to-date patient records
- continuity of care, including effective communication processes where all information is streamed through the case manager
- case managers having the necessary skills for the role, as well as clear role boundaries and accountabilities.

(Ross *et al* 2011)

Further reading

Edwards N (forthcoming). *Community services: how they can transform care*. London: The King’s Fund.

Ross S, Curry N, Goodwin N (2011). *Case management: what it is and how it can best be implemented*. London: The King’s Fund.

Intermediate care, re-ablement and rehabilitation

Intermediate care services, including rehabilitation and re-ablement, have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up).

Re-ablement can enable people to stay in their own homes for longer, reduce the need for home care and improve outcomes for users. Re-ablement costs slightly more than traditional home care, but there is a strong probability of cost savings in the long term (Social Care Institute for Excellence 2013).

Rehabilitation and re-ablement provided at home is cheaper than rehabilitation and re-ablement when it is provided as bed-based care, and in many cases services provided at home are preferred by service users; however, access to rehabilitation and re-ablement outside acute hospitals varies significantly (NHS Benchmarking Network *et al* 2013). For example, the number of intermediate care beds commissioned by clinical commissioning groups varies from more than 70 to fewer than 10 (per 100,000 weighted population) and the number of referrals to home services varies from nearly 2,500 to fewer than 100. The National Audit of Intermediate Care 2013 identified getting service provision up to the level of the best performers as a key priority.

Key pointers from evidence include:

- shared and comprehensive assessment of needs and personalised plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of service users
- commissioning for outcomes, not time periods and tasks, for example, with lump sum payments, to ensure people move on as soon as they are ready or are able to spend longer than six weeks if necessary
- workforce led by a senior clinician, with an appropriate skill-mix and with specific re-ablement training and skills that are distinct from broader home care services and focus on supporting people to do things for themselves
- adequate provision for rehabilitation and re-ablement outside acute hospitals, based on demographic characteristics of the local population
- spot purchasing nursing home beds or new forms of sheltered or retirement housing known as 'extra care housing' to provide rehabilitation and re-ablement and prevent hospital admission or discharge from hospital to long-term care
- where a person needs ongoing support at the end of rehabilitation and re-ablement, planning care to provide those services and maintain the progress.

(SCIE 2013)

Further reading

Social Care Institute for Excellence (2013). *Maximising the potential of re-ablement*. London: SCIE.

NHS Benchmarking Network, British Geriatrics Society, Association of Directors of Adult Social Services, College of Occupational Therapists, Royal College of Physicians, Royal College of Nursing, Chartered Physiotherapists, The Patients Association, Royal College of Speech & Language Therapists, NHS England (2013). *National Audit of Intermediate Care 2013* [online]. Available at: www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/ (accessed on 17 December 2013).

Managing emergency activity, discharge planning and post-discharge support

Emergency admissions account for more than 70 per cent of hospital bed days (Poteliakhoff and Thompson 2011). Factors associated with increased rates of admission include age, social deprivation, morbidity levels, living in an urban area, ethnicity and environmental factors (Purdy 2010). A lack of alternative options frequently leads to patients being admitted to hospital when it is not clinically justified. It is vital that there is capacity to offer rapid responses in the community that offer an alternative to a hospital stay (Edwards, forthcoming).

Eighty per cent of emergency admissions whose length of stay exceeds two weeks are aged over 65. Poteliakhoff and Thompson (2011) suggest that focusing on reducing length of stay for older people may have the most potential for reducing use and cost of hospital beds. If all areas achieved the rate of admission and average length of stay of those in the lowest 25th percentile, 7,000 fewer hospital beds would be needed across England (Imison *et al* 2012).

NHS and social care should work together to provide good discharge planning and post-discharge support. A structured individualised discharge plan can reduce readmissions by around 15 per cent (Shepperd *et al* 2010). Early supported discharge has been shown to enable people to return home earlier, remain at home in the long term and regain their independence in activities of daily living (Fearon and Langhorne 2005).

Key pointers from evidence include:

- early discharge planning to ensure referral to community services is in place in advance of discharge
- an agreed discharge process that includes timescales and protocols for assessment and decision-making for different agencies to work together
- ensuring patients with existing community services are discharged as soon as possible with care re-started
- use of ‘discharge to assess’ models to enable people to be assessed in their own homes
- rehabilitation to ensure people do not become dependent or disabled in hospital
- ‘in reach services’ from social care and community services
- supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports.

(Oliver *et al*, forthcoming)

Further reading

Poteliakhoff E, Thompson J (2011). *Emergency bed use: what the numbers tell us*. London: The King’s Fund.

Shepperd S, Doll H, Angus RM, Clarke MJ, Iliffe S, Kalra L, Ricauda NA, Tibaldi V, Wilson AD (2009). ‘Avoiding hospital admission through provision of hospital care at home: a systematic review and meta-analysis of individual patient data’. *Canadian Medical Association Journal*, vol 180, no 2, pp 175–82.

Oliver D, Foot C, Humphries R (forthcoming). *Making our health and care services fit for an ageing population*. London: The King’s Fund.

Medicines management

The proportion of patients receiving five or more drugs increased from 12 to 22 per cent between 1995 and 2010 (Duerden *et al* 2013). Between one-third and one-half of medication prescribed for long-term conditions is not taken as recommended (Nunes *et al* 2009), and around 7 per cent of hospital admissions have been associated with adverse drug reactions (Pirmohamed *et al* 2004). As the number of people taking multiple drugs increases, so do the challenges for clinicians in managing this (Duerden *et al* 2013). The cost savings associated with these could be substantial.

Key pointers from evidence include:

- effective team working between patients, doctors, nurses and pharmacists avoids the risks of polypharmacy
- educational information and outreach services reduce prescribing and monitor errors, for example, training in managing complex multi-morbidity and polypharmacy for general practitioners, orthogeriatricians or nurse specialists
- use of IT and decision-making support tools
- longer GP consultations for patients with multi-morbidity to allow sufficient time for the use of drugs to be reviewed
- enabling patients to attend a single clinic to have their long-term conditions reviewed by a clinical team, rather than several disease-specific clinics
- improved systems for transfer of patient medication details at admission and discharge
- medication reviews or practice-based audits linked to peer review of prescribing practices
- providing clinicians with benchmarked information on prescribing performance
- use of pharmacy technicians to support general practices
- taking into account patient perspectives, as some patients face challenges in managing their medications and patients may not be taking the drugs that clinicians think they are.

(Duerden *et al* 2013; Naylor *et al* 2013)

Further reading

Duerden M, Avery T, Payne R (2013). *Polypharmacy and medicines optimisation: making it safe and sound*. London: The King's Fund.

Mental and physical health needs

Between 12 and 18 per cent of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems.

(Naylor *et al* 2012)

Many patients who are frequent attenders at A&E have an untreated mental health problem (NHS Confederation 2009). The Joint Commissioning Panel for Mental Health (2012) suggests that liaison services should be provided in A&E departments for patients who have a mental and physical disorder to ensure all their needs are met. Rapid Assessment Interface and Discharge (RAID), a model for liaison services which includes health and social care capacity as well as specialist skills to provide a complete mental health service in an acute trust, has been shown to reduce hospital bed use, particularly by older people (Parsonage and Fossey 2011).

Key pointers from evidence include:

- improved identification of mental health needs among people with long-term conditions
- strengthened disease management and rehabilitation by including psychological or mental health input
- commissioning services based on the collaborative care models recommended by NICE (2009) to improve the interface between primary care, mental health and other professionals
- expanding Improving Access to Psychological Therapies services to support people with long-term conditions
- improving the mental health skills in general practice and intermediate care, with training designed specifically for primary care professionals.

(Naylor *et al* 2013)

Further reading

Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012). *Long-term conditions and mental health: The cost of co-morbidities*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health (accessed on 19 December 2013).

NICE (2009). *The treatment and management of depression in adults with chronic physical health problems*. NICE Clinical Guideline 91.

Parsonage M, Fossey M (2011). *Economic evaluation of a liaison psychiatry service*. London: Centre for Mental Health.

Improving management of end-of-life care

The estimated costs of caring for people at the end of life run into billions of pounds (National Audit Office 2008). Identification of people who are at the end of life and co-ordination of care can improve the quality of care, and there may be some scope for cost savings through reduction of unnecessary admissions into the acute setting (Naylor *et al* 2013).

Marie Curie provides an end-of-life nursing service that includes hands-on care and emotional support to enable people with a terminal illness to die at home. The service provides discharge support, integrated health and social care and urgent care. In a recent evaluation of the service, the Nuffield Trust found that people in the Marie Curie nursing service were less likely to have an emergency admission at the end of life and had reduced hospital costs (Chitnis *et al* 2012). Their findings support the case for investing in services to improve care for people at the end of life.

Key pointers from evidence include:

- facilitation of discharge by ensuring there is adequate capacity to provide end-of-life care outside of the hospital setting, for example, by investing in services such as Marie Curie nursing service
- rapid response services being available during periods out of hospital to prevent emergency admissions to hospital at the end of life
- centralised co-ordination of care provision in the community
- 24/7 care outside of hospital to prevent emergency admission and facilitate discharge from hospital at the end of life.

(Naylor *et al* 2013)

Further reading

Public Health England, National End of Life Care Intelligence Network at www.endoflifecare-intelligence.org.uk/home

Chitnis X, Georghiou T, Steventon A, Bardsley M (2012). *The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life*. London: Nuffield Trust.

Delivering integrated care

The Nuffield Trust (Bardsley *et al* 2013) recently evaluated more than 30 community-based integrated care innovations and found limited impact on emergency hospital admissions. However, areas with well-developed, integrated services for older people have been found to have lower rates of hospital bed use, and areas with low bed use have been found to deliver a good patient experience as well as lower readmission rates (Imison *et al* 2012). Integrating primary and social care has been shown to reduce admissions, and integration of primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions (Curry and Ham 2010).

In Torbay, which has developed an integrated health and social care economy, they were able to reduce the number of delayed transfers of care from hospital to a negligible number, reduce emergency bed day use for people aged 85 and over by 32 per cent between 2003 and 2008 and reduce emergency bed day use for people aged over 65 to the lowest in the region, at 1920 per 1000 population compared to an average of 2698 per population in 2009/10 (Thistlethwaite 2011). One of the consequences was that average daily bed day use in Torbay fell from 750 beds in 1998/99 to 502 beds in 2009/10 (Thistlethwaite 2011).

The Better Care Fund represents a commitment to promoting integration but making integrated care happen is challenging.

Key pointers from evidence include:

- find common cause with partners and be prepared to share sovereignty
- develop a shared narrative to explain why integrated care matters
- develop a persuasive vision to describe what integrated care will achieve
- establish a shared leadership
- create time and space to develop understanding and new ways of working
- identify service users and groups where the potential benefits from integrated care are greatest
- build integrated care from the bottom up as well as the top down
- pool resources to enable commissioners and integrated teams to use resources flexibly
- innovate in the use of commissioning, contracting and payment mechanisms and the use of the independent sector
- recognise that there is no 'best way' of integrating care
- support and empower users to take more control over their health and wellbeing
- share information about users with the support of appropriate information governance
- use the workforce effectively and be open to innovations in skill-mix and staff substitution

- set specific objectives and measure and evaluate progress towards these objectives
- be realistic about the costs of integrated care
- act on all these lessons together as part of a coherent strategy.

(Ham and Walsh 2013)

One way of bringing together the different approaches outlined in this paper is to make use of the house of care model (Coulter *et al* 2013).

The house of care model

This is a model of delivering personalised care that aims to provide people with the knowledge, skills and confidence to manage their condition in the context of their everyday life. The model encompasses all people with long-term conditions, not just those in high-risk groups and is a whole-system approach that aims to make best use of local authority services, community resources and health services by commissioning for local populations and providing care planning for individuals.

Key recommendations include:

- promote a shift to an anticipatory and planned approach to caring for patients with long-term conditions
- monitor the extent to which patients are engaged in decisions, have personalised care plans and receive co-ordinated services and appropriate support for self-management
- ensure good-quality training courses in care planning and self-management support are available and that staff are encouraged to attend them
- agree common goals for care planning and provide analytical support and feedback
- develop and make available directories of community services and other non-traditional self-care support services
- ensure that electronic health records are fit for care planning and that information is shared with other organisations
- allow patients to access their electronic medical records and develop shared records for care planning.

Further reading

Bardsley M, Steventon A, Smith J, Dixon J (2013). *Evaluating integrated and community-based care: how do we know what works?* London: The Nuffield Trust.

Thistlethwaite P (2011). *Integrating health and social care in Torbay: improving care for Mrs Smith.* London: The King's Fund.

Ham C, Walsh N (2013). *Making integrated care happen at scale and pace: lessons from experience.* London: The King's Fund.

Coulter A, Roberts S, Dixon A (2013). *Delivering better services for people with long-term conditions: building the house of care.* London: The King's Fund.

A full list of references is available separately at: www.kingsfund.org.uk/bettercarefund

The King's Fund provides a wide range of resources and support for those involved in integrated care.

System leadership

Building collaborative leadership across health and social care organisations

This new programme has been designed to support chief executives to lead their organisations more effectively within the current health and social care system. It will allow leaders time and space in which to develop the skills and behaviours to support a more collaborative style of leadership.

For more information contact Nicola Walsh n.walsh@kingsfund.org.uk

Learning networks

The Fund runs a number of learning networks on integrated care that support communities of health and care organisations to develop and implement joined-up care at scale and pace. The networks provide an opportunity for peer-to-peer learning, challenge, and information sharing, and the opportunity to work through issues with colleagues facing similar challenges. External speakers are invited to share expertise, and the groups are also able to draw upon insights from staff at the Fund.

For more information contact Beatrice Brooke b.brooke@kingsfund.org.uk

Free resources

Sam's story A three-minute animation on why integrated care matters.

Integrated care map A range of case studies to help showcase integrated care in action.

Perspectives on integrated care Video interviews with a number of leaders across NHS trusts and CCGs on the barriers and enablers to joining up care.

Integrated care bulletin Keep up to date with our monthly email containing the latest news, policy and guidance on integrated care.

Integrated care LinkedIn group Network with other people involved in implementing integrated care.

Publications

Our most recent work includes:

Health and wellbeing boards: One year on examines how health and wellbeing boards have used their shadow year, what they have achieved, and whether they are providing effective leadership across local systems of care.

Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success explores the key components of effective co-ordinated care through a study of five UK-based programmes.

The quest for integrated health and social care: A case study in Canterbury, New Zealand tells the story of the journey made by the District Health Board for Canterbury, New Zealand, towards its goal of providing integrated care for all, and considers the lessons that can be learned from the Canterbury experience.

Integrated care in Northern Ireland, Scotland and Wales looks at what the health and social care system in England can learn from the experiences of the other countries of the United Kingdom.

Making integrated care happen at scale and pace: Lessons from experience summarises 16 steps that need to be taken to make integrated care a reality and draws on work by The King's Fund and others to provide examples of good practice.

Find these resources at www.kingsfund.org.uk/joinedupcare

The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel 020 7307 2400

Registered charity: 1126980
www.kingsfund.org.uk

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.