Integrated Health & Social Care
The Holy Grail

Oxford July 2016
Terry Bamford
Integration

• A Government Imperative
• Interdependence of health and social care.
• Attractive to NHS:- control over domiciliary care – end to delayed discharges
• Attractive to LAs – NHS resources protected
• Possible economies in Delivery Costs
The ‘Buts’

• NI integrated for 45 years. Limited impact
• Joint Care planning (1974)
• Health Act Flexibilities (1999)
• Care Trusts (2000)
• Better Care Fund (2014)
• Different Funding streams and pressures.
• NHS Bureaucracy
Different Cultures

**NHS**
- The KCMG stereotype
- Individual Autonomy of Consultants and Nurses
- Risk Averse culture

**LA Social care**
- Empowerment
- Shared decisions in teams
- Democratic control
- LA as corporate parent
- Risk taking and Normalisation
But the NHS is Changing fast

- Partnerships with Patients
- Self management
- Co production
- Patient held records
- Holistic care
- Emphasis on measurable outcomes
What worked in NZ

- GPs & Hospitals: one system, one budget
- Agreed evidence based clinical pathways

Outcomes:
- Lower rates of admission
- Reduced length of stays
- Fewer readmissions
- Reduced waiting times
- Measurable gains from integrating primary and secondary care
What works: Preconditions

- Cultural change: Patients First
- Commitment from the top
- Communication on project, purpose and pathways
- Clarity about roles and responsibilities
The Grail can be a mirage

- NW London Pilot Projects
- Evidence of impact
- Are the 4 ‘C’s in place
- Where do we want to be?