SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE

Expert Panel Report

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The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave of their time and expertise to informing this work. The report would not have been possible without their involvement.

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SECTION 1

THE PANEL'S REMIT AND THE POLITICAL SUMMIT

In his speech of 4 November 2015, the then Minister for Health, Simon Hamilton MLA, announced that in response to recommendation 1 of **The Right Time, The Right Place** report by Sir Liam Donaldson, he would appoint an expert, clinically led panel to consider and lead an informed debate on the best configuration of Health and Social Care services in Northern Ireland.

Sir Liam's report stated:

"A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standards of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest".

The Panel was appointed in January 2016 and comprises local and international members. The Panel was given the remit to:

- Produce a set of principles to underpin reconfiguration of health and social care services.
- Support and lead debate including at a political summit to be held in early 2016 to agree the principles.
- Use the results of the political summit to develop a clinically informed model for the future configuration of health and social care, which will ensure world class provision for everyone in Northern Ireland.
- Clearly quantify the specific benefits in health outcomes that will be derived from the new model, both for individuals and the Northern Ireland population as a whole.

Political Summit: 17th February 2016

The panel along with MLAs and advisors from the DUP, Sinn Fein, UUP, SDLP and Alliance met for a one day health summit to discuss the need for change and agree a set of principles that would guide the panel in structuring a New Model of Health and Social Care for the people of Northern Ireland. Each party provided both verbal and written comments to a 'draft set of principles'. In turn the panel considered all comments and revised the principles to take as many of these on board as possible.

The final set of principles is attached at Annex A.

Engagement

The Panel has engaged extensively with stakeholders across health and social care, and the following key messages were heard consistently:

- The unsustainable nature of the 'status quo'. Major workforce gaps in all areas of the current model of service requiring significant investment in agency staff to maintain the current distribution of acute care.
- Underinvestment in primary and social care, the very services that can prevent hospital admission, because of over-investment in the current hospital model.
- Even with the funding used to purchase independent sector and 'in-house' waiting list initiatives, there are increasing delays for elective care.
- The contribution of unpaid carers and the voluntary sector, and the desire for the voluntary sector to be a trusted partner in care.
- Independent providers are delivering significant elements of care in domiciliary and residential care home settings and are struggling to cope with current funding levels.
- The need to invest in improving the health of our population and to take a more co-ordinated approach to supporting people with complex needs.

SECTION 2

THE BURNING PLATFORM – AN UNASSAILABLE CASE FOR CHANGE

Context

In the course of its work, the Panel has heard repeated references to 'review fatigue'. In essence, there seems to be a sense that the Health and Social Care (HSC) system has repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for change, but subsequently failing to enact the necessary transformation to make these happen. The timeline at fig. 1 gives a sense of the main reforms and reviews that the system has experienced since the 1970s.

Across the system, there has been a broad consensus among those the panel has spoken to that there is a need for transformational change in the way services are delivered and the way our system is organised. It is important to fully understand the nature of the challenges and demands that health and social care services face, and also the reasons why the model that is currently in place is outdated and is not the one that Northern Ireland needs. Many of these issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated to us from a number of different sources, who made clear their concerns with regard to factors such as rising demand, changing demographics and patterns of illness, financial sustainability, workforce planning and vulnerable services. Although there are committed and talented people at all levels of the system, the system itself is not making the most effective use of the available public funds to meet service users' needs.

Northern Ireland is not alone in facing these challenges. Health and social care systems across the developed world are currently struggling with the question of how to adapt their services to deal with continuously rising and changing patterns of demand. Most countries also recognise that simply adding more money and resources to tackling these issues is not enough to make services higher quality and sustainable, radical transformation is required. This is not an easy thing to do; change and transformation are always difficult, they create uncertainty and they require us to give up what we have in exchange for something new. This is particularly difficult when it involves something that is very important to us, such as the health and social care services that we and our families will all need to call on at some point in our lives.

Fig. 1 – Reviews and Reforms of Health and Social Care in Northern Ireland

1973 The HPSS (NI) Order provided for the establishment of four Health and Social Services Boards, responsible for administering and arranging provision of services.

1989 A Government white paper introduced the concept of an internal market. In Northern Ireland, this led to the establishment of 19 Trusts.

1998 Fit for the Future proposed the abolition of the internal market with commissioning decisions taken as close as possible to patients and clients and centred on primary care.

2001 The Acute Hospitals Review suggests the establishment of a single Strategic Health and Social Services Authority to replace the four HSS Boards. It also recommends moving to a service with 9 acute hospitals

2002 Developing Better Services supports significantly reducing the number of HSC organisations, including the creation of a single regional authority. Also recommends the 15 Local Health and Social Care Groups (LHSCGs) should be brought together.

2002 GP fundholding abolished. Arrangements for LHSCGs, as committees of the four HSS boards are put in place to assess need and design services. 15 were in place by 2005.

2005 The Appleby Review focuses on the need for rigorous performance management and greater incentivisation of strong performance.

2007 The then Minister decides against a regional Health Authority. Instead, he confirms the creation of 5 new integrated Trusts, 5 Local Commissioning Groups, a smaller Health and Social Care Board focused on commissioning, financial and performance management, and a Public Health Agency.

2011 Transforming Your Care sets out a broad new model of care, moving away from hospitals and into primary, community and social care services. Recommends 5-7 hospital networks

2014 Sir Liam Donaldson endorses the policy behind TYC but recommends the appointment of an impartial panel of experts to deliver the right configuration of HSC services.

2015 Following the Donaldson report and an internal review of commissioning, the then Minister launches a consultation on a review of the HSC administrative structures. The review recommends abolition of the HSCB.

2016 The appointment of an international expert panel to develop a clinically informed model for the future configuration of health and social care.

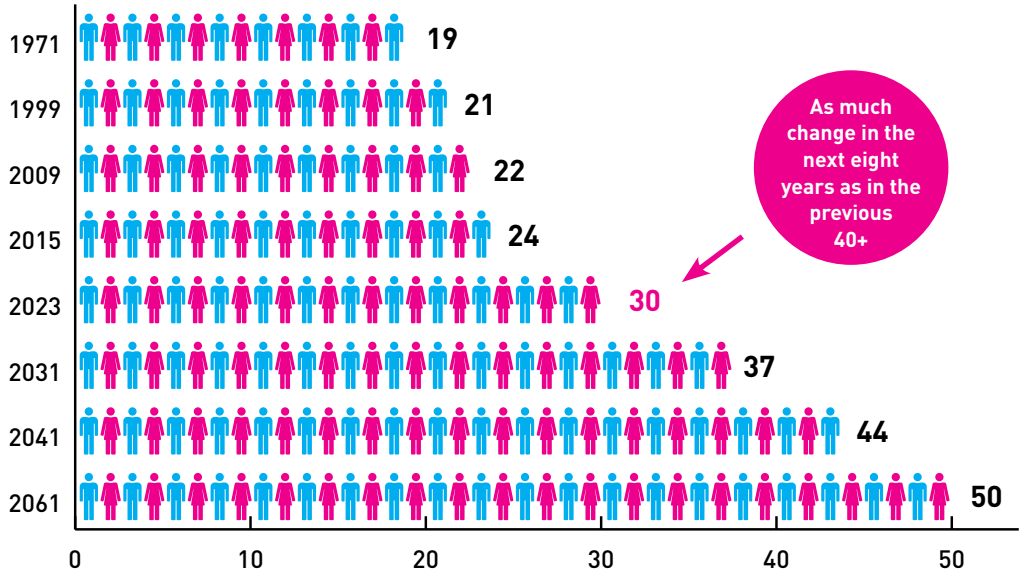
However, it is important that the case for change is clearly understood by those who use and those who deliver these services, and also the risks of not making these changes in a planned and transparent way. In this section of the report, the evidence that the existing system is already struggling to sustain services in the face of these changing circumstances is set out and the case made for new service models. Without systematic and planned change, already stretched services will undoubtedly be forced into unplanned change through fire-fighting and crisis.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it. This report presents an opportunity that must be seized and acted upon.

Demographic Change

As a population, we are living longer than ever before and, for most of our lives, are healthier than ever before. When the NHS was created in 1948, life expectancy was 65.8 years for men and 70.1 years for women. It is now 78.1 for men and 82.4 for women. The number of older people in our community is also increasing as a proportion of the overall population. In 2013 there were estimated to be 279,000 people aged 65 and over, with 33,000 of them over 85 years. This is projected to increase considerably in the next 20 years to 456,000 and 79,000 respectively. As the graph below demonstrates, the demographic shift for the period from 2015-2023 will be equal to the demographic shift in the preceding 40 years.

Fig. 2 – Population Projections (2015-2061)



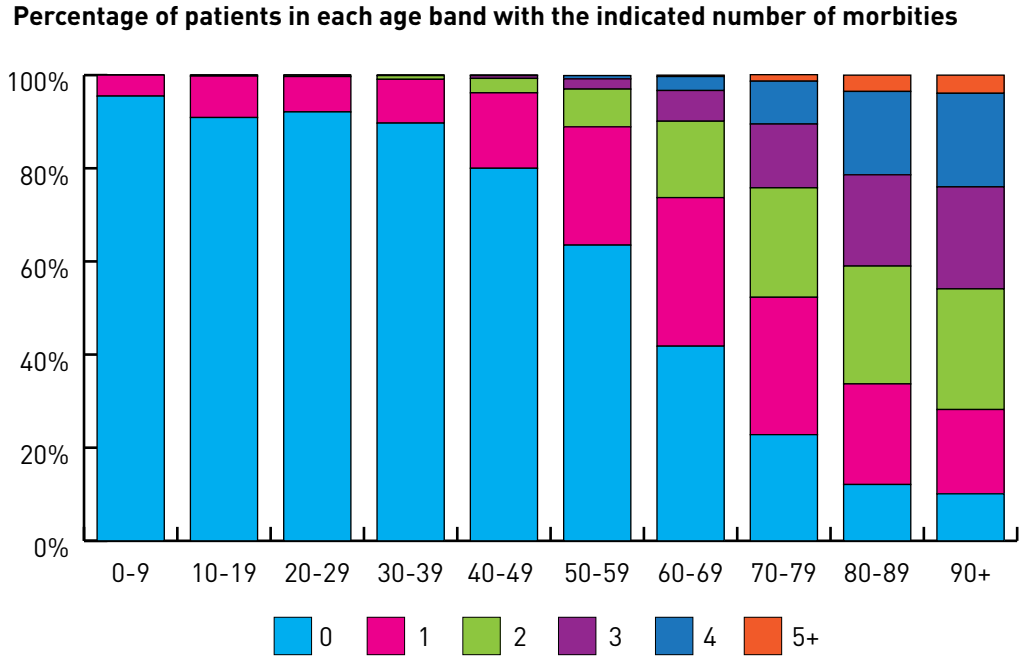
An ageing population: Number of older people (65+) per 100 aged 16-64

It is a similar picture across the UK and Ireland. However, out of all the UK countries, at 43.1% Northern Ireland had the largest percentage growth of people aged 85+ between mid-2004 and mid-2014. This is projected to continue over the 25 year period between mid-2014 and mid-2039.[1]

This increase in life expectancy is a great achievement, but it signals a major shift in demography and in patterns of demand for health and social care services. Ageing brings an increased likelihood of some degree of disability, dependency and illness, and older people are now the main users of Northern Ireland's health and social care services. The rate of disability among those aged over 85 is 67% compared with only 5% among young adults.[2] Dementia is also a growing issue for our older population, with 60,000 people projected to be suffering from the condition by 2051.[3] In addition, the profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses.

As well as living longer, developments in how we are able to treat and manage conditions mean that we are all much more likely to develop and live with one or more long term conditions. The table below[4] clearly demonstrates that as we get older, the likelihood of multiple morbidities increases dramatically, meaning that the care and treatment that we require becomes much more complex.

Fig. 3 – Co-morbidities by Age Band



1. NISRA Statistical Bulletin: 2014-Based Population Projections for Northern Ireland (published 29 Oct 2015)
2. Transforming Your Care, Health and Social Care Board, December 2011
3. Dementia Strategy, DHSSPS, 2010
4. Source – Health and Social Care Board, 2016

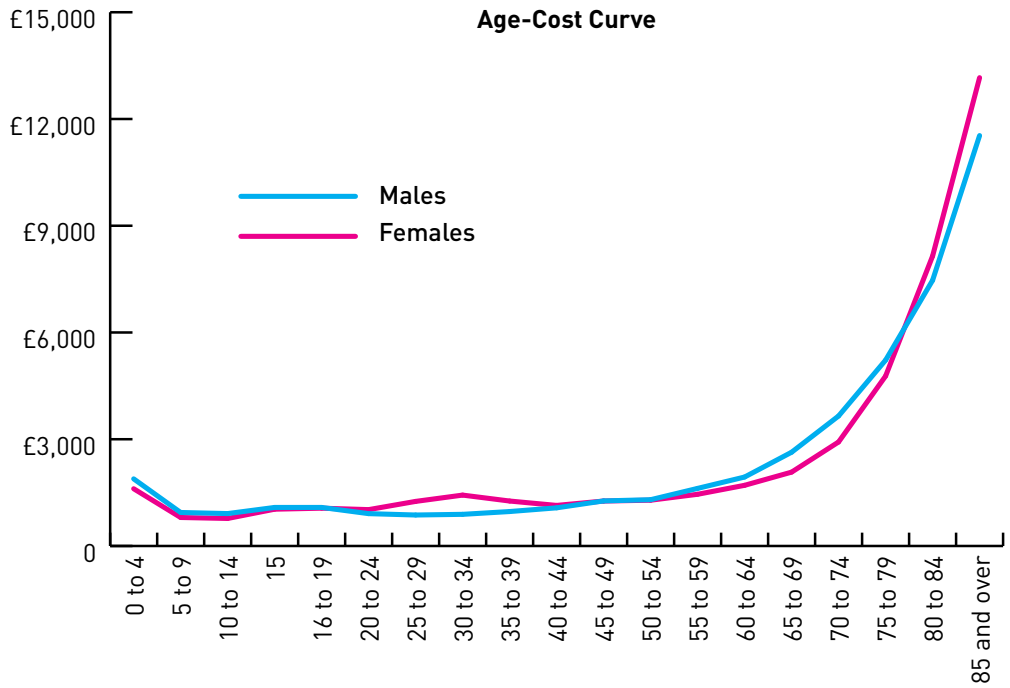
Impact on the HSC system

According to the latest figures, currently in Northern Ireland:

- Two thirds of acute hospital beds are currently occupied by people aged over 65;
- 9,670 people over 65 live in residential care or nursing homes;
- Approximately 23,400 users weekly receive domiciliary care.

In terms of costs, users aged over 65 account for more than two-fifths of HSC spending – 42%, compared to their population share of 14%. Whereas the average cost of treating a 55-59 year old stands at £1,970 per head, this rises to over £6,000 for 75-79 year olds and £14,000 for the over 85s.[5]

Fig. 4 – Age/Cost Curve



Ultimately, all of these figures and statistics illustrate a significant success story for Health and Social Care. As a population, we are seeing a marked reduction in acute life-threatening illnesses, but in their place we are now dealing much more commonly with long term conditions and disability as a result of the population's increased longevity.

The pressure that this is placing on the HSC's finite resources cannot be resolved by continuing to rely on the current acute care model. The change in the nature of the demand facing the system is not reflected in the ways services are designed

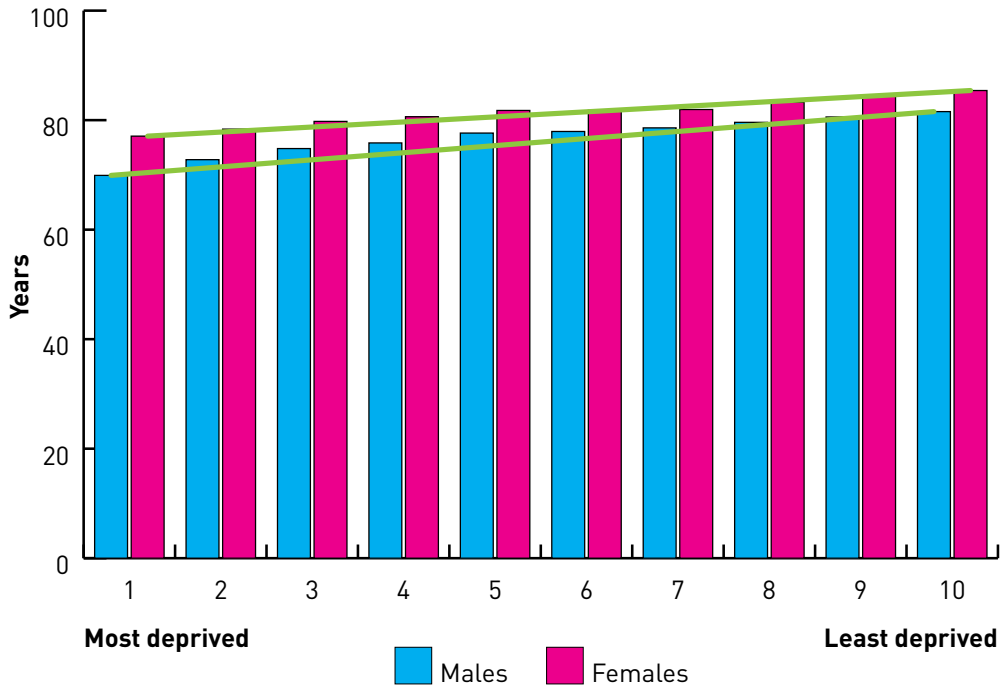
5. Source – Department of Health

and delivered. The vast majority of care is provided in the person's home or in local communities by unpaid carers, primary and community care teams, and the voluntary and independent sector. Acute hospitals are designed to deal with acute illness, not chronic conditions, and yet the beds in acute wards are filled with those whose needs may well be met more effectively and more efficiently elsewhere. The question that needs to be posed is whether the current system, which was set up to meet the needs of the mid to late 20th century, is still the right one to meet the changing patterns of illness and demand that we face in the 21st century.

Health Inequalities

While overall people are living longer and healthier lives, health inequalities continue to be a major issue. Life expectancy for males in the most deprived areas of NI is on average 7.5 years less than their counterparts in the least deprived areas. For females, the differential is 4.3 years.[6]

Fig. 5 – Deprivation & Life Expectancy



6. Source – Department of Health

The healthy life expectancy of people in the most and least disadvantaged areas differs dramatically. On average males live 58. 7 years in good health, females 62.2 years. However, female healthy life expectancy in the most deprived areas is 14.2 years lower than in the least deprived areas; and comparable figure for male healthy life expectancy is 11.8 years.

These inequalities also have a detrimental impact on the HSC system.

- There are 9 admissions to hospital for every 20 people in the most deprived areas compared to 6 admissions for every 20 people in the least deprived areas;
- Emergency admissions to hospital are 74% higher in most deprived communities than in the least deprived;
- Elective admissions to hospital are 25% higher in most deprived communities than least deprived;
- Hospital day cases are 21% higher in most deprived communities than least deprived.

Evidence from Marmot's review of health inequalities in England indicates that addressing health inequalities requires co-ordinated action across the wider determinants of health.[7] Action is required across government, to do more to improve universal public services as well as more targeted services for those with greater need.

In fact, research shows that only about 20% of health outcomes are related to clinical care: 10% is related to physical environment (air and water quality, built environment, etc); 40% is related to socio economic factors (education, employment, social support, community safety); and 30% is related to behaviours.[8] The diagram below shows some of the key indicators highlighting the gaps between most and least deprived.[9]

Fig. 6 – Health Inequality Indicators

Indicator	Baseline Year	Unit of Difference	Simple Gap
Male Life Expectancy	2009-11	Years	7.2
Female Life Expectancy	2009-11	Years	4.4
Infant Mortality[20]	2007-11	Deaths / 1,000 live births	0.8 (16%)
Smoking during Pregnancy	2012	Percentage	22 (280%)
Breastfeeding	2012	Percentage	30 (52%)
Key Stage 2 - Communication	2011/12	Percentage	20 (24%)
Key Stage 2 - Mathematics	2011/12	Percentage	21 (24%)
GCSE	2011/12	Percentage	22 (35%)
Alcohol-related Admissions	2009/10 - 2011/12	Admissions / 100,000 population	1,246 (452%)
Teenage Births	2011	Births / 1,000 Females	3.9 (570%)
Suicide	2009-11	Deaths / 100,000 population	21 (244%)

7. Fair Society, Healthy Lives, Marmot, 2010
8. http://www.countyhealthrankings.org/our-approach, County Health rankings and roadmaps, Robert Wood Johnson Foundation
9. Source – Department of Health

We can see that health and health inequalities are interrelated with the economy, economic inactivity, poverty, social isolation, educational underachievement, criminal justice, regeneration, and many other parts of government.[10]

Access to health and social care services is of course an essential component for the population's health outcomes, but as mentioned above, there is evidence that it is not in itself as important as lifestyle and environment – the circumstances in which people live, work and bring up their children.

While much of this is beyond this panel's terms of reference, it is clear that the Department of Health needs to continue to work in partnership with other departments and sectors to tackle the underlying social, economic and environmental determinants of health across the population. Local health and care partnerships, if properly organised, can also do much through local initiatives and shared budgets to address these fundamental determinants of health and wellbeing. As a major employer, the HSC has much to contribute to 'pathways to employment' through apprenticeships and other schemes to improve employability, and the estate owned by the HSC can provide opportunities for affordable housing. The HSC can also be a leader in the 'green economy' and improve the environment in local areas.

Rising Demand

As mentioned above, the demand for health services is growing and will continue to grow, driven by demography, an increase in chronic conditions, emergence of new technologies and changing practice in health care.

Currently in Northern Ireland:

- 1 in 5 people have a long-standing health condition;
- 60% of people are overweight (37%) or obese (23%);
- Almost one in five adults in Northern Ireland shows signs of a mental illness;
- 10.3% of the population claim Disability Living Allowance;
- The population is getting older;
- People have higher expectations.

These factors are creating pressures across the system and putting increasing demands on an already stretched system.[11]

10. Marmot, 2010

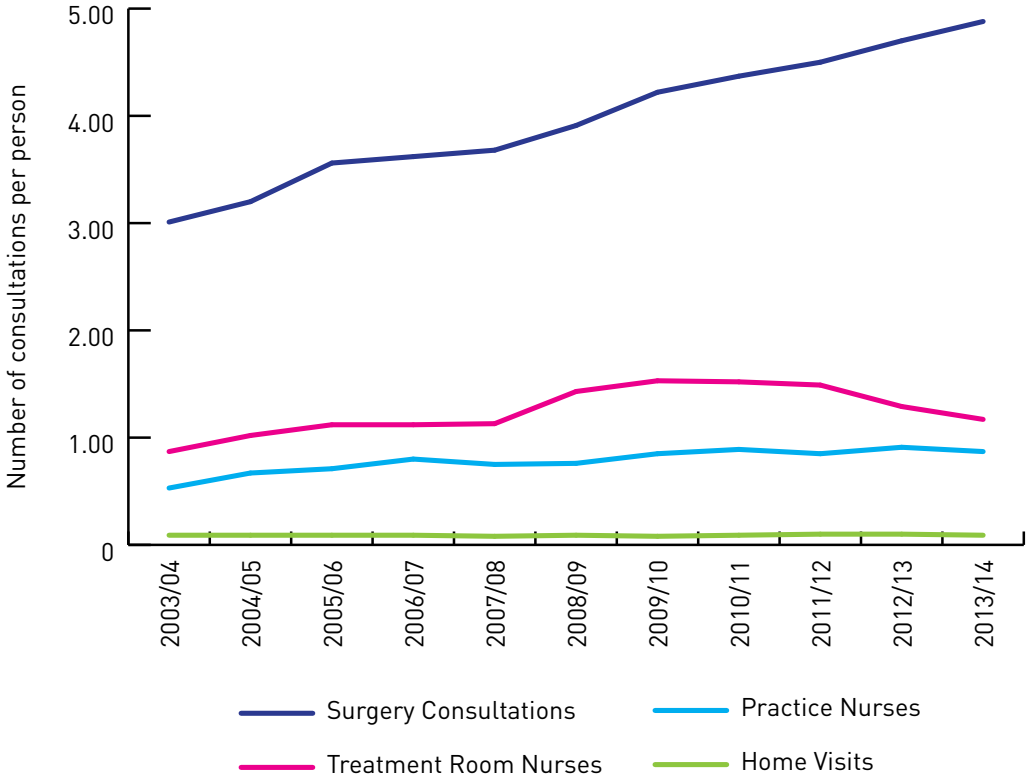
11. Source – Department of Health

Primary Care Service

Primary Care, as provided by General Practitioners (GPs), is the entry point to the Health and Social Care system for the majority of clients. Over the period 2008/9 to 2013/14, the demand for access to GP surgeries has increased on average by 21.5% whilst over the same period demand for GP Out of Hours (OOH) services has increased by 18%.

As the figure below shows[12], since 2003, there has been a steady and persistent rise in consultation rates for GPs. In 2008/9, 10.2 million consultations were undertaken by GP Practices; in 2012/13, 12.4m consultations were undertaken. This equates to an average of 6.9 consultations per patient per year in NI which is at the very high end of the spectrum compared with other OECD countries. In the south of Ireland the figure is 3 consultation per patient per year.

Fig. 7 – Consultation Rates



In conjunction with the rise in the number of consultations, there is also a growing number of complex patients who are more likely to have several co-morbidities.

12. Ibid

This rising demand cannot be resolved by the existing reactive model of care.

Hospital Services

People who require more specialist care are referred by their GP to the acute hospital sector. In addition to this, Emergency Departments provide a 'front door' to people who either self refer or who are assessed by primary care as needing urgent care. In 2011, **Transforming Your Care** forecast that the demand for acute services could grow by around 4% per year by 2015 and suggested that without change this would require:

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 40,000 extra ambulance responses.

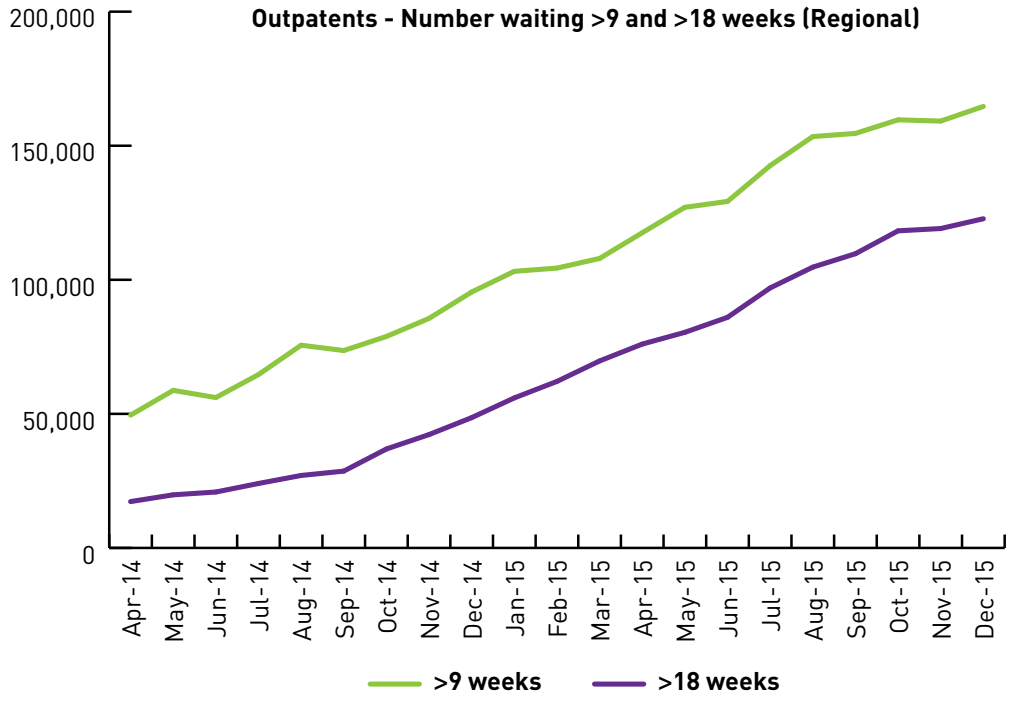
In fact, these estimates have proved to be a significant underestimate. The Department of Health's figures show that:

- The number of outpatient appointments, including appointments in the independent sector, increased by almost 121,000 between 2010/11 and 2013/14.
- The number of inpatient and day case hospital admissions, including those in the independent sector, increased by almost 48,000 by 2013/14.
- The number of Category A, B and C ambulance responses increased by almost 52,000 between 2010/11 and 2014/15.
- There has been a 5.7% increase in the number of inpatient admissions to hospital over the period. However, within the overall figures, there has been a 13.3% increase in non-elective admissions.
- In 2014/15, more than three-quarters (77.9%) of inpatient admissions were non-elective compared to 72.6% in 2010/11. Such an increase in emergency and urgent admissions can impact on hospitals' capacity to meet the demand for elective care, meaning more cancelled operations and appointments, and longer waiting times as priority is given to responding to the increasing demand for urgent care. This has been a major factor in the rise in waiting lists and waiting times for elective care in Northern Ireland.

In 2014/15 the financial constraints on the public sector led to a reduction in both in-house and independent sector waiting list initiatives. As a result, the number of outpatient appointments and hospital admissions dipped slightly (although still remaining significantly higher than 2010/11) while demand continued to increase. This resulted in sharp increases in waiting times and waiting lists (see table below[13]).

13. Source - HSCB

Fig. 8 – Outpatient Waiting Times



These figures more accurately reflect activity rather than demand. The increase in elective care waiting times indicates that there is further, unquantified demand for care.

As the growing waiting lists clearly show, the existing model is not addressing these challenges effectively.

200000

>18 weeks

>9 weeks

150000

100000

50000

Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15

Social Care Services

Although health and social care services are integrated in terms of delivery organisations in Northern Ireland there are differences between them. Provision of social care is often determined by different legislation. Unlike healthcare it is not universally free at the point of delivery with adults receiving social care being subject to means testing.

There is a far greater diversity of providers of social care than health care with very significant amounts of social care being delivered by the private and voluntary sectors. How to deliver adult social care on a sustainable basis in ways that reflect people's preferences for how they want to lead their lives is an important challenge but this has not been the focus of this report and it is understood that the Department of Health is undertaking a separate exercise to consider these issues. They are however related. The purpose of social care is to promote social wellbeing including protection from abuse, reducing social isolation and the

promotion of independence. Poor social wellbeing can have a negative impact on the quality of people's lives, including their health and in turn can have an impact on other public services, including healthcare, criminal justice and the benefits system. Social care can be particularly important in helping prevent people from being admitted to hospital and in facilitating their discharge when medically fit. Pressures on social care will inevitably have an impact on healthcare.

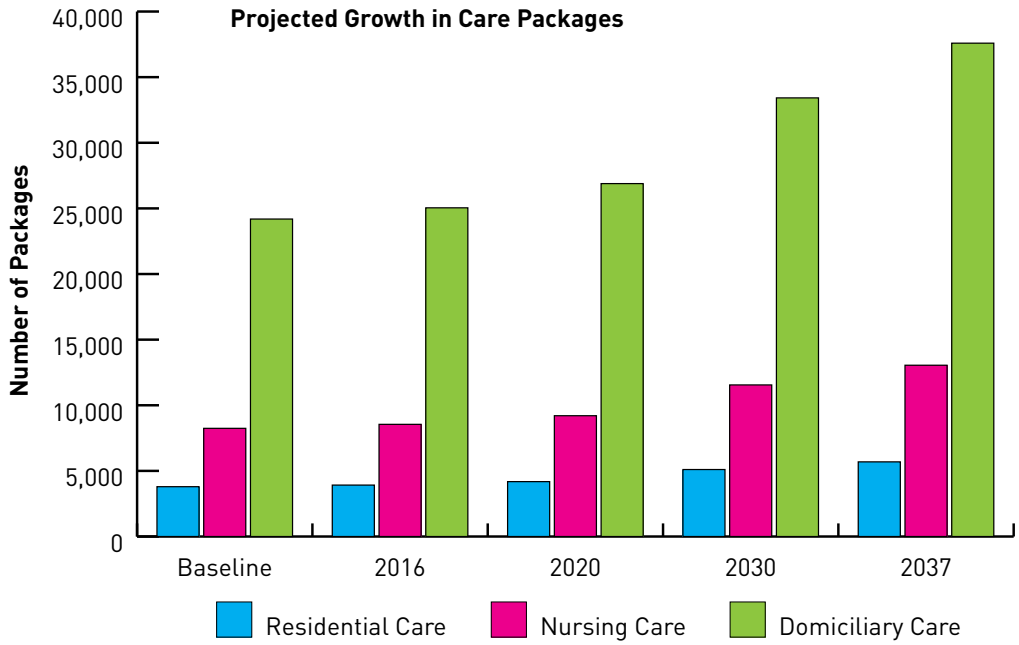
Expenditure on the Elderly Programme of Care amounts to 62% of total expenditure on adult social care services, with £543m of a total £873m being spent in this area.[14] Therefore, it is clear that an increase in the older population will require more support from the adult social care system and will require significant additional resources to adequately provide for people in need of care and support.

Using NISRA 2014 based population projections the Department of Health has carried out a crude projection of future demand for domiciliary care, residential care and nursing home care following the same growth rate as the population (18-64 and 65+).[15] The projections indicate that:

- an additional 4,050 care packages will be required in 2020 compared to current levels, an increase of 15%;
- an additional 20,101 care packages will be required in 2037 compared to 2016, an increase of 68%.

The graph below demonstrates the projected growth in the numbers of packages required:

Fig. 9 – Projected Growth in Care Packages (estimate)



14. Source – Department of Health

15. NISRA 2014-Based Population Projections, Projections by sex and single year of age (published 29 Oct 2015)

Demand and the Patient/User Experience

Of course, none of the preceding three service areas exists in isolation and any increase in demand, or lack of capacity to deal with this demand, in one part of the system has significant implications for the others.

This can be demonstrated most clearly by the impact caused by unmet demand for social care at both the front end (i.e. admission to hospital) and back end (i.e. discharge from hospital) of the system. The level of care people receive in their own community increasingly plays an important role in supporting people to live in their own homes and reducing the need for medical interventions either in a primary or secondary care setting. It also plays a fundamental role in the way the system operates by providing a way out of hospitals and a route back to the community or to an individual's home.

The sum of all this pressure is building to create a perfect storm for the entire Health and Social Care system. Patients are admitted to hospital unnecessarily because they can't access the treatment they need in their community, and, once admitted to hospital, are forced to stay longer than they need to because of the absence of domiciliary care packages to support them at their homes. This immediately causes:

- Pressures on the number of available beds;
- Unnecessarily busy Emergency Departments;
- Reduced capacity for dealing with elective/scheduled care;
- Poorer patient experience;
- Increased pressures on health and social care staff.

Ultimately, if there is insufficient capacity in social care to meet demand, this has a serious impact across the system in terms of increased GP appointments, Emergency Department attendances, higher rates of hospital admission and delayed discharges for patients who are well and ready to leave the hospital setting.

Workforce

The HSC's workforce is its biggest resource, its biggest strength and its biggest cost. Our health and social services cannot function without the commitment and skills of the people who work in them. These are also the people who have to cope at the coalface with the impact of the enormous pressures caused by rising demand.

Health and social care systems in Northern Ireland and in other jurisdictions, are reporting severe difficulties in recruiting and retaining staff. There is a growing doomsday scenario of not having enough GPs, hospital consultants and junior doctors, nurses, Allied Health Professionals, and social care staff that will inevitably lead to people not receiving the care they need.

There is also a recognised frustration among the highly educated and experienced workforce at all levels of the system with the lack of opportunities to work to the full level of competence to which they are trained.

Current health and social care models and the workforce designed to provide and implement those models are not sustainable in the long term and focus too much on a paternalistic approach based on ill health rather than working with patients towards a model of self care that is based on maintaining the health of the population. Breaking down the professional boundaries between staff and creating new generic roles is critical to providing an integrated, sustainable model of care for the population.

The transformation required in workforce will require a significant mind shift from the traditional, hierarchical and often professional silo approach to roles and responsibilities. It will require the relaxing of some of the strong and restrictive professional regulatory barriers that often delineate one professional role from another. For a workforce that maintains patient safety, professional regulation will always remain a prerequisite to protect the public from rogue professional practice.

A key message from the preparatory phase of producing this report was that without a radical review of the workforce in Northern Ireland the ambition to deliver co-ordinated care around patient need at population health level, local community level and individual level, the required transformation will not be possible.

Some of the issues and challenges facing workforce development currently in NI, as in the rest of the UK, have been highlighted in the Nuffield Trust report - Reshaping the Workforce to Deliver the Care Patients Need, 2016. They include:

- Lack of role clarity
- Lack of regulation and competency framework
- Understanding the implications of nurse staffing ratios
- Fragmentation of care
- Professional resistance[16]

Recent reviews of the service in NI (TYC, the Donaldson Review, Quality 20/20 etc.) have identified that in order to transform services fundamentally, it will require a modern health and social care workforce that can work collaboratively to meet the needs of the population.

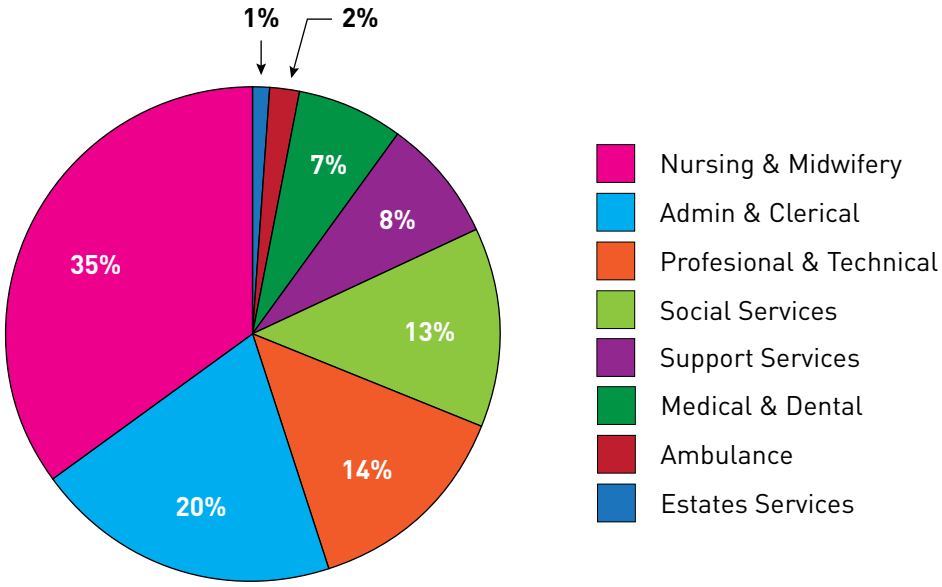
16. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

An approach to a workforce that responds to a population health model requires one of a blended nature where staff, professional and unregistered/unregulated, are recognised for the combined expertise they bring to a health and social care team that is built around the needs of patients. This will require a real shift from the current, sometimes narrow professional boundaries, to one that recognises that nurses, doctors, allied health professionals, and Health Care Assistants all have a role to play and one that focuses on having the right people in the right place at the right time to provide/contribute to the best care pathway for patients.

The success of any new service model will be absolutely dependent on staff being employed and deployed in such a way that makes the best use of their skills and which allows them to continue to develop as professionals while providing the services that users and patients need. The patient experience, and their perception of the quality of care they receive, depends in a very significant way on having well-trained, experienced and motivated frontline staff.

The HSC currently employs 54,637 whole time equivalent members of staff. The mix of staff is primarily driven by the need to support the existing care model, which is institutionally based. Comparing the most recent data with the mix of staff set out in TYC, it would appear that there has been little progress in attempting to shift resources away from this model. (See chart below)

Fig. 10 – Workforce Mix



The Panel has found that one of the major flaws of the current medical workforce mix is that it is focused on filling rotas and maintaining existing services, even where there are clear signs that these are not sustainable, rather than on detailed forecasting of demography and need. As one professional put it, "we are currently papering over the cracks in the current system, rather than investing in long term strategic change".[17]

As a case in point, it is proving extremely difficult to recruit and retain junior medical staff to deliver services where they would be unlikely to get the experience they need in terms of volumes and case mix in order to maintain their skills and develop new skills. This is reflected in the current, highest ever level of vacancies in training posts.[17]

Locum/Agency Costs

In recent years there have also been stark increases in costs associated with locum and agency staff to provide a safe service where it is not possible to recruit to permanent positions. The Northern Ireland HSC currently spends almost £77 million on locum and agency staff across the HSC workforce and these costs have been steadily rising. This is more than it spends on the entire GP OOH service.

Fig. 11 – Locum/Agency Spend 2010/11-14/15[18]

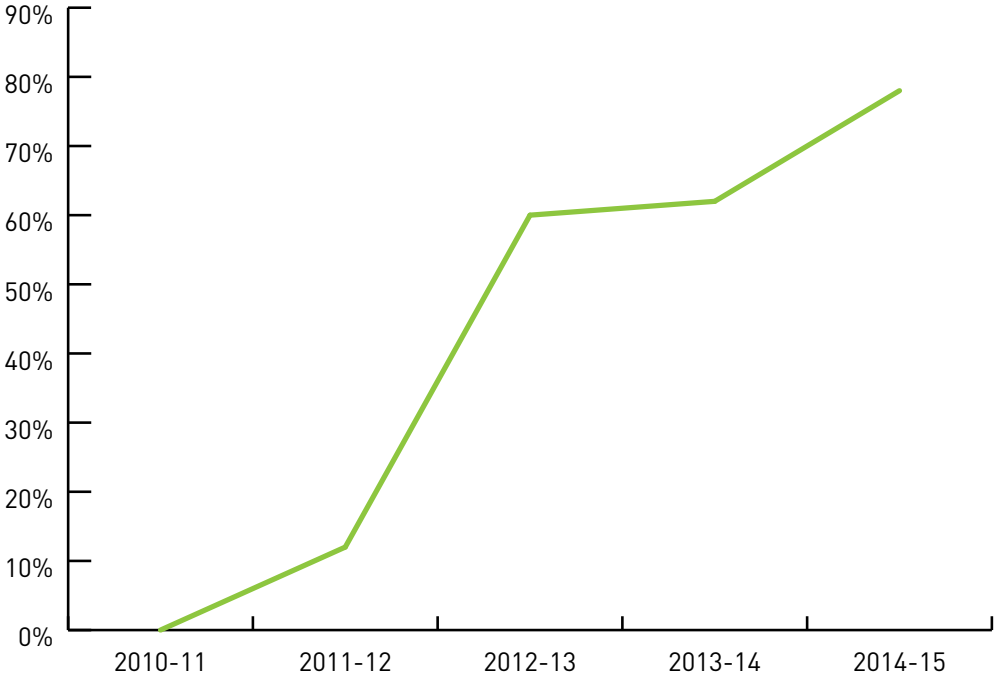
Agency Spend (includes locums)	2010/11	2011/12	2012/13	2013/14	2014/15
Medical & Dental	23,644,956	23,093,817	32,439,996	32,558,600	38,506,733
Nursing & Midwifery	6,916,885	8,641,658	9,852,129	11,116,340	12,094,055
Prof & Tech	1,217,178	2,388,060	4,940,249	3,978,227	3,039,152
Admin & Clerical	5,002,680	6,618,493	10,915,492	10,830,821	10,561,767
Support Services	2,033,150	2,882,374	4,725,091	5,273,308	6,312,881
Estates & Maintenance	0	0	10,084	601	19,945
Social Services	4,082,394	4,620,066	5,529,989	5,819,582	5,811,160
Ambulance	140,208	89,451	140,436	101,210	135,929
Other	0	22,429	124,726	0	26,988
Total	43,037,451	48,356,348	68,678,192	69,678,689	76,508,610

17. Source - NIMDTA

18. Source – Department of Health

In only five years, the amount the HSC spends on agency and locum cover has increased by 78%. The panel has even been presented with anecdotal evidence that for some junior doctors, the benefits of taking on locum work have superseded the benefits of having a permanent position.

Fig. 12 – Total Annual Locum/Agency Spend Increase from 2010 Level



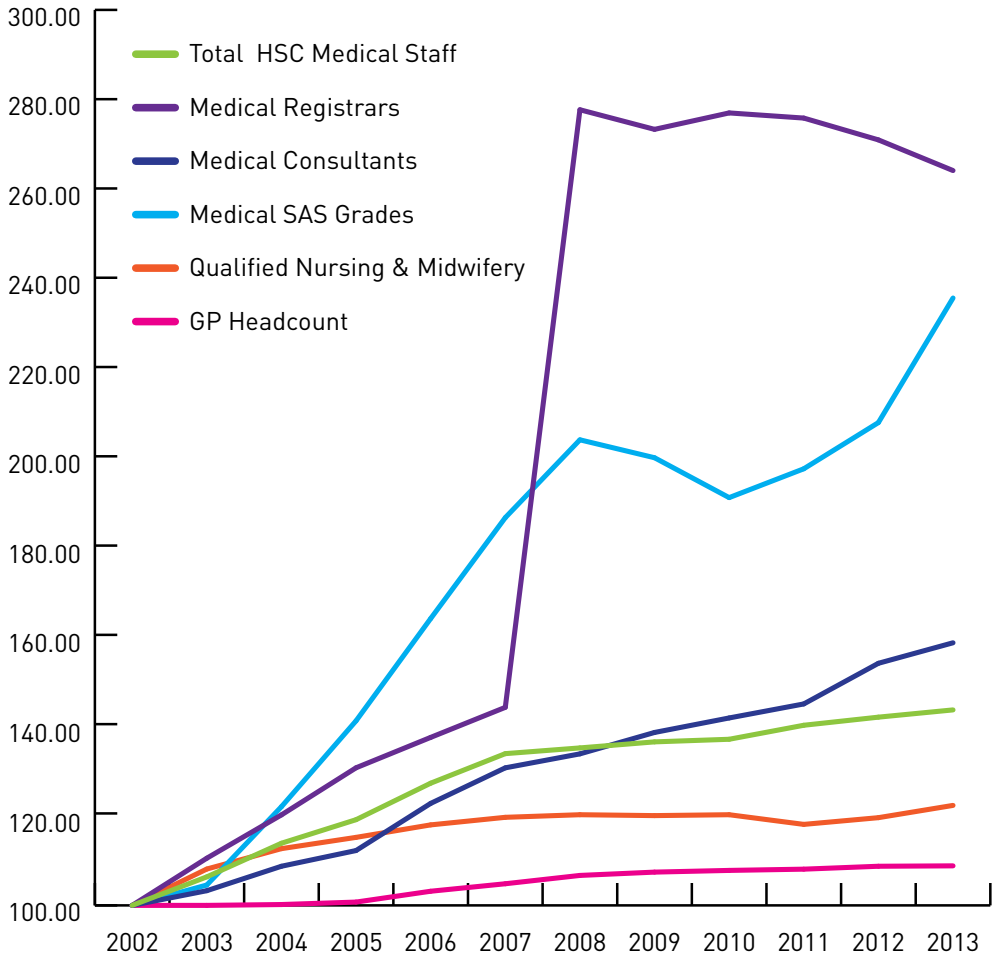
Much of the marked increase shown above is due to the high cost of filling rotas and propping up services where there is little or no chance of recruiting staff into permanent positions. It is also worth highlighting that what the system spends on locums or agency staff is money that is not available for investing in other parts of the HSC. Locums are expensive to employ and this money could be much more effectively invested in developing services that are sustainable in the long term. This would also have real benefits for staff, who would have improved professional development and job satisfaction, and for patients, in terms of the quality of care they receive and the continuity of the people delivering that care.

The locums themselves are of course not the problem, but their presence on this scale is a symptom of the structural problems facing the service. The answer is not providing more funding to try to fill these vacancies. This hasn't worked. The answer is changing the model of care to make sure that we create the right kinds of posts for all health professionals working in the system – posts that give our workforce the opportunity to use and develop their skills as part of wider teams, working together to best meet patients' needs. Many permanent staff have highlighted continuity and consistency issues in a service that relies on transitory locum and agency staff.

Primary Care Workforce

There are 347 General Practices in Northern Ireland, which are staffed by 1279 GPs. Data produced by the Department of Health suggests that the growth in the GP medical workforce has not kept pace with demand, or indeed with the growth in hospital medical staff. Furthermore, the average list size of 1641 patients per GP is the highest in the UK.

Fig. 13 - Index of Northern Ireland Medical and Nursing Workforce 2002 – 2013 (base 100)[19]



The age profile of the general practice workforce also shows that just under a quarter of GPs here are aged 55 or older, which means that many will be planning to retire in the near future.[20]

19. BMA Northern Ireland, General Practice in Northern Ireland: The case for change, February 2015

20. Ibid

Fig.14 – GP workforce by age band

AGE BAND	% OF GPs
29-34	11
35-39	18
40-44	14
45-49	16
50-54	17
55-59	16
60-64	6
65 and over	2

Social Care Workforce

Social care is different from the other parts of the system insofar that it is largely commissioned by the HSC from for-profit and voluntary sector providers. The independent sector now provides 100% of nursing home care, 83% of residential care and 62% of domiciliary care. There is also still a significant proportion of care that is provided in-house by Health and Social Care Trusts and they and the independent sector are often put in the difficult position of competing for the same pool of staff.

Fig. 15 – Sectoral Distribution of Care Providers

21. Can we trust the trusts? (ICHP, UKHCA) 2013

Approximately 12,000 people are employed in the residential, nursing home and domiciliary care sectors.[21]

There are some significant concerns about the availability of an adequate future workforce to meet growing demographic demand. In England, for example, it is estimated that an additional one million care workers will be required by 2025.[22]

Recruitment and retention difficulties may, in part, be due to terms of employment including the use of zero hours contracts and staff being paid below the minimum wage.[23] The Commissioner for Older People has also identified the need for a well trained and registered social care workforce which is respected, valued and properly remunerated with opportunities for career progression.

In recent years, some providers have argued that the fees paid by the HSC are insufficient to attract and retain staff and that this risks creating instability, threatening the economic viability of their services. Indeed, some domiciliary care providers have already withdrawn from the market, citing affordability as the reason. Similarly, in the residential and nursing home market there have been some high profile closures, with the potential for more in the coming year.

This is a great, and growing, risk to the entire HSC. As we have stated above, if the social care sector fails to meet demand this will place enormous pressure across the rest of the system – particularly in relation to hospital admissions and discharges.

In the context of the demographic challenges outlined above, it must always be remembered that the most important, and the largest group by far, of staff delivering care services in Northern Ireland is unpaid.

Carers NI estimate that carers save the government some £2.4 billion and it is clear that the support of carers is absolutely essential in order to ensure the sustainability and viability of the system. Engaging and supporting carers is a fundamental aspect of maintaining service users within their own home and it is essential that the HSC improves its performance in this area.

22. The Future Care Workforce (ILC) 2014

23. The scale of minimum wage underpayment in social care (Resolution Foundation) 2015

Nursing and Midwifery

There are in excess of 16000 registered nurses and midwives employed by the HSC in Northern Ireland. This constitutes almost one third of the health and social care workforce in a variety of settings.

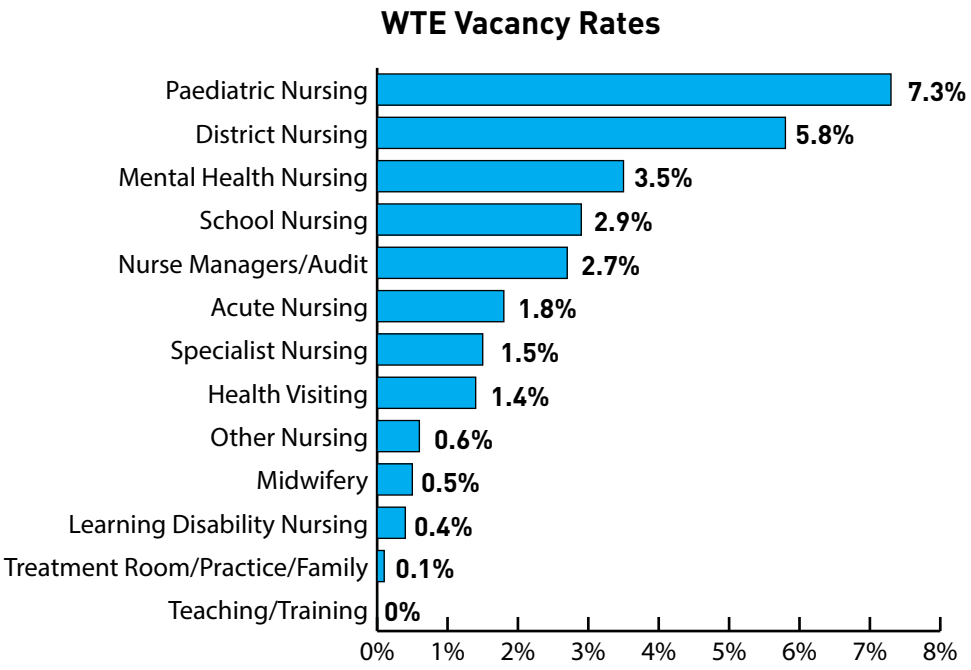
Fig. 16 – HSC Registered Nurses & Midwives as at 31st March 2014[24]

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	16,646	14,328.7

Figures from 1st October 2015 show that there were 531 (480 whole time equivalent) vacancies.

A vacant post is defined as a post '**actively being recruited to**'. The Department of Health collects data on vacancies via a survey twice a year. The figure below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.[24]

Fig. 17 – Available Vacancy Rates of Permanent Posts (based on whole-time equivalent) as at 30th September 2013

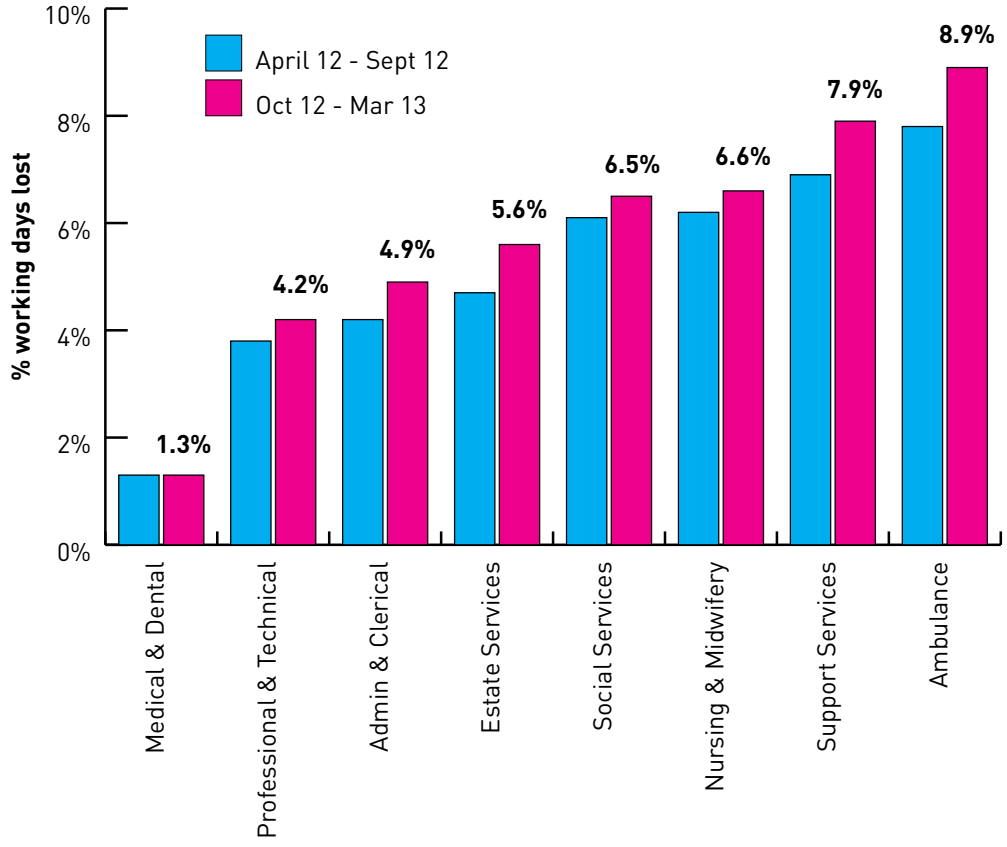


24. Source – Department of Health

Organisations reported that they did not expect to be able fill all these vacancies. In particular, they noted difficulties at a local level in recruiting to a number of specialties, including mental health services, care of older people, non-acute hospital care, theatres, critical care, general medicine, community, learning disability and prison health. However the composition of difficult to recruit specialities varied from Trust to Trust.

In addition, the graph below shows absence rates by occupational family across the HSC. We can see that absence rates are rising across all areas.[25]

Fig. 18 – Absence Rates by Occupational Family

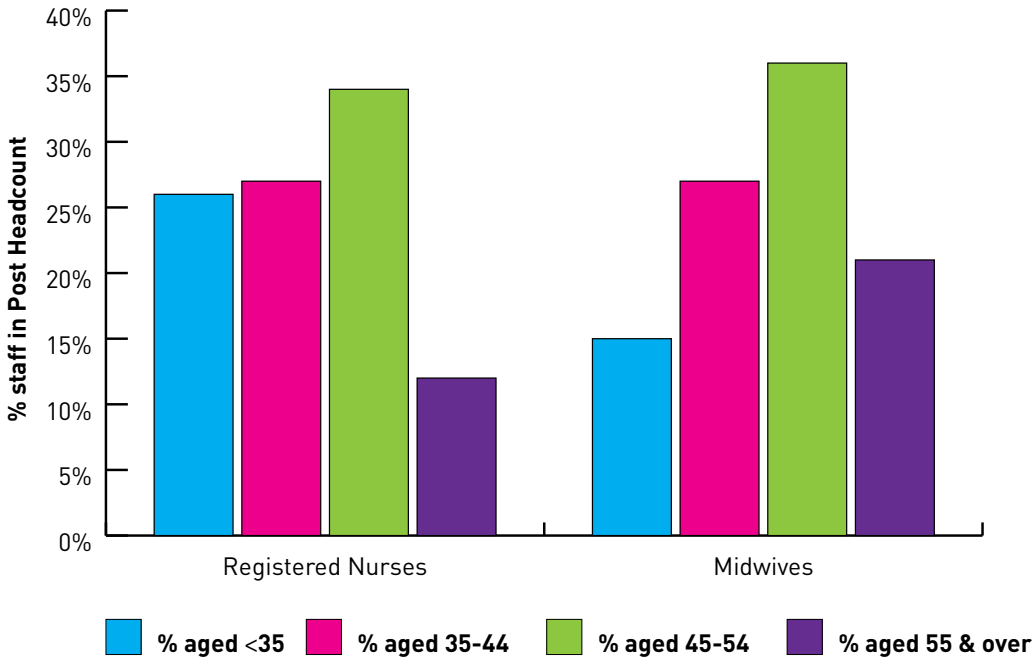


25. Source – Department of Health

26. Source – Department of Health

Furthermore the age profile of the nursing workforce shows the majority of the qualified staff to be above 45 years old, within a 10 -15 year period of average retirement age. The graph opposite shows the nursing and midwifery workforce broken down by age.[26]

Fig. 19 – Nursing and Midwifery Workforce by Age



Working patterns have also changed significantly. Almost half of qualified nurses are now working part time and almost two thirds of midwives.

Earlier this year, the then Minister took action to address these recruitment issues by increasing the number of commissioned student nurse places in Northern Ireland universities by 100 for the 2016/17 intake. This is very positive, but it will not impact on the service until 2019/2020. Steps are currently being taken to support a region wide recruitment process for nurses from EU and Non-EU countries.

Staff Morale

These issues are also reflected in the reported experience of staff in the HSC. In the most recent HSC staff survey, only 35% of staff felt that there were enough staff in their team to carry out the work and a significant proportion (36%) reported having experienced injury or illness as a result of work related stress. HSC Occupational Health Consultants have noted an increase in the number of staff presenting with stress related illness.

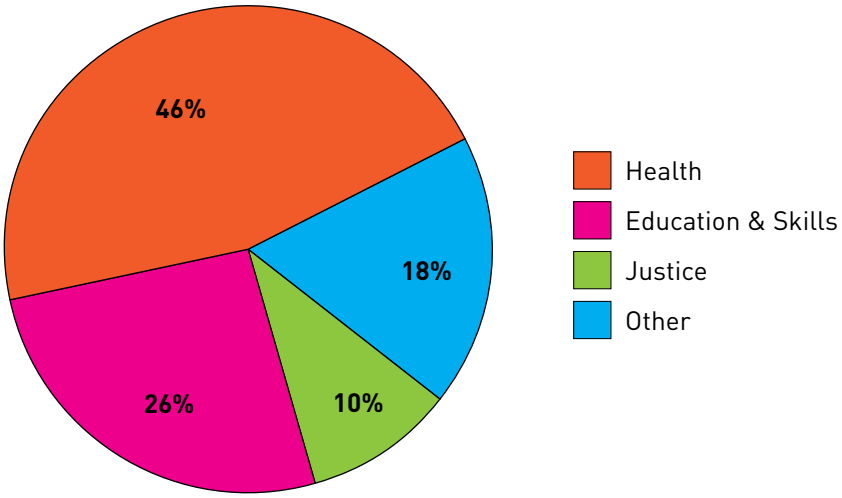
The cumulative effect of staff vacancies is ever-increasing workloads, higher risk of illness and a constant focus on the short term over the strategic. This risks creating a culture that exists by 'fire fighting' only. Innovation, learning from best practice and implementation of new systems are the unfortunate casualties of such a system. In all the encounters with stakeholders, from every part of the health and social care system, the panel have received the same message in terms of the need to invest properly in the staff that provide health and social care in voluntary, community, primary and secondary care settings.

The demands facing the current service model are putting severe pressures on the workforce. This is not fair to them or to the people who rely on them for care. Resolving this is not about money, it is about creating an environment in which staff are enabled and empowered to do the jobs they have been trained to do in a way that meets patients' needs. As the evidence above demonstrates, the current model has the patients in the wrong place and at the wrong time; this brings organisational de-motivation as staff feel unable to provide the highest quality of care to those they serve.

Financial Sustainability

As can be seen in the chart below, the Department of Health's budget is the largest among the Executive departments by some distance, with a budget of almost £4.6 billion, or 46% of the entire NI Executive spend.[27] The next largest sector in terms of budget is Education & Skills, with a little more than half of the health and social care budget.

Fig. 20 – Northern Ireland Budget by Sector



If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the Health and Care system as currently configured would require at least a 6% budget increase each year simply to stand still.[28]

Using this rationale, if the system continues in its current form, we can expect costs to double by 2026/27 simply to maintain current levels of performance.

Other

Justice

Education & Skills

27. OECD Reviews of Health Care Quality: United Kingdom 2016, p242

28. http://www.nuffieldtrust.org.uk/node/4190)

Fig. 21 – HSC – Projected Costs 2014/15 – 2020/21

Year	Total (£billion)	Year	Total (£billion)
2014/15	£4.6	2021/22	£6.92
2015/16	£4.87	2022/23	£7.34
2016/17	£5.17	2023/24	£7.78
2017/18	£5.48	2024/25	£8.25
2018/19	£5.81	2025/26	£8.75
2019/20	£6.16	2026/27	£9.23
2020/21	£6.53	2027/28	£9.83

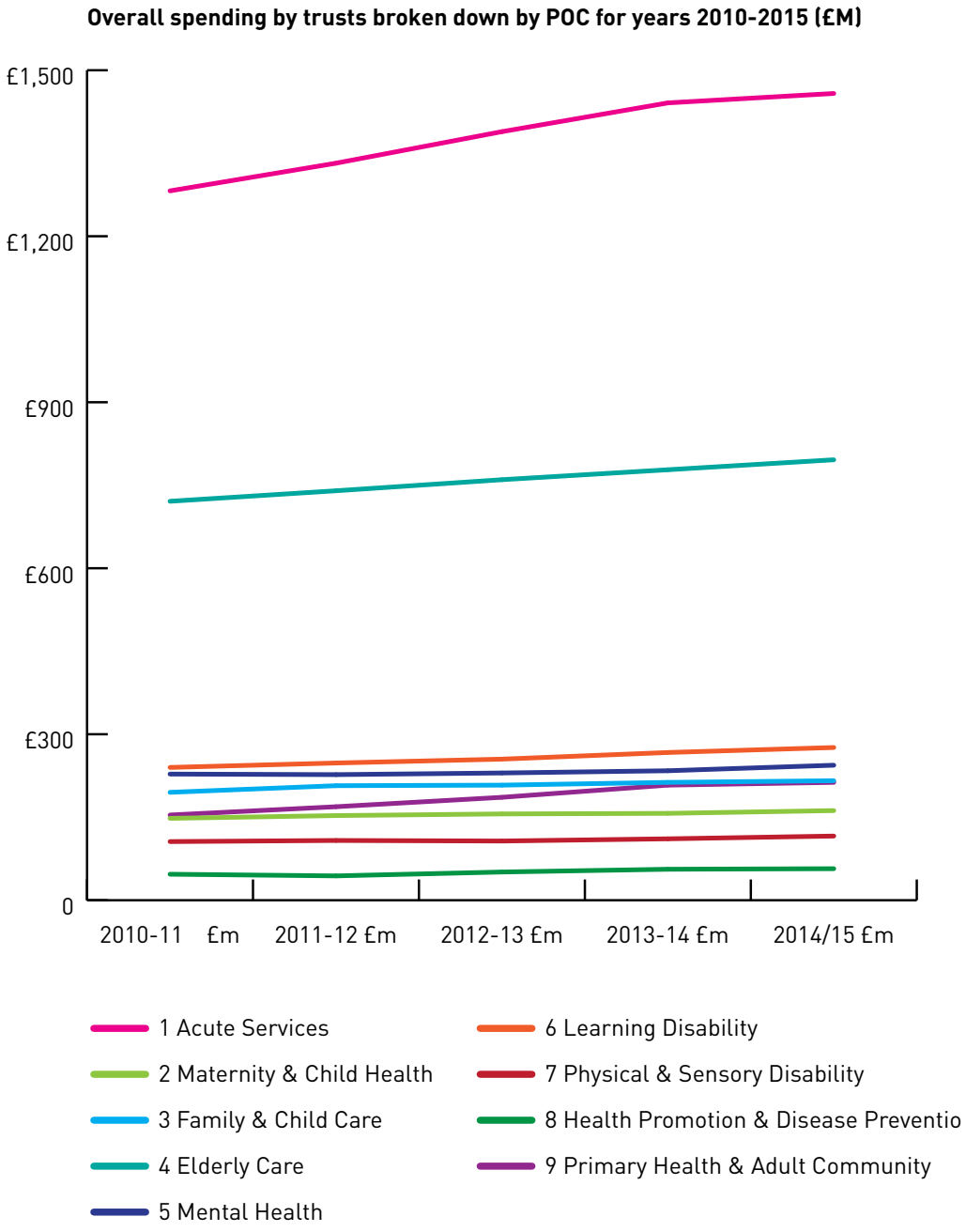
Although it is now more than ten years old, Professor John Appleby's 2005 review was an exhaustive look at how resources were being used across the system, with a particular focus on elective care and waiting times. Appleby updated his own results in 2011 and found that per capita spend in Northern Ireland was roughly 11.5% higher than in England, but that there is an 11.6% higher level of need. We can therefore draw the conclusion that the system is as well funded as other UK jurisdictions, with perhaps a very slightly lower level of funding per head once local levels of need and deprivation are taken into account.

However, Appleby's review also found significant disparities in some programmes of care. For example, according to his figures, mental health needs in Northern Ireland were estimated to be nearly 44% higher than in England, while actual per capita spending on these services was in fact 10-30% lower.[29]

These findings would support the argument that it is not the level of funding that it necessarily the problem, rather than how it is used to deliver services. If we consider the division of funding within the system by programme of care, it can quickly be seen that the majority of resources are invested in the acute hospital sector, which dwarfs all of the other programmes of care in scale.

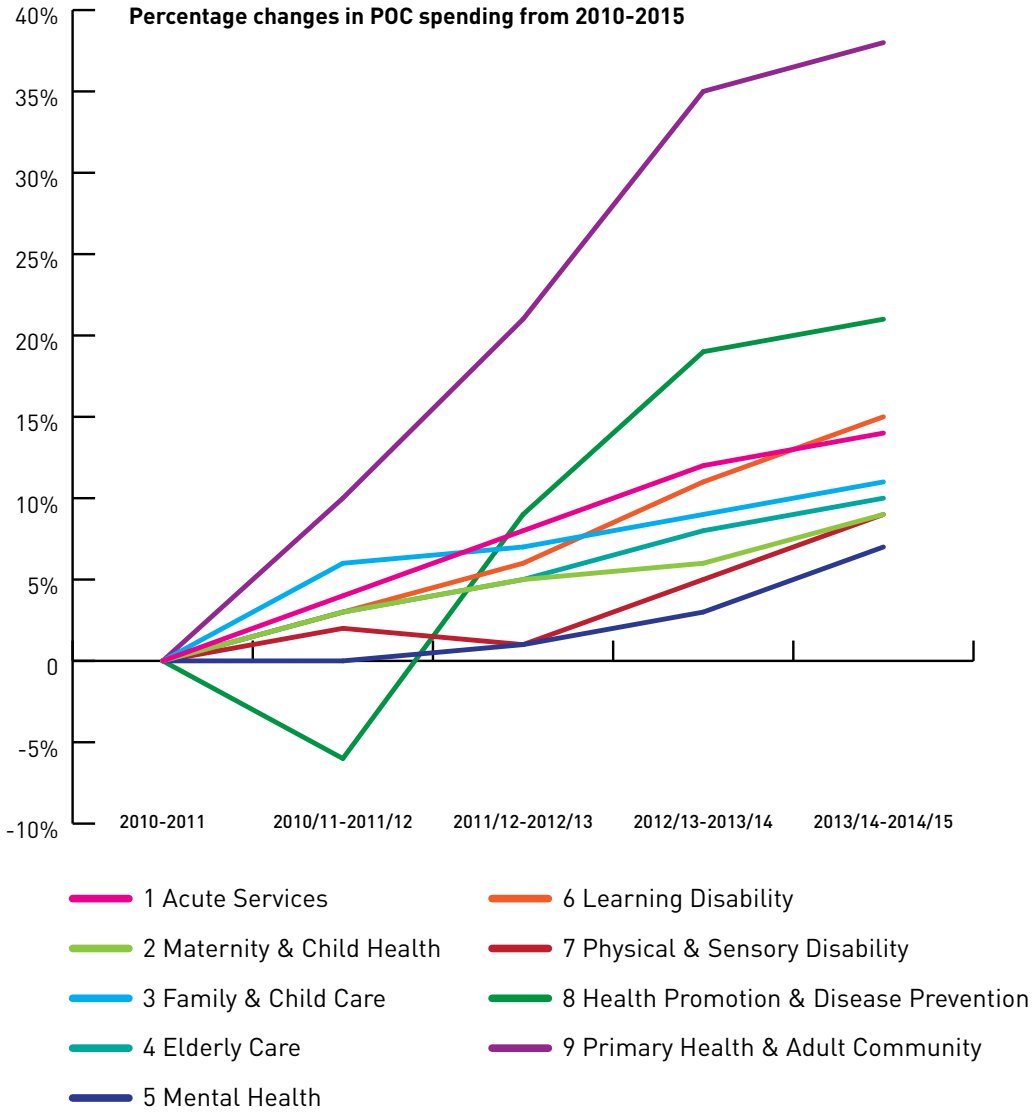
29. Appleby, J (2011) Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12-2014/15, Department of Health

Fig. 22 – Funding by Programme of Care 2010/11-2014/15



As we can see from the graph above, spending on the acute sector continues to grow, although it is reassuring to note that the rate of increase has slowed down when compared to other programmes of care. While this may be indicative of a push by the system towards community based services, it also illustrates clearly that there is still a long way to go in making the shift from acute to community real and meaningful.

Fig 23 – Rate of Increase of Spending by Programme of Care 2010/11 – 2014/15



The OECD's report on Healthcare Quality across the United Kingdom, published in 2016, concluded that while there were examples of good practice in shifting resources from the acute sector to the community sector, there was no evidence that this was being managed systemically or strategically. Their report also concluded that funding was largely managed in silos and was often based on historical funding arrangements rather than an assessment of population need.

For a budget this size, the current one year commissioning cycle is also far too inflexible and short term to allow for any sustained investment or innovation. The Panel has heard from many sources that this prevents long term strategic planning and encourages a short term 'sticking plaster' approach to services, perpetuating the status quo rather than enabling transformation.

A real strategic approach to this will require a greater level of inter-sectoral funding, longer term commissioning cycles, and increased work across government to address the wider health determinants.

SECTION 3

VISION FOR A NEW MODEL FOR HEALTH AND SOCIAL CARE – ORGANISING FOR SUCCESS

There is an unassailable case for change. If we do not change the way we provide health and social care, the situation will only continue to get worse – the demand will continue to increase, activity will remain static and waiting times will continue to lengthen.

Following on from the evidence above, it is clear that:

- Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.
- Transformation will require key cultural and operational changes in health care systems and in the way these systems are accessed by the public.
- Something very different has to happen at the delivery of care level.
- The funding mechanisms are not currently sufficiently aligned with the need to integrate care at the provider level.
- Health and social care are not working together as effectively as they might. If they were, there would be better outcomes and reduced waste.
- Front line improvements and innovation at the provider level need to be encouraged, sustained and scaled up where they can demonstrate three outcomes of the Triple Aim.
- The workforce needs to be empowered and engaged in designing the new models of care.
- The public should be honestly informed about why change is needed. Service users should be supported and encouraged to become 'informed and expert patients' who take individual action to manage their own health and well-being.

Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.

The Panel has heard a strong sense of frustration among those working in the system, particularly from those on the front line, that the current pattern of investment which is prioritised to maintaining the current configuration of hospital

care would be better utilised in a new model of care outside hospital which better supports improved population health and well-being. The Donaldson report also identified the need to rationalise hospital infrastructure as a key part of reform.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services.

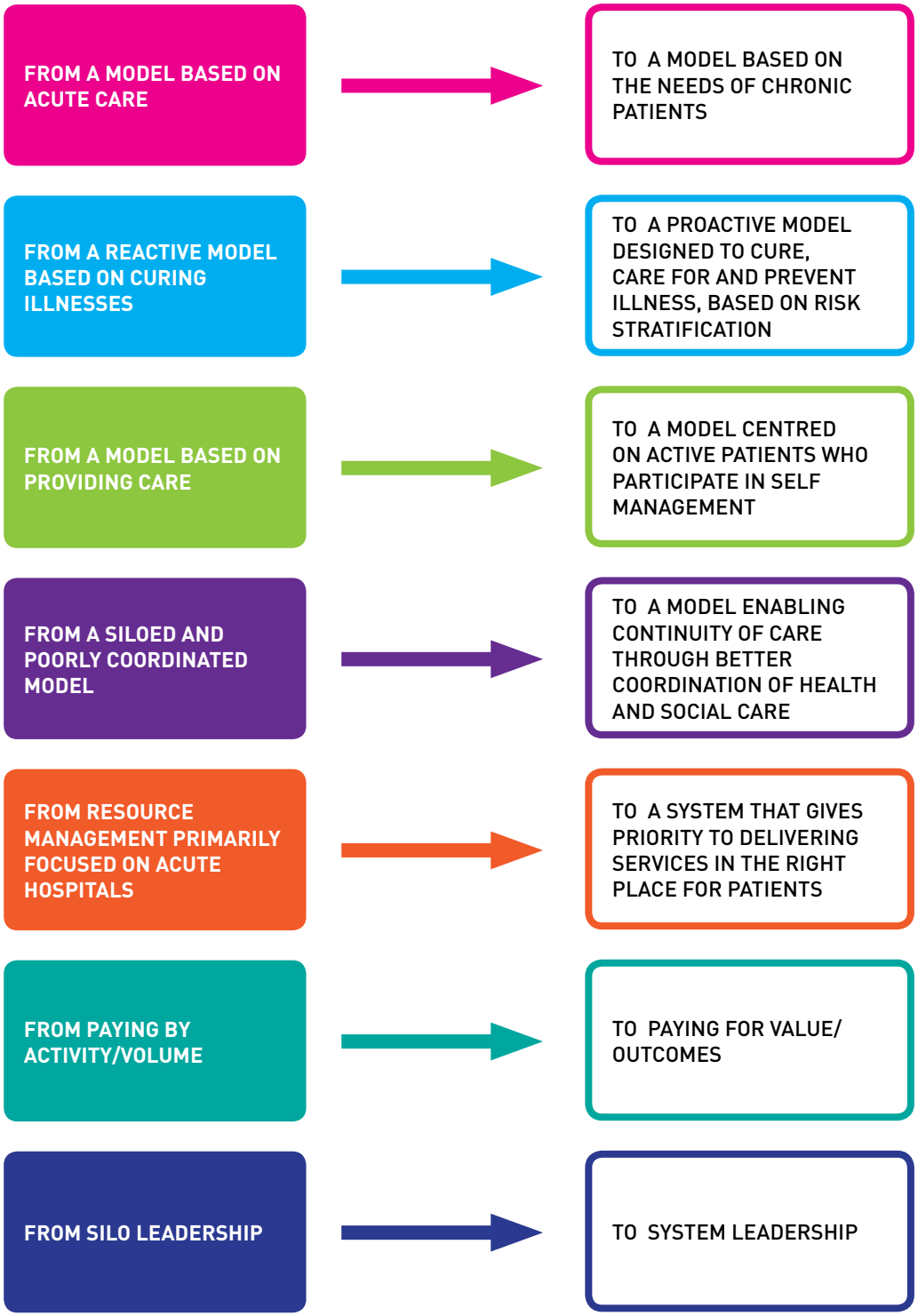
As a panel, we agree that it will absolutely be necessary to rationalise the provision of some specialist acute services as part of changing the service delivery model. As identified by Hayes, Compton and Donaldson, the current configuration of acute services is simply not sustainable in the short to medium term. As part of the transformation process, it will be necessary to reorganise services in such a way that resources are freed up from some parts of the existing model in order to allow them to be used for implementing new models that will offer higher value care. With respect to how this rationalisation is achieved, we will come back to this later in the report.

However, rationalising services is not the same as transforming the health and care system and the two should not be confused. The current overreliance on acute infrastructure is a contributory factor to the challenges facing the sector rather than their sole cause. While some rationalisation and concentration of specialist resources will be necessary to allow new delivery models to take effect, they are not ends in themselves. The meaningful transformation is in moving to a more patient centred, population health model, delivered at a sustainable cost.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services. In some cases this may mean that some buildings/hospitals will close; in others it may mean that these buildings are used in different ways to provide a more effective and responsive service to meet the local population's needs.

The table opposite shows the main ways in which the system needs to change.

Fig 24 – Transformation



The Triple Aim

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

Although health care systems internationally are different from each other in many ways, they all have the same fundamental challenges:

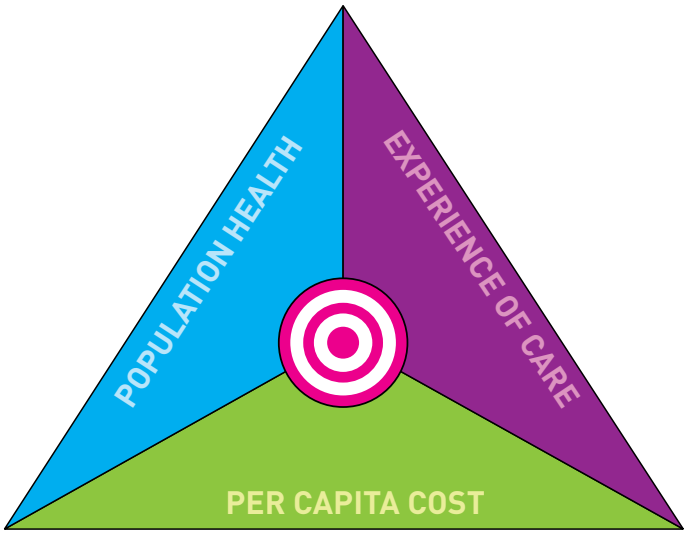
- All have sub-optimal organisation of care;
- Most are paying for volume and not for value;
- All use about 50% of expenditure on only 5% of the population;
- All have key challenges in prevention, quality and patient safety;
- Chronic patients receive fragmented and non continuous care; and,
- All could do more to reduce costly hospital admissions and readmissions.

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI). It is characterized by a simultaneous focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

Fig. 25 – The Triple Aim



The Triple Aim is perceived by many as a key framework to improve services, but it will not happen at scale unless there is a powerful policy intervention regionally as well as empowered innovation at a local level. The Panel proposes to use this framework to move forward on the broader health and social care transformation.

Of course, all of the policies and strategies in the world will not succeed if they do not pay attention to the people who deliver services on the front line. On this basis, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

The ongoing economic crisis in Europe has made the numerous vulnerabilities of all health care systems more visible. The immediate reaction in many countries has been cost containment. Senior leaders have reacted to this difficult immediate context by seeking efficiencies and, as a result, day to day crisis management has been centred on taking some major cost containment decisions, especially regarding human resource salaries, the pharmaceutical budget and co-payments.

However, there is a growing acknowledgement that these interventions do not correct the main problem of health care – its basic design around reactive episodic care and a weak focus on population health.

In other words, even if these crisis decisions are handled in an effective way, they do not create in themselves the capacity for health systems to cope with the future challenges of demography, chronicity, prevention, fragmentation, sustainability and patient centeredness.

Today in Europe, as well as elsewhere, most of the policy decisions in health care are not about having to decide whether to ration or to transform. Rather it is about finding the right balance of both and not letting rationalisation dominate the broader transformation. This document considers both agendas, and the Panel would recommend progressing and managing them both simultaneously.

The Triple Aim provides a new framework for a strategic response. While it may sound theoretical, it is practical in its application and has already been used to guide a number of prototypes in Northern Ireland which are already showing powerful results. We will cover some of these projects later in the document.

Advancing towards a Local Accountable Care System

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos.

The Panel has heard consistently and agrees that care should be personalised, preventative, participative and predictive. However none of those objectives can be achieved in the present reactive and fragmented system. The HSC therefore requires a new organisational form at the local delivery level, an organisational arrangement which will allow those approaches to be embedded in the culture of everyday health care.

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos. We need to move away from this hospital centred model of care to a more integrated model.

The Panel has heard of changes to the provider sector that are already being carried out to achieve the size and scale required to better manage, and indeed change, the current demand for services. General Practice is moving from the 'small business' approach to bring together Practices within larger geographies as 'Federations'. By working more collectively, it is hoped these Practices can share skills and services, manage workforce pressures, operate more efficiently and more effectively meet the rapidly increasing demand for primary care services. Services within Trusts are increasingly networking on a cross-Trust, cross-profession and indeed NI-wide basis where these services are specialised and there is a need to collaborate to meet demand. Trusts sub-contract with the community, voluntary and independent sectors for health and social care provision. There is a mix of provider models for GP OOH services.

So the provider sector – Primary Care, Trusts, 3rd sector and independent sector – is already becoming increasingly integrated and inter-dependent without structural reform. However, this is happening in the absence of strategic intent, and is operating under traditional contract models and output targets that do not support the system transformation which is required to address the challenges set out in section 2. This report proposes the development of Accountable Care Systems to integrate – by agreement, and without the need for structural reform – the provider sector to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes under agreement with the commissioning system to be decided by the Minister.

There are models where this collective provider model is starting to emerge. For example, the Sustainability & Transformation Plans (STPs) in England, where 44 planning and delivery systems have been set up based on geographical footprints, and charged with planning and delivering system-wide change. This will include a more integrated approach to health and well-being, self care, more proactive care for those with the most complex needs, and a smaller, more efficient hospital sector. This is all intended to both improve care outcomes and drive out collective financial deficits in their areas. Accountable Care Systems will also provide a structure for better patient engagement, empowering people to become active participants in their own care.

There are lessons learned from Accountable Care Systems elsewhere that provide evidence of the key components that can be put in place to drive more integrated working without structural reform. These are:

- Size and scale – the population footprints must be of sufficient size to manage the majority of population's care needs, to take accountability for managing variations in demand and expenditure, and to take 'internal decisions' to change the delivery of care, but also importantly to support local partnership working and risk sharing;

- A defined population where the new model of care can be delivered at pace, focusing on the stratified risk of that population – already available in General Practice if this information is collated and shared;

- New working arrangements, including shared leadership, shared accountability and devolved budgets, development of new roles to push the boundaries of the skilled but not qualified workforce and the 'generic professional case manager', and a partnership approach with the 3rd sector to deliver a more standardised service offering within local communities to reduce loneliness and isolation, improve well-being and to provide high quality care;

- New support tools, including shared information, accessible patient and client records, and a capitated funding system that incentivises an integrated provider response;

- Service user engagement, at population, service and individual level;

- Cost and quality measures which are measurable, comparable and outcome based.

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites, that they are sustainable in the long term, that inefficient duplication is avoided, and that they can be supported and incentivised to innovate and to develop world-class treatment.

Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model — set at a regional level

Transformation to deliver the Triple Aim will also require a new approach to the commissioning and delivery of care. The Department of Health carried out a review of commissioning in 2015 and found that the current system was complex, slow to take strategic decisions, unresponsive and with too much emphasis placed on

activity/volume over value/quality. The current commissioning model has also failed to effectively shift accountability to the provider level and this has led to an overly transactional approach. It is worth highlighting that the lack of a devolved budget and insufficient autonomy have been identified in other jurisdictions as key reasons why some population based models have not achieved their potential.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations.

Building on Existing Foundations

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations. The Panel believes that many of the key elements of a more integrated organisation, such as Integrated Care Partnerships as 'learning labs' for what will make integrated delivery systems work best and the emerging GP Federations, are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes in order to truly become local Accountable Care Systems.

Furthermore, Northern Ireland has already made real progress in establishing an array of management and organisational processes, all of which help to provide the tools needed to move forward quickly. However these need to be further developed and strengthened in the following ways:

Adding Depth to Structural Integration of Health and Social Care

The formal integration of health and social care should be a key strength of the existing system and will provide a strong foundation to pursue reform. However,

in practice, the benefits of integration have not been fully exploited and it would seem that there are still significant administrative silos that prevent this happening. Integration in name only is not enough and if the Panel's proposed model is to be successful there has to be better integration between all parts of the health and social care system. This level of integration will require a great deal more work on how the system plans, funds and purchases care across acute care, general practice and community health, and social care provided by statutory, independent and community , voluntary and charitable providers.

The development of the Accountable Care Systems suggested in this report will greatly reinforce the necessary health and social integration on the ground.

The primary function of social services is to improve and protect people's social wellbeing when it is vulnerable. Social wellbeing refers to the extent that people are socially connected, engaged in purposeful activity, in control of their own lives and are protected from abuse and exploitation. The primary reasons to promote and protect people's social wellbeing are because it is essential to people's quality of life and it safeguards people's human rights. However not surprisingly there is also a strong relationship between people's social wellbeing and their health. This is one of the main reasons integration between health and social care services is seen as a desirable feature of healthcare systems.

The health impact of better integration between health and social care services is reinforced by more and more studies. The impact of social factors such as income, educational attainment, access to nutritional food, good quality housing and employment status is well documented. There is a growing evidence base and literature about the importance of social determinants of health in improving the health of populations. The relative contributions of genetics (20%), health care (20%), and social, environmental and behavioral factors (60%) are well documented.[30]

Northern Ireland is better placed than others to continue reinforcing the combined action of health and social services. The move to local integrated systems of care will provide an even better platform for this happen. However it can also present challenges.

When difficult funding decisions need to be made it can be difficult to secure investment in social services when faced with competing demands for healthcare investment. However there is a strong economic rationale for investing in social interventions.

The increasing use of new commissioning models (payment models) will be a key lever towards improved health and social integration. New payment models that hold these local integrated care organisations accountable for people's health and the cost of treatment can be used to maximise the benefits of integration. A focus on holistic outcomes that includes the promotion of social wellbeing and penalises outcomes that undermine it, such as unnecessary hospital readmissions, will make the health and social care system more sustainable and more importantly improve people's quality of life.

30. Chiu, G. et al. (2009) Relative contributions of multiple determinants to bone mineral density in men. Osteoporos Int, 20(12), 2035-2047