

# Health Integration:

The Best Way to Secure  
Better Outcomes?

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## Whither integration?



**For almost as long as the NHS has existed, greater health integration has been a “holy grail” for policymakers. The fact that it is *still* an ongoing objective speaks volumes about the success of past attempts.**

This publication asks if integration is really the best way of securing improved health outcomes. In particular, it looks at the shaky record of integration, and at some of the alternative collaborative approaches which focus on ‘front end’ rather than ‘back end’ provision.

We face unprecedented pressures on public services – many are familiar with the “graph of doom” which has dominated discourse in this area for the last decade, showing rising public service consumption and falling revenues. But the scale of many of the forthcoming challenges has yet to become fully apparent.

For instance, something cited at a recent King’s Fund event is the size of the over-85 demographic. Although this is a small group, for obvious reasons it is a group requiring particularly high concentration of healthcare and social care. The present generation of 85-year-olds was born in 1931, which had some of the lowest birth rates in the UK’s history. But over the next 15 years, as the ‘Baby Boomers’ start to get into the over-85s category, the numbers involved will soar. The demographic pressures on the UK are therefore huge.

Traditional responses to this have tended to be of a rather technocratic nature, with only limited success. This publication proposes some alternative approaches. We have been helped in the process by various senior health and care practitioners sharing their thoughts with us at an event under the Chatham House rule – as such, all views quoted in here are unattributable to individuals, but reflect ongoing conversations in the sector.

## Where we are, and how we got here

### **Health integration is nothing new. Ever since the inception of the National Health Service over 70 years ago, successive governments of all parties have tried to improve the efficiency of the NHS through greater integration of its services.**

The NHS's own founder, Aneurin Bevan, described it in 1948 as “the biggest single experiment in social service that the world has ever seen undertaken.” Yet closer integration was desired from an early stage. In 1956, Labour MP Arthur Blenkinsop observed that, “Co-operation between general practitioners and health visitors...is lacking in many cases”. That same year, Conservative health minister Robin Turton argued, “What is most needed at the present time is the prospect of a period of stability.”

Yet the ensuing decades have seldom seen much stability. As health minister in the early 1960s, Enoch Powell oversaw various attempts at greater integration. Further measures in the governments of Wilson, Heath and Thatcher followed. As Thatcher's Secretary of State for Social Services, Patrick Jenkin, remarked in 1979, “Our proposals are designed... to bring health authorities closer to the people.” In the early 2000s, efforts towards de-integration ensued with the introduction of foundation hospitals, although the Labour Health Secretary at the time, Patricia Hewitt, identified her aim as, “Services that are flexible, integrated and responsive to peoples' needs and wishes.” In the 2010-5 coalition government, Lib Dem Deputy Prime Minister Nick Clegg expressed an aim, “to join up care around people's lives.” The recent Health and Social Care Act 2012 can therefore be seen in the context of long-running, decades-old attempts at integration. Politicians of all parties, as well as civil servants, have expressed a striking consensus around wanting greater health integration. So why haven't we achieved it, and why is there even a consensus as to what is meant by it?

If there is one thing we can infer from the repeated attempts at integration, it is that failed attempts to integrate are almost as old as the NHS itself. And, to paraphrase Einstein's famous dictum, the definition of insanity is doing the same thing over and over again, and expecting different results.

## “We’re doomed?” What have we learned from doing this (over and over again) in the last 70 years?

**Many of the problems faced in integration are seemingly intractable. A purely technocratic solution alone will not “square the circle” this time around, any more successfully than it did in the 1960s, 1970s, 1980s, 1990s or 2000s.**

The *Oxford English Dictionary* defines integration as, “The making up or composition of a whole by adding together or combining the separate parts or elements; combination into an integral whole: a making whole or entire. (Often opposed to differentiation.)” The emphasis of the very term is therefore on *centralisation* - which explains much of the frustration around how it has been executed.<sup>1</sup>

If we are to find a fresh solution, then a fresh approach at least holds out a chance of not meeting the same fate. It is therefore suggested that health policy presents a series of systemic problems rather than technical problems – and so systems-based solutions across the board offer more promising outcomes.

As part of this, a recurring obstacle in attempted health integration has been a mindset that prioritises processes. This is, in many ways, quite understandable as the self-fulfilling outcome of a focus on integration. It does, however, have the disadvantage of completely overlooking one rather crucial output in the system: the citizen. To quote one senior health practitioner, “It all feels very much like *Fawlty Towers* – no-one likes to admit that they’ve got a bit of Basil Fawlty in them, but there is a surprisingly widespread feeling that the whole hotel would be run much better, if only it wasn’t for the nuisance of all the guests getting in the way.”<sup>2</sup>

The implementation of the Health and Social Care Act 2012 can therefore be seen as the latest in a long line of attempts at integration over the last 70 years. Its effects, and its scope for disruption, remain considerable as health and care practitioners are still trying to work the subsequent reorganisation of health and social care into day-to-day delivery – with challenging implications for budgets.

But if we return to the *Oxford English Dictionary*, another definition is open to us, deriving from a mathematical context: “The operation of finding the integral of a given function or equation.” This gives us a very different definition, with the emphasis on finding synergy and common strands, rather than on ever more centralised control. This offers a far more promising definition of integration than that which is usually meant.

<sup>1</sup> Integration, n.” *OED Online*. Oxford University Press, September 2016. Web. 17 November 2016.

<sup>2</sup> Confidential information.

## Population Health

**In the last four decades, much of the work around public health has been revolutionised by our evolving understanding of “population health”.<sup>3</sup> Population health is defined as the health outcomes across a group of individuals, including the distribution of such outcomes within the group. It is not solely determined by access to health services, but also by access to other, related services, and their knock-on impact on health outcomes.<sup>4</sup>**

Much of the pioneering research on population health has been carried out in California. The Institute for Population Health Improvement at the University of California Davis has run programmes focusing on a broad range of issues such as vaccines, tobacco, and cancer registry, where selective interventions have only met with limited success, and so a “population health” approach has yielded more promising results. Even areas of care which would traditionally be approached in a siloed way – such as veterans’ care – have been approached in a “whole population” approach, looking across the State of California. Given that California has a population larger than many countries (some two-thirds that of the UK), and has numerous demographic similarities with a similarly ageing population, the approaches may well have direct applicability to the UK.

In the UK, a number of centres of study around population health have arisen in recent years. UCL’s Faculty of Population Health Sciences is one of a new breed of university “super-departments”, combining the different approaches of seven different disciplines, and applying them to teaching and training around public health.

The Glasgow Centre for Population Health, run by NHS Greater Glasgow and Clyde, has been working since 2004 to connect Glasgow’s NHS to leading research around population health. In areas such as cancer treatment, Glasgow has been at the forefront of trialling ‘population health’ approaches which necessarily involve greater integration of services for improved outcomes.

More recently, there has been a flurry of research in this area in the UK. The King’s Fund has published Ham and Alderwick’s substantive report on place-based care,<sup>5</sup> and Eduserv has produced its own report on health and social care integration.<sup>6</sup> Meanwhile, much of the framework for integration is set out in Public Health England’s recent *Fit for the Future* report.<sup>7</sup> And NHS England’s integration pioneers programme has produced its own report on the progress undertaken two years into the programme.<sup>8</sup> There is, therefore, a growing body of major UK work in this field, in addition to the theory and practice developed in California.

<sup>3</sup> See Dorothy Porter, ‘The History of Public Health: Current Themes and Approaches’, *Hygiea Internationalis* 1.1 (1999), pp. 9-21, <http://www.ida.liu.se/ext/inhph/intern/ra/002/first.pdf>.

<sup>4</sup> *Ibid.*, p. 15.

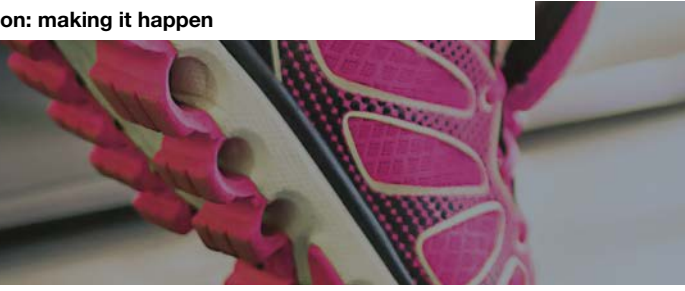
<sup>5</sup> See Chris Ham and Hugh Alderwick, *Place-Based Systems of Care: A Way Forward for the NHS* (London: King’s Fund, 2015), [http://www.kingsfund.org.uk/sites/files/kt/field/field\\_publication\\_file/Place-based-systems-of-care-Kings-Fund-Nov-2015\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kt/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf).

<sup>6</sup> Jos Crees (ed.), *Health and Social Care integration: Confronting the Challenges* (London: Eduserv, 2016).

<sup>7</sup> *Fit for the Future – Public Health People: A Review of the Public Health Workforce* (London: Public Health England, May 2016), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/524599/Fit\\_for\\_the\\_Future\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524599/Fit_for_the_Future_Report.pdf).

<sup>8</sup> *People Helping People: Year Two of the Pioneer Programme* (London: NHS England, 2016), <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>.

## Population Health and Health Integration: making it happen



**Despite the obvious synergies, there is a natural tension between Population Health and Health Integration. By its nature, Population Health involves disruption, innovation, and experimentation. Health Integration is concerned with securing ever more predictable outcomes. Moreover, Population Health is primarily concerned with outcomes, and Health Integration is primarily concerned with inputs.**

Yet there are also a number of shared goals between the two approaches: a focus on avoidance rather than cure, a focus on lower-level, early interventions to stave off more serious interventions later on, and in particular, these crystallising in focusing on developing healthier lifestyles across the population.

A 'Population Health' approach in the UK has allowed us to not only identify whole-population threats to public health, but to also identify geographical and demographic subsets of the population that suffer from particular challenges. For instance, one can identify disparities such as life expectancy in different parts of the UK – as low as 45 in some wards of Blackpool, and in the high 70s in some parts of South-East England.<sup>9</sup> And even surveying healthier segments of the UK population, challenges arise from lengthening lifespans – for instance, amongst UK residents in their 60s, every additional day lived now yields an extra hour in life expectancy. Yet for every additional hour of life expectancy, one can expect two or three comorbidities.<sup>10</sup> It is unsurprising, in addressing massive health disparities like this, that Population Health remedies often involve integrated solutions.

Three key factors are worth stressing on the interface between Population Health and Health Integration:

### **Critical mass**

Successful population health policies depend on achieving "critical mass", through economies of scale. This applies across the public sector, and indeed, across different sectors. With many of the key determinants of public health being in the private sector – whether it be through peoples' diets and leisure, or in their choice of healthcare providers – successful population health initiatives depend on using influence rather than direction.

Nonetheless, there are a number of policy areas where the state effectively has a monopoly or near-monopoly, and so greater integration can deliver very real outcomes. In many parts of the country, transport is an obvious example. For instance, Greater Manchester, and the West Midlands, as part of their "Devo Max" bids, will be responsible for transport policy. The Mayor of London has been responsible for transport policy for over 16 years. Several of the major combined authorities which are proposed will have transport as part of their remit. And in a very different context, in more heavily rural areas such as Cumbria, transport provision is absolutely key to access to services, including health. It is worth noting that even with the big combined authorities, they are often structured around nearby unitary

<sup>9</sup> *Recent Trends in Life Expectancy at Older Ages* (London: Public Health England, 2015), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/403477/Recent\\_trends\\_in\\_life\\_expectancy\\_at\\_older\\_ages.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403477/Recent_trends_in_life_expectancy_at_older_ages.pdf).

<sup>10</sup> *Ibid.*



authorities, and so it will be more important than ever for there to be some measure of co-operation with neighbouring authorities outside their boundaries.

This principle applies more widely – service delivery units will only have a sizeable “critical mass” to have a real impact if they start looking to greater co-operation across different sectors, different industries, different government departments. In each case, the first starting point is effective stakeholder mapping: what are your aims? Who is affected? Who already has an impact on delivery? Who could have an impact on delivery?

### The Citizen

The theory and practice of integration has delivered successes (and failures) in securing efficiencies, reallocating resources, and refining processes. But the approach of integration often misses out one key person: the citizen.

As one senior health care professional remarks, “What’s being integrated is health and social care rather than support around the individual – so the way it’s being framed is systemic.”<sup>11</sup> The problem with this approach is that it does lend itself to not only repeating the structures of the existing system, but also replicating the same systemic problems.

Integration is fundamentally about “sorting out the back office”. There is much room for that – although the number of recurring attempts to do so over the decades is surely a warning that the approach may yield diminishing returns. Citizens play an almost peripheral role in integration, other than as Key Performance Indicators.

If there is to be much political and social “buy-in” for greater integration – and health professionals would do well to consider whom they are ultimately employed by – then the time may be ripe to abandon the language of ‘integration’, and to refocus on patients, citizens, and population health.

### The Financial Context

The economic outlook for the years ahead remains cautious to say the least. Ongoing austerity, the short-term and medium-term ramifications of Brexit, and ever greater demographic challenges to public services will all put severe pressures on health practitioners. Simply put, doctors are being asked to do more with less. Better integrated population health approaches, focusing on *preventative* strategies, offer a rationalised (and rationed) way of addressing this.

### But will this be enough?

The key question, is what can be done at pace, and at scale, within the obvious financial constraints? One social care practitioner asks, “In the south of England, only a small minority of people who receive social care are funded by local government. The majority are self-funders, in whole or in part. How do we integrate with these providers?”<sup>12</sup> This broader financial context underlines the inter-relationship between different bodies, sectors and providers. One crucial way of regulating such relationships – and keeping them tethered to public demands around services – is through the new Sustainability and Transformation Plans (STPs).

<sup>11</sup> Confidential information.

<sup>12</sup> Confidential information.

## Sustainability and Transformation Plans – a “Population Health” approach

**In December 2015, the government set out a need for Sustainability and Transformation Plans across NHS England, in each area of 44 areas of health and social care delivery, and these are currently being rolled out as a means of ensuring greater integration and greater reconciliation to local resourcing.<sup>13</sup>**

Yet simply having a plan will not in itself create a culture shift, or even necessarily bring about change. The plans themselves vary considerably in scope, from ambitious, long-term journeys of 20 to 30 years, to more modest proposals to engage with citizens and revise aims accordingly.

If STPs are to have more success than previous attempts at integration, they will need to avoid the drawbacks of the less successful attempts to go down this route. In particular, they will want to avoid being seen as “top down”. Fortunately, STPs are envisioned by NHS England as “collective discussion forums”, and should be seen as a negotiated, contested space. There will be a larger “public narrative” challenge in summarising what STPs are about – each plan does something different, and so STPs as a whole defy easy categorisation. There is therefore ample room to make the STPs process about *people*, and about involving people in the whole process, to deliver more user-oriented health and social care.

A crucial corollary of this will be transparency. Public healthcare professionals enjoy some of the highest level of confidence in public opinion – but this does not extend to social care professionals, or to NHS administrators, so continued public support should not be taken for granted. This is particularly true given the record NHS deficits incurred in recent years, which are unlikely to instil confidence. Strong transparency around STP aims, and around their responsiveness to public opinion, can therefore strengthen their legitimacy as well as improving outcomes.

The leadership challenge will be in marshalling this public input into a viable delivery plan. What is noticeable is that such plans are underway across the UK – but are not a part of STPs. Instead, we see them in action through negotiations such as devolution to combined authorities, with their healthcare dimensions. Many English healthcare practitioners are

<sup>13</sup> See *NHS Planning and Operational Guidance, 2017-2019* (London: NHS England and NHS Improvement, 2015), <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>.

enviously looking to Greater Manchester, with its ‘Devo Manc’ arrangements, as something of a ‘beacon’ to be emulated. But in amidst the rush to emulate ‘Devo Manc’, it is worth emphasising that the *structures* are less important to emulate than the ‘journey’ and process. There, a complex series of agreements has been hammered out by exploring alternative lines of communication, well outside the STPs’ remit – and yet directly relevant to health integration. “Some of us felt like we were being eaten up”, observes one care practitioner, who then noted that “When we took engagement seriously, we found integration became a lot easier, and a lot less scary.”<sup>14</sup>

Marrying STPs with a “population health” approach, and steering them through with extensive public engagement, therefore seems like a highly promising direction of travel – but proceeding from the planning stage to the implementation stage is more of a challenge in drawing these threads together. By way of a toolkit for this, the Leadership Centre has published *The Art of Change Making*, a freely-available resource setting out a range of approaches that can be used for change makers.<sup>15</sup> Each STP area therefore has a range of options open to it in realising co-crafted agreements that engage with citizens, and have essential public “buy in”.

<sup>14</sup> Confidential information.

<sup>15</sup> John Atkinson, Emma Loftus and John Jarvis (eds), *The Art of Change Making* (London: Leadership Centre, 2015), <https://www.leadershipcentre.org.uk/docs/The%20Art%20of%20Change%20Making.pdf>.

## Leadership of Place: pooling authority, and effective use of overview and scrutiny

**In 2007, the Leadership Centre developed the concept of “leadership of place”; itself an evolution of Sir Michael Lyons’s “place-shaping” agenda.<sup>16</sup> It focused on the way that those in public policy (particularly politicians, but also civil servants) could use their leadership role to convene and combine other key stakeholders in delivering place-based solutions.**

Lyons was interested in the role of local politicians with “place-shaping”. “Leadership of place” has more to do with leaders functioning as part of a much wider system, forging alliances and shared goals with synergy groups and organisations. In the years since then, the Leadership Centre has been involved in helping leaders around the UK put these principles into action, whether through pilots such as ‘Calling Cumbria’ and the more widely-rolled-out ‘Total Place’ that was trialled in Birmingham, through to its more recent work around health and social care integration.

More recent work on integration has convinced us that ‘place-shaping’ is more relevant than ever in the fields of health integration and population health. Moreover, health and social care providers hold an almost unrivalled position of respect within the community,<sup>17</sup> and are well-placed to play an active role in leading on place-based approaches to health outcomes.

Many of the Leadership Centre’s key practice lessons on “leadership of place” remain as relevant as ever, specifically:

<sup>16</sup> See *The Politics of Place* (London: Leadership Centre, 2007), and then further refined in *Leadership of Place: The Role of Overview and Scrutiny* (London: Leadership Centre, 2008), <https://www.leadershipcentre.org.uk/docs/ScrutinyOverviewFinal.pdf>. For Lyons’s work on “place-shaping”, see Sir Michael Lyons et al, *Lyons Inquiry into Local Government: Place-Shaping, a Shared Ambition for the Future of Local Government* (London: The Stationery Office, 2007), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/229035/9780119898552.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229035/9780119898552.pdf).

<sup>17</sup> ‘Politicians Are Still Less Trusted Than Journalists, Estate Agents, Bankers – Ipsos MORI Veracity Index 2015: Trust in Professions’ *Ipsos MORI*, 22 January 2016, <https://www.ipsos-mori.com/researchpublications/researcharchive/3685/Politicians-are-still-trusted-less-than-estate-agents-journalists-and-bankers.aspx>.

## **The role of collaboration, and of co-designing and co-delivering outcomes**

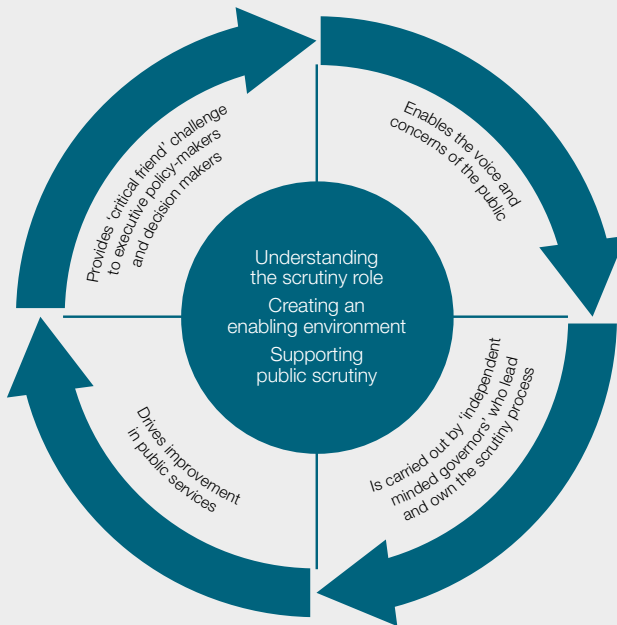
Collaboration is at the centre of leadership of place. Not only is it invaluable in rendering a vision, it is essential in coming up with the vision in the first place. Much has been written about “co-design”, but the Leadership Centre often works more around “co-crafting” – design can be an impersonal, mass-produced process, preoccupied with back-end functions in much the same way as integration, whereas a “co-crafting” approach involves time, skill and customisation around individual circumstances. (Although the scalability of bespoke solutions is a wider question.) The National Co-Production Advisory Group’s motto is “Think Local, Act Personal”. A co-crafting approach to population health would come closer to “Think Personal, Act Local”.

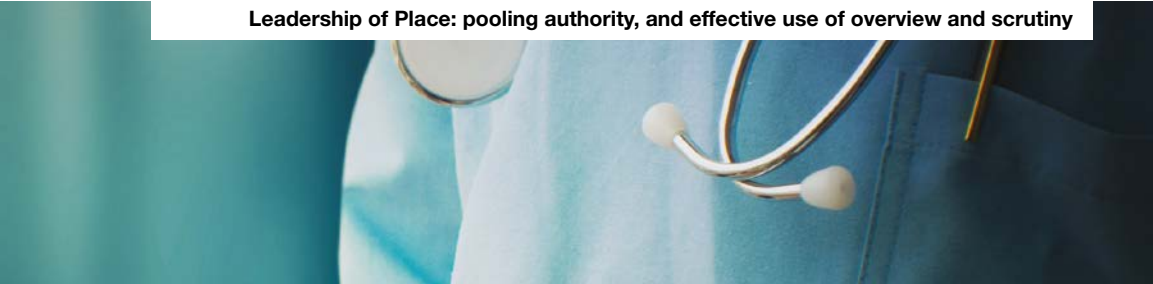
## Leadership of Place: pooling authority, and effective use of overview and scrutiny

### The role of scrutiny

One particular example is the effective use of Overview and Scrutiny. With a strong ‘transparency’ strand being key to the success of STPs, an effective use of scrutiny is more important than ever. The essential part of this in any good governance structure gives a great deal of impetus to develop strong place-based solutions that reflect the needs and resources of an area. Given the paramount importance of Overview and Scrutiny in health and social care (and the high stakes involved when it is inadequate – as with, say, the “Baby P” case), this is if anything even more central to health and social care than it is to local government.

The Centre for Public Scrutiny have released the “wheel of effective scrutiny” diagram showing how scrutiny effectiveness can be maximised. Effective scrutineers take a proactive role in redirecting an organisation, and in reinventing practices to meet local needs.





### **Crossing institutional boundaries**

With power and responsibility ever more diffusing, there is a general “crisis of governance” across all institutions. If you ask “Who is in control?”, the one thing most people can all agree on – politicians, businesspeople, civil servants, journalists, experts – is “Not me!” With state ‘command and control’ levers producing diminishing returns, effective policymakers find themselves increasingly in the game of convening and influencing, rather than directing.

The crucial role of overview and scrutiny role in health outcomes – combined with the legitimacy of public input into STPs and other ad hoc plans – gives policymakers a unique legitimacy to convene others, and to be convened; it is a two-way process. The Leadership Centre has actively championed such collaborations in health, taking a broad ‘population health’ approach.

These often consider the totality of health influencers – working environment, home environment, diet, transport, quality of life. Only an active engagement with the providers and influencers of each of these is likely to yield real, sustained change.

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# Conclusion

The history of health integration in the UK has, sadly, been a history of empty rhetoric. Politicians of all parties have sought reforms to bring about closer integration as a means of securing better health outcomes. There is something repetitive about a further bout of such reorganisation hoping to secure yet further improved outcomes.



That does not completely invalidate integration as an approach to health. But it is worth asking what we are integrating provision for? If it is to secure better health outcomes in citizens, then the citizen has tended to be left out of a lot of discourse around this.

Surely a better starting point is the citizen. And surely a focus on citizens – through ‘population health’ approaches which are co-designed and co-crafted with citizens – stand a better chance of obtaining improved outcomes? A shift from “What are your aims?” to “What are your citizens’ ambitions?” is what is advocated here.

Policymakers and practitioners in health occupy a uniquely strong position. They retain strong public confidence, and are well-placed to convene and to be convened. With the rolling out of Sustainability and Transformation Plans, these could provide a greater spur to involving citizens in a co-crafted ‘population health’ approach; one that stands a far better chance of ‘squaring the circle’ of rising demand and falling revenue than a focus on integration. However, policy ambitions need not be restricted to simply box-ticking through the STP exercise; many of the most meaningful collaborations are being conducted well outside of its remit. It is, however, a useful mechanism to encourage the conversations and collaborations that could redesign health service delivery, in a more citizen-focussed way. The Leadership Centre is working hard to offer the tools to empower policymakers and citizens to fully engage in this ongoing process.

## Bibliography

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Dorothy Porter, 'The History of Public Health: Current Themes and Approaches', *Hygiea Internationalis* 1.1 (1999), pp. 9-21, <http://www.ida.liu.se/ext/inhph/intern/ra/002/first.pdf>

### Reports and pamphlets

*Fit for the Future – Public Health People: A Review of the Public Health Workforce* (London: Public Health England, May 2016), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/524599/Fit\\_for\\_the\\_Future\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524599/Fit_for_the_Future_Report.pdf).

*Leadership of Place: The Role of Overview and Scrutiny* (London: Leadership Centre, 2008), <https://www.leadershipcentre.org.uk/docs/ScrutinyOverviewFinal.pdf>.

*People Helping People: Year Two of the Pioneer Programme* (London: NHS England, 2016), <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>.

*The Politics of Place* (London: Leadership Centre, 2005), [https://www.leadershipcentre.org.uk/images/leaderofplace\\_brochure.pdf](https://www.leadershipcentre.org.uk/images/leaderofplace_brochure.pdf).

*Recent Trends in Life Expectancy at Older Ages* (London: Public Health England, 2015), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/403477/Recent\\_trends\\_in\\_life\\_expectancy\\_at\\_older\\_ages.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403477/Recent_trends_in_life_expectancy_at_older_ages.pdf).

Jos Crees (ed.), *Health and Social Care integration: Confronting the Challenges* (London: Eduserv, 2016).

Chris Ham and Hugh Alderwick, *Place-Based Systems of Care: A Way Forward for the NHS* (London: King's Fund, 2015), [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Place-based-systems-of-care-Kings-Fund-Nov-2015\\_0.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf).

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Sir Michael Lyons et al, *Lyons Inquiry into Local Government: Place-Shaping, a Shared Ambition for the Future of Local Government* (London: The Stationery Office, 2007), [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/229035/9780119898552.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229035/9780119898552.pdf).

Seth Thévoz (ed.), *Commercialisation: Options in Local Government Finance* (London: Leadership Centre, 2016), [https://www.leadershipcentre.org.uk/docs/Commercialisation\\_web.pdf](https://www.leadershipcentre.org.uk/docs/Commercialisation_web.pdf).

### **Other sources**

'Politicians Are Still Less Trusted Than Journalists, Estate Agents, Bankers – Ipsos MORI Veracity Index 2015: Trust in Professions' *Ipsos MORI*, 22 January 2016, <https://www.ipsos-mori.com/researchpublications/researcharchive/3685/Politicians-are-still-trusted-less-than-estate-agents-journalists-and-bankers.aspx>.

Notes from LGC & HSJ Integration Summit 2016, held under the Chatham House rule, with the anonymity of comments preserved.

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