

Local Government Association

Stepping up to the place

Part B: Evidence review

October 2018

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1 Introduction

The Local Government Association (LGA) with its partners NHS Confederation, NHS Clinical Commissioners and the Association of Directors of Adult Social Services (ADASS) published their shared vision for integrated care [Stepping up to the place](#) in June 2016. Since that time there has been significant further work carried out across the country. This has developed our understanding of what good looks like in terms of delivering health and wellbeing outcomes for local populations and necessitated a refresh of the vision.

The LGA commissioned the Institute of Public Care at Oxford Brookes University to undertake an evidence review, which is intended to support the refresh of the shared vision, as well as provide an overview of current practice within this agenda. The review explored two questions:

- 📍 Is the original vision still valid given the current context, and learning from practice since 2016?
- 📍 Where are we now in terms of delivering the vision? What is the experience across England, what are the barriers, and what are the enablers?

The review report is provided in three sections:

Part A: Review of the vision. This provides a summary of the findings from the evidence review and explores the implications of these for the vision.

Part B: Evidence review. This sets out the review of evidence in detail, providing examples to illustrate current practice, the barriers and the enablers.

Part C: Case studies. These are a series of new case studies describing current experience and good practice in delivering integrated care.

This evidence review was carried out between March and August 2018, and considered three main sources of evidence:

- 📍 Published material including case studies or examples as well as evaluations.
- 📍 Material available but not published, as provided by the LGA.
- 📍 Discussions with individual case study sites either to clarify or update published material or to enable the development of new case studies.

Given the scope and complexity of the integration agenda, and the range of activity being undertaken across the country, this evidence review provides a sample of the evidence and focuses, to a degree, on sites known to be developing good practice in specific areas rather than carrying out a comprehensive mapping of activity. It is important to note that due to the relatively short time scale for carrying out the review and the scarcity of information on impact, it is not possible to gauge the prevalence of these characteristics.

Stepping up to the place describes the essential characteristics of what good looks like in terms of improving people's health and wellbeing outcomes. For the purposes of this review these characteristics have been grouped across three themes:

Leadership and accountability

1. A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.
2. A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.
3. Locally accountable governance arrangements encompassing community, political, clinical and professional leadership that transcend organisational boundaries, are collaborative, and where decisions are taken at the most appropriate local level.
4. Locally appropriate governance arrangement which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.

Delivering integrated care

5. Services and the system are designed around the individual and the outcomes important to them and developed with people who use or provide services and their communities.
6. Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.
7. A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

Shared systems

8. Common information and technology – at individual and population level – shared between all relevant agencies and individuals and use of digital technologies.
9. Long-term payment and commissioning models, including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.
10. Integrated workforce planning and development, based on the needs and assets of the community, and supporting multidisciplinary approaches.

This evidence review (Part B) has been divided into three sections that match the three themes above. Each section provides a brief introduction to the characteristics of the theme and some initial context; explores current practice including barriers, enablers and any evaluative information about its impact; and then provides a commentary on the lessons to be drawn from the evidence. The commentary is included in Part A in the summary of findings where further consideration is given to its implications for the vision.

2 Shared leadership and accountability

As outlined in the original vision for integrated care, one of the elements considered key to delivering an integrated care system is shared leadership and accountability, including having a shared vision.

A vision for shared leadership and accountability¹ ‘what good looks like’

Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries, are collaborative, and where decisions are taken at the most appropriate level.

Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of their governance such as combined authorities, devolved arrangements or NHS planning requirements.

A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

A variety of joint or collaborative governance arrangements have been developing across England, helping to drive forward the integration of health and social care and providing accountability for the new ways of working. These include health and wellbeing boards, Sustainability and Transformation Partnerships (STPs) and devolution.

However, the evidence shows that as important, if not more important, are the behaviours, values and cultures that are or can be exhibited or promoted within these governance arrangements. Collaboration, an inclusive approach, and relationships built on trust are all seen to be vital ingredients in successful integration and the improvement of outcomes for local communities.

The development of a shared vision and the approaches to articulating this are discussed variously across this evidence review (for example in terms of coproduction with local communities, defining a shared organisational culture, and articulating the outcomes for integrated commissioning functions). In this section the focus is on the leadership culture, behaviours and accountability needed to support integration, as well as the various governance structures behind it, where again the development of a vision shared by the system is seen to be key in the evidence.

2.1 Leadership and accountability in practice

Whilst the formal governance structures are a key element of moving towards delivering integrated care, as discussed above the role of non-structural characteristics are often recognised as more important as success factors:

“Embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration. This can take many

¹ NHS Confederation (2016, p.12) *Stepping up to the place*. Available at: <http://www.nhsconfed.org/resources/2016/06/stepping-up-to-the-place-the-key>

years because the cultures and working practices in the health and local government sectors are very different.”²

This section explores the leadership cultures and behaviours which are seen to be effective, how these are being developed in practice, and what this means for the vision for integrated care.

2.1.1 Cultures and behaviours

2.1.1.1. Leadership across a system

Even if a local system has not developed formal arrangements for integration, the principle of shared leadership is an important factor in making a positive impact:

“The concept of shared leadership is about transcending individual organisations and their interests, and coming together to make a combined effort on behalf of local people. This may mean on occasion overriding the best interests of one constituent organisation in favour of the best interests of the system as a whole, and therefore of people who use or will use services. It may also mean one or more existing bodies devolving power and/or funds so that the whole system can be more powerful and effective.”³

An alternative descriptor is that of “system leaders”: a series of interviews with people who could be described as “system leaders” identified several themes around what makes it work:⁴

- 👤 It requires a conflicting combination of constancy of purpose and flexibility.
- 👤 It takes time – often a lot of time – to achieve results.
- 👤 It starts with a coalition of the willing.
- 👤 It is important to have stability of at least a core of the leadership team across those involved.
- 👤 Patients and carers are crucial in helping design the changes.
- 👤 System leadership is an act of persuasion that needs to have an evidence base for change – not least because that is the key tool for persuading the unconvinced.
- 👤 As several interviewees put it in one form or another, ‘you can achieve almost anything so long as you don’t want to take the credit for it’. You have to ‘give away ownership’.

Examples of shared or system leadership behaviour have been found and demonstrate the importance of this to joint working, as illustrated in the examples below.

² National Audit Office (2017, p.8) *Health and Social Care Integration*. Available at <https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration-Summary.pdf>

³ Local Government Association (2014, p.9) *Making an impact through good governance: A practical guide for health and wellbeing boards*. Available at: <https://www.local.gov.uk/sites/default/files/documents/making-impact-through-goo-f63.pdf>

⁴ The Kings Fund (2015, pp.7-8) *The practice of system leadership: Being comfortable with chaos*. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/System-leadership-Kings-Fund-May-2015.pdf

Luton Improvement Leadership Collaborative

A focus on leadership development enabled improved working relationships across organisations. Together the organisations co-designed solutions to improve patient experience, care quality and efficient service utilisation. This involved:

- 📍 A leadership collaborative with senior representatives from organisations across the health and social care economy. The aim of the programme was to bring leaders together and focus on integration.
- 📍 External organisations, bringing expertise from outside the health and social care sector, provided training and facilitation on a variety of transformation and management topics.

Critical Enablers:

- 📍 Leaders were provided with “protected time” in which to discuss shared challenges and identify differences between their organisations.
- 📍 Flexibility in the scope of issues covered by the Improvement Leadership Collaborative allowed senior leaders to maximise the value of their investment.

East Riding of Yorkshire: The chair recognises the individual value of health and wellbeing board members and empowers individuals to take a leadership role themselves. When a single health and wellbeing board member is better placed to lead a discussion about a particular topic, the chair delegates responsibility to them. This further strengthens joint ownership and shared responsibility.⁵

Rotherham Integrated Care Partnership Place Board

The Partnership is responsible for the delivery of the Place Plan and is co-chaired by the Chief Executive of the council and Chief Officer of the CCG with membership of senior leaders from adult social care, public health, the hospital and community trust, mental health trust, GP federation, the umbrella organisation for the voluntary and community sector and the chair and vice chair of the health and wellbeing board.

Board members have spent time developing a culture of close working and peer support. Relationships are built on trust that has been established through understanding each other's issues and ways of working, gained by spending time in partner organisations, seeing the world through a different lens and 'walking in each other's shoes.' The result is a set of shared values including seeing the whole person and acknowledging the breadth of their needs - medical and non-medical - and taking a whole system approach to change. The closely knit Chief Executive and Director level leadership team meet weekly to problem solve together in the style of a high level action learning set and value the different perspectives that make them stronger as a team.

Download the full case study [here](#)⁶

⁵ Shared Intelligence (2016) *Effective Health and Wellbeing Boards: Findings from 10 Case Studies*. Available at: <https://www.local.gov.uk/sites/default/files/documents/effective-health-and-well-4c3.pdf>

⁶ Rotherham Case study available at

<https://www.local.gov.uk/sites/default/files/documents/Rotherham%20Case%20Study%20-%20final.pdf>

2.1.1.2. Organisational culture

The culture of the different organisations potentially involved in planning and delivering integrated care is a key enabler or barrier to effective working. Organisational culture has been described variously, so for example⁷: “*the values and beliefs that characterise organisations, as transmitted by socialisation processes that newcomers have, the decisions made by management, and the stories and myths people tell and retell about their organisations.*”

It has been argued⁸ that the development of integrated care and support requires an acknowledgement of the need for cultural change. Seeking to retain existing cultures inevitably leads to a fight for dominance and a concern that the culture of one or other of the partners in the collaboration will win out. The drive to deliver integrated care and support should lead to the emergence of a new cultural identity, one committed to the integrated working agenda.

The same review of research evidence argues that delivery on the dimension of culture requires:

- 📍 Acknowledgement of the differing cultures of different organisations, professions and individuals
- 📍 Awareness of the need to facilitate, promote and foster the development of a fresh emerging culture
- 📍 Effective communication of the emerging cultural identity
- 📍 Leadership which encourages positive risk-taking and rewards innovation and engagement with unfamiliar activities or approaches
- 📍 Addressing issues for front-line staff
- 📍 Navigating and overcoming barriers of communication and perception

Whilst there is evidence of attention being paid to addressing organisational culture, as illustrated variously below, there is not a consistent and early acknowledgement of this as a critical element of effective leadership practice in terms of integration.

In Kent a range of stakeholders were involved in a Local Vision programme that set out to implement an integrated commissioning approach. It was felt that progress had stalled due to issues of power and trust, and an unwillingness by some to relinquish control. The system was very complex, involving the county council, big NHS trusts and a number of smaller CCGs, health and wellbeing boards and district councils. A combination of work with individuals, and then bringing them together in open space

⁷ Schneider, B and Barber, KM (2014). Introduction: the oxford handbook of organizational climate and culture In: Schneider, B and Barbera, K M eds. Oxford: Oxford University Press, pp. 3–20, The Oxford Handbook of Organizational Climate and Culture.

⁸ Institute for Research and Innovation in Social Services (2013) *Delivering integrated care and support*. Available at: <https://www.iriss.org.uk/sites/default/files/2016-07/iriss-delivering-integrated-care-and-support-2013-12.pdf>

events, without a formal agenda but with a clear shared ambition, was crucial to making progress⁹

Leeds' overarching vision is to improve quality of care and outcomes for people with complex needs by overcoming the fragmentation associated with multiple providers. The vision is articulated through a person-centred vision statement and a common narrative to create a shared purpose and outcomes for integration in health and care. They have developed 'I statements' and design principles for integration, keeping the voice of the people of Leeds at the heart of everything they do. A fundamental part of their approach is to involve people at every stage, to the extent that they have developed a Leeds charter for involvement in integration. This engagement approach with organisations and users is supporting the creation of a culture of cooperation, co-production and coordination between health, social care, public health, other local services and the third sector.¹⁰

Greater Manchester: Successful health and care devolution, or integration, depends on stakeholders placing less importance on their individual organisational interests and focus instead on their collaborative impact for people in their place. And place doesn't start and end at the city region: the Greater Manchester experience shows that micro-commissioning and neighbourhood approaches can also have their role to play in controlling demand and delivering a broader health and care strategy.¹¹

Norfolk: a future leaders training programme was specifically targeted at changing attitudes and behaviours of a mixed cohort of leaders across the care system, with specific targeted development on the aptitude and capacity to lead and influence models of integrated care. The Norfolk programme appears unique in its focus on mid-level and future managers rather than existing leadership. The iterative, rapid-cycle approach to content development does not appear to have been studied elsewhere but may be a valuable approach for other training and leadership programmes to consider due to positive feedback from participants¹².

Challenges included uneven distribution of participants across health and social care. According to the programme directors, the programme take up was not equal from a health and social care perspective, and as a result, social care was over represented. They reflected that if given another opportunity, it would be preferable to hold more joint marketing events and seek additional promotion from high level managers. Another challenge was finding time to devote to integration work on top of the day job.

Critical Enablers:

⁹ The Leadership Centre (2015) *The Revolution will be Improvised Part II: Insights from places on transforming systems*. Available at: <https://www.leadershipcentre.org.uk/wp-content/uploads/2016/03/Revolution-will-be-improvised-Part-2-Sept16.pdf>

¹⁰ Local Government Association (2016) *The journey to integration Learning from seven leading localities*. Available at: <https://www.local.gov.uk/sites/default/files/documents/journey-integration-learn-31c.pdf>

¹¹ PWC (14 March 2017) *Where next for health and social care devolution?* Available at: <https://www.pwc.co.uk/who-we-are/regional-sites/midlands/insights/whats-next-for-health-and-social-care-devolution.html>

¹² <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31392453>

- 👤 Flexible, rapid-cycle approach to content development, which allowed content to adapt in real time to the participants' needs and feedback
- 👤 Leadership programme content is specific to the challenges facing health and social care managers rather than generic management development

Haringey's approach to integration using action learning sets incorporates a proven method of developing leadership skills with an inclusive structure that engages stakeholders. Action learning sets have been proven to develop executive, managerial and collaborative leadership skills, coaching skills and improve the ability of managers to develop integrative and mutually beneficial solutions to conflict situations.

Croydon has found that investment in organisational development has been instrumental in changing attitudes at all levels, right from the top. Acknowledging that relationships between the partners had often been difficult and previous attempts at integration had failed, it was agreed early on that staff needed to be given the chance to unpick behaviours and cultures that had previously driven silo working and lack of respect for each other. The work has challenged senior leaders to frontline staff across the Alliance organisations to ask themselves the question "do we speak well of each other" and to reflect on how to improve relationships.

A programme management team that draws on membership from different partner organisations has been modelling new behaviours in a pragmatic way. Working in an open plan work area, a combination of both commissioning staff and operational staff interact on a daily basis, getting to know each other, building trust, sharing ideas, learning and problem solving together.

This is a work in progress, which has only scratched the surface so far as the ambition of the programme is to see behaviour changes across 6 different organisations plus over fifty local GP practices, the voluntary sector and the local population. Future plans include shared staff induction content, shadowing and coordinating of recruitment and training.

Download the full case study [here](#)¹³

2.1.2 Accountability and decision making

2.1.2.1. Accountability to local communities

An important issue and challenge in working across systems, and particularly across health and social care, is the difference in accountability within different organisations. A recent review of STPs noted:¹⁴

¹³ Croydon Case study available at

<https://www.local.gov.uk/sites/default/files/documents/Croydon%20Case%20Study%20-%20final.pdf>

¹⁴ London South Bank University (2017, p.4 and 6) *Sustainability and Transformation Plans: How serious are the proposals? A critical review*. Available at:

https://www.lsbu.ac.uk/_data/assets/pdf_file/0019/114409/sustainability-and-transformation-plans-critical-review.pdf

“With local government democratically accountable to its local population, working to meet local needs; and with the NHS accountable through NHS England and NHS Improvement; planning together over a wider footprint in terms of population, with completely different accountabilities, means the starting point for STP-level collective decision-making and planning is a challenge”.

The same review also noted: *“But overall it is unclear, given STP partners’ own accountability to their local populations, how the STPs themselves are to be held accountable to their ‘footprint’ population, and there is a danger of a distance emerging between the decision-makers and the public.”*

However, the evidence suggests that this issue is being considered and attempts being made to ensure a level of accountability to local communities.

In Greater Manchester, public engagement is embedded in the plan, including over 6,000 meetings held to gain a greater understanding of the issues, more than 2.5 million social media engagements, and over 300 staff and community group meetings to date. On the other hand, attendees reflected that STPs have been more introspective and in some cases lack the skills needed to deliver meaningful public engagement¹⁵

Hackney: The voice of the service user is at the forefront, and each meeting begins with a service user talking about their experience of using health and social care services in Hackney. This puts the service user at the fore, bringing a focus on place and on the communities the health and wellbeing board serves, and can give the impetus for the health and wellbeing board to take action. For example, at one meeting, a service user spoke on behalf of East London Vision about access to services for those with visual impairments, and queried the health and wellbeing board’s commitment to improving this. By the following meeting, partner organisations including the council and acute hospital had taken action such as providing training to library staff and developing easy read materials.¹⁶

In Rotherham a communications and engagement group, including communications leads from all partners, meets on a regular basis to develop specific communication and engagement activity, including local media. Communication is carried out in a simple and easy to understand way, that demonstrates how local services are being transformed and promotes community understanding and feedback. An infographic and animation (http://preview.beach-design.co.uk/nhs_rotherham/) has been used as a key tool in articulating how local priorities are closely interlinked to deliver better, more accessible services in the coming years.

¹⁵ PWC (14 March 2017) *Where next for health and social care devolution?* Available at: <https://www.pwc.co.uk/who-we-are/regional-sites/midlands/insights/whats-next-for-health-and-social-care-devolution.html>

¹⁶ Shared Intelligence (2016) *Effective Health and Wellbeing Boards: Findings from 10 Case Studies*. Available at: <https://www.local.gov.uk/sites/default/files/documents/effective-health-and-well-4c3.pdf>

2.1.2.2. Decision making

The NHS England Board¹⁷ included amongst its principles for going forward with devolution: the principle of subsidiarity, ensuring that decisions are made at the most appropriate level. This principle means decisions will be made as close to the individual as possible, and counters the potential for large health and social care governance structures which are divorced from their local communities and yet are making decisions which impact on their health and wellbeing.

Examples can be found where large geographical areas are working together, such as London or Greater Manchester, as well as on a smaller scale such as a small number of London boroughs working together.

London Health and Care Collaboration:¹⁸

“Collaboration and new ways of working will be needed between commissioners, providers, patients, carers, staff and wider partners at multiple levels. Recognising that the London system is large and complex, commissioning and delivery will take place at three levels: local, sub-regional or pan-London. A principle of subsidiarity will underpin our approach, with decisions being made at the lowest appropriate level.”

“While embedding subsidiarity, we will ensure the strategic coherence and maximise the financial sustainability of the future health and care system across London. Political support for jointly agreed change will be an important feature of the arrangements. New London-level arrangements, including governance and political oversight, will be established to secure this. We commit to minimising bureaucracy as much as possible to enable delivery of local innovation.”

Greater Manchester¹⁹

A set of Greater Manchester wide supra-organisational governance structures and leadership arrangements have been established to support the delivery of the vision. While the existing organisational structures, governance arrangements and accountabilities remain, there is a clear sense that they are becoming less important. In part this is seen in the reduced importance of organisational boundaries and the shift in the locus of decision-making from individual organisations to groups of organisations in localities and from national bodies to GM. It is also reflected in the coming together of providers and commissioners and of local authority and NHS organisations, and the shift from contractual to relational modes of interaction.

There has been no explicit statement about the likely future of existing organisations. In the meantime, shared leadership arrangements – for example across LA/CCG and across health/social care provision – are developing.

¹⁷ NHS England (2015) *Board Paper. Devolution – Proposed Principles and Decision Criteria*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2015/09/item4-board-29-09-15.pdf>

¹⁸ London Councils (2015) London Health and Care Collaboration Agreement. Available at: https://www.london.gov.uk/sites/default/files/london_health_and_care_collaboration_agreement_dec_2015_signed.pdf

¹⁹ The University of Manchester (2016) *Researching Health and Social Care Devolution: Learning from Greater Manchester*. Available at: <https://www.health.org.uk/sites/health/files/GM%20HSC%20devolution%20interim%20findings%20-%20201-3-2017.pdf>

2.1.2.3. Accountability and regulation

“Accountability” in the health and social care sector has been described as broadly “*about how the behaviour of a large number of professional people can be influenced to maximise the health and wellbeing of a population*”.²⁰

Accountability is a complex issue with individuals feeling accountable in many directions, so for example: to their patients/service users; to their staff; to their local communities; to their professional bodies; to their electorate and/or local communities; to commissioners and/or funders; to regulators; and to national government.

Currently, accountability is largely organisation based rather than looking across the system, although work is underway to respond to the complexity of providing integrated care, for example through the development of the logic model²¹ for integrated care, which describes what good looks like, provides a visual depiction of how a fully integrated health and care system might be structured and function, and the outcomes and benefits it should deliver for those who use services and their carers.

The remit of the Care Quality Commission (CQC) is to ensure the quality of services among health and social care providers. However, the regulation is currently designed to inspect and monitor autonomous provider organisations, and not new integrated organisations (such as accountable care organisations or the vanguards). CQC has recognised that there are numerous starting points for integration, and local experiences and successes vary. The regulatory system needs to adapt to account for more complicated and integrated delivery systems, new care models and their governance arrangements. In addition, NHS Improvement has a remit to regulate NHS trusts through its Single Oversight Framework, which assess performance against five themes: quality, operational performance, finance and use of resources, strategic change, and leadership and improvement capability. NHS England sets the overall commissioning strategy and clinical priorities for the NHS, and commissions primary care services as well as some specialised and public health services.

There are different national performance measures and targets across different sectors; there are examples of local integrated areas developing a shared view of how to tackle through this through the development of local good practice guidance, and local measures.

As well as a fragmented inspection regime and multiple commissioning bodies, there are multiple national outcomes frameworks across sectors and no one set of integration metrics. A key barrier is that there is no single national organisation or body, with clout, that oversees the multiple regulatory bodies, sets of performance metrics and outcomes frameworks.

In terms of monitoring and oversight, there is substantial variation in arrangements at local level. There are good examples of areas which have had integrated working for some time, with shared indicators and common monitoring systems. For example, one approach focuses on a quarterly meeting involving the leader of the council, the chair of the trust and other senior representatives, which scrutinises a joint

²⁰ The Health Foundation (2016, p.7) *Simpler, clearer, more stable: Integrated accountability for integrated care*. Available at: <https://www.health.org.uk/sites/health/files/SimplerClearerMoreStable.pdf>

²¹ www.scie.org.uk/integrated-health-social-care/measuring-progress/logic-model

performance report and ensures simpler, clearer, more stable compliance with key standards, as well as looking ahead to new opportunities. Other areas have to report in multiple ways, e.g. where social care is run on a county-wide basis, but there are several CCGs, which sometimes find it difficult to agree a joint approach.²²

2.1.3 Conclusion

There is clear evidence that the importance of leadership relationships, behaviours, and cultures has been recognised in the strategic development of integrated care. It is less clear whether there is a good understanding of the importance of taking proactive approaches to developing and embedding positive behaviours, or an understanding of the link between this and the delivery of better health and wellbeing outcomes.

In terms of accountability there is a tension between the development of governance arrangements which cover large geographical areas, and the strengthening of accountability to local communities. There are examples of arrangements which seek to build and maintain these relationships, whether this is through active community engagement in governance activities, or through active pursuit of the principle of subsidiarity. However, there is not a clear sense of this being recognised as a critical feature of effective integrated care nor of its effectiveness being actively evaluated.

The evidence suggested that effective integrated care systems are finding ways to work around the regulatory systems which are not designed for integrated organisations or services. This is not necessarily easy and requires a shared focus on the outcomes being sought, and an agreed approach to resolving potential conflicts across regulatory systems. The development of a single framework that supports integration and whole system thinking would be a key step forward.

2.2 The role of governance arrangements

This section considers the role of the main strategic governance arrangements in transforming health and care systems, and the lessons to be learnt about what makes them more effective. Formal governance structures have been seen to be the key drivers for transformation, for example:

- 📍 Health and wellbeing boards “offer new and exciting opportunities to join up local services, create new partnerships with GPs, and deliver greater democratic accountability”²³
- 📍 STPs “offer the best hope for the NHS and its partners to sustain and transform the delivery of health and care.”²⁴

However, an evaluation of the New Care Models Programme²⁵ found that it was the informal relationships which formed the starting point: “*sites did not rush to create new*

²² The Health Foundation (2016) *Simpler, clearer, more stable: Integrated accountability for integrated care*. Available at: <https://www.health.org.uk/sites/health/files/SimplerClearerMoreStable.pdf>

²³ The King’s Fund (2012, p.1) *Health and wellbeing boards: System leaders or talking shops?* Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/health-and-wellbeing-boards-the-kings-fund-april-12.pdf

²⁴ The King’s Fund (2017, p.2) *Delivering sustainability and transformation plans*. Available at: <https://www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans>

²⁵ The Health Foundation (2017, p.11) *Some assembly required: implementing new models of care*. Available at: <https://www.health.org.uk/publication/some-assembly-required>

organisational forms and contractual arrangements. Instead, often building on years of work before the programme, they used informal partnerships to develop collaborative relationships and redesign care.”

North East Lincolnshire: The Union

The NHS and local government in North East Lincolnshire have joined formally as a Union and have been working together for more than ten years with a common aim to improve outcomes for their population. A shared vision for their 'place', owned across political parties and supported by good and trusting relationships has driven a joint approach to commissioning, service delivery and financing to the point that integration is now viewed as 'business as usual'.

This has been enabled by the Union's Partnership Board, which provides single strategic leadership across the CCG and the council's people related functions, and delivery of Section 75 health and social care arrangements. The Union is a relatively lean and uncomplicated model driven by a common purpose and commitment evolved over the years. Each statutory organisation (CCG and council) continues to discharge their retained responsibilities and decision making powers through their governing bodies (Cabinet and scrutiny committee for the council and governing body for the CCG), but delegates delivery to the Partnership Board and joint executive team that underpins it. No new organisation has been created.

Download the full case study [here](#)²⁶

In other areas, significant time and resources have and continue to be devoted to the creation and development of formal governance structures to support the integration agenda; this section considers the characteristics that make these effective.

2.2.1 Health and wellbeing boards

Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public health responsibilities²⁷.

In view of their statutory role in bringing local government and health together to agree what the health and care needs are of the local population and presenting these in a health and wellbeing strategy which provides the foundation for planning services, they are a key mechanism for bringing about integration. As well as bringing together clinical, political, professional and community leaders, increasingly they are drawing in other public services including housing, jobs and environment so that the approach to improving health and wellbeing is as broad as possible, includes prevention and is place based. It also means that there is a sharing of responsibility for difficult decisions, particularly in securing sustainable and transformed services. Significantly, it is the health and wellbeing boards that are responsible for signing off the local Better Care Fund (BCF) plans: the first nationally mandated pooled budget.

²⁶ North East Lincolnshire case study available at:

<https://www.local.gov.uk/sites/default/files/documents/North%20East%20Lincolnshire%20Case%20Study%20-%20final.pdf>

²⁷ The Kings Fund (22 June 2016) Health and Wellbeing Boards Explained. Available at:

<https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained>

Durham health and wellbeing board – enabling integration and providing quality assurance²⁸

Durham health and wellbeing board has a reputation for strong leadership, forward thinking and mutual respect between partners. In 2016 the board had a development day to which all chief officers, including the Acute Trust, Mental Health Trust, CCG and council were invited. The question for discussion was whether Durham had taken integration as far as it could go.

Encouraged by the discussions that day, a new integration working group of chief officers started to make ambitious plans for new ways to collaborate. One of their workstreams, led by the CCG, was to re-design community services putting primary care at the centre, focusing on prevention and early intervention and integrating teams from health and social care at all levels. A director level post was created to drive forward change and put in place a Memorandum of Understanding to secure engagement of partners. A steering group has been established with senior staff membership. The group reports progress to the health and wellbeing board.

Procurement is now complete and a contract has been awarded. A new chief officer will lead the service, which combines thirteen different teams. As the contract is mobilised, the health and wellbeing board will be keeping a watchful eye on progress. As the Board is responsible for signing off the Better Care Fund, under which this initiative sits, it has a role in performance monitoring and will not be shy of challenging when it needs to.

This example demonstrates how a health and wellbeing board is fulfilling its duty to act as an enabler and to quality assure initiatives that drive integration as a vehicle for improving health and care outcomes for their local population.

While integration of health and care is a continuing priority nationally and locally, the most recent report of the longitudinal review of health and wellbeing boards²⁹, points to new challenges:

- 📍 An environment that is more pressurised and politically turbulent
- 📍 The NHS focus on sustainability and transformation plans across 44 geographical areas i.e. new sub-regional governance and organisational arrangements
- 📍 A focus on winter pressures and the performance of A&E departments, and a requirement to set up A&E delivery boards that operate across different areas to health and wellbeing boards
- 📍 The huge financial and operational pressure that the NHS and local authorities both face
- 📍 The extent to which integration of health and care can contribute to meeting the current financial pressures

²⁸ Telephone conversation with Lesley Jeavons, Director of Integration, who works across the NHS / LA, 24th May 2018

²⁹ Shared Intelligence (2017) *The power of place: Health and wellbeing boards in 2017*. Available at: <https://www.local.gov.uk/sites/default/files/documents/The%20power%20of%20place%20health%20and%20wellbeing%20boards%20in%202017.pdf>

The research suggests five factors which may have a significant influence on the effectiveness or not of a health and wellbeing board to implement the vision of integrated care in the current context:

1. **A focus on place** as the most effective health and wellbeing boards act as 'anchors of place'
2. **Committed leadership** exerting influence across the council, place and health and care system
3. **Collaborative plumbing** to underpin the leadership of place and influence the STP
4. **A geography that works** or the capacity to make the geography work
5. **A Director of Public Health that gets it** and who can support placed-based leadership

Of these, a focus on place was found to be the defining characteristic of the most effective health and wellbeing boards in the 2017 study, combined with a reassertion of a focus on the wider determinants of health (which requires a place-based approach).

Examples of the characteristics of good governance in relation to health and wellbeing boards were found to be broad membership, a focus on the wider wellbeing agenda, and aligning workstreams as illustrated in the examples below.

Bath and North East Somerset health and wellbeing board - a forum for stakeholders to share ideas and formulate the vision³⁰

The Bath and North East Somerset health and wellbeing board is a high level strategic body that provides an opportunity for a wide range of partners to come together to discuss health and wellbeing related topics and themes, agree on shared ambitions and set the long term strategic vision for improving outcomes in the local population.

Membership has recently been broadened to include the local Acute Trust, the Police, Fire and Rescue, the local universities and FE college, the voluntary sector, housing, mental health and primary care. Providers such as Virgin Care who recently won the contract for delivering all health and social care services for adults and most of children services are also invited to attend and their participation has been found to be very helpful.

The agenda is driven by the council and CCG, but other partners are encouraged to make suggestions. Every meeting focuses on a cross cutting theme such as mental health, to ensure that it is of interest to all attendees. Developmental sessions are held outside the meetings to work up the themes and help to add value for members. Bringing diverse organisations together helps to break down barriers, develop greater understanding and build trust.

While the Board is seen to be a good starting point for integration, Bath and North East Somerset is in the process of changing its governance arrangements to implement an integrated approach at an organisational level. A new structure has

³⁰ Telephone conversation with Dr Ian Orpen, Co Chair of Bath and North East Somerset Health and Wellbeing Board, 23rd May 2018

come into being (on a shadow basis for the first year) consisting of a Health and Care Board that brings together the CCG and People Directorate of the Council (Adults, Children's and Public Health) plus other Council Directorates that impact on the wider determinants of health such as Planning and Environment. Closely linked is a new delegated decision-making body made up of Cabinet and CCG Board representatives that meets in public and makes decisions that will be legally binding. This 'work around' is modelled on the Greater Manchester model and in time it is expected that there will be a single leader across organisations and staff will work out of the same building.

The health and wellbeing board will continue to support integration by providing a forum where a broad group of stakeholders can share ideas and articulate the vision, while new structures enable joint delivery of services on the ground like the new primary care centre that incorporates a children's centre and a library.

Warwickshire and Coventry Alliance Concordat

In April 2018, an integration summit was held which led to the development of the Coventry and Warwickshire Alliance Concordat, which sets out how organisations involved with the two health and wellbeing boards will interact with one another to deliver better health and care services for residents. The Concordat has been useful as a standing document providing a reference point when reviewing the behaviours and commitment needed to sustain true system change. The health and wellbeing boards have also established Memorandum of Understandings with the Warwickshire Health, Adults Social Care and Children's Overview and Scrutiny Committees, and local Healthwatch. These help identify the best forum for consideration of topics and issues. The Warwickshire health and wellbeing board has also developed an information sharing strategy, setting out an approach to information sharing between Boards and across organisations, which will improve patients' experience of care.³¹

Barking and Dagenham, Havering and Redbridge, joining up Better Care Fund Plans

The two Boards have been working together to develop and implement an aligned Better Care Fund plan which reflected common areas by aligning resources and activities under the following themes:

-  Prevention and managing demand
-  Market development and sustainability
-  High impact change model
-  Protecting social care and maintaining independence

They are now moving towards a closer integration of BCF workstreams, so for 2018-19 the plan is to implement a number of key deliverables:

-  A single section 75 agreement across the commissioning partners

³¹ Shared Intelligence (2016) *Effective Health and Wellbeing Boards: Findings from 10 Case Studies*. Available at: <https://www.local.gov.uk/sites/default/files/documents/effective-health-and-well-4c3.pdf>

- 📌 A single governance group comprising senior and key officers, replacing local governance arrangements in each of the boroughs but retaining principal oversight by each respective health and wellbeing board
- 📌 A shared BCF workplan to focus resources and activity on system wide deliverables, ensuring that where agreed, business as usual is free to deliver.

Kingston health and wellbeing board – driving improvement on the ground³²

Kingston's health and wellbeing board has provided leadership, guidance, stability and a 'can do' attitude over the last three to four years as health and social care have explored new ways of working together to improve local outcomes.

Despite cultural differences between the Council and the CCG, and the different lines of accountability - the Council's outwards, to its local population, the CCG, upwards to NHS England - both are committed to integrated working. When it was clear that merging the two organisations was not going to be legally possible, they decided to carry on acting as though they were a single entity and keep pushing the boundaries. Time spent understanding each other's cultures and requirements has been invaluable. Some early wins that have helped build the foundations include getting sign up from the local Foundation Trust for closer working both strategically and operationally and making good progress on bringing all the GPs in the borough into a single organisation practice.

Two major projects demonstrate how the partnership led by the health and wellbeing board is being implemented on the ground. The first has led to better coordinated and more cost effective and efficient care. GPs, social workers and hospital staff carried out an audit of the current care pathway using imaginary service users and found there were 48 points of contact with a professional at a cost of between £30-40,000. Working together to create a leaner model, the points of contact dropped to 17 at a cost of £10,000, largely due to consultants being less risk averse when discharging patients home. Using the new model over the winter of 17/18 helped to reduce delayed discharges to one.

The second project is 'the Kingston Care passport', a single co-ordinated record of care that can be accessed by health and social care professionals. This has been challenging and is still ongoing, but with support from the health and wellbeing board, looks to increase its coverage across all GP practices.

The overarching message is that the health and wellbeing board is seen as a stable entity, committed to making integration happen and improve outcomes for local people, whatever changes there might be in organisational structures.

Wiltshire health and wellbeing board – a stable and positive presence at the heart of improving health and wellbeing for its population³³

Wiltshire's health and wellbeing board has benefited from a broad membership right from the start. This includes the CCG, the mental health trust, GPs, the acute hospital, police and crime commissioner, fire and rescue, and the ambulance service.

³² Telephone conversation with Councillor Kevin Davis, Leader of Kingston Council, 8th June 2018

³³ Telephone conversation with Baroness Jane Scott, Leader and Chair of Wiltshire Health and Wellbeing Board, 15th June 2018

The Chair felt that it was important to have providers around the table including representation from both secondary and primary care, despite some resistance, to ensure that tensions could be aired and all perspectives could be represented and part of decision making.

The Board sees itself as sitting right at the heart of improving health and wellbeing in Wiltshire. Far from being a 'talking shop', the Board takes its responsibilities seriously for example ensuring that the Better Care Fund is used wisely to change the system for the better.

Although there have been challenges along the way, not least in bringing two very different cultures together, successes spearheaded by the Board include a joint commissioning board for adult care that is working well, a change in hospital processes, procedures and relationships between GPs and hospices that has improved end of life care and single assessments at home not in acute hospitals that has helped to reduce delayed discharges.

There has also been a focus on children's needs and services, often seen as secondary to adult social care including some innovative work to improve end of life care and getting the right support and facilities in place for young people who have been arrested.

A recent CQC inspection described the Board as having strong leadership, a quality that the Chair maintains is essential. In an ever changing landscape, where different accountabilities and regulations can get in the way of innovation and creativity, the health and wellbeing board maintains a stable and positive presence, determined to make integration happen for the good of Wiltshire's local population.

2.2.2 Sustainability and transformation partnerships

Sustainability and transformation plans were introduced by the NHS as its main vehicle for transforming health and care services in England in line with the Five Year Forward View. Forty-four local areas were required to submit plans in October 2016 covering all aspects of NHS funding as well as focussing on better integration with social care. The average population size of an STP area is 1.2million people and most cover several health and wellbeing boards and CCGs.

The vision for STPs is that they will drive a genuine and sustainable transformation in health and care outcomes between 2016 and 2021. It is intended that they will help build and strengthen local relationships, enabling a shared understanding of the current situation, the ambition for 2021 and the concrete steps needed to get there.

To deliver these plans NHS providers, CCGs, local authorities, and other health and care services have come together to form STP 'footprints'. These are geographic areas in which people and organisations work together to develop robust plans to transform the way that health and care is planned and delivered for their populations³⁴. In the Five Year Forward View Next Steps, published in 2017, the NHS took its vision one step further by boldly stating: "*Our aim is to use the next several years to make the biggest national move to integrated care of any major western country.*"

³⁴ NHS England (2016) *Sustainability and Transformation Plan Footprints*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/stp-footprints-march-2016.pdf>

A new emphasis was given to the formation of sustainability and transformation partnerships following principles that include the following:

- 📍 STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations
- 📍 The way STPs work will vary according to the needs of different parts of the country. We do not want to be overly prescriptive about organisational form
- 📍 The STP board will be drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate
- 📍 An STP chair/leader will be appointed using a fair process, and subject to ratification by NHS England and NHS Improvement
- 📍 The success of STPs - and their constituent organisations – will be by the results they are able to achieve
- 📍 Ensure local people have their say. We expect local people to be involved in the development of STP plans, and how they will be implemented

STPs are described as “*a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most*”³⁵. Arguably STPs do not provide the whole system governance structure to support the transformation of care in the way that health and wellbeing boards have the potential to do, although the partnerships in some areas are developing beyond the limited focus on health and social care.

Frimley Health and Wellbeing Alliance³⁶

The Board is a non-executive group covering 5 local authorities: Surrey, Bracknell Forest, Windsor & Maidenhead, Slough and Hampshire and the CCG and covers 30 organisations with a population spread of 800,000. The Board acts as a vital link between the STP and the local communities it serves. Memorandums of Understandings are in place to guide partnership working. Leaders work together closely to understand each other’s issues, define what they want to achieve and what success would look like. The approach is participative, inter-collegiate and solution focused. There is a recognition that the challenges of improving health and wellbeing are better addressed collectively rather than individually.

Strong relationships between leaders have developed over a long period of time working together, building a bedrock of confidence and trust and there is now total alignment between the local authorities and CCG and a whole system that is described as being “in balance”. For the health partners, (plus a devolved budget for social care from Surrey County Council in respect of Surrey Heath CCG) this includes sharing responsibility for financial control, so that underspends in one part of the system support overspending in another part.

³⁵ NHS England (2017, p.32) *Next Steps on the Five Year Forward View*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

³⁶ Telephone conversation with Sir Andrew Morris, Chief Executive Frimley Health NHS Foundation Trust, 9 May 2018

The Alliance is supported by leaders and members within local government as well as the CCG. The breadth of services that local authorities deliver, e.g. housing, education as well as social care, is seen to be particularly valuable in addressing the wider determinants of health and moving forward the prevention agenda. Local authorities also provide access to the public through well-established engagement activity.

The Alliance has created a 'one page plan' that outlines five year priorities (national and local), transformation initiatives, cross cutting programmes and enablers. Key messages about how services are changing are disseminated through the Board members, ensuring that communications are clear and consistent.

Nottingham and Nottinghamshire STP, joining up with Housing

Many STPs are focusing primarily on bringing health and social care together to transform services and improve outcomes for their population. Nottingham and Nottinghamshire are going beyond this approach to include housing - one of the key wider social and economic determinates of health. Their STP partnership and plans include the following proposals³⁷:

- 📌 The plan recognises that people are living longer and that many, especially those living with multiple conditions, may be vulnerable due to their housing.
- 📌 Where possible services that do not need to be delivered in a hospital setting will be delivered in different ways, for example, through the use of assistive technology to deliver care in the community and in people's homes.
- 📌 An STP advisory group allows the voluntary and community sector, including home care providers and care homes, to contribute to the plan
- 📌 More people will be offered the 'warm homes on prescription' scheme so that they can more easily afford to heat their home.
- 📌 The plan aspires to better support from housing providers to ensure that accommodation for people being discharged from hospital is safe to return to.

The full case study can be downloaded [here](#)³⁸

Somerset STP, drawing on the strengths of the voluntary and community sector

The Richmond Group of charities is working with Somerset STP to integrate the voluntary and community sector offer into the health and care system as part of a project supported by Public Health England called Doing the Right Thing (DTRT)³⁹. The Group has summarised the additional value that the voluntary and community sector can bring to the health and social care system as follows:

- 📌 brand and credibility

³⁷The King's Fund (2018) *Housing and Health: opportunities for STPs*. Available at: https://www.kingsfund.org.uk/sites/default/files/2018-03/Housing_and_health_final.pdf

³⁸ Nottinghamshire case study available at: <https://www.local.gov.uk/sites/default/files/documents/Nottinghamshire%20Case%20Study%20-%20final.pdf>

³⁹ The Richmond Group of Charities (2016) *Doing the Right Thing*. Available at: <https://richmondgroupofcharities.org.uk/doing-the-right-thing>

-  positioning and reputation
-  flexibility and innovation
-  access and reach
-  leveraging additional resources

The first collaboration project to be chosen is between primary care and the community and voluntary sector to scale up social prescribing across the county and funding has been obtained from the Life Chances Fund to support the work as a demonstrator project so that the learning can be extended beyond Somerset.

It is still early days to assess whether sustainability and transformation partnerships are having a positive impact in achieving the vision for integrated care. Emerging sticking points include⁴⁰:

-  Pressures facing local services are significant and growing, and the timescales available to develop the plans have been extremely tight
-  The original purpose of STPs included the development of new models of care and making prevention and public health a priority. However, the emphasis has shifted over time to how STPs can bring the NHS into financial balance (quickly)
-  Existing NHS structures and legislation may not help to facilitate joint working and collaboration, or collective governance
-  The limited time available to develop STPs has made it difficult for local leaders to meaningfully involve all parts of the health and care system particularly clinicians and frontline staff
-  Likewise, there has been a lack of sufficient engagement with communities and their elected representatives. A survey of senior councillors in May 2017 found that 69% of respondents didn't think they had been sufficiently engaged⁴¹
-  Another survey found a lack of clarity around the authority of STPs, their partnership arrangements and the public's role in the plans⁴²

A recent review⁴³ of community health services found that provider trust leaders felt STPs were focusing on the reconfiguration of acute services rather than planning to strengthen and expand community services: *“only two thirds of trust leaders said community services in their local area were somewhat influential in shaping their STP. If new care models, STPs and integrated care systems (ICSs) are to flourish, it is vital that community services and the prevention agenda are at the centre of these plans”*.

⁴⁰ The King's Fund (2016) *Sustainability and transformation plans in the NHS: how are they being developed in practice?* Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_in_NHS_Kings_Fund_No_v_2016.pdf

⁴¹ Local Government Association (2017) *STP Survey of Councillors*. Available at:

<https://www.local.gov.uk/sites/default/files/documents/2017-06-28%20STP%20survey%20-%20Full%20findings%20report%20FINAL.pdf>

⁴² London South Bank University (2017) *Sustainability and Transformation Plans: How serious are the proposals? A critical review*. Available at

https://www.lsbu.ac.uk/_data/assets/pdf_file/0019/114409/sustainability-and-transformation-plans-critical-review.pdf

⁴³ NHS Providers (May 2018) *NHS Community Services: Taking Centre Stage*

2.2.3 Devolution and combined authorities

Devolution is one of the most fundamental changes to the way decisions are made for local areas and how public services are funded. In England, devolution is the transfer of power and funding from national to local government. It is important because it ensures that decisions are made closer to the local people, communities and businesses they affect. Devolution provides greater freedoms and flexibilities at a local level, meaning councils can work more effectively to improve public services for their area⁴⁴.

A combined authority (CA) is a legal body set up using national legislation that enables a group of two or more councils to collaborate and take collective decisions across council boundaries. It is far more robust than an informal partnership or even a joint committee. The creation of a CA means that member councils can be more ambitious in their joint working and can take advantage of powers and resources devolved to them from national government. Nine combined authorities have been established so far (of which seven have secured devolution deals and six have in place directly elected mayors)⁴⁵.

The notion of devolving health care was not core to the original devolution agenda, which focused on driving local economic growth. The inclusion of health and social care in the Greater Manchester devolution agreement in 2015 was ground-breaking in terms of allowing local councils and the NHS to take control of the region's £6 billion health and social care budget, alongside housing, transport and skills. Since then, another five areas have specifically included health in their deals - Cornwall, NE Combined Authority, West Midlands, Liverpool City Region and London. The deals to date include a requirement that local areas deliver financially sustainable health and social care systems by 2020.

While devolution is seen to be an important model to enable further integration of health and social care, the move towards devolution and/or combined authorities involves huge systemic changes and the impact of this new form of governance will not be clear for some time. One report suggests that the core objective of devolution in relation to health and care is unclear: "*is it reducing health inequalities, delivering locally tailored, integrated care and improving population health? Or is it a way of achieving savings and reducing spending in the future?*"⁴⁶

Greater Manchester (GM)

Greater Manchester's Memorandum of Understanding for Health and Social Care devolution was signed in February 2015 and includes NHS England plus the 10 GM councils, 12 Clinical Commissioning Groups and 15 NHS and Foundation Trusts. Local Health and Social Care decision makers have control of an estimated budget of £6 billion. In developing an Integrated Care System, Greater Manchester has built on a broadly based and long-established public-sector partnership of health and social care organisations led by local authorities. It has also been able to access its share of

⁴⁴ Local Government Association (undated) *What is devolution?* Available at: <https://www.local.gov.uk/topics/devolution/what-devolution>

⁴⁵ Local Government Association (undated) *Combined authorities*. Available at: <https://www.local.gov.uk/topics/devolution/combined-authorities>

⁴⁶ The King's Fund (2015, p.15) *Devolution Briefing: what it means for health and social care in England*. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/devolution-briefing-nov15.pdf

the national Sustainability and Transformation Fund to pump prime improvements in care and this has helped enable the area to make faster progress. The vision is to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester. One of the essential means of achieving this is through aligning the health and social care system far more widely with education, employment, skills and housing. The model entails a commitment to shared decision-making. This involves a ceding of some individual organisational autonomy – and changing of behaviours – by both local authorities and NHS organisations.

The underlying principle of the devolution strategy is that effectiveness and efficiency of the health and social care system requires wholesale transformation as opposed to incremental change. Key characteristics include:

- 📌 Shifting the balance of spending to prevention and early intervention
- 📌 Making use of a Transformation Fund of £450m to drive the changes in health and social care required to address the financial gap. The Fund must be used to drive change in the way that existing resources are used, for example through the creation of new service models.
- 📌 A consistent and standardised approach to commissioning and provision of health and social care across GM
- 📌 Ten Local Care Organisations (LCOs) with place based hubs. Priorities include enabling conditions to be managed at home and in the community, a wide range of partners providing early help and prevention; and supporting individuals & communities to take more control over their own health
- 📌 LCOs varied models of delivery and contracting structures e.g. informal alliances, corporate joint venture
- 📌 Other workstreams include adult social care transformation, mental health and wellbeing strategy, primary care transformation, population health plan, and a health and employment initiative

Cornwall

Cornwall was the first rural area in England to secure a devolution deal in 2015. It includes integrated health and social care; transport; employment and skills; EU funding; business support; energy; the public estate; heritage and culture.

The Shaping our Future programme⁴⁷ describes how partners are working together as a Transformation Board, to bring health and social care together. A new draft report, New Frontiers, outlines proposals for a second devolution deal to increase the social, economic and environmental resilience of Cornwall, in particular in response to the changes that Brexit will bring. Devolution is referred to as a “strategic enabler, supporting delivery of our transformation plans for health and social care” which include:

⁴⁷ Cornwall and the Isles of Scilly Health and Social Care Partnership (2018) *Transformation Board Meeting 06 April Summary Report*. Available at: <http://doctrinary-shapingourfuture.cornwall.nhs.uk/DocumentsLibrary/ShapingOurFuture/TransformationBoardMeetings/Mi nutes/1819/201804/HealthAndSocialCareDevolutionNewFrontiers.pdf>

-  Supporting an upgrade in prevention
-  Creating an innovation testbed for rural and island communities
-  Establishing a devolved place based five-year funding settlement to enable local partners to co-ordinate budgets across health, social care, public health and health-related funds

2.2.4 Integrated care systems, accountable care organisations

Integrated Care Systems (ICSs) have come into being in areas where commissioners, NHS providers, GP networks, local councils and others have voluntarily agreed to take shared responsibility for how they operate their collective resources for the benefit of the local population. There are currently fourteen integrated care systems, the aim of which is to improve health and care by:⁴⁸

-  Supporting the integration of services, with a particular focus on those at risk of developing acute illness and hospitalisation.
-  Providing more care through redesigned community- and home-based services, including in partnership with social care, the voluntary and community sector.
-  Ensuring a greater focus on prevention of ill health and population health outcomes.
-  Allowing systems to take collective responsibility (in ways which are consistent with the existing statutory framework) for how they best use resources to improve quality of care and outcomes.

2018/19 Planning Guidance⁴⁹ states the essential characteristics of an ICS as:

-  Strong leadership, including local government
-  The capability and infrastructure to execute priorities
-  A track record of delivering the priorities in the Next Steps on the Five Year Forward View
-  Strong financial management
-  Coherent and defined population, where possible sharing local government boundaries
-  Plans to integrate primary care, mental health, social care and hospital services to redesign care around people at risk of becoming acutely unwell

In some areas, local health systems are also developing proposals that would see single providers take contractual responsibility for providing a range of services, spanning primary, acute, community and mental health. These providers can be called 'accountable care organisations', or ACOs.

South Devon and Torbay Integrated Care System

Integration of care has been in place in Devon for some years, having formed the first Integrated Care Organisation in the country to bring together acute and community and social care services to form a single provider organisation. As one of the

⁴⁸ NHS England (2018) *Breaking down barriers to better health and care*. Available at: <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

⁴⁹ NHS England and NHS Improvement (2018) *Refreshing NHS plans for 2018/19*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf>

Pioneers⁵⁰, they have continued to develop a wellbeing-focused approach to delivering care that empowers individuals to live healthier, happier and more fulfilling lives, making best use of the assets available to them within their own families and local communities, and reducing reliance upon statutory services to ensure a more sustainable model of care.

Greater integration with partners in the wider system including the voluntary and independent sector aims to deliver person centred care that feels seamless:⁵¹

- 📌 Torbay and South Devon Trust provide acute, social care and community services which include occupational therapists, physiotherapists, community nurses and social workers
- 📌 Three-way risk sharing agreement in place between Council, CCG and NHS Trust
- 📌 Pooled budgets including social care funding and Better Care Fund
- 📌 Review of commissioning arrangements – public health and social care integrated within the council, informal movement towards merger with CCG, a number of roles now being single leads across health and care
- 📌 Social care and housing under same director in council, so opportunities for aligning plans

Key challenges include:

- 📌 Making pooled budgets work and understanding how the funding has been spent/what has been achieved
- 📌 Maintaining a strong presence and voice for social care in a system that is very dominated by the NHS
- 📌 More work to be done with the voluntary and community sector – building resilience

Positive outcomes include:

- 📌 Pooled budgets have facilitated joint working and enabled a focus on the person. Benefits include easier management of Continuing Health Care
- 📌 Joining up teams has led to a more flexible approach to roles e.g. social care tasks carried out by community nurses, so providing more seamless care
- 📌 Delayed Transfers of Care figures are good – scrutiny has shown that monies are being used in an appropriate way

2.2.5 Conclusion

Formal structural arrangements have been put in place to try to break down old divides between health, housing and social care, and across sub-regions, and to invest in ways to prevent illness and keep people out of hospital. NHS organisations and councils are joining forces in a variety of ways to integrate services and to make best use of

⁵⁰ NHS England (2016) *People helping people*. Available at: <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>

⁵¹ From interview with Head of Partnerships, People and Housing, Torbay Council, April 2018

extremely tight resources. The essential aspects of leadership that formal governance structures must enable are:

- 📍 The leadership qualities inherent in the governance structure are critical – strong leadership, trust and respect between leaders
- 📍 Equality amongst the leaders of different organisations/sectors, without one organisation dominating
- 📍 A shared focus on a meaningful ‘place’ or community is seen to be a key enabler to thinking and delivering across the whole system
- 📍 An inclusive approach to governance, i.e. beyond health and social care, and in terms of health, beyond traditional players to include GPs, community health, etc
- 📍 A sense that this is not something that can be created overnight, and that should be allowed to develop and emerge at a pace that suits local circumstances (so creating a new governance structure will not solve issues immediately or without the other characteristics being in place). It may well be that a more robust approach is to develop the formal governance arrangements after the non-structural elements are in place
- 📍 A sense that there are and will be different routes into delivering integrated care, and these will be dependent on history, funding opportunities, and local circumstances. It is not clear from the evidence whether one route is more effective at delivering improved health and wellbeing outcomes for local communities than others

It is notable that, whilst individual boards and partnerships appear to be beginning to develop an understanding of the impact of their work on outcomes for local communities, this is an emerging picture and often focused more on outputs at a systems level (such as delayed transfers of care) rather than health and wellbeing outcomes for individuals.

3 Delivering integrated care

As outlined in the original vision for integrated care, the way services are organised and delivered around the needs of individuals is a key element of this agenda.

A vision for integrated care⁵² ‘what good looks like’

A shared commitment to improving local people’s health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.

Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provides services and their communities.

Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.

⁵² NHS Confederation (2016, p.11) *Stepping up to the place*. Available at: <http://www.nhsconfed.org/resources/2016/06/stepping-up-to-the-place-the-key>

A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

Delivering the vision generally requires system transformation although without a 'one size fits all approach' as different places will develop a system tailored to local needs and aspirations. The approach taken to designing and delivering integrated care systems will also need to reflect local circumstances and priorities, including tackling organisational cultures and practices and developing a shared commitment to a shared outcome.

The transformed system will typically involve developing a local 'model of care'. A model of care is how one organises services to improve people's health and wellbeing, from prevention of ill health all the way through to meeting complex health and social care needs.

Models of care can reflect structural approaches and systems, for example, through devolution, health and wellbeing boards, sustainability and transformation partnerships, joint commissioning, and new organisational structures and teams. They can also be developed using non-structural approaches that focus on the individual and how services are delivered, for example, joining up around clinical provision, pathways, priorities and population groups. Whichever route (or combination) is taken, the impact for the individual and the delivery of their health and wellbeing outcomes is the key measure of success.

3.1 Delivering integrated care in practice

The vision for integrated care puts citizens and communities in the driving seat; services and systems must be designed around and with the individual and seek to deliver the outcomes important to them. There have been many national policy initiatives which arguably have driven local delivery of these approaches over the last decade, so for example, as summarised in one overview:⁵³

- 📌 Integrated Care Pilots, 2009
- 📌 Integrated Care and Support Pioneers, 2013
- 📌 Better Care Fund, 2014
- 📌 Care Act, 2014
- 📌 New Models of Care (Vanguards) Programme, 2015
- 📌 Integrated Personal Commissioning Pilots, 2015
- 📌 Sustainability and Transformation Partnerships, 2015
- 📌 Primary Care Home Model, 2015
- 📌 Devolution of responsibility for health care funding (Devo Manc), 2015
- 📌 Accountable care systems, 2017

These have impacted on the specific approaches taken in local areas. A recent NHS online briefing and suite of resources designed for communities and staff explains why services needed to change, provides a timeline showing the key milestones in the

⁵³ https://www.gtc.ox.ac.uk/images/Mays_Slides.pdf

journey so far and local examples of how new approaches are making a positive difference⁵⁴.

The key enablers of better health and wellbeing for all are shown in the diagram below. This section explores to what degree these approaches are reflected in current models of care, whether they are being delivered effectively and what impact they are having.⁵⁵



3.1.1 Place-based

Service delivery needs to be in the right place – in or close to home or neighbourhoods, making the most of strengths and resources in the community as well as meeting their needs. A single system wide assessment of the needs of the local population provides the starting point for planning and shaping models of care. Under the Health and Social Care Act 2012 local health and wellbeing boards are responsible for producing a Joint Strategic Needs Assessment (JSNA) which looks at the current and future health and care needs of its local population to inform and guide the planning and commissioning of health, wellbeing and social care services within a local authority area.

Devon JSNA⁵⁶

- 📌 Is concerned with wider social factors that have an impact on people's health and wellbeing, such as housing, poverty and employment
- 📌 Looks at the health of the population, with a focus on behaviours which affect health such as smoking, diet and exercise
- 📌 Provides a common view of health and care needs for the local community
- 📌 Identifies health inequalities
- 📌 Provides evidence of effectiveness for different health and care interventions

⁵⁴ NHS England (2018) *Breaking down barriers to better health and care*. Available at: <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

⁵⁵ For example see https://www.thinklocalactpersonal.org.uk/assets/Reports/Collaborative_healthcare_-_IC_final_1.pdf

⁵⁶ Devon County Council (Undated) *What is the JSNA?* Available at: <http://www.devonhealthandwellbeing.org.uk/jsna/about/>, accessed 18th July 2018

-  Documents current service provision
-  Identifies gaps in health and care services, documenting unmet needs

The JSNA is used to inform a local area's Health and Wellbeing Strategy and 'place plan', the latter being seen as a key mechanism for implementing a joined up approach to delivering wide ranging health, wellbeing and social care goals.

Rotherham's Place Plan

Rotherham's Integrated Health and Social Care Place Plan is closely aligned to the aims in the [Joint Health and Wellbeing Strategy: A Healthier Rotherham by 2025](#), with the strategy setting the vision and direction for all health and wellbeing partners, and the Place Plan being the delivery mechanism for the 'integrated health and social care' elements.

The Place Plan does not replace partners' individual plans but rather builds upon them by taking a common lens and identifying key areas for collaboration. The Plan links across to the South Yorkshire and Bassetlaw Integrated Care System (formally the Sustainability and Transformation Partnership) and is seen to be the best vehicle for driving through 80% of health and social care improvements in the Rotherham area (the remaining 20% that concern specialist services is managed regionally). The Place Plan has also been turned into a lively animation (http://preview.beach-design.co.uk/nhs_rotherham/) that gets the key messages across in a fun and accessible way and has been an important tool in communicating with health and care staff and the public.

Download the full case study [here](#) ⁵⁷

3.1.2 Person-centred care

Person-centred care is generally understood to mean an approach which is holistic, meets the person's needs and priorities before those of the system or its professionals, engages people in their care as fully as possible, and attempts to support people to take decisions and to be as much in control as possible. There are various definitions of person-centred care and it can incorporate a wide range of approaches. National Voices have described key aspects as: information, communication, participation, care planning and care coordination. Approaches to incorporating it within health and social care as a mainstream approach are at different levels of maturity, but it commonly forms a key element of the (national) initiatives to transform care, such as the Integrated Personal Commissioning Programme⁵⁸, Think Local Act Personal partnership, and the personal health budgets learning network.

For example, the premise that people are experts in their own lives and responsibility for better health must always be shared was at the heart of the Integrated Care and Support Pioneers Programme. The 25 integrated care pioneer sites have the shared goal of putting the needs and experiences of people at the heart of the health and care system; to move away from reactive, episodic healthcare and toward a system of preventative, holistic care and support and to tailor care to the needs and preferences of

⁵⁷ Rotherham case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Rotherham%20Case%20Study%20-%20final.pdf>

⁵⁸ Integrated Personal Commissioning programme (undated) <http://www.ipcprogramme.org.uk/>

individuals, their carers and families.⁵⁹ The Programme adopted a definition of integrated care that is user-led, drawing on the work of National Voices and using ‘I statements’ which detail how the integration of care and support looks from the perspective of the person using the services, for example: “*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me*”⁶⁰. An evaluation of the Programme⁶¹ states that this approach has helped to reduce confusion, repetition, delay, duplication and gaps in service delivery and people getting lost in the system.

A recent evaluation of New Models of Care found that vanguard sites had started with a small segment of the population to test out and develop the best ways of involving people locally: *one such method was asking patients and families to say what was important to them, which focused care development on the creation of the right outcomes. For example, an EHCH used ‘I’ statements to co-design desired outcomes for care home residents – building on previous work by National Voices.*⁶² Whilst this evaluation did not look at the impact on outcomes for individuals it did suggest starting small and local did support the development of integrated approaches and ways of engaging with and understanding the needs of local populations.

Leeds’ overarching vision is to improve quality of care and outcomes for people with complex needs by overcoming the fragmentation associated with multiple providers. The vision is articulated through a person-centred vision statement and a common narrative to create a shared purpose and outcomes for integration in health and care. They have developed ‘I statements’ and design principles for integration, keeping the voice of the people of Leeds at the heart of everything they do. A fundamental part of their approach is to involve people at every stage, to the extent that they have developed a Leeds charter for involvement in integration.⁶³

3.1.3 Prevention and early intervention

The development of preventative approaches and those which promote independence and wellbeing have gained importance since the implementation of new duties in the Care Act 2014. Prevention and encouraging people to be more proactive about their health and wellbeing is also central to the vision of the NHS Five Year Forward View. Preventive services such as reablement, rehabilitation, telecare and befriending schemes aim to help people stay independent and maintain their quality of life, as well as to save money in the long term and avoid admissions to hospital or residential care.

Promoting good health and wellbeing for all citizens improves quality of life, is good for the economy as people are more productive and saves on the high cost of health and social care interventions when people fall ill. Prevention requires a broad range of

⁵⁹ NHS England (2016) *People helping people*. Available at: <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>

⁶⁰ Think Local Act Personal and National Voices (undated, slide 5) *A narrative for person centred care*. Available at: www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf

⁶¹ NHS England (2016) *People helping people*. Available at: <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf>

⁶² Health Foundation (2017, p.13) *Some Assembly Required: implementing new models of care*. Available at: <https://www.health.org.uk/publication/some-assembly-required>

⁶³ Local Government Association (2016) *The journey to integration Learning from seven leading localities*. Available at: <https://www.local.gov.uk/sites/default/files/documents/journey-integration-learn-31c.pdf>

partners to promote healthy lifestyles and support people of all ages to make behaviour changes that will help to protect them from serious mental and physical health problems especially as they get older, e.g. improving diet and physical activity to prevent obesity/diabetes. Improving population health also means addressing all the social determinates that influence health across the life course such as education, employment, income, housing and relationships.

A key aspect of this is promoting self-care and being responsible for one's own health and wellbeing: to do so successfully means changing the relationship between the state and the citizen, from paternalism to enabling. Implementing a self-care, enabling approach will mean making good use of insights about and measures of patient activation (patient activation is a widely recognised concept that describes the knowledge, skills and confidence a person has in managing their own health and care). People who have low levels of activation are less likely to play an active role in staying healthy. The relationship between patient activation and health outcomes has been demonstrated across a range of different populations and health conditions⁶⁴. Measuring patient activation scores as part of behaviour change programmes could, for instance, provide a useful means of assessing changes in behaviour and in evidencing progress towards the NHS public health strategy 'Making every contact count'.

The prevention and early intervention examples found range from individual projects or initiatives, to wider system approaches whether through targeting those at risk, or through taking all contact opportunities to improve health and wellbeing. There is a wide selection of case studies available on the LGA website <https://www.local.gov.uk/topics/social-care-health-and-integration/public-health>.

Integrated care system healthier living project - Fleetwood

Healthier Fleetwood is an initiative helping people to improve their lifestyles, for example by encouraging young people to get involved in sport; or older people to take part in social prescribing activities such as choir practice and supports recovering addicts. The aims are to improve the health and wellbeing of the people of Fleetwood and to spread the initiative to other towns facing similar health challenges⁶⁵.

Tower Hamlets Together Making Every Contact Count

Using a MECC approach (Making Every Contact Count⁶⁶) more than 1,000 staff from 90 local organisations have been trained so far. An evaluation of the programme showed that 95% of those trained felt more confident to raise matters with clients and 92% felt they had improved skills to help people make lifestyle changes. In addition, the social prescribing team has connected patients to 1,500 local voluntary sector organisations to help [support them to stay well](#).

Sheffield People Keeping Well

⁶⁴ The King's Fund (2014) *Supporting people to manage their own health: an introduction to patient activation*. Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf

⁶⁵ [Watch more](#) on the BBC news website.

⁶⁶ Health Education England (undated) *Making Every contact count*. Available at: www.makingeverycontactcount.co.uk/

The programme focusses on identifying people at risk of declining health and wellbeing and by using individual and community assets aims to prevent people needing long term formal care and support. The initiative includes a good combination of multi-disciplinary teams, a network of community support workers and development of local community partnerships. Sheffield University has partnered with the local authority and CCG to help them conduct a thorough evaluation of the work. Core service principles and an outcomes framework have been co-produced with health and social care professionals, the voluntary, community and faith sector, providers and citizens. Community partnerships have been commissioned to deliver outcomes based on local needs⁶⁷

Bolton Staying Well Check

The Staying Well Check is aimed at people aged 65 and over who have been identified as at high risk of developing future health and social care needs. People are identified using GP registers and applying the Potential Care Need Index. The Index classifies individuals aged over 50 according to their risk of future early reliance upon intensive social care and support service. The Wellbeing Coordinators interact with a variety of workforces, including GPs, hospitals, social care, mental health and the voluntary sector. Using an asset-based approach allows Coordinators to maximise the resources available to the person, instead of taking a one-size-fits-all approach.

The Staying Well Check is a two-way conversation between the Wellbeing Coordinator and client to identify personal risk factors using an innovative approach that identifies both assets and needs. This conversation identifies actions to reduce risk, and the Coordinator creates a network of community providers identified for the benefit of the person. In addition, Coordinators could provide a variety of tasks such as printing medication guidance or providing support in a GP visit.⁶⁸

North Yorkshire Innovation Fund⁶⁹

Funded by North Yorkshire County Council's Health and Adult Services Directorate, the Innovation Fund aimed to support voluntary and community organisations in innovative approaches to provide early intervention or prevention measures. The overall goal was to transform adult social care in the county and help to prevent, reduce or delay the need for statutory social care services. The Innovation Fund awarded grants against these three themes:

-  Reducing loneliness and isolation
-  Prevention and falls
-  Supporting people to remain in their own homes

Over four funding rounds, 28 projects received funding worth a total of £1.13 million. The last round of funding occurred in January 2017 and future innovation is to be supported as part of the Stronger Communities programme. In a Year 3 impact report, Innovation Fund projects reported tangible outcomes for the people who used

⁶⁷ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=29444709>

⁶⁸ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31392357>

⁶⁹ Social Care Institute for Excellence (2018) *Growing innovative models of health, care and support for adults*. Future of Care Number 6 January 2018. Available at: <https://www.scie.org.uk/future-of-care/adults/whole-area-innovation>

their services, including improved mental health, reduced social isolation and enhanced independence. However, providers also reported ways in which being an Innovation Fund beneficiary helped them to scale up their activity, beyond the initial impact of the funding itself. Most notably this included the following:

- 📌 The funding helped providers to trial and pilot new models of delivery and to evaluate what worked and its impact. This experience – and evidence – enabled several providers to secure investment from other funding schemes after the innovation funding finished.
- 📌 Providers also reported increased opportunities to collaborate and work in partnership with other local services. This helped build up networks and resilience.

North East Lincolnshire Preventative Services Market Development Board

Prevention and wellbeing have been a long-standing aim for North East Lincolnshire. The shared aspiration is for:

“people to be informed, capable of living independent lives, self-supporting and resilient in maintaining/improving their own health. By feeling valued through their lives, people will be in control of their wellbeing, have opportunities to be fulfilled and are able to actively engage in life in an environment that promotes health and protects people from avoidable harm”.

North East Lincolnshire has established a Preventative Services Market Development Board, attended by community, adult social care, and CCG representatives. Gaps within community resources are analysed, and third sector community organisations and charities are offered the opportunity to bid for non-recurrent seed funding. There is a strong emphasis on sustainability, so successful tenders must be able to demonstrate a sustainable model. Successful ventures include:

- 📌 new, affordable chiropody services for older people which is contributing to a reduction in falls amongst the elderly
- 📌 a meal delivery service that also provides help in other areas to support independent living, which has significantly reduced the call on adult social care budgets

Download the full case study [here](#) ⁷⁰

Community catalysts⁷¹

Community entrepreneurs run very small local enterprises that provide a range of social care, housing, leisure and health services or informal supports. These include support helping people to gain a new skill or to lead a healthy life. They are offered to to by a wide range of people and organisations in the community, including disabled and older people and family carers. They are essential to the success of personalisation and integration, forming a vital part of a diverse local market.

⁷⁰ North East Lincolnshire case study available at:

<https://www.local.gov.uk/sites/default/files/documents/North%20East%20Lincolnshire%20Case%20Study%20-%20final.pdf>

⁷¹ www.communitycatalysts.co.uk

3.1.4 Strength-based approaches

A strengths or capabilities-based approach ('asset-based' in the US) involves considering a person's needs, but looking also for their current and potential strengths, skills and capabilities, including the capabilities of their family and social networks. This way of working helps people to develop their confidence and resilience, with positive consequences for their health and wellbeing. Professionals who take this view of the people they work with may see themselves as facilitators and enablers, rather than assuming a superior, or paternalist attitude. Indeed, for professionals individually and for organisations, to enable and empower individuals it will be important not to be too risk averse.

This way of working has formed a key and overt aspect of the approach taken in a number of areas to delivering integrated care both in the way professionals work with individuals, and also with local communities.

The Wigan Deal⁷² is an informal agreement between the Council and everyone who lives or works in Wigan, to work together to create a better borough. It is driving new relationships between citizens and services, and between staff and management across the council.

The Deal has encouraged a different type of conversation between Council and citizens. Instead of looking at residents as a collection of needs and problems, the borough views everyone as individuals who have strengths, assets, gifts and talents. This asset-based approach has:

- 📌 driven awareness of a richer range of local assets
- 📌 generated a new approach to investing in those community assets
- 📌 empowered staff with the training and tools to connect individuals to resources
- 📌 concentrated resources at key stages, for example around reablement

This approach has led to a reduced demand for formal care, removed capacity that doesn't address demand (e.g. the borough has reduced the number of day centres from 15 to 5), reduced the number of permanent admissions to residential/nursing care and increased staff satisfaction.

Developing a strength-based approach in Kirklees⁷³

Kirklees has implemented a strengths-based approach aligned to Care Act principles as part of its new vision for the Council in supporting communities to do more for themselves and each other and keeping vulnerable people safe and in control of their lives. In providing and delivering services the focus is on only the things the Council can do and the value base and cultural change required to deliver them. It recognises as an underlying principle that to continue to provide services within available resources, it has to fundamentally change the culture of the organisation and the way

⁷² Social Care Institute for Excellence (2018) *Growing innovative models of health, care and support for adults*. Future of Care Number 6 January 2018. Available at: <https://www.scie.org.uk/future-of-care/adults/whole-area-innovation>

⁷³ Department of Health (2017) *Strengths-based social work practice with adults*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652773/Strengths-based_social_work_practice_with_adults.pdf

staff work, working to their strengths as professionals and ensuring systems are reconfigured to support people working with a strengths-based approach.

Kirklees has defined key behaviours that set out what each member of staff can expect from each other and commissioned a learning and development programme to support working positively with people with complex needs and to move away from a dependency mindset to a more enabling approach. Care Act champions were identified to maintain momentum and provide ongoing support to managers in engaging with their staff and sharing information around the change process. Peer group support and regular team feedback sessions are also embedded in the programme.

Leeds Neighbourhood Network Schemes⁷⁴

Neighbourhood Network Schemes are community-based, locally led organisations that enable older people to live independently and proactively participate within their own communities by providing services that: reduce social isolation; provide opportunities for volunteering; act as a 'gateway' to advice/information/services. The first Neighbourhood Network Scheme was established in Leeds in 1985. There are now over 40 schemes working throughout the city supporting over 25,000 older people every year. Using an ABCD approach the Neighbourhood Networks focus on identifying the existing gifts and capacities of people and their communities to encourage change and development from within.

South Tyneside – Engaging the local community to 'change the conversation'

South Tyneside is undertaking a programme of fundamental cultural and behaviour change for staff and residents, based on promoting self-care through all health, care and community services. Central to this is the 'Changing Conversations' approach. Changing Conversations has two aims:

- 📌 Health and social care staff and volunteers in all sectors have conversations that enable people to be active members of their 'care team'
- 📌 The environment of South Tyneside supports people's contribution to their health and wellbeing

An asset-based approach has been used to look at the collective resources which individuals and communities have – internally, externally and collectively – which help protect against poor health and support the development of health and wellbeing. A draft community asset map of Hebburn has been produced covering people, communities, environment and physical assets. The map will be used by staff promoting self-care to identify the range of support and opportunities in the area.⁷⁵

Asset-based community development in Northumberland⁷⁶

⁷⁴Department of Health (2017) *Strengths-based social work practice with adults*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652773/Strengths-based_social_work_practice_with_adults.pdf

⁷⁵ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31392325>

⁷⁶ Public Health England (2018) *Case study: Asset-based community development in Northumberland* <https://www.gov.uk/government/case-studies/asset-based-community-development-in-northumberland>

The public health team at Northumberland County Council is taking a fresh approach to improving health outcomes in their population and reducing avoidable health inequalities. The focus is much more upstream and asset based with the ambition of achieving countywide, resilient, flourishing communities who have high levels of wellbeing. It is collaborative and community focused and has involved listening to what local people say helps them to feel well and gives them a purpose in life. This insight is helping the team reshape the joint health and wellbeing strategy to address, within public health responsibilities, what really matters to local people and what will achieve the sustainable outcomes.

Using the concept of asset-based community development, Northumberland public health team has been working with communities to identify the communities' own assets and resources. The focus of this work was in the north of the county as it had strong community anchors and is a rural area that does not have access to the broad range of services available in the more densely populated areas of the county.

The approach focuses on the conditions that create good health and wellbeing such as feeling connected, doing things you're good at, and building confidence and skills, rather than the negative factors which create ill health such as excessive alcohol consumption, smoking, lack of physical activity, or poor diet.

3.1.5 Co-production

Definitions of exactly what co-production means still vary but it is the term that is gaining common currency as the way to describe working in partnership with people who use services, carers and citizens to improve public services⁷⁷. Implementing co-production is challenging and complex. It involves looking at every aspect of how an organisation works.

Co-production occurs where people who use public services, front line workers and planners all work together as equals, from the beginning of decision-making and throughout. Conversations are likely to begin with questions such as "What does a good life look like?" and "What sort of community do we want to live in?" rather than, "What should happen to this service?"

Key features of co-production initiatives include:

- 👤 Defining people who use services as assets with skills
- 👤 Breaking down the barriers between people who use services and professionals
- 👤 Building on people's existing capabilities
- 👤 Including reciprocity (where people get something back for having done something for others) and mutuality (people working together to achieve their shared interests)
- 👤 Working with peer and personal support networks alongside professional networks
- 👤 Facilitating services by helping organisations to become agents for change rather than just being service providers.

⁷⁷ <https://www.scie.org.uk/publications/guides/guide51/files/guide51.pdf>

Co-production links closely to person centred care planning⁷⁸. While co-production happens at the macro level to improve the design and delivery of services, person centred care planning happens at the micro level, involving individuals more directly in the services they use as well as taking responsibility for costs and risks, for example through the use of direct payments and personal budgets. Both approaches represent a shift in power and decision making away from organisations, to enable the service user to determine what will best meet their needs.

Tower Hamlets Together

A multispecialty community provider vanguard⁷⁹, Tower Hamlets is encouraging residents to find and develop resources and skills within themselves and their communities and to have the confidence to work in partnership with services to improve their own and their families' health and wellbeing. Co-production is at the heart of their transformation programme. Examples of how they are engaging citizens include:

- 📍 Establishment of a stakeholder council which comprises members from a range of different groups and organisations, representing people with different types of needs and provides input and challenge to the Tower Hamlets Together Board.
- 📍 Development of a community research network using community volunteers to feed in views of service users who are seldom heard. By gathering and sharing community insights, the network aims to inform and enable co-produced and solution-focused approaches to service delivery and commissioning for all Tower Hamlets Together stakeholders

Citizen Ambassador for mental health in Surrey

A new citizen ambassador for mental health in Surrey Heartlands, is taking the lead in ensuring patients, families and communities have a voice to shape and improve care for those living with mental health issues. [Read her blog on the National Voices website⁸⁰](#).

3.1.6 Networked models of care

Professionals who view the people they work with as partners with their own strengths and expertise, may start to see themselves as facilitators and enablers and the services they provide as only one part of a person's support eco-system. Most cost-effective interventions are likely to be those which are arranged around and in support of an individual's most important relationships. This is regardless of the structural arrangements as, for instance, having multi-disciplinary teams doesn't in itself guarantee a strengths-based approach, which is a key enabler of integration.

Rotherham: integrated locality model – the 'village' pilot

The Rotherham 'Village' pilot was established in 2016 to develop and test a model based on a multi-professional team delivering health and social care to a General Practice population in a single seamless pathway. The client receives co-ordinated

⁷⁸ https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Co-production-for-personal-health-budgets-and-Integrated-Personal-Commissioning_S7.pdf

⁷⁹ Tower Hamlets Together <https://www.towerhamletstogether.com/>

⁸⁰ National Voices (1 May 2018) *Becoming a citizen ambassador for mental health*. Available at: <https://www.nationalvoices.org.uk/blogs/citizen-ambassador-mental-health>

care from a single case management plan and lead professional. The multi-professional team brings together primary and secondary care, social care, mental health, community services and the voluntary sector, reducing the reliance on the acute sector. A phased implementation for the seven other localities is planned this year which will also include transformation of the care home sector.

One interesting feature is that the joint care planning and support addresses both the psychological and physical needs of an individual recognising the huge overlap between mental and physical wellbeing. In this approach, service integration is a vehicle to deliver parity of esteem.

Evaluation of this pilot showed evidence of a positive impact on emergency admissions from locality working: all Rotherham localities saw an increase in emergency admissions between 2015/16 to 2016/17, whilst 'the village' saw a 2.1% decrease. There were also reductions in hospital length of stay for the Village patients as well as the number who were able to safely return home immediately following discharge. All of these positive outcomes showed the benefits of integrated working in 'the village' over the other localities.

Download the full case study [here](#)⁸¹

Age UK Personalised Integrated Care

Personalised Integrated Care programme brings together voluntary, health and care organisations in local areas to help older people who are living with long-term conditions and are at risk of recurring hospital admissions. The programme is supporting at least 500 older people over fifteen months from July 2017. Those older people are likely to be living with at least two long term conditions and had at least two unplanned admissions into hospital over the last twelve months.

Age UK work with organisations to co-design and co-produce an innovative combination of medical and non-medical support that draws out the goals the older person identifies as most important to them. Through the programme, Age UK staff and volunteers become members of primary care led multi-disciplinary teams, providing care and support in and through the local community. The Integrated Care Programme covers the DGS&S (Dartford, Gravesham, Swanley and Swale) CCG (Clinical Commissioning Group) area. The three new North Kent sites launched in 2017.

A vital part of the success of the programme will be the engagement and active participation of key GP practices across these three areas to work closely with Personal Independence Coordinators (PICs), support workers and volunteers, in identifying those patients that match the programme criteria and might best benefit from this specific support. At the heart of the Personalised Integrated Care programme lies a pathway that brings together local voluntary and health and care organisations to help put the older person in control of their health and enable them to regain their independence and quality of life.⁸²

⁸¹ Rotherham case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Rotherham%20Case%20Study%20-%20final.pdf>

⁸² Age UK (6 August 2018) *Personalised Integrated Care*. Available at: <https://www.ageuk.org.uk/our-impact/programmes/integrated-care/>

North London Cares⁸³

North London Cares is a community network of young professionals and older neighbours helping one another in a rapidly changing city. Founded in 2011, its objectives are to:

- 📌 reduce isolation and loneliness among older people and young professionals alike
- 📌 improve the connection, confidence, skills, resilience and power of all participants so that neighbours can feel part of a changing city rather than left behind by it
- 📌 bring people together to reduce the gaps across social, generational, digital, cultural and attitudinal divides.

Independent evaluations have shown that North London Cares has reduced loneliness and increased the wellbeing of those involved, with 73% of older neighbours reporting feeling less isolated as a result of participating in its activities.

In 2014, South London Cares was founded. In 2017 the model expanded into Manchester and there are plans for branches elsewhere. Key factors supporting scaling up, include:

- 📌 Provision of advice from experts in business growth and finance, e.g. in managing risk and developing effective governance arrangements
- 📌 Co-production – always listening to the people involved, responding to their needs and drawing into their ideas
- 📌 When moving your model into a new area, understanding it will be very different, and will need a unique approach which reflects local circumstances
- 📌 Recruiting, developing and retaining people with strong values, ideas and energy.

3.1.7 An experience of seamless care

“The essence of integrated care is that individuals received the care services they are in need of when and where they need them. It is care which appears seamless to the service recipients and devoid of overlaps or gaps to service commissioner and providers.”⁸⁴

There are multiple examples of the development of integrated care teams and other integrated delivery approaches, and emerging understanding of the impact of these on various elements of the system (such as hospital admission or discharge), but the experience of these for the individual is less clear.

Mid Nottinghamshire Better Together vanguard programme

In Nottinghamshire, the creation of new integrated care teams including GPs, specialist nurses (e.g. diabetes, cardiac), social workers and a voluntary sector worker aims to provide seamless care. They work closely with other community teams to provide better, joined up care for patients who are at high risk of being admitted to

⁸³ <https://northlondoncares.org.uk/home>

⁸⁴ Van Raak, A., Mur-Veeman, I., Hardy, B., Steenberg, M. and Paulus, A. (eds) (2003) *Integrated care in Europe: Description and comparison of integrated care in six EU countries*, Elsevier Gezondheidszorg, Maarssen, NL

hospital. See YouTube clip⁸⁵. One of the challenges has been bringing together teams that have different ways of operating, thinking about risk, different protocols and requirements from their accountable body and are therefore reluctant to do things differently.

⁸⁵ <https://www.youtube.com/watch?v=S3PZZS5tCyw>

NHS Sutton CCG Enhanced Care in Care Home

Sutton Homes of Care vanguard⁸⁶ is working to improve the quality of life, healthcare and health planning for people living in care homes. Following national guidance⁸⁷, the framework for enhanced health in care homes in 2016, Sutton developed an innovative approach to smooth the transition between care home and hospital, called the Red Bag pathway. The bag is used to send key documents about a resident's needs with the resident if they have to go to hospital. Key outcomes are:

- 📌 Residents are spending less time in hospital. The Red Bag gives hospital staff more of the information they need to manage a resident while in hospital and support the discharge of a resident
- 📌 Residents can be transferred to hospital more rapidly in an emergency, as care home staff can readily transfer relevant paperwork to ambulance staff
- 📌 An increase in the skills, confidence, and work satisfaction of care home staff through improved communication and knowledge sharing amongst care home, ambulance and hospital professionals, and the development of mutual respect.

Encompass in East Kent

13 general practices are collaborating to improve care for a population of 170,000. The multi-community speciality provider has five community hubs bringing together multidisciplinary teams of GPs, community nurses, social care workers, mental health professionals, pharmacists, health and social care co-ordinators and others. These teams manage the care of individuals who have been identified as being at high risk of hospital admission. Other initiatives include a database of voluntary and community services, a social prescribing service and drop-in dementia clinics. Early evidence suggests that these changes have led to year-on-year reductions in emergency admissions to hospitals.⁸⁸

Team without walls in Dudley

By joining up GPs and other healthcare professionals around the patients in a 'team without walls', Dudley's vanguard has made great strides in supporting people to self care. [Watch⁸⁹](#) their story.

Calderdale single gateway to health and social care

The Gateway brought together social care advisors with nurses, trained clinical advisors and occupational therapists to provide a single point of access to community services. It provides information advice and guidance which connects people back to their communities and natural networks of support, avoiding unnecessary admissions to hospital and care homes.⁹⁰

⁸⁶ Sutton CCG (undated) Enhanced Health in Care Home. Available at:

<http://www.suttonccg.nhs.uk/vanguard/Programme-Aims/Pages/Enhanced-Health-in-Care-Home.aspx>

⁸⁷ NHS England (2016) The framework for enhanced health in care homes. Available at:

<https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>

⁸⁸ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31392485>

⁸⁹ <https://www.youtube.com/watch?v=KgfphBw6ZR8>

⁹⁰ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31447941>

3.1.8 Conclusion

The evidence is clearly highlighting that the development of transformed care systems includes common themes often articulated within shared visions:

- 📌 Taking a wider view of health and wellbeing for individuals and communities, including looking at preventative approaches.
- 📌 Working at a more local level, whether this is with individuals, communities or taking a “place-based” approach. This includes how an understanding of local needs is developed, how services are commissioned, designed and developed, and how services are delivered.
- 📌 The important role of voluntary and community groups in providing local, strengths-based support.
- 📌 Taking a person-centred approach that promotes independence and self-care.
- 📌 Developing a different relationship between individuals, local communities and professionals working with them, which shifts power and responsibility, and taps into a wider pool of resources.
- 📌 Using “I” statements to articulate and promote the importance of the design and delivery of care being personalised to an individual.
- 📌 The importance of not assuming “one size fits all” – there are a wide variety of models and approaches albeit sharing common themes.

However, while we found many examples of areas that found these approaches enabling in improving health and care outcomes for individuals and their whole population, it has not been possible within the time available to make an assessment of how widespread or embedded these ways of working are and whether they are representative of the bigger picture. It is also early days for these places to have fully evaluated and shown what difference they are making.

Looking at the wider literature, a number of studies appear to suggest that there may be a gap between the vision for integrated care and the reality. An early evaluation of the Integrated Care and Support Pioneers⁹¹, suggested that while many of the Pioneers had the ambition to provide more care in the community and to promote greater self care and preventative strategies to keep people well, the feasibility of these approaches was questioned. From a broad range of initiatives at the outset, there were signs of a “lowering of ambition” to a more limited set of initiatives – use of care navigators, locality based multi-disciplinary teams, care planning and more support to carers.

More recent research findings looking at the development of person centred care across health and social care present a mixed picture: *“from the patchy data available it appears some aspects of person-centred care are being consistently achieved in mainstream services. Others are not, or aren’t even being measured. People’s experience can be highly variable depending which services they use, what their needs are, and who they are.”*⁹² The same report highlights the need to develop measures so

⁹¹ Policy Innovation Research Unit (2016) *Early evaluation of the Integrated Care and Support Pioneers Programme. Final Report*. Available at:

http://piru.lshtm.ac.uk/assets/files/Early_evaluation_of_IC_Pioneers_Final_Report.pdf

⁹² National Voices (2017, p.4) *Person-centred care in 2017: Evidence from service users*. Available at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/person-centred_care_in_2017_-_national_voices.pdf

leaders of integrated systems can understand whether they are delivering person centred care.

More fundamentally, another report by Age UK⁹³ claims that “for many older people and their families it seems, getting access to decent quality, reliable home care, and maintaining it, is a real battle.” Their summary of the current situation presents a picture where service delivery is characterised by:

- 👤 Long waits to get an assessment
- 👤 Services that are disjointed or simply unresponsive
- 👤 Social services refusing to get involved
- 👤 Fundamental lack of capacity in the system
- 👤 Poor quality services and support
- 👤 Support and services being cut back
- 👤 Help for families providing care being withdrawn

When it comes to emergency admissions to hospital, although some of our case study areas had seen a decrease, in response to the new initiatives they had put in place, nationally the picture presented by the [Public Accounts Committee report](#) 8th June 2018 is one of increasing demand:

“Emergency admissions to hospitals continue to rise, despite the NHS’s efforts to reduce them. It is lamentable that nearly 1.5 million people could have avoided emergency admissions in 2016–17 if hospitals, GPs, community services and social care had worked together more effectively. It is frustrating that NHS England and partners are making some progress in reducing the impact of emergency admissions for patients and hospitals when they do happen, but no impact on reducing the numbers of admissions that could have been avoided.”

4 Shared systems

A key enabler (and potential barrier or inhibitor) of delivering integrated care is the effectiveness of shared systems to support its planning and commissioning, and the delivery itself. Whilst there is a risk that focus will be on these systems rather than the health and wellbeing of individuals within local communities, as outlined in the original vision for integrated care, they do need to be considered and developed to support the delivery of integrated care.

A vision for shared systems⁹⁴ - what good looks like

Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies. Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability. Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches

⁹³ Age UK (2018) *Behind the Headlines: the battle to get care at home*. Available at: <https://www.ageuk.org.uk/latest-press/articles/may-2018/3-million-hours-of-home-care-lost-due-to-council-cuts/>

⁹⁴ NHS Confederation (2016, p.13) *Stepping up to the place*. Available at: <http://www.nhsconfed.org/resources/2016/06/stepping-up-to-the-place-the-key>

This section explores the evidence in the following key systems: commissioning; funding; workforce; and information technology.

4.1 Commissioning for health and wellbeing

The UK Cabinet Office and the Commissioning Academy give the following explanation of commissioning: *'We "commission" in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.'*⁹⁵ This section explores what approaches are being taken, and what is known about their impact in terms of delivering integrated care.

Commissioning will be a critical element of delivering a transformed care system and it appears in the evidence in various ways:

- 📍 Developing a shared set of commissioning outcomes for a specific place or community which forms the basis for delivering effective integrated care. This will need to be based on a shared understanding of local needs and aspirations, and an agreed sense of priorities across the system.
- 📍 Commissioning can take place at an individual level and the development of integrated personal commissioning reflects the growing interest in providing individuals with direct control over the use of personal budgets.
- 📍 Strategic commissioning as an activity can take place in a variety of ways:
 - 📍 Separately within individual organisations;
 - 📍 Separately but with shared or common outcomes;
 - 📍 As a joint or integrated function seeking shared outcomes.
- 📍 Aspects of commissioning, notably procurement approaches, can be delivered in ways which support integrated approaches.

4.1.1 Shared commissioning outcomes

The recent Integrated Commissioning for Better Outcomes Framework⁹⁶ sets out principles for the development of a range of integrated commissioning standards:

- 📍 A focus on the benefits for the '3 Ps': people, places, and populations, with the individual person at the heart of the approach.
- 📍 A focus on outcomes over 'episodes of care'.
- 📍 Recognition that integrated commissioning needs to happen at multiple levels: with individuals and their families and carers; with communities; and across larger populations.

⁹⁵ Local Government Association (2018, p.6) *Integrated commissioning for better outcomes: A commissioning framework*. Available at: https://www.local.gov.uk/sites/default/files/documents/25.70_Integrated%20Commissioning%20for%20Better%20Outcomes_final.pdf

⁹⁶ Local Government Association (2018) *Integrated commissioning for better outcomes: A commissioning framework*. Available at: https://www.local.gov.uk/sites/default/files/documents/25.70_Integrated%20Commissioning%20for%20Better%20Outcomes_final.pdf

- 📍 Awareness and acknowledgment that commissioning is about more than procuring services, it is about a wide variety of activities which improve the outcomes and the lives for people, places and populations.
- 📍 Awareness that language matters and that words and concepts can have multiple meanings.
- 📍 A belief that understanding and respecting our differences (of history, culture, legal responsibilities, and ways of working) enables us to work better together.

The Framework goes on to describe four domains: building the foundations; taking a person-centred, place based and outcomes focused approach; shaping provision to support people, places and populations; and continuously raising the ambition.

The evidence review has found examples where systems have developed shared/agreed outcomes for individuals to inform their design and delivery of integrated care although with different linkages to commissioning activity.

Croydon

In Croydon an engagement exercise with local people has developed five outcomes to improve their lives which form the basis of their outcomes commissioning:

- 📍 I want to stay healthy and active for as long as possible
- 📍 I want access to the best care available in order to live as I choose and as independent a life as possible
- 📍 I want to be helped by a team/person that has had the training and has the specialist knowledge to understand how my health and social care needs affect me
- 📍 I want to be supported as an individual with services specific to me
- 📍 I want good clinical outcomes

Croydon has introduced a number of tools to manage commissioning and contracting across the system. Each organisation in the Croydon Alliance is responsible for their own organisational policies and regulatory requirements but are all working to a shared performance management framework to ensure that shared objectives are being realised and risks are jointly identified and mitigated.

Download the full case study [here](#)⁹⁷

There are examples of outcomes based commissioning where specific services have been commissioned using outcomes based approaches.

Rochdale⁹⁸

⁹⁷ Croydon case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Croydon%20Case%20Study%20-%20final.pdf>

⁹⁸ Rochdale Borough Council and the Pennine Acute Hospitals NHS Trust (2017) *Welcome to Heywood, Middleton, Rochdale Care organisation and integrated care system*. Available at:

<https://www.scie.org.uk/files/integrated-health-social-care/better-care/fund-guidance/midlands-thematic-2017-11-28/intermediate-care.pdf>

Aims and objectives: To commission and provide a re-designed, transformative model of Intermediate Tier Services (ITS) that will through outcomes-based commissioning, provider collaboration, including voluntary and third sector, reduce admissions to unplanned and long-term care, and improve the experience and outcomes for those receiving it.

Action: An outcomes-based tender with a lead provider collaborative, jointly commissioned by the CCG and local authority adult care service for an incentivised contract year 1-5, issued November 2014, awarded 24th April, and mobilised 1st September 2015.

A suite of services delivered in partnership with acute trust as prime vendor and a provider collaborative including; local authority, GP federation and GP out of hours provider, voluntary and third sector part of the partnership and delivery model.

Model comprises Urgent Community Care (crisis response and home care pathway); two bed based units (including one newly designed on Rochdale Infirmary site); integrated assessment and reablement service; borough wide pharmacy; enhanced GP and consultant provision; Care Connector Service and Transfer of Care (Discharge Facilitation).

Lessons learnt/next steps:

-  Changing mindset and culture to deliver integrated services through alliance of providers with third sector provider(s) as part of the partnership and service delivery model.
-  Integrated governance between organisations framework and toolkit developed.
-  A 6% Reduction in Home Medicines Review patients admitted to hospital for unplanned care. This represents 470 less admissions, year to date. Reduction in length of stay from 35 days to average 20 days in the first year.
-  Positive service user, carer and staff experience

4.1.2 Integrated personal commissioning

The Integrated Personal Commissioning programme⁹⁹ (aims to ensure that services are tailored to people's individual needs, building on learning from personal budgets in social care and progress with personal health budgets. Through the programme, people, carers and families with a range of long-term conditions and disabilities are supported to take a more active role in their health and wellbeing, with better information and access to support in their local community, and greater choice and control over their care. Integrated Personal Commissioning will be the main model of care for 5% of a local system's population, including people with multiple long-term health conditions or disabilities, people with severe and enduring mental health problems, and children and adults with complex learning disabilities and autism.

Where someone is part of the programme or has a personal health budget, they will: ¹⁰⁰

⁹⁹ NHS England (undated) What is Integrated Personal Commissioning (IPC)? Available at: <https://www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/>

¹⁰⁰ NHS England (2017) *Interactive IPC operating model*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/06/IPC-operating-model.pdf>

- 📍 Be able to access information and advice that is clear and timely and meets their individual information needs and preferences
- 📍 Experience a coordinated approach that is transparent and empowering
- 📍 Have access to a range of peer support options and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing
- 📍 Be valued as an active participant in conversations and decisions about their health and wellbeing
- 📍 Be central in developing their personalised care and support plan and agree who is involved
- 📍 Be able to agree the health and wellbeing outcomes they want to achieve, in dialogue with the relevant health, education and social care professionals.

If this leads to a personal budget, integrated personal budget or personal health budget, a person will:

- 📍 Get an upfront indication of how much money they have available for healthcare and support
- 📍 Have enough money in the budget to meet the health and wellbeing needs and outcomes agreed in the personalised care and support plan
- 📍 Have the option to manage the money as a direct payment, a notional budget, a third party budget or a mix of these approaches
- 📍 Be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their personalised care and support plan.

Where someone has a personal health budget, they should experience all the key features listed above, not just those specifically listed under the personal budget section.

Nottinghamshire: Integrated Personal Commissioning in practice

Staff in Nottinghamshire who have implemented this model emphasise that it's about the individual being more empowered and involved in their own care planning. Different conversations with patients (who qualify for Continuing Health Care funding) need to be instigated, moving the focus away from 'what's the matter with you?' to 'what matters to you?' This generates a wider range of solutions which may be more satisfying to the individual, as well as being cost effective. Initial pilots have shown average cost reductions of around 17%.

Nottinghamshire's advice for others who would like to adopt this approach is to:

- 📍 Start small and scale it up
- 📍 Do it gradually so as not to have a big impact on contracts
- 📍 Use real life examples to explain it to people
- 📍 Have a go, it's not for everyone
- 📍 Help providers to see it's not a threat to health jobs, for example training PAs to do a range of short-term health tasks to avoid lots of professionals visiting separately
- 📍 Work with the willing
- 📍 Focus on the person and the systems will follow

Download the full case study [here](#)¹⁰¹

4.1.3 Delivering integrated commissioning

As with other aspects of integrated care, there are various forms integrated commissioning may take. They have been described as:¹⁰²

-  Strategic, involving the complete integration of the processes and governance of the member organisations
-  Geographic, covering all services with a certain place or for a group of people; this can involve virtual arrangements where activity is aligned but not under single management
-  Commissioning can take place at system, team or locality level, or at the level of the individual service user
-  It can involve clinical commissioners joining with council commissioners, and/or commissioners and providers”

The context for taking integrated approaches to commissioning is complex, with often competing or different rules and requirements. The legislative framework for different parts of the system is different, so for example the Care Act 2014 governs adult social care; the Health and Social Care Act 2012 sets out the responsibilities for health commissioning, with NHS England setting the rules for NHS services; it also requires local authorities to provide some public health services, whilst others are commissioned by NHS England under the National Health Service Act 2006. An important area of difference is around the relationship with the market: local authorities have a duty to promote diversity and quality in the care and support market in their local area, whilst the NHS does not have an equivalent duty. This can give rise to very different approaches and cultures around the provider market and the procurement of services.

Plymouth

Plymouth has been at the forefront of integrated commissioning. The key aspects of their approach are outlined below:

-  Co-location of commissioners
-  Shared resources (buildings, spaces, people, expertise)
-  Joint social events and organisational development
-  Integrated governance arrangements – in their case the health and wellbeing board is positioned as the system leadership group and the Integrated Commissioning Board reports to it
-  Four system commissioning strategies
-  One director of integrated commissioning

¹⁰¹ Nottinghamshire case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Nottinghamshire%20Case%20Study%20-%20final.pdf>

¹⁰² Local Government Association (undated) *Integrated commissioning and provision*. Available at:

<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/integrated-commissioning-and-provision>

- 📎 'Cradle to Grave' Fund established using Section 75 agreement between CCG and Council. Integrated funds £638 million gross (£462 million net)
- 📎 Risk share and financial framework - risk share mechanism, with a specified ceiling, which will operate as a "backstop" to the agreement

Download the full case study [here](#)¹⁰³

North East Lincolnshire

Historically, joint working has focused on a 'lead commissioner' model (delegation of functions by each partner to the other, with a transfer of funds); for example, as lead commissioner, the CCG buys all residential and nursing care on behalf of itself and the Council. The arrangements in place have permitted the pooling of funding to enable integrated services to be commissioned from providers. Although technically there are detailed arrangements for the governance of pooled funds with the section 75 agreement, in practice budgets and contracts are fully operationally integrated. It is the responsibility of the lead commissioner to ensure that funds are used appropriately and that the under and overspends are managed.

Download the full case study [here](#)¹⁰⁴

4.1.4 Procurement mechanisms

Approaches to procurement are seen to play a role in the effective delivery of integrated care. Traditionally in both health and social care activity based 'tariff' payments or block contract payments have traditionally been utilised. Alternative payment models that can be used in commissioning integrated services include:

Capitation is a means of paying 'a provider or group of providers to cover the majority (or all) of the care provided to a target population...across different care settings' (NHS England/Monitor 2014). These payments are a lump sum per patient with an estimate of the population to be served. An advantage of this is increased awareness of service costs and budgetary requirements.

Risk/Gain/Loss Share models provides an opportunity for providers and commissioners to establish a network to identify and distribute financial gains or losses. Comparisons are drawn between the estimated and actual contract spend, any surplus or deficit is then shared amongst the group.

Outcome or Incentive payment models Risk/Gain share models are frequently combined with capitation as a means of establishing a comprehensive outcomes focused payment model in which a proportion of a capitated payment is awarded pending achievement of mutually agreed outcomes. Amounts of payment withheld can vary from relatively small amounts up to the majority of the payment.

¹⁰³ Plymouth case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Plymouth%20Case%20Study%20-%20final.pdf>

¹⁰⁴ North East Lincolnshire case study available at:

<https://www.local.gov.uk/sites/default/files/documents/North%20East%20Lincolnshire%20Case%20Study%20-%20final.pdf>

Whatever approach is being taken to strategic commissioning in terms of integration, the procurement mechanisms can both create challenges (for example, with different expectations around risk sharing) as well as supporting whole system approaches through involvement beyond traditional organisational boundaries.

East Sussex Grants: As part of the whole system health and care transformation programmes East Sussex Better Together and Connecting For You, East Sussex County Council has developed a system wide asset-based approach to prevention and early intervention with a view to making sustainable change at scale and pace. A system of grant making has been established to encourage a 'whole settings' approach to prevention and health improvement in a range of settings. This has proved successful in both education and health settings. It provides an opportunity to receive a grant to support identification and implementation of individual setting's own evidence-based plans and priorities, encouraging ownership and 'buy-in' from participants. Evaluation currently under way includes assessment of community benefit and return on investment for health and care as well as the impact on the local economy.¹⁰⁵

Isle of Wight – example of alliance contracting¹⁰⁶

The Isle of Wight have focused their integration agenda on creating a single care model for the island 'building collaboration to deliver shared outcomes'. They have done this through a new care model focusing on care pathways and outcomes and though a new business model focused on how they organise themselves.

This has involved market engagement to create an alliance agreement with providers. This has created a huge culture shift from an environment of competition and secrecy among providers to one of collective accountability and openness including around charges. The Alliance principles, which all partners have signed up to are:

-  Trust
-  Openness
-  Collaboration and partnership
-  Learning

Initially it felt very threatening and hasn't been without its challenges. It has taken considerable emotional energy and time from those involved. Service contracts are still in-place, the focus has been on bringing providers together to do business together, to focus on person-centred outcomes, co-production and to adopt an iterative, 'test and learn' approach to delivering integrated services. Balancing the needs of immediate versus pace of change demands has also been a challenge.

Their approach was 'ground up' with a focus on care models which was enabled through leadership changes, new capacity through the appointment of transformation roles and a huge effort focused on relationship building. They feel that a key enabler

¹⁰⁵ Local Government Association (20 February 2018) *East Sussex County Council: community asset-based transformation programme*. Available at: <https://www.local.gov.uk/east-sussex-county-council-community-asset-based-transformation-programme>

¹⁰⁶ Telephone conversation with Jonathan Smith Assistant Director of Integration, June 2018

was a clear vision with people at the centre so that all parties could see where they were trying to get to and that people were the driving vision behind changes. A key driver is the delivery of Quality Improvement Plan outcomes including delivering best clinical outcomes through:

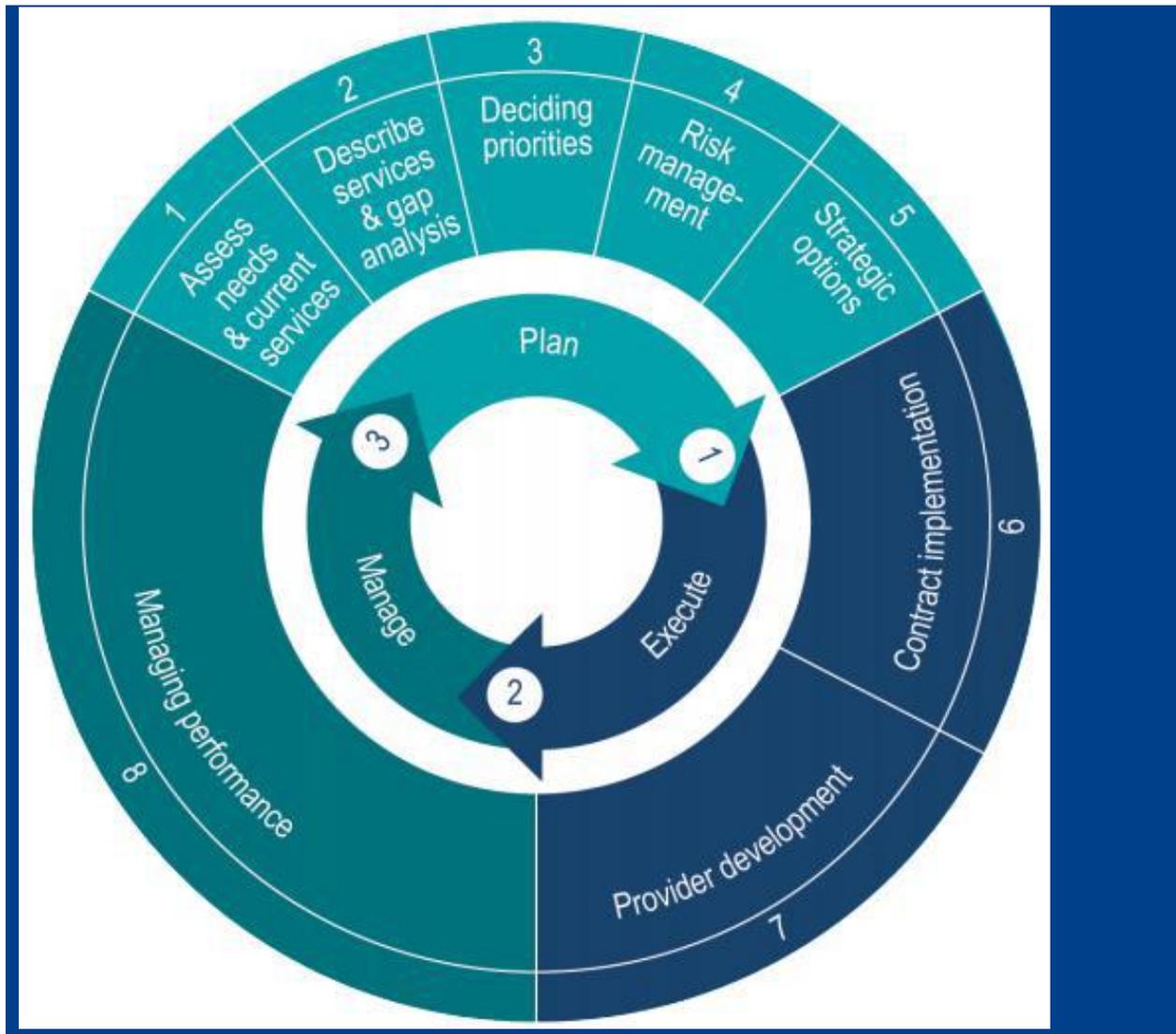
- 📌 Doing the right things in the right way, by the use of innovation and ensuring our teams base their practice on the best available evidence
- 📌 Better use of resources – seeking to achieve ‘more for less’ by getting evidence into practice and ensuring audit drives improvement
- 📌 Right patient, right place, right time - Ensure that all patients are located in the most appropriate place from admission to discharge

Advice they would give to others is to not underestimate the complexity and effort needed in bringing teams together. Also proof of concept ‘systems readiness’ was key and if not done fully can backfire. A detailed plan of how to take people on the journey with you and their in-put to this to prepare for the changes is needed. Focus on why it’s a positive experience and effective communications to ensure people are informed, engaged and prepared to learn.

The Systems Readiness Plan includes:

- 📌 Co-design to develop being an Alliance
- 📌 Comms & engagement
- 📌 Align provider delivery model
- 📌 Outcomes framework
- 📌 Cost, incentives & payment modelling
- 📌 Overcoming barriers
- 📌 Strengthening & streamlining decision making

The below diagram sets out the Alliance Management Group’s management model:



4.1.5 Measuring impact

Impacts, outcomes and benefits can be measured at a number of levels, including both integrated commissioning and commissioning of integrated services, and cover both benefits to the system and outcomes for the individual. For example:

- 📍 How, at a system level, an integrated commissioning strategy is helping to achieve the local vision for health and wellbeing
- 📍 How, at a system level, integrated commissioning structures and processes are leading to organisational efficiencies, better intelligence led commissioning, better market management, more effective use of workforce capacity and estates etc
- 📍 How, at a service level, the commissioning of integrated services is leading to more joined up pathways and better outcomes and experiences for people
- 📍 How, at an individual level, more integrated approaches mean that there are consistent expectations and conversations about the relationship between individuals and public sector services, and their relevant responsibilities.

At a national level, the Social Care Institute for Excellence (SCIE) has developed tools for measuring progress in an integrated system. The 'logic model'¹⁰⁷ for integrated care describes what good looks like, providing a visual depiction of how a fully integrated health and care system might be structured and function, and the outcomes and benefits it should deliver for those who use services and their carers. It describes:

- 📍 the enablers of integration
- 📍 the key components of integrated care
- 📍 the outcomes for people who use services, for the integrated services and for the wider health and care system
- 📍 the long-term impacts and benefits.

SCIE is also supporting the Department of Health and Social Care with the development of an Integration Scorecard¹⁰⁸, which will combine outcome metrics, financial performance, user experience and process measures. This is a work in progress, linked to the government's aim to help local areas to measure progress towards integrated health and social care by 2020.

In the meantime, recognising the need to evaluate new ways of delivering health and care, some areas have developed their own arrangements including working with local universities to measure impact.

Rotherham's partnership with Sheffield Hallam University

Rotherham has been delivering a social prescribing service for a number of years. In order to decide whether to upscale the initial 3 year pilot, they commissioned Sheffield Hallam University to evaluate its effectiveness both for individuals who had used the service and as a cost benefit exercise to demonstrate value to the system as a whole.

Summary headlines were as follows:¹⁰⁹

- 📍 The analysis identified an overall trend that points to reductions in service users' demand for urgent care interventions after they had been referred to Social Prescribing
- 📍 Analysis of wellbeing outcome data showed that, after 3-4 months, 82 per cent of Service users, regardless of age or gender, had experienced a positive change the estimated total NHS costs avoided between 2012-15 were more than half a million pounds: an initial return on investment of £1.43 for each pound (£1) invested

4.2 Funding

Financial arrangements and how they can inhibit or promote integrated care are a well-rehearsed issue. Challenges include:

- 📍 How to shift money across a system to support the transformation of care models.

¹⁰⁷ www.scie.org.uk/integrated-health-social-care/measuring-progress/logic-model

¹⁰⁸ www.scie.org.uk/integrated-health-social-care/measuring-progress/scorecard

¹⁰⁹ Sheffield Hallam University (2016) *Evaluation of the Rotherham Social Prescribing Pilot*. Available at: <https://www4.shu.ac.uk/research/crest/ourexpertise/evaluation-rotherham-social-prescribing-pilot>

- 📍 How to avoid prioritising short term funding crises over longer term funding arrangements and benefits.
- 📍 How to use funding approaches to support and enhance integrated care models

This section explores two specific aspects: the impact of the Better Care Fund on the delivery of integrated care; and the use of budget sharing mechanisms in the same way.

4.2.1 Better care fund

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Partnerships as the impetus for their integration efforts. The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

For 2017-19, there are four national conditions (rather than the previous eight):

- 📍 Plans to be jointly agreed
- 📍 NHS contribution to adult social care is maintained in line with inflation
- 📍 Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care
- 📍 Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: delayed transfers of care; non-elective admissions (General and Acute); admissions to residential and care homes; and effectiveness of reablement.

As the first mandatory pooled budget the Fund has the potential to be key to driving joint working. The National Audit Office made the following commentary on the effectiveness of the Fund in its first year¹¹⁰:

- 📍 Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year.
- 📍 The Better Care Fund has been successful in incentivising local areas to work together: more than 90% of local areas agreed or strongly agreed that delivery of their plan had improved joint working.
- 📍 Local areas reduced permanent admissions of older people (aged 65 and over) to residential and nursing care homes. They also increased the proportion of older people still at home 91 days after discharge from hospital receiving reablement or rehabilitation services.

¹¹⁰ National Audit Office (2017, p.8) *Health and Social Care Integration*. Available at <https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf>

4.2.2 Budget sharing mechanisms

Four approaches to sharing budgets have been identified by CIPFA¹¹¹:

- 📌 Aligned Budget Arrangements: Under this arrangements budgets remain with the individual organisation but a joint board comes together to agree joint objectives and how individual organisations activities can be aligned to maximise the synergies between them.
- 📌 Lead Body Arrangements: One of the organisations takes on a lead body role and administers a total budget on behalf of the individual organisations to achieve jointly agreed objectives. Expenditure may be controlled by a joint board but day to day financial management will be undertaken by the lead body.
- 📌 Joint Commissioning Arrangements: The individual organisations come together to commission a third party to provide a service on their behalf. A joint board will usually set the objectives and contract terms but delivery will be down to the third party at a cost set out in the contract.
- 📌 Joint Venture Arrangements: This is where a separate entity is established by the individual organisations to deliver the activity or function. A joint board will set objectives and key activities for the organisation which may either be freestanding or controlled by the individual parties.

Northumberland¹¹²

Commissioning and payment model: Northumberland's Locality Integrated Networks were built on risk sharing mechanisms between the CCGs, local authorities and providers. Funding for the Frail Elderly Pathway is drawn from primary, secondary and community care budgets to create an integrated funding stream. This removes confusion and disputes about budget responsibilities. Derek Thompson commented: *"Things get difficult when people fall out over organisational boundaries or who gets paid what. Unless you have a really strong relationship this can be a serious difficulty."*

There was relatively little focus on developing new commissioning and payment models and the simple commissioning structure allowed this aggregation. This simple approach stands in contrast to some other models that have focused on trying to incentivise different organisations to work collaboratively. Northumbria Healthcare NHS FT internally funded some of the additional services. A key lesson is funding for new services will need to be agreed and implemented for integration to be delivered

Southampton Single Service with pooled budget¹¹³

The formation of a single service with a pooled budget, single management structure and joined up processes was developed to:

¹¹¹ A CIPFA Introductory Guide for CCGs: Pooling Budgets and Integrated Care June 2011

¹¹² Local Government Association (2016) *The journey to integration Learning from seven leading localities. Case study Northumberland*. Available at:

<https://www.local.gov.uk/sites/default/files/documents/lga-journey-integration-l-c5c.pdf>

¹¹³ Better Local Care (undated) *Health and Social Care Integration*. Available at:

<http://www.betterlocalcare.org.uk/in-your-area/southampton/news/southampton-urgent-response-service/>

-  To reduce unnecessary hospitalisation and admission to residential and nursing homes
-  To reduce hospital delays and excess bed days
-  To invest in more home-based rehabilitation and reablement services

An outcome-based service specification was created; this was focused on hospital and care/nursing home avoidance and hospital discharge.

To bring together community teams under one management structure, a project manager was appointed to manage formal staff and the creation of an integrated management structure. The overall service manager then continued service development to form two teams: the Urgent Response Team (URS) and the Community Independence Team (CIT).

To redistribute resources, a formal Local Authority driven consultation process was undertaken, resulting in an inappropriately used rehabilitation unit being decommissioned, and the commissioning of a home-based rehabilitation service, six rehabilitation beds in residential care homes and three extra care housing options.

The integrated team is operational and working well, which is demonstrated by the functionality of the six rehabilitation beds; availability of extra care housing as short-term accommodation; reablement into the home; and a pooled budget arrangement between providers now agreed.

Hertfordshire: Better Care Fund Pooled Budget Arrangements

The BCF pooled budget arrangements were set up to maximise opportunities for joint commissioning, joint working and joint financial planning across health and social care; to have a shared vision of integrated service development.

A larger pooled budget has enabled greater opportunities for integration and investment in large-scale initiatives (e.g. Rapid Response). It has also allowed a system wide review of spending on out of hospital services which has aided the development of joint commissioning intentions in the STP. Understanding one another's spending has enabled informed conversations on future ideas for integration and/or spending differently, for example, plans for integrated flexicare model where every bed is to be commissioned using one system. It has been important to allow sufficient time for decisions / updates to undergo varied governance processes across organisations.

Success factors include:

-  Strong and trusted relationships between NHS and social care, built on a history of communication and partnership working
-  A level of transparency over financial arrangements.

- 📌 Having one team responsible for actual management of the pooled budget (in Hertfordshire, this was HCC's finance team) but with regular contact with other teams.
- 📌 Having a joint vision of what greater integration will achieve (that incorporates individual organisational plans), as well as the system impact of not tackling current health and social care pressures.
- 📌 Joint understanding of role of social care, with NHS investing in protection of social care.¹¹⁴

Plymouth: one system, one budget

The development of an ambitious, system wide approach to funding has been a key enabler in Plymouth's journey to integration. A Section 75 agreement, and risk share arrangements were put in place early on, thanks to cross party political support and a strong commitment to collaborative working from the health and wellbeing board. Where budgets couldn't legally be pooled they were aligned.

The Fund is truly 'cradle to grave' and covers

- 📌 Public Health
- 📌 Leisure Services
- 📌 Housing Services
- 📌 Children's Services (including the schools grant)
- 📌 Adult Social Care
- 📌 Primary Care
- 📌 Community Health Services
- 📌 Acute Provision
- 📌 Running Costs

Download the full case study [here](#)¹¹⁵

4.3 Workforce

The NHS workforce comprises 1.318 million staff¹¹⁶, while an estimated 1.48 million staff make up the social care workforce¹¹⁷. The workforce is intrinsic to quality of care and accounts for the greatest proportion of NHS costs. It is not surprising therefore that the role of the workforce in delivering a health and social care system able to meet the demands of the future is a key consideration.

4.3.1 New roles and new ways of working – see also section 3.1.7 seamless care

There are three ways that work roles may change in the development of integrated care:

¹¹⁴ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=29444453>

¹¹⁵ Plymouth case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Plymouth%20Case%20Study%20-%20final.pdf>

¹¹⁶ NHS Confederation (14 July 2017) *NHS statistics, facts and figures*. Available at:

<http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>

¹¹⁷ Skills for Care (2017) *The state of the adult social care sector and workforce in England*. Available at: www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/publications/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

- 📍 New leadership and management roles (e.g. nurse led care or case management, systems leadership, integrated leadership/management roles)
- 📍 New professional roles (e.g. pharmacy involvement, community connectors, care co-ordinators, health coaches)
- 📍 New working environments (e.g. multi-disciplinary pathways, interdisciplinary meetings, prevention, person-centred, asset based approaches)

The successful development of new roles¹¹⁸ entails significant management challenges. A culture of protecting professional and organisational identities is one of the most prominent barriers to new ways of working, especially where established skills and roles are reconfigured. Other barriers include overestimating the capacity of individual roles to deliver integrated care, difficulties in making these roles sustainable over time, and poor accountability and oversight of staff in roles that do not fit into established structures.

New roles to support integrated care by working across organisational boundaries are only effective when they are part of a system-wide process of integration. The support of senior leaders is crucial for establishing a framework for integration, legitimising new ways of working, and ensuring a climate and processes are established that enable practice to develop in the desired direction.

Trusted Assessor Newcastle Gateshead CCG¹¹⁹

The approach to implementing trusted assessment involved:

- 📍 identifying the best team to develop trusted assessment – using an interface team of nurse, physiotherapist, occupational therapist and social worker
- 📍 developing a trusted assessment tool with care partners – undertaking an interagency review of existing tools and stakeholder consultation to develop a trusted assessment tool
- 📍 testing the process within a safe environment – with patients transferring from hospital to stepdown beds
- 📍 evaluating the impact – which showed that 66 per cent of patients were transferred the same day, 28 per cent the next day and 3 per cent at a later date. Issues identified related to mobility, communication and discharge planning.

4.3.2 Workforce planning

The National Audit Office¹²⁰ notes that there are around 1.34 million jobs in the adult social care sector in England. This excludes an estimated 145,000 jobs for personal assistants, employed by recipients of personal budgets and self-funders and 91,000 care jobs within the NHS. Amongst its findings on a review of the adult social care workforce it found the following challenges in terms of strategic planning:

¹¹⁸ The King's Fund (2016) *Supporting integration through new roles and working across boundaries*. Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Supporting_integration_web.pdf

¹¹⁹ Local Government Association (19 January 2018) *Newcastle Gateshead CCG: trusted assessment*.

Available at: <https://www.local.gov.uk/newcastle-gateshead-ccg-trusted-assessment>

¹²⁰ National Audit Office (2018) *The adult social care workforce in England*. Available at:

<https://www.nao.org.uk/wp-content/uploads/2018/02/The-adult-social-care-workforce-in-England-Summary.pdf>

- 📍 The lack of an up-to-date national strategy
- 📍 Local and regional bodies and partnerships not taking a lead on workforce planning and the absence of a national strategy
- 📍 No oversight of regional or local workforce planning

A recent report looking at the management of demand across 15 local authority health and care systems recommended that: “*Councils and NHS partners should develop system-wide strategic workforce plans including a career framework across health and care roles to ensure that they are able to recruit and retain the right skills and maintain the capacity and capability needed to deliver care to the local population*”.¹²¹

As an example of the pressure within the system: a recent review of community health services found that: “*The supply of community staff has not kept pace with demand and trusts face worrying shortages in key staff groups, such as district nursing and health visitors. Trusts are also struggling to recruit and retain the staff they need to deliver high quality care, due to the low profile of the community sector. Two thirds of trust leaders that responded to our survey are “worried” or “very worried” that they will not have the right numbers, quality and mix of staff to deliver high-quality care in one year’s time.*”¹²²

In social care, provider workforce issues are equally pressing: recruitment, retention and turnover rates are all worrying. For example, registered nurses in nursing homes for older people have a turnover rate of 32.7%. Turnover for registered nurses in adult social care is higher than for other professions represented in the sector namely social workers and occupational therapists¹²³. Problems in recruitment and retention mean that many nursing homes are reliant on overseas recruitment of nurses, and the issue may be getting more acute as uncertainty over Brexit continues.

The establishment of governance structures such as health and wellbeing boards, STPs and ICSs provide an opportunity for strategic system-wide workforce planning to address shortages in the health and care workforce (including social care staff). This will ensure organisations are not competing for the same limited pool of staff, and enable development opportunities across local areas.

East Riding of Yorkshire: Joint ownership of the health and wellbeing board leads to greater levels of joint working. Recently the health and wellbeing board held a discussion about how each organisation had its own workforce development plan, meaning four separate reports would have to come to the health and wellbeing board. The health and wellbeing board jointly decided to develop a whole systems workforce development plan covering four organisations (two CCGs, a provider organisation and the council), which will help to avoid siloed working and reinforce the sense that the health and wellbeing board is jointly owned. This will also help to avoid duplication and ensure a universal approach to workforce issues.¹²⁴

¹²¹ iMPower (2018, p.6) *The two billion pound question: Is there an opportunity to move from meeting to managing demand?* Available at: <https://www.impower.co.uk/wp-content/uploads/Collaborative-Report-15-March-2018.pdf?x63202>

¹²² NHS Providers (May 2018) *NHS Community Services: Taking Centre Stage. The state of the provider sector.* Available at: <https://nhsproviders.org/state-of-the-provider-sector-05-18/key-points>

¹²³ Institute of Public Care (2017) *Market Shaping in Adult Social Care.* Available at: http://ipc.brookes.ac.uk/publications/Market_shaping_adult_social_care.html

¹²⁴ Shared Intelligence (2016) *Effective Health and Wellbeing Boards: Findings from 10 Case Studies.* Available at: <https://www.local.gov.uk/sites/default/files/documents/effective-health-and-well-4c3.pdf>

North East Lincolnshire

In common with most areas, North East Lincolnshire lacks an adequate supply of suitably trained and qualified health and social care workers. Being geographically remote from larger centres of population, it is hard to get staff to come to and to stay in North East Lincolnshire; this is one of the top priorities for the Union (the NHS and local government in North East Lincolnshire have joined formally as a Union). A strategic approach to workforce recruitment and development has been put in place, drawing on the Council's Outcomes Framework Lead for Skills and Learning and a local website promoting the benefits to living and working in health and social care in the area 'work smart live well'.¹²⁵

Download the full case study [here](#)¹²⁶

4.3.3 Training and skills development

The skills needed to deliver integrated care often already exist within the workforce; the issue is how these skills are shared and distributed as part of an overall integrated system of care that spans organisational boundaries. Skills in communication, management and creating relationships are vital, and may be required by professional and non-professional groups more broadly. As mentioned in section 2.1.1, organisational development (for all staff not just leaders) is vital in addressing the cultural barriers to integration. Interdisciplinary training, training of practitioners as well as managers, and cross-organisational placements can help develop and spread the necessary skills and competencies.¹²⁷

North East Lincolnshire – developing shared principles that govern how care is delivered

Integrated teams of health and social care staff have become the norm in North East Lincolnshire. The focus now is to develop shared principles that govern how they deliver care. This has been happening through a programme of joint training to foster value driven practice based on understanding of public law principles and rights based approaches, underpinned by legislation such as the Human Rights Act 1998, and the Mental Capacity Act 2005. Work is also underway to ensure cohesion between children and adult service teams, with a focus on consistent adoption of strength or asset based social work practice.

Download the full case study [here](#)

¹²⁵ <http://worksmartlivewell.co.uk/>

¹²⁶ North East Lincolnshire case study available at:

<https://www.local.gov.uk/sites/default/files/documents/North%20East%20Lincolnshire%20Case%20Study%20-%20final.pdf>

¹²⁷ The King's Fund (2016) *Supporting integration through new roles and working across boundaries*.

Available at:

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Supporting_integration_web.pdf

Community Education Networks¹²⁸

Health Education North West London developed a pathway based multi-professional approach to Community Education Provider Networks (CEPNs) to bring together health and social care service providers, community groups and education providers focused around enabling the development of learning communities. These networks focus on different parts of the health and social care workforce, patients and the public systematically improving services by learning with and from each other. The model promotes:

1. Facilitating integrated care through provision of educational projects and programmes across the whole workforce
2. Acting as a catalyst for the adoption of best practice through the creation of learning communities across healthcare including social service and community groups
3. Creating new innovative educational models to support local workforce transformation and enable service redesign through educational redesign along pathways
4. Engaging patients and the public in the training and education of the healthcare workforce

All our CEPNs comprise some combination of education providers, patient and community groups, and primary care and community service providers along with those in secondary care, who individually or collectively form platforms to share their knowledge, skills and expertise in delivering healthcare. These networks deliver multi-professional education and training to healthcare workers, resulting in improved patient experience and bringing care closer to home.

Haringey

Key Features

This study highlights two important components of the wider programme to integrate health and social care of those over 65:

-  An externally facilitated training programme for workforce development;
-  A programme to promote independence, Neighbourhoods Connect, which leveraged existing community assets and initiatives to engage the socially isolated.

Critical enablers

-  Knowledge of existing community services
-  Clear identification of target group
-  Involving the voluntary sector
-  Innovative ways to reimburse people rather than purely monetary
-  Identifying champions to move things forward
-  Trusting relationships between organisations in the community

¹²⁸ Health Education South London (2015) *Community Education Provider Networks – using education to support service transformation*. Available at: <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/04/community-education-prov-networks.pdf>

-  Partnership working
-  Using existing services which have local knowledge
-  Using local employees/volunteers
-  Facilitated opportunities for staff from other organisations to meet and plan together
-  Developed relationships and networks in the community
-  Right level of staffing with embedded workers

Northumberland Locality Integrated Networks¹²⁹

Recruitment around the LINs was small scale, with more emphasis on reorienting and refocusing the existing workforce. This included GPs, district nurses, community matrons and social workers working together as multi-disciplinary teams (MDTs) to support high-risk patients and agree interventions. Training was focused on working within an MDT, understanding and owning the team's purpose, vision and developing areas of cross discipline working. Community nursing also delivers a care homes training programme specifically to improve care planning, care coordination and record keeping.

Bolton's Culture Club aimed to improve patient-centred behaviours among health and social care professionals to create better integration of care within and across health and social care organisations. It adopted a case study approach to challenge the workforce's thinking and was inclusive to all of those working across the sectors.

The Club was funded by the BCF and facilitated by an external, private company. The Culture Club had two different groups: non-manager and managers, both from health, social care and mental health. Staff from administration, new recruits, long-standing employees, trainers, and front-line staff, among others, all attended the Club. Examples of topics discussed at the Club included: What does being person-centred mean? What are the values/principles in a person-centred service?; the impact of our attitude and behaviours on others; tools and techniques to support person-centred approaches (e.g. Five Ways to Wellbeing); and case study discussions.

Critical Enablers

-  Making space for employees of all levels to come together
-  Recognising when something has not worked and working together to find solutions
-  Independently facilitated discussion, inputs and outputs
-  Developing relationships to build trust and respect with other workers
-  Opportunity to understand others' roles

¹²⁹ Local Government Association (2016) *The journey to integration Learning from seven leading localities. Case study Northumberland*. Available at: <https://www.local.gov.uk/sites/default/files/documents/lga-journey-integration-l-c5c.pdf>

4.3.4 Integrated apprenticeships

Integrated Apprenticeship programmes have been developed for potential employees in health and social care to be able to provide person centred care (which is one of the principles of integration), and to gain knowledge and transferrable skills whilst experiencing the different systems and cultures across both sectors. There is a trajectory of integrated Apprenticeships from joint learning through to fully integrated Apprenticeships. This trajectory is likely to be:

Stage 1 - Bringing health and social care apprentices together for joint learning

Stage 2 - Offering rotational placements

Stage 3 - Providing fully integrated roles

Stage 4 - Truly integrated schemes with dual employers

A recent study¹³⁰ of current practice suggests that currently integrated Apprenticeships are at stage 2. It found that integrated Apprenticeships projects were successful in:

- 👤 Encouraging an integrated culture and sharing learning
- 👤 Providing valuable work experience in different sectors
- 👤 Improving partnership working
- 👤 Facilitating the acquisition of a diverse range of knowledge and skills
- 👤 Indicating sustainable integrated Apprenticeship programmes

The top five key challenges were:

- 👤 Complexities of partnership working
- 👤 Sourcing and arranging rotational placements
- 👤 Time and resource needed to support apprentices
- 👤 Recruitment of apprentices
- 👤 Varying terms and conditions/pay

According to the feedback from key experts, locality managers and case study organisations, integrated Apprenticeships are in reality rotational Apprenticeships. The demand for integrated Apprenticeships will track the progress of the healthcare and social care integration strategy, as new integrated roles emerge, requiring integrated health and social care skills, training and qualifications. Rotational Apprenticeships, in the meantime, have been found to be valuable in gaining a wider understanding of the journey people take when they require healthcare and social care support; in giving apprentices an opportunity to decide which career option they wish to pursue and in improving the transfer or sharing of knowledge from one sector to another in the pursuit of improved quality of care.

Plymouth's integrated workforce strategy

Working with the university and the unions, new apprenticeship programmes and career pathways have been developed which enable staff to gain skills in both health

¹³⁰ Skills for Care and Skills for Health (2017) *Scoping Integrated Apprenticeships in Health and Social Care: Final Report*. Available at:

http://learning.wm.hee.nhs.uk/sites/default/files/ICT_Integrated%20Apprenticeships%20Final%20Report%2012%20June%202017.pdf

and social care disciplines through a set of generic competences. The recruitment model has been changed to recruit for attitude and aptitude and provide the necessary skills training. This has resulted in district nursing teams going from 50% down on staff numbers to being oversubscribed. The local authority has been on a significant transformation journey since 2013/14, upskilling existing employees from within the organisation to become specialists in delivering change. This has included a project management apprenticeship programme which has now developed key project leaders from entry level to experts.

Download the full case study [here](#)¹³¹

4.4 Information technology

Information and technology have been identified¹³² as key enablers for the delivery of integrated care designed, commissioned and delivered about the needs of the individual. This section looks at how they are already contributing to three outcomes:

1. Care delivery that is better co-ordinated, interventions that take place early, and citizens needing to tell their story only once rather than multiple times.
2. Commissioners able to make better decisions that deliver value for money including improved outcomes for citizens.
3. Care professionals able to deliver care more efficiently and effectively, working collaboratively across organisations.

4.4.1 Sharing of information

There are perceived to be three objectives for the development of the sharing of information across organisations:

- 👤 People will only have to tell their story once. Professionals are able to see a single and joined up view of the person and their “whole” journey via a shared care record, not just the aspects relating to their particular organisation.
- 👤 People will experience services as more seamless. Services will be more connected – there will be improved information sharing across organisations so that professionals have access to the information they need at the time they need it.
- 👤 People will be supported to remain independent. Information will be used to identify people at risk and support preventative-based approaches to care.

The digital maturity self-assessment¹³³ carried out in early 2016 by the Local Government Association and partners found that 90% of respondents were involved in some form of information sharing initiative across children’s or adult services; only 15% currently contribute to a consolidated view of the citizen’s health and care record, and

¹³¹ Plymouth case study available at:

<https://www.local.gov.uk/sites/default/files/documents/Plymouth%20Case%20Study%20-%20final.pdf>

¹³² Institute of Public Care and Local Government Association (2016) *Transforming social care through the use of information and technology*. Available at:

http://ipc.brookes.ac.uk/publications/LGA_report_on_information_and_technology.html

¹³³ Local Government Association (undated) *Social Care Digital Maturity Self-Assessment*. Available at:

<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/social-care-digital-maturity>

fewer have access to this; however, around 40% have access to information to support transfers of care across care settings from health and care providers.

A small number of regional health and care collaborative communities across England have been invited to bid for national investment in shared health and care records. The regional collaborations will compete to become one of five new Local Health and Care Record Exemplars (LHCRE), each potentially receiving up to £7.5m in national investment, which bidders will be expected to match fund. Each regional LHCRE will build on existing local work on shared records to further develop joined up regional health and care information reference sites, focused on improving direct patient care.

Leeds Person Held Record¹³⁴

Leeds City Council in partnership with NHS organisations across the city has started the development of an open platform-based Person Held Record so as to enable residents to better manage their health online. This is being developed as part of a three year pilot. The technology will be built on an open-source platform for the health and care sector, developed in Leeds by the Ripple Foundation. It is hoped to build up to 1,400 users during the three-year project. The start of the city-wide PHR project follows extensive engagement with individuals, care professionals and stakeholders across Leeds to understand their needs and aspirations. It has been described as being about “*empowering citizens, supporting towards more proactive care, self-management to help towards alleviating pressures felt at the front line*”.

Cumbria¹³⁵

Cumbria is one area that has implemented an electronic referrals and matching system used across health, adult and children’s services – this system is now running over 1,000 referrals a month. The system (Strata) enables NHS Trusts to automatically make referrals to social care (both children’s and adult) reducing form filling and drastically cutting the time needed to make a referral. Similar approaches are now taking place with care providers such as care homes.

The introduction of e-Referrals in Cumbria (through Strata) has been a catalyst for improved communication and goodwill between health and social care partners. Efficiency savings to date across the local area are estimated at £400,000 per year. One practitioner said [it] “saves me an hour’s photocopying for each Continuing Healthcare case”.

Connecting Care: Bristol, North Somerset and South Gloucestershire Partnership¹³⁶

Connecting Care is a partnership across the Bristol, North Somerset and South Gloucestershire area. The partnership comprises 17 organisations (including three

¹³⁴ Digital Health (undated) *Leeds council develops Person Held Record for locals*. Available at: <https://www.digitalhealth.net/2017/10/leeds-develops-person-held-record-locals/>

¹³⁵ Institute of Public Care and Local Government Association (2016) *Transforming social care through the use of information and technology*. Available at: http://ipc.brookes.ac.uk/publications/LGA_report_on_information_and_technology.html

¹³⁶ Institute of Public Care and Local Government Association (2016) *Transforming social care through the use of information and technology*. Available at: http://ipc.brookes.ac.uk/publications/LGA_report_on_information_and_technology.html

councils, hospital trusts, ambulance trusts, GPs and community health providers) with 14 individual client record systems interacting between them.

Client data is gathered from each participating organisation and carefully matched to display an integrated data set for each person. Information is shared securely across the area and is updated on a daily or real-time basis depending on source. Role based access ensures that viewing information is restricted on a 'needs to know' basis. For instance, social workers cannot see medical test results or x-rays. Practitioners have to state a reason for wanting to view a record from a drop-down menu and if valid, are granted time-limited access.

Barnsley's Holistic Care Project is seeking to connect the hospital (Lorenzo) adult social care (Liquidlogic), CACI, and Jontek systems. This would connect patient information across hospital, home care, telecare and reablement services through an information hub.

Some 7,000 people use Barnsley telecare services (such as having a falls detector), and around half of these also receive services such as home care, reablement and community healthcare. Connecting care provision in hospital to care in people's homes gives a direct link which can be used to identify and address problems at an early stage.

In particular:

- 📍 Hospital professionals will have information about the individual's social care history immediately available to allow planning for discharge at point of admission
- 📍 Workers in the community will get real time alerts to intervene, initially focused on falls prevention and medication compliance, and subsequently extending to dementia and better detection of underlying medical conditions

Access to digital care information is expected to bring about many improved outcomes in terms of individuals' improved experience of services and better health, wellbeing and independence. It is also expected to reduce hospital admissions, speed discharge, and reduce bed days. As such, it contributes to Barnsley's Better Care Fund plan.

Over time, the growing volume of information on care processes and outcomes available from the hub will be used to support future service developments.¹³⁷

Berkshire's Connected Care Interoperability Solution

This model aims to align a large number of organisations and systems across the local care system. Embedded context launching has been imperative to high usage (ease of use). This enables a simple, clean, interface within core systems. Enhancements and developments are being worked through by a whole system clinical group.

The technology includes:

¹³⁷ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31391525>

-  Wearable devices that capture activity data and store this data in the cloud (Azure)
-  A mobile application that helps visualise activity and provides insights on progress (using cloud based machine learning). A patient portal that allows access to the Berkshire Record (GP data, results, hospital information, etc.) and provides information, resources and signposting to services¹³⁸.

4.4.2 Enabling integrated commissioning

The complexity of the journeys taken by individuals through the health and care systems, and the range of organisation-specific information systems, create challenges for the commissioner seeking to understand current and future demand and supply across the system. There can also be information governance challenges around sharing information about individuals to inform commissioning decisions. However, as discussed elsewhere in this evidence review, having a focus on a particular place or community is a key characteristic, and the ability to understand demand and supply within that focus is an important enabler of this.

There appear to be relatively few examples of this fully integrated dataset designed to support aspects of commissioning.

The Kent Integrated Dataset¹³⁹ is a whole population place-based person level linked dataset designed and currently co-funded by Kent County Council and the CCGs in Kent. It is used to support evaluation, public health monitoring and demand modelling. The dataset links person level activity and cost data from almost all NHS providers across Kent, including about 70 per cent of GP practices (as at October 2016), acute, community, mental health, out of hours, and hospices and other non-NHS administrative datasets, such as adult social care – and anonymised information is used to support analysis.

Since 2015, nine analytical projects have been being carried out, including: demand and capacity review and matched cohort analysis of the impact of fire and rescue home safety visits on A&E attendances.

4.4.3 Enabling technology

The ability to support mobile and remote working has been recognised as critical to enabling placed-based working and multi-disciplinary team working. Technology which enables care professionals to work remotely and to work in integrated teams includes:

-  Offering secure and remote access to key care systems from offices outside of the estate.
-  Simple collaborative tools such as shared email directories, shared calendars, service directories or instant messaging platforms that can be used across organisations.

¹³⁸ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=31595717>

¹³⁹ Institute of Public Care and Local Government Association (2016) *Transforming social care through the use of information and technology*. Available at: http://ipc.brookes.ac.uk/publications/LGA_report_on_information_and_technology.html

Cross-organisational working: Leeds, Kent and London – Govroam

To support mobile and remote working, including accessing records from cross organisational locations and working in multidisciplinary co-located teams, the concept of 'govroam', a national unified approach, was developed in spring 2016. Its aim is to encourage free movement across sectors and geographical boundaries.

Originally promoted by the Joint Information Systems Committee (Jisc) the Yorkshire and Humber Public Services Network (YHPSN) has been involved more recently as an early adopter, promoting the approach and benefits regionally (including across Leeds City). Other early adopters also include Kent and London region.

Govroam will allow for practitioners from different organisations to connect to systems automatically and securely, e.g. using WiFi, with a single profile, across multiple organisations and sites, with authentication being controlled by the home organisation of each user.

All sensitive data will be encrypted and the aim is to have a wide target audience, including third parties, third and voluntary sectors. It aims to eventually provide a nationally available service which may not be confined to WiFi and may include access by a range of secure devices and mobile networks.

Poole's Reducing Admissions Project has focused on an increase in the use of higher level assistive technology to support independent living. In particular, the Borough has purchased 40 sets of 'Just Checking' equipment which provides a sensor for every door in someone's property. There is a daily report on movements within the property so that mobility and wandering can be monitored remotely. This promotes individual and family confidence and provides a remote view of events. The Borough tend to leave the equipment in situ for a week or two and then the family can rent similar equipment if they require continuation of the confidence it brings.

Beyond the use of technology, the project also covers provision of respite for carers – enables them to have a break from their duties. The Council funds step down beds for interim care in local residential homes in Poole at no cost to clients. The use of the step down bed promotes recovery.

Short term night care service funded by the council allows people to go home where neither they nor family and carers has confidence that they can cope with nights at home. The service comprises 2 people who provide a sit-in night care service at no charge for 2-3 weeks to build confidence that the client and carer can cope at home.

The groups of staff involved have a diverse range of experiences, so the support element is particularly crucial in spreading good practice and growing confidence across the team. The entire process has enabled the team to learn to 'think outside the box' and to take appropriate risks where they might otherwise take the obvious route.¹⁴⁰

¹⁴⁰ <https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=29444965>

4.5 Conclusion

This section has considered the evidence at a high level across a range of whole system enablers. Whilst a more detailed analysis would provide a greater understanding of the significant variety of approaches being taken in these areas, there are themes emerging which relate to the vision:

- 📍 Developing shared outcomes to inform commissioning activity creates and supports a shared vision for integrated care. It provides a mechanism which helps develop a different relationship between commissioners, providers and citizens. It also provides a starting point for tackling the difficult issues such as risk sharing and funding.
- 📍 It is unclear what the relationship is between the integration (or not) of commissioning functions and the delivery of better outcomes for individuals. However there is clear recognition of the potential benefits of commissioning in some form across a system both in terms of strategic commissioning and within that of procurement.
- 📍 The Better Care Fund has been successful in places in incentivising joint working, and this in itself can support the development amongst partners of a greater understanding of different parts of the system as well, potentially, of building transparency.
- 📍 Budget sharing mechanisms are seen as a way of creating opportunities for taking joined up or integrated approaches to the commissioning and delivery of services. They require partners to resolve the challenges around risk sharing, as well as requiring a clear understanding of expenditure across the system on a specific issue.
- 📍 The availability of the workforce is a major challenge for the delivery of integrated care, but there is limited evidence of the development of integrated workforce planning. However, there is more evidence of workforce development which either takes an integrated approach to its delivery (for example having a focus on a particular care pathway) or is designed to develop new behaviours and skills as needed to work in an integrated system.
- 📍 Whilst there is evidence that organisations are beginning to tackle the challenge of information sharing across systems this is still in relatively early stages; it is however widely recognised as a major enabler for the delivery of integrated care.
- 📍 There is limited evidence of areas using information technology to support whole system commissioning, nor does it appear to have been recognised as key to the delivery of integrated care. Information technology as an enabler for integrated working is also relatively under-developed in terms of the evidence.