

From the Ground Up

A report on integrated care design and delivery



About CHP

Community Health Partnerships (CHP) is an independent company, wholly owned by the Department of Health. It was established to deliver a new model of investment into primary care, Local Improvement Finance Trust (LIFT), a national programme of public/private joint ventures designed to deliver clean, modern, purpose-built premises and public sector infrastructure.

The LIFT programme has been instrumental in delivering a strategic step change in primary and social care facilities. By the autumn of 2009, 48 LIFT companies had been established in England, working with local public sector organisation to provide bespoke, tailor-made facilities. These companies have generated over £2,000m in investments to develop more than 250 new integrated community buildings, which include a wide variety of services delivered to promote healthier communities.

About ICN

The Integrated Care Network (ICN) has over 7,000 registered members and provides information and resources to frontline NHS, local government and third sector organisations seeking to improve the quality of support to service users, patients and carers by integrating the planning and delivery of services.

Key to the role of ICN is facilitating communication on integration between frontline organisations and government in order to support the implementation of policy and adoption of practice.

ICN is part of DH Care Networks and further information can be found at www.DHcarenetworks.org.uk/icn/

About IPC

The Institute of Public Care (IPC) is one of Britain's leading knowledge transfer organisations working across primary care, social care and supported housing. A Centre of Oxford Brookes University, its purpose is to enhance the quality of services received by users of public welfare organisations through:

- Applied research and consultancy.
- Management practice and development
- Dissemination of knowledge.
- Information management (including specialist software development).

Published January 2010

Contents Page

Joint Foreword

1. Introduction

- 1.1 Purpose of the Report
- 1.2 How it has been developed and how is it structured
- 1.3 Accompanying materials

2. Understanding Integrated Care

- 2.1 What do we mean by integrated care?
- 2.2 Identifying issues in integration
- 2.3 Defining the characteristics of managing integrated care

3. Eight Elements of Integrated Management Practice

- 3.1 Building on partner strengths
- 3.2 Identify a common need and set of outcomes
- 3.3 Integrated management and governance
- 3.4 Defining service user pathways to determine what to integrate
- 3.5 Engaging stakeholders in the design and delivery of services
- 3.6 Getting quality information
- 3.7 Integrating the workforce and workplace management
- 3.8 Defining the infrastructure, buildings and facilities

4. Integrated Care – The Case Studies

- 4.1 Case Study 1: The Walkden Centre, Salford
- 4.2 Case Study 2: Mill Rise Village, Knutton and Cross Health, Staffordshire
- 4.3 Case Study 3: Community Homes Resettlement Project, Norfolk
- 4.4 Case Study 4: Oxfordshire Older People's Services

5. Conclusions

6. Appendix

- 6.1 Integration: Policy time line
- 6.2 Annotated bibliography
- 6.2 Websites and organisations

Joint Foreword

A cornerstone of government thinking is the need to improve the integration of services. Some of the mechanisms are enshrined in the NHS Act 2006 and further emphasised in subsequent policies and strategies such as the Putting People First concordat, Lord Darzi's Next Stage Review of the NHS, and more recently the Care and Support Green Paper, Shaping the Future of Care Together. As a consequence, we now have a firm commitment to integrated working across health and social care economies, and wider community services. We are looking to build on this.

Importantly, at a local level, commissioners and providers are also now increasingly taking into account the experiences of service users and patients and making improvements in the way services are designed and delivered.

From the Ground Up, and the accompanying guide, re-enforces the benefits of integration and underlines the two key components required to make integration work – strong local leadership and sound organisational approaches. Clearly one without the other is not likely to lead to sustainable practice. It also offers helpful ideas and checklists to ensure that the goal of integration does not get lost in the detail of achieving it.

The report also conveys another message. That integration need not involve huge service re-design, it can mean integrated commissioning, integrated management or service delivery, or integrated premises and facilities. Integration is not prescriptive and does not have to adhere to a single model, typology or approach. The test is will the outcomes for service users and patients be improved if these services are brought together, and will it deliver benefits to all stakeholders.



David Behan
Director General Social Care,
Local Government and
Care Partnerships



Dr Sue O'Connell
Chief Executive,
Community Health
Partnerships

1 Introduction

1.1 Purpose of the report

This report was jointly commissioned by Community Health Partnerships and the Integrated Care Network and compiled by the Institute of Public Care, Oxford Brookes University. It aims to support service commissioners; including those involved in planning, service delivery, finance and infrastructure as well as local partnerships, who are looking to develop integrated care services. The report:

- Offers an overview of the policy framework for integration.
- Presents an outline of the approach to integration taken by four examples of different types of integrated care service.
- Analyses the elements of success in integrating care, and presents a model of design and delivery for managers to consider in relation to their own services and planning new facilities.
- Concludes with a range of hints and tips based on the research undertaken to develop this document.

1.2 How has it been developed and how is it structured?

The report is based on background research conducted over a period of five months by the Institute of Public Care, Oxford Brookes University. This included:

- A desk based review of available academic literature, policy documentation and guidance published by the Department of Health and other health, housing and social care organisations.
- A series of interviews with a range of stakeholders involved in supporting the development of integrated care at a national policy level.
- Telephone interviews with commissioners, facilities and service managers, finance teams and providers, as well as associated partners across England, in relation to developing and delivering integrated services.
- Four in-depth case studies of integrated services and facilities looking at the processes by which the services were identified and developed.

1.3 Accompanying materials

Community Health Partnerships (CHP) and the Integrated Care Network (ICN) have also produced an 'easy to follow' guide. This is in 3 parts:

Part 1: The Context and policy timeline

Part 2: Toolkit

Part 3: Case studies

The guide can be downloaded from their respective websites. In addition, a wall chart to help planners, commissioners, asset managers and providers who are seeking to integrate services and buildings is available to download to get printed.

2 Understanding Integrated Care

Integration has been a theme of health and social policy since the inception of the welfare state. It has been given added impetus in recent years with a shift towards the greater personalisation of services, effective partnership funding, better joined up working, the search for greater efficiencies and improved outcomes for patients/service users.

The most recent drivers for integration include:

- Better access to services, more local provision and commissioning care to support well being through preventative measures highlighted by Lord Darzi's Review, High Quality Care for All¹ and Transforming Community Services².
- Putting People First through needs based commissioning to provide equitable access to services and a single community based support system³.
- Harnessing the whole system to deliver better outcomes for people through extensive needs and market analysis to shape the care environment, and the transformation of communities⁴.
- Developing sustainable communities in recognition of the link between high quality buildings and services, housing, transport and the local environment, and health and well-being⁵.

Importantly the principles on which these changes should be based include:

- Identifying population needs through public health analyses and frameworks for joint commissioning such as local area agreements and joint strategic needs assessments to deliver acute, primary and social care and health and social services for local populations.
- A new emphasis on partnership arrangements by enabling financial legislation through the introduction of section 31 flexibilities of the 1999 Health Act (and latterly section 75 of the 2006 update, The National Health Service Act).
- The improvement of links between segregated services to provide seamless, high quality services for the tax payer.
- Commissioning care and services for local populations.
- The promotion of overall well-being and a focus on prevention rather than the treatment of specific disease or ill-health.
- Placing the service user/patient at the heart of the new system by focussing on outcomes.
- Realising the cost efficiencies that integration can bring to free up resources for priority spending.

Yet despite this major push from government, the development of integrated care services across England remains patchy; and understanding what constitutes integrated care can be difficult with several of the managers and commissioners interviewed for this report commenting "*...it's difficult to describe, but we all know it when we see it*"⁶.

¹ Department of Health (2008), High Quality Care for All (2008)

² Department of Health (2009), Transforming Community Services

³ HM Government (2007), Putting People First: a vision and commitment for the transformation of adult social care

⁴ Department of Health (2009), Transforming Community Services

⁵ Department of Communities and Local Government (2003), Sustainable Communities: Building for the future.

⁶ Key stakeholder interview

A timeline of key developments in integrated care since 1997 is given in 6.1.

2.1 What do we mean by integrated care?

Several attempts have been made at defining integrated care. The most recent of these include the Integrated Care Network (ICN) publication *A Practical Guide to Integrated Working*⁷ which describes integrated care services as:

“... a single system of needs assessment, service commissioning and/or service provision”

and argues the fundamental principle for integrated care is:

“... to improve the quality and appropriateness of services and support received by users... and ... service user experience and outcomes”.

*Integrated Care: A guide for policymakers*⁸, published by the World Health Organisation suggests services can be integrated at a functional, organisational, professional and/or clinical level; with integration happening across organisational boundaries to align strategic approaches to care (vertical integration) or within organisations and across departments (horizontal integration). In practice however, integrated care services can range from basic co-location of services which complement one another and provide service users and patients with a one-stop-shop approach to care, through to specific integrated care pathways, in which everyone understands what each other is doing to deliver a seamless set of services based on health, social and well-being. Leutz^{9, 10} had already introduced his six laws of integrations following research in both America and the UK, stating:

- It is possible to integrate some of the services for all of the people, and all of the services for some of the people, but it is essential to target service integration where it is most needed, otherwise it can be both costly and result in decrease in quality.
- There are some areas which will always remain difficult to resolve eg the different approaches between funding health and social care. It is therefore up to the practitioners to develop approaches to ensure the user experience is not lessened by these differences.
- Integration requires both initial investment and also time and resources to implement. It will take a long time to establish and requires complex cultural and practical change.
- There may be unintended outcomes to integrating services. Integration to one person may result in the fragmentation of another service to another user. It is important to consider this when planning services.
- Integration should involve the patient or service user in its design if it is to be successful. This requires managers to actively seek out service user views, and to understand the drivers for integrating a service from all perspectives.

⁷ Thistlethwaite, P. (2008), *A Practical guide to integrated working*. Integrated Care Network

⁸ Lloyd, J. and Wait, S. (2006), *Integrated Care: A Guide for policymakers*. Alliance for Health and the Future. London, England,.

⁹ Leutz, W. (1999), Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *The Millbank Quarterly* 77(1):77-110

¹⁰ Leutz, W. (2005), Reflections on Integrating Medical and Social Care: Five laws revisited. *Journal of Integrated Care* 13(5): 3-12

- Integration happens at a local level, arguing that all the national policy guidance in the world would not successfully integrate services without local buy-in.

2.2 Identifying issues in integration

Despite the extensive literature and push from Government to integrate care services, it is clear there is no simple formula and that integration remains difficult for many organisations. The reasons for this are unclear, although the historical and structural differences between health organisations and local authorities are deeply rooted and difficult to overcome, with significant variations in the way that care is managed and commissioned¹¹. For example, social care relies on service user contributions, and has a considerable history of outsourcing, meaning the decision about the location of provision does not always rest with commissioners. It is currently focussed on giving service users a greater say over their care in particular through transferring the fiscal means of control, whilst the purchase of care remains a means tested provision in England. In comparison, health services are free at the point of access. They are organised around conditions and disciplines with a tradition of professionals making decisions on behalf of patients. Service purchase still remains predominantly in the hands of commissioners as do decisions about location.

There are examples of where integration has worked well. For example, services aimed at supporting those with learning disabilities or mental health issues, where the use of legislation and Health Act flexibilities has brought about significant changes in the structure and provision of care, has led to marked improvements in outcomes for service users¹². However, more often than not, what underpins success is the commitment of individuals involved in delivering services to changing practice, by moving away from more institutionalised approaches to care. In the case of clinically integrated systems within the NHS, Chris Ham¹³ asserts that national policy can act as both a facilitator and a barrier to integration, especially when the incentives at a local level are underdeveloped. In these cases, the success or failure of the integrated services depends heavily on the dedication and tenacity of local teams to continue to deliver services, regardless of the barriers or setbacks faced. A recent review of integration in six European countries came to similar conclusions, highlighting that successful integration is dependent not just on the co-ordination of management structures, but also professional values and interests of those involved.¹⁴

This points to the need for substantial changes to the culture of care delivery, with the policy makers, commissioners and managers we interviewed arguing that: “...people don’t want to continue to work in a muddle”¹⁵, and “... we need to simplify processes so it is easier for people to get hold of the right types of support”.¹⁶

¹¹ Glasby, J (2003), Hospital Discharge: Integrating Health and Social Care. Radcliffe Publishing

¹² See Appleton, S (2009), Integration and learning disability: A briefing paper for the Integrated Care Network; Appleton, S (2009), Integration and mental health: A briefing paper for the Integrated Care Network; Appleton, S (2009), Integration and older people: A briefing paper for the Integrated Care Network.

¹³ Ham, C (2008), Integrating NHS Care: Lessons from the front line. The Nuffield Trust.

¹⁴ Mur-Veeman I, van Raak A, and Paulus A (2008), Comparing integrated care policy in Europe: Does policy matter? Health Policy. 85: 172-183

¹⁵ Interview with PCT commissioner

¹⁶ Key stakeholder interview

But, obtaining support to address this is difficult; partly because the amount of investment in terms of both money and resource is substantial, and also because a single solution is often inappropriate. These practical issues pose real challenges for joint commissioning and service delivery, from trying to align budgetary cycles, through to understanding which pathways can be usefully integrated and which should remain separate. In particular, areas which are likely to be of significance are:

- **Personalisation:** Both health and social care are undergoing significant changes in their approach to care, moving away from support and the treatment of disease towards re-ablement and well-being¹⁷. This change requires investment in time and money to ensure staff are appropriately trained and developed, and will demand new ways of working within local authorities and health care organisations. Managers will need to examine the boundaries between services, and look at how care can be delivered within a more personalised environment with increasing choice and independence.¹⁸
- **Procurement:** Decisions need to be made about what is procured together or individually, who does what and how to accommodate different ways of working. Good top-level leadership and drive from the local authority, the PCT and the LIFT Company (LIFT Co) are all needed if the complexities of working together are to be successfully tackled. However, leadership alone is not sufficient, there also needs to be a robust project management and review process. If integrated schemes are to work well then obstacles need to be identified in advance and removed (tools such as Strategic Health Asset Planning and Evaluation tool and work of the Healthy Urban Development Unit in London can also assist in this area).¹⁹
- **Governance:** The level of, or differences in, autonomy across organisations can hinder significant changes to services or facilities where one partner has a vested interest in maintaining the status quo. For instance, PCTs are answerable to the Strategic Health Authority, but local authorities are accountable to elected members who bring different and frequently conflicting agendas to the table when making decisions around large investments in services.
- **Indicators:** Differences in performance management regimes and indicators do little to enhance the delivery of joint ventures and services between PCTs and local authorities, and can often mean duplication in terms of monitoring services. Integration is more likely to be driven by a stronger focus on outcomes rather than continuing to measure performance through the volume of service or treatments available. It is important to agree locally what success would look like for the local community, and measure progress against corresponding outcomes with appropriate indicators.
- **Investment:** The ongoing implications of a significant economic downturn on the money available for service development and renewal may mean some organisations are reluctant to take the risk of investing in substantial service development and capital projects. However, restrictions on spending may also help to act as an incentive to drive service provision closer together particularly in some geographical locations where travel and infrastructure costs are high and the growth in the older peoples' population and/or long term conditions are

¹⁷ For example, see the Department of Health's CSED Homecare Re-ablement approach

¹⁸ HM Government (2009), Shaping the future of care together Green Paper. Department of Health.

¹⁹ Community Health Partnerships (2008), LIFT – Enabling Integrated Services, Co-location and Partnership Working. Community Health Partnerships; the Department of Health Strategic Health Asset Planning & Evaluation tool; and the Healthy Urban Development Unit (HUDU) toolkit.

at their greatest.²⁰ LIFT Co can help with clarifying options available and how to move forward with an integrated approach:

*"LIFT Co will act as the strategic accommodation services planner for the health and social care economy in the Area in cooperation with the Participants."*²¹

- **Innovation:** The new duty to innovate²² challenges strategic health authorities to respond to local needs, involving where possible patients, carers and the public in co-designing innovative solutions. In the context of enabling integration, this could add yet another layer of complexity to the integration agenda – or it could act as a catalyst to help ensure that local imaginative solutions are formulated for local people and communities.

Yet in many cases these challenges may also provide opportunities for better integration through:

- Developing partnerships between providers.
- Looking at how existing legislation can help to overcome barriers to working together.
- Redesigning care pathways.
- Testing out new and innovative approaches.²³

In a policy environment that has seen an increasing emphasis on outcomes and individual choice, an increase on the ground in integrated services providing a simplified easy-to-use experience for individuals is a crucial step in achieving those policy objectives. Local and national agendas will form parameters that shape the nature of the integration and also provide opportunities for innovation.

2.3 Defining the characteristics of managing integrated care

From the case studies (see section 4) and the literature review there are clearly a range of characteristics which describe integrated care services. For example:

- They tend to be based upon partnerships between health, social care and housing.
- Usually (although not exclusively), services are focussed on specific care pathways.
- They have a focus on outcomes which comes from a thorough understanding of local need and a shared understanding across partner organisations about what they are trying to achieve.
- They bring together different areas of expertise to help achieve specific patient or service user outcomes.

²⁰ Department of Health (2009), Use of Resources in Adult Social Care: A Guide for Local Authorities

²¹ Clause in the LIFT Strategic Partnering Agreement

²² The new legal duty for SHAs to promote innovation has been made through directions given in exercise of the powers conferred on the Secretary of State under section 8 of the National Health Service Act 2006. These directions apply to every Strategic Health Authority in England. See Department of Health (2009), Creating an innovative culture: Guidance for strategic health authorities (SHAs): a new duty to promote innovation. Department of Health.

²³ Department of Health (2009), Integrated Care Pilots: An Introductory Guide. (In July 2009, 16 Integrated Care Pilots began a two year programme to test and evaluate innovation in integrated care..

- Integration is designed to make services more streamlined and, ultimately, more efficient through the better co-ordination of resources and information to prevent hospital admissions and reduce pressure on acute services.
- Integration may develop serendipitously through co-location, but more commonly tends to occur because of a mixture of overarching goals and operational policies; the restructuring of managerial relationships to better align processes and decisions; and/or financial integration through pooled budgets and combined resources.
- A shared understanding of the difference between value-for-money, affordability and cost.

These characteristics do not arise by chance and represent a series of challenges, and opportunities for managers. Some of them are organisational, some are more to do with the style of leadership on offer. These challenges include:

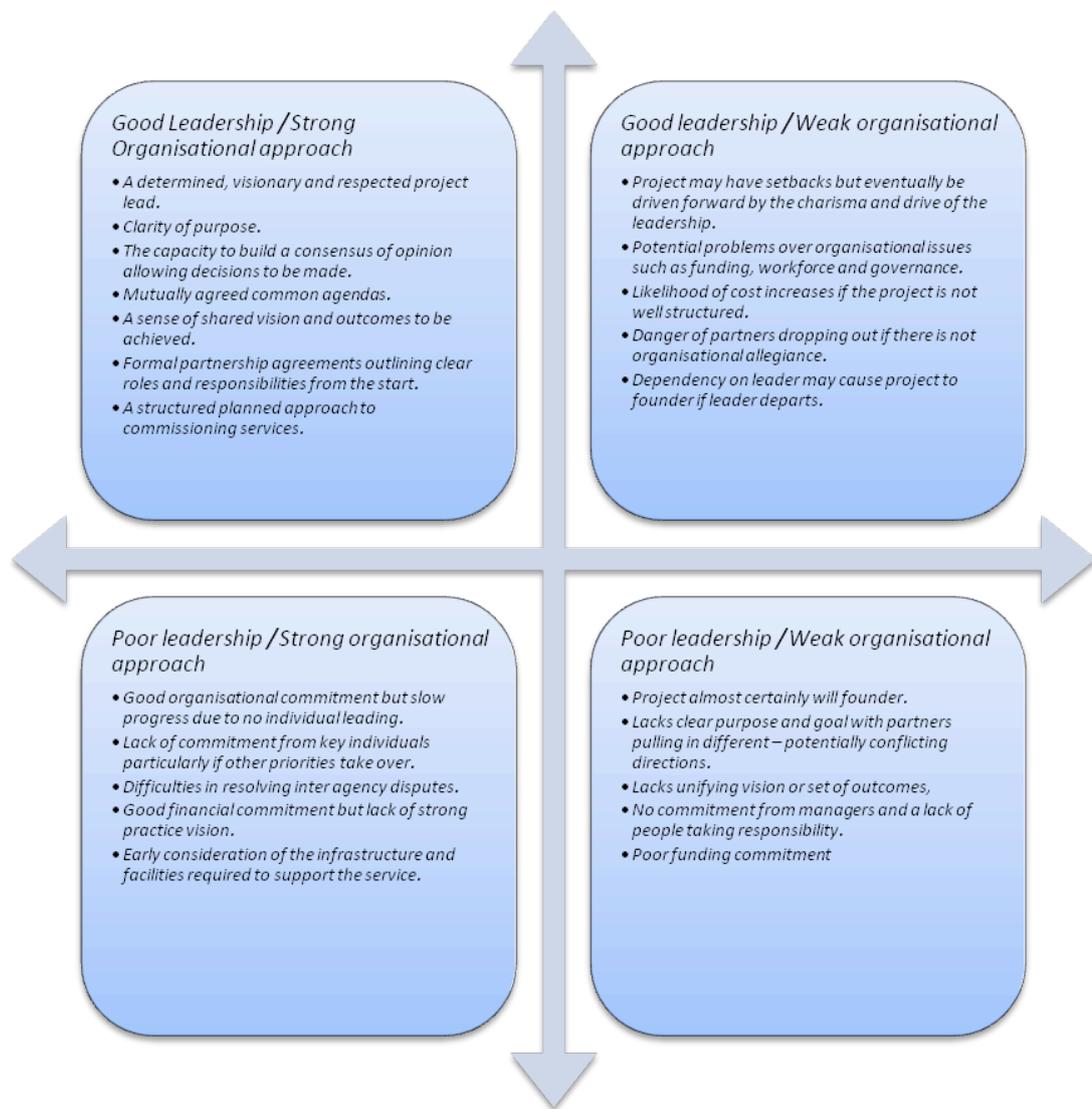
- Ensuring value for money through investment which provides better, more appropriate services that meets the needs of local populations.
- Identifying resources and funding through allocation of existing funds, or through accessing funding streams from public and/or private partnerships and seeking efficiencies by maximising value for money eg, by aligning health, social care, and housing amongst others.
- Developing the infrastructure for integration so that it enhances the way in which people work and is tailored to deliver the required outcomes, rather than adding an additional layer of bureaucracy.
- Designing a Strategic Service Delivery Plan²⁴, recognising that *"Buildings and infrastructure are the slowest of strategic resources to respond to change"*²⁵.
- Utilising telecare and telehealth technologies²⁶ using the opportunities provided through redesigning care pathways.
- Establishing working relationships and a culture which supports integration.
- Deciding whether or not the service is a bolt on to existing services or part of the core business.
- Working with the differences in management approach and boundaries within health organisations and social care.
- Resolving the practicalities of dealing with different needs and performance management systems such as case management, common assessment frameworks, joint commissioning.

Over and above these particular characteristics and challenges, there are basically two defining features that drive successful integration: strong and determined leadership, and a structured and purposeful approach to project management. These twin themes of organisational management and leadership approach can be arranged into a two dimensional matrix as the diagram following illustrates.

²⁴ The Strategic Service Delivery Plan is a document that should *"bring together the service vision of local public sector organisations to describe a local economy service strategy to radically improve the health and well being of local communities. It should identify the new facilities needed to deliver that strategy and link health and social outcomes with infrastructure development"* CHP Guidance (2005)

²⁵ Pam Chapman, Head of Strategic Asset Management Department of Health at the Department of Health's Transforming Community Services workshop

²⁶ The Department of Health funded Whole System Demonstrator (WSD) programme is a two year research project to find out how technology can help people manage their own health while maintaining their independence.



Therefore, where an organisation, or a group of partners, sits within the matrix, is likely to determine success in developing an integrated service. Obviously, to have the best chance partner organisations need to try and position themselves in the top left hand corner, with strong leadership and a well structured approach to organisational change and delivery.

Eight elements of management practice have been defined through case studies which can help to drive integrated care and cut across these twin themes of leadership and organisational management.

Eight Elements of Integrated Management Practice



These eight elements of integrated management practice are explored in more detail in the next section. They are illustrated by case study examples showing how the various elements are displayed in practice.

3 Eight Elements of Integrated Management Practice

This section identifies eight key elements of Integrated Management Practice that came through the lessons learned from the four case studies highlighted in section 4. The elements are:

1. Building on partner strengths:

Case Study example: Mill Rise village, Knutton and Cross Heath, Staffordshire

Throughout the interviews for this guide, commissioners and policy makers spoke about the importance of partnership working stating that:

“... [successful] integration is based upon really strong insoluble partnerships as a result of time and long-standing relationships.”²⁷

“... professionals need to be able to understand commonalities as well as each other’s specialities... it’s about learning to respect those who can get the best outcomes [for the service user]”²⁸

Recognising that each partner brings to the integration discussion a unique skill set and expertise²⁹ is important. This includes building relationships and understanding how each partner works, their priorities, standards and budgetary timescales.^{30,31} Each of the examples outlined in the case studies spent a considerable amount of time establishing their partnerships, prior to and during the development of the service.

Steps to support this include *The Commissioning Framework for Health and Well-being*³² which focuses social care commissioners on developing strategic approaches to investment to secure reductions in the cost of ill-health in the future. And, at the same time, *World Class Commissioning* sets out a vision for commissioning services through PCTs working with partners to optimise the delivery of effective care whilst *Transforming Community Services* pushes PCTs to consider the development of services within the context of the local area agreement and local strategic partnerships.

2. Identifying a common need and set of outcomes:

Case Study examples: The Walkden Centre, Salford; NHS Norfolk and Norfolk County Council

A common need for, or vision of, a service helps in enabling partners to work through the difficult stages of service development and ensure the work programme does not falter. As one manager clearly stated *“...Developing a shared vision when the starting points between health and social care are so very different is a real challenge for commissioners and managers”³³* across health and social care alike. At the heart of this should be the Joint Strategic Needs Assessment (JSNA). However, in relation to the construction of specific services, JSNAs may not provide enough detail, and it may be necessary to carry out considerable additional work to make the leap from broad based demand to the specific identified need for a particular service. It is often helpful to identify first and foremost the outcomes that partners are trying to achieve before moving into the detail of planning provision. Common outcomes can then be used as a basis against which future decisions can be made about outputs and action plans.

²⁷ Local Government Association interview

²⁸ Key stakeholder interview

²⁹ Gleave, R (2009), *Across the Pond – lessons from the US on integrated healthcare*. The Nuffield Trust.

³⁰ Eg Peck, E and Crawford, A (2004), *‘Culture in Partnerships – what do we mean by it and what can we do about it?’* Integrated Care Network. Department of Health

³¹ Eg Watson, L. (2007), *Presentation on managing change in long term conditions*. Integrated Care Network. Department of Health.

³² Department of Health (2007), *Commissioning framework for health and well-being*

³³ Key stakeholder interview

3. Integrated Management and Governance:

Case Study example: NHS Norfolk and Norfolk County Council

“...Partnerships present a challenge to the principles of public sector corporate governance... [and are]... an area of considerable complexity and potential confusion.”³⁴

Although not the most exciting end of planning integrated care, having robust management and governance arrangements are an important component of successful projects. For some of the case studies using health act flexibilities was a key part of their arrangements. However, it is not essential and does not apply where health services are not part of integration plan. In general managers felt there still needed to be better alignment between national drivers across health and social care.

Best practice from the literature and the case studies presented here would suggest overcoming these difficulties through:

- Formal partnership agreements outlining clear roles and responsibilities from the start.
- Developing mechanisms to ensure that business is conducted in an open and transparent manner.
- Conducting independent evaluations of the work of the partnership to provide useful feedback and identify the benefits.
- Developing integrated performance frameworks for the partners.
- Actively seeking the involvement of service users and carers throughout the development of a partnership and ensuing service³⁵.

4. Defining Service User Pathways to determine what to integrate:

Case Study Examples: The Walkden Centre, Salford; Oxfordshire Older People's Services.

Mapping service user pathways and understanding peoples' route into, through and out of services can clearly help in the alignment of provision. It can help identify which elements of the service are amenable to integration and the areas which need to be addressed, such as information sharing and the skills and expertise needed to support the user. Examining the referrals process and looking at ways of improving initial assessments can often help to target resources more effectively, by ensuring the right support is provided at the right point in time. In defining pathways it is important that partners listen to the experience of service users. Well conducted consultations will quickly and invariably reveal the trail of where there is duplication of provision, or where a service is poor because one element does not know what the other is delivering. Moreover, by introducing new service user pathways, managers and providers will need to think carefully about how they respond, and what additional skills their staff are likely to need in order to be able to deliver care effectively.

5. Engaging Stakeholders in the design and delivery of services:

³⁴ Sullivan, H. and Skelcher, C (2002), Working across boundaries: collaboration in public services, Basingstoke, Palgrave.

³⁵ Glasby, J. and Peck, E (2004), Integrated working and governance: a discussion paper. Integrated Care Network. Department of Health

Case Study Example: Mill Rise Village, Knutton and Cross Heath, Staffordshire

Stakeholder engagement is increasingly seen as an essential part of developing a patient centred approach to delivering health and social care by:

- Informing the design of services and ensuring they meet the need of the user and their carer.
- Exploring the impact of the service on all those involved by bringing together a range of expertise and knowledge.
- Helping to establish support and buy-in for service change, allowing managers to identify the areas which are likely to have most impact.

Service users and carers can provide useful insights to the design and development of services; whilst consulting with a range of professional and clinical stakeholders such as clinicians, representatives of the acute and secondary sector, and social care providers can help ensure that services are integrated across organisational boundaries. Understanding who the stakeholders are for each service, and adopting a structured approach to their involvement helps to maintain the momentum for projects; identify issues as they arise and find solutions when things do not go to plan. A range of activities can be used to support stakeholder engagement including user forums, focus groups, formal consultation exercises and regular open meetings. The key to success is having someone take responsibility for overseeing the process and that messages are consistent.

6. Getting quality information:

Case study examples: The Walkden Centre, Salford; Oxfordshire Older People's services

There are a number of different types of information that drive and support integration. For example:

- Information that provides the rationale for change, eg, service users experience of duplication and waste.
- Information to manage the business, eg, common referral and assessment processes.
- Information about performance, eg, has integration produced better outcomes for service users.

There are often hurdles to be overcome in developing common information systems. For example, concerns about confidentiality may be genuine, they may equally be an excuse on which to hang a refusal to change existing practice with some arguing “... *it's too easy for commissioners...[and managers]...to find reasons not to integrate services.*”³⁶ But, there are often real practical issues which need to be overcome including working out what information is relevant and needs to be shared, as well as ensuring that the types of data collected can provide the information each individual partner organisation needs. For example, information sharing should be focussed on improving the co-ordination of care and supporting performance management arrangements³⁷, but local authorities often have a large range of projects with complex information needs and information sharing arrangements can include more than one PCT, and in shire counties these arrangements are only confounded by the

³⁶ Key stakeholder interview

³⁷ Gleave, R (2009), *Across the Pond – lessons from the US on integrated healthcare*. The Nuffield Trust.

two-tier relationship between the county and the various districts³⁸. In these cases, information management across organisations is also hampered by the pace of change driven by central government and it is all too easy for organisations to view only their data needs and requirements when there are variances in the way data is collected and managed between different health organisations within one area.

Yet integration needs a strong evidence base, particularly if it is to overcome historical inter-agency or interdepartmental prejudice. Being able to argue why there are benefits in combined provision, together with the costs and consequences of not combining, will be important in developing the case for integration. Some of this will mean focussing on the outcomes to be achieved rather than on what outputs are to be delivered.

7. Integrating the workforce and workplace management:

Case study examples: Community Homes Resettlement Project, Norfolk; The Walkden Centre, Salford; and Oxfordshire County Council

There are a range of practical issues around integrating separate workforces. For example: the NHS is an employer in its own right, with competition for staff between primary and acute trusts, and increasingly from private sector providers. With its strong brand and range of specialist roles, it is easy to identify NHS employees and to monitor, evaluate and to respond to any deficit in the workforce. In contrast the social care workforce is much more diverse, with a range of different structures and approaches; from in-house provision through to externally commissioned services providing a range of services with different goals and functions. Complicated by employment legislation, formal integration (where there is to be a transfer of staff from one organisation to another) can cause significant delays to the development of a new service, and needs careful navigation with input from human resources and legal services³⁹.

8. Defining the infrastructure, buildings and facilities:

Case study examples: All case studies

Research from the Picker Institute (2009) highlights the importance of the good building design to the patient experience and quality of care. The overall functioning and efficiency of buildings contributes to the care experience, and impacts on workplace efficiency, recruitment and job satisfaction for staff⁴⁰ and well designed buildings and infrastructure can help deliver better integration between services. Yet whilst this is the case, the infrastructure and facilities needed to support integration are often over looked until the end of the service development, but to be effective should be more than an afterthought.

Suitable infrastructure requires a substantial amount of investment, sound project skills to manage the process and access to a range of experts to deliver it. Local authorities and healthcare organisations often struggle to resource such projects stating “... *there is tension between operational management and project management in large scale facilities development*”⁴¹ compounded by the fact there is

³⁸ Russell, P (2003), Data sharing: The key issues – a local authority perspective. Department of Health

³⁹ Citerella, V (2009), Advisory note 5: Integrating the Workforce. Care Service Improvement Partnership: Integrated Care Network

⁴⁰ Sheldon, H., Sinayuk, L. and Donovan, S. (2009), Designing GP buildings: Staff and patient priorities for the design of community healthcare facilities in Lambeth. Picker Institute, Europe.

⁴¹ Key stakeholder interview

a growing difference “... between health and adult social care, with the latter pulling away from service delivery requiring investment in capital assets.”⁴² Maximising upon opportunities available to health and social care organisations through the involvement of specialist help via an area’s LIFT Co, can address the issues around meeting a range of different agendas. Moreover, the LIFT Co brings with it the necessary project management and planning expertise to help develop local health, social care and well-being infrastructure and supports better and more efficient procurement processes to increase value for money.

4 Integrating care – The Case Studies

This section describes the four practice examples which have contributed to the development of the integrated management model guide. Each of the examples shows how local areas have tried to respond to significant policy developments. They cover:

- The range of different types of integrated services which can be developed to meet policy requirements.
- The areas which had to be addressed by service managers, project teams, commissioners and providers in order to deliver integration.
- The critical success factors which enabled the organisations to integrate their care provision.
- The issues which commissioners, managers and project teams faced in developing each of the services, and importantly how these were overcome.

Interviews were undertaken with a range of people involved in the development of each of the services, such as:

- Representatives from the PCT and local authorities involved in developing the services such as health and social care commissioners, project managers, finance teams, estates managers.
- A range of organisations which were involved in the delivery of integrated care such as local development agencies, GP practices and service providers.
- Staff involved in delivering the services.
- Service users and patients where possible.

The case studies provide examples of how the eight elements described in the preceding section were dealt with by local teams. Each of the elements covered by each study is indicated within the diagram in dark blue.

⁴² Key stakeholder interview

4.1 Case Study 1: The Walkden Centre, Salford



Overview

- A joint service centre providing accessible primary care and local authority community services.
- One of three completed centres across Salford.
- Integrated Customer Services functions allow cross-referrals between local authority and primary care services.
- Supported by IT systems and management structures which allow better integration.

Background and Building on Partners' Strengths

In 2000 Salford was ranked the ninth most deprived district in England with high mortality and unemployment rates; child poverty amongst the worst in England and high incidences of chronic diseases.

To improve the health outcomes for the local population Salford Partners⁴³ began to explore the development of a series of new and enhanced primary healthcare centres across the city which would relocate services from the Acute Trust into more accessible and convenient locations. However, discussions between the NHS and the local authority soon revealed they were trying to address a common set of needs and issues across both organisations, including:

- That service users across organisations were often one and the same, and that user needs are frequently inter-related. For instance, poor health is linked to poor housing, whilst poor education and unemployment often go hand in hand.
- The common need to renew local health **and** community infrastructure in an area where there are considerable health inequalities and deprivation.
- The need to provide accessible services in areas where local people 'go' in order to raise awareness and usage of existing services across the whole of Salford.
- The potential benefit of developing a 'life-trigger' model where service users could be signposted and referred to a range of different services across the NHS and local authority by better information sharing and collaborative working.

By working together at the planning stage with the local Manchester, Salford and Trafford (MaST) LIFT Co; the PCT and local authority recognised they could target their shared audience more effectively and achieve economies of scale to provide better and more appropriate infrastructure for Salford's residents. It was agreed the

⁴³ Consisting of Salford Royal Hospitals NHS Trust, the NHS North West Executive, Salford and Trafford Health authority, Salford City Council, the University of Manchester, Salford Community Health Care NHS Trust, Salford East Primary Care group and Salford West Primary Care Group.

PCT and local authority would work in partnership to integrate services where possible and develop four joint service centres, known as 'Gateway Centres', across the city, that would host a range of primary care and community services for local people, and contribute to the much needed renewal of local infrastructure. Three of the four centres have now been developed, and the Walkden Centre is the most recent of these.

The Walkden Centre opened in November 2008 offering Salford residents a range of primary care services focussed around rehabilitation and therapy and a variety of local authority and voluntary services such as:

- A drop in service for housing and council tax benefit and advice and information on other council services.
- Adult, children's and young people's libraries.
- Free PC use and internet access.
- Community and public meeting rooms for use by local groups, eg Mother and toddler groups, and other organisations providing community services.
- A dental surgery.
- A GP surgery.
- Physiotherapy services.
- Access to a district nursing team.
- Other health services such as audiology, orthoptics and occupational therapy.

The centre is open from 8am to 10pm, Monday to Friday and 8.30am to 1pm on a Saturday offering access to services and the facilities outside of normal working hours.

Identifying a Common Need and Outcomes

Throughout the development of the Walkden centre there has been a strong focus on the outcomes the partner organisations have been trying to achieve. These were:

- Increase the numbers of people accessing core health related services as well as new primary, community and health prevention services.
- Improve the long-term management of chronic disease.
- Increase the efficiency and quality of health and local authority services through integrated working practices.
- Contribute to urban regeneration through the provision of modern and fit-for-purpose facilities and services.

The benefit of such an approach is that every decision in the design and delivery of the centre has been based upon what the service user needs. Although still early days, the centre's footfall has continued to grow, with demand for the IT and computer room and library facilities increasing as more people become aware of the facilities on offer. Service user feedback is regularly sought, with positive comments about the facilities and services on offer, and the centre is looking at the ways in which it can monitor its success in achieving the health and well-being outcomes it set out to deliver.

Infrastructure, Buildings and Facilities

Due to the nature and capital build element of the programme, the MaST LIFT Co was involved early on in the planning process to help the partners maximise the opportunities available to them when developing local infrastructure. The LIFT Co brings with it a range of benefits including expertise in planning and managing large capital build programmes, a history of working with the PCT and more efficient

procurement processes. In this particular case, MaST was able to draw upon its extensive design and build knowledge to ensure the buildings were designed to meet current standards and service user needs as well as being based upon good design principles through maximising space and light. For instance, communal space is a theme throughout the building for both service users and staff. A large atrium lets in as much natural light as possible and provides a welcoming entrance to the building and communal staff areas allow staff to meet and relax; helping to promote the overall 'joint' service delivery ethos.

During the Gateway Centres' design and build phase, the project team maintained a strong focus on the outcomes they wanted to achieve, and agreed a set of underpinning principles to support these. These were:

- The centres would be located centrally, for instance near a local shopping centre with good transport links to attract new service users and re-engage with local communities.
- They would have a significant amount of flexible space in which a range of services could be delivered.
- Each of the centres would provide a range of specialist equipment to enable specific primary care services to be outside of the local hospital. To ensure this was properly resourced each centre would have a specific 'care' focus to enable the PCT to invest in better equipment.
- The centres would enhance the local health economy rather than replace existing services unnecessarily.
- Each Gateway centre would be open to any resident within the Salford area, not just those in the immediate locality.

An important part of the development was the involvement of local communities in the design of the building through commissioning local artists to work with community groups to develop large art installations, and consulting with local communities about the types of services they would like offered.

Service User Pathways

All three Gateway centres aim to meet the demands laid out in the *Our Health, Our Care, Our Say* white paper for community health care. Identifying what could and couldn't be integrated early on was essential. For instance by analysing customer pathways and looking at the numbers of people using existing services it was possible to estimate the types and volume of services which the centres would need to provide and deliver. Common contact points between the local authority and PCT were identified, and ways of integrating these were examined to determine where an enquiry or referral to one service could trigger a referral to another. For example, if someone goes into the Walkden Centre wishing to register with a local GP, staff at the centre can explore whether or not the customer is new to the local area and what other services they may be eligible to receive.

This simple yet effective approach is designed to provide seamless links between local authority and primary care services from the service user perspective and requires:

- A willingness to share information between the local authority and the PCT.
- Training in each other's systems.
- Customer relationship software and IT management solutions to support the new ways of working.
- A suitably trained workforce in order to identify the various customer pathways and possible interventions.

Piloting specific approaches before the centre opened allowed many of the initial teething problems to be ironed out, and introducing new services over time enabled staff to learn as they developed the centres, rather than assuming it would all flow smoothly on the first day of opening.

Information Sharing

Critical to the success of the joint working across the centre has been the investment in suitable information systems which allow the local authority and PCT to combine many of their administrative functions and reduce duplication of effort. A central, off-site booking system reduces the need for multiple receptionists and service managers; whilst the central reception team can access information to support individual service users via a customer relationship management system. This allows them to bring a range of services under one roof, and tailor the initial interaction with the service user and flag-up other services which they may find of benefit.

This approach to customer profiling enables the PCT and local authority to profile customer needs, on the principle that if they provide services which are relevant to the individual, the uptake of services will be greater. It also has the added benefit of supporting the PCT and local authority to share information through the better understanding of each others information requirements. For example, the PCT was struggling to find appropriate measures to assess the uptake of the winter 'flu vaccination, but now the eligibility information held by the local authority is available to the PCT enabling them to improve their performance information. Whilst only in the early stages, it is hoped this ability to share information between the organisations easily and readily, will continue to help drive forward high quality service provision within the Salford area based on identifiable need.

Workforce and Workplace Management

Because of the integrated nature of the customer service function within the Walkden Centre, a significant amount of time and effort has been put into the development of the 'front-of-house' team before the centre opened.

Front-of-house staff underwent practical training in the range of services the centre offers, as well as more specific training around PCT priorities such smoking cessation and falls clinics. Staff are now able to identify those who may benefit from the support and provide further information should the service user require it. The PCT supported this by providing education and training for the staff, and both the PCT and local authority staff underwent training on each others IT systems.

Issues around longer opening hours were resolved by reviewing staff needs and developing a range of shift options. Moreover all staff – including visiting clinicians – undergo an induction programme which highlights the principles and approaches to working in the centre, to help set expectations, and overcome some of the different working practices and cultures which could occur when bringing together such a diverse range of people. Informal interactions between staff are also encouraged with a shared staff room and a staff forum.

Integrated Management and Governance

Throughout the development of the Gateway centres, there were a range of practical issues which needed to be addressed; not least because the centres brought together two sets of very different services.

It was agreed the legal framework covering the arrangements between the local authority and the PCT was best served through an interface agreement, outlining

who is responsible for overseeing and funding different elements of the service. The interface agreement includes detail on the:

- Principles underpinning the partnership.
- Governance and reporting requirements.
- Detail around the property management and maintenance which are expanded on in the lease plus agreement with the LIFT Co.
- Payments and budgets for the provision of soft facilities management within the centre.
- Performance management.

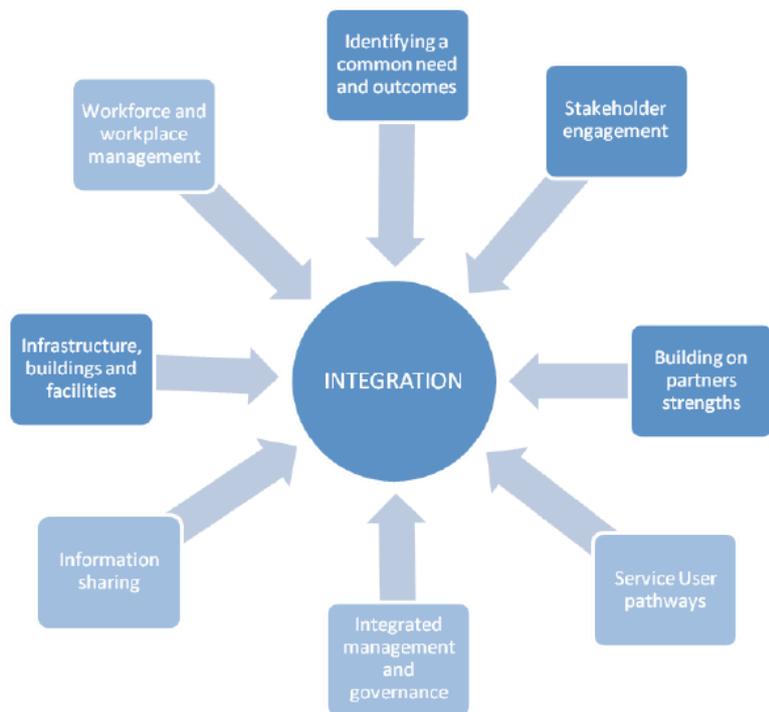
In addition to this, the day to day management of the centre is provided by a 'floating' team of five general managers which allows them to work across all three Gateway Centres, and to develop a strong understanding of what works well and what doesn't. It means each centre is managed in the same manner, and provides a consistent approach for the public when accessing the different services on offer. Moreover, there is no administrative function located within the Walkden Centre, and all appointments are booked through a central, off-site team. By implementing this approach, they have reduced the need for individual reception areas for the services provided, and front-of-house staff are able to inform clinicians and advisers when a customer or service user has arrived.

Conclusions and Best Practice

The Walkden Centre provides a good example of how through a strong, shared vision it is possible to bring together seemingly disparate services. Key points to note are:

- A good understanding of local population needs and the constant monitoring of how service users interact with services, enables the partners to look at new ways of improving service delivery.
- Focussing on outcomes throughout the design and delivery phase kept the development on track and helped people to concentrate on the important aspects of the services.
- Piloting new approaches allows managers to assess their effectiveness before they are rolled out more widely.
- Good information systems can enhance the quality of the service integration.
- Consideration of the culture which the service wishes to foster and looking at how staff will work together enables the centre to run smoothly and provide better services for users.
- Although services do not always lend themselves to 'whole system' integration, by mapping service user pathways, the centre integrates processes and procedures to provide the user with a seamless experience.
- A joint commitment by the PCT and the local authority to making the centre work well.
- A joint approach to infrastructure development enabled economies of scale and delivered a high quality building within a deprived area.

4.2 Case Study 2: Mill Rise Village, Knutton and Cross Heath, Staffordshire



Overview

- An Extra Care Housing village with primary care services on site.
- Flagship development for the local area with restaurants, hair salon and café open to the general public.
- Unique partnership between the Local Authority, PCT, LIFT Co and Regeneration partners and housing providers.
- Maximised land use and shared development costs across partners.

Background

Mill Rise Village comprises an extra care facility and Primary Care Centre located in the Knutton and Cross Heath area in Newcastle-under-Lyme. It provides sixty, one and two-bed apartments for older people and a range of health services, including GPs, podiatry, physiotherapy and community nursing services. A mixed tenure scheme, Mill Rise gives the opportunity for people who are aged 55 or over, to live independently for as long as possible whilst providing on-site care and support when needed. The Primary Care Centre is open to the wider community and includes an integrated pharmacy. There are also a range of communal areas including gardens and allotments, a public restaurant and gym.

With significant health inequalities and an ageing population, the Mill Rise development represents the first Extra Care Housing (ECH) scheme for frail and older people within the area and will be a gateway to other mixed tenure developments as the local authority and RSL replace their existing sheltered housing provision.

Identifying a Common Need and Outcomes

At the heart of the development and services on offer are the outcomes which the village is trying to address, including:

- Reducing admissions into residential care through prevention and early intervention measures.
- Reducing social isolation by supporting the local community through the provision of a range of services.
- Promoting active ageing and improve the management of long term conditions through access to high quality care and health services.
- Creating a village centre for the whole community.

The partners recognise that service delivery needs to reflect this and the RSL is working closely with the care provider to ensure the facilities and services enhance one another whilst the PCT are carefully commissioning services to meet the needs of the older people living within the Village, as well as commissioning health services for the wider population. These latter services include clinics around the management of long-term conditions such as COPD and diabetes, as well as ante-natal and smoking cessation clinics.

Building on Partners' Strengths

The successful completion of the Mill Rise development has been highly dependent on the strength of the partnership on which it is based. The scheme brought together eight partner organisations with a shared vision to deliver both better services for the local community and renew infrastructure within the area. The partners are:

- Prima 200 (LIFT Co).
- Aspire Housing (RSL).
- NHS North Staffordshire.
- RENEW North Staffordshire.
- Newcastle-under-Lyme Borough Council.
- Staffordshire County Council.
- Homes and Communities Agency (formerly English Partnerships and Housing Corporation).

The idea for the scheme arose through discussions between the PCT, who were already exploring the development of a healthcare centre on an alternative site with planning permission ready to proceed; the local LIFT Co, Prima 200; and Aspire Housing who were renewing their sheltered housing provision within the area.

By pooling resources and expertise the PCT and Aspire realised there would be significant benefits to combining the two developments, not least increasing the value for money achieved through better efficiencies in terms of costs and the provision of a wider range of services. Involving the LIFT Co helped them to realise this by providing skills and expertise in design, planning and procurement to assist the overall development.

Importantly for them, as an Area of Major Intervention (AMI), Knutton and Cross Heath forms one of nine Housing Market Renewal Pathfinders funded by the Department of Communities and Local Government via RENEW North Staffordshire – a partnership designed to promote housing market renewal in the area. Involving them in the Mill Rise partnership added credibility to the Village by placing it within the heart of the regeneration project, and linked it with the strategic priorities of other local agencies to maximise the value of the overall development. Moreover, gaining the support of the Housing Corporation and the local authority early on in the process meant the partners could ensure they met planning regulations and timetables throughout the development.

Stakeholder Engagement

One of the biggest hurdles the partners had to overcome was the fact that by combining the ECH Scheme with the primary care centre, the original site designated for the PCT was no longer suitable. Having fought hard for a new health centre, local people were reluctant for the centre to be moved and getting their support was critical if the programme was to succeed. The partners recognised this as an issue and throughout the development of the village, stakeholder engagement has been given priority; not just in terms of public opinion, but also ensuring that Councillors

and local politicians and professional groups such as OTs, physiotherapists and GPs were familiar with the Village and its objectives.

The partners adopted a structured approach to engagement and appointed one person to develop internal and external links with key people and oversee a range of engagement activities including:

- The formation of the Friends of Mill Rise Group comprising people who were interested in the development and their families. Formally constituted, the group meet monthly and have provided considerable input into the design of the building and care provision. The current chair is also an active member of the local over-50s forum which provides useful links into wider community issues.
- A series of road shows held at venues such as the library, and community centres.
- Letters to everyone in the area receiving care and support and Disabled Facilities Grants.
- A range of multiagency events to raise awareness amongst professional groups as to what extra care housing schemes could bring, and what the development was hoping to achieve. This included occupational therapists, physiotherapists, district nurses, telecare staff and housing advice officers.
- A number of events for local people including turf cutting ceremonies, time capsule projects with local schools and Christmas parties with local sheltered housing schemes.
- A series of focus groups within the local community to explore what services were most needed and how these could be best addressed. There are also plans to engage GP practice managers in what extra care could offer to encourage better referrals into the scheme.

The benefits of adopting such a structured approach to stakeholder engagement are clear:

- It helped to maintain the momentum and enthusiasm for the initiative when the project seemed to be developing slowly.
- It encouraged commitment and buy-in from local communities and health and social care professionals to support the scheme once it opened.
- The information provided helped to shape the design and delivery of the final project.

Infrastructure, Buildings and Facilities

Mill Rise Village is one of the few ECH schemes in England which combines accommodation with primary care facilities on site, and demonstrates how housing, health and the local LIFT Co can work together to deliver integrated care services. It recently also won a national retirement housing award. (For more information and tools on ECH, visit the Department of Health's Housing Learning and Improvement Network website at www.DHCareNetworks.org.uk/housing/).

The Village also provides a number of public facilities with the aim of supporting regeneration in the area and encouraging the local population to access health services which they may have previously found difficult. This has been a particularly important principle for the partners in terms of the development and design of the facilities. They wanted the local community to feel like they owned the development to encourage them to use the facilities on offer and prevent it becoming institutionalised. Its central location, next to a busy supermarket means that it's

easily accessible for the residents, their visitors and the local community; and for those that would struggle to access the Village there are now additional public transport routes being provided.

The Friend of Mill Rise group contributed heavily to the internal design and fixtures and fittings of the development to provide a functional and attractive environment for residents and their visitors; whilst the public areas also bring together a restaurant, café, bar and hair salon for the general public. Moreover the supermarket has agreed to provide additional motability scooters for residents who wish to shop there.

The development did bring some challenges with it; such as managing the expectations of so many different partner organisations. The lessons learned through this process include agreeing a set of design principles which meet everyone's requirements at the start of the programme which would have helped the project remain on-track, particularly when the PCT underwent a major restructure and commissioning priorities changed. Importantly, the development has proved the concept of partnership working within the area and there are plans for similar schemes elsewhere.

Conclusions and Best Practice

Several aspects of the Mill Rise development provide good examples of how to tackle integrating care. These are:

- Understanding how the services strategically fit and meet other organisations' agendas.
- Managing complex partnership through regular meetings and taking the time to share and understand each partner's priorities, as well as utilising their skills and expertise.
- Commissioning services to maximise local resources and ensure better value for money.
- Strong stakeholder engagement strategies helped promote the development of the service and also encouraged buy-in from a host of interested parties.
- The strong emphasis on community services helped to establish a blueprint for further developments in the future.

4.3 Case Study 3: Community Homes Resettlement Project, NHS Norfolk and Norfolk County Council



Overview

- Resettlement project for those with learning difficulties from traditional NHS campuses into supported living accommodation within the community.
- Based upon an existing Section 75 for learning difficulties, it combines health, social care and housing to promote independence and choice for service users.
- Highly structured project management with integrated community teams involving services users and their families throughout the process.

Background

In response to *Valuing People, Valuing People Now* and *Our Health, Our Care, Our Say*, Norfolk County Council and NHS Norfolk looked to close its 10 NHS campuses and move 70 adults with learning difficulties (LD) into a supported living environment. The project was designed to deliver and promote a person centred approach to care; moving LD provision away from a model of care driven by the overall needs of the service, towards a model which encouraged personal autonomy and choice.

With an existing s75 for LD services in place, and an already joint LD team across the PCT and local authority; NHS Norfolk, its provider organisation – Norfolk Community Health and Care – and Norfolk County Council’s approach has involved supporting NHS campus residents to move into houses within local communities where service users would have security of tenure with care provided based on individual needs assessments and health action plans. It was agreed early on the campus closure programme needed to fit within the existing financial envelope, rather than requiring substantial additional investment from either the NHS Norfolk or the local authority, and that it would be based upon the principles *Valuing People* throughout.

Building on Partners’ Strengths

Much of the work undertaken by the campus closure team has been as a direct result of the partnership work between the local authority (housing and social care) and the PCT as a result of policy and legislative changes which have enabled closer working relationships and pooled budgets. LD services are delivered through a fully integrated health and social care team, with a pooled budget and the local authority acting as lead commissioner. This integrated approach has been cascaded down to a local district level through five local community teams who are responsible for working directly with the housing and care providers, and service users and their

families as part of the campus closure project. The local community teams comprise a range of health and social care workers including OTs, physiotherapists, housing and social care staff, who work together to ensure each individual service user is properly assessed prior to their transition into supported living accommodation.

Integrated Management and Governance

The commitment to integrated service provision is mirrored in the management structure of the LD team at both a County and a local level. At a County level the project is overseen by a Project Board set up for this purpose as a sub group of the pooled fund Commissioning Group. The day-to-day management of the campus closure project is provided by a dedicated project manager and a project team has been set up. In addition there are a number of project sub groups which oversee specific aspects of project delivery (accommodation, finance, human resources).

The project manager – although employed by the local authority – oversees the activities carried out by the project team, which includes both health and local authority staff, thereby ensuring the needs of all organisations are taken into consideration as the project progresses.

The project team is involved in a number of individual resettlement project groups, responsible for developing individual properties and the services linked to these. These discrete project groups, which meet monthly, work closely with the campus residents and their families/advocates to ensure the best possible solution to the service user's accommodation and support needs is found within the allocated budget. These groups are mostly chaired by the project manager, and include a range of staff and stakeholders with different skills and expertise. This includes OTs, Care Managers, existing campus staff, the Registered Social Landlord (RSL) commissioned to develop the accommodation, as well as the chosen care provider.

Care providers and RSLs are chosen based on a competitive tendering process, and work closely with the project team and with key stakeholders throughout. Care and support in people's new homes is provided on a 24/7 basis and monitored against the care plan to make adjustments as needed.

Infrastructure, Buildings and Facilities

There were a number of key decisions which influenced the type of supported living environment developed in Norfolk. These were:

- The decision not to go down the new build route as the timescales involved would be unpredictable, and it was clear that people's needs could be met via properties purchased on the open market following appropriate conversion work achievable within the building's existing footprint. Each property houses between 2 and 4 adults within extensively refurbished accommodation.
- Each development reflects individual preferences identified via extensive needs led, person centred, processes including multidisciplinary assessments, housing needs assessments, and person centred plans. Housing specifications are developed based upon these and special attention is given, where relevant, to developing assistive technology options.
- The importance of finding properties within locations which were suitable for family and friends, and staff to access, with good public transport links and parking for adapted vehicles.

The housing specifications prepared by the OT's outline the type of accommodation needed in order to maximise the comfort, wellbeing, and independence of the

people involved. These specifications were shared with RSLs and informed the subsequent search, purchase, and conversion of each of the properties.

Priority has been given to promoting socially inclusive outcomes, in domestic settings, which enable people to have far greater levels of choice and control over their lives than achievable within the NHS campuses. Agreeing these priorities at the start of the programme have enabled the project team to draw up detailed specifications for the properties needed, based on their understanding of what they will, or won't, compromise on during the development. Throughout this process campus residents and family members are encouraged to participate in key decisions such as the location of the property and who lives with whom. They are encouraged to visit the sites once they have been purchased, and again during and after refurbishment. The process is designed to take into account both the residential requirements of the individual, and their overall well-being, by considering their long term aspirations, and opening up a wider range of options and opportunities for each person.

Workforce and Workplace Management

One of the biggest issues around the development of the supported living environment has been the change from internal NHS provision, to externally commissioned care through an independent provider. This raised a number of issues for the managers involved.

For instance some staff had to be made redundant, whilst others could be transferred from the NHS campuses to the care provider. However this presented a significant challenge, both in terms of maintaining morale and reducing uncertainty for those staff members who did not transfer straightaway and also in terms of implementing employment legislation and the Transfer of Undertaking (Protection of Employment) Regulations (TUPE). Working through the TUPE implications has been a complex undertaking, there being no fixed template of where TUPE does or does not apply, and the outcomes have been different for individual NHS campuses. Fully understanding the implications of the TUPE regulations at an earlier stage would have helped smooth this process, and reduced delays in the overall programme of work. However, given the complexity of the regulations this was always going to be an issue that would need great time and resource investment throughout.

Where TUPE does apply, the move from an NHS campus to a supported living environment has meant a significant adjustment for the staff involved. Staff transferring from the NHS campuses are given the opportunity to undergo training provided by the new care provider in advance of taking up their new posts. This enables them to take on board the ethos and principles underpinning service delivery. It has also been important for the new care providers to make full use of campus staffs' substantial knowledge of the individual service users during the transition stage. This has involved careful transition planning to help minimise the potential for undue anxiety and stress during the period of transition into supported living, and to ensure that the new service provider has all of the information that it needs to provide a safe and appropriate service.

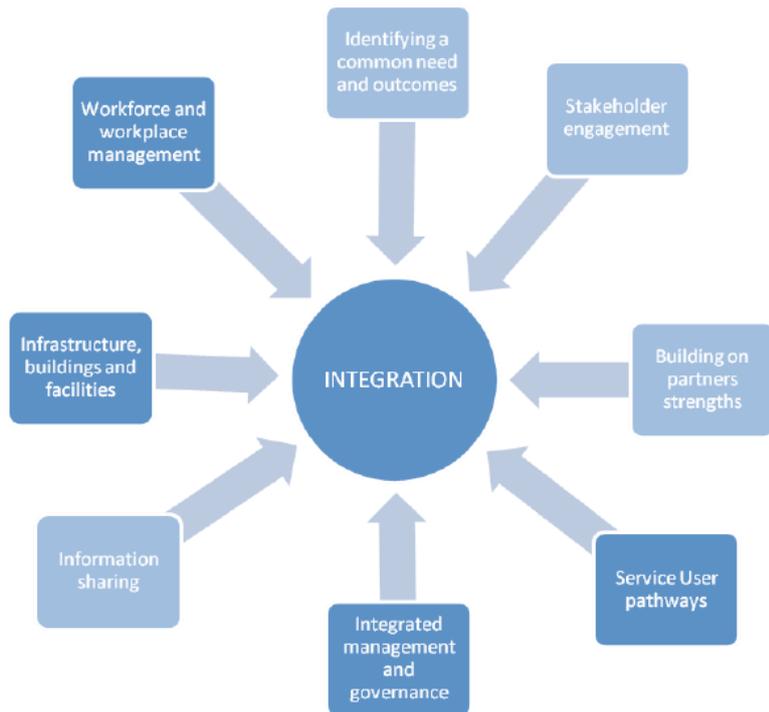
Conclusions and Best Practice

The Norfolk Campus Closure Case Study demonstrates how localities are responding to significant changes within the national agenda, and how the use of legislation such as s.75 Health Act flexibilities can help to support this. Key lessons are:

- A dedicated, multi agency, multidisciplinary project team working closely with service users and key stakeholders, can deliver high quality supported living alternatives.

- Being clear about the vision of the new pattern of services, and about the ethos and principles underpinning these, and about the overall budget for the programme at the start, helps to remain on time and on budget.
- Using national policy to drive changes and existing mechanisms such as s75 can help support the development of new integrated services by cutting out much of the red-tape associated with budgets and commissioning.
- Working closely with service users and their families/advocates, and maintaining a person centred approach throughout, helps to ensure the relevance of services to individual needs and preferences.
- Good communication from the outset, and throughout, about the planned changes and what these do and do not mean, has been essential to ensuring that key stakeholders, including family members, are able to sign up to the process.
- When considering the transfer of staff from one organisation to another, a systematic approach to assessing the full range of HR implications, including the involvement of HR departments, legal teams and the Trade Unions at the start of the process is essential.

4.4 Case Study 4: Oxfordshire Older Peoples' Services



Overview

- An integrated approach to the development and funding of services for older people through the use of pooled budgets and joint commissioning arrangements.
- Integration of health, social and community services and Mental Health Trust through pooled budgets.
- The development of integrated care premises in Oxford City in response to demand.
- Specifically focused on the falls and intermediate care services.

Background

With an increasing older people's population Oxfordshire PCT and the local authority (Oxfordshire Social and Community Services) have a long established partnership approach to delivering the care of Older People within Oxfordshire.

The partnership delivers a number of integrated care pathways, in line with national initiatives and policy⁴⁴ through ongoing investment and service review to deliver "...a fully joined up strategy to achieve joined up outcomes for older people"⁴⁵, including:

- Intermediate Care.
- Falls Service.
- Day care services.
- Domiciliary care.
- Equipment Services.

Specific areas of integration in Older People's services include:

- Shared care protocols for Domiciliary Care.
- Intermediate care places in Nursing Homes.
- First response re-ablement service.
- Integration of Access Team, First Response, Intermediate care.
- Integrated health and social care resource centres.
- Single contracting team dealing with Community Home care contracts.
- Adult placement respite care.

⁴⁴ Commissioning Strategy for Older People (2007-2010), Oxfordshire Social and Community Services.

⁴⁵ Commissioning Strategy for Older People (2007-2010)

Integrated Management and Governance

The Older People services within the County are underpinned by a range of joint agreements, frameworks, strategies and pooled budgets including:

- Oxfordshire Local Area Agreement.
- PCT Integrated Service Improvement Plan.
- PCT Delivery plan.
- Supporting People Strategy.
- Safeguarding Adults Plan.
- Carer's Strategy.
- Oxfordshire Workforce Strategy.⁴⁶
- Joint Commissioning Strategy for Older people (2009–2012)⁴⁷ (JCS).

These are supported by a Section 75 agreement for Older People's services between the PCT and the local authority, which covers all care home placements, domiciliary services, equipment, intermediate care, falls prevention services and continuing healthcare. The s.75 agreement is underpinned by a number of factors including:

- Sound governance arrangements across organisations.
- Formal monthly management meetings to oversee the pooled budget.
- Clearly identified joint performance management arrangements.
- An established pattern of working between the partners which is based upon trust and confidence.
- Clear and agreed outcomes for the service user.

It brings with it a range of benefits for both the PCT and the local authority such as:

- The more effective use of resources.
- Improved communication and data sharing.
- A better understanding of the different roles health and social care play in supporting older people.
- The flexibility to deliver care in a number of different environments including private care homes.
- A joint commissioning role between health and social care to improve integration.

Joint health and social care steering groups help to oversee the delivery of individual services, and report back on issues such as the standards of assessment and management plans. In the case of the Falls service, the integrated delivery of care and support has had a marked effect on improving the outcomes for older people with falls being reduced by 39% in one care home project; and a recent National Audit of Falls and bone health saw the service achieve many of the recommended domains for essential components of structure, process and actions for organisations in delivering the recommendations of the NSF for older people⁴⁸.

⁴⁶ Commissioning Strategy for older people (2007-2010), Oxfordshire Social and Community Services

⁴⁷ Oxfordshire's Joint Commissioning Strategy for Older People (2009-2012), Oxfordshire County Council, Oxfordshire PCT (DRAFT)

⁴⁸ National Falls and Bone health Public Audit Report (2009), Royal College of Physicians, rcplondon.ac.uk/clinical_standards

The well-embedded approach to delivering integrated care within Oxfordshire means the PCT and local authority are now exploring a range of possible services which may benefit from integration in the future including better end-of-life care, acute service discharge planning and a joint commissioning team for Older People's services.

Identifying a Common Need and Outcomes

Although the partnership approach within Oxfordshire has been in existence for some time, the relationships between the organisations are constantly worked at, and underpinned by a strong vision and set of clear outcomes. The services are designed to address a range of health outcomes for the local older people's population including:

- A reduction in admissions of older people to acute care by increasing prevention and early intervention.
- Maintaining more older people in the community safely and healthily.
- Improving access to services across the whole County.
- Reducing the time and figures for delayed discharges from acute care.

Service User Pathways

Considerable time and effort has been put into improving service user/patient pathways within Oxfordshire to provide a more seamless approach to care. For instance, the Falls Service was developed in 2004, in recognition that falls are a major source of disability and a leading cause of mortality in those over 75 and a key priority within the NSF for older people.⁴⁹ Preventing falls and supporting people to regain their independence remains a challenge for many health and social care organisations due to the extent of occurrence and the implications for the independence and future care of the individual involved. The service links acute provision within the Oxford Radcliffe Hospital Trust with the community and voluntary sectors to reduce the incidence of falls in older people in Oxfordshire; and maintain independence quality of life of those falling or who are at risk.

It brings together a range of expertise and skills including:

- Acute care.
- Physiotherapists.
- Occupational therapists.
- Falls Specialist Nurses.
- Exercise co-ordinators.

The service:

- Provides training for care home staff and falls assessments.
- Aims to raise overall awareness of falls in all health and social care areas.
- Signposts older people to falls clinics and workshops.
- Provides discussion and exercise programmes for older people in all community and hospital based environments.
- Deliver balance and safety programmes in day hospitals.
- A project targeting high risk groups implementing prevention approaches.
- Has ongoing support from a clinical lead within the acute trust medical to provide advice for the staff involved in delivering the service.

⁴⁹ National Service Framework for Older People (2001), Department of health

- Links with the ambulance service to improve the care of fallers by accepting referrals, implementing prevention of falls and reducing ambulance call rates.

One important aspect of the service is that referrals can be accepted from any source, including from service user and/or their family/carers. The response is person-centred and tailored to the specific needs of the individual. It can include referral onto an exercise programme, occupational therapy assistance, physiotherapy, balance and safety group, day hospital medication or back to the GP where further medical input can be sought.

The intermediate care service was established in 2006 to deliver rehabilitative services to people over 18 years following treatment in hospital, to enable them to regain their independence, and promote earlier discharge as well as reduce inappropriate admission to hospital; although in practice the majority of service users are over 65 years. Specified outcomes for intermediate care by the PCT are:

- Maximising participation of the patient in a social setting.
- Maximising individual's autonomy and enablement.
- Maximise the patient's functional ability.
- Minimise the pain, disability and distress to the patient.
- Minimise the distress/stress on the patient's family/carers⁵⁰.

The service operates in three key areas:

- Domiciliary care, by managing the service user within their own home to prevent admissions into bed-based care settings, and enable early discharge from acute care through rehabilitation programmes within the home.
- Intermediate care beds, providing a continuum of care between acute and home care settings, through intensive rehabilitation which cannot be carried out at home due to medical needs.
- Day services, providing specialist rehabilitation services within a day-care setting, such as falls and balance classes, rehabilitation gym sessions and dementia groups. This aims to increase active participation within the community, and reduce longer term admission into bed-based care.

Where intermediate care is required, a needs assessment is carried out by using a single assessment process, by a multi-disciplinary health and social care team; and if required, support is provided for up to six weeks following discharge from hospital, or to prevent admission in the first place.

Importantly both the falls and intermediate care services have focussed on:

- Providing person-centred care.
- Single assessment processes to reduce duplication of effort.
- Working across health and social care boundaries.

Infrastructure, Buildings and Facilities

Although not specifically housed within one facility, providing accessible care to Oxfordshire residents has been a significant consideration in the design of services across the local authority and PCT. Maximising opportunities to co-locate services within new, or existing facilities where appropriate has helped to ensure that services remain accessible. For instance, intermediate care and physiotherapy are

⁵⁰ Oxfordshire PCT Service Specification: Intermediate Care Oxfordshire. Final Version April 2008

located in the LIFT Co developed East Oxford Health Centre, which provides a modern and flexible environment in which to provide clinics and promote health and well-being and offers good public transport links. Moreover, its close proximity to other services such as the Oxford Carer's Centre means the services can be easily accessed by local people. It also encourages patients to access a range of additional services including:

- Pharmacy.
- Psychiatrist.
- Counsellors.
- Physiotherapy services for the City.
- Health Visitors.
- Out of Hours services.
- Dentistry.
- Interpreter services.
- Advocacy services.
- Café.
- Citizens Advice.

Workforce and Workplace Management

One of the most difficult challenges for Oxfordshire has been around ensuring a suitably trained and well supported workforce. For the Falls service, each clinical member of staff undergoes education and training in bone health and falls assessment, to be able to provide high quality input into the assessment, treatment and prevention for people over the age of 60 years. Whilst the intermediate care service brings together a range of different practitioners including therapists, health and social care staff. The service also works in partnership with case managers across the County who manage very high intensity users, with the aims of preventing admissions and facilitate discharge.

Bringing together this wide range of professionals has not been easy, and Oxfordshire PCT and local authority have had to overcome individual working practices and cultures; differences in job descriptions, employment regulations and conditions of employment and pay scales; and provide suitable management structure to enable effective partnership working and information sharing. These have been partly overcome through the introduction of generic job descriptions under the 'Agenda for Change'⁵¹, which saw a standardising of pay structure and career frameworks in the NHS, and by developing a collaborative approach to service development, by involving staff and supporting professional status through recognition of skills and knowledge. Team members also receive ongoing training about all aspects of the services, including joint training on both the health and social care IT systems and the single assessment process.

⁵¹ Modernising your organisation (2007), Department of Health

Conclusions and Best Practice

Oxfordshire County Council and the PCT have a long history of working in partnership to deliver Older People's services across the County. Their approach is based upon:

- A solid strategic understanding of where and how the services fit within the context of both the local authority and PCT priorities.
- The use of legislation to help support the development of integrated health and social care services.
- A good understanding of patient and service user pathways and using this to develop new and innovative approaches to delivering care.
- Developing management structures which support the sharing of information.
- Maximising opportunities to locate services in new facilities and better, more accessible locations for the public.

5 Conclusions

The complexity of pulling these elements together from the service design and delivery perspective should not be underestimated, and to do so effectively requires managers to have a strong understanding of the rationale for their decisions and the mechanisms by which they can be implemented. Based on the case studies' experience, for integrated services to flourish, managers must:

- Clearly map the strategic fit of each of the partner organisations to identify opportunities as they arise.
- Make the time and effort to understand each other's agendas.
- Have the right people with the right level of decision making power together around the table.
- Integrate services that offer a logical fit.
- Agree with partners the core principles of the services to be developed and working out which areas can be compromised on further down the line.
- Look at integrating processes as well as services.
- Seek management solutions which are both flexible and innovative.
- Have trust and confidence in each of the partners and recognise that all are working to the same outcomes.
- Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes.
- Recognise that efficiency does not lead to integration, but integration can lead to more efficient working practices.
- Pay attention to issues in procurement early on, whether they are about how to integrate different legal and planning processes or address issues around building design and IT infrastructure. There are numerous examples where good planning at the start of projects saves considerable expenditure further down the line.
- Finally, underpinning all of the above remain the reasons for integration. For a successfully integrated care service, the outcomes must shape the form that enables them to happen.

As referred to earlier, the accompanying 'easy to follow' guide, *From the Ground Up: A guide to integrate service delivery and infrastructure*, offers managers a Design Framework for Integration: an Integration Checklist to help chart the project's progress towards integration as well as helping managers to identify the types of activities that may need to be undertaken to support; and it provides a series of hints and tips for planners, commissioners, estate managers and service providers seeking to design and deliver integrated care services and associated infrastructure for their local health and care economies.

6 APPENDIX

6.1 Integration: A policy timeline

The following timeline identifies key policies, papers and changes to legislation which have contributed to the integration agenda.

| | | |
|------|--|---|
| 1997 | <i>The New NHS: Modern, Dependable</i> ⁵² | Charged strategic health authorities to produce local plans for improving health based on co-operation between PCTs and Local Authorities and which covered the “... range, location and investment required in local health services to meet the needs of local people.” |
| | <i>Social Services Achievements and Challenges</i> ⁵³ | Called for a reassessment of the role and structure of traditional social services functions in line with changing public expectations. |
| 1999 | <i>The Health Act</i> ⁵⁴ | <p>Section 31 of the Health Act allowed the NHS and health-related local authority services to integrate resources and functions through:</p> <ul style="list-style-type: none"> • Lead commissioning: where one partner commissions’ services on behalf of both partners under a jointly agreed set of aims and objectives, through the use of allocated budgets which are managed through a co-ordinated pattern of spend. • Integrated provision: where one partner acts as the ‘host’ for services and oversees the management on behalf of both partners. • Pooled budgets: where a single budget (made up of contributions from both partners) is managed by one or other of the partners thus removing the traditional boundaries of care between health and the local authority. |
| | <i>National Service Frameworks</i> ⁵⁵ | <p>National Service Frameworks introduced into the NHS, covering the highest priority conditions around chronic illness such as heart disease and cancer, as well as mental health, older people and diabetes.</p> <p>They were developed in partnership between health and voluntary organisations, set out a range of quality standards, and provided guidance on how organisations could achieve them through national service models; local action and national programmes for implementation; and a series of national milestones to assure progress, with performance indicators to support effective performance management.</p> |

⁵² The New NHS: Modern, dependable (1997), Department of Health

⁵³ Social Services Achievements and Challenges (1997), Department of Health

⁵⁴ Health Act (1999)

⁵⁵ For instance, see National Service framework for mental health: modern service standards and models (1999), Department of Health, and the National Service framework for older people (2001), Department of Health.

| | | |
|------|---|--|
| | | They provided a framework for providing integrated services and for commissioning services across the spectrum based on local roles and whole systems approaches. |
| 2000 | <i>The NHS Plan</i> ⁵⁶ | <p>Set out a vision for care based upon Health Act flexibilities which allowed “... <i>social services and the NHS... [to]... come together with new agreements to pool resources...[and]... in the future, social services will be delivered in new settings, such as GP surgeries, and social care staff will work alongside GPs and other primary care and community health teams as part of a local care network.</i>”</p> <p>The Plan established Care Trusts to bring together the commissioning of services historically managed separately by local authorities and the NHS. Focussing on older people, those with learning disabilities and mental health services, Care Trusts were designed to encourage local organisations to commission and provide care based on the needs of their local population through multidisciplinary teams and integrated housing provision.</p> <p><i>The NHS Plan</i> also announced major new investment in NHS estate funded through public capital and private finance initiatives, to address chronic underinvestment in infrastructure and support the redevelopment of hospitals and primary care facilities.</p> |
| 2001 | <i>Health and Social Care Act</i> ⁵⁷ | <p>Set out new role for local government in the scrutiny of local health services.</p> <p>Provided for the establishment of Care Trusts.</p> <p>Mandatory duty on all local authorities to provide direct payments to all those who were eligible.</p> |
| | <i>NHS Local Improvement Finance Trust Scheme</i> ⁵⁸ | <p>The introduction of the NHS Local Improvement Finance Trust (LIFT) by Partnerships for Health Limited (PfH) – a joint venture between Partnerships UK (PUK) and the Department of Health (DH).</p> <p>Its objective was to develop, deliver and generate investment in a new and innovative national procurement programme for improving primary care facilities. In 2006 DH acquired the outstanding shareholding owned by PUK, and PfH’s role gained additional focus including supporting integration and partnerships across health and social care. It has remained a vehicle for improving local integrated infrastructure ever since and was renamed Community Health Partnerships in 2007.</p> |

⁵⁶ The NHS Plan (2000), Department of Health

⁵⁷ Health and Social care Act (2001)

⁵⁸ <http://www.communityhealthpartnerships.co.uk/index.php?ob=1&id=23>

| | | |
|---------------------------|--|--|
| 2001 (Updated 2009) | <p><i>Valuing People: A New Strategy for Learning Disability for the 21st Century</i>⁵⁹</p> <p><i>(and its update Valuing People Now)</i>⁶⁰</p> | <p>Promoted “... <i>holistic services for people with learning disabilities through effective partnership working between all relevant local agencies in the commissioning and delivery of services</i>” and called for the development of Learning Disability Partnership Boards. It called for the closure of long-stay hospitals and campuses, and for those living with learning disabilities to be offered the opportunity to live within local community settings.</p> <p><i>Valuing People Now</i> emphasised personalisation and independence through advocacy and support for housing, transport and education and transferred the commissioning responsibilities for learning disability services to local authorities in April 2009. Local authorities now take responsibility for the co-ordination and integration of social services provision and housing, whilst allowing the NHS to concentrate on providing high quality healthcare for those that require it.</p> |
| 2002 | <i>Wanless Review</i> ⁶¹ | <p>Challenged the Government not only to spend money, but to examine how resources were used through the development of a ‘whole systems’ approach to care to deliver better outcomes for those who need it most.</p> <p>It recognised that health care in the UK was changing; moving away from the treatment of infectious diseases towards managing chronic conditions, including cancer and coronary heart disease, often linked to lifestyle factors such as smoking and alcohol consumption and also the impact of living to an older age with increased vulnerability to disease and disability.</p> <p>The Review also highlighted the health inequalities which existed between genders, ethnicity, geographic location and socio-economic groups.</p> |
| 2004 | <i>Choosing Health</i> ⁶² | <p>Introduced the concept of partnership arrangements with statutory bodies, the voluntary sector, faith organisations, business and the media to provide consistent messages and enable the public to make better choices.</p> |
| 2004 onwards | <i>Department of Health: Extra Care Housing Fund</i> ⁶³ | <p>Designed to support innovative approaches to developing extra care housing, and promote partnerships between housing and social care.</p> |

⁵⁹ Valuing people: A new strategy for learning disability for the 21st century (2001), Department of Health

⁶⁰ Valuing People now: A new three year strategy for people with learning disabilities (2009), Department of Health

⁶¹ Securing good health for the population (2002), Department of Health

⁶² Choosing Health: Making Healthy Choices Easier (2004), Department of Health

⁶³ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4130323

| | | |
|---------|--|---|
| 2004/05 | <i>Local Area Agreement Pilots</i> ⁶⁴ | <p>LAAs were originally developed in 20 pilot areas as three-year agreements between local government and their partners to improve the quality of life for local people.</p> <p>It is designed to improve central/local relations; to improve service delivery; to improve efficiency; to improve partnership working; and to enable local authorities to provide better leadership.</p> <p>They have since been rolled out to all 150 upper-tier local authorities.</p> |
| 2005 | <i>Independence, well-being and choice</i> ⁶⁵ | <p>Called for better integration between social care with PCTs to deliver personalised care for individuals and changing the focus from outputs of care to outcomes for the service user.</p> |
| 2006 | <i>Our Health, Our Care, Our Say</i> ⁶⁶ | <p>Introduced practice based commissioning to realign health and social care to deliver more services, more effectively and closer to home.</p> <p>Joint commissioning was seen as a key factor in supporting this work, by linking up health and social care teams through joint posts to tackle some of the biggest care issues such as long-term conditions and older people's provision.</p> |
| | <i>Strong and Prosperous Communities</i> ⁶⁷ | <p>Challenged local authorities to become responsible for 'place shaping' through strategic leadership and provided a strong legal framework for the involvement of citizens in delivering responsive services.</p> |
| | <i>National Health Service Act</i> ⁶⁸ | <p>Consolidated previous legislation and removed the inconsistencies within previous Health Acts.</p> <p>S.31 of the 1999 Health Act was replaced by s.75 of the National Health Service Act 2006.</p> |

⁶⁴ A process evaluation of the negotiation of pilot Local Area Agreements – final report (2007), Department of Communities and Local Government

⁶⁵ Independence, well-being and choice (2005) Department of Health

⁶⁶ Our health, our care, our say (2006) Department of Health

⁶⁷ Strong and Prosperous Communities (2006), Department for Local Communities and Government

⁶⁸ National Health Service Act (2006)

| | | |
|------|--|---|
| 2007 | <i>Putting People First</i> ⁶⁹ | <p>A concordat between central and local government, the NHS and Adult Social Care and care providers calling for a “...<i>high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers,</i>” through “... <i>a single community based support system focussed on the health and well-being of the local population..</i>”</p> <p>It charged local authorities with system-wide transformation by 2011 focussing on four areas:</p> <ul style="list-style-type: none"> • Universal services including health, community care, local government and the wider issues of housing, education/training, benefits advice and employment. • Early intervention and prevention. • Choice and control. • Social capital. |
| | <i>Commissioning Framework for Health and Well-being</i> ⁷⁰ | <p>Shifts care from the treatment of the ‘sick’ towards a preventative approach to keep people fit and healthy, through providing people with more choice and control and the introduction of Joint Strategic Needs Assessments for the NHS and local authorities.</p> <p>It is based upon eight key principles:</p> <ul style="list-style-type: none"> • Putting people at the centre of commissioning • Understanding the needs of populations and individuals. • Sharing and using information effectively. • Assuring high quality providers for all services. • Recognising the interdependence between work, health and wellbeing. • Developing incentives for health and wellbeing. • Making it happen – local accountability. • Making it happen – capability and leadership. |
| | <i>Mental Health Act</i> ⁷¹ | <p>Amended the 1983 Act and expanded the group of practitioners who could take on the functions previously undertaken by a social worker.</p> <p>Moreover, support for mental health workforce through the ‘New Ways of Working’ programme has allowed responsibility for care to be distributed among members of mental health teams to ensure advanced skills are most effectively deployed.</p> |

⁶⁹ Putting People First (2007), HM Government

⁷⁰ Commissioning framework for health and well-being (2007), Department of Health

⁷¹ Mental Health Act (2007)

| | | |
|------|---|--|
| 2008 | <i>High Quality Care for All</i> ⁷² | <p>Based upon extensive consultation with both staff and patients the review introduced the concept of better access to primary care services through the development of polyclinics and delivering care closer to home.</p> <p>It announced the development of a series of integrated care pilots which would deliver services at the frontline of health care, operating alongside hospital, community care and social services.</p> <p>Every PCT was charged with commissioning comprehensive wellbeing and prevention services in partnerships with local authorities.</p> |
| | <i>Health and Social Care Bill</i> ⁷³ | <p>Contains significant measures to integrate health and social care including the creation of the Care Quality Commission bringing together health and social care regulators into one regulatory body.</p> <p>Extended the direct payments, which had been introduced through the <i>Community Care (Direct Payments) Act in 1996</i>, to those who 'lack capacity' to have their payments made to a 'suitable person' who can receive and manage the payment on behalf of the service user.</p> |
| | <i>World Class Commissioning</i> ⁷⁴ | <p>Launched as a result of the Darzi review, World Class Commissioning seeks to improve the way health and care are commissioned through better governance, and a strategic long term vision for delivering health care.</p> |
| 2009 | Prevention Package | <p>Promotes best practice around falls prevention and effective fracture management; introduces measures to improve access to affordable footcare services; updates national Intermediate Care guidance; and summarises existing progress on audiology and telecare.</p> |
| | Care and Support Green Paper, Shaping the Future of Care Together | <p>Called for local authorities to "<i>harness the capacity of the whole system</i>" by developing commissioning strategies to stimulate high quality care environments whilst balancing the need to invest in high intensity care and early intervention/re-ablement services.</p> |
| | Dementia Strategy ⁷⁵ | <p>Called for better education and training for professionals to recognise and understand dementia.; better integration between GPs and Mental Health teams, and high quality care and support for dementia sufferers within the community.</p> <p>It required local health and social care organisations to develop a joint dementia strategy by identifying the needs of people with dementia and their carers.</p> |

⁷² High Quality Care for All (2008) Department of Health

⁷³ Health and Social Care Bill (2008) Department of Health

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill/DH_080426

⁷⁴ World Class Commissioning: Vision Document (2008) Department of Health

⁷⁵ Living well with Dementia: A national dementia strategy (2009) Department of Health

| | | |
|------------|---|--|
| 2009 | Transforming Community Services ⁷⁶ | Guidance reiterating the messages from <i>High Quality Care for All</i> and detailing how the commissioner/provider split will work within PCTs to provide community services based upon need and the types of organisations which could address this need. |
| | Integrated Care Pilots ⁷⁷ | <p>The Integrated Care Pilot programme was developed to test a range of models of integrated care. Aimed at a range of different stakeholders and based on the principle that each pilot addresses local needs, the programme will be evaluated against local and national outcomes such as:</p> <ul style="list-style-type: none"> • Improved quality of care, health, equity and economy, at a faster rate than in comparable populations. • Improved patient and user satisfaction, reported outcomes and quality of life. • Improved partnerships in care provision • Better use of scarce resources and more effective and economic delivery systems. • Improved relationships, governance, risk management and innovation in specific delivery systems. |
| | Polyclinic launch in London ⁷⁸ | Announced in Lord Darzi's report, Healthcare for London introduced a number of polyclinics in Jun 2009 to combine GP and routine hospital care with wellbeing and support services such as benefits support and housing advice in modern, fit-for-purpose facilities. The polyclinics will provide easier and better access to services for their local communities and reduce waiting times within local hospitals. |
| | Total Place | Announcement of 13 pilot sites in England to examine the totality of public spending in a range of different service areas with a view to cutting duplication, saving money and improving service delivery. |
| 2009 /2010 | Care and Support White Paper (forthcoming) | This will build on the Care and Support Green Paper and is expected to set out the framework for a National Care Service and closer integrated working between health and local government. |

⁷⁶ Transforming Community Services: enabling new patterns of provision (2009)
Department of Health

⁷⁷ http://www.dh.gov.uk/en/Healthcare/IntegratedCare/DH_091112

⁷⁸ <http://www.healthcareforlondon.nhs.uk/polyclinics/>

6.2 Annotated Bibliography

Policy and Guidance

Alliance for Health and the Future – Integrated Care: A Guide for Policymakers, James Lloyd and Suzanne Wait (2006)

This publication explores the presentations and outcomes of research at the European Social Network Conference (Edinburgh, 2005). It introduces the rationale for behind integrated care, its benefits for different users and suggestions of the different levels at which integration should occur as well as the different types of integration. Analysing the various outcomes of integration on different users and providers, it describes specific challenges and provides specific steps for policymaker direction. http://www.ilcuk.org.uk/files/pdf_pdf_7.pdf

Care Services Efficiency Delivery – Home Care Re-ablement Approach, Department of Health (2009)

CSED's Homecare Re-ablement work seeks to improve choice and quality of life for adults who need care. The work focuses on four main projects: Review of continued roll-out and support for re-ablement; Prospective longitudinal study; Homecare re-ablement for those on maintenance packages; Post-initial re-ablement phase. <http://www.dhcarenetworks.org.uk/csed/Solutions/homeCareReablement/>

Care Services Improvement Partnership – Laying the Foundations for Better Acute Mental Healthcare (2008)

This workbook provides assistance for commissioners and providers of acute mental health services seeking to improve and develop their current services. It involves a step-by-step process of strategic analysis and modelling, to support the redesign of acute mental health services and infrastructure.

<http://www.virtualward.org.uk/silo/files/csip-finalpdf.pdf>

Community Health Partnerships and Integrated Care Network – From the Ground Up: A guide to integrate service delivery and infrastructure (2009)

A practical guide to accompany the report by IPC to help local planners, commissioners, facilities and services managers plan for integrated services. It sets out the context, a framework for service design and its application in the four case studies.

<http://www.communityhealthpartnerships.co.uk/publications>

Community Health Partnerships – LIFT: Enabling Integrated Services, Co-location and Partnership Working (2009)

A document highlighting LIFT initiatives and providing examples of working partnerships and integration between Local Authorities and PCTs. Identifying the benefits of co-located services it provides illustrated case studies of how the development of fit for purpose infrastructures has enabled Local Authority and PCTs to meet the diverse needs of their communities. Alongside this it gives clear guidance of the important elements of successful joint working.

<http://www.communityhealthpartnerships.co.uk/index/PDF>

Community Health Partnerships – Future Proofing Care Outside Hospital. A LIFT Toolkit for professionals, PCTs and Local Authorities (2008)

A brochure providing detail on how the LIFT programme can assist professionals in delivering changes in delivery of care. This is directed at Local Authorities, GPs and PCTs and provides process examples and approaches for the delivery of services. As a brief guide it aims to provide direction towards further resources.

<http://www.communityhealthpartnerships.co.uk/index/PDF>

Communities and Local Government – Empowering communities to influence local decision making; Evidence-based lessons for policy makers and practitioners (June 2009)

This document draws on a systematic review of published evidence and analysis of where empowerment has worked. The report identifies key lessons for policy makers and practitioners. Building on some of the key policies outlined in the *Communities in control: real people, real power*, it outlines six key methods to facilitate empowerment which aim to influence and shape local decision making.

<http://www.communities.gov.uk/documents/localgovernment/pdf/1241955>

Department of Health – World Class Commissioning – Vision (2007)

A statement of intent for good practice and building on the strategic direction for healthcare, this paper emphasises the role of commissioning in this development with a long term approach. The importance of partnership working, engaging with the public and ensuring communities have input and consideration in the commissioning and development of services with clear aims for delivery of improved health outcomes.

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning>

Department of Health – Use of Resources in Adult Social Care: A guide for local authorities (2009)

Guide designed to assist local authority senior managers in making a self-assessment against their progress in the use of resources. It offers advice as to how managers can make shifts in the balance of the use of their money to get both efficient and effective services.

http://www.dhcarenetworks.org.uk/library/Resources/Personalisation/Personalisation_advice/298683_Uses_of_Resources.pdf

Department of Health – Integrated care pilots: an introductory guide (2009)

An introductory guide to the national programme of integrated care pilots and evaluation. It provides a summary of the work each pilot will be doing as they implement and test their models of integrated care.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106206.pdf

Department of Health – Transforming Community Services & World Class Commissioning: *Resource pack for Commissioners of Community Services* (2009)

This resource pack sets out key principles for commissioning effective and responsive community services based on good practice. Based on six core service areas of the Transforming Community services programme, it provides a route map for commissioners. Using the foundations of the world class commissioning cycle, competencies and effective health care pathways and a bibliography it informs and signposts commissioners.

<http://www.dh.gov.uk/en/Healthcare/Primarycare/TCS/Worldclasscommissioningforcommunityservices/>

Department of Health – Transforming Community Services–Enabling new patterns of provision (2009)

A best practice guidance publication which builds on the quality emphasis of High Quality Care For All, aimed at providers of community services to meet the challenges of how the needs of the communities can be met and how change can be implemented in order to ensure a well supported transformation of services. Key messages for this include following good workforce practice, effective and sustained engagement with key local stakeholders. Local decisions are encouraged with an emphasis on the need for robust consultation processes. It sets out guiding principles which ensure the progression of integrated care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197

Integrated Care Network Briefing Papers developed by Appleton, Steve – Integration and learning disability, Integration and mental health, Integration and older people, Department of Health (2009)

Three new briefings on integration from the Integrated Care Network (ICN) and endorsed by the Valuing People Team at the Department of Health. The briefings

have been produced to address some of the key developments in relation to people with learning disabilities, mental health or older people and offer a summary of policy and examples of current best practice and innovation. They also feature tips for commissioners of health and social care for getting the most from integration.
www.integratedcarenetwork.gov.uk

Integrated Care Network – Integrated Working and Governance: A discussion paper. Care Services Improvement Partnership (2004)

This paper is the result of a series of telephone interviews with the chairs and chief executives of seven care trusts with regard to governance issues. The Integrated Care Network (ICN) commissioned the University of Birmingham's Health Services Management Centre (HSMC) in response to requests from the seven care trusts to examine the nature of corporate care trust governance. Discussion around the issues, which include partnership working, roles, accountability and users and carers, is developed, providing suggestions for ways forward within each section.
www.integratedcarenetwork.gov.uk

Integrated Care Network – Strengthening Service User and Carer Involvement: a guide for Partnerships – A discussion paper. Care Services Improvement Partnership (2006)

This paper provides assistance for organisations working in partnership to involve service users and carers. Using a framework for thinking about types of involvement, it addresses key issues for organisations for approaching this from different levels. Within the paper there are suggested methods of approach and case studies for examples. Beginning with the background of legislation and examining why service user and carer involvement is required, this document provides a basis for how this could be applied in the planning of integrated services.
<http://www.dhcarenetworks.org.uk/icn/Topics/Browse/whatIs/Involvement>

Integrated Care Network – Whole Systems Working – A guide and discussion paper. Care Services Improvement Partnership (2006)

This paper examines the whole system approach, what is it and how can it be managed, with illustrations it aims to clarify complex social approaches to whole system working serves as a guide to the characteristics of policy formulation and implementation in the joining up of health and social care.
<http://www.dhcarenetworks.org.uk/icn/News/NewsArticle>

HM Government – Shaping the future of care together Green Paper. (2009)

Spells out a vision for a National Care Service, the options for reform, and how the new system could be organised and paid for. It identifies six elements that would define a National Care Services: prevention services; national assessment; joined up service; information and advice; personalised care and support; fair funding. It emphasises the importance of integration in the future of Health and Social Care Services and gives a commitment to improve and increase integrated services in the future.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102732.pdf

Housing Learning & Improvement Network – Extra Care Housing Toolkit, Care Services Improvement Partnership (2008)

This Toolkit developed by the Housing Learning and Improvement Network contains sections that cover in detail the essential elements in developing extra care housing from overall strategy, needs analysis, assessing current and potential supply, implementation and evaluation.

<http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/type/resource/?cid=1508>

**King's Fund – Policy Framework for Integrated Care for Older people.
Developed by the Carmen, Penny Banks (2004)**

This policy framework provides offers a checklist for governments, nationals and regional who aim to improve services for older people through integrated care. However, it also aims to engage older people, carers and organisations, service providers and commissioners. Providing key components for national policy, it also includes recommended actions to support implementation of policy. The framework is based on the central themes of the International Plan of Action on Ageing (United Nations 2002).

http://www.kingsfund.org.uk/research/publications/policy_framework.html

The Built Environment

Building Futures – 2020 vision: our future healthcare environments

The 2020 Vision Research Project, commissioned by The Nuffield Trust, the RIBA Future Studies Group and undertaken by the Medical Architecture Research Unit (MARU) at South Bank University. This document provides a summary of the key findings of the study, which aimed to identify current social, economic and technological influences, with the aim of encouraging better engagement between design and healthcare.

<http://www.buildingfutures.org.uk>

Commission for Architecture and the Built Environment – Buildings and Spaces: Why design matters (2006)

This paper briefly outlines the programme for design and buildings and promotes good design and good quality in its framework. By explaining the key areas and implications of buildings and planning, including health and social care and the wider impact on the community, it calls for public involvement and provides information and key resources.

<http://www.cabe.org.uk/publications/>

**Commission for Architecture and the Built Environment – Lewisham Primary Care Trust, Children and Young People's Centre
Design and innovation for primary health and social care (2005)**

This publication details a design competition that was used in successfully procuring a new building for health and social care services for children and young people in Lewisham, South London. Taking an illustrated tour of the process, it shows how the four teams responded to the management changes and also explains how healthcare environments affect the service users.

<http://www.cabe.org.uk/publications/>

Community Health Partnerships – Commissioners Investment & Asset Management Strategy (CIAMS): Understanding your estate (2009)

The development of a CIAMS builds on existing practice and promotes a complete alignment between a PCT's commissioning strategy and its plans for the future of primary and community care estate. This is a guide to the information that is needed to be included within the estate audit and subsequent estate strategy.

<http://www.communityhealthpartnerships.co.uk/index.php?ob=3&id=773>

Community Health Partnerships – Commissioners Investment & Asset Management Strategy (CIAMS): The Planning Function Requisite Skills Checklist (2009)

Building on the guide 'Understanding your estate', this document highlights the skills required to complete the development of a CIAMS.

<http://www.communityhealthpartnerships.co.uk/index.php?ob=3&id=809>

Department of Health – A guide to the NHS for local planning authorities (2007)

This short guide provides an overview of the NHS and the key principles of public health aimed at local planning authorities. By setting out how planning impacts on the wider health issues, it establishes how planning authorities may link with NHS organisations in an integrated approach to long term health and social care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078977

Department of Health – A guide to town planning for NHS staff (2007)

This guide is aimed at chief executives in the NHS trusts, directors of public health and directors of estates and facilities. By outlining the town and country planning system in England, and with specific reference to the issues relating to health services, it explains the links between planning and health and encourages involvement in the planning process.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078977

Department of Health, Strategic Health Asset Planning and Evaluation (SHAPE) tool

This tool is a web enabled, evidence based tool designed to support and inform strategic planning.

www.shape.dh.gov.uk

Healthy Urban Development Unit – Integrating health into the Core Strategy. A Guide for Primary Care Trusts in London

This guide demonstrates to PCTs how they can be involved and influence the spatial plans that councils are required to prepare. It may also be useful for boroughs to establish whether they are getting the best from the health sector to produce a sound plan. The strategic policies that guide development of Local Development Framework's (LDF) are identified.

http://www.healthyurbandevlopment.nhs.uk/pages/key_docs

Healthy Urban Development Unit– Watch out for health: A checklist for assessing the health impact of planning proposals

This document provides an outline of both positive and negative effects of developments on health, and is designed to be used at an early stage of a project action plan. By identifying potential critical issues related to proposed developments, it serves to provide a topic list for consideration and discussion.

http://www.healthyurbandevlopment.nhs.uk/pages/key_docs/key_documents

Healthy Urban Development Unit – Health and Urban Planning Toolkit (2007)

Providing a step-by-step approach to improve engagement between Primary Care Trusts and Local Planning Authorities, this toolkit provides detail on how to integrate health into the Local Development Framework and the planning application process. Directed at both PCT's and boroughs it aims to clarify the common goals and understanding of how health and wellbeing can be supported through planning and policy.

http://www.healthyurbandevlopment.nhs.uk/pages/key_docs/key_documents

Healthy Urban Development Unit – London Thames Gateway Social Infrastructure Framework: A toolkit to guide decision making at the local level

This Toolkit provides an analysis of different approaches to mapping and predicting future need. Using an electronic Social Infrastructure Planning Model, it aims to assist in the planning for a new social infrastructure across the London Thames Gateway. There is also an analysis of existing and alternative approaches to delivery and a summary of key criteria for considered.

http://www.healthyurbandevlopment.nhs.uk/pages/int_social_infra/integrating_social_infrastructure

Integrated Care Network and Communities and Local Government – Commissioning housing support for health and wellbeing, Care Services Improvement Partnership (July 2008)

This report aims to help commissioners in health, local government and other public services achieve better services through providing examples of expertise and best practice around integrated service planning and provision. Addressing the issues of housing and its role in promoting health and wellbeing it illustrates different models through which localities can achieve integration across services.

<http://www.dhcarenetworks.org.uk/IndependentLivingChoices/Housing/Topics/browse/Housing/HousingSupport>

6.3 Websites and Organisations

Commission for Architecture and the Built Environment

The CABE site has an extensive range of resources with sections devoted to health, inclusion and sustainability and case study links, initiatives and resources.

<http://www.cabe.org.uk/#2>

Community Health Partnerships

This website contains information about a range of public and private partnerships. With resources and information about specific services and a wide range of documents by other organisations, it contains a wide range of guidance for development of integrated health and local authority services.

With clear explanation regarding its role for delivering the Local Improvement Finance Trust (LIFT) Initiative and financial, management and consultancy services in this area, and with news updates of developments and events across all regions, CHP provide useful information on all stages of developments.

<http://www.communityhealthpartnerships.co.uk>

Healthy Urban Delivery Unit

With core aims of improving communication and cooperation between spatial planning and health sectors in London, this site contains links for information, advice and support. Easy to use with key documents and updates, the site is funded by the 31 NHS PCTs across London.

<http://www.healthyurbandevlopment.nhs.uk/>

Integrated Care Network

This website provides information and support to frontline NHS local government organisations. By providing this, it aims to support the quality of provisions to service users and carers through integrating the planning and delivery of services. It facilitates the communication links between organisations and government which promotes a common theme of effective policy and practice synergy.

<http://www.dhcarenetworks.org.uk/icn/>

Local Partnerships

The Local Partnerships' website is a joint venture between the Local Government Association and Partnerships UK (incorporating 4ps). The site provides support to local public bodies with an overall aim of enhancing the quality of people's lives through improving the organisations and bodies' ability to source and deliver high quality, cost-effective public services and infrastructure. By links and information the site points to innovative ideas for solving emerging problems and areas of information include sourcing and commissioning skills, programme and project management capabilities, procurement, negotiating and contract management capacity.

<http://www.localpartnerships.org.uk>

NHS Primary Care Commissioning

This site provides support for commissioning, contracting and communications support aimed at SHAs, PCTs and the Department of Health. It requires subscription for its services, and is a useful resource for providing insight into national policy, implementation and best practice in commissioning and contracting across all areas of primary and community care.

<http://www.pcc.nhs.uk/>



Community Health Partnerships
New Kings Beam House
11th Floor
22 Upper Ground
London
SE1 9BW

Integrated Care Network

Integrated Care Network
Department of Health
Wellington House
133–155 Waterloo Road
London
SE1 8UJ



Institute of Public Care
Oxford Brookes University
1st Floor South Suite
Midland House
Botley
Oxford
OX2 0PL

