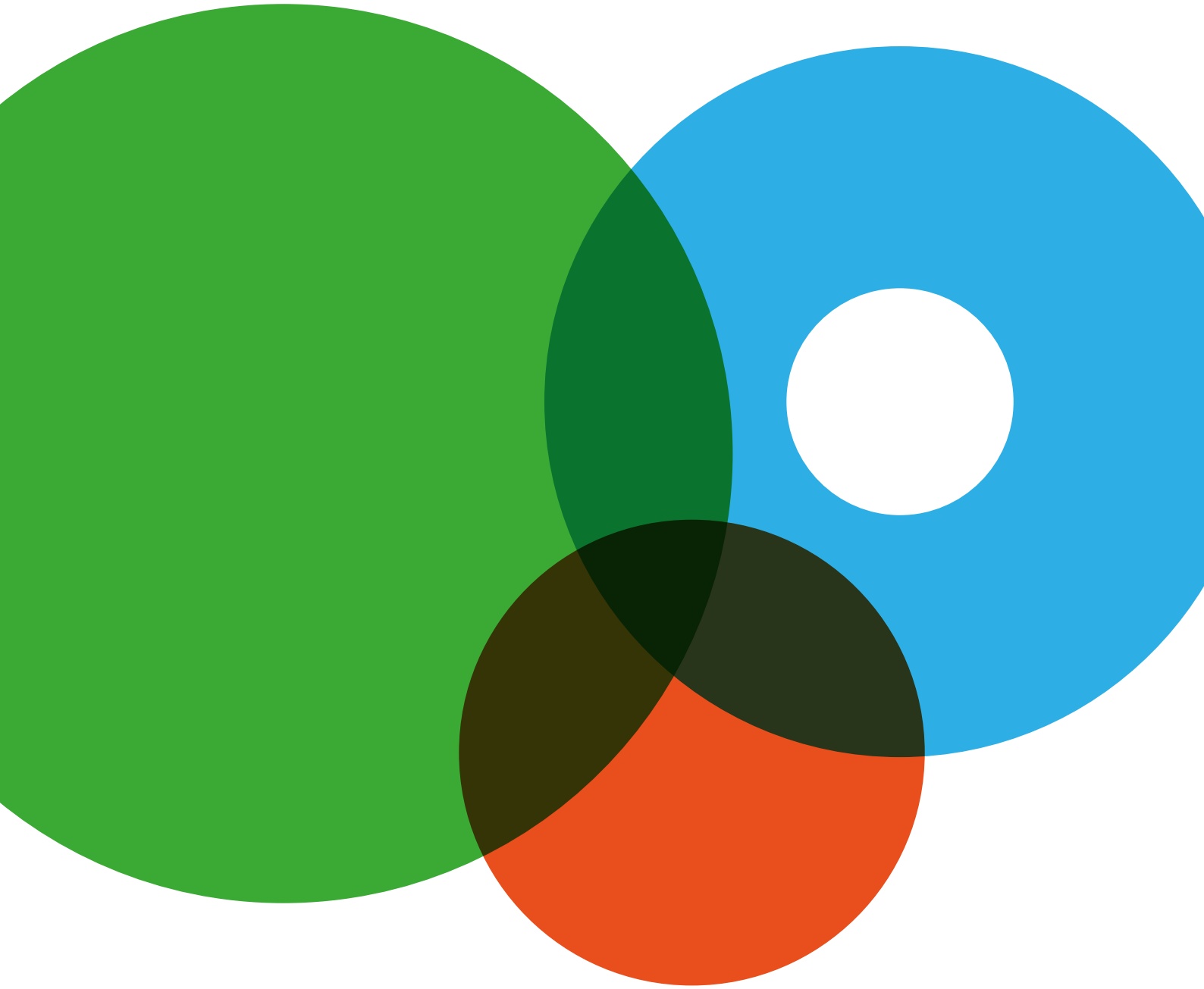
Local Government Association

NHS CONFEDERATION

Stepping up to the place

The key to successful health and care integration



directors of adass
adult social services

NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups

Contents

"We are very pleased to have developed and shaped this vision with our partners across the system, who like our member CCGs, recognise that the integration of health and social care is key to delivering truly person-centred care and that we must focus on the concept of place-based commissioning. Fulfilling the vision we've collectively set out here at a local level is also critical if we are to achieve our shared ambitions of transforming care and delivering better outcomes for our populations."

Dr Amanda Doyle and Dr Graham Jackson, Co-chairs, NHS Clinical Commissioners

"Integration is an important step towards transforming services for adult social care so they are sustainable for the future, but cannot be seen as an end in itself. It is a means to improving outcomes and the experience for individuals who receive care and health services. It is clear that the need to transform services has never been greater, given our ageing population and the complex care and health needs of people who we are supporting and of course the unprecedented financial pressures facing local government and adult social care.

"When we need care and support, we need services that are personalised, of good quality, that address our mental, physical and other forms of wellbeing, and are joined-up around our individual needs and those of our carers. Our care and support needs to be well connected to the community in which we live."

Harold Bodmer, President, ADASS

"We've made great strides over the last few years to bring together services to get better services, better health and wellbeing outcomes and better use of our resources, but we need to go further and faster in order to address the demographic and financial challenges facing us. Through our shared vision, we are supporting local political, clinical and community leaders to ensure that integration moves from the sidelines to the mainstream."

Councillor Izzi Seccombe, Chair, LGA Community Wellbeing Board

"This report sends a clear message that to improve the standard of care that we deliver to people we must better integrate our health and care services. The NHS continues to face unprecedented demand and challenging financial circumstances. Against this background, we need to make sure we are utilising all the collective resources of a 'place' to benefit our local communities. There is now a real urgency to deliver on this ambition. Our shared vision, outlined in this report, is matched by the commitment shown by the whole health and care sector to provide integrated services to those that need it most. The report sets out guidelines for local leaders, drawn from what we have learnt so far and offered to support them to step up the pace of transforming care. Our priority now must be to turn rhetoric into action so that we can realise a health and care system that meets the needs of people today and tomorrow."

Stephen Dorrell, Chair, NHS Confederation

1

Our shared vision

Introduction

Bringing together health and social care has been a constant and dominant policy theme for many decades, and many places around the country are already demonstrating the potential to do things differently.

We – the Association of Directors of Adult Social Services, Local Government Association, NHS Clinical Commissioners and NHS Confederation – believe, however, it is time to change gear. The status quo is no longer an option, and everyone must innovate and transform on a scale and at a pace not yet seen.

The imperative to integrate and transform has never been greater – from finding ways to organise services around the demands of a population with more complex and chronic health and social needs, to responding to the extremely challenging financial context for the NHS and local government. Integration is not an answer in itself, or a panacea for the system's financial challenges. Its primary purpose is to shift the focus of health and care services to improving public health and meeting the holistic needs of individuals, of drawing together all services across a 'place' for greatest benefit, and of investing in services which maximise wellbeing throughout life.

We believe it is time to put integrated systems and services to the test, to translate aspirations into action, and to ensure they deliver for our citizens. So we have come together to describe what a fully integrated, transformed system should look like based on what the evidence tells us. This builds on our existing joint work over many years, and takes it to the next level – to call on local and national stakeholders to work together to ensure integration becomes integral to a transformed system. In short, to enable integration to be seen as business as usual.

To make this happen, we call on everyone to join us in testing and developing the principles and practices set out in this vision, to learn and to share, to challenge and to deliver. This will involve pushing ourselves and our partners to deliver the best outcomes for our communities. It will mean understanding the big issues that need to be addressed – at a local and national level – to make integration not only happen but to make sure it improves the health and wellbeing of our populations. This includes acknowledgement and redress from national leaders that the unprecedented pressure on funding remains one of the greatest risks to success.

It will mean being clear why partners stand together, stepping outside institutional siloes and navigating multiple meanings of 'place'. It means redesigning the health and social care landscape together, decommissioning services as well as creating new ones, sharing risks and jointly being responsible for what may be difficult decisions within a complex, challenging and changing system. To really make a difference, it will be a demanding task at times, but is one we must, and can, achieve together.

What are we calling for?

- Local systems to embed integration as 'business as usual'.
- A collective approach to achieving integration by 2020.
- Consensus and action on the barriers to making integration happen.
- Dialogue with national policy makers on ensuring integration is effective.
- Ongoing testing and evaluation to develop the evidence base.
- National partner action to enable the minimum requirements to integrate effectively.

Our vision for integrated care

Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities. They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners with citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizens' wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services.

Why integrate?

Integration is not an end in itself. A clear consensus has developed that redesigning services around the needs of individuals in a place provides the best opportunities to improve people's health and wellbeing including closing health inequalities, and helping to bring financial sustainability. Increasingly, as financial and performance pressures continue to increase, the focus is on changing the conversation about the objectives of health and social care.

This consensus has developed from the evidence emerging from the many places implementing integrated approaches – including trailblazers such as integrated care pioneers and vanguards, as well as national programmes including the Better Care Fund. The evidence indicates that integration results in improved clinical outcomes and a better patient experience. There is also evidence that integrated, person-centred services can change the pattern of demand and bring service efficiencies. There is less evidence, however, that integration, on its own, will address the serious financial challenges facing the system. This evidence base is explored in section two of this document: What we have learnt about successful integration.

What are the big issues to address?

Implementing our vision for integration requires system transformation. To succeed, local and national leaders have to address a number of fundamental questions.

Although different places will develop an integrated system tailored to local needs and aspirations, there are common issues to address, and these are explored in section three of this document: What are the big issues for local and national leaders?

What we can achieve through integration

Individuals

- Information, advice and support to improve physical, mental, emotional and economic health and wellbeing throughout life.
- Information, advice and support that helps you take care of your own health and wellbeing.
- More choice and control over the services you receive, such as through a personal budget.
- Support developed jointly with practitioners, built around your needs as a whole person.
- Confidence that local services are safe, effective, high quality and accountable.
- Control of and access to your own information.

Communities

- Stimulating and supporting communities to be active, safe and well, making the most of their own strengths and resources.
- As taxpayers, confidence that the local system is effective and offers value for money.
- Ongoing information and opportunities to hold local leaders to account for progress on health outcomes.
- Health and care that supports better health and wellbeing for all, and a closing of health inequalities.
- Opportunities to shape local services and plans for change.

Local health and wellbeing systems

- Collective leadership, which drives culture change, accepts responsibility for achieving the vision and ensures commissioning for and provision of better outcomes.
- Local revenue-raising powers and greater flexibilities and freedoms to deploy resources according to local need.
- A workforce that meets the needs of citizens, and is equipped to deliver holistic, proactive, integrated care.
- A clear shared vision and action plan based on the needs of the community and designed with them, backed by clear system governance.
- Models of care and support that enable the shared vision and flexibility to meet the varying needs of the population.
- A joint understanding of the resources available locally, and agreement to direct them to the most effective interventions.

Government and national bodies

- A permissive culture and increasing devolution or delegation of resources and decision-making to local clinical, political and professional leadership.
- Driving forward devolution or delegation of regulation and performance management of local services, and a recognition that a sector-led approach to improvement is the most effective way of ensuring continuous improvement in local services.
- A single national outcomes framework for health, public health and social care, with flexibility to enable local leaders to determine their priorities.
- Investment in building the capacity and competency of the workforce to provide integrated care.
- Simplification of the rules to support comprehensive information-sharing at all levels.
- Funding and financial systems which incentivise integrated, preventative, proactive and community-based services.
- Empowering local systems by supporting flexibility to design services around local needs.

What do we need to make integration happen?

We agree a fully-integrated system should have the following essential characteristics:

Shared commitments

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

What does this mean?

- Moving away from a focus on episodic care and treating ill health towards an emphasis on independence, wellbeing and holistic care for everyone.
- Understanding the needs and wishes of citizens, including the resources they and those around them can contribute to their own health and wellbeing.
- Bringing together all the assets in a place to stimulate and support individuals, families and communities to be more able to lead happy, safe, independent and fulfilled lives.

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

What does this mean?

- Involving individuals and communities in decisions at all levels of the system, from jointly writing a care and support plan with service providers, to groups of community stakeholders playing a central role in designing, implementing and reviewing services.
- Ensuring services treat people with dignity and are personalised to their needs, and are based on a single system-wide assessment of the needs of the whole population.
- Giving citizens greater choice and control of services and support, including encouraging the use of a personal budget for health and social care.

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

What does this mean?

- Offering information, education, advice and support to enable everyone to understand how to make changes for a healthier lifestyle and support their care needs.
- Building capacity in the community to be able to support all citizens to make full use of community and social networks and activities.
- All system leaders and practitioners actively ensuring their actions support their shared vision and their contribution to improving health and wellbeing.

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

What does this mean?

- Changing the perception of health and care from just treating ill health or substantial care needs to one which keeps people well and safe, leading happy and fulfilled lives.
- Redirecting investment to prioritise public health and community services, as well as wider issues affecting health such as education, housing and jobs for all citizens.
- Having open and trusting relationships with partners, stakeholders and the public from which to make effective, targeted and needs-based decisions about service provision.

Shared leadership and accountability

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

What does this mean?

- Leaders stepping beyond their organisation's walls to listen and understand each other, and to lead and make decisions collectively for the benefit of citizens.
- Local leaders being best placed to interpret and respond to community needs drawing in wider services and local resources where appropriate to improve health and wellbeing.
- Leaders being inclusive and collegiate, investing time and energy in relationships, ceding some control, and navigating complexity across multiple accountabilities.

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

What does this mean?

- Navigating across footprints and local identities which exist within any one place, ensuring that the focus remains on what most benefits local populations taking account of whole community need and multiple organisational governance.
- It can mean health and wellbeing boards agreeing to sit within larger arrangements as well as establishing alternative partnerships to carry out business effectively.
- It can mean multiple arrangements for different purposes – the key is ensuring decision-making is with the right people and in the right place.

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

What does this mean?

- Working together to align priorities and responsibilities, including overcoming cultural and performance challenges to establish a common language and set of objectives.
- Exploring the many ways to integrate health and care to find the models and approaches which best meet local needs and aspirations.
- Developing a system which works cohesively, with individual services that are high-quality and safe, and is sustainable in terms of services, markets and workforce.

Shared systems

8 Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies.

What does this mean?

- A common information basis and sharing for planning purposes and shared care records – both for individual care and population-based planning.
- Service arrangements and plans involve enabling and empowering people through technology, and also meaning they tell their story only once.
- Developing a shared risk stratification model to identify individuals most at risk.

9 Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.

What does this mean?

- Aligning commissioning across all budgets, whether pooled or not, focusing on outcomes and increasing investment in community services that build independence.
- Agreeing how to assess and share risk between partners.
- Shared long-term planning, which charts an achievable course to transform services and improve health, wellbeing and financial sustainability.

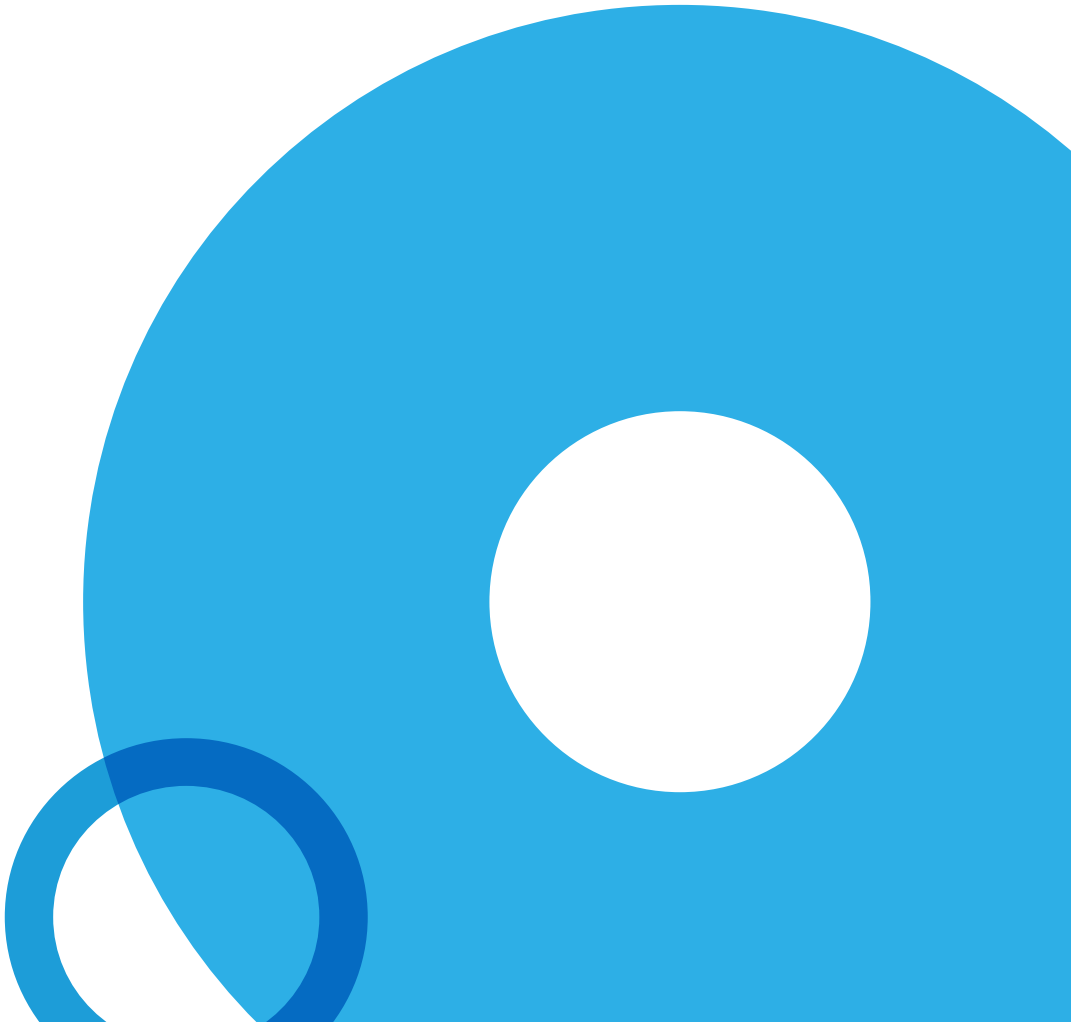
10 Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.

What does this mean?

- Developing a joint workforce strategy across the health and care system, involving formal and informal workforces, and based on the needs of the population.
- Investing in changing skills and behaviours towards ones which enable person-centred, coordinated care in order to promote people's independence and wellbeing.
- Practitioners across health and care disciplines working seamlessly together to plan and provide care which is proactive and holistic, and supports independence.

2

What we have learnt about successful integration



Introduction

The essential characteristics in our vision for a fully integrated health and care system are based on considerable learning and evidence from across the country, where local leaders are transforming services for the benefit of their users and residents. From vanguards to integrated care pioneers, the Prime Minister's Challenge Fund to Transforming Care, there is a groundswell of good practice from which we can learn.

Though integrated systems can take any shape, depending on local need, the evidence base points towards a number of key elements and characteristics that they must have in order to succeed. These are the basis of our vision, and are explored in more detail in this section.

The impact of integration is hard to measure. It can take years to materialise, and there are currently gaps in the evidence base. All the signs, however, indicate that integrated care can be effective in meeting the needs of an ageing population, particularly one with more complex, chronic health needs. Care that is centred around the person improves the patient experience and clinical outcomes, such as fewer emergency admissions to hospital or better quality of life, and brings service efficiencies.

Transformation, where successful, is iterative and requires trial and error, incremental change, and sustained effort and commitment. Many case studies in this section point to the importance of starting small, where it most makes sense to test and refine thinking, and to build engagement, momentum and learning to deliver lasting change. The evidence points to the need for investment to enable transformation. In the 2015 Challenge, NHS Confederation, NHS Clinical Commissioners, Local Government Authority and Association of Directors of Adult Social Services, among others, have called for a transformation pot to enable this, as have The King's Fund and The Health Foundation in the publication *Making change possible: A transformation fund for the NHS*.[1]

This learning is not new – from the Wanless review of social care[2] to Total Place, from children's trusts to the *Five Year Forward View*,[3] many programmes and initiatives have advocated the principle of partnership working across a locality. More recent initiatives, including the Better Care Fund and new care models continue to develop and test place-based approaches.

This section does not seek to repeat the range of learning and good practice evident across the country, but to point to where local experience is showing the way in improving people's health, wellbeing and care experience. A key resource in developing this section is the recent Local Government Association publication, *The journey to integration – Learning from seven leading localities*.[4]

The Health Foundation provides a comprehensive timeline[5] and resource library charting the history of adult social care and integration. The King's Fund has produced a map of case studies.[6] Further compilations and reports are listed throughout and at the end of this document, with thanks to the organisations from which this document draws evidence.

Shared commitments

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

Areas that are at the cutting edge of integration are demonstrating that the most effective approaches to enable a shared focus on communities' health and wellbeing are underpinned by a shared narrative of why integrated care matters, a comprehensive assessment of people's needs and priorities, deep community engagement, and payment and commissioning systems which align financial incentives with improvements in population health and wellbeing. These aspects and characteristics will be explored further in this section.

These areas have designed their system around the needs of their population's health. This approach enables leaders to think differently about the needs and solutions for local communities, bringing in wider factors which affect health, addressing inequalities in health and wellbeing, and considering needs holistically, encompassing multiple morbidities and contributing factors. Increasingly, this involves wrapping the whole system around shared priorities, utilising all the assets and resources across the locality.

To find out more, please see these reports and case studies:

- Local Government Association: *The journey to integration: Learning from seven leading localities*
- The King's Fund: *Population health systems: Going beyond integration care; and Place-based systems of care*

For links to the reports and case studies referred to in this document, please go to: **www.nhsconfed.org/steppingup**

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

All the evidence underscores that strong leadership and shared purpose must be underpinned by deep, meaningful and ongoing dialogue with all stakeholders in a system, from leaders, managers and workers to the public, communities and those using services. This dialogue must occur at every stage of designing, developing, delivering and evaluating services, ranging from individual care planning to whole-system reform. This dialogue must seek to understand health and wellbeing in broad, holistic terms, seeing it from the point of view of the individual, not the service or organisation.

At individual service planning levels, this means co-creating personalised care plans. A core tool, initially utilised by the integrated care pioneers, is National Voices' 'I statements', which states as an overarching principle: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[7] These statements can be used to frame the partnership between professionals and those using health and care services. It also means developing the services that individuals say are important to them.

To find out more, please see these reports and case studies:

- Local Government Association: *Health and Wellbeing Board good practice – Durham: 'Big Tent' events*
- Threshold Pathways to Independence: *Stockport's Targeted Prevention Alliance,* [online]
- Oxleas NHS Foundation Trust: *Case study: Greenwich – Co-ordinated care – a patient's story*

- National Voices: *What is the role of VCSE organisations in care and support planning?; Supporting shared decision-making: A summary of the evidence;* and *Enhancing experience of healthcare: A summary of the evidence*
- NICE: *Community engagement: Improving health and wellbeing and reducing health inequalities*

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

Investment in more preventative, proactive and responsive care is a key component of integration. The evidence strongly suggests that asset-based approaches, which focus on communities' skills and capacities rather than their deficits, help people to improve their resilience, independence and wellbeing. They also enable leaders to see their local system differently, working with their communities to share and shift resources to support improved health and wellbeing.

These approaches build the capacity of individuals and the community to take control of their own health and wellbeing. Effective approaches include health education, community coordination roles and peer support to encourage people to share knowledge, experience or practical help with each other. In addition, there are interventions which enable individuals to be responsible for their own care, such as patient activation, expert patient programmes, or health trainers or coaching.

Frequently, these approaches involve increasing use of voluntary and community sector organisations, such as in working with individuals to agree their care plans, expanding volunteer, community or peer roles, or undertaking 'social prescribing' where community and social activities are promoted as routes to better health and wellbeing.

At a system level, taking responsibilities for one's contribution includes leaders and partners being clear of their roles and responsibilities, developing trust in each other's commitment to deliver. This requires clarity of shared vision and priorities across all partners, covering both short- and long-term timeframes, and backed by a strong narrative and roadmap for change, with achievable steps towards the long-term vision. The acid test of this is when individual organisation's actions are evidently coherent within the shared vision, even when they are working within their own organisation. Another lesson is the need to invest levels of resource in programme management commensurate with the scale of challenge and ambition of transformation.

To find out more, please see these reports and case studies:

- Cornwall Pioneer Knowledge Bucket: *JSEC briefing on the approach and findings from the matched cohort evaluation of the Age UK Living Well programme*; and *Living well* infographic
- NHS Clinical Commissioners: 'Social prescribing to improve outcomes in Gloucestershire', *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*, pp30–31
- National Voices: *Peer support: What is it and does it work?;* and *Supporting self-management: A summary of the evidence*
- The Health Foundation: *Heads, hands and hearts: Asset-based approaches in health care*

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

The evidence is showing that transformation through integration, through embedding person-centred approaches, requires a transformation in perceptions of healthcare, among leaders, the health and care workforce and the public alike, towards one that keeps people well rather than focusing on treating ill health. This emphasis on more preventative approaches usually involves shifting resources 'upstream' to community or home settings to emphasise wellbeing rather than ill health, and increasingly of utilising the full spectrum of local services to improve community's health and wellbeing. Typically it means investing in community-based services as well as tackling the wider issues that can affect health, ranging from alcohol and diet, to poverty, housing quality or employment.

Given the financial and performance pressures across local systems, changing investment to prioritise community and social support can involve difficult disinvestment decisions. Prevention is no longer an optional add-on, it is an essential lever to improving people's health and experience of care, and the financial sustainability of the system.

To find out more, please see these reports and case studies:

- Bristol Ageing Better: *Bristol – A brilliant place to grow old*, [online]
- NHS Southampton City CCG: *Mental health matters in Southampton*, [online]
- NHS Confederation: *Dorset fire and rescue service – case study*, [online]; *Bradford – case study*, [online]; and *Humberside fire and rescue service – case study*, [online]
- Local Government Association: *Prevention: A shared commitment*
- NHS Clinical Commissioners: *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*
- National Voices: *Promoting prevention: A summary of the evidence*
- Public Health England: *Health and care integration: Making the case from a public health perspective*

Shared leadership and accountability

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

Effective system leadership requires collaborative, inclusive governance arrangements across all agencies in a place – it is not enough to be a coalition of the willing, or of like-minded sections of the system. It is vital that every part of the local system is engaged.

Overwhelming evidence indicates that strong relationships are the most important factor in leading successful transformation, ones which enable leaders to overcome organisational boundaries for the benefit of the whole system and the whole population. Where this is working well, it is often because local leaders at all levels – clinicians, health and care workers, managers and communities – are taking bold steps to move away from traditional ways of working individually towards collaborative approaches that benefit all.

This takes time, effort and sometimes a leap of faith to develop these system behaviours. Many innovating localities point to working together on a collective problem to build relationships and trust, such as collaborating on a contract bundle, integrating pathways around a population group, or developing federations or new organisational forms.

There is growing evidence of the value of health and wellbeing boards in joining up strategic commissioning of health and care, of taking a preventative, place-based approach and of bringing together key local players and public services within a very difficult financial climate. It is crucial that they increasingly demonstrate their value in balancing the short-term priorities within a longer-term vision, and of harnessing the energy within their geographical area to underpin a strategic focus on delivery. Devolution is another way of implementing the principle of subsidiarity it built on the premise that decisions taken more locally better serve the population.

To find out more, please see these reports and case studies:

- Local Government Association: 'Leadership', *The journey to integration*: *Learning from seven leading localities* pp51–54
- The King's Fund: *System leadership: Lessons and learning from AQuA's integrated care discovery communities; The practice of system leadership: Being comfortable with chaos*; and *Making integrated care happen at scale and pace*
- The Leadership Centre: *The revolution will be improvised part II: Insights from places on transforming systems*

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

Good governance ensures clear accountability. The strongest lessons from innovating systems are that governance arrangements must allow transformation to take place, and that any changes must ensure form follows function. A lack of clear, shared governance structures is seen by many leaders as a barrier to creating joined-up and integrated plans.

The nature of the governance arrangements is entirely down to local context, though typically they start with a partnership-wide board to oversee developments. There are existing structures, most notably health and wellbeing boards, which have a statutory role in bringing local government and health together to agree what the health and care needs

of the local population are and plan services on this basis. In other places, new forms are developing, such as creating group structures and qualified majority voting, as is emerging in Greater Manchester. New integrated models, such as accountable care organisations, have also begun to go beyond existing governance mechanisms.

In other localities, agencies have come together to create networks or partnerships, backed by a compact that sets out responsibilities as well as dedicated programme management support. Others still have developed infrastructure underneath their health and wellbeing board, such as an executive group or wider stakeholder fora. The key is ensuring that lines of sight, up through the NHS as well as outwards to local communities, are clear and understood.

Another lesson from these localities has been to ensure decisions are taken at the most appropriate level – and that this will vary according to context. This is particularly the case when reconciling multiple planning requirements. Currently, the Better Care Fund, devolution, sustainability and transformation plans, co-commissioning, and health and wellbeing strategies may dominate, but at any time, there are always multiple competing demands on local systems. The key is aligning around the shared vision for the patch, keeping decisions as local as possible. Many also point to creating governance which can adapt and flex to local circumstances, for example developing 'systems within systems' to respond to multiple priorities and visions.

To find out more, please see these reports and case studies:

- Local Government Association: *The journey to integration: Learning from seven leading localities; Body of knowledge on HWBs*, [online]; and DevoHub – *Building the evidence base*, [online]
- Greater Manchester Combined Authority: *Taking charge of our health and social care in Greater Manchester*

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

All the evidence points to the need to have a clear, shared vision which is built around the needs of the local community, with clarity about what partners, services and objectives are needed to achieve the vision. This must be backed by a strong narrative, clear long-term goals and a roadmap for change, to bring coherence to what is likely to be a fluid and challenging environment which must respond to a range of short- and long-term pressures and ambitions.

To be successful, committed leaders highlight the need for sustained partnership work to develop a common narrative and case for change, noting that this collective commitment, including clinical, managerial and political leaders, creates significant drive and momentum for change. Furthermore, this approach emphasises that integration is not an end in itself. Key too is ensuring the vision focuses narrowly on the most important system issues, ones which need collective action and which will make the biggest impact on people's health and wellbeing.

Increasingly local health and wellbeing strategies are providing the platform for this collective action, with local partners coalescing around the priorities of their population and finding local solutions to often multi-faceted problems. These strategies are grappling with the 'big' issues using a wide range of intelligence, both quantitative data and qualitative engagement of communities. They are considering both the issues and the solutions in the broadest terms, drawing in other public services including housing, jobs and environment, linking improving health and wellbeing with growth and prosperity.

It is clear there is no single definition of or approach to integration. The evidence points to arrangements and organisational forms building on local circumstances and ambitions – be they joint commissioning, integrated provision or devolved arrangements. It is seen too that any given health and

care economy will likely have a diversity of provider and commissioning models that span organisational and service boundaries, according to different objectives.

Integration does not always involve structural changes to organisations, however. In 2010, the King's Fund concluded that organisational integration alone is unlikely to deliver better outcomes, and that attention should focus on clinical and service integration. Many localities have developed integrated community health and care teams, usually around GPs or neighbourhoods. Similarly many are integrating around pathways, priorities or population groups. There is a growing evidence base, too, for the most effective interventions to underpin new care models – *The journey to integration* explores the most common across the case studies.

To find out more, please see these reports and case studies:

Strong visions

- NHS Providers: *Birmingham Community Healthcare NHS Trust: Healthy villages and the complete care model*
- The King's Fund: *Integrating health and social care in Torbay: Improving care for Mrs Smith*
- Wiltshire Council: *Public health in Wiltshire – Public health intelligence*, [online]
- NHS Clinical Commissioners: 'Addressing preventable early deaths in Brighton and Hove', *Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis*, p8

Integrating

(see 'Shared systems' on pages 22–25 for further examples)

Around a population group

- NHS Confederation: *Growing old together: Sharing new ways to support older people; Walsall Healthcare NHS Trust – case study*, [online]; *South Warwickshire NHS Foundation Trust – case study*, [online]; and *Liverpool – case study*, [online]

Around older people

- The King's Fund: *Making our health and care systems fit for an ageing population; Providing integrated care for older people with complex needs: Lessons from seven international case studies*; and *Coordinated care for people with complex chronic conditions: Key lessons and markers for success*

Proven interventions

- Local Government Association: 'Impact', *The journey to integration: Learning from seven leading localities*, p17
- The King's Fund: *Transforming our health care system: Ten priorities for our commissioners*; and *Clinical and service integration: The route to improved outcomes*
- The Nuffield Trust: *Evaluating integrated and community-based care: How do we know what works?*
- NHS Providers: *Right time, right place commission into transfers of care: Evidence review*

Shared systems

Integration can take many forms but the evidence points strongly to several underlying enablers. These are explored more fully in the publication *The journey to integration: Learning from seven leading localities*.

8 Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies.

There is strong evidence that the free flow of information is an essential prerequisite to making change happen – the sharing of information is required not only around an individual's care, but also must underpin population-based approaches such as proactively targeting preventative support to people at greater risk of poor health, as well as system-wide issues such as workforce reform.

The evidence, captured in *The journey to integration*, suggests that it is essential to understand the totality of your population's needs, and segment them into different groups to identify those most likely to be admitted to hospital. More sophisticated systems are broadening their focus to consider all health and care needs. Typically integration programmes have used these tools to identify the top 1–2 per cent at risk of admission, who are the most costly patients, to proactively target with more preventative and personalised support. The early evidence suggests that this narrow focus is not sufficient to have the impact desired on demand, outcomes or cost, and that leaders must extend the scope of transformation programmes to cover larger proportions of the population if they are to achieve their intended impact.

The use of technology to improve outcomes and experience of care is also proving a vital driving force for change. Most commonly this includes the use of telecare and telehealth systems, such as using video conference consultations, or installing monitoring devices in care homes or private homes to enable passive remote patient monitoring. Technology is also increasingly useful in terms of supporting people to look after themselves, such as self-care apps.

To find out more, please see these reports and case studies:

- Local Government Association: 'The flow of information', *The journey to integration: Learning from seven leading localities*, pp36–39
- NHS Islington Clinical Commissioning Group: *Integrated digital care record and person held record full business case*
- NHS: 'Nottingham City: Treating people through technology' and 'Leeds: Tele X marks the support', *People helping people: Year two of the pioneer programme*, pp60–61 and pp62–64
- NHS Providers: *Telemedicine at Airedale NHS Foundation Trust: Better care in the community for elderly patients*
- The King's Fund: *The digital revolution: Eight technologies that will change health and care*, [online]; and *Reading list – Technology in health and social care: telehealth, telecare and telemedicine*

9 Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.

A clear lesson is that payment reform is needed to fund direct changes in care and change incentives for organisations. Whatever the locally chosen financial model, this must be underpinned by the needs of the population seen as a whole. What matters is aligning commissioning activity and payment mechanisms across organisations and creating strong, shared risk assessment and risk sharing. This can include reframing the commissioner/provider divide, to one of strategically commissioning provision around the needs of the local population, or groups within it. This requires careful understanding of the demand, costs and outcomes of the population, and consequently a very clear understanding of how to share risk equitably across partners. It also requires ongoing communication and engagement across providers, commissioners and the community to develop and embed a shared vision.

Commissioning models can range from pooling budgets, using integrated or joint commissioning, commissioning around outcomes, or developing capitation or personal budgets – how this is configured is for local determination. For example, Salford Royal NHS Foundation Trust working with a local mental health trust and CCG are creating a single health and social care budget by pooling funds. In Northumberland the local authority will be the strategic commissioner across all health and care spend. Meanwhile in Plymouth there is joint commissioning and delivery of adult social care and community health provision.

Integrated provider forms, similarly, are evolving to meet local need. The vanguard programme is testing different forms, including joining acute provision with primary care, as well as bringing all out-of-hospital provision together around GP practices. Some localities are combining the services into one organisation, others are developing federated or partnership models.

To find out more, please see these reports and case studies:

- The Nuffield Trust: *The NHS payment system: Evolving policy and emerging evidence; New models of primary care: Practical lessons from early implementers*; and *Provider chains: Lessons from other sectors*
- North West London: *Finance, analytics and information tools,* [online]; and *Governance and contracting tools,* [online]
- The King's Fund: *Commissioning and contracting for integrated care; Accountable care organisations in the United States and England*; and *Options for integrated commissioning: Beyond Barker*
- Royal College of Physicians/Royal College of General Practitioners: *Patient care: A unified approach*

10 Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches.

It is evident that integration cannot occur without creating new ways of working across organisations and between professional and managerial teams. Overwhelmingly, the evidence shows the importance of planning and training the workforce around the needs of the population, which requires a profound shift in the thinking of workforce planners and of those providing care. In addition, the evidence highlights that the workforce must be seen in the widest possible context, including voluntary and community partners as well as carers and the private and independent providers in the social care market.

The most powerful way to develop the workforce to work in new ways is to engage them in designing and implementing the new approaches. It is critical to help workers to understand the person-centred narrative and case for change, and for them to feel empowered to own and develop it within their own practice. This culture change takes considerable time and effort. Some key learning points include the need to consider the skills and competencies required in the workforce, rather than the professionally defined roles and tasks. In addition, of developing new roles to support integrated working. The most common ones include care coordination or of shifting expertise to new settings, such as moving specialities from acute to community settings.

There are a range of proven benefits of integrated approaches which can support the development of integrated workforces. These include case management and care coordination through multi-disciplinary teams, which typically have lead professionals and employ joint assessment and planning arrangements.

To find out more, please see these reports and case studies:

- Local Government Association: 'Workforce', *The journey to integration: Learning from seven leading localities*, pp44–47
- NHS Confederation: *Cumbria Partnership NHS Foundation Trust – case study*, [online]
- NHS England: *MDT development: Working towards an effective multidisciplinary/multiagency team*
- The King's Fund: *Specialists in out-of-hospital settings: Findings from six case studies*

For links to the reports and case studies referred to in this document, please go to: **www.nhsconfed.org/steppingup**

Further reading

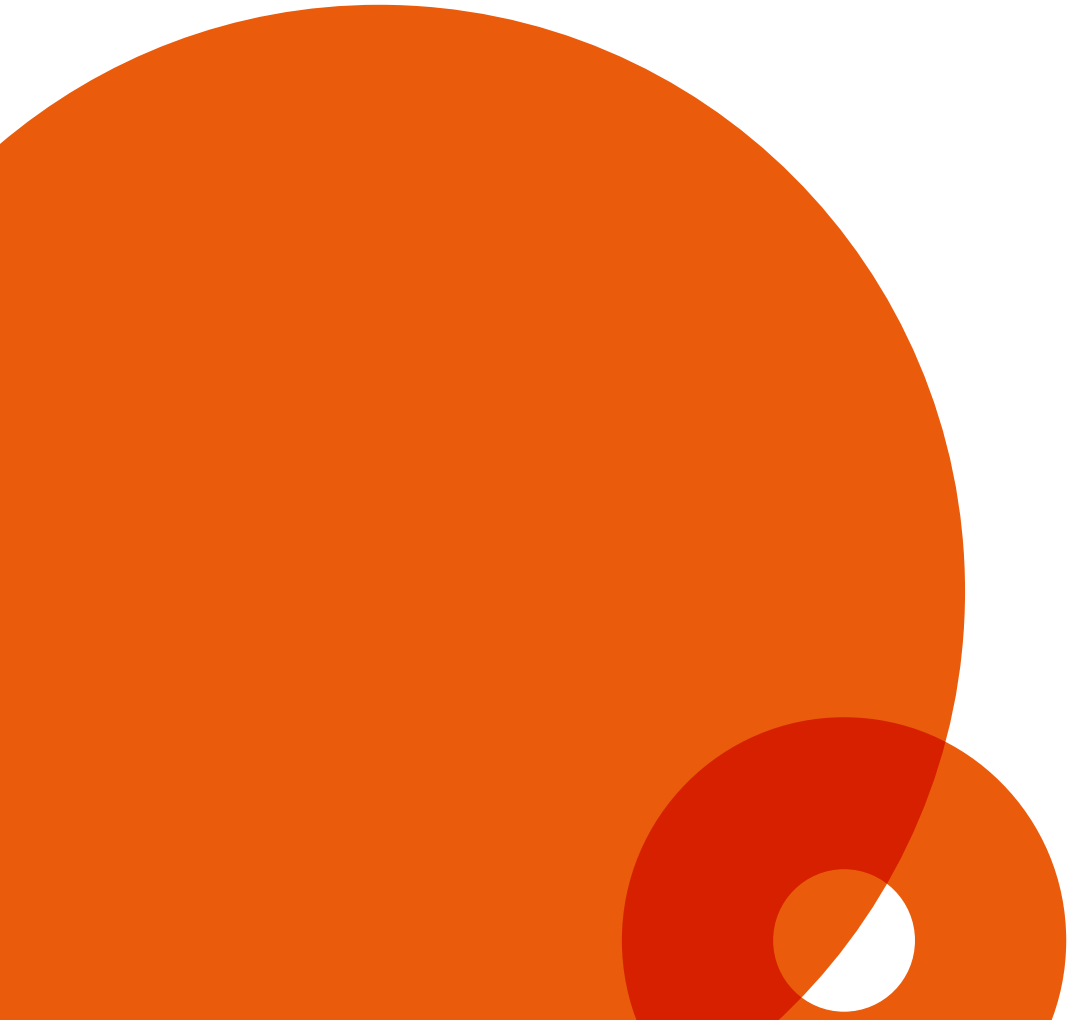
- Local Government Association: *The journey to integration: Learning from seven leading localities; Integrated care pioneer programme annual report 2014; Integrated care pioneer programme annual report 2015; Integrated care value case toolkit*, [online]
- NHS Confederation: *All together now: Making integration happen*
- NHS England: *New care models – vanguard sites*, [online]; *Prime Minister's GP Access Fund*, [online]; *Integrated personal commissioning (IPC) programme*, [online]
- NHS Providers: *Locally driven change: Selected case studies*, [online]
- The King's Fund: *Integrated care reading room*, [online]

References

1. The King's Fund and The Health Foundation (2015), *Making change possible: A transformation fund for the NHS*
2. Wanless D (2006), *Securing good care for older people: Taking a long-term view*, The King's Fund
3. NHS (2014), *Five year forward view*
4. Local Government Association (2016), *The journey to integration: Learning from seven leading localities*
5. The Health Foundation, *Adult social care and integration*, [online], accessed May 2016
6. The King's Fund, *Integrated care map: examples of new models of care in practice*, [online], accessed May 2016
7. National Voices (2013), *A narrative for person-centred coordinated care*

3

What are the big issues for local and national leaders?



Introduction

If we – the Association of Directors of Adult Social Services, Local Government Association, NHS Clinical Commissioners and NHS Confederation – are serious about implementing our vision for integration and achieving better health outcomes, this will require wholesale system transformation. System change requires local leaders and national policy makers to address some big questions that arise from integrating two very different systems.

Different areas may come to different conclusions about the shape of services, governance of the system and the underpinning infrastructure required to develop a fully integrated system, but there are fundamental questions which are common to all areas embarking on integration. These are discussed on the following page. The evidence and rationale behind these questions is captured in section two of this document: What we have learnt about successful integration.

We are also developing a self-assessment toolkit for local system leaders to provide a framework with which to assess and challenge their current capacity to lead system transformation and to identify what they need to do. This will be published in July 2016.

Our vision for integrated care

Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities. They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners with citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizens' wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services.

Our full vision is available in section one of this document: Our shared vision.

Questions for local and national leaders

Local	National
Shared commitments	
Are local political, clinical, commissioning and community leaders clear on why and how integration will improve their citizens' health and wellbeing, and how these support transformation locally, irrespective of national requirements and imperatives?	
	Does national policy for and action on health and social care empower and support local leaders or act as a barrier?
Is your vision grounded in promoting wellness, supporting citizens and the whole community to be more able to lead happy, safe, independent, fulfilled lives? Does it include appropriate allocation of resources to support them in this way?	
	Do national policies and actions support local action?
Shared leadership and accountability	
Do governance structures have the appropriate accountability and authority to take decisions on integrated planning, commissioning and oversight?	
Do governance structures, including in devolved areas and for NHS footprints, build on or align with existing structures for integrated planning and commissioning? Do strategic governance structures build on and have the support from those on a smaller footprint?	
Do all system leaders work together to ensure that there is meaningful and ongoing engagement with all local stakeholders and citizens? Are all system leaders authentically committed to taking responsibility for decisions about service change to improve health outcomes beyond their own organisational boundaries?	
Shared systems	
	What can national policy makers do to align more closely the funding of health and social care at national level to enable local leaders to provide seamless care? Are national policy makers considering to what extent a fully integrated health and care system is possible while health services are free at the point of delivery and adult social care services are means tested? If means-testing is retained, at what level of need should the threshold be set, in order to avoid displacing demand onto healthcare?
Are local leaders able to ensure that resources are directed to their shared priorities, and are sustainable in the long term? Do legal and reporting requirements allow this freedom and flexibility?	
Do local leaders all work to a common set of performance indicators and outcome measures? Do they have shared information in order to have sufficient oversight of their shared outcomes and performance?	
	How can national policy makers reconcile the different accountabilities, performance and regulatory frameworks across health and care? Should the approach be place-based? And what are the respective responsibilities of local leaders and national policy makers in regulation?
How will system leaders ensure that they have a workforce able to deliver new integrated ways of working?	

Key components of integrating health and social care

Successful transformation is iterative requiring sustained effort and commitment as well as financial investment to make it happen. Evidence shows the importance of starting small, testing and refining, building in engagement and learning. The importance of leadership and shared purpose underpinned by ongoing dialogue with all stakeholders in the community cannot be overstated.

These are the other key components for effective integration, drawn from the evidence we have so far:

Shared commitments

This means:

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

The evidence is showing that transformation through integration, through embedding person-centred approaches, requires a transformation in perceptions of healthcare, among health and care leaders, and the public alike, towards one that keeps people well rather than focusing on treating ill health.

Shared leadership and accountability

This means:

- Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries, are collaborative, and where decisions are taken at the most appropriate local level.
- Effective system leadership requires collaborative, inclusive governance arrangements across all agencies in a place – it is not enough to be a coalition of the willing, or of like-minded sections of the system. It is vital that every part of the local system is engaged.
- Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.
- Good governance ensures clear accountability. The strongest lessons from innovating systems are that governance arrangements must allow transformation to take place, and that any changes must ensure form follows function.
- A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.

Shared systems

This means:

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

Further information

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