Shifting the centre of gravity

Making place-based, person-centred health and care a reality

Report

Contents

Foreword

This report sends a clear message that we, the Association of Directors of Adult Social Services, the Association of Directors of Public Health, the Local Government Association, NHS Clinical Commissioners, the NHS Confederation and NHS Providers, remain fully committed to working together to transform health, care and wellbeing services to improve people's health and care outcomes.

Since our first joint vision, 'Stepping up to the place' in 2016, much has changed, and we have experienced challenges and successes. The examples in this report show what can be achieved by system leaders and staff from local government, the NHS, the voluntary, community and social enterprise sector, and service user and carer groups working together to improve health and deliver person-centred care.

Based on learning from the past two years, 'Shifting the centre of gravity' sets out our refreshed, shared vision and the actions that will help local systems to progress their work on system-wide transformation. We ask you to use this vision to shape your own work on integrated health and care. We will continue to support you to implement the shared vision by collaborating to provide good practice information, case studies, tools, guidance and support programmes.

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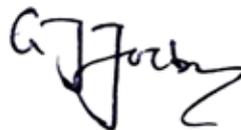
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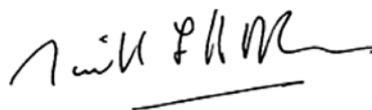
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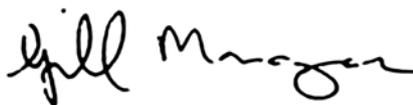
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Executive summary

Transforming health and care places allegiance to shared aims for integration above organisational goals.

Background

In 2016, the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA), NHS Clinical Commissioners and the NHS Confederation published 'Stepping up to the place'[1]. This set out our shared vision for transforming health, care and wellbeing and the key actions that national and local organisations should take to successfully integrate health and care.

Now, in 2018, joined by NHS Providers and the Association of Directors of Public Health (ADPH), we have refreshed our vision and action priorities to make sure they remain relevant for the next phase of transformation. The refreshed vision is based on a wide-ranging review, including a study of progress since 'Stepping up to the place' and the implications for our original vision, commissioned from the Institute of Public Care (IPC) at Oxford Brookes University. This included case studies on six localities – Croydon, Dorset, North East Lincolnshire, Nottinghamshire, Plymouth and Rotherham – and an evidence review of good practice which includes many case examples.

The review also draws on recent reports on integrating health and social care from national bodies; learning from a wide range of case studies showing good practice in implementing integrated health and care; and the ongoing experiences of our members in planning and delivering integrated health and care in the context of very real operational pressures, which were fed into the review through the steering group for the refreshed vision.

Overall, the review found many excellent examples of how partners are making real progress in improving outcomes for individuals and populations, so that people are healthier and more able to lead independent and fulfilled lives. We recognise too that progress on integration continues apace in many areas, not least Greater Manchester, where arguably they are furthest advanced in adopting a strategic place-based and person-centred approach aimed at maximising health and wellbeing[2]. A selection of examples is included in section four of this report.

The review also found that the biggest challenges for organisations working on integration were the severe financial pressures facing every part of the health, care and wellbeing system. This has meant that sometimes the focus has shifted from long-term, sustainable transformation to fire-fighting the results of insufficient funding and rising demand. 'Shifting the centre of gravity' describes the shifts that need to be made so that partners can remain on track to achieve the benefits of integration.

At the time of writing, there is a new five-year financial settlement for the NHS, and an NHS long-term plan is being developed alongside the much-delayed Green Paper on adult social care. These documents will set out the direction for health and care in the coming years. Integration and prevention are expected to be key elements of the NHS

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1 NHS Confederation and partners, 2016, 'Stepping up to the place: the key to successful health and care integration' www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf

2 LGA, 2016, 'Charting the progress on the health devolution journey: early lessons from Greater Manchester' www.local.gov.uk/charting-progress-health-devolution-journey

long-term plan and, as partners working with NHS England and NHS Improvement to develop the plan, we have used emerging information to shape this report. As yet, there is no long-term funding settlement for adult social care. We are agreed that without a sustainable settlement, the ability of organisations to deliver the full benefits of transformation will be in doubt.

The review's key findings

Shared outcomes
Our original vision stressed the importance of place-based, person-centred care which delivers the outcomes that are important to individuals. Person-centred care is a success story of integration because it is increasingly used as the basis for good practice across health, care and wellbeing. A description of what 'good' looks like in person-centred care (including some of its key components, such as co-producing outcome statements with individuals and using these to assess the impact of services) is included in section four. We now need to build on this progress so that a person-centred approach becomes standard practice in health and social care.

'Stepping up to the place' also identified preventing poor health and reducing health inequalities as an important element in integration, both to improve the lives of individuals and to reduce demand on health and care services. Section four of this report describes some of the excellent work that is taking place to make improving health and wellbeing 'everyone's business'. However, the review found that the long-term nature of prevention meant that it was particularly vulnerable to dropping down the agenda when organisations have to deal with short-term pressures.

'Shifting the centre of gravity' brings these elements together and identifies them as central to successfully achieving whole-system transformation. We recommend that the focus of transformation should be maintained on:

- Delivering outcome-focused, person-centred care in or close to people's homes with a focus on self-care and community engagement, so that people can lead healthier, more independent and fulfilled lives.
- A population health focus, preventing poor health and reducing health inequalities by mobilising all the assets of partners across a place to help people lead healthier, happier lives with less need to access health and care services.

We also recommend that these elements should form the basis of a national vision for transformation.

The review identified several enablers and barriers to transforming health, care and wellbeing. There was a strong view that time, space and resources were needed to develop integrated systems and approaches. Dedicated funding for transformation is essential for progress at scale, as is collecting and sharing learning and providing tools and support.

Barriers to integration were identified as structural factors, such as separate outcomes frameworks that encourage partners to meet organisational priorities rather than collaborating on system-wide priorities. Many of these barriers are long-standing, previously identified in 'Stepping up to the place', and we recommend that these need to be tackled as soon as possible. Unrealistic expectations about what can be achieved from integration – in terms of timescales and financial savings – are another barrier. We believe that it is essential to be realistic about what benefits integration can deliver, and how long it will take.

Shared leadership and accountability
Those contributing to the review stressed the importance of establishing a collaborative culture to break down the organisational barriers that can make integration difficult. Section four describes helpful ways in which partners have come together to understand each other's priorities and pressures, and to build shared values and working practices.

Although the importance of overcoming cultural barriers is well recognised, surprisingly, there is little information on how this can be achieved in health and care. We recommend that this should be addressed by sharing information on good practice.

Successful integration requires leaders who are equipped to work collaboratively, with the right attitude and behaviours, to identify where working together will improve health and care outcomes, and to make this happen through positive partnerships. Section four describes some of the key attributes of collaborative leadership. We recommend that training and developing leaders who are skilled in collaborative working should be a priority.

Since 'Stepping up to the place', a range of models and systems have been developed across the country and, alongside these, different governance arrangements designed to fit the needs of local areas. It is important that we learn from these models to identify the most effective arrangements. In section four, we identify key elements that governance models should include.

Workforce capacity is a major challenge to the delivery of integrated care. A shortage of workers overall means that staff may need to be deployed to where services are under pressure, rather than being involved in service development. Health and care workers need to be skilled in working in integrated settings and be able to use their expertise to make multidisciplinary working a success. Section four sets out some good practice in this area, such as a place-based approach to looking at the housing and transport needs of the workforce. We recommend that workforce planning and development should be integrated, covering both health and care, nationally and locally.

Shared systems

The review noted that several levels of place-based working are emerging as the basis for collaboration in new models and systems. These include the large areas of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) for strategic commissioning and economies of scale; local areas for place-based approaches to health, care and wellbeing involving a wide range of partners; and neighbourhoods serving communities, often based around primary care.

These levels provide a useful framework for developing integrated care and facilitating subsidiarity – where decisions are made at the appropriate level for population needs.

Work on the NHS long-term plan is considering which functions work best at each level.

New systems and models need to reflect factors such as geography, rurality and other local needs, and there is no 'one size fits all' solution. We believe that place-based systems should be established or amended following local discussion and considering the role of all the partners who contribute to health and care in a place, including housing, employment and training, and emergency services. Where new systems and models will result in improved health and care outcomes, organisations should work across boundaries.

Integrated commissioning across health and social care is being adopted in many areas. To assist this, the LGA and NHS Clinical Commissioners have published a resource, 'Integrated commissioning for better outcomes – a commissioning framework'[3]. The review found a range of budget-sharing mechanisms being used to join the commissioning and delivery of services – both formal Section 75 partnership agreements and informal alignment.

3   LGA and NHS Clinical Commissioners, 2018, 'Integrated commissioning for better outcomes' www.local.gov.uk/icbo

Given the complexities of this area of collaboration, there was a desire for more guidance on the boundaries of shared budgets.

The review found significant variation in progress on information sharing across health and care: some areas have made significant progress, despite the challenges, while others are at an early stage of development. There is clear potential to learn from the areas that are already more advanced.

Our vision and how to make it a reality

Based on the information from the review, we decided that our vision and priority actions were still relevant but would benefit from some updating. Our new vision for the future of health, care and wellbeing is set out in section two. It is focused on people, rather than systems or structures, to make sure our attention remains on what really matters. The headlines are:

- individuals using health and care services experience positive outcomes

- individuals, populations and communities maximise their health and wellbeing

- front-line staff use their experience and expertise to shape seamless care

- leaders work effectively across health and care to drive transformation.

In section three, we set out our key recommendations for what action national and local leaders can take to transform health, care and wellbeing. Section five provides a detailed integration checklist which can be used by partners to check their progress.

1 Introduction

At this pivotal moment it is vital that local government and the NHS are equal partners in planning the future of health, care and wellbeing, so we can move forward together to improve outcomes for individuals, communities and populations.

Background

In 2016, the ADASS, the LGA, NHS Clinical Commissioners and the NHS Confederation published our shared rationale for a place-based, person-centred approach to population health and a shared vision for integrated care and support. Our joint policy document, 'Stepping up to the place: the key to successful health and care integration', drew on research evidence, including learning from seven leading localities[4]. It described what we can achieve through bringing together health, care and wellbeing in terms of better outcomes for individuals and populations, joined-up services and effective use of resources.

We also identified the essential components which underpin effective integration – shared commitments, shared leadership and accountability and shared systems – and highlighted the action required at local and national level to make integration happen.

As membership organisations supporting improvement across the NHS and local government, we gave a commitment to support our members to act together to drive forward person-centred health and care.

Since then, our shared approach to integration has provided a framework for sharing good practice, producing information and guidance, and delivering development and improvement support[5]. Our systems leadership support offer has been delivered in over 30 areas and has been evaluated positively in helping clinical, political and professional leaders move forward with their plans for joining care and support.

In 2018, joined by NHS Providers and the ADPH, we have refreshed our vision and action priorities to make sure they remain relevant for the next phase of transformation. The refreshed vision is based on a wide-ranging review involving the following elements:

- A study of progress since 'Stepping up to the place' and the implications for our original vision, commissioned from the Institute of Public Care (IPC) at Oxford Brookes University[6]. This includes case studies on six localities – Croydon, Dorset, North East Lincolnshire, Nottinghamshire, Plymouth and Rotherham – and an evidence review of good practice which includes many other case examples[7].

- Recent reports on integrating health and social care from national bodies.

4   LGA, 2016, 'The journey to integration: learning from seven leading localities'
      www.local.gov.uk/sites/default/files/documents/journey-integration-learn-31c.pdf

5   LGA and NHS Clinical Commissioners 'Health and care political and clinical leadership offer'
      www.local.gov.uk/sites/default/files/documents/25%2063%20The%20health%20and%20care%20political%20and%20clinical%20leadership%20offer_v02.pdf
6   IPC/LGA, 2018, 'Stepping up to the place, part A: review of the vision'
7   IPC/LGA, 2018, 'Stepping up to the place, part B: evidence review'
      www.local.gov.uk/sites/default/files/documents/Part%20B%20-%20Evidence%20Review%20October%202018%20WEB.pdf

- Learning from a wide range of case studies showing good practice in implementing integrated health and care.

- The ongoing experiences of our members in planning and delivering integrated health and care in the context of very real operational pressures, which were fed into the review through the steering group for the refreshed vision.

- An LGA survey of council leaders and portfolio holders on adult social care funding issues and local progress on integration.

The challenging financial and demographic environment

Since 'Stepping up to the place' was published, health, social care and public health have faced even greater service pressures and funding challenges. Despite being successful in achieving efficiency savings, years of insufficient funding have meant it has become ever more difficult for the NHS[8] and local government[9] to continue to deliver the level and range of services that people expect.

This has been compounded by growing demographic-led demand – the ageing population, an increase in people with mental health problems and more people with complex health and care needs. This demand is set to increase significantly over the next 20 years[10].

Pressures can be seen throughout the system, including:

- an increase in calls to ambulance services, in people attending A&E and rising demand for other hospital services

- growth in demand for mental health and community services, and heightened pressure on child and adolescent mental health services

- tight eligibility for adult social care, meaning fewer people receive more intensive support

- higher caseloads for GPs.

Going forward, there is now more certainty about NHS funding. The NHS will receive an average 3.4 per cent increase in annual funding for five years from 2019-20 – an increase of around £20.5 billion a year by the end of the five years. While the increase has been welcomed, the settlement is tight, and there are questions about how realistic it is to expect the NHS to go beyond recovering performance to make further significant improvements and meet future demand.

At the time of writing, a long-term funding settlement for adult social care is not expected until the 2019-20 spending review. It is critical that sustainable funding is allocated to adult social care. Without this, the ability of organisations to deliver the full benefits of transformation will be in doubt, and investment in the NHS will be undervalued.

The long-awaited Green Paper on adult social care, which is expected to set out proposals for sustainable funding, was postponed until autumn 2018 so that it could be aligned with the NHS long-term plan, which will describe how the NHS funding settlement will be used to improve quality, efficiency and outcomes, and will set the future direction for the NHS. Integration and prevention are key elements of the long-term plan and, as partners working with NHS England to develop the plan, we have used emerging information to shape this report.

8   NHS Confederation, 2018, 'Securing the future: funding health and social care to the 2030s'. www.nhsconfed.org/resources/2018/05/securing-the-future

9   LGA, 2018, 'The lives we want to lead: the LGA green paper on adult social care and wellbeing' www.local.gov.uk/about/news/lga-launches-own-green-paper-adult-social-care-reaches-breaking-point

10 Public Health England, 2018, 'Health profile for England' www.gov.uk/government/publications/health-profile-for-england-2018

Against this background, measures to prevent poor health and to join health and social care are essential for making the best use of resources. However, caution is needed about expectations for any financial efficiencies that can be realised. In its report on health and care integration in 2017[11], the National Audit Office concluded that "benefits have fallen far short of plans" and warned that sustainability and transformation plans should not be "over-optimistic". Those contributing to the review are clear that savings from integration are likely to be modest and that the primary reason for integration should be improving health, care and wellbeing outcomes for people, rather than making savings.

A changing landscape of reforms

Recent years have seen many new national initiatives, care models and development programmes aimed at reforming the NHS and promoting integration. These include sustainability and transformation partnerships (STPs), integrated care pioneers, new care models vanguards, integrated personal commissioning demonstrator sites, accountable care organisations (ACOs), integrated care providers (ICPs) and integrated care systems (ICSs).

Many of these programmes and models are in a state of ongoing change. For example, integrated care pioneers were succeeded by new care models vanguards; ACOs became ICPs and are now focused on contracts between a commissioner and providers[12]. Sustainability and transformation plans became partnerships and are now developing into ICSs[13].

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11 National Audit Office, 2017, 'Health and social care integration'
www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf
12 NHS England, 2018, 'Consultation on contracting arrangements for ICPs'
www.england.nhs.uk/new-business-models/publications/consultation-contracting-arrangements-for-icps/
13 NHS Providers, 2018, 'Key questions on the future of STPs and ICSs'
www.nhsproviders.org/key-questions-for-the-future-of-stps-and-icss

This is a highly complex and challenging environment, but it also offers many opportunities for improving health and care outcomes, some of which are described in the case examples set out in section four. A key message in this report is that we must collaborate as partners to find shared solutions to the challenges we face and to make the most of our opportunities. National and local partners from across the NHS, local government and the voluntary, community and social enterprise (VCSE) sector must work together, and with people who use services and carers, to shape a sustainable landscape which results in improved health, care and wellbeing outcomes.

Shifting the centre of gravity

Based on information from the review, we have identified a number of shifts that need to be made to deliver effective health, care and wellbeing transformation into the future.

- A person-centred approach that delivers care and support in partnership with individuals and, where they wish, their families and communities, to achieve the best outcomes for them, rather than designing systems and processes around organisational silos.

- A place-based approach that involves all partners collaborating to improve health and wellbeing, rather than a focus on separate organisations and structures.

- A model of care and support that promotes health and wellbeing, independence, community support and self-care in or close to people's homes, to reduce the need for unplanned hospital admissions and long-term residential care.

- A shift to prevention to improve population health and wellbeing, to reduce the overall need for care and support, rather than a reliance on providing services to meet health and care needs.

- Better alignment between nationally set targets and the priorities identified by local partners.

- Equality between the NHS and local government in planning the future of health, care and wellbeing, with decisions taken collaboratively from the earliest stage.

- A better balance between responding to short-term pressures while still maintaining the focus on longer-term transformation.

We have refreshed our vision for transforming health, care and wellbeing, and the priority actions for national and local partners, to reflect these shifts.

Our vision is set out in the next section. It is focused on people rather than systems or structures – people who will experience improved health and care outcomes and people who enable effective integration to take place. It is aspirational, but realistic about what can be achieved in the challenging environment in which we are working.

2 Our vision

Individuals using health and care services experience positive outcomes

We want every individual who uses a health or care service to be able to say that it was delivered in the right place and in a timely, joined-up way which respected their dignity and engaged them fully. We also want them to be able to say that they felt safe and that the service resulted in improvements to their lives – better physical and mental health, greater independence and feeling more included in society. To make this happen, people who use services and carers will be involved in shaping and evaluating integrated services.

Individuals, populations and communities maximise their health and wellbeing

Only by working together can we turn the tide of poor health, so individuals, populations and communities become healthier, health inequalities are reduced and there is less demand on health and care services. Improving population health is central to our plans for system-wide transformation and should not be diverted by short-term pressures. We recognise that individuals are also responsible for improving their own health and independence, and we will support them to do this. This includes 'health in all policies' and extra investment in areas of acute deprivation or need.

Front-line staff use their experience and expertise to shape seamless care

Front-line staff, such as those working in multidisciplinary neighbourhood teams, make integration a reality for people using our services. We will create a collaborative culture across organisations involved in health, care and wellbeing, and provide opportunities for staff from all sectors to come together and use their shared experience and expertise to shape the working practices and systems that result in effective integration.

Leaders work effectively across health and care, and drive transformation

Health and social care leaders from all sectors set the culture and pace of transformation. Our leaders will have the skills and understanding to work effectively across the health, care and wellbeing system. They will develop a collaborative culture with behaviours based on respect and listening to others, while also having the confidence to challenge and make clear decisions to drive transformation at pace and scale.

3 Making the vision a reality – key actions for partners

A focus on person-centred care, individual outcomes and empowering front-line staff to develop how they can work better together will help overcome organisational silos

Key actions for national leaders

Central Government, NHS England and NHS Improvement working with other national partners and with local government, NHS organisations, the VCSE sector and people who use services and carers.

Establish a national vision for transformation
Establish a national vision for transformation to give a clear message about the importance of delivering better health and care outcomes through person-centred care in or close to people's homes and making the shift to prevention.

Consider the NHS and local government as equal partners
Ensure that the NHS and local government are considered as equal partners in developing integration and that discussions about major reforms, nationally and at all levels of place, involve all partners from the earliest stage.

Realistic, locally-driven targets
Ensure that national expectations and targets for savings and the speed of reform are realistic. Consider the impact of national targets on local areas so they align better with locally agreed integration priorities.

Tackle barriers to integration
Address systemic barriers that encourage organisations to focus on their own priorities rather than collaborate on shared outcomes – moving from separate outcomes frameworks and regulatory regimes to an approach that considers how integration works as a whole. Clarify legal questions that are raised about governance and shared finance, and technical issues relating to finance and IT.

Transformation funding and support
Continue to provide dedicated transformation funding to enable partners to develop and test integrated approaches that meet local needs, and to roll out what works at scale. Ensure that new models are evaluated and learning is shared.

National membership organisations: ADASS, ADPH, LGA, NHS Clinical Commissioners, the NHS Confederation and NHS Providers working with NHS England and other partners.

A comprehensive approach to sharing learning and independent support:
- provide information on good practice through case studies and research

- produce guidance to support transformation, particularly on topics identified in this review including culture change, governance and IT

- continue to provide support and development programmes that are independent or peer-led, particularly to equip leaders and staff to work collaboratively and to enable local organisations to make progress on integration, whatever their starting point.

National organisations working with Health Education England and Skills for Care and with local partners.

Integrated workforce planning and development

Ensure that national training and development for leaders, professionals and workers equips them to work in integrated systems and settings. This will include establishing common working practices, such as person-centred care and collaborative leadership behaviours, throughout the health and care workforce. Ensure that national workforce planning covers both health and social care.

Key actions for partners involved in STPs/ICSs and local transformation

Leaders and staff from all sectors and organisations, people who use services, carers and communities.

Comprehensive, aligned vision

The vision for transformation should include delivering outcome-focused, person-centred care and preventing poor health and reducing health inequalities. There should be alignment of the vision and strategic plans across STPs/ICSs and local levels.

Measure progress on a community health and care model

Ensure there are clear plans for shifting appropriate activity and resources from acute hospital and long-term residential care into an integrated community health and care model, and ways of measuring that this shift is taking place.

Make best use of all assets

Operate a place-based approach involving a range of partners beyond the health and care sectors to make full use of all the assets that have an impact on health and wellbeing.

Involve people who use services and carers

Ensure robust arrangements are in place to involve people who use services and carers in shaping and evaluating services based on outcomes that are important to them.

Use the skills and expertise of staff to develop integrated systems

Ensure that mechanisms are in place to enable front-line staff from all partner organisations to come together to help shape good practice in integration.

Demonstrate progress on integration in the following areas:

- developing outcome-based, person-centred care in community settings

- preventing poor health and tackling health inequalities

- establishing a collaborative culture

- skilling leaders to work across health, care and wellbeing

- accountability and governance

- workforce planning and development across health and social care

- shaping place-based systems and new care models

- establishing integrated commissioning

- integrated budgets and resources

- information sharing and information technology.

Section five of this report provides a detailed checklist for partners to check progress on integration in the areas listed above.

4 Key themes identified in the review

"There is a strong sense of the importance of effective leadership. By this we mean a different kind of collaborative leadership focused on place and people, not organisations."

Institute of Public Care, Oxford Brookes University, 2018.

Shared outcomes

Outcome-based, person-centred care in community settings – what 'good' looks like

The review found that outcome-based, person-centred care is increasingly becoming standard practice across health and care. There are many aspects to this but, briefly, it involves a partnership between the individual (and their carer/family if appropriate) and the worker, rather than an approach in which a professional decides what is best or decisions are taken for organisational convenience. Together they identify what outcomes the person wants to achieve – such as greater independence so they can return to work – and how this can be supported, such as the person learning self-care techniques to take greater control over their condition.

Integrating for outcomes in Croydon

Croydon has built positive relationships across health and care to put in place a ground-breaking, legally binding 'Alliance Agreement' committing key health and social care partners, including Croydon Council, the clinical commissioning group (CCG), health providers and the VCSE sector, to shared approaches and principles for 10 years. The agreement underpins Croydon's priorities for early intervention, prevention and place-based working. At its heart is a set of 'I' statements, devised by local people that encapsulate the outcomes they want to improve their lives.

Croydon's 'I' statements are:

- I want to stay healthy and active for as long as possible.

- I want to access the best care available in order to live as I choose and as independent a life as possible.

- I want to be helped by a team or person that has the training and has the specialist knowledge to understand how my health and social care needs affect me.

- I want to be supported as an individual with services specific to me.

- I want good clinical outcomes.

IPC 'Integrating health and social care: Croydon case study':
www.local.gov.uk/integrating-health-and-social-care-croydon-case-study

Integration and person-centred care go hand in hand because if different bits of the system are not coordinated, the individual will have a disjoint experience. Similarly, person-centred care as a working practice aligns the approaches of workers from different professions, reinforcing a seamless approach. There is significant evidence showing the benefits of integrated care for people who use health and care services in terms of improved outcomes and positive experience[14].

Drawing together community health, mental health, primary care, social care and VCSE community support so that they operate seamlessly has become a key model for delivering personalised care. Multi-agency teams, co-located and based around GP practices, such as the 'primary care home' model[15], are being established in many areas. Sometimes these are joined up with community development initiatives providing low-level support in neighbourhoods, perhaps through social prescribing.

A list of other important approaches to person-centred, place-based care is included in the integration checklist in section five.

Contributors to the review agreed that national and local leaders who are responsible for planning integration need a thorough understanding of person-centred care and how integrated community health and care services operate. If they have never worked in this area, visiting services in person will deepen their understanding.

Community-based services in Plymouth

'Livewell' is Plymouth's community interest provider, commissioned by the CCG and Plymouth City Council to provide integrated community health and social care services. Livewell provides adult social care and all primary health community-based services (excluding GPs), and works closely with the VCSE sector in local communities. The city has continued to invest in preventative services because prevention is seen as a key enabler to wellbeing and health improvements. Plymouth has started to implement community wellbeing hubs as flexible bases for multidisciplinary teams where the public can access information, advice and support. The plan is to have a hub in each GP area. Hubs form part of Plymouth's 'one public estate' strategy, which focuses on making better use of all public buildings across the city.

IPC 'Integrating health and social care: Plymouth case study':
www.local.gov.uk/integrating-health-and-social-care-plymouth-case-study

Single point of access (SPA) in North East Lincolnshire

The SPA provides a single 24/7 route for accessing care and support. The telephone triage system offers a streamlined multi-agency approach to ensure callers reach the right person at the right time. The SPA was originally developed as a demand management model for adult social care in 2008, and was subsequently merged with the existing GP out-of-hours health triage service. It was extended again in 2012 to include an in-hours triage service and community occupational therapy and physiotherapy access functions. More recently, an SPA Facebook page has been developed, through which SPA staff are accessible 24/7, including clinical support to care homes and other professionals. Currently around 12,000 calls per month are received into the SPA.

14 National Audit Office, 2017, 'Health and social care integration'
    www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

15 National Association of Primary Care 'Primary care home' model:
    www.napc.co.uk/primary-care-home/

The SPA delivers:

- integrated multidisciplinary triage across health and care, including mental health

- the ability for providers to co-operate rather than simply competing

- reduced delays and duplication, creating efficiencies in the wider system

- easier identification of the most vulnerable and frequent users of health and social care through integrated case record systems

- promotion of self-care and independence

- improved user experience and easier access to information and advice – a Govmetric system enables callers to leave instant feedback, and feedback is consistently good.

IPC 'Integrating health and social care: North East Lincolnshire case study':

www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

Preventing poor health and tackling health inequalities – what 'good' looks like

The review found a strong view that prevention was central to integration, but also a feeling that it was not always fully understood.

Prevention involves tackling the wide range of determinants that contribute to poor health in individuals and populations, with the aim of promoting health and wellbeing and reducing health inequalities. Prevention is often categorised in three levels – primary, secondary and tertiary[16]. Primary prevention involves activity to reduce the risk that people will develop poor health, such as designing the built environment to encourage exercise, universal lifestyle services to help people adopt healthier behaviours, or asset-based community development[17] in areas with health inequalities.

Secondary prevention involves more targeted interventions for people who are at risk of developing illness, such as diabetes screening or case finding in GP practices. Tertiary prevention refers to helping people who already have a life-limiting condition to improve their quality of life or independence, such as initiatives to help people with mental health conditions retain or enter employment.

All three levels of prevention are crucial to the integration agenda. Prevention was identified as a priority in the 'NHS five-year forward view'[18] and remains a priority in the NHS long-term plan.

Social prescribing in Rotherham

As part of integrated arrangements, Rotherham has a £500,000 contract with Voluntary Action Rotherham to allocate funding to VCSE organisations that are providing activities as part of the social prescribing programme, recently expanded to those at risk of hospital admission and people with mental health problems. Headlines from an evaluation by Sheffield Hallam University include:

- reduced demand for urgent interventions

- 82 per cent of service users reported a positive change after three to four months

- estimated cost avoidance to the NHS over three years was around £500,000, an initial return on investment of 43 pence for each pound invested.

www4.shu.ac.uk/research/cresr/ourexpertise/evaluation-rotherham-social-prescribing-pilot

Primary prevention is acknowledged as beneficial for individuals, as essential to reduce or stabilise future demand on health and care, and as contributing to wider economic prosperity. However, because its outcomes are often long-term, at a time of reduced resources, there is concern that the focus is shifting to secondary or tertiary prevention, which have more immediate results.

16 LGA, 2017, 'Must-knows for elected members: prevention' www.local.gov.uk/must-knows-elected-members-prevention

17 LGA, 2017, 'Public health working with the VCSE sector' www.local.gov.uk/public-health-working-voluntary-community-and-social-enterprise-sector-new-opportunities-and

18 NHS England, 2014, 'NHS five-year forward view' www.england.nhs.uk/five-year-forward-view/

If primary prevention is not properly supported and resourced, there are questions for the future sustainability of health and care. The leader of the NHS long-term plan prevention working group, Public Health England Chief Executive Duncan Selbie, has called for "less rhetoric and more action" in investment and implementation, with a focus on smoking, obesity and cardiovascular disease[19].

Pan-London smoking cessation transformation programme

London councils have worked together on interventions at scale to tackle smoking on a pan-London basis. This successful programme has involved a new model of smoking cessation in primary care, pooling resources to fund a digital platform to provide online smoking cessation advice and resources, a 'Stop Smoking London' helpline to provide telephone-based support, and a series of London-wide campaigns. The model has been adopted for the childhood obesity transformation programme.

www.adph.org.uk/networks/london/programme/smoking-cessation

Public health teams have been involved in developing integration in systems across the country[20]. A key focus has been to bring together partners beyond health and care, such as housing, police and business, to tackle the social determinants of poor health through joint action in health and wellbeing strategies. In some local areas, such as Somerset and Dudley, public health has been at the centre of 'flipping the system' so that preventing poor health is at the centre of transformation. In other areas, such as London, and Cheshire and Merseyside, public health has scaled up to work across wider footprints.

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19 'Public health matters' blog, 2018, www.publichealthmatters.blog.gov.uk/2018/09/06/prevention-and-the-nhs-long-term-plan-3-ways-we-can-save-more-lives/

20 LGA and ADPH, 2016, 'Public health's role in local government and NHS integration' www.local.gov.uk/public-healths-role-local-government-and-nhs-integration

Involving public health in whole-system integration

Dudley public health team has been a key partner in supporting the development of Dudley's multi-speciality community provider and potential integrated care provider, which aims to incentivise preventative approaches to improve health and wellbeing and reduce the need for intensive health and care services. It also has a lead role in supporting Dudley Council's vision to develop new ways of working with communities, based on promoting community resilience rather than traditional top-down services.

LGA 'Public health transformation five years on':

www.local.gov.uk/public-health-transformation-five-years

National and local system leaders responsible for planning integration need a good understanding of all aspects of prevention and public health. If they have never worked in this area, visiting services in person and spending time with public health teams will deepen their understanding.

A list of health and wellbeing interventions that contribute to integration is in the integration checklist in section five.

Collaborating to tackle health priorities across Cheshire and Merseyside

Cheshire and Merseyside's public health collaborative, 'Champs', brings together the skills and expertise of nine public health teams to improve health and wellbeing across the sub-region. Champs focuses on tackling high-level priorities that are common to every area where progress can be best made through collective action. Champs has been successful in areas including reducing high blood pressure, reducing suicide and improving the mental resilience of children and young people.

Supporting transformation

Maintaining focus

The review found concerns that organisations were being diverted from work on transformation – generally to respond to immediate pressures, such as short-term measures to help NHS organisations achieve financial balance, or to meet nationally set targets, such as reducing delayed transfers of care when local targets had been agreed.

It is recognised that this presents a dilemma because financial and service pressures are very real. However, if time and investment are not allocated to transformation, health and care will remain stuck in perpetual fire-fighting mode.

A new national vision for transformation would help to give a clear message about the importance of delivering better health and care outcomes through person-centred care in or close to people's homes and making the shift to prevention.

Transformation involves making best use of resources across a place-based system. Rather than a narrow focus on the health and social care sectors, a wide range of partners, such as housing, transport and the business sector, should be involved. For example, working together to increase affordable housing to attract health and care workers. Similarly, transformation is not just about integrating front-line services, but about considering how all the assets and functions of a system, such as estates and IT, can work together more effectively.

Collaborating to develop housing models in Dorset

Dorset's 'Building Better Lives' programme is looking to deliver different models of housing with care, including relocatable housing for adults with learning disabilities, accommodation with care and care homes, to help meet demand and relieve pressure on hospital delays. The programme works closely with the STP estates work stream to ensure a joined-up approach to the reduction of community hospitals and the development of primary and community care hubs that are connected to local neighbourhood plans, which set out housing development plans. Six locality blueprints have been developed based on population projections and existing demand information.

Transformation funding

Having the organisational capacity to work towards the vision for whole-system transformation is essential. The Better Care Fund (BCF), currently the sole example of nationally mandated integrated funding across health and care, has proved very useful for allowing areas to develop transformation through testing out and implementing integrated models. Many of the examples in this report involve BCF funding. One concern about the BCF is that it has been diverted to tackle immediate pressures, rather than transformation, and there was a view that it should continue but with greater emphasis on local agreements[21]. There was a strong view that dedicated transformation funding, to provide capacity for activity such as project management, short-term double running of services and evaluation, is essential for future progress at scale.

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21 LGA, 2018, 'Adult social care funding and integration survey: research report July 2018'
www.local.gov.uk/adult-social-care-funding-and-integration-survey-research-report-july-2018

Tackling delayed transfers of care in Ipswich and East Suffolk

There has been a major transformation in how partners in Ipswich and East Suffolk work together to tackle delayed transfers of care. For example, on the 1 February 2018, just 10 delayed transfers of care were reported; on the same day in 2017 it was 49.

Achieving this change has involved effective use of the BCF, including:

• system-wide transformation

• a shift in organisation cultures

• ongoing operational oversight to identify opportunities for change.

LGA, 'Tackling delayed transfers of care in Ipswich and East Suffolk':
www.local.gov.uk/tackling-delayed-transfers-care-ipswich-and-east-suffolk

Transformation support
Support for transformation was also seen as a priority. This includes making sure that reforms are based on learning from best practice in the UK and abroad. To accompany 'Stepping up to the place', the partners developed a system-wide offer of support to develop leadership, financial capacity and other key elements of transformation. Evaluations of the offer show that this has made a useful contribution to developing good practice in leading and managing in an integrated system[22]. The offer is now being updated to meet developing needs.

Similarly, participants on the BCF support programme[23] have found this particularly useful, because the facilitators are highly skilled and experienced and are also independent of regulators. This means that they can work in a supportive way to co-produce solutions.

The programme is offered to areas who need help with issues of integration around the BCF, and also to those which are performing well but want support to reach the next level of integration. The BCF programme has also resulted in a range of useful resources such as tools and guidance[24].

A national commitment to dedicated funding and developmental programmes to support transformation is needed.

Better Care Fund support programme assists system-wide reform in Southend

Southend-on-Sea was assessed regionally and nationally as being a mature health and care system, on track to deliver on its BCF plan for 2017-19 and potentially to graduate to a lighter BCF oversight regime. Southend was part of the first round of integrated care pioneers and has established four localities providing a range of integrated health, care and wellbeing services such as care co-ordination, multidisciplinary teams, social care workers assigned to GP practices, domiciliary care re-tendered to a locality basis and a dementia navigation service.

Southend had been exploring options to stretch its ambitions for integration and invited the BCF support programme to undertake developmental work. The support programme is seen as providing a catalyst for Southend to work with partners to align locality-based integration in the South East Essex integrated care system footprint (part of the Mid and South Essex STP).

www.local.gov.uk/sites/default/files/documents/case-study-southend-sea-d-1d1.pdf

22 LGA 'Supporting health and wellbeing boards and system leaders'
www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/supporting
23 LGA 'Better care support offer'
www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-support-offer

24 LGA, 2018, 'Hospital to home transfers: resources and emerging good practice'
www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice

Tackling barriers

In its 2018 report on 20 local system reviews to assess the effectiveness of joined-up care and support for older people[25], the Care Quality Commission (CQC) identified that the current nature of processes such as funding flows, commissioning, performance management and regulatory regimes encouraged organisations to focus on individual performance, rather than on working together to jointly improve outcomes. It concluded that shared system leadership, culture and vision were all vital characteristics of a well-functioning system.

The IPC review also found that separate performance regimes and outcomes frameworks encourage organisations to prioritise their own organisational performance rather than collaborate, even if this will not improve overall outcome for individuals and populations.

Focusing on one part of the system is unlikely to solve system-wide problems. For instance, while performance on delayed transfers of care has improved, this has generally not had a positive impact on A&E performance. Approaches that examine how the system operates as a whole, based on outcomes for individuals using services and shared metrics, will encourage collective responsibility. The CQC local system reviews, which looked objectively at how local partners were working together across the whole system rather than focusing on a single pressure point or organisation, are a positive approach.

Shared leadership and accountability

Collaborative culture

The review found that areas that have been involved in successful integration agree that developing a culture of mutual trust and respect is fundamental.

A collaborative culture is the glue that holds systems together, particularly at times of challenge and dispute. A collaborative culture develops over time based on how organisations behave towards each other. Establishing shared values, behaviours, understanding, vision and agreements all contribute to this.

For example, in its 2018 system review[26], the CQC emphasised that organisations should be regarded as equal partners in developing integrated systems. In terms of behaviours, this could be translated into an agreement that major decisions that impact on other partners will only be taken following discussion and negotiation.

A collaborative culture is particularly important in health, care and wellbeing integration because there are often tensions between different groups, such as commissioners and providers; the NHS and councils; the VCSE and commissioners; and patient and service user groups and statutory organisations. Tensions may arise from practical issues, such as finance, but are often down to different cultures in which people see things in different ways.

Culture change in Dorset

Dorset is one of the first wave of integrated care systems. After a bumpy start with a lack of understanding of each other's roles and responsibilities, leaders from the council – both members and officers – and from the CCG started to meet informally and get to know each other. Relationships improved despite their different cultures, systems and processes. The importance of culture has been recognised as a key enabler or potential barrier to the success of transformation plans. Plans are in place to tackle and address culture issues to better understand each other's roles, reactions, resource limitations, team structures and capacity to facilitate transformation.

25 Care Quality Commission, 2018, 'Beyond barriers: how older people move between health and care in England' www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

26 Care Quality Commission, 2018, 'Beyond barriers: how older people move between health and care in England' www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

The IPC case studies undertaken for this review show that some areas have overcome previously poor relationships by proactively changing cultures. Organisations that now have strong, long-term relationships often started this by tackling differences in culture.

An important element of developing shared culture is for people to understand their partners' priorities, pressures and ways of working. For example, a community nurse might shadow a social worker undertaking assessments and care planning, and the social worker could shadow the nurse on their home visits. Together they would be well placed to advise how a multiagency team could run more effectively. Or a leader without a background in public health could familiarise themselves with community lifestyle services and see what they achieve. The need for people to develop system-wide knowledge and understanding is a theme that runs throughout this review. A list of helpful approaches to culture change is included in section five.

Although there is extensive acknowledgement that cultural change is essential, so far there is little comprehensive information on the options for achieving this in health and care. It would be helpful if good practice in developing shared cultures was collated and disseminated.

Organisational development in Croydon

Partners in Croydon have invested in an organisational development programme. Unpicking behaviour and cultures that had previously driven silo working has challenged senior leaders and frontline staff across the alliance organisations to ask themselves the question 'Do we speak well of each other?' and to reflect on how to improve relationships. The aim of the programme is to make behaviour change across six organisations, more

than 50 GP practices, the VCSE sector and the local population. Culture change has been helped by having a programme management team with members from different organisations and co-located, open-plan offices that allow commissioning and operational staff to build trust, share ideas, learn and problem-solve together.

Leadership

Effective leadership creates the right conditions for transformation. The review identified the need for capable, confident and collaborative system leaders who understand how partner organisations operate and can work effectively across the whole place to address common challenges. Confident, competent leaders with the right attitude and behaviours can set realistic targets for outcomes, savings and timescales. They can 'push back' at demands that they do not believe are achievable but can also challenge themselves, their organisations and the whole system to develop.

The IPC study points to some of the key features of system leadership, as outlined by the King's Fund[27]. These include working in collaboration; distributing leadership and enabling other people to act; being prepared to give up some of one's own power and control; equality among leaders of different organisations/sectors without one organisation dominating; stepping outside 'silo' thinking; and focusing on the broader needs of place and how these can be better addressed by combining resources.

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27 The King's Fund, 2015, 'The practice of system leadership: being comfortable with chaos'
www.kingsfund.org.uk/sites/default/files/field/field_publication_file/System-leadership-Kings-Fund-May-2015.pdf

Leadership team in Rotherham

In Rotherham, the closely-knit chief executive and director-level leadership team meets weekly to problem-solve together in the style of a high-level action learning set. Partners have spent time developing a culture of close working and peer support. Relationships are built on trust that has been established through understanding each other's issues and ways of working, gained by spending time in partner organisations, seeing the world through a different lens and 'walking in each other's shoes'. The result is a set of shared values including seeing the whole person, acknowledging the breadth of their needs and taking a whole-system approach to change.

The level of commitment of the partners in Rotherham is described as being such that they put the collective aims of the integrated care board above those of their own organisations.

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www.local.gov.uk/integrating-health-and-social-care-rotherham-case-study

Leaders are role models, responsible for modelling behaviours and ensuring that they become embedded across the system to promote collaborative culture. Many of the leadership developments taking place in local systems focus on setting up shared leadership arrangements – joint teams, often co-located, enabling leaders to discuss and problem-solve together so that consistent messages are delivered.

It is also important to note that being a health, care and wellbeing system leader involves huge pressures and challenges, so support is essential for them to work effectively.

Leaders driving culture change in Plymouth

In Plymouth, culture change has been led from the top, with system leaders co-located rather than isolated in separate offices. Working from 'hot desks' they are visible and accessible to staff and deal with problems together using a strengths-based, 'can do' approach. Leaders recognise the need to constantly align priorities across the system.

IPC 'Integrating health and social care: Plymouth case study':

www.local.gov.uk/integrating-health-and-social-care-plymouth-case-study

Accountability

With new models and systems to join care and support, it is essential that robust arrangements are in place to ensure clear lines of accountability to the public and establish system-wide governance. This is a complex task, particularly given the different approaches to governance within local government and NHS bodies – and within a legislative framework that was originally designed to drive competition, rather than collaboration, in the NHS.

Accountability and governance arrangements for the main system partners – councils and NHS bodies – run through different lines. At a national level, the NHS is answerable to Parliament, through the Secretary of State for Health and Social Care, for the delivery of political priorities set by Government and reflected in the NHS Mandate. NHS England and NHS Improvement, which are currently establishing ways of working in greater alignment, develop national policy for the NHS and play a role, alongside the Care Quality Commission (CQC) for providers, in overseeing the performance of CCGs and providers.

Locally, CCGs are accountable to their governing bodies, which include clinicians and lay members. All NHS trusts are accountable to their boards; NHS foundation trusts have a direct line of accountability to Parliament and to the public via their council of governors. VCSE organisations are generally accountable to their boards of trustees. Local government is bound by national laws and regulations, and is held to account by its local population through local government elections. CQC inspects the quality of a range of social care services either provided or commissioned by councils.

Sustainability and transformation partnerships have substantial influence but do not, as yet, have a statutory basis. Health and wellbeing boards are, so far, the only partnership arrangement in the current system formed on a statutory basis, bringing together political, clinical and community leadership as equal partners. The review found that some health and wellbeing boards are at the heart of driving change, whereas others operate in a more limited fashion around the local health and wellbeing agenda[28].

In this complicated and shifting landscape of new models and systems, many partners have developed arrangements for accountability and governance that work for them, as demonstrated in the case examples in this section. This is another important area of work in which information should be collected and learning shared.

As in so many areas of integration, there is no 'one size fits all' model for accountability and governance, but arrangements for accountability should include these important elements:

- clear lines of accountability to local people

- clinical and professional expertise in oversight and decision-making

- elected members proving democratic

28 Shared Intelligence, 2017, 'The power of place: health and wellbeing boards in 2017 www.local.gov.uk/sites/default/files/documents/The%20 power%20of%20place%20health%20and%20wellbeing%20 boards%20in%202017.pdf

accountability in oversight and decision-making

- a shift in balance from national to place-based system accountability

- the experience and voice of people who use services, carers and communities within decision-making.

Leadership team in Dorset

Dorset's systems leadership team includes councillor representation from the relevant portfolio holders to provide strategic direction. They are supported by the two health and wellbeing boards, which have the two shadow integrated health partnership boards aligned to them. Within this governance structure there is an ongoing focus on data to influence and shape future modelling and spend. Dorset is looking to add the transport partnership board to its governance structure, in recognition of the key role that transport plays in maintaining the health and wellbeing of the local population.

IPC 'Integrating health and social care: Dorset case study': www.local.gov.uk/integrating-health-and-social-care-dorset-case-study

Partnership board in North East Lincolnshire

North East Lincolnshire's partnership, 'the Union', has a partnership board providing single strategic leadership across the CCG and the council's people-related functions and delivery of Section 75 health and social care arrangements. The Union was designed as a relatively lean and uncomplicated model in which each statutory organisation continues to discharge their retained responsibilities and decision-making powers through their governing bodies, but delegates delivery to the partnership board and joint executive team. The health and wellbeing board plays no direct role in the new governance arrangements beyond signing off the BCF element of the pooled

fund. However, it fulfils an important role in terms of its sponsorship of the health and wellbeing strategy and joint strategic needs assessment, and as a forum for aligning collective effort from a wide range of stakeholders.

IPC 'Integrating health and social care: North East Lincolnshire case study':
www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

A place-based approach in Rotherham

In Rotherham, the health and wellbeing board oversees five priority areas: building stronger communities, skills and employment, integrated health and social care, town centre, and a place to be proud of. Integration is overseen by an integrated care partnership place board, co-chaired by the council chief executive and the CCG chief officer, which is responsible for the integrated health and social care place plan, which links across to South Yorkshire and Bassetlaw STP. There is a strong emphasis on tackling the social determinants of health and the life course and an asset-based approach through activity such as seed-funding community assets, co-design with local communities, 'making every contact count' and social prescribing.

IPC 'Integrating health and social care: Rotherham case study':
www.local.gov.uk/integrating-health-and-social-care-rotherham-case-study

Workforce

The review found that workforce capacity is a major challenge to the delivery of integrated care. Both health and social care are affected by the impact of the national living wage, the increase in vacant posts and the effect of Brexit on the supply of staff from abroad. Stagnant wages in the social care sector, coupled with pay increases for NHS staff, will attract nurses and others away from the care home sector. There are widescale shortages of NHS clinical staff, particularly nurses and GPs[29]. In adult social care the provider sector is increasingly fragile[30] – largely due to increasing wage costs and the level at which local authorities can afford to set fees.

A shortage of workers overall will impact on the ability of organisations to develop integration – for instance, staff may be diverted to focus on service pressures rather than service development. A joint approach to workforce planning is needed at national and local levels to address the shortages in the health and social care workforce. The review found examples of how areas were taking a place-based approach to workforce planning, such as considering the housing and transport provision that would attract more workers.

Integrated workforce model in Nottingham and Nottinghamshire

Nottingham and Nottinghamshire have established five work streams that will provide the foundation for the development and delivery of a five-year workforce plan to deliver STP ambitions. It will build capacity and capability across the system to re-design the workforce of the future, enable them to be deployed more flexibly to where their skills are needed, and equip them with the skills to work in new ways and in the new teams of the future.

The work includes a joint workforce learning and development plan that promotes the delivery of core social care and health strategic objectives, such as an integrated information and advice offer, and a focus on embedding prevention through, for example, reablement, technology-enabled care and self-care.

29 The Health Foundation, 2017, 'Rising pressure: the NHS workforce challenge'
    www.health.org.uk/publication/rising-pressure-nhs-workforce-challenge
30 ADASS, '2018/19 Budget survey'
    www.adass.org.uk/nhs-pressures-and-care-market-failures-across-country-means-short-term-funding-must-continue-adass-budget-survey-reveals

In 2016, the Kings Fund publication found limited evidence of the development of integrated workforce planning[31]. However, there were more examples of workforce development, such as new behaviours and skills needed to work in an integrated system and establishing new integrated roles that could work across the system.

The review found many examples of workforce development and flexibility, including:

- new joint roles to support integration, such as care co-ordinators

- more posts jointly appointed – such as public health or adult social care leaders appointed across local government and CCGs

- multidisciplinary teams and the leadership and supervision to manage workers from different professions

- engaging the workforce in designing and implementing new approaches

- shared professional practice and professional development, such as all front-line staff being skilled in person-centred care

- deploying staff as needed across a system

- health and care systems sharing recruitment, selection, induction and training.

Leaders of local systems should assess the changes needed to equip their workforces for integration, so they are skilled in working across systems. They will need to work closely with local partners in colleges and universities and with national bodies such as Health Education England and Skills for Care.

Workforce strategy in Plymouth aligned with economic development

Plymouth is developing an ambitious workforce strategy to improve recruitment across the health, care and wellbeing market. This is part of the local economic growth agenda. Working with unions and the university, new apprenticeship programmes and career pathways have been developed to enable staff to gain skills in health and care through a set of generic competencies. The recruitment model has been changed to recruit for attitude and aptitude and to provide the necessary training. This has resulted in district nurse teams going from 50 per cent vacancies to being over-subscribed. Broadening the remit of support workers and undertaking joint work have resulted in improvements across teams, and have helped with the implementation of a person-centred 'discharge to assess' model.

IPC 'Integrating health and social care: Plymouth case study':
www.local.gov.uk/integrating-health-and-social-care-plymouth-case-study

Shared systems

Shaping place-based systems and new care models

The landscape of health and care integration is still being formed, and health and care systems are at different stages of developing integrated systems, models and programmes. At the time of writing, two of the 14 areas that are currently part of the ICS programme have a devolution approach, three STPs in the North East are seeking to merge to create a larger strategic footprint over a largely rural geography, some ICSs are following the STP footprint but others, such as Frimley, cover smaller areas[32].

31 The King's Fund, 2016, 'Supporting integration through new roles and working across boundaries'
www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Supporting_integration_web.pdf

32 NHS Providers, 2018, 'Key questions on the future of STPs and ICSs'
www.nhsproviders.org/key-questions-for-the-future-of-stps-and-icss

In local developments, some areas are establishing comprehensive models stemming from a long history of working together. Others are starting with smaller initiatives, such as multidisciplinary teams in defined neighbourhoods, and rolling these out based on the evaluation of pilots.

The NHS long-term plan will include further clarification on NHS system architecture to inform future planning.

Another layer to place-based systems is devolution. The inclusion of health and social care in the Greater Manchester devolution agreement in 2015 enabled local councils and the NHS to take greater control over the region's £6 billion health and social care budget alongside housing, transport and skills. Since then, another four areas have specifically included health in their deals: Cornwall, West Midlands, Liverpool City Region and London. The deals to date include a requirement that local areas deliver financially stable health and social care systems by 2020[33].

Place-based systems of care are the building blocks of the transformed health and social care landscape in which organisations collaborate to improve health, care and wellbeing across defined populations and geographical areas[34]. The emphasis has shifted from what organisations 'do' to what organisations 'do together'.

In Greater Manchester, the partners in each of the 10 boroughs have established a local care organisation (LCO) as the vehicle to transform services to improve citizens' health and wellbeing and integrate care. Each is pooling funding into a single budget, managed through integrated commissioning arrangements, while services are also coming together through multidisciplinary neighbourhood teams and a shifting of care into the community.

Each LCO, however, is different, depending on the needs of the place, its strengths, challenges and priorities. For example, Salford City Council and the CCG created a joint commissioning board to oversee a pooled budget of virtually all health and care funding. The commissioners jointly contract Salford Royal Foundation Trust, an integrated care organisation, to provide hospital, community, primary and social care services. In a number of the boroughs – Tameside, Trafford, Rochdale, Wigan and Oldham to date – the councils and CCGs share a chief executive/accountable officer.

'The Union' in North East Lincolnshire

North East Lincolnshire has a long history of strengthening partnership arrangements, dating back to 2004. Building on this, an integrated care partnership has been created through which providers have come together as a single legal entity, 'Together Ltd', to reshape pathways, redesign delivery models and realign resources to ensure people receive responsive, consistent, high-quality care. Together Ltd will eventually be funded through a capitated budget operating under a single contract. The next stage of the journey for the council and CCG as joint strategic commissioners was the formation of an enhanced partnership called the Union, which went live in September 2017 with a joint chief executive.

IPC 'Integrating health and social care: North East Lincolnshire case study': www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

Several levels of place-based systems are emerging as the basis of new models for health and care, and the review highlighted that it would be useful to explore these.

33 Institute of Public Health/Oxford Brookes University, 2018
34 Kings Fund, 2015, 'Place-based systems of care' www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

STP and ICS

- Some aspects of health, care and wellbeing are most effectively commissioned and delivered on a strategic basis, as in STP and devolved area footprints. This is where economies of scale can be made by sharing resources and taking a strategic population approach. A growing number of health and wellbeing boards are now joining up to work together across larger footprints, and many CCGs are working together through collaborative commissioning and other joint approaches.

- It is also worth noting that ambulance and specialised services will generally be commissioned across an even larger geographical footprint, to ensure the scale and population cover required.

Local

- The area that often corresponds to top-tier and unitary councils, health and wellbeing boards and to one (or more) CCG(s). This level of place is often defined by partners coming together to make best use of the 'local pound'. It is the base for much health, care and wellbeing planning, commissioning and delivery. This includes partners from beyond health and social care, from business, housing, planning and so on, coming together on a place-based approach to wellbeing, such as in 'healthy town' type initiatives.

Neighbourhood

- This level is effective for neighbourhood planning and delivery across health, local authority and the VCSE sector. Examples are the 'primary care home' model and primary care networks, and the many integrated multidisciplinary health and care teams already working effectively on the ground. Neighbourhoods are also the place at which work with local communities, such as asset-based community development, is most effective.

- Work on the NHS long-term plan is developing greater understanding about the levels – described as 'system', 'place' and 'neighbourhood' – and which functions, services and decisions are best carried out at each.

Neighbourhood planning in Dorset

In Dorset, 'mini health and wellbeing boards' based on GP localities bring together a wide range of local partners from health, social care, housing and the VCSE sector to establish place-based plans and responses at a micro level.

IPC 'Integrating health and social care: Dorset case study':
www.local.gov.uk/integrating-health-and-social-care-dorset-case-study

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Taken together, the three levels provide a coherent framework for strategically planning and commissioning health, care and wellbeing to deliver support closest to people's homes, while also, wherever possible, realising economies of scale. The three levels provide a framework for subsidiarity in commissioning – commissioning at the appropriate level for population needs.

The focus on place-based system working means that there have been opportunities to develop a range of structures and systems which fit the needs of geographies and populations and which are shaped by local leaders – clinical, political and community – based on engagement with people who use services and carers. This is a welcome development, reflecting the long-held view across health and care that there is no 'one size fits all' structural solution and that top-down models should not be imposed.

No geographical boundary will ever be perfect, there is no ideal population number for each level of activity, and factors such as rurality and access will have a major impact on configurations. Establishing place-based systems can be problematic, especially if they are new systems that cut across existing borders of established working and result in added complexities.

The following principles should be considered in developing these:

- place-based systems should be established or changed only following local discussion and negotiation

- achieving improved outcomes for people who use services is the key factor in establishing new systems

- places that are well established, recognised by citizens and unlikely to change in the coming years make sense as the basis for a system

- boundaries should not just consider health and care but the wide range of partners which contribute to health such as police, fire and rescue, housing and so on

- organisations should be flexible about working across boundaries.

The variety of models and systems being devised brings opportunities to identify the most effective approaches to integration – those that will endure and result in the best outcomes. However, as yet there is little formal evaluation of these, so caution is needed before they are rolled out and scaled up. In its 2018 examination of value for money in vanguard new care models[35], the National Audit Office found early signs of a positive impact on emergency admissions but concluded that, so far, the impact and sustainability of vanguards remain unproven. NHS England intends to publish an evaluation of the vanguard programme in 2018.

The Social Care Institute for Excellence (SCIE) has developed a 'logic model' for measuring progress in integrated systems[36]. SCIE is also supporting the Department of Health and Social Care with the development of an 'integration scorecard' to combine outcome metrics, financial performance, user experience and process measures[37].

Some local systems have built evaluation into their models and programmes, often through BCF funding, which provides very useful information – not just locally, but country-wide. Ensuring learning about what works and what does not is collected and disseminated widely is a vital part of rolling out integration.

Evaluating multidisciplinary teams in Nottinghamshire

In Nottinghamshire, much effort was put into setting up and building relationships within multidisciplinary teams based around GP surgeries. An evaluation of the effectiveness of the teams by Nottingham Trent University[38] found that effectively embedding social care led to a more positive risk-taking approach than might otherwise have been adopted by health colleagues. Cost savings and improved outcomes include:

- a reduction in hospital admissions

- a reduction in admissions to residential and nursing care

- greater use of lower-level services that help to maintain wellbeing and independence, enabling people to remain at home.

Where integration was done effectively, cost savings were made. In one integrated team, total social care costs were on average £4,445 less per service than the rest of the district (over the 135-day study period). In another team they were £2,750 less.

IPC 'Integrating health and social care: Nottingham case study':
www.local.gov.uk/integrating-health-and-social-care-nottingham-case-study

35 National Audit Office, 2018, 'The health and social care interface'
    www.nao.org.uk/report/the-health-and-social-care-interface/
36 SCIE, 'Logic model for integrated care'
    www.scie.org.uk/integrated-health-social-care/measuring-progress/logic-model
37 SCIE, 'Integration scorecard 2020'
    www.scie.org.uk/integrated-health-social-care/measuring-progress/scorecard

38 Nottingham Trent University, 2017, 'Evaluation of the social care role in integrated primary care teams for older adults who have complex needs in Nottinghamshire: final report'
    irep.ntu.ac.uk/id/eprint/32630/1/10128_Mutale.pdf

Testing and evaluating new care models in Croydon

An important element of Croydon's approach to integration has been to test out and evaluate two new models of integrated care that it piloted over a period of one year – 'integrated community networks' and 'living independently for everyone'. In the first model, multiagency teams called 'huddles' meet weekly at the GP surgery to proactively plan the care of people with complex needs, to reduce the risk of hospital admissions. Early indications show 14 per cent fewer hospital admissions. The second model focuses on promoting independent living for older people through reablement, rehabilitation and rapid response, delivered seamlessly by an integrated team of social and health care professionals operating out of a single building with one budget. The 'discharge to assess' element of this has successfully reduced the length of stay for people in hospital and reduced long-term care packages post-reablement.

As sufficient benefits were demonstrated to reassure partners that the new ways of working should continue and be expanded, the approach was agreed in a legally binding agreement for a further nine years until 2027.

IPC 'Integrating health and social care: Croydon case study':
www.local.gov.uk/integrating-health-and-social-care-croydon-case-study

Evaluating the 'Village' project in Rotherham

The 'Village' project tested a model based on a multi-professional team delivering health and social care to a general practice population in a single pathway. The team brings together primary and secondary care, social care, mental health, community services and the VCSE sector. Evaluation of the pilot showed a positive impact on emergency admissions and hospital length of stay, with more people able to return home safely immediately following discharge. For example, while all Rotherham localities saw an increase in emergency admissions, during the same period the 'Village' saw a 2.1 per cent decrease. A phased implementation for the six other localities in Rotherham is planned and will also include transformation of the care home sector.

IPC 'Integrating health and social care: Rotherham case study':
www.local.gov.uk/integrating-health-and-social-care-rotherham-case-study

Integrated commissioning

In 2018, the LGA and NHS Clinical Commissioners published 'Integrated commissioning for better outcomes – a commissioning framework'[39]. This is a tool to support local government and the NHS to implement the integration agenda and to promote consensus on good practice. It sets out standards and ways of making progress on integrated commissioning within four domains, including 'taking a person-centred, place-based and outcomes-focused approach'. The framework is a helpful resource for local partners developing integrated commissioning.

Care market management in Dorset

In Dorset, the council and the CCG have developed a joined-up approach to proactive care market management though a contract framework called 'Dorset Care'. Initially focusing on home and community services for older people, it is now extending into learning disability and mental health services. The framework provides a platform for dialogue with the market and creating rapid solutions for arising pressures. It has been used to create a rapid response to winter

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39   LGA and NHS Clinical Commissioners, 2018, 'Integrated commissioning for better outcomes'
www.local.gov.uk/icbo

pressures, funded by the local hospital to improve the timely discharge of patients.

IPC 'Integrating health and social care: Dorset case study':
www.local.gov.uk/integrating-health-and-social-care-dorset-case-study

The framework also recognises some fundamental differences between NHS and local government commissioning. For example, local government has a market shaping duty to promote diversity and quality in the market of care and support for people in their area, but there is no equivalent duty for the NHS. However, there are fundamental building blocks of commissioning and contracting, such as needs analysis reflected in joint strategic needs assessment, data analysis, procurement and contract management, which will always be relevant to integrated commissioning.

The review found that strategic commissioning in the NHS is in a state of development. As well as an increasing emphasis on subsidiarity, the distinction between commissioner and provider is becoming less clear, with some providers commissioned by CCGs to both deliver and design services for a population group. Providers are increasingly working in partnership to deliver contracts, including NHS trusts working with the VCSE sector. NHS Clinical Commissioners and NHS Providers are working with others to explore how such place-based planning and delivery can best work in practice.

Integrated funding arrangements in North East Lincolnshire

Historically in North East Lincolnshire, joint working focused on a 'lead commissioner' model with pooled funding. For example, as lead commissioner, the CCG buys all residential and nursing care on behalf of itself and the council. Although technically there are detailed arrangements for the governance of pooled funds with the Section 75 agreement, in practice budgets and contracts are fully operationally

integrated. It is the responsibility of the lead commissioner to ensure that funds are used appropriately and that the under- and over-spends are managed.

IPC 'Integrating health and social care: North East Lincolnshire case study':
www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

Partners have identified the need for support in understanding some of the technical aspects related to strategic commissioning, such as capitated budgets, data gathering and analysis, risk stratification and predictive modelling[40].

There is no doubt that models for commissioning will continue to change and evolve in the coming years. An area identified in the review as needing further development is individual commissioning through personal health budgets and personal care budgets/direct payments, which needs to be developed and aligned with integrated commissioning.

Personalised health budgets in Nottinghamshire, Gloucestershire and Lincolnshire

The three 'accelerator' sites are introducing a commissioning model using personal health budgets. The model involves different conversations with patients (who qualify for continuing healthcare funding), moving the focus away from 'what's the matter with you?' to 'what matters to you?' – making the individual more empowered and involved in their own care planning. Initial pilots have shown average cost reductions per budget of around 17 per cent.

IPC 'Integrating health and social care: North East Lincolnshire case study':
www.local.gov.uk/integrating-health-andsocial-care-north-east-lincolnshire-case-study

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40 NHS Clinical Commissioners, 2018, 'Steering towards strategic commissioning'
www.nhscc.org/latest-news/strategic-comm/

Funding and resources

Budget-sharing mechanisms are a way of creating opportunities for joining the commissioning and delivery of services. Local systems are involved in a range of budget-sharing arrangements, including pooling through formal Section 75 partnership agreements and informal local agreements in which budgets are aligned.

Some systems have shared budgets across the health, social care and public health interface. Others are focusing on pooling or aligning budgets in defined service or geographical areas, such as mental health or local neighbourhoods. The extent of arrangements is often related to the length of time the partners have been successfully working together.

Plymouth's integrated fund

Plymouth worked with Bevan Brittan LLP to deliver a Section 75 agreement financial framework and risk-sharing agreements for an integrated fund which commenced in 2015. The fund covers cradle-to-grave services including public health, leisure services, housing, children's services, adult social care, primary care, community health services and acute provision, along with running costs. Where budgets could not legally be pooled they were aligned. Joint commissioning arrangements were further developed into a single commissioning function, with team members employed by host organisations but working to four shared commissioning strategies and supported by an integrated finance team.

Examples of shared arrangements related to budgets include:

- system-wide financial modelling

- formal risk-sharing agreements

- an 'open books' policy, particularly when considering savings or efficiencies across organisations

- considering the full range of resources, including assets such as estates.

The review found uncertainty about the extent and limits of Section 75 agreements, and that more guidance on how it can be used in practice would be helpful.

The review found some support for the NHS moving away from payment-by-results and tariffs, in which providers are paid on the basis of activity, to capitated funding in which the costs to the whole system of an individual's care are identified so that it can be used more effectively. This approach is seen by some as providing a better basis for the shift to community services and the development of personal health budgets. Outcome-based funding, which would incentivise activity based on system-wide priorities, is also being explored in some areas.

Sharing financial responsibility in Croydon

Croydon spent a lot of time on financial modelling and found that a 'do nothing' position for the over-65s was not sustainable, and that it was better to tackle issues together so the whole system can benefit. It is developing systems of joint financial responsibility, such as a shift of money from the CCG to the council in recognition that additional social care was required to support timely discharge of patients requiring reablement.

Payment-by-results arrangements are seen as counterproductive to partnership working as they create incentives in acute trusts to drive up activity to increase income. Croydon's 'Alliance Agreement' states an intention to introduce outcome-

based payments, which over time will form an integral part of a capitated payment system.

IPC 'Integrating health and social care: Croydon case study':
www.local.gov.uk/integrating-health-and-social-care-croydon-case-study

Information sharing and information technology

Information sharing across the health and care system is widely recognised as a major enabler for the delivery of integrated care. However, the review found that while some organisations have made significant progress with this, in other areas it is still at a relatively early stage of development. Sharing information across IT systems which can't talk to each other is often identified as a major challenge for integration, because of dilemmas as to whether to set up a new shared system or open an existing arrangement to other partners – both with their own problems of cost and effectiveness.

The ability to share information results in a more seamless experience for people using services – information only having to be given once – as well as streamlined referral and communication processes. It also provides opportunities to analyse data relating to issues such as demand and capacity, risk stratification and the impact of specific interventions, all of which will support more effective commissioning.

While areas tend to implement shared systems on an incremental basis, the full aim is to share, as relevant, across acute and community health care, mental health, primary care, social care, and relevant VCSE and independent sector providers. Increasingly, systems are also looking at how IT can enable individuals to hold their own records and interact digitally with health and care workers for advice and information, so they can better manage their own care and alleviate front-line pressures.

NHS England has set up a 'Local health and care records exemplars' programme.[41] This involves a small number of systems receiving national match-funding to build on local work for shared records, to further develop joined-up regional information reference sites focused on improving direct patient care.

With IT being one of the key priorities of the Secretary of State for Health and Social Care, Matt Hancock, a greater national focus can be expected.

Single database in North East Lincolnshire

North East Lincolnshire was the first area to establish a single database for adult social care, community health and primary care, in 2010. 'SYSTM1' provides an integrated case record with electronic transfer of referrals, currently shared by 80 per cent of primary care, all of social care and community health services, and with mental health due to join in 2018. A number of challenges relating to data sharing were solved by embedding private areas and reinforcing data principles with partners.

IPC 'Integrating health and social care: North East Lincolnshire case study':
www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

Leeds person-held record (PHR) programme

Leeds has started the development of an open platform-based PHR to enable residents to better manage their health online. This is being developed as part of a three-year pilot involving the Ripple Foundation. It is hoped to build up to 14,000 users over the pilot period. The project is based on extensive engagement with individuals, care professionals and stakeholders.

www.leedscarerecord.org/leeds-council-develops-person-held-record-locals/

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41   NHS England 'Local health and care records exemplars programme'
www.england.nhs.uk/publication/local-health-and-care-record-exemplars/

IT developments in Nottinghamshire

In January 2019, Nottinghamshire partners are due to establish a portal allowing health and social care staff to view records for specific individuals using their NHS number as a matching field. In May 2018, they established a system of automatic messages and workflows which allows updates and assessment notices to be shared. This has shaved an average 4.5 hours off the previous processing time for referrals of hospital patients to social care.

IPC 'Integrating health and social care: Nottingham case study': www.local.gov.uk/integrating-health-and-social-care-nottingham-case-study

Shared service provider in Plymouth

The council and CCG established a shared service provider, DELT, in 2015, initially to manage, develop and maintain IT systems, with ICT staff from both organisations transferring into the new entity. The company's configuration lends itself to additional back-office functions being transferred at a later stage, and recently this has included council payroll services.

IPC 'Integrating health and social care: Plymouth case study': www.local.gov.uk/integrating-health-and-social-care-plymouth-case-study

5   Integration checklist

This checklist covers the main areas where progress needs to be made for effective integration. It can be used to assess shared progress on integration by partners involved in STPs/ICSs and local transformation – leaders and staff from all sectors, people who use services and carers, and local communities.

Shared outcomes

Transformation

- The vision for transformation includes delivering outcome-focused, person-centred care and preventing poor health and health inequalities. There is alignment of vision and strategic plans across STPs/ICSs and local levels.

- There are clear plans for shifting appropriate activity and resources from acute hospital and long-term residential care into an integrated community health and care model, and clear ways of measuring that this shift is taking place.

- There is a place-based approach involving a range of partners beyond the health and care sectors, to make full use of all the assets that have an impact on health.

- Robust arrangements are in place to involve people who use services and carers in shaping and evaluating services based on outcomes that are important to them.

- Mechanisms are in place to enable front-line staff from all partner organisations to come together to help shape good practice in integration.

- Dedicated transformation funding is identified to provide capacity to develop integrated care programmes and services that meet local priorities (this will be largely subject to the availability of national funding).

- Leaders responsible for integration have a good understanding of the main elements: community health, primary care, social care, mental health, acute care services and public health, and how they can best work together across all sectors, including the VCSE sector.

Outcome-based, person-centred care in community settings

When developing outcome-based, person-centred care in community settings, the following measures are in place or under development:

- Using 'I' statements to form the basis of outcomes, designed with people who use services and carers. These would form the basis of evaluating services based on people's experience.

- Robust arrangements to involve people who use services and carers in shaping and evaluating services.

- Agreement on what constitutes high-quality, person-centred care in each main area of health and care delivery, such as learning disabilities, and plans to jointly improve quality and standards in these areas.

- Integrated person-centred safeguarding arrangements.

- Proactively deploying new technology, including innovations such as robotics and personal digital devices for self-care. Joining provision of assistive technology, community equipment and adaptations. Wherever possible, technology should result in more cost-effective and sustainable support.

- Shared health and care records and better information sharing, including across the VCSE and independent sectors.

- Integrated approach to assessment and care planning across all sectors.

- Integrated approach to encouraging self-care so people can maintain their own health and independence wherever possible.

- Integrated approach to personalised health and care budgets and direct payments.

- Integrated information and advice services.

- Establishing multidisciplinary teams that are co-located and based in neighbourhoods, often around GP surgeries.

- Developing community assets with the VCSE sector to provide low-level support in neighbourhoods.

Preventing poor health and tackling health inequalities

Public health is recognised as a key element of integration:

- Health and care leaders understand how public health operates, including the levels of prevention and tackling the social determinants of health, and how these support transformation.

- Public health leaders are included in planning transformation.

- Plans for prevention, as developed through health and wellbeing strategies, align with plans for integration.

- Public health teams collaborate at scale on priorities across an STP/ICS footprint or more widely.

When developing plans to prevent poor health and reduce health inequalities, the following measures are in place or under development:

- Activity focused on geographical areas and communities at risk of health inequalities.

- Screening programmes, including NHS Health Check, made accessible to people at risk of health inequalities.

- Healthy pharmacy initiatives.

- Integrated wellness services in accessible settings.

- Integrated and accessible 0-5 and 5-19 services.

- 'Health in all policies' (HiAP)[42] approaches in which partners from health and care and beyond, such as housing and transport, collaborate to tackle shared health priorities.

- 'Making every contact count',[43] in which front-line staff from all partners are trained to make brief health interventions.

- Social prescribing in primary care linked to activity funded in the VCSE sector, such as exercise classes or parenting groups.

- Developing community assets with the VCSE sector to improve health in neighbourhoods with a joined-up approach to all community development in the local area.

- Activity to encourage people to take personal responsibility for improving their health.

- Employment and training initiatives for people with mental health conditions and other groups at risk of social exclusion.

Shared leadership and accountability

Collaborative culture

The relationship between partners (and whether these facilitate or hinder integration) has been considered, and action taken to develop a collaborative culture. Measures include some of the following:

- Independently facilitated sessions to identify and agree shared values and behaviours.

- Organisational development programmes such as action learning sets.

- Bringing together staff from all partner organisations to shape new services.

- Leaders and staff from different organisations and sectors coming together with people who use services, carers and the public, to shape a shared vision of transformation.

- Shadowing schemes, mentoring and job swaps.

- Opportunities for partners to meet informally.

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42 'Heath in all policies: a manual for local government' www.local.gov.uk/health-all-policies-manual-local-government

43 'Making every contact count: taking every opportunity to improve health and wellbeing' www.local.gov.uk/making-every-contact-count-taking-every-opportunity-improve-health-and-wellbeing

- Developing staff as project managers or change leaders.

- Shared training, for instance developing person-centred care or 'making every contact count'.

- Protocols and agreements setting out how organisations will, for example, manage risk, make decisions and manage disagreements.

- Organisational arrangements involving co-location, open plan working and joint posts.

Leadership

Work has taken place to determine the skills and capacity needed for collaborative leadership across an integrated environment, and a range of training and support opportunities are in place.

Some key elements of collaborative system leadership include:

- With partners, develop a shared vision for system-wide transformation to form the guideline for partnership working.

- Ensure that the vision and the actions that underpin it are understood and embraced across all partners, at all levels of individual organisations and by service users and the public.

- Encourage a collaborative culture by facilitating understanding among colleagues of the roles they undertake and the pressures they face.

- Model behaviours that reinforce collaboration.

- Listen to the views of experts – clinicians, professionals, front-line staff, people who use services and carers – to inform decision-making.

- Ensure that mechanisms for involving people who use services and carers are robust and influential.

- Use the principle of subsidiarity across place-based systems so that decisions are delegated to the most local level.

- Ensure that top-level agreements, such as how funding is allocated, are written

down, worked out in detail and clearly communicated to those who will implement them.

- Set aside space, time and resources to develop system-wide priorities and innovations wherever possible.

Accountability and governance

The following elements are part of any new governance arrangements:

- Clear lines of accountability to local people.

- Clinical and professional expertise in oversight and decision-making.

- Elected member involvement, proving democratic accountability in oversight and decision-making.

- The experience and voice of people who use services, carers and communities within decision-making.

The training and support needs of individuals and organisations involved in governance arrangements, such as health and wellbeing boards, have been addressed to make sure these are equipped to take on their role in overseeing transformation.

Workforce

Shared approaches to workforce planning and development include the following:

- An integrated workforce plan to increase supply and capacity.

- Collaboration with local colleges and universities.

- Integrated workforce development so that the workforce is equipped to work in integrated services, such as promoting shared professional practice based on person-centred care.

- Integrated working is included as part of all professional development.

- Working with staff and unions to develop agreements for flexible working practices that deploy staff across systems to meet local need.

- Working with staff and unions to identify and develop any new roles that are needed

for integrated services, such as through integrated apprenticeship programmes.

- Considering sharing systems across partners, such as recruitment and selection, induction, HR functions such as payroll, and training opportunities.

Shared systems

Shaping place-based systems and models
The following principles are used when developing place-based systems:

- Local discussion and negotiation take place before new systems and models are established.

- Develop subsidiarity – planning, decision-making and delivery at the most appropriate level.

- Achieving improved outcomes for people who use services is the key factor in establishing new systems.

- Places that are well established, recognised by citizens and unlikely to change in the coming years make sense as the basis for a system.

- Boundaries are not just focused on health and care organisations but also on the wide range of partners which contribute to health such as police, fire and rescue, housing and so on.

- Organisations are willing to work across boundaries where this will result in improved health and care outcomes.

- New models, systems and services are evaluated, and learning shared.

Integrated commissioning and best use of resources
Integrated commissioning is in place or planned, underpinned by financial sharing arrangements. Specific developments include:

- Using the framework for integrated commissioning[44] developed by the LGA and NHS Clinical Commissioners when developing commissioning arrangements.

- Integrated personal commissioning through personal health budgets and integrated personal budgets is being developed.

- System-wide financial modelling has taken place.

- There are plans to pool or align budgets across the whole of health, care and wellbeing to underpin joint commissioning arrangements.

- An 'open books' policy operates, particularly when considering savings or efficiencies.

- Risk-assessment and risk-sharing arrangements are in place.

- Metrics are used to trace shifts in expenditure, from acute and long-term care to investment in community-based care and prevention.

- Local approaches to outcome-based, capitated funding are being considered.

- The best use is being made of the range of resources across partners, including estates and back-office functions.

44 LGA and NHS Clinical Commissioners, 2018, 'Integrated commissioning for better outcomes' www.local.gov.uk/icbo

Information sharing and information technology

Progress on setting up arrangements to share information across health and care has been assessed and the following developments are in place or planned:

- A system that allows health and care professionals to see and amend individuals' records and make electronic referrals to speed the referral process.

- A system that allows partners to analyse and aggregate data to underpin better commissioning, including demand management and risk segmentation.

- Integrated data-sharing protocols support safe information sharing.

- The system extends across primary care, community and mental health, social care, the acute sector and the VCSE and independent sectors where relevant.

- Systems are being developed to allow individuals to access their records, communicate with services and manage aspects of their health and care.

References

Association of Directors of Adult Social Services, '2018/19 Budget survey'

www.adass.org.uk/ nhs-pressures-and- care-market-failures- across-country-means-short- term-funding-must-continue- adass-budget-survey-reveals

Care Quality Commission, 2018, 'Beyond barriers: how older people move between health and care in England'

www.cqc.org.uk/publications/ themed-work/beyond-barriers- how-older-people-move- between-health-care-england

The Health Foundation, 2017, 'Rising pressure: the NHS workforce challenge'

www.health.org.uk/publication/ rising-pressure-nhs-workforce- challenge

Institute of Public Health, Oxford Brookes University and LGA, 2018, 'Stepping up to the place, part A: review of the vision'

Institute of Public Health, Oxford Brookes University and LGA, 2018, 'Stepping up to the place, part B: evidence review'

www.local.gov.uk/sites/default/ files/documents/Part%20B%20 -%20Evidence%20Review%20 October%202018%20WEB.pdf

The King's Fund, 2015, 'The practice of system leadership: being comfortable with chaos'

www.kingsfund.org.uk/ sites/default/files/field/ field_publication_file/System- leadership-Kings-Fund- May-2015.pdf

The King's Fund, 2015, 'Place-based systems of care'

www.kingsfund.org.uk/ sites/default/files/field/field_ publication_file/Place-based- systems-of-care-Kings-Fund- Nov-2015_0.pdf

The King's Fund, 2016, 'Supporting integration through new roles and working across boundaries'

www.kingsfund.org.uk/ sites/default/files/field/field_ publication_file/Supporting_ integration_web.pdf

LGA and partners, 2016, 'The journey to integration: learning from seven leading localities'

www.local.gov.uk/sites/default/ files/documents/journey- integration-learn-31c.pdf

LGA, 2016, 'Heath in all policies: a manual for local government'

www.local.gov.uk/health- all-policies-manual-local- government

LGA, 20016, 'Making every contact count: taking every opportunity to improve health and wellbeing'

www.local.gov.uk/making-every- contact-count-taking-every- opportunity-improve-health-and- wellbeing

LGA, 2017, 'Must-knows for elected members: prevention'

www.local.gov.uk/must-knows- elected-members-prevention

LGA, 2017, 'Public health working with the VCSE sector'

www.local.gov.uk/public-health- working-voluntary-community- and-social-enterprise-sector- new-opportunities-and

LGA, 2018, 'The lives we want to lead: the LGA green paper on adult social care and wellbeing'

www.local.gov.uk/about/news/ lga-launches-own-green-paper- adult-social-care-reaches- breaking-point

LGA, 2018, 'Adult social care funding and integration survey: research report July 2018'

www.local.gov.uk/adult-social- care-funding-and-integration- survey-research-report-july-2018

LGA, 2018, 'Hospital to home transfers: resources and emerging good practice'

www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice

LGA and NHS Clinical Commissioners, 2018, 'Integrated commissioning for better outcomes'

www.local.gov.uk/icbo

LGA and Association of Directors of Public Health, 2016, 'Public health's role in local government and NHS integration'

www.local.gov.uk/public-healths-role-local-government-and-nhs-integration

LGA, 'Better Care Fund support offer'

www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-support-offer

LGA, 'Supporting health and wellbeing boards and system leaders'

www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/supporting

National Association of Primary Care 'Primary care home model'

napc.co.uk/primary-care-home/

National Audit Office, 2017, 'Health and social care integration'

www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf

National Audit Office, 2018, 'The health and social care interface'

www.nao.org.uk/report/the-health-and-social-care-interface/

NHS Clinical Commissioners, 2018, 'Steering towards strategic commissioning'

www.nhscc.org/latest-news/strategic-comm/

NHS Confederation and partners, 2016, 'Stepping up to the place: the key to successful health and care integration'

www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf

NHS Confederation, 2018, 'Securing the future: funding health and social care to the 2030s'

www.nhsconfed.org/resources/2018/05/securing-the-future

NHS England, 2014, 'NHS five-year forward view'

www.england.nhs.uk/five-year-forward-view/

NHS England 'Local health and care records exemplars programme.'

www.england.nhs.uk/publication/local-health-and-care-record-exemplars/

NHS England, 2018, 'Consultation on contracting arrangements for ICPs'

www.england.nhs.uk/new-business-models/publications/consultation-contracting-arrangements-for-icps/

NHS Providers, 2018, 'Key questions on the future of STPs and ICSs'

www.nhsproviders.org/key-questions-for-the-future-of-stps-and-icss

Nottingham Trent University, 2017, 'Evaluation of the social care role in integrated primary care teams for older adults who have complex needs in Nottinghamshire: final report'

http://irep.ntu.ac.uk/id/eprint/32630/1/10128_Mutale.pdf

Public Health England, 2018, 'Health profile for England'

www.gov.uk/government/publications/health-profile-for-england-2018

'Public health matters' blog, 2018

https://publichealthmatters.blog.gov.uk/2018/09/06/prevention-and-the-nhs-long-term-plan-3-ways-we-can-save-more-lives/

Social Care Institute for Excellence, 'Logic model for integrated care'

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

Social Care Institute for Excellence, 'Integration scorecard 2020'

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

Shared Intelligence, 2017, 'The power of place: health and wellbeing boards in 2017'

www.local.gov.uk/sites/default/files/documents/The%20power%20of%20place%20health%20and%20wellbeing%20boards%20in%202017.pdf

Further reading

Department of Health, 2016, 'Web resources on place-based systems of care'

www.gov.uk/government/publications/place-based-services-of-care/placed-based-services-of-care

Health Education England, 'Our work – person-centred care'

https://hee.nhs.uk/our-work/person-centred-care

The Health Foundation, 2016, 'Overview of person-centred care'

https://personcentredcare.health.org.uk/overview-of-person-centred-care/what-person-centred-care

The Health Foundation, 2017, 'Some assembly required: implementing new models of care'

www.health.org.uk/publication/some-assembly-required

Institute for Fiscal Studies, 2018, 'Securing the future: funding health and social care to the 2030s'

www.ifs.org.uk/publications/13028

'Integrated personal commissioning programme'

www.ipcprogramme.org.uk/

Institute of Public Health, Oxford Brookes University and LGA, 2016, 'Report on information and technology'

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

The King's Fund, 2017, 'Integrated care partnerships and accountable care organisations in the NHS in England'

www.kingsfund.org.uk/publications/making-sense-integrated-care-systems

The King's Fund, 'New models of care online resource'

www.kingsfund.org.uk/topics/new-models-of-care?gclid=EAIaIQobChMImeyuopnZ3AIVBUkYCh2EdAl4EAAYASAAEgJDC_D_BwE

LGA, 2016, 'Efficiency opportunities through integration'

www.local.gov.uk/our-support/efficiency-and-income-generation/care-and-health-efficiency

National Audit Office, 2018, 'Developing new care models through NHS vanguards'

www.nao.org.uk/report/developing-new-care-models-through-nhs-vanguards/

NHS Clinical Commissioners, 2017, 'Steering towards strategic commissioning'

www.nhscc.org/latest-news/strategic-comm/

NHS England and NHS Improvement, 2018, 'Refreshing NHS plans for 2018/19'

www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

NHS England, 2016, 'People helping people'

www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf

NHS England, 'What is integrated personal commissioning (IPC)?'

www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/

NHS Providers blog, 'Unanswered questions for the future of STPs'

http://nhsproviders.org/news-blogs/blogs/unanswered-questions-for-the-future-of-stps

Social Care Institute for Excellence, 2016, 'Person-centred care'

www.scie.org.uk/prevention/choice/person-centred-care