Integrating Better

A guide

Integration and Better Care Fund

NHS England

Acknowledgements

This guide would not have been possible without the work of the 16 local areas who have contributed. It is through their learning and willingness to share their experience that we have been able to compile this guide. We especially thank them for helping us to sense check and edit this document based on their experience.

- Bexley
- Bracknell Forest
- Croydon
- Gloucestershire
- Haringey & Islington
- Harrogate
- Leeds
- Lincolnshire
- North East Lincolnshire
- Rochdale
- Somerset
- Southampton
- Stoke-on-Trent
- Wirral
- Wokingham
- Wolverhampton

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We have worked with numerous stakeholders in order to develop this product and we thank them for their input. They include:

- Care Provider Alliance
- Care Quality Commission
- Members of the Association of Directors of Adult Social Services
- Department of Health and Social Care
- Ministry for Housing, Communities and Local Government
- National Institute for Health and Care Excellence
- NHS Confederation
- NHS Providers
- Public Health England
- Social Care Institute for Excellence

Contents

1. Introduction

In this guide we refer primarily to integration between health and other local services linked to health or social care, including work undertaken in the community by third sector and voluntary groups.

1.1 What is this guide?

This guide and the resources within it are designed to support local areas on their journey to integrate services by reflecting good practice. **We have worked with** 16 local areas to develop this guide, via workshops and interviews.

The approach to producing content for the guide builds on material developed by the Better Care Support Team and the New Care Model Vanguards, as well as national sector bodies such the Local Government Association (LGA) and the Social Care Institute for Excellence (SCIE).

The how-to elements of the guide are structural enablers for the Integrated Personal Commissioning programme[1] and the National Institute for Health and Care Excellence's (NICE) Quality Matters work.[2]

1.2 Why now?

Local commissioners and other health and care staff have told us that it remains difficult to deliver integrated services even though there is often agreement around the driving principles.

We heard that local leaders struggle with:

- Changing demographics; ageing populations with multiple long-term conditions mean that care pathways are often complex
- Making a clear economic case for integrating services
- Scaling up successful pilots of integrated services to a place or system level
- Spreading principles of integration from one part of a local health and care system to another

1.3 Who is the guide for?

The guide is aimed at directors, service managers and operational staff in both health and social care. It covers:

- Integration from leadership and service delivery perspectives, along with steps to move from theory into practice
- Lessons from localities that have implemented these services, including evidence of their effectiveness
- Links to relevant guidance and working documents used to support integration

With the input of the 16 local areas we have developed both universal approaches to integration and some specific themes.

1.4 How to use the guide

Integration and transformation is done differently across the country and there is value in tailoring approaches to your local context. The recommendations in this guide reflect the common features of good practice from the local areas we have worked with, rather than an evaluation of all national practice. Therefore, apply the elements that you feel will work best for your services and locality.

The sections in the guide include:

Section	Description
Leading for integration	How to provide the foundations to drive and deliver effective integration. A good place to start to consider how to build an effective vision for integration, and develop buy-in amongst staff and partners.
Universal approaches	Examples of key services and approaches that are needed for effective integration. Consider how far these are in place in your local area and identify areas for development.
Theme sections & case studies	Providing practical service examples under three themes where integration can have a specific impact. These resources will support you to design and deliver local services in a way that achieves the best outcomes for the public and enhance staff engagement.
'Starting point' documents	An assortment of relevant documents that can be used as templates, worked examples or 'off the shelf' material to support the development of your locally integrated services.

Throughout the guide, links to other documents are provided for more information or to access supporting tools. Further resources are provided in the **Resource List** at the end of this guide.

2. Leading for Integration

Leaders create and sustain the environment for integrating services. Feedback from the areas we worked with agreed that it is up to local leaders of different organisations to enable integration by developing a suitable vision as well as ensuring that changes to ways of working can outlast their roles.

Relevant ICS tier	
2.1 Developing a shared vision	System
2.2 Engagement and co-production	Place
2.3 Leadership by example	System
2.4 Culture	Place

Providing leadership for integration is not a one-way street; to be meaningful there should be a visible ongoing commitment from senior leaders and regular, ongoing dialogue between leaders, staff, people with lived experience and the public.

The approaches to leadership described in this chapter are also enablers which will support the implementation of the Comprehensive Model for Personalised Care.[3]

2.1 Developing a shared vision

A shared vision provides a rationale and justification for pursuing integrated services, the aspiration reflecting what all partners (local authorities, NHS organisations, voluntary and community sectors, providers and people with lived experience) want to achieve in their medium-long term future.

Being clear about what you want to achieve provides the context for change. From our research with Wokingham and Bexley, a multi-year vision that includes public engagement can be delivered by;

- Regular consultation and co-production with key partners including staff, politicians, local people and people with lived experience
- Asking questions to establish the outcomes everyone wants
- Referencing intended benefits and challenges for staff and individuals
- Agreeing a common language from both a health and social care perspective
- Publicising the vision through team meetings, induction documents and relevant public forums
- Revisiting the vision every few years to check its relevance and the commitment of partners to implementation

2.2 Engagement and co-production

Engagement between leaders, their staff and the public is essential to changing the conversation on how services are delivered. Meaningful engagement starts when setting the vision and includes both planning and delivery. Adopting a coaching approach can help to enable staff to see their role in achieving the vision.

Stoke noted that this provides people with an opportunity to comment on how the vision is being delivered, as well as encouraging them to take ownership of change and can identify 'quick wins' to make services better aligned. Existing co-production and staff forums are useful in driving engagement. Feedback on these conversations will ensure people know about the changes, but also feel part of them. Using case studies and examples of good practice will help to build people's understanding of what to expect and build support for change.

Co-production fundamentally recognises how people can contribute to care and support at all levels. It increases the scope for people to influence and shape the support they receive as an individual and as a community. It also enables strong working relationships built on direct, regular contact with senior managers and proximity to decision-making. This model changes relationships between people with complex health needs, the Voluntary and Community Sector (VCS) and statutory services that are central to effective change. This has most recently been demonstrated through the Personalised Care programme.[4]

2.3 Leadership by example

Our work with Leeds showed that management across different organisations need to be visibly open to service changes that may involve them losing elements of direct control but which empower their staff. They said leaders must be brave enough to see through new approaches even when they may not be delivering quick results and the need to communicate upwards that tangible benefits will take time to achieve.

Croydon noted that practitioners need permission to try new things, rather than being punished if something goes wrong. Taking an open and courageous approach will trickle down, and staff will feel supported to embrace new ways of working while learning from what goes wrong.

Leadership should recognise that improving outcomes in one area may result in an impact in another area. The risk and outcomes need to be shared and owned across organisations to collectively resolve these issues.

2.4 Culture

Shifting the way that people work across organisations is challenging when delivering integrated services. A joint organisational development (OD) strategy will support delivery of the vision, and consider staff at all levels.

A joint organisational development strategy could encompass:

- Individual members of staff and teams being encouraged to learn about and shadow other roles to understand the pressures each other faces
- 'A day in the life of' sessions where team members swap stories to increase understanding
- Joint training across staff groups and organisations
- Aligning appropriate Standard Operating Procedures (SOPs) and policies across organisations to facilitate staff to be able to work in the same way as their partner organisation(s)
- Peer reviewing anonymised cases to understand what practices can be changed to deliver better outcomes
- Having *change champions* at each level who people can talk to about their concerns
- Rotating the organisation that has the lead responsibility for OD periodically so everyone has ownership over the agenda and maintain momentum
- Regular feedback on how the OD work is progressing to inform improvements

3. Universal approaches to integration

Our research found that some essential services and approaches underpin health and social care integration across different points in pathways. Many areas will have most, if not all, of these approaches in place to some degree. This section of the guide gives more information on how to ensure they are working as well as possible.

Relevant ICS tier	
3.1 Governance	System
3.2 Commissioning	System
Joint Commissioning: Wirral – Teletriage	System
3.3 Establishing a common approach to risk stratification across all partners	System
3.4 Information sharing	System
3.5 Multidisciplinary team working	Place
Multidisciplinary team working: Stoke-on-Trent - Meir Hub model	Place

3.1 Governance

Upfront agreement and ongoing adherence to joint governance arrangements across organisations are vital to the continued success of integrated services, regardless of the type of service and the organisations involved.

Integrated services are usually trialling a new way of working and there is an accompanying risk that they will not deliver the intended results. Thus, they require ongoing oversight from all parties to make sure that emergent issues and opportunities for improvement are addressed.

Governance arrangements tend to be complex where collaboration is in its infancy, with streamlining and delegation being introduced as joint working practices and trust deepens. To help with this, North East Lincolnshire suggested that commissioners and providers work together to streamline performance metrics, which can help maintain a focus on the key outcomes (not outputs) that matter, such as improving quality of life or life expectancy. Where possible this includes joint data collection and reporting to encourage alignment and reduce reporting burdens.

Several integrated services may be put into practice in any one area, it makes sense to streamline governance and oversight to a body that has accountability to make decisions across different organisations. Some areas have started to establish this, with reporting arrangements to the Health and Wellbeing Board or Sustainability and Transformation Partnerships (STP) working groups.

Several areas, including Leeds and North East Lincolnshire noted that ongoing governance must be established before a service begins operating. This provides staff and the public with clarity on how and when changes will be made.

3.2 Commissioning

The benefits of considering health and social care needs together are well recognised. Local health and care commissioners are increasingly working together to arrange specific services that support people to be as independent as possible and are flexible to local need.

Given the interdependencies of all health, care and wider services within a local health economy, many places including Leeds have taken an integrated approach to commissioning across a much wider range of services. Commissioners and providers working together to develop joint pathways, shared outcomes and processes helps balance the needs of the population with the responsibilities and pressures of the different organisations involved. This joint approach will reduce the likelihood of 'cost shunting' and other unintended effects that focussing on one particular issue can bring without consideration of the whole system.[5]

Joint Commissioning: Wirral – Teletriage

Adult social care and the CCG jointly commissioned a 24/7 clinical Teletriage service in 2017-18 for all 76 older people's residential and nursing homes in the borough to increase both health and social care outcomes.

Wirral has a high number of care homes and an increasing older population with an increasing number of A&E attendances and admissions from care homes.

Teletriage was designed to:

- Reduce avoidable ambulance calls and conveyances
- Reduce A&E attendances and admissions
- Improve patient experience
- Provide care in patients' place of residence

Care homes have been provided with 4G and wifi enabled iPads, superfast broadband, secure nhs.net email addresses, along with training and ongoing IT support. Care home staff have been trained to take basic observations and have been equipped with blood pressure monitors, thermometers, urine dip sticks and oximeters. When a resident becomes unwell, care home staff use teletriage to Skype with a nurse practitioner or GP who will offer advice, prescriptions, same day GP visits, onward referral, monitoring or support for end of life care.

Wirral teletriage team have built strong relationships with care homes, becoming the first point of contact to access a multi-disciplinary team across acute, community and general practice. The teletriage nurse practitioners have strong relationships with community geriatricians and palliative care teams, along with access to a visiting GP and community services such as continence service, tissue viability, speech and language therapy, crisis response to residential homes and the patient's own GP.

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The service is delivered by Wirral Community NHS Foundation Trust and was created in partnership with Wirral Council, Wirral CCG and Wirral University Teaching Hospitals NHS Foundation Trust, Primary Care Wirral GP Federation and the independent care home sector. The project was supported by Innovation Agency (Academic Health Science Network North West).

Early results show uptake of teletriage is associated with a **significant decrease in 111 calls** from care homes - **69% lower** in June - August 2018 compared to 2017 plus a **sustained 13% decrease** in ambulance conveyances to A & E for May - September 2018 compared with the same period in 2017.

3.3 Risk stratification

When speaking to local areas, we discovered some components to risk stratification were common across multiple areas. Further information is also provided in section 6.1 (Using population level information to highlight cohorts at 'high risk').

Risk stratification combines data from across health and social care / wider local authority services to identify people who are at risk of a condition escalating or developing. Work in Leeds across health and care partners on risk stratification has enabled services to be targeted or tailored to different populations' needs. By understanding whether people's conditions are likely to worsen, and identifying the relevant services to mitigate this, individuals can be supported to maintain independence and prevent their care needs increasing. **Risk stratification is increasingly used to support the use of MDTs (see 3.5).**

Examples of a common approach to risk stratification include:

- Using data and modelling to generate insight and predictions for social isolation and under-identification of long term conditions/other diseases
- Jointly identifying individuals who do not use statutory services or are at risk of regular A&E/GP attendance
- Jointly agreeing outcomes for the above cohorts
- Planning early stage interventions such as community navigators, social prescribing and loneliness prevention
- Planning proactive community services such as falls prevention or home checks
- Planning community interventions to prevent hospital admission for those with multiple long-term conditions (see more on this in the **'Care and Support in a Crisis'** section)

Wokingham identifies those in the top 10% of statutory health and social care use. From this cohort individuals are flagged for review by the community-based MDT if any of the following criteria are triggered:

- Individual has two unplanned admissions to hospital in the past year;
- Individual has two or more falls registered in the past year;
- Individual has two or more active long-term conditions that are unstable;
- Individual is prescribed five or more oral medications or there are concerns about their ability to self-medicate
- Individual is a frequent attendee at A&E

When comparing data for the 6 months following their intervention with the previous 6 months, A&E attendances for the cohort fell 36% and non-elective admissions fell by 44%.

3.4 Information sharing

The timely sharing of appropriate information about individuals' care, preferences, and treatment across organisations underpins joined-up services. All areas that we worked with acknowledge that sharing this information;

- leads to more informed decision-making
- reduces duplication of services
- alerts partners to gaps that must be met to support an individual's needs
- builds a common understanding and shared culture across practitioners

From a service-planning perspective, sharing management, performance, outcomes and financial data as well as appropriate data about your population will lead to "one version of the truth", build trust and a 'one system' mind-set.

- Be pragmatic
- Gain consent from the public when required
- Share information in any format that works, for example an excel spreadsheet or through securing log-ins for different organisations to enable access where systems cannot be combined[6]

Below are principles Bexley recommended when sharing information to make it as easy as possible:

- Respect confidentiality and data protection, but recognise that the General Data Protection Regulation (GDPR) is not a barrier to sharing information for the benefit of the individual.
- The Health and Social (Safety and Quality) Act 2015 sets a duty for information to be shared where it facilitates care for an individual and it is legal to do so.
- The seventh Caldicott principle stipulates that the duty to share information can be as important as the duty to protect patient confidentiality.
- Health and social care professionals are confident to share information in the best interests of their patients and service users within the framework set out by the Caldicott principles and accompanying guidance.
- Data sharing agreements/systems provide examples of how local areas have successfully shared information within legal frameworks.

3.5 Multidisciplinary team working

A multidisciplinary team (MDT) may be composed of a variety of professionals and volunteers such as:

- social workers
- nurses
- occupational therapists
- doctors of different specialities
- representatives of independent organisations providing care

Stoke found that taking a MDT approach to assessment and care management helps provide the range of perspectives necessary to consider the whole needs of a person. MDTs can ensure people receive the right intervention at the right time more readily than if these professionals worked independently.

From both Stoke and Leeds' experience, an MDT has:

- A set of "core professionals", to which different practitioners are added **(for example from mental health, housing and the voluntary sector)** meaning MDTs become flexible and responsive to the needs of individuals.
- Practitioners who are able to influence their composition, especially in relation to local need.
- A Ways of Working charter that gives equal weighting to the views of all professionals.
- Guidelines on how decisions are made and how this is communicated to individuals.
- Co-located community teams from different local services. This leads to better communication, more transparent shared decision-making, increased trust and joint ways of working. Getting a physical location may be hard, but you may be able to use GP practices or local community assets in neighbourhood locality teams. Virtual meeting facilities can also support MDT working so that not all professionals need to attend in person.

Professionals working in MDTs should take a strength-based approach to assessment. This way all staff consider the whole person and their individual goals rather than only their 'need'. Professionals should also be aware of – and able to refer to – the local Social Prescribing offer so they can provide links to wider social support.

Multidisciplinary team working: Stoke-on-Trent – Meir Hub model

Stoke-on-Trent's Meir Partnership Care Hub is an example of a MDT team which provides place based care and supports Primary Care by helping vulnerable households.

It is a 'ground-up' model based on the following principles:

- Putting the person at the heart of what we do
- Working to resolve/address needs as opposed to simply referring on
- Identifying sustainable solutions which prevent individuals from returning to the system or entering crisis and causing high costs to the system

It consists of Adult Social Care, the local NHS Trust, GP practices, Primary Care service providers and wider public sector partners including the police and fire services. The Voluntary and Community Sector (VCS) also play a role: over 7 VCS organisations provide services or support, often more low level interventions such as discharge support and help with everyday tasks (form filling, debts advice, fire safety). This can prevent people entering statutory or secondary services.

The MDT has wide referral options and named contacts in the VCS to enable easy referral pathways.

Through co-location, sharing assessment procedures and common sign-up to the aim to support individuals in their home wherever possible there has been a 30% reduction in referrals into secondary care. Timescales for service users accessing a successful outcome have been significantly reduced and staff also reported more effective and quicker communication with less 'wasted' communications.

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Relevant Starting Point Document: Outcomes Map

"Access and awareness of the voluntary sector has made my job a lot easier, it's really good to be able to pick up the phone, or have a conversation in the team room with somebody who I know, and discuss a referral, and we trust each other's assessment"

Social Worker reflections on the Meir Care Hub

4. Promoting self-care and independence through prevention

Helping to support people to live healthy lives cannot be done through the delivery of reactive health and care services alone. Many individuals could benefit from earlier intervention from local services such as housing, employment support and social support in order to empower them and help them maintain their independence for longer.

Local areas working with us on this theme agreed that prevention opportunities are often missed because health and social care professionals are not working together with wider public services to signpost individuals to relevant services. Much can be achieved by ensuring that wider public services consider how they can maximise their support for the local population's health and wellbeing to ensure that health and care pathways make the most of the full range of services on offer in the community.

Relevant ICS tier	
4.1 Create an environment individuals and their families can easily navigate	Neighbourhood
4.2 Develop a strong social prescribing offer	Neighbourhood
Social Prescribing Standard Model	Neighbourhood
4.3 Ensure that partners beyond statutory health and care services are considered as part of prevention service design	Neighbourhood

4.1 Create an environment individuals and their families can easily navigate

Navigating multiple services and organisations is challenging for the public and practitioners alike, can result in confusion and people being bounced from one service to another. A Single Point of Access (SPA) is a first point of contact for people seeking information, referrals and support regarding social care and other community services. It can streamline access to information and support, enabling self-management by ensuring people are directed to the right service at the right time.

Harrogate and Wirral also noted that regardless of whether there is an SPA or not, it is important to have a no wrong door policy. Regardless of where someone accesses social care, they are supported to get the right service for them rather than turned away. This allows people to access support more quickly and teams to handle enquiries as far as possible rather than increasing referrals into statutory health or care services.

Several localities noted that setting up a SPA can be difficult **– the following steps represent a useful starting point:**

- Map out all the referral and escalation routes (including social prescribing) for your SPA
- Establish a physical location – within community MDTs, hubs or call centres
- Align or co-locate a few services at a time rather than all at once
- Create a telephone triage service
- Develop a single or aligned referral and assessment process

4.2 Develop a strong social prescribing offer

Social prescribing services enable all local agencies to refer people to a link worker. Link workers focus on what matters to the person and help to connect people to community groups and agencies for practical and emotional support. Bracknell Forest noted the positive impact that meeting these needs can have on health and wellbeing, as well as reduction of demand on GPs and other services. Common examples include exercise programmes, community activities to prevent isolation or cookery classes.[7]

In 2017/18, as part of developing **Universal Personalised Care**, NHS England engaged a wide range of stakeholders to explore what makes a good social prescribing scheme. The key features below have been developed collaboratively with a range of partners, including people with lived experience, social prescribing practitioners and commissioners:

Social Prescribing Standard Model:

- Social prescribing connector schemes are commissioned collaboratively, working with the voluntary and community sector and people with lived experience
- There is a clear and easy referral process from GPs, GP practices and other channels, to social prescribing link workers
- Link workers are typically located in primary care through Primary Care Networks, as part of a wider network team
- Link workers receive accredited training and ongoing development to support their role
- Link workers give people time and start with 'what matters to you?' They co-produce a simple plan or a summary personalised care and support plan as per the standard model, based on the person's assets, needs and preferences
- There are up to 5 link workers per Primary Care Network, supporting up to 3% of the local population, or around one full-time equivalent link worker per 10,000 local population
- Link workers work with people on average over 6-12 contacts, and hold a caseload of a minimum of 200-250 people per year

Local areas should have:

- A clear understanding and map of existing communities, community assets, high impact interventions and gaps
- A whole-system strategy to develop community-based approaches

From our work with Leeds, the following additional considerations are helpful to optimise a social prescribing service:

- Build on existing links between services across the VCS, NHS and local authority
- Co-ordinate existing services and (if needed) commission new programmes
- Establish a member of staff to develop the offer and assess whether it meets local need
- Cultivate a community navigator role to proactively identify those who may benefit from preventative services
- Develop an online portal which can be regularly updated with activities
- Keep GPs and other prescribers informed of what is on offer (via the portal)

4.3 Ensure that partners beyond statutory health and care services are considered as part of prevention service design

Wirral and others said that **public sector partners** including the fire service, police and particularly local housing services can play a significant role in primary prevention and normalising conversations about health and wellbeing.

The supporting case studies from Gloucestershire provide examples of how such partners can be engaged by commissioners to support locally agreed health and care outcomes and as a result reduce the potential requirement for people to access more intensive services later on. In particular people's housing conditions, and the services that can support with this, are a key enabler to delivering better outcomes for the public.

Engaging local organisations from the independent sector as partners is also crucial when designing prevention pathways. Their reach into the community can help with identifying and delivering interventions that will help to strengthen the local preventive offer.

5. Supporting care closer to home

People are generally healthier and happier when their needs are met where they live – that is usually in their own home but it may also be in supported housing or a care home. To support better outcomes for individuals, health and social care services need to work together to enable care to be delivered at home wherever possible, particularly when individuals are in contact with multiple teams or organisations on an ongoing basis.

All of our partner areas agreed that separate ways of working and poor communication between social care teams and health services leads to gaps in individuals' care, increasing their risk of needing to visit their GP or A&E. Working in a more collaborative and integrated way helps to combat this risk.

In this section, common features identified from the work of our local areas demonstrate how to strengthen the joint role and coordination of teams within the community setting to provide a more 'seamless' care experience for people via proactive information sharing and case management.

Relevant ICS tier	
5.1 Establish community-based Multi-Disciplinary Teams to align assessment and case management for people with multiple long term conditions	Place
Community-based Multi-Disciplinary Teams: Bexley – Integrated case management	Place
5.2 Bring health and care commissioners and providers together	Place
Partnership Working: Lincolnshire - Trusted Assessor	Place
5.3 Develop relationships between the supported and residential care home sectors and other community services	Neighbourhood
5.4 Providing comprehensive support to carers so they can support the wellbeing of the person they care for and themselves	Neighbourhood
Support to Carers: North East Lincolnshire - Carer support	Neighbourhood

5.1 Establish community-based Multi-Disciplinary Teams to align assessment and case management for people with multiple long term conditions

For people in receipt of multiple services, an integrated approach to case management rooted in community-based MDT meetings can help. Bexley noted that when people's care needs change, a conversation between the relevant professionals will ensure they receive the most appropriate care in a timely way – with the person's preferences at the centre of decision making. Regular contact between relevant professionals outside MDT meetings will further enhance joint decision making.

External partners are essential, Southampton said that GPs are a key partner and including them will reduce gaps in this pathway. They should be engaged through local Federations and Local Medical Councils, or by using local practices as a hub. Also important are community care (particularly domiciliary care) as people encounter them often, staff know people's history and can be useful in an MDT.

Community-based Multi-Disciplinary Teams: Bexley – Integrated case management

Bexley's approach to Integrated Case Management (ICM) supports their overall 'care closer to home' offer via three ICM teams aligned to three Local Care Networks, who meet monthly to review a mix of 8-12 existing and new cases. The ICM meetings discuss anyone over 18 at risk of a crisis if no action is taken, and uses an enablement approach to person-centred care. The approach is about intervening early to prevent crisis, not just about preventing hospital admissions; these are complex cases, which require the engagement of everyone involved in supporting that person in the community. GPs and other professionals can make a single referral to the ICM meeting with access to a range of expertise, advice and support from across secondary care consultants, adult social care, primary care and the voluntary sector. Bexley's social prescribing scheme, **Community Connect**, and other voluntary sector partners have also been instrumental in supporting patients which has avoided the need for interventions from statutory services and improved patient outcomes as a result.

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5.2 Partnership working between commissioners and providers across both health and social care

Working together to move beyond the traditional commissioner/provider relationship can support integrated service delivery. Local areas agreed that the key factor for success in this area was to bring together providers of similar services with health and social care commissioners and practitioners regularly. They can then discuss and work through key issues and simplify processes. In particular, areas reported that this approach often identified particular 'quick wins' that lead to better ways of working and can have a major impact to individuals to improve their experience in a crisis situation.

Outputs might include:

- **The development of common discharge forms** and processes for care homes and the way they interact with health services (particularly hospitals or ambulatory care)
- An agreement or a MoU with independent domiciliary care providers around the flexible provision of additional care in response to early signs of a crisis
- The development of the **trusted assessor (TA) role** through joint working has been demonstrated to shorten hospital discharge times and reduce administration time for care home providers. TAs can be used for other scenarios, for example in domiciliary care and to do equipment assessments.

Partnership Working: Lincolnshire – Trusted Assessor

The Trusted Assessor programme in Lincolnshire was established to reduce delays caused by getting people out of the acute sector and into care homes, and to increase trust and understanding between the acute sector and care homes. Trusted assessors, employed by the local care association on behalf of the care sector, may assess patients who are coming out of hospital on behalf of the home to ensure that they arrive at the home as soon as possible. The assessor has a degree of neutrality, but is answerable to the manager on whose behalf they prepare the assessment, which enhances the relationships with care homes. The programme has made estimated savings of £400k and significantly reduced bed days.

"We feel that we trust your judgement on these assessments prior to people returning home, when you've been involved the transition has been very smooth".

Beverley Murray, Registered Manager, Scimitar Care Hotels PLC, Waterbeach Lodge

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Relevant Starting Point Documents:

- Assessment form
- Person Specification

5.3 Develop relationships between the supported and residential care home sectors and other community services

The majority of people in England who use health and care services live in non-specialist housing, but just under 1 million people live in supported accommodation or care homes. People living in these settings should have the same access to services as people living in their own home. North East Lincolnshire noted that this requires commissioners and providers to work together to ensure that care homes or supported housing schemes do not become disconnected from additional services that may be on offer from the wider community health and care offer.

The following points describe steps that local areas have taken to make sure that supported housing and care homes are linked into the wider community offer. Further guidance can be found in the **Enhanced Health in Care Homes Framework.**

All localities we worked with said that **Advanced Care Planning** was vital for care home residents (completed with a GP or other clinician) in order to determine their preferences in the event of a crisis. This will reduce the likelihood of people attending hospital unnecessarily and where they do not want to.

Southampton said that emergent needs can be assessed and met in a timely way by residential home and supported housing providers proactively liaising with the local community geriatrician, GP and district nursing services (or other relevant specialist clinicians) to arrange regular clinical check-ups for residents; consolidating these check-ups so that clinicians are not visiting the same housing scheme multiple times a week.

Awareness of the most up to date **National Early Warning Score (NEWS2)** between health staff and care homes will ensure that all care homes have the same understanding of individual's risk factors and only escalate when needed.

5.4 Providing comprehensive support to carers so they can support the wellbeing of the person they care for and themselves

Unpaid carers are the largest health and social care workforce – with an estimated 6.5 million unpaid carers across the UK[8] – and yet there is often a lack of support for them built into pathways of care. All of the local areas agreed how important it is for carers to be involved in all care decisions of the person they are caring for, where the person wants it. Local carer support services are often commissioned by the local authority, but training for primary and community staff in the local offer and assessment processes needs to take place to realise increased involvement of carers in decision making and help them navigate local services.[9]

Southampton noted that training health and social care practitioners in community health settings to give carer assessments and authorise interventions/assistance helps to sustain existing care arrangements for longer, which supports individual outcomes, and reduces demand on local health and care services. In recognising the value that well-supported carers provide to the health and social care system, many local areas are moving to commission a multi-faceted carers' support offer consisting of information and advice, support groups and social activities. Wirral said that consolidating support for carers into one place (virtual and/or physical) can help make the local offer to carers clear and easier to access – and have integrated their carer support service into wider services.

The **NHS Long Term Plan** commits to strengthen carer identification and support, including out of hours support and resources for general practice, which will help to scale and spread these examples of good practice.

Support to Carers: North East Lincolnshire – Carer Support Service

There are around 16,000 carers in North East Lincolnshire, their work helps to save £356 million for the local economy annually. The Carers' Support Service is provided by a VCS organisation and offers a range of support to carers, including:

- Information, advice, advocacy, holistic therapies, befriending and counselling services
- Training on stress management, assertiveness, legal matters, first aid, back care, managing challenging behaviour and IT
- An innovation fund to access external training, support and services
- Peer group support: art groups, sewing, groups for those caring for people with specific conditions

From the last carer survey, as a result of the service:

- 100% of 370 carers felt the service was well informed and effective

As a result of using the service:

- 72% felt that their emotional and mental well being had improved
- 94% felt more able to cope with their role
- 90% felt more supported in their role

By supporting carers in this way, the area ensures there is less carer burnout and that people in receipt of care are better looked after.

North East Lincolnshire also provides half day carer awareness training to health staff so that they are aware of the support for carers and the challenges they face.

Contact Details: NELCCG.AdultSocialCare@nhs.net / beverley.compton@nhs.net

"The carers system is one of the best in the area, the help and support they give is tremendous, I couldn't ask for more."

"Finding this service at this time is the single most important thing I have discovered, ever."

6. Care and Support in a Crisis

This section suggests how to strengthen integrated services for people experiencing a health crisis, including ensuring they are supported in their own home, care home or supported housing wherever possible.

Many of the interventions described here are referenced in the **High Impact Change Model** [NHS England badged self-assessment tool] and this chapter shows examples of how places have put the models from theory into successful practice.

Relevant ICS tier	
6.1 Using population level information to highlight cohorts at 'high risk'	System
6.2 Support admissions avoidance via a community-based response to a crisis	Place
Admissions Avoidance: Manchester - The Living Longer Living Better Programme (LLLB)	Place
6.3 Improving information-sharing across providers in a crisis, or following a crisis	System
Shared Care Records: Bexley - Connect Care	System
6.4 Applying the principle of multi-disciplinary working to support hospital discharge and admission	Place
Discharge: Somerset Home First	Place
6.5 Establish processes that link primary care and community teams after a crisis	Place

6.1 Using population level information to highlight cohorts at ‘high risk’

By sharing information across social care and health databases, populations can be stratified based on the risk of potential escalation. This can lead to targeted interventions for individuals known to multiple agencies who are known to be at higher risk of entering a crisis in order to help them stay well.

Examples of relevant information that can be shared include:

- the General Frailty Index information collected by GPs
- public health data
- reasons for local delayed transfers of care (DTOC)
- Hospital Episode Statistics (specifically around admission reason/readmission rates)
- aggregated data of individuals with long term conditions from primary, social care and community care

6.2 Support admissions avoidance via a community-based response to a crisis

Rapid response/admission avoidance teams are typically MDT practitioner teams consisting of professions including nurses, occupational therapists, physiotherapists and social workers – the mix of professionals depends on the cohort. They respond to emergency referrals often within 2-4 hours and support individuals with immediate needs that can be dealt with in the community rather than calling an ambulance.

Lincolnshire noted that rapid response teams linking to or integrated with temporary community support packages helps individuals maintain their independence after a crisis. The links to services making up these support packages vary depending on need, but may include re-abling domiciliary care support and temporary intermediate care/step-up beds.

Bracknell Forest suggested that hosting professionals from health and social care based services within A&E departments including social workers, mental health liaison and carers support services can also support people being admitted to hospital where their needs can be better met in another setting.

Admissions Avoidance: Manchester – The Living Longer Living Better Programme (LLLB)

LLLB has changed how health and social care services are delivered and coordinated in Manchester. As part of this, Manchester Community Response – North, a new integrated service delivery model was developed in partnership by;

- Pennine Acute Hospitals NHS Trust
- Manchester City Council and
- North Manchester CCG

The service was co-identified, co-designed and co-produced to avoid hospital admissions and reduce lengths of stay in hospital. It embedded a learning culture that has developed capability, capacity and confidence to work together.

The model sought to address siloed working, duplication and fragmentation. It delivered a short term period of rehabilitation of up to 6 weeks, according to the assessed needs of the person. The service components are:

- Crisis Response – a 7 day a week multi-disciplinary urgent care service providing acute care
- Care at home
- Intermediate Care Beds – both enhanced and residential
- Home Pathway Therapy
- Primary Assessment and Reablement
- Navigators – a hospital based service taking referrals from A&E and Medical admissions unit
- Preventing admissions by rapid deployment of community resources

Information obtained from the Better Care Support Team, not directly from the local area.

The updated cost benefit analysis (CBA) has shown a higher benefit on first years activity (£1.11) compared with the initial work (£1.03); in year 2 the CBA is expected to increase to £1.69 for one year's investment. The integrated key performance indicators continue to exceed in performance. Below are some examples:

- The trusted assessments on the acute wards have reduced time taken from recommendation for reablement service from 2 days to 0.5 days
- Crisis Response has tripled throughput and achieved 97% deflection
- 100% customers assessed within 24 hours
- 100% of customers assessed within an hour
- Increase in independence has risen in last quarter to 83% from annual average of 78%
- Family Friends Test increasing trend over past year to 100%

6.3 Improving information-sharing across social care and health providers in a crisis, or following a crisis

There are many practitioners and organisations involved during or soon after a crisis and information changes rapidly so remaining up to date to avoid unsafe or inefficient treatment, and avoid someone re-telling their story, is vital. Having multiple sources of information across different providers acts against this.

a) Developing Shared Care Records

'Shared care records' are being developed in some places so that up to date information on an individual's care can be accessed and edited by those who need it in one place.

b) Developing practical information sharing solutions across providers

Developing shared IT solutions can be time-consuming and costly; therefore some local areas have enabled 'read-only' and varying levels of access to patient records for their partners. Independent social care providers can also access NHS Mail[10], which is a secure means to share information about an individual.[11]

c) Embedding the red bag scheme

The Red Bag scheme[12] has successfully demonstrated a set of principles that ensure information about a person is effectively transferred between care home and hospital settings. When a person becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. The individual keeps these things with them as they move through the hospital and into a different setting.

Shared Care Records: Bexley – Connect Care

Connect Care is a local electronic record being implemented in Bexley, Greenwich and Lewisham. It allows important information from separate record systems to be viewed quickly and safely by staff directly involved in a person's care on a need to know basis. The Bexley system is connected to a similar Local Care Record across other parts of South East London so that information can be shared more widely between health and social care services. This means that care staff – such as GPs, hospital staff, district nurses and social workers – in the sub-region have immediate access to the information they need to give individuals the right care. Time between referrals and treatment is quicker and staff have the right information in real time – so individuals do not have to repeat their story several times.

Contact Details:
ASC.Performance@bexley.gov.uk

Relevant Starting Point Documents:

- Partnership MoU
- Discharge Passport

6.4 Applying the principle of multi-disciplinary working to support hospital discharge and admission

Integrated multi-disciplinary teams made up of staff from a range of acute and community services can support better discharges and address frequent A&E attendees compared to separate teams of specialists.

By taking a holistic view of a person's medical and social needs a MDT can plan a safe discharge. MDT members would normally include:

- therapists (particularly OT)
- social workers (including mental health teams if relevant)
- community nurses
- community geriatricians
- representatives from the social care provider sector

a) Discharge[13]

From Croydon's experience, MDT teams – and particularly social care-based staff such as Occupational Therapists – can work with A&E and acute departments to help them determine whether someone should be treated in hospital or could be managed in the community. This helps to avoid delayed transfers of care.

Haringey noted that the VCS can be a key part of an MDT – they can support return to home for people who are mostly independent but need some support to settle at home. They can also signpost them to other support services.

Discharge: Somerset – Home First

The Somerset Home First collaboration consists of a team of individuals from different health, social care and third sector backgrounds that supports individuals to return home from hospital as soon as they are medically ready to do so. The team organise suitable temporary re-ablement style care to be in place as soon as an individual goes home and then carry out a holistic range of assessments within the home environment rather than multiple assessments from separate teams in a hospital setting. People are twice as likely to be discharged at the right time if managed through the Home First pathways and ongoing support needed by an individual has reduced. Delayed transfers of care in Somerset have fallen by 75% over the past two years.

Contact Details:
TDBaverstock@somerset.gov.uk

Relevant Starting Point Documents:

- Referral Form
- Logic Model

b) Admittance avoidance

Frequent Attender programmes identify and work with people who have higher than average interactions with health and social care for their cohort, and seek to ensure contact points with services are most effective. Areas which have successfully implemented Frequent Attender programmes:

- Developed relationships with senior A&E clinicians to understand why they think there are frequent attendees in their particular local context
- Developed a business case for a MDT in an acute setting, based on avoiding A&E presentations and admissions and increasing outcomes for people
- Were able to readily access information on people in receipt of multiple services presenting at A&E. In some cases, members of the health or social care team responsible for these individuals are also available on-call to support appropriate decision making by the clinician, helping to prevent avoidable admission.

6.5 Establish processes that link primary care and community teams after a crisis

Joint working between GPs and community staff from both health and social care sectors can prevent a crisis re-occurring. One example of this is through automatic referrals for individuals to relevant community MDTs following a crisis episode (see **Supporting care closer to home**). For individuals at immediate risk, these teams can also develop proactive community crisis plans based on their known physical, mental and social issues.

7. Conclusion

This guide is intended to be a starting point. It should help local areas assess how they relate to areas who are well developed in certain areas of integrated care delivery. It also highlights the types of activity that can help local areas progress joint working between health, care and wider services.

It is not the be-all and end-all of integration, and we acknowledge there will be good practice that is not covered. However, it is an accurate representation of our work with the 16 local areas who took part in this project and a snapshot of where their integration journey was at in Autumn 2018.

Demonstrating impact, whether that is increasing quality of life, value for money or something else, is the starting point to spreading good practice. The services that we have covered have all demonstrated impact in some way and we recognise they are still developing and producing further results. Discussions with our stakeholders indicate that peer to peer conversations between people who are designing and delivering integrated services was the most beneficial way of spreading good practice. We encourage readers to **get in touch with the local areas** mentioned in this guide to understand how their journey is evolving.

8. Local areas and contact details

Area	Expertise	Contact details
Bexley	Information sharing Integrated case management Joint Memorandums of Understanding	**ASC.Performance@bexley.gov.uk**
Bracknell Forest	Social Prescribing	**Steve.Eker@bracknell-forest.gov.uk**
Croydon	System level integration and bringing organisations together	**one.croydon.alliance@croydon.gov.uk**
Gloucestershire	Housing services Joint Fire and Rescue service	**Kimforey@nhs.net**
Haringey & Islington	Relationship building between leaders Culture change	**harccg.integratedandplannedcare@nhs.net**
Harrogate	Embedding culture	**jane.baxter1@nhs.net**
Leeds	Risk Stratification Multi-disciplinary teams Social Prescribing	**Health.PartnershipsTeam@leeds.gov.uk**

Area	Expertise	Contact details
Lincolnshire	Trusted Assessor programme	**Michelle.Colbourne@lincolnshire.gov.uk** **Carolyn.Nice@lincolnshire.gov.uk**
North East Lincolnshire	Home care Single Point of Access	**NELCCG.AdultSocialCare@nhs.net** **beverley.compton@nhs.net**
Somerset	Multi-disciplinary teams Home first from hospital service	**TDBaverstock@somerset.gov.uk**
Southampton	Joint assessment	**communications@solent.nhs.uk**
Stoke on Trent	Multi-disciplinary teams	**social.care@stoke.gov.uk**
Wirral	System wide culture change and governance	**wiccg.intouch@nhs.net**
Wokingham	Governance Joint Memorandums of Understanding	**Rhian.warner@wokingham.gov.uk**
Wolverhampton	Community admission avoidance	**andrea.smith21@nhs.net**

9. Helpful Resource List

In addition to resources already referenced, the following documents offer practical advice and tools which can support local areas in progressing aspects of integration.

- NHS England, Integrated Personal Budgets and Personal Health Budgets
- NHS England, Resources to support health and social care staff to reduce delayed transfers of care
- NHS England, Quick guides to support health and social care systems
- LGA, Self Assessment Tool
- LGA, Shifting the Centre of Gravity
- NICE, Quality Improvement Resource
- NICE/SCIE, Person centred care planning
- NICE/SCIE, Better Home Care
- NHS Providers, New care models – governance between organisations
- NHS Providers, 8 step guide to accountable care
- NHS Providers, Learning from the new care model vanguards
- SCIE, Logic Model
- SCIE, Guide to co-production
- SCIE, Asset based place
- Think Local Act Personal, Personalised Care and Support Planning Resources
- Think Local Act Personal, Asset based Area

10. Case Studies

Area	Topic	Relevant ICS tier
Croydon	Bringing organisations together to deliver integration	Place
North East Lincolnshire	Single Point of Access	Neighbourhood
Leeds	Social Prescribing	Neighbourhood
Bracknell Forest	Online social prescribing platform Social Prescribing	Neighbourhood
Gloucestershire	Fire and Rescue	Neighbourhood
Gloucestershire	Health and Housing	Neighbourhood
Leeds	Community Multi-Disciplinary Teams	Place
North East Lincolnshire	Integrated commissioning for home care	Neighbourhood

Croydon: Bringing organisations together to deliver integration

Relevant ICS tier | Place

At a Glance:

- Development of an outcomes based contract for older people, an agreed model of care and a health and care partnership – The One Croydon Alliance
- Development of 'I' statements to establish an outcome based commissioning approach
- Introduced two new service models;
  - Integrated Community Networks (multi-disciplinary locality working)
  - Living Independently for Everyone (integrated re-ablement, rehabilitation and rapid response services)
- Six months after roll-out a return on investment study noted;
  - a 7% reduction in avoidable admissions to hospital – which had increased to 15% by January 2019
  - the calculated benefit of ICNs was £1.44 for every £1 spent
  - the calculated benefit of LIFE was £2.67 for every £1 spent

Integrating Better Primary reference point:

2.4: Culture

Other Integrating Better reference points:

- **Chapter 2: Leading for Integration**
- **6.2 - Support admissions avoidance via a community-based response to a crisis**

Contact Details:
one.croydon.alliance@croydon.gov.uk

A. Summary

Since 2014, health, care and community leaders in Croydon have been working to reshape their health and social care system through greater integration. This has developed from early partnership working in 2014 to develop shared commissioning outcomes, to an outcomes-based contract called the One Croydon Alliance Agreement and development of an agreed new model of care.

The Alliance agreement sets out clearly shared principles and an approach to:

- decision making
- risk sharing
- commercial strategy
- termination and exit
- contract management

The signing of the local Alliance agreement was the culmination of extensive relationship building as well as a detailed out of hospital business case and marks the start of the next chapter in Croydon's integration journey.

This case study gives an overview of how the Alliance came about, what has made it work and its impact

B. History

Croydon has faced a number of challenges that have placed pressure on the health and social care system, including:

- Financial pressure across both the Local Authority and NHS with both the CCG and the Acute & Community Trust being in financial special measures at a key point in the programme development;
- System pressures caused by a growing older population compounded by having a significantly high number of residential and nursing homes compared to most London boroughs, all contributing to high levels of non-elective admissions;
- A history of limited partnership working across organisations, siloed working, lack of trust and unsuccessful integration attempts.

In 2014, the Council and CCG jointly undertook engagement with the public to develop five 'I statements'. These were used by the CCG and Council to establish an outcome based commissioning approach for people aged over 65. In 2018, these statements were revised to become People's Aspirations so they can now be applicable to the whole population.

The outcome based approach helped to focus any transformation on the person receiving support, improved working relationships and enabled partners to put services on a more sustainable footing by better aligning providers and commissioners, health and social care.

In response to the development of the new outcome based contract, local health and care providers created an Accountable Provider Alliance in 2015 to develop and deliver a new model of care. This was eventually succeeded by the formation of a commissioner/provider alliance in 2016 with a joint commitment to delivering shared outcomes. A Service Operations Manual (integrated contract) was designed to complement existing services – it relates to the service contract that each provider holds but does not replace it.

In April 2017 commissioners and providers signed a one-year Croydon Alliance Agreement to test out the impact of the two new initiatives and develop a case for extending the agreement until 2027: in April 2018, the Alliance members signed an extension to the agreement for a further 9 years.

People's Aspirations

1. I am in control of my own health and well being
2. I am able to stay healthy, active and independent as long as possible
3. I live in an active and supportive community
4. I can access the support my family and I need
5. I can access quality services that are created with me and my family in mind

Integrated Community Networks:

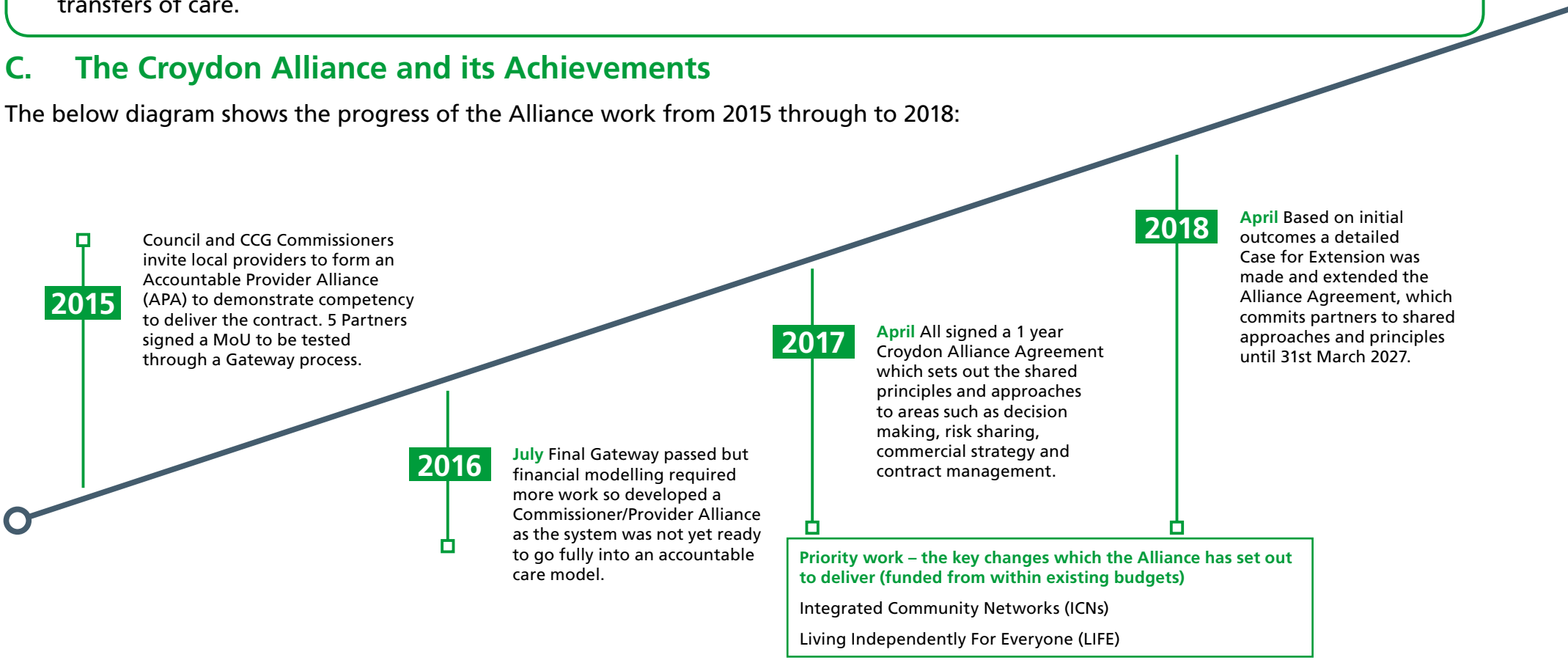
- Multi-agency locality working based on local GP networks.
- Proactively plan the care of people with complex health and social care needs.
- Core multiagency teams undertake weekly huddles.
- Core multiagency teams are supported by a new role, Personal Independence Coordinator from Age UK Croydon.
- The new way of work has already had a significant impact on reducing non elective admissions for older people.

Living Independently for Everyone:

- Brings together existing and new services to provide integrated re-ablement, rapid response and rehabilitation for residents over 65 years of age.
- For those that need support for a safe early discharge or to prevent admission to hospital or other escalating care needs.
- The key characteristic is **'one team, one budget, one name'** working from one site.
- The service has already made a significant impact on implementing Discharge to Assess and the reduction in delayed transfers of care.

C. The Croydon Alliance and its Achievements

The below diagram shows the progress of the Alliance work from 2015 through to 2018:



Alliance achievements

The Alliance was able to bring the different members together with a shared vision and turn this into action. Through building relationships and joint working, the Alliance overcame many boundaries to deliver the phase one new models of care – Integrated Community Networks (ICNs) and the Living Independently for Everyone (LIFE) service.

Six months after the roll out of these new initiatives the Alliance undertook a return on investment study and noted;

- a 7% reduction in avoidable admissions to hospital (which had increased to 15% by January 2019)
- the calculated benefit of ICNs was £1.44 for every £1 spent
- the calculated benefit of LIFE was £2.67 for every £1 spent

Alliance Membership	How the Alliance works
• Croydon Council • Croydon CCG • Croydon GP Collaborative (representing nearly all local GPs) • Croydon Health Services NHS Trust • The South London Maudsley NHS Foundation Trust • Age UK Croydon	• All governance is underpinned by the Alliance Agreement which sets out the shared approaches and principles. • A Transformation Board comprised of chief executives and clinicians steers the priorities of the Alliance and is responsible for the governance of the agreement and strategic decisions. This is chaired by an independent chair (from a public sector but not a health or social care background). • A Delivery Board is responsible for assurance and delivery of the priority work and a Strategic Development Board leads on transformation and innovation planning. All boards are supported by health and social care professionals as part of a professional cabinet that scrutinise and help to develop proposals. • All strategic decisions are still subject to governance of the partner organisations. • Delivery groups link with the boards covering different work streams, with every project under the alliance including patient/ service user involvement.

D. Key challenges and what made integration possible in Croydon

1) A shared vision, partnership and governance

Partners' commitment to the 10-year Alliance agreement was made possible by building trust and joint working. The shared 'I' statements sat at the heart of the vision and provided the basis for borough-wide priorities, which are focused on early intervention, prevention and locality working. These have now been used to develop the People's Aspirations which apply to whole population.

The Alliance has enabled partners to align and join up provision, yet also strikes a good balance between both joint working and each organisation maintaining its sovereignty. They remain responsible for their own contracts while being bound by shared;

- strategy
- vision
- values
- behaviours

Key outcomes have been;

- reductions in variation of care
- financial savings
- better patient experience
- improved quality of outcomes around re-ablement

A key part of the transformation programme has been to increase partnership with the Voluntary and Community Sector. This includes having Age UK Croydon as part of the original Accountable Provider Alliance and later as an equal member of the One Croydon Alliance Agreement. Age UK Croydon's leaders had the opportunity to contribute to shaping the Alliance and it has enabled them to develop their role to support capacity in the voluntary and community sector.

Patients have also been a central partner in local developments with boards having active patient representatives and Specialist User Engagement Group that has been part of the programme from the beginning.

All partners admit that they did not fully understand each other's perspectives and their historic relationships were an initial block. This resulted in Croydon investing in organisational development beginning with the executives and system leaders who formed the Alliance boards to help them build better relationships and a better understanding of each other's roles, organisations and the challenges they individually face. The leaders admit the journey has not always been smooth and they encourage others to;

- invest in building trust
- be honest with each other
- ensure that the attention is on developing purposeful and proactive relationships

The partners also highlighted the value of investing in capacity in senior roles to support the transformation.

2) Changing the culture

Croydon realised that organisational development was essential for all levels of the organisation. The investment of time and money was also replicated at an operational level to support the development of integrated working and for teams to learn together. This emphasised that good relationships are integral to the success of integration and need to be worked on at all levels, activities included;

- 'A day in the life' sessions where frontline staff explained their roles and responsibilities.
- Joint visits, training and assessments provided opportunities for staff to better understand each other and start to work better together.
- Co-location and joint working practices were also key in building common purpose.
- Also, significant investment in fostering Multiagency working around Primary care with the introduction of 'huddles', a mini MDT meeting which enabled proactive care planning for people with complex health and care needs.
- The borough has also introduced a trusted assessor function within the LIFE team to streamline paperwork and improve access to equipment.

3) Making a successful case for change

The One Croydon Alliance integration has been funded from within existing local budgets (with no national initiative funding), the out of hospital business case to implement the first phase of changes was an £8m investment predicated on transformation achieving a £12m saving.

The business case for this investment was predominately focused on reducing non-elective admissions and the length of stay in hospital, both key performance challenges locally. Nonetheless, the business case also explored how community services and improved hospital discharge could mutually reinforce each other and preventative working could benefit all partners. Key to the signoff of this significant investment was transparency in the costs and benefits to the local system, with all partners able to understand their contribution and an honest view of the work required to get there.

Although there was significant financial analysis carried out as part of this business case, building positive relationships between partners and the need to do things differently were key. A return on investment analysis carried out in February 2018 showed that the metrics put into the business case had started to be delivered and meant that partners were comfortable agreeing that the Croydon Alliance could be extended until 2027.

E. Future Plans

The next steps for the Alliance include consolidating the work on the new initiatives in the first phase and taking action lessons from the Return on Investment review.

The Alliance is now exploring options to extend the agreement to a wider population but there is already a commitment to this partnership approach for the whole population as part of this Health and Care Partnership.

Phase two initiatives include;

- a major programme to work with care homes including introducing the learning from the Airedale vanguard project to use telemedicine to improve the care of residents and reduce non-elective admissions;
- improvements in end of life care and falls reduction;
- the further development of locality based care as a major programme.

In addition, the borough is investing in supporting the local voluntary sector to develop local partnerships around six GP networks. This is intended to support greater sustainability and quality of the sector, without imposing a solution or model from above.

North East Lincolnshire:
Single Point of Access

Relevant ICS tier | Neighbourhood

At a Glance:

- Developed a Single Point of Access as the single route into care and support
- Manages system-wide demand
- Available to public and professionals
- In 2017, resolved;
  - 26% health calls as self-care
  - 67% out of hours mental health calls on the phone
  - 73% social care calls on the phone
- Success reported by staff are reductions in:
  - long term care admissions
  - number of social care referrals

Integrating Better Primary reference point:

Chapter: 4. Promoting self-care and independence

4.1: Create an environment individuals and their families can easily navigate

Other Integrating Better reference points:

- **3.5 – Multi-Disciplinary Team working**
- **4.2 – Develop a strong social prescribing offer**
- **5.1 – Establish community based Multi-Disciplinary Teams**
- **5.4 – Providing comprehensive support to carers so they can support the wellbeing of the person they care for and themselves**

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A. Summary

North East Lincolnshire's Single Point of Access (SPA) started out as a social care-only model for demand management in 2008 and is now a 24/7 365 days-a-year single route into care and support. The SPA is overseen by a single manager and staffed by health, mental health, therapy and social care professionals.

Key Facts	Partners involved
• North East Lincolnshire population of 160,000 • 30 GP practices • 12,000 monthly calls into the SPA • 24/7 365 service	• CCG • Community Trust • Adult Social Care • Patients and carer groups • Mental Health Trust • GPs • Voluntary and Community Sector

B. History

In 2008 North East Lincolnshire Care Trust Plus[14] established a social care demand management model, operating a call centre staffed by social care practitioners. Its primary aim was to manage the demand for adult social care by streamlining access through a single point. People were offered consistent personalised solutions, varying from;

- support to maximise personal assets, to
- signposting to alternative support services, to
- delivering a face-to-face crisis response.

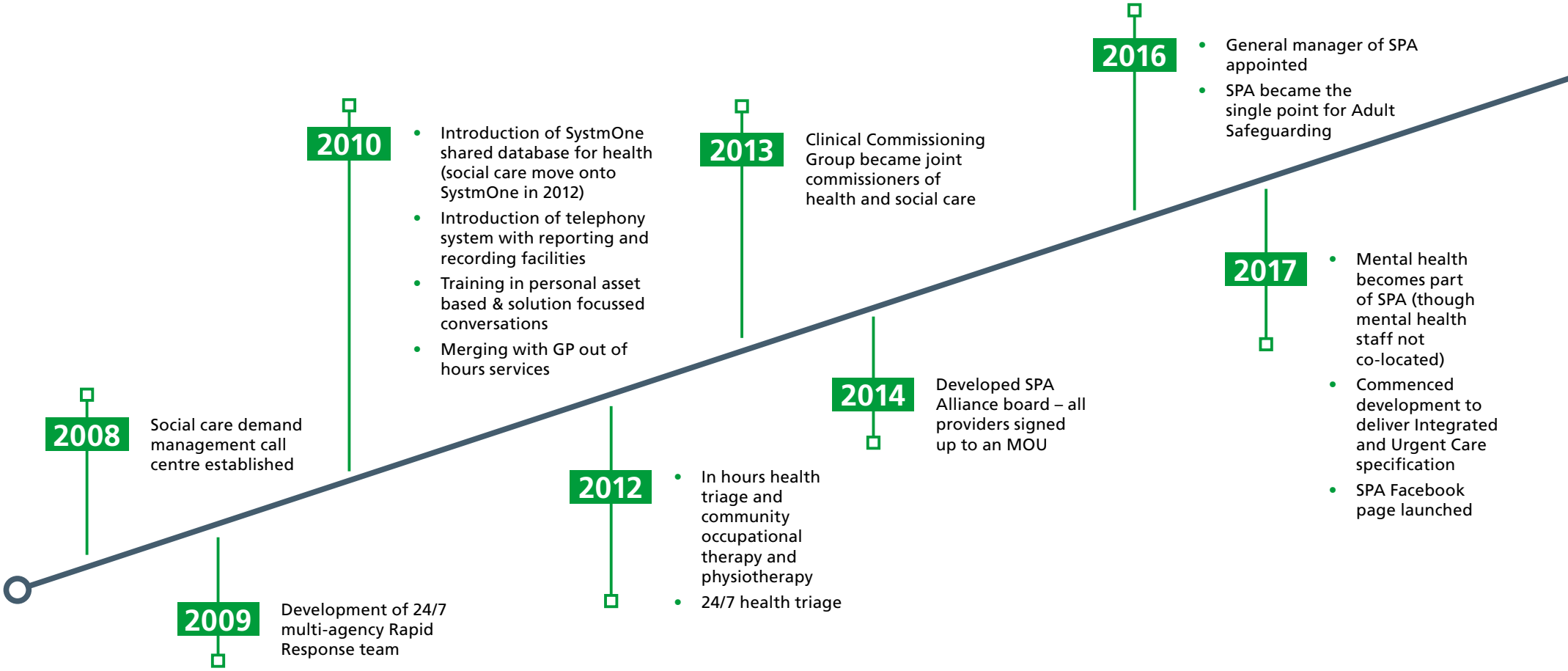
All solutions were aimed at maximising independence.

Subsequent public engagement gave a clear message that having multiple referral and access points made it hard to navigate the system and get support. One thing people consistently asked for was a single place to access support. At the same time North East Lincolnshire was also exploring how to better manage demand to reduce system pressures.

In response, North East Lincolnshire decided to develop and integrate the existing social care call centre with other partners to give people a single point of access.

Developing the SPA was an iterative process which brought in different professionals over time based on what was possible in terms of buy in and co-location. Since 2014 this has been overseen by a multiagency SPA Alliance which is supported by a memorandum of understanding.

Timeline of SPA development



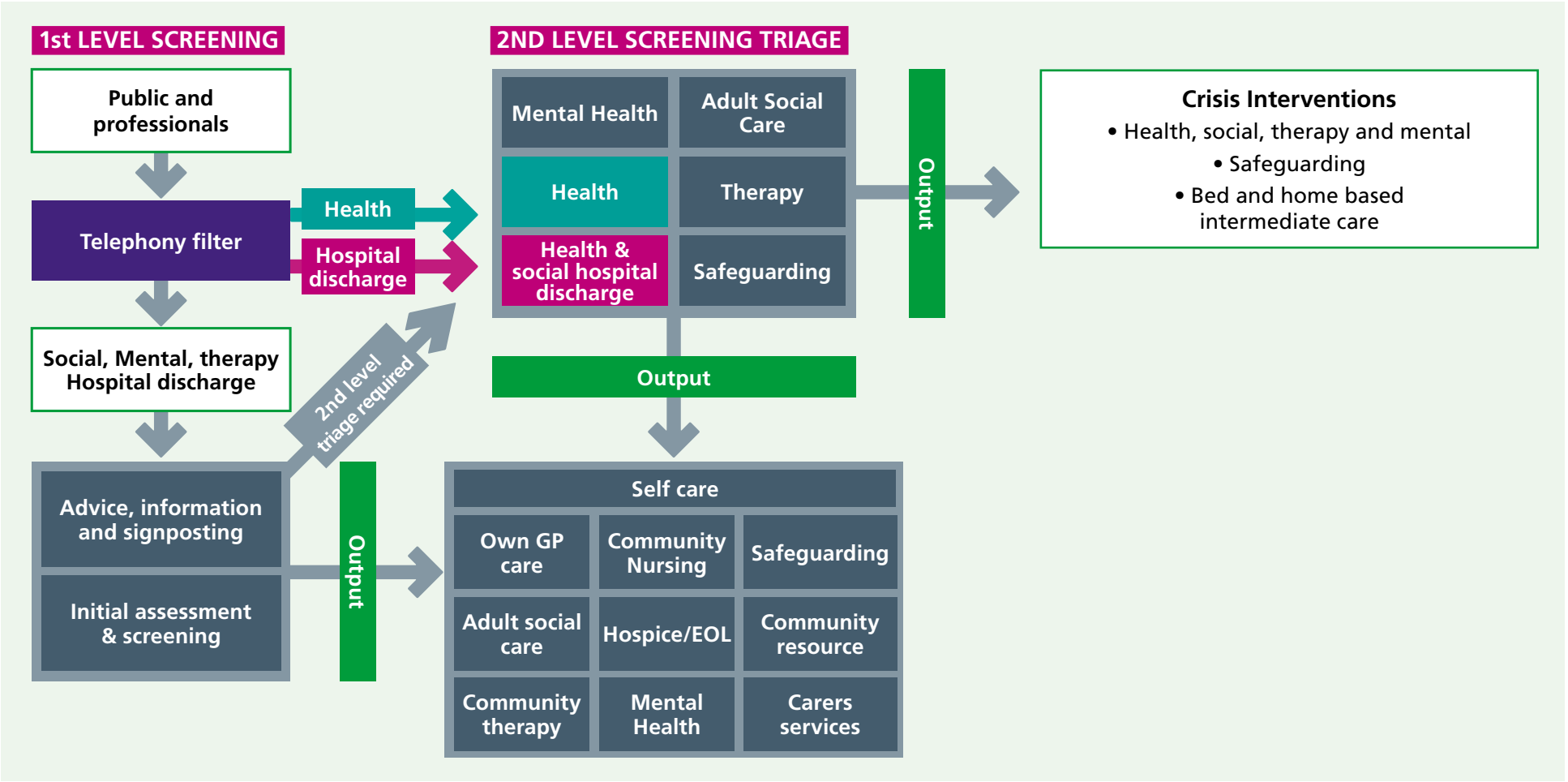
When practitioners became part of the SPA they did not move organisations and retained separate pay scales, uniforms and contractual terms. Staff are line managed through the organisation that employs them, although the management of the SPA is overseen by a single jointly appointed manager.

Funding for the SPA also comes from individual organisations' budgets rather than a pooled fund. Funding came from existing operational budgets, rather than from a new business case as Alliance partners agreed that demand management and prevention would lead to long term savings and better outcomes for individuals. Elements like telephony, estates and infrastructure are funded by one partner and then used by others. This is a result of the organic and incremental way that the SPA has developed, referred to by one member of staff as: "doing the right thing first then sorting out the rest later".

How the SPA works

The SPA receives a call from a member of the public or professional then triages the call to relevant professionals who can direct them to support. As staff are co-located, if there is a need for multiagency input into a case, multi-disciplinary discussions can happen then and there.

The diagram below outlines the SPA's operating model:



C. Key challenges and what made the SPA work

1) Joint working and co-location

Joining up staff from different organisations was a steep learning curve. As the pace of change was very rapid but irregular it was hard to keep a clear structure around staff engagement or deliver consistent organisational development. In response to this, staff workshops and training took place and had a positive impact on the SPA. For example, training on 'solution focussed call handling' and strengths based approaches encouraged and empowered staff to be more creative in the support and advice they gave.

Co-location was key to the success of the SPA. Co-location enabled professionals to better understand each other's roles, professional boundaries and scope of practise, supporting them to work more collaboratively. However, it has been recognised that more consistent organisational development and engagement from the start could have made things happen more smoothly.

Early recruitment to the SPA did not focus as strongly on competencies around integrated working, meaning while practitioners were good at their own role some were not as strong as pushing integrated working forward. Subsequent recruitment paid more attention to the skills that would help staff to collaborate better with others. This has led to better working relationships and staff who are more committed to integration.

2) Information Sharing and IT

One of the main challenges of bringing teams together was the use of different databases and care records. This resulted in duplication of information gathering and frustrated collaboration across professions when collecting SPA performance data.

In 2012 adult social care moved onto SystmOne (the same information management system as health colleagues) and so was able to share information and transfer referrals electronically (mental health will also transfer to SystmOne in September 2018). Community health teams and social care now both use SystmOne as their primary data recording and client file system and approximately 80% of GP practices also use SystmOne (the remaining 20% preferring to remain on other systems such as EMIS). The use of a shared system has minimised risks of people falling through gaps between services, improved transferring calls and improved recording of professional involvements. Challenges that arose around information governance were resolved by introducing role based access, by using the regional Humber Data Sharing Charter and by securing consent every time the client record is accessed.

3) Technology, intelligence and logistics

Having multiple providers for IT systems and initially not having an advanced telephony system made it hard to further integrate and develop the SPA.

As a result, partners aligned IT providers and invested in a new telephony system. This system was more resilient, made managing and triaging calls easier and improved evaluation and reporting. For example, by analysing call data a lack of available chiropody for older people was identified. In response the CCG supported a third sector provider to meet this need thus reducing risk of falls. The telephony system also enabled the SPA to use recordings of old calls for quality assurance and for staff training.

With most partners on the same case management system and with the new telephony system it also became possible to design reporting which met performance requirements. This has reduced duplication around data input and made it possible to conduct trend analysis to better understand peaks and troughs in demand.

The SPA was not tendered and did not have a service specification, therefore partners needed to rely on interpersonal relationships to make things happen. This was reinforced through evidence that the SPA was having an impact on people's outcomes and staff workloads (shown by case studies and staff feedback) and through governance (such as the SPA Alliance). However, not being limited by a specification and not having to structurally integrate staff also meant that the SPA could grow quickly and flexibly.

D. Evaluation and Outcomes

Using the integrated care record (SystmOne) has allowed for longitudinal analysis, able to evidence the presenting need, support received and the final outcomes achieved. Of the ~12,000 monthly calls into the SPA, one of the main outcomes is the high proportion of cases resolved at the first point of contact, without the need to refer onto other agencies, for example in 2017:

- 73% of social care calls
- 67% of mental health out of hours calls
- 26% of health calls

Other successes in terms of demand management and quality that have been reported by staff are:

- Reduction in long term care admissions
- Moving higher proportions of people into prevention and wellbeing services
- Reduction in number of social care referrals
- Improved satisfaction with care and improved perception of care
- Easier for staff and the public to navigate the system

North East Lincolnshire has now initiated a piece of work to better quantify the system benefits and outcomes of the SPA.

E. Future Plans

Now that the SPA is well embedded in the system, the main focus is continuous improvement. For example, analysis of calls and referral patterns are used to improve how calls are handled and identify gaps in delivery which commissioners resolve with providers as they did with Chiropody.

However, beyond business as usual improvements there are further areas in which North East Lincolnshire are looking to develop their SPA offer, including:

- Developing a single point of information involving all agencies which better maps the services and assets available within the community
- Linking up better with 111 and making sure the models align where possible
- Piloting secure video consultation with care homes to improve triage at a point of crisis and improve the quality of decision making

Leeds:
Social Prescribing

Relevant ICS tier | **Neighbourhood**

At a Glance:

- Development of a city wide social prescribing service through three separate providers with future plans for delivering an even more coherent approach
- Outcomes from the three services include;
  - 70% engaged with service following referral
  - Reduced primary care and GP appointments
  - Improved well-being and reduced anxiety and depression amongst user cohort

Integrating Better Primary reference point:

Chapter: 4. Promoting self-care and independence

4.2: Develop a strong social prescribing offer

Other Integrating Better reference points:

- **3.2 – Commissioning**
- **3.5 – Multi-Disciplinary Team working**
- **5.1 – Establish community based Multi-Disciplinary Teams**
- **5.4 – Providing comprehensive support to carers so they can support the wellbeing of the person they care for and themselves**

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A. Summary

The aim of Leeds' social prescribing services is to;

> "empower individuals to take control of their own health and wellbeing"

They work with people on issues such as social isolation, housing or financial worries which impact on health and wellbeing.

Commissioned by the CCG[16], the 3 social prescribing providers focus on areas of Leeds where health inequalities are highest, co-designing plans with service users.

Key Facts	Partners involved
• 840,000 Leeds Population • 101 Leeds GP practices • 3 Social Prescribing services • Over 5000 referrals to the Social Prescribing services in 2017 • 33 Link Workers employed as part of this model • 4 evaluations (2 schemes had 1 evaluation and the other had 2)	• Public Health • CCGs • Primary Care • City Council • Third Sector providers • People, their families, their carers

B. History

In 2014 the first social prescribing service, Age UK's Making the Link pilot, was launched in Leeds, funded by the Big Lottery and focussing on areas of high deprivation. When evaluated it demonstrated a significant reduction in the numbers of non-elective admissions and therefore a 39% reduction in spend in the 9 months post intervention.

Following this pilot work, local Public Health and Leeds CCGs worked with partners to explore how to expand this approach. From analysis of the pilot and joint analysis of health and social care data it was clear that tackling the 'wider determinants of health' could have a positive impact both on individuals and the wider system.

Over the next 2 years, the scaling up of social prescribing services was coordinated by a multiagency steering group which reported to the city-wide Self-Management Steering Group although individual services remained governed by each CCG. By 2016 all of Leeds was covered by a social prescribing service.

The three services:

Service	Date Launched	Key info
Patient Empowerment Project (PEP)	October 2014	• Supporting those aged 18+ in Leeds West, to improve health and wellbeing, address wider determinants and support people to manage long term conditions • Focus on individuals with one or more of: depression, diabetes, COPD or cardiovascular disease • 89% referred have a mental health condition – stress, anxiety, not coping, isolation, pressures of debt • Around 50% referred by GPs, 46% self-referred
Connect For Health	January 2016	• Supporting those aged 14+ in Leeds South and East. • Focussed on working with the third sector to meet local needs • Provides information and advice virtually and 1:1 meetings to provide further support for those who need it • Average age of those supported was 53.5 years old
Connect Well	April 2016	• Supporting those aged 18+ in Leeds North. Model was driven by member practices. • Operated in 7 GP practices and then scaled to North Leeds GP Consortia • Two tier model 1) Signposting 2) Social prescribing plan • Majority of referrals had one or more chronic conditions (including mental health)

While there was some variation between the three services in terms of the geography, their target participants and the drivers behind them, they all broadly worked in the same way:

Referral	Referrals were mainly from GPs, self-referrals and social care
	Services avoided strict eligibility criteria to allow for flexibility in meeting people's needs and using whatever community resources that can help them
Signposting and navigation	The service signposts people to different types of support that can meet their needs
	Typically for those who do not need ongoing support but are struggling to navigate services
Social prescribing plan	For people who are more complex and or need more support, Link Workers co-produce a plan helping them to self-manage and be more independent
	Where necessary they can draw on community services, e.g., • Befriending • Mind Peer Support • Carers Leeds • Healthy Lifestyle classes • Adult Social Care • debt management
Follow up	For the most complex individuals, support is provided by the Link Worker, usually over a 3-month period or less for those requiring more 'light touch' support

All the social prescribing services are run by third sector providers and are supported by **Link Workers**, as local knowledge and expertise in working with vulnerable and more marginalised communities is key to addressing the needs in local communities.

These workers are either employed directly by the social prescribing providers or GP practices and many are co-located within GP practices.

Through co-location and Link Workers integrating with **Local Care Partnerships** they are building strong relationships with primary care.

C. Key challenges and making social prescribing work

1) Engagement and Partnerships

To design the social prescribing contracts each CCG worked closely with partners and experienced providers using their frontline experience to understand how services could best engage the public. Patient experts also participated in the design and evaluation of tenders. Through this engagement the CCGs were able to launch social prescribing successfully tailored to local needs and reduce the risk of future operational issues arising. The merger of the CCGs into one body from April 2018 is now supporting the drive to align the delivery of the three services and develop one model with a cohesive core service offer for the city.

There was an understanding locally that measurable financial impact and improved personal outcomes may take years to demonstrate. As a result, Leeds focused on elements that could demonstrate immediate impact (modelled from the 2014 pilot scheme), positive service user stories and the positive impact on demand recognised by GPs. Having practitioners act as advocates of the services and showing some of the potential impact allowed social prescribing services to develop and expand without having to wait for a final evaluation.

2) New ways of working

Social prescribing was a significant change for both the public and social prescribing provider staff. The CCGs and providers advanced an organisational development approach which made sure that provider staff had the right skills for example, motivational interviewing and coaching skills. This ensured that staff were able to successfully deliver the model, work in a strength based way and co-design plans with people.

3) Systems, processes and information sharing

Information sharing across organisations was hard, therefore making it more difficult for health and social care colleagues to work together. Leeds achieved this by using existing IG protocols, for example Link Workers in GP practices being able to use pre-existing information sharing agreements and the Leeds Data Model (an integrated data set which allowed evaluators to measure statutory service use post intervention[17]).

There were also some concerns about the level of risk that could be managed, since many people who were referred presented with complex and often chaotic lifestyles. By ensuring that there were robust escalation and safeguarding processes the system could take a risk positive approach.

4) Supporting providers

Social prescribing providers made referrals into other third sector and community organisations. To mitigate risks around them not being able to cope with increased referrals, third sector grants were made available in two of the CCG areas during 2015-2018 to support increased demand. Feedback on gaps in provision were used to inform CCG and Council commissioning intentions and have led to closer joint working around the third sector.

D. Evaluation and Outcomes

The success of social prescribing services was established by each service having an independent evaluation funded by Leeds CCGs.[18] Having evaluators involved from the beginning was essential to make sure the right data was being captured.

This evaluation assessed:

- impact on service users through validated tools such as the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)
- impact on people's service use after social prescribing support, such as fewer GP appointments
- case studies and interviews with service users and staff

Service	Date Launched	Key Information from the Evaluation
Patient Empowerment Project (PEP)	October 2014	• 70% engaged with service following referral • Reduction in Primary Care appointments at 9 & 12 months post intervention • Significant improvements in self-reported wellbeing, health related quality of life and confidence in managing long-term conditions
Connect For Health	January 2016	• 70% of individuals engaged with the service following referral in Y1 rising to 75% in Y2 • 77.5% of service users had an improved wellbeing score • Statistically significant improvement in self-reported health status • Levels of anxiety or depression were significantly lower
Connect Well	April 2016	• Reduction in the number of GP consultations for the cohort receiving long term interventions • Statistically significant improvements in SWEMWBS scores for the cohort supported – of 83 patients with a planned closure and scores pre- and post-intervention, 88% saw their scores improve

A further evaluation of the link workers in the **Connect for Health** service found that they had, in many cases, enabled many individuals to have a more positive and optimistic view of their life often through offering opportunities to engage in a range of hobbies and activities in the local community.

E. Future Plans

Having demonstrated success through the evaluation, the next step for Leeds is to commission a single model of social prescribing by September 2019. The CCG has supported work to align the existing contracts during 2018 to accompany the move to a single NHS Leeds Clinical Commissioning Group from April 2018.

In the future, Leeds will look to:

- Continue to align with the developing Local Care Partnerships with social prescribing link workers being part of the extended health and care team in the Local Care Partnerships
- Increase focus on supporting those living with frailty and supporting self-management
- Embed principles of strength based working, Better Conversations and a 'think family' approach

What users and professionals said about Social Prescribing in Leeds

One service user said: "I'm really grateful to you for all you've done. You have got me out of this rut, learning new things and meeting people. **I'm happiest I have been in a long time"**

A GP noted "Mr A needed home visits 1 or 2 times a week. These have not been needed since the Social Prescribing team's involvement"

A service user said of their Link Worker: "She took the time out to learn about me and to actually help me and look for things that I needed and not just in general"

Of a survey of 603 people who had used social prescribing, 83% said it was beneficial

Bracknell Forest: Changing care and support in the community

Relevant ICS tier | Neighbourhood

At a Glance:

- A large transformation programme focussed on social care allocation, personalisation and developing community based support
- Introduction of Community Connectors to help people meet their non-statutory health and social care needs by connecting them with community groups and services
- Development of an online portal 'Help Yourself', offering community activities used by the public and Community Connectors
- Increased use of Personal Health Budgets – proportion of people known to social care who have a personal budget increased from 23% to 44% over one year period

Integrating Better Primary reference point:

Chapter: 4. Promoting self-care and independence

4.2: Develop a strong social prescribing offer

Other Integrating Better reference points:

- **3.2 – Commissioning**
- **3.5 – Multi-Disciplinary Team working**
- **5.1 – Establish community based Multi-Disciplinary Teams**
- **5.4 – Providing comprehensive support to carers so they can support the wellbeing of the person they care for and themselves**

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A. Summary

Since 2016, health and social care partners in Bracknell Forest have transformed both statutory and non-statutory community services to deliver more personalised care, empower people to do more for themselves and support greater market sustainability.

This case study looks at what has made system change successful, particularly;

- the 'Help Yourself' portal,
- changes to the social care market and
- the 'Community Connector' role.

Key Facts	Key Partners
• Bracknell Forest unitary authority – population of 120,000 • 3 Community Connectors • 400 services on Community Map	• Local Authority o Adult Social Care o Public Health o Housing • CCG • Acute Trust • Voluntary and Community Sector (VCS) providers

B. History

In 2016, Bracknell Forest Council reviewed adult social care support with a view to provide more personalised and preventative services and make savings. The review found that prescriptive care plans and reliance on statutory support were common, costly and did not offer people the choice they wanted.

These findings led to a change in adult social care practice; emphasising personalised, strengths-based approaches and placing the social care provider market and voluntary and community sector on more sustainable footings. Key to the proposals was a shift towards enabling people to help themselves and access support from within the community.

It was also recognised that working closely with health partners and the voluntary and community sector would lead to greater benefits. While adult social care and Public Health led the transformation programme they also worked closely with health partners, such as through the Better Care Fund Board and the newly developing Integrated Care System (ICS) Board.

C. Change Programme

1) Help Yourself Portal[19] and Community Connectors

Adult social care and Public Health worked closely with community providers to develop an online portal offering a free channel for community groups to promote their offer, featuring a directory and searchable map.[20] Anyone who provides services or support to people who have health or social care needs (including community groups, independent providers and the voluntary sector) can be part of the portal.

People and/or Community Connectors use the portal to find groups or activities in their localities. Community Connectors help people meet their non-statutory health and social care needs, for example loneliness, by connecting them with community groups and services. There are three Community Connectors who support people that may have difficulty navigating local services or who may lack the confidence to join a new group or activity. The Community Connectors can receive referrals from any health and social care staff and are not restricted by formal eligibility criteria such as social care assessments or Continuing Health Care. This early intervention approach and improved use of community resources has ensured people remain independent and at home for longer.

2) Personal budgets and allocation of resources

The fragility of the local care market caused the council to explore alternative community support options. Personal Health Budgets, including direct payments have helped achieve this by allowing people to buy support directly rather than being limited to what the council commissions. **The Help Yourself portal** has now become the main channel to connect people with care and support organisations.

In line with the council increasing the number of personal budgets, the CCG also increased the proportion of people offered Personal Health Budget direct payments through the Local Authority managed pilot. This has enabled Continuing Healthcare Pathways to become more integrated so that the support that people receive can be more seamless, planned more holistically and is not limited to what either 'health' or 'social care' commission. Moreover, people receiving a Personal Health Budget also use Help Yourself and the Community Connectors, giving a consistent experience across health and social care and further encouraging Help Yourself to be a single forum for all providers.

To inform the redesign of Adult Social Care services Bracknell Forest Council commissioned a resource allocation tool. This helped social care practitioners determine the level of resources that are sufficient to meet each individual's care and support needs and the actual cost to provide this in the local market. It ensured a consistent approach for different client groups and pathways.

3) Shaping the market

The council had historically grant funded many community and voluntary sector providers; this prevented innovation as each provider held different pots of money for different services commissioned on an annual basis. In response, grant funding was largely removed and the numbers of personal budgets increased to encourage a market that would be more responsive to what people wanted.

To make the home care market more sustainable and work in a more person-centred way, Bracknell Forest reduced the overall number of care providers (from 22 to six) and made contracts outcomes based, moving from payment on a "time and task" basis to payment if the provider delivers the outcomes agreed with the individual and their social worker.

Finally, Help Yourself has given health and social care commissioners better intelligence to understand unmet need and help shape the market. For example, in response to unmet need or provider failure, support such as a dementia care home and community step-up/ step-down provision has been commissioned – the latter a joint venture between the council, CCG and the acute hospital trust.

4) Changes to frontline practice

To be successful in changing the market Bracknell Forest also realised they needed to support frontline staff to work differently, particularly in social care. Recognising the challenge for operational staff to deliver both business-as-usual priorities and the new model, senior leaders at the council acknowledged that performance against certain metrics might dip during the transformation. Their backing was crucial in giving staff permission to innovate and so reduced the risk of a return to old ways of working.

Another key operational change was the introduction of a more strengths based approach. This replaced lengthy assessments with a shorter one which captures the conversation with the individual and focuses on their goals and needs, supported by the council's Learning and Development Team. The council also introduced more streamlined budget sign-off for social workers and has made small discretionary sums of money available to them for one-off interventions to support someone in crisis or prevent a future risk.

D. Key challenges and what made this work

1) The case for change

Due to a desire to improve choice and manage financial pressures, the council recognised a need to change the way that people engaged with statutory support as well as voluntary and community sector services. However, such large-scale transformation brings significant risks, especially when it was hard to attribute savings to any one specific intervention. This made it essential to engage elected members and senior health and social care leaders. For example, Councillors were convinced by several presentations detailing the change projects and specifically how together, they would enable a saving of £1.8m in 2017/18. Historical spend and operational practice highlighted higher allocations of care funding as practitioners were risk averse and took a 'paternal' approach to identifying care and support; rather than working with the individual to identify their strengths and available networks.

2) Engaging with the public and providers

To successfully make these changes to community services it was fundamental that providers and the public were engaged.

Statutory provider concerns focused on whether volumes of work would stay the same and the impact of outcomes based payments. Community and voluntary sector providers commissioned by the council were concerned about the removal of grant funding and how their services and support may need to change.

The council attended Provider Forums and public meetings to reassure them. The communications highlighted why the changes were necessary to provide the best support for the public and there would be plenty of opportunities to provide this. Furthermore, new opportunities would be created by increased numbers of direct payments and information captured on unmet need which could highlight business opportunities for providers.

Community meetings held with the public and providers also allowed the Council to communicate how assessments and services would work more collaboratively with people who use services and their carers, with focus more on outcomes. This was positively received by the public and gave an opportunity for residents to share their lived experience with the Council and explain what they needed. To keep people informed of how changes were progressing, in-person meetings were supplemented by monthly communication updates.

E. Evaluation and Outcomes

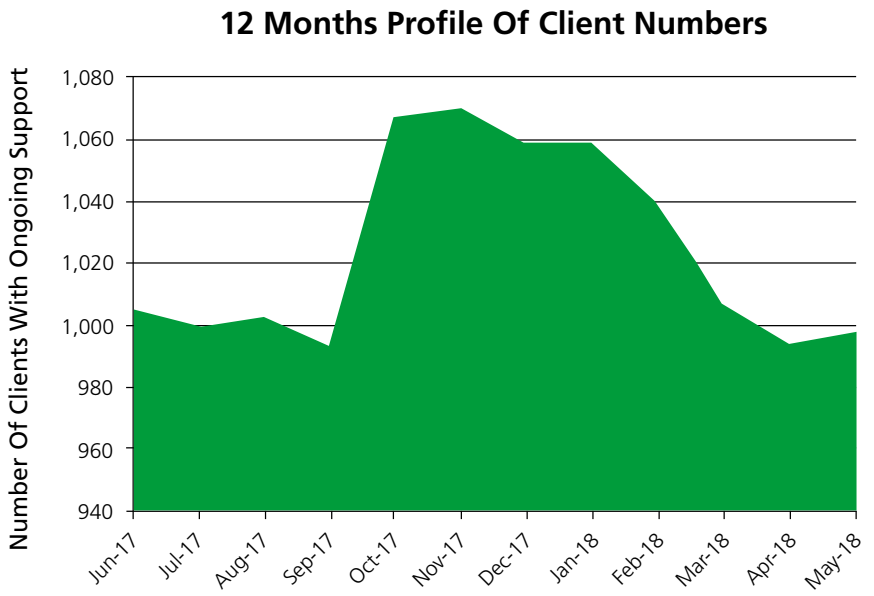
Bracknell Forest monitored the success of this work through a combination of system wide indicators and local metrics, focussed primarily on the impact of changes on social care.

Existing metrics were used to reduce the administrative burden on staff and providers where possible. However, for parts of this work (such as the Community Connectors) causation was a challenge to prove, so operational feedback from practitioners and providers has been used to determine whether these services were working.

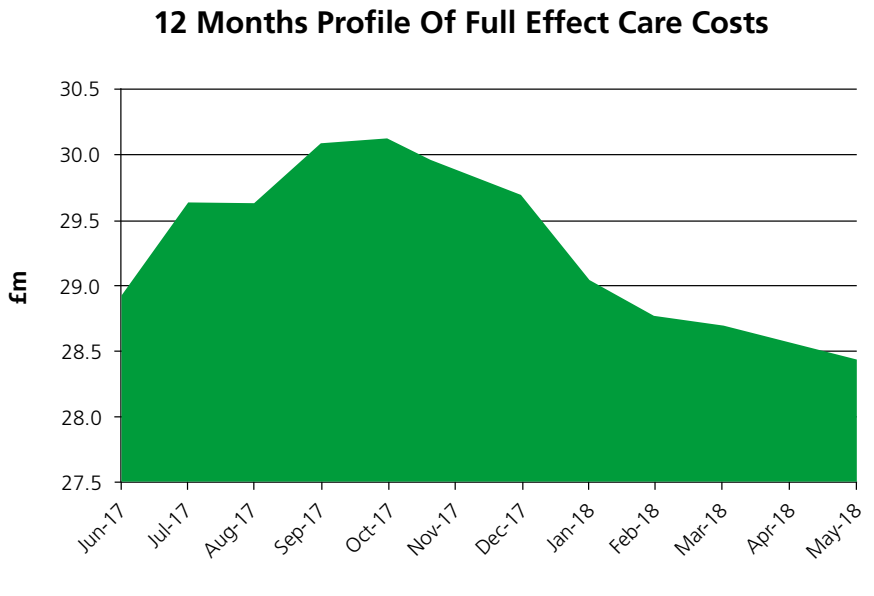
Key outcomes:

- Over a year, the proportion of people known to social care who have a personal budget increased from 23% to 44%
- Significant numbers of people using the Help Yourself site with 4,397 unique hits between June and August 2018
- Reduction in Adult Social Care costs per client as illustrated by the below graphs

Clients with Ongoing Support Needs



Care Costs Including Client Contributions



F. Future Plans

The evaluation indicates some promising system-wide indicators. In addition, because these are fairly recent, the impact of changes to markets and social care practice are expected to show increase over time.

Bracknell Forest has identified a number of priority areas for future work:

- Slough Borough Council are to lead on the integrated commissioning of Continuing Health Care packages on behalf of the CCG and two of the three East Berkshire Local Authorities (with a view to the third authority joining if there is proof of concept)
- Develop other market areas such as Personal Assistants and scope potential for a Shared Lives scheme
- Working across health and social care to look at developing non-specialist support roles which better support integrated health and social care working

Gloucestershire: Working with the Fire and Rescue service

Relevant ICS tier | Neighbourhood

At a Glance:

- An example of integration beyond health and social care sectors
- Gloucestershire Fire and Rescue Service integrated with Adult Social Services
- Acts as a responder for approx. 500 users of the Telecare Service
- Quicker discharge from hospital and smaller packages of care

Integrating Better Primary reference point:

Chapter: 4. Promoting self-care and independence

4.3: Ensure that partners beyond statutory health and care services are considered as part of prevention service design

Other Integrating Better reference points:

- **3.2 – Commissioning**
- **3.5 – Multi-Disciplinary Team working**
- **5.1 – Establish community based Multi-Disciplinary Team**

Relevant starting point documents:

- **Fire Service MoU**

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A. Summary

Since 2015, in response to reduced emergency call outs, Gloucestershire's Fire and Rescue service has tried to work more preventatively and become more involved with Health and Social Care services.

This case study looks at how Telecare[21] and integrated working with the Fire Service became established and how it has helped to enable hospital discharge, support people to remain at home and manage crisis better in the community.

B. History

In winter 2015 Public Health England and Gloucestershire County Council carried out a pilot to reduce pressure on health and care services with the Fire Service. In line with the national picture the number of fire related emergency call outs had reduced dramatically in Gloucestershire;

- 63% fewer fires than 10 years previously, and
- 20% reduction in the number of incidents attended over the past 5 years.

Key Facts	Partners involved
• Gloucestershire population of 860,000 • Telecare response service serves 2,500 adults • Around 500 people are supported by Telecare Service where a Firefighter acts as responder • Over 8,000 people per year receive a Safe and Well Check from the Fire Service	• County Council; o Fire and Rescue o Adult Social Care o Public Health • Telecare Provider • Domiciliary care providers • Age UK • British Red Cross • Hospital Trust • Ambulance Trust • Police

As a result, Gloucestershire Fire and Rescue explored new ways to support communities and people at risk. The work carried out by the Fire Service included enhancing their current work and exploring new areas of support including:

- Safe and Well checks
- flu jabs
- falls prevention, and
- identifying and supporting social isolation

This showed the potential for even more significant ties with Health and Social Care. Following this, Adult Social Care approached Fire and Rescue to understand how they could assist in reducing hospital admission and discharge:

- Some people in hospital did not have family or friends to act as a telecare responder for their alarm. This meant that they were unable to return home and more likely to end up in a care home or remain in hospital unnecessarily.
- People who did not have a responder in the community were more likely to have larger packages of care or be admitted to a care home prematurely. This option addressed the risk of remaining in hospital but often made them dependent on more intensive and expensive care than they needed.

Initial scoping explored commissioning a home care provider to deliver an on-call type service – however, this was costly and implementation would have taken too long to meet the immediate hospital pressure.

Following this, Fire and Rescue worked closely with Adult Social Care Commissioning and the Telecare provider to co-design and mobilise a pilot service. In this pilot, Firefighters became responders for people with an alarm.

Service Model

A

When an alarm is activated, the monitoring centre notifies the Control Centre, who mobilise the appropriate Firefighter responder.

B

They will go out to check on the person who activated their alarm.

C

When they arrive at their home they check to see what the problem is, assess whether it's something they can resolve by themselves or whether they need to access other support such as:

- An ambulance call-out to take someone to hospital
- Rapid access to domiciliary care for an immediate personal care need
- Third sector domestic support for food shopping if there is nothing in the house

D

As part of their response, when a Firefighter attends the person's home they will also identify potential risks to the person and put in preventative support to manage crisis such as:

- Looking at the home for environmental hazards and getting a Safe and Well assessment scheduled
- Putting basic equipment in place such as grab rails or commodes on a trusted assessor basis
  - o e.g. to support someone through a period of poor health or better cope with reduced mobility
- Making onward referrals to third sector organisations
  - o e.g. to support social isolation or provide domestic support
- Raising a safeguarding concern with Social Care

After promising early results and a good reception from both Fire and Rescue staff and service users this project was embedded countywide and is now a mainstream offer for around 500 individuals at any one time. This helps to;

- reduce length of stay in hospital,
- reduces over-prescription of care and
- means that people at risk can be better supported in a crisis.

Improved joint working between the Fire Service and Health and Social care is part of a wider agenda including:

Services/Support Delivered by Fire and Rescue	People targeted for support
• Telecare Response • Safe and Well Checks • Fire Stations as Safe Havens • Response for those with a memory impairment who go missing • Trusted equipment assessment, for example, to install adaptations such as grab rails or equipment like commodes	These interventions can support a wide range of people but the system has identified as a priority those: • Aged 65+ • who live alone/are socially isolated • are living with disabilities/long term conditions • with memory impairment • who misuse drugs or alcohol

Firefighters are well placed to be responders due to First Aid and moving and handling training. However, as part of a wider learning and development strategy the Fire Service also identified areas to upskill staff around Health and Social Care, for example dementia training and encouraging Firefighters to be active in their local communities. The public also hold a high level of trust in Firefighters, therefore they are able to quickly build effective relationships to support people.

C. Key challenges and what made things work

1) Asset based approach

Designing and procuring a new service would have taken a long time and been logistically difficult given Gloucestershire's rural geography. By working in partnership and bringing together the services and skills that already existed in the system Gloucestershire mobilised a successful service at scale and pace. Further to this, using existing services and budgets to design this solution meant that having Firefighters as alarm responders was sustainable and scalable after the initial pilot.

2) Relationships and trust

Supporting staff to work in different ways and tackling risk aversion was a key challenge. For example, there were anxieties about what Fire and Rescue staff would be able to do and how risks would be managed. This was mitigated by increasing understanding of Firefighters' skills and training such as first aid and moving and handling to show that they were well suited to this role. Also by aligning the Telecare Alarm response to other commissioned services such as rapid access to home care, Firefighters being unable to do personal care was not a problem. Building on existing relationships and creating better shared understanding helped to embed this service quickly and allowed partners to work in new ways.

There were three challenges that needed resolving:

1. People's health and care needs were worsening in hospitals and care homes
2. The system was under pressure and acute hospitals struggled with demand
3. Placing people in long term bed based care at a point of crisis meant it was less likely that they would return home and created significant financial pressure on adult social care budgets

3) Training and Organisational Development

Fire and Rescue working more closely with Health and Social care came about through all partners building understanding of each other and identifying where support could best be directed. This includes dementia training, ensuring that supporting their local community was part of job descriptions and working to change Fire Stations into Safe Havens for people with mental ill health and learning disabilities. By proactively developing their workforce and investing in learning and organisational development the Fire Service were more able to integrate and have more successfully supported the local population, managed demand on health and social care and made changes which staff have responded to positively.

D. Evaluation and Outcomes

Analysis from Fire and Rescue has shown improved levels of retention and job satisfaction among staff and is therefore important for recruitment.

For the Telecare Response outcomes reported included:

- Quicker discharge from hospital and reduced reliance on bed based pathways
- Reduced prescription of care, smaller packages and fewer long term residential placements
- Improved individual outcomes and increased feelings of safety and security at home

E. Future Plans

Supporting telecare response is now mainstream and funded from business as usual budgets on a 'Pay as You Go' basis.

Building on existing services, partnerships and successes the system is currently exploring how Fire and Rescue can better support non-injurious falls and act as co-responders for cardiac care to better manage demand on ambulatory care and prevent hospital admissions.

Gloucestershire: Housing and Partnership working

Relevant ICS tier | Neighbourhood

At a Glance:

- Range of projects and partners to improve health outcomes through housing approaches
- Pooling Disabled Facilities Grant (DFG) monies so the whole county to benefit from the £5 million Warm Homes Fund
- Improved feeling of self-worth and reduction in anxiety for those who have received support
- Increased take up of benefits leading to reduction in fuel poverty

Integrating Better Primary reference point:

Chapter: 4. Promoting self-care and independence

4.3: Ensure that partners beyond statutory health and care services are considered as part of prevention service design

Other Integrating Better reference points:

- **3.2 – Commissioning**
- **3.5 – Multi-Disciplinary Team working**
- **5.1 – Establish community based Multi-Disciplinary Team**

Relevant starting point documents:

- **Housing partnership MoU**

A. Summary

The causal link between people's health and housing has been a key driver for Gloucestershire's housing strategy which forms part of their Sustainability and Transformation Plan (STP) prevention work stream.

This case study looks at services and projects sitting at the intersection between Housing and Health, specifically how building strong partnerships has allowed Gloucestershire to improve health outcomes through housing approaches.

Key Facts	Partners involved
• Population - 640,000 • £5m grant fund to Warm Homes Fund • Poor outcomes for older people in poor housing: o More likely to have fair, bad or very bad health compared with those in good housing (58% vs 38%) o 19% suffer from low mental health compared with 11% in good housing	• Housing Associations • County Council o Adult Social Services o Public Health o Fire Service • 6 Borough and District Councils • CCG • Third Sector Organisations

B. History

Gloucestershire recognised that addressing poor housing could lead to better health outcomes, and the inclusion of the Disabled Facilities Grant (DFG) in the Better Care Fund (BCF) from 2015 acted as a trigger to deliver better outcomes in this respect.

Following discussions at Gloucestershire's BCF housing group, 6 District/Borough Councils, the CCG and County Council agreed to contribute additional funding to focus on housing services that could contribute to better health.

A collaborative workshop between District Councils, County Council, CCG, housing providers and the third sector established local priorities, underpinned by a Joint Housing Action Plan and a Memorandum of Understanding.

Priority areas included supporting people to remain independent and reducing pressure and spend on health and social care and this work formed part of the STP.

The following summarises projects that form part of the Joint Housing Action Plan:

Area	Description	Further Detail
Disabled Facilities Grants (DFG)	Integrated services and assessment funded by pooled DFG	• Hub and spoke model • Lead Occupational Therapist in each locality • List of adapted properties by locality • Funding of grants over £30k • Supporting both adults and children
Warm and Healthy Homes	Warm & Well – insulation and heating improvement	• CCG funded Warm and Well programme - improving energy efficiency and reducing fuel poverty • Successfully bid for an additional £5m from Warm Homes Fund, joint bid from District Council, energy agency and the CCG – runs from November 2017 to March 2020
	Citizens' Advice Bureau (CAB)	• Providing energy saving, benefits and billing advice • Links made between CAB and respiratory and acute discharge teams
	Gloucestershire Energy Efficiency Grant	• GEEG+ (Gloucestershire Energy Efficiency Grant) top up for various heating and insulation measures
	Build2Low Carbon	• Build2Low Carbon project – across 6 European countries to reduce fuel poverty and increase energy efficiency
	Park Homes	• Looking to map hospital admissions from park homes in the county • Potential to target a vulnerable section of the population with retrofit of the park homes

Area	Description	Further Detail
Falls Prevention	Pick up service	• Pick up service that ensures a clinical triage from the ambulance trust • In development and due to start in Autumn/Winter 2018
	Falls prevention and risk stratification	• Reviews of polypharmacy from GPs and pharmacists • Targeted risk stratification work with care home to reduce falls • District based falls prevention groups and networks
	Home adaptations	• Adaptations made to people's homes through Home Improvement Agencies to reduce risk of falls
	Hoarding	• Pilot project in Cheltenham looking to provide intensive support to address the underlying reasons for hoarding • Linking with local mental health trust and specialist community interest company
Independent Living Centre	One Stop Shop	Project plan in development for One Stop Shop centres to provide: • Information and advice around self-management • Support for people to know what kinds of equipment are available and how they could use it • Promotes self-assessment and purchase of equipment with support • Facility to enable clinical assessment when necessary

Area	Description	Further Detail
Frailty	Joint working between housing and clinical staff	• From April 2018 housing posts working with both acute discharge team and community based Frailty Service to support discharge and keeping people at home
	Benefits advice and support	• When identified, emphasis on trying to divert people better into community wellbeing and social prescribing • Focus on non-health/care needs
	Home sharing	• Aiming to launch a home sharing scheme in partnership with Age UK Gloucestershire • Older person shares with a younger person in exchange for reduced rent and 10 hours of support a week which may include things like cooking or helping with IT.

C. Key challenges and successes

1) Building relationships

Bringing unfamiliar partners together to focus on a newly shared agenda was challenging. District Councils, County Council, CCG, housing providers and the third sector agreed their priorities, deliverables and red lines at a workshop. A workshop also held with District Council staff, Occupational Therapists and others so relationships could be built across organisations with back office and frontline staff. Working in this way helped to build trust and shared understanding between roles, through sharing operational experience.

Projects are led by:

- health and social care commissioners
- District Councils or
- third sector partners.

This reinforces partnership working, increases ownership, and means that projects are led by the most relevant organisation.

Finally, securing external funding meant that it was easier for partners to work together as there were no organisational restraints on how and when money was spent.

2) How to do joined up working

All partners are part of a MoU (linked to the STP) that forms part of the governance structure.

With the Disabled Facilities Grants pooled budget there were concerns around who would benefit, what was legally possible and whether the plans were flexible enough. By clearly communicating the technical and legal details of how pooled funding would work, trust was built amongst partners. Pooled money was also used as revenue to support change, for example, to fund new roles like joint working between housing staff and frailty teams.

D. Data, information and making a case for change

A historic focus on hospital discharge made it difficult to shift the focus to community and prevention. To mitigate this, the CCG leadership took a lead role in communicating the importance of prevention.

Trying to deliver integration with all partners at the same time proved challenging. As a result, Gloucestershire initially developed the concept with those who were most on board and then developed an evidence base to bring others on board.

Gloucestershire has been working to join up district housing and public health analysis to provide an integrated data set. However, because this was not available the most significant drivers for change were:

- qualitative feedback and service user stories
- initial outcomes and savings from projects
- national data around health and housing

E. Evaluation and Outcomes

Building these partnerships meant that Gloucestershire achieved far more than single agencies. For example, pooling DFG monies allowed the whole county to benefit from the £5 million Warm Homes Fund. The pooled fund has underwritten the risk of receiving a grant in arrears, something no single agency would have been prepared to face alone.

Joining up professionals across organisational boundaries has led to better shared understanding and meant referrals can happen earlier, for example, Citizens' Advice Bureau (CAB) linking in with respiratory teams.

Key findings from the evaluation include:

- Using the BRE calculator[22] has shown that the housing work is expected to make savings to health and some wider societal savings – however, specific savings figures have not yet been calculated and it is harder to identify social care savings using this calculator
- Before and after surveys from CAB show improved feeling of self-worth and reduction in anxiety for those who have received support[23]

Overall…	Before	After
How satisfied are you with your life nowadays?	3.5	5.6
To what extent do you feel that the things you do in your life are worthwhile?	4.2	5.8
How anxious did you feel yesterday?	5.7	4.8

- Increased take up of benefits leading to reduction in fuel poverty
- Difficult to demonstrate the impact of preventative support, especially where people are receiving support from multiple services at once

Case Study - Mary

- Aged 75 diagnosed with cancer and undergoing chemotherapy
- Living on her own she was very concerned about her health and her mental health was suffering as a result
- In her baseline assessment she reported 8/10 for feeling anxious and 3/10 for feeling worthwhile
- Receiving support around her finances identified some benefits that she was eligible for and a grant from Warm and Well allowed her to get her boiler replaced saving money and making her home nicer to live in
- A follow up assessment recorded 5/10 for anxiety and 6/10 for feeling worthwhile alongside the expected health benefits of having a warmer home

Further evaluation of the DFG work has been commissioned.

F. Future Plans

While there have been some promising impacts of partnership working around Housing and Health there are many planned areas for improvement and integration:

- Improve evaluation of preventative work such as Warm Homes and falls prevention to be able to quantify impact
- Working with District Councils to ensure that local plans and developments support improved health and care outcomes – making sure that plans submitted through the usual process are 'age and disability-proofed'
- Improving engagement with housing providers, as currently there is not a single forum which brings them all together

Leeds: Multidisciplinary community approach

Relevant ICS tier | Place

At a Glance:

- Development of Neighbourhood Teams, community MDTs based around GP lists
- Engaged with partners such as housing and voluntary organisations
- Improved: independence, mobility, self-management, personal safety, long term care management, appropriate medication
- Reduced: hospital admissions, reliance on carers, risk of falls

Integrating Better Primary reference point:

Chapter: 5. Supporting care closer to home

5.1 Establish community-based Multi-Disciplinary Teams to align assessment and case management for people with multiple long term conditions

Other Integrating Better reference points:

- **3.5 – Multi-Disciplinary Team working**
- **4.2 – Develop a strong social prescribing offer**

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A. Summary

Leeds community health and social care services have developed a model of collaborative working at a neighbourhood level based on building productive and positive relationships between staff.

This case study explores how Leeds has developed multidisciplinary community teams and how they located them into local communities to achieve better experience for people who use services, their families and their carers.

Key Facts	Partners	Staff involved in the Neighbourhood MDTs
• 840,000 Leeds population • 13 Neighbourhood Teams (Integrated Community health and social care teams) • 37 Neighbourhood Networks • 101 Leeds GP practices • Teams vary in size per locality from around 60 to 120 staff	• City Council – Adult Social Care & Public Health • Community Trust • Mental Health Trust • Acute Trust • Leeds CCGs[24] • Primary Care • Third Sector providers • People, their families and their carers	• Community matrons • District nurses • Social workers • Intermediate care staff • Rehab care managers • Staff from specialist services as required (e.g. mental health or learning disability)

B. History

Prior to the development of Neighbourhood Teams;

- social workers operated in large area teams covering approximately 1/3 of the city each.
- District nurses in 12 teams (based on geographical boundaries) and community matrons worked to a small number of GP practices.
- These differences limited opportunities to develop relationships and hampered effective joint working around people's care.

While only a small proportion of each organisation's caseload overlapped, frontline staff noted that coordination of support between organisations was not consistent enough and could work better.

Consequently, Adult Social Care and Leeds Community Healthcare NHS Trust scoped how to work in a more joined up way – focusing on better day to day collaboration and effective multidisciplinary case management.

Early adopter neighbourhood teams:

- Leeds Community Healthcare and the Local Authority worked together to set up three initial early adopter sites for neighbourhood teams (one in each CCG area).
- Staff reported better outcomes for individuals and improvements to relationships.
- Based on these early successes the decision was made by the community trust and local authority to rollout the model over nine months until 12 teams were established, giving full coverage across Leeds.
- These teams worked in the same footprint as the district nursing teams and were typically co-located in the district nursing offices.

Primary Care:

- Although community health and social care were working more effectively they remained disconnected from primary care.
- GP practices, particularly in more densely populated areas of Leeds had patients supported by 3 or 4 different neighbourhood teams, hampering effective MDT working.
- 12 months after the initial scale up, team boundaries were reviewed and it was agreed that MDTs would be built around GP practice lists rather than strict geographical boundaries which resulted in 13 rather than 12 teams and based more around natural communities.

Staff and Funding:

- Leeds decided that movement of staff across organisations and pooled budgets were not a necessary precondition of better joint working across organisations and professions.
- Therefore, line management of staff remained within their host organisation.
- Likewise, Neighbourhood Teams remained funded from each separate organisation's mainstream budget.
- This allowed for changes to be made rapidly because Leeds did not have to deal with the time consuming financial or HR implications of moving staff and budgets.
- While developing this model Leeds took a 'discovery not design' approach, encouraging teams to try out new ways of working that suited their local communities.
- This helped to ensure staff buy-in and develop robust MDT structures over time.
- However, to maintain a level of consistency and quality, a core offer was developed which agreed a set of working arrangements with local GP practices, this could then be built on to meet local requirements.
- This was formalised in a contractual arrangement signed by Leeds Community Healthcare, the lead CCG and local GP practices.

Engagement:

Each Neighbourhood Team builds relationships with local voluntary sector and community groups. This varies depending on the location of the team and the needs of the people being supported, but by engaging partners such as housing or voluntary organisations, the Neighbourhood Teams are able to ensure more effective care planning and wrap everything around the individual.

C. Key challenges and what made the community teams work

1) Building relationships

Co-location was integral to making joint working logistically easier and helping staff to better understand each other's roles. This was further enhanced through running workshops and encouraging staff to shadow each other's roles. As people moved between offices and started working with new colleagues welcoming and leaving lunches were organised. These supported people to both say goodbye to colleagues and to welcome new opportunities and get to know new colleagues. This engagement and co-location set the groundwork for staff to work more efficiently together and reduce duplication. For example, staff were able to agree the best approach to supporting a person together, therefore minimising unnecessary handoffs and delays.

2) Estates and infrastructure

Co-location of staff was a key enabler but difficult due to the number of staff and the property available. A pragmatic asset-based approach by all partners was key to resolving this. Both the NHS and the Local Authority identified where teams could successfully co-locate such as Community Trust sites and worked to unblock any initial barriers around networks, IT or telephony. For example, whilst longer term solutions were being explored, home broadband was used for several months in the early adopter sites so that social work staff could access their systems.

3) Strength based working

Co-location in neighbourhood bases enabled health and social care staff to build relationships with one another. However, social workers did not always feel they had the time to make the most of being based in the heart of the community. Their role remained largely a mix of home visits and office-based activity.

In 2016 Leeds Council took a new approach to social care practice – strengths based social care. This moved social care practice from a deficit based model (solving problems for people) to one which focused on what individuals can do and what is important to them. This shift in practice was hugely supported by being based in neighbourhoods and reducing administrative tasks. For example, by stripping back assessment paperwork and requiring staff to focus on a strengths-based conversation which is captured on a "conversation record".

Social Care staff from the Neighbourhood Teams have invested time in building strong relationships with community groups and increasingly see people in local community settings rather than their own home, helping people to better explore what they can do for themselves.

D. Evaluation and Outcomes

An evaluation was carried out in 2014 to monitor and support the implementation of case management meetings and highlight some of the benefits. At these all members of the team could bring cases for discussion, improving multiagency planning and enhancing understanding of each other's roles;

- 861 individuals were discussed at case management meetings
- meetings between May to October 2014
- for the evaluation, quarterly case studies were produced by the teams for a number of these cases
- evaluation of these case studies and staff feedback highlighted the below outcomes:

Individual Outcomes	**Improved**	• Quality of life • Independence • Carer support • VCS involvement • Living conditions • Personal hygiene • Diet and fluid intake	• Social life • Mobility • Mood • Self-management • Continence • Personal safety
	Reduced	• Anxiety/Panic attacks • Risk of hospital admission • Symptoms	• Reliance on carers • Carer stress
Clinical Outcomes	**Improved**	• Pain control • Long term care management • Safety	• More appropriate medication • Communication between professionals/agencies
	Reduced	• Hospital admissions • GP/Community Matron visits • ICT involvement following discharge	• Dependency on medication • Risk of falls • Duplication

E. Future Plans

The Neighbourhood Team were established in 2014 and Leeds continues to monitor and develop their partnership approach, working towards the priorities in the Leeds Health and Wellbeing Strategy 2016-21[25] including:

- Embedding Local Care Partnerships (LCPs), the 18 multi-agency local level strategic partnerships based around GP registered populations which include statutory and third sector organisations as well as elected members and local people.
- Increasing the focus on prevention and changing how the public and services interact. For example, further developing 'Talking Points' which are venues where people can book an appointment to have a conversation with an adult social care staff member. These may include Health Centres or Libraries.

North East Lincolnshire:
Integrated Commissioning for home care

Relevant ICS tier | Neighbourhood

At a Glance:

- Working closely with providers and practitioners to build a higher quality and more sustainable home care market, to support people better in their own homes
- Home care now supported by a pooled budget, annually agreed by the CCG and Council
- Pooled budget funds both social care home care and CHC home care
- Move away from 'time and task' to outcomes based contracts in Adult Social Care
- Same financial envelope delivering better value for money – increased service user satisfaction and improved care worker retention

Integrating Better Primary reference point:

Chapter: 5. Supporting care closer to home

5.3 Develop relationships between the supported and residential care home sectors and other community services

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A. Summary

North East Lincolnshire has faced challenges supporting people in their own homes due to a difficult home care market, poor relationships between providers and practitioners and financial pressures.

B. History

High levels of deprivation and resulting health inequalities have created a dependency on home care. Home care is often a pressure point for health and social care systems because emergent needs typically arise at home.

Key Facts	Partners involved
• North East Lincolnshire population of 165,000 • 30 GP practices • 5 home care providers • Approximately 740 people are in receipt of home care • Life expectancy is 11.9 years lower for men and 8.5 years lower for women in the most deprived areas than the least deprived	• North East Lincolnshire CCG • North East Lincolnshire Council • Care providers o Focus Independent Adult Social Work o Care Plus Group o Navigo • Northern Lincolnshire and Goole NHS Foundation Trust

However, there were real challenges to delivering home care in North East Lincolnshire. Its geographic remoteness made recruitment particularly difficult and the rates the Council could afford to pay providers were quite low. This made it hard for providers to deliver the care required and caused tensions between home care providers and the practitioners who micro-commissioned care. Finally, care was often not an attractive career choice for people due to high travel time and having to deliver 'time and task' style care. This meant that there was weak care worker retention and fewer care hours available than the system needed.

Health and social care had been integrated under North East Lincolnshire CCG since 2013. As a result, home care and Continuing Health Care (CHC) were already commissioned by the same organisation and it was clear that the home care market was struggling. Through analysis of the market and the financial position of both the Council and the CCG it was clear that the status quo was unsustainable as there were not enough care hours available and there was no money available to increase care provider rates.

To explore how to change the market successfully within the existing financial envelope North East Lincolnshire engaged providers through Provider Forums and contractual meetings. They sought to improve relationship with providers and understand why there were issues with recruitment and retention. Alongside this North East Lincolnshire CCG spoke to frontline social work staff to gain their insights into how to improve home care.

Working with financial officers and local politicians there was approval to change the way the home care market operated. However, there were fears that changing ways of working would increase spend. To make a case for change, the CCG worked with providers and social workers to pilot a new model. This new model encouraged more outcome-based home care rather than prescriptive 'time and task' care and gave more flexibility to providers with how packages of care could be delivered. To enable this change, a pool of top-up funding was set aside in case providers needed to exceed their commissioned hours.

Practitioners and home care providers both reported improved outcomes for individuals and the additional funding was scarcely used. Therefore, the business case submitted to make changes noted that things could change and improve within the same cost envelope. By showing it could work in practice the CCG was able to secure the sign-off from financial officers and elected members to do something different.

Changes to home care

Home care contracts were recommissioned resulting in fewer providers with larger market shares and larger geographic areas to cover. The intention was to improve both the overall viability of the market and give providers more flexibility in how they could deliver care. Following the learning from previous pilot work, new contracts were made more outcomes focussed. This gave the home care providers the space to work more flexibility to meet someone's needs and better structure rounds of care. Therefore, providers could improve the staff offer related to travel time and how care is delivered, tackling key causes of care worker dissatisfaction – however recruitment and retention remain challenging.

Home care is now supported by a pooled budget which is annually agreed and signed off by the CCG and Council. This budget funds both social care home care and CHC home care. Therefore, it enabled a culture where integrated teams could put in place the right support to help meet someone's needs irrespective of budget sign-off and without waiting for a full assessment.

C. Key Challenges and what made these integrated changes work

1) Engagement and relationships

Tensions between practitioners and care providers due to operational pressures and the weak position of commissioners caused by a difficult market was a real risk. To combat this, commissioners proactively engaged both providers and operational staff to understand the pressures better, understand how to improve things and start to build more productive working relationships between them.

Moving beyond a strict commissioner provider relationship and working together to solve problems was key to the success of this work. Commissioners made a conscious effort to have open and honest conversations and build relationships through;

- attending Provider Forums
- having ad hoc discussions
- checking in on progress and
- troubleshooting at regular contractual meetings

Through this engagement North East Lincolnshire CCG were able to outline the scale of financial challenges, show their commitment to wanting to improve things as a partnership and design a solution that worked for all partners.

This engagement however, is an ongoing process as tensions still arise between social care practitioners and home care providers as a result of operational issues like hospital delays. As a result, at times commissioners have to work as an intermediary to unblock problems and prevent relationships worsening.

2) Pooled budgets and contract management

There was agreement that things had to change for home care – however, these changes needed to be stable and not overly reliant on interpersonal relationships. To mitigate this, home care contracts were changed to reflect the new focus of the system and codify strong quality standards and practice.

North East Lincolnshire CCG is responsible for commissioning both adult health and social care so disagreements around who funds a package of care are relatively uncommon. However, having a pooled budget has still reduced administrative delays in getting sign-off for packages of care. The pooled budget means that health and social care staff can work more easily as a single team – putting in place appropriate support and then later establishing whether this is funded by health or social care.

D. Evaluation and Outcomes

Despite these changes the average spend on home care per service user in North East Lincolnshire remained the same. Additionally in the new tender, care provider rates were kept around the same meaning that changes to home care could be sustainably funded.

However, whilst the overall financial envelope has not changed, home care now provides better value for money than previously due to increased service user satisfaction and improved care worker retention.

Key outcomes:

- Improved service user satisfaction with care (compared to a baseline prior to changes)
- Improved care worker retention
- Improved relationships and better collaboration between operational staff and care providers
- A less fragmented home care market

E. Future Plans

Developing the home care market and making changes to care practice will take a long time and will require continued investment of time and energy.

Some of the areas which North East Lincolnshire are looking to develop in the future from this home care improvement work are:

- Looking at points of transition and how these are better supported, for example from children's services to adults
- More complex care delivery to people in their own homes so those with higher needs can be supported in the community, for example looking at intravenous therapy or blood tests
- Providers to be more responsive, particularly around responding to crisis in the community so people can avoid having to go to hospital