

How to... work together to achieve better joined-up care

**Integration and
Better Care Fund**

Edition 2: August 2019



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Integration and Better Care Fund series

This series of guides was originally developed to support the mobilisation of Better Care Fund programme plans across the country. These guides continue to be of practical use to everyone involved in planning and delivering joined-up, integrated care for individuals and communities, person-centred care as part of BCF plans as well as other programmes that foster collaborative cross-system working under the new goals and ambitions of the NHS Long Term Plan. This includes frontline professionals and managers, commissioners, as well as councillors and board members in local government and the NHS, community and voluntary groups, independent providers and groups speaking for people who use health and care services.

- [How to... lead and manage better care](#)
- [How to... bring budgets together and use them to develop coordinated care provision](#)
- [How to... understand and measure impact](#)
- [Sharing risks and benefits of integrated care: quick guide](#)
- [Transfers of care: signposting resource](#)

1 Introduction

“People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined-up services help improve the health and care of local populations and may make more efficient use of available resources.”

2017–2019 Integration and Better Care Fund Policy Framework, the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government

“The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care.”

2019–2020 Better Care Fund Policy Framework

This guide focuses on supporting people to co-produce and co-deliver joined-up services across health, social care and other public services. In particular, it looks at how the use of the skills, knowledge and resources of individuals, communities and the workforce can support more integrated care. It can be used by anyone working to achieve better joined-up services at a local level including Better Care or integration leads, as well as individual partners.

It looks at:

- joint working at different levels
- challenges that may be faced
- practice examples from across the country
- how to apply learning locally.

Key messages

The key messages from this guide are:

- Joint working does not happen without planning, sign-up from all parties and sustained effort. It is not a new concept, but all organisations will face challenges in making it successful and sustainable.
- Joint working needs to happen at every level to achieve joined-up care, with buy-in from all those involved. It requires change across multiple organisations, across all levels and, importantly, across communities, including local residents.
- Co-production with local people and communities is critical. They provide essential insights and are a valuable asset to the development of integrated services. Co-production can enable people to help shape how services are designed and developed.
- Practical steps can be taken to support joint working – taking it one step at a time is acceptable. This guide contains examples of how different areas have tackled problems associated with joint working in practice.

2 The case for joined-up care

Implementing joined-up, integrated care is about improving people’s lives and delivering better outcomes. This is based on a broad view of health and wellbeing – including personal dignity, individual control over day-to-day life and participation in work, education, training or recreation, as enshrined in the Care Act 2014.

Today, people are living much longer, and often have highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

Having a clear plan to develop joined-up care is a key requirement of the Better Care Fund policy framework and is a central theme of the NHS Long Term Plan.

Properly integrated care will help countless individuals throughout the country who currently may have to tell their story multiple times to lots of different professionals, may not be able to receive care at home when they want to, or may be passed from service to service, rarely being asked about what is important to them.

Making this happen demands a fundamentally different approach that responds to what people want and need, rather than simply offering whatever services are available.

People – whatever their roles in using, delivering or planning services – are central to developing an integrated approach.

In this guide we use the term ‘joined-up care’ to describe how different health, care and other services are brought together to meet the needs, choices and aspirations of the individual. This is based on the narrative of person-centred coordinated care developed by National Voices and others.



Source: National Voices’ vision for person-centred coordinated care (National Voices)

Building blocks for effective, sustainable change

There is no 'one size fits all' generic model that can be rolled out across the country. Local needs and circumstances vary, so each area will need to establish its own place-based approach. In this guide we help you to explore practical steps for how to achieve joint working through genuine partnership between senior leaders and managers, councillors and boards, community leaders and a range of frontline professionals and staff. The guide focuses on the key building blocks for effective joint working:

Engaged communities with a voice and an active role in better care

Frontline staff embracing and driving change

Managers doing things differently and empowering their teams.

How to... lead and manage better care and How to... bring budgets together and use them to develop coordinated care provision highlight the importance of common themes such as building trust to cementing strong relationships, being clear about accountability, and systems leadership at every level in taking forward change. All of these components are essential to support effective joint working.

“Valery was referred to Health as a physio referral for ‘confidence building on stairs’, our integrated triage function identified that she was already known to Social Services and has a stairs assessment booked the following week. Through discussing her case jointly, it was established that Valery was actually bed-bound and needed support to get out of bed. The Intermediate Care Team prioritised her case and arranged for an occupational therapist to complete a joint visit with the Social Services occupational therapist in order to prescribe some basic physiotherapy exercises.”

Jo Frazer, Head of Kent Adult Social Care and Health PMO/STP Partnership Lead

3 Co-producing ideas and solutions

Challenges

- Managing our health and care is the responsibility of individuals and their families, communities, professionals and statutory services. Each stakeholder will have a different view of the optimum balance of responsibilities.
- Co-production with local people and communities will challenge the existing balance of power within the local health and care system, and is likely to require cultural change at all levels.
- Engagement with local people and communities can be superficial and an afterthought, rather than an integral part of the change process.
- Organisations often engage with the ‘usual suspects’ and miss out on the views, experiences and assets of seldom heard parts of the community.
- Health and care jargon can be difficult for people to understand, and can lead to misunderstandings.
- Balancing people’s expectations with capacity requires an open and mature debate with all parties.

Key actions

- Take a person-centred, not a service-centred approach, to developing joined-up care.
- On an individual level, give people more opportunities to be involved in decisions about their own health and care. See [People in control of their own health and care](#) (The King’s Fund) and [Person-centred care in 2017](#) (National Voices).
- Encourage and support people and communities to take an active role in service delivery.
- Co-produce solutions and services with local people and communities from the outset. The Social Care Institute for Excellence (SCIE) provides recommendations on how to develop co-productive approaches in organisations and projects based on a framework for change management. See [Co-production – what it is and how to do it](#).
- Take an asset-based approach to partnerships with communities, including the voluntary sector and local people. Focus on what they can bring alongside their needs. See [Asset-based places: a](#)

[model for development](#) (SCIE) and Public Health England’s [A guide to community-centred approaches for health and wellbeing](#).

- The NHS Long Term Plan commits that all sustainability and transformation partnerships will become integrated care systems (ICSs) by 2020. ICSs will have a key role in working with local authorities and providers to make shared decisions on how to use resources, design services and improve population health. All STPs and ICSs will have a partnership board, which should include local government and voluntary and community sector partners. See [Sustainability and transformation partnerships](#) (NHS England, 2019), and [Making sense of integrated care systems](#) (The King’s Fund, 2018).
- Assess local progress in developing joined-up care by using tools such as [the Better Care Fund self-assessment and evaluation tool](#) and [Shifting the centre of gravity: making place-based, person-centred health and care a reality](#).
- Have a clear engagement plan to ensure a comprehensive approach. NHS England has produced a bite-sized

guide, **Principles for participation in commissioning**, which outlines the rationale and principles behind participation, as well as reviewing the engagement cycle and setting out practical steps providers can take.

Joint working means valuing citizens as equal partners in co-producing and delivering joined-up care.

Local people: the real experts by experience

At least five million adults use a combination of health and care services, and 6.5 million people provide unpaid care to relatives and friends, amounting to an estimated **£132 billion a year worth of support**. Around three million people undertake voluntary work within health and social care.

These are the real experts on how health and care systems do – or do not – work together to meet people’s needs. They provide the critical and unique perspective required to reshape the system, and they bring strengths and networks to support improvement. Yet

their contribution is too often overlooked or undervalued.

As noted in the **NHS Five Year Forward View**, ‘patients, their families and carers are often “experts by experience” and their voice is crucial to service and system redesign’.

Furthermore, there is evidence, as shown in The King’s Fund report, **Volunteering in health and care**, suggesting that volunteering is not only beneficial for the people who receive help, but also for the volunteers themselves, in terms of improved self-esteem, wellbeing and social engagement.

Higher levels of social integration and lower levels of loneliness increase people’s health and happiness and have far-reaching

“*... new models [of care should] also draw on the “renewable energy” of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.*”

Simon Stevens, Chief Executive, NHS England

consequences for educational attainment and the reduction of crime.

This section outlines approaches to supporting joined-up working through co-production, asset-based places, engagement and self-care.

Co-producing change with people and communities

To make change effective, it should be co-produced with local people and communities. This means local leaders sharing power and responsibility with local people to design services and working arrangements that reflect their experience, needs and preferences.

To engage effectively with people and communities, providers will need:

- time, resources and skilled staff
- authentic relationships with shared purpose, responsibility and trust
- genuine leadership commitment to active listening and willingness to take action for change together.



SCIE's co-production resource explains how to put co-production approaches into practice in organisations and projects. It uses a whole-system approach and a 'jigsaw model' for the management of change.

The four pieces of the jigsaw are:

- **culture** – the beliefs and values that define organisations and the way they work
- **structure** – the way organisations are arranged and the systems set up to carry out their work
- **practice** – how organisations and the people who work for them carry out their work
- **review** – monitoring how the work is carried out and the outcomes or impacts that result from the work.

Checklist

Issues to consider include:

- Get real commitment to sharing power between professionals and the public, for example, through co-chairing meetings.
- Make co-design/co-delivery sessions accessible and inclusive for people with a range of different needs.
- Manage any conflicts that may potentially arise and equally share responsibility for resolving these.
- Balance the time required to properly engage with the public at a pace which works for them, with programme delivery needs and deadlines.
- Reimburse people appropriately for their time and expenses, so that they feel valued and can afford to take part in a way that is sustainable and does not undermine other voluntary activity.
- Engage with a range of people who reflect the diversity of local communities and are relevant to the particular services in question.
- Train both professionals and public and community representatives in working together in a new way.
- Keep people up to speed on the health and care system in a way that allows them to contribute freely and with knowledge.



Case studies

Working Together for Change (WTfC) is a best practice approach to co-producing change with people and families. Its simple six-stage process is designed to be low cost and low tech, and can help commissioners and providers make better use of scarce resources and improve productivity, leading to better outcomes for people by ensuring services provide the things they want and need in a way that makes the most sense to them.

Working Together for Change has been used to great effect by providers and commissioners to review how well services match the priorities of local populations. Some examples include the following:

- **MacIntyre**, an award winning national provider, has recently adopted Working Together for Change as a means to embed co-production across its services.

- In Lancashire, the process has become a core part of the commissioning cycle and is run regularly to ensure commissioning priorities reflect what people most want and value from services. Most recently, commissioners used the process to help review how well direct payments (DPs) were working for people and what the future shape of direct payment support services should look like. See **TLAP: Direct payments used to purchase personal assistants – Lancashire County Council**.
- The process has also been used at a sub-regional level in the Manchester region to inform the first ever sub-regional **market position statements** (MPSs). Trafford, Manchester and Stockport councils have used the Working Together for Change process to ensure that the market position statements give the right messages about what services should be provided in the future.

There are also examples of co-production in the **SCIE Co-production guide**, including how local authorities, care, health and housing providers have taken a co-productive approach to developing and delivering services.



Co-production: tools and resources

The challenge of co-production – Nesta and New Economics Foundation. This is a discussion paper on how equal partnerships between professionals and the public are crucial to improving public services.

Co-production in social care – what it is and how to do it – SCIE guide. This is a guide to what co-production is and how to develop co-productive approaches to working with people who use services, and carers. It is aimed at managers and commissioners, frontline practitioners, people who use services and carers. It includes practice examples and short videos.

An asset-based approach to communities

Every area has the potential to achieve more through the effective use of all the skills, knowledge and assets available within communities, including the public, private and voluntary sectors.

This is known as an asset-based approach, where the emphasis is on people's and communities' assets, alongside their needs.

Policy-makers, local authorities, the NHS and other providers of public services are looking to broaden their offer by tapping into the wealth of resources, capabilities and networks that are the natural fabric of the communities they serve. The aim is to signpost people to, and connect them with the types of support that are more appropriately provided by the voluntary, community and social enterprise sectors.

Based on emerging evidence, SCIE suggests that there is no one-size-fits-all method of designing and implementing an asset-based approach (see **Asset based places: a model for development**). At its core, it starts with the individual person and place seeking to identify and build upon existing strengths, rather than impose an external framework or preconceptions of what is required to facilitate change.

Checklist

Five key enablers or building blocks can support local areas in implementing an asset-based approach.

- Reframe the narrative from needs to assets:** bring together local people to co-produce an area-wide vision of how an asset-based approach might look in practice. Agree and adopt the building blocks of a whole-system model to begin to change embedded organisational cultures. An asset-based approach recognises the potential of people's strengths and resilience. It moves the narrative from solutions that are narrowly focused on needs towards policies and interventions that are redesigned around what people and communities already possess and are capable of doing.
- Build and update a map of personal and community assets:** support staff to introduce asset-based mapping into daily assessment and care of people who use services, to build a directory of individual and local resources. This could be available online and should be regularly updated.



- **Connect people to each other and to wider community assets:** bring people together through social prescribing, peer mentors, link workers and care navigators.
- **Grow and mobilise community assets:** create the right environment for an asset-based approach to succeed by engaging commissioners, supporting the voluntary sector, building partnerships and trialling outcomes-based payment mechanisms.
- **Develop evidence and simple measures which go beyond proxy approaches, such as reduced hospital admissions or delayed transfers of care:** this will help to articulate the broader benefits of an asset-based approach to the system and communities, and disseminate good practice and learning.

Leaders within local government and the NHS have an important role to play. This is covered more fully in [How to lead and manage better care](#). Key areas include:

- Leadership to develop and implement the vision of asset-based approaches, including representation from the voluntary and community sectors at strategic and governance levels.
- Co-production and partnerships to develop services, plans and strategies with local people.
- Training and development to enable frontline staff and residents to work together.
- Devolution of more power to neighbourhoods so that community groups can offer places to meet or provide community development support.
- Investment in the voluntary, community and social enterprise sectors.
- Inclusive commissioning that draws on the expertise of communities to prioritise outcomes that are important to them.
- Participatory budgeting to give local people a say on priority-setting and spending.

Providers should develop a clear strategy for building community capacity and asset-based approaches, which could include investing in schemes such as local area coordination, time-banking, befriending, community navigation, community circles, peer support and volunteering. Providers should also consider the role of communities in a workforce development strategy, focusing on the role of carers.

The use of digital technology, blended with offline support, is a powerful tool to support a community-centred approach – from the basics of using social media to the development of community platforms to engage, share information, provide peer support and enable collective action.



Tools and resources

Asset-based places: a model for development – SCIE. An asset-based approach places the emphasis on people's and communities' assets, alongside their needs. This briefing suggests a framework for local areas to enable asset-based approaches to thrive. It is based on SCIE's research for the Greater Manchester Health and Social Care Partnership.

Building Community Capacity – Think Local Act Personal. Resources and examples of helping communities to support themselves. Includes information on the 'Building community capacity practitioners network', which is open to anyone interested in developing strong and inclusive communities.

Community planning toolkit – Community Places. This is a toolkit to support the community and voluntary sectors' involvement in future community planning processes. The toolkit is primarily for the community and voluntary sector. It will however be useful for a range of partners participating in community planning, including local authorities, elected representatives, statutory service providers and private sector interests.

The toolkit contains five themes which are essential for effective community planning practice:

- **Community planning**
- **Community engagement**
- **Working together**
- **Achieving alignment**
- **Outcomes approach**



Case studies

Examples of applying a community-centred approach in practice include the following:

- **Barnwood Trust – You’re Welcome.**

You’re Welcome is the Barnwood Trust’s community-building programme which aims to increase the involvement of disabled people and people with mental health problems in creating communities and places where everyone is included and no one is isolated.

- **Move More Sheffield.** Move More is a Sheffield-wide strategy that is being delivered by partners across the city. The catalyst for Move More was the establishment of the National Centre of Sport and Exercise Medicine (NCSEM), which is an Olympic Legacy programme. The objective in Sheffield is to create a culture of physical activity to improve the population’s health. Since it began, the strategy has commissioned three locations where medical intervention and physical activity are combined.

- **Community health champions.** Health champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and wellbeing in their communities. Since the success of the original community health champions in communities and workplaces, the role and supporting relationships have been adapted, allowing citizens to work as health champions in new and dynamic settings, including GP practices and acute hospitals.

- **Social prescribing in Rotherham.** The Rotherham Social Prescribing Service is commissioned by NHS Rotherham Clinical Commissioning Group (CCG) as part of a wider approach to GP-led integrated case management. At its core, a team of voluntary and community sector advisers (VCSAs) provides a single gateway to voluntary and community support for GPs and people who use services. The service is especially aimed at users with

complex long-term conditions (LTCs) who are the most intensive users of primary care resources.

- **Assessment and care planning: 3 Conversations model.** The ‘3 conversations’ model is an innovative approach to needs assessment and care planning. It focuses primarily on people’s strengths and community assets. It supports frontline professionals to have three distinct and specific conversations:

The first conversation is designed to explore people’s needs and connect them to personal, family and community sources of support that may be available.

The second conversation seeks to assess levels of risk and any crisis contingencies that may be needed, and how to address these. This conversation is client-led.



The third and final conversation focuses on long-term outcomes and planning, built around what a good life looks like to the user, and how best to mobilise the resources needed (including personal budgets), and the personal and community assets available.

- **The Tinder Foundation** has a national network of 5,000 community centres which support people who are digitally excluded to go online.

Engagement: beyond tokenism

Effective engagement and co-production requires a clear plan that takes into account the views of a wide range of individuals and groups, including those who work with and represent patients and people who use services.

To ensure that services meet the needs of the local population, a wider range of views about what people want from local services should be sought and considered.

The plan to achieve this should cover different channels, considering the communication preferences of different demographic groups. Some people will respond well to traditional consultations, where they are asked to respond to a paper document setting out a range of questions or scenarios. Others will prefer the opportunity to discuss their views face to face, and some may be interested in contributing online or through social media.

Areas should engage the local voluntary and community sectors in design, evaluation and co-production, tapping into their different networks and ability to have conversations with citizens in a different way to statutory organisations.

Virtual communities such as **Mumsnet** and **I Want Great Care**, provide other channels for reaching beyond the 'usual suspects'.

Tools and resources

Building Better Participation – National Association for Patient Participation. All GP practices in England must have a patient participation group (PPG) and make reasonable efforts for this to be representative of the practice population. The National Association for Patient Participation provides a resource guide to help GP practice patient participation groups work effectively.

Healthwatch. Healthwatch is the independent consumer champion for health and care. Its role is to 'make sure that those who run health and care services understand and act on what really matters to people'. The Healthwatch network is made up of local Healthwatch across each of the 152 local authority areas, and Healthwatch England is the national body.

Locally, Healthwatch voices people's concerns and provides feedback to service providers and commissioners. Through local engagement, Healthwatch collects vital data on how and why people use services in their area. Healthwatch's place on the health and



wellbeing board means local Healthwatch can represent the voice of people in decision-making. Local Healthwatch directly supports people in their community by giving them information or signposting them to local services they need.

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- **Community engagement**
- **Working together**
- **Achieving alignment**
- **Outcomes approach**

Case studies

- **Brighton and Hove's community engagement framework:** a document that provides a clear definition of community engagement and sets specific standards for this.
- Engage East Midlands' **self-assessment toolkit for partnerships:** practical assistance for partnerships to self-assess current levels of community participation, identify the participation they would like to have and undertake a series of exercises to help partnerships get from where they are now to where they want to be.
- **The NHS Citizen model – NHS England.** NHS Citizen is a new approach to how NHS England gives citizens a voice and enables them to influence its work. To date, it has involved online and offline conversations and over 4,000 people have contributed to discussions about the work of NHS England.

4 Frontline staff

Challenges

- Frontline staff are operating in a challenging environment and may be suffering from change fatigue (see page 18).
- There can be multiple uncertainties about how and when their roles may change.
- Staff may feel that they lack control over change.

Key actions

- Ensure clear, honest communication to maintain trust throughout the change process.
- Co-produce a shared agenda for change with staff. A good example is **Salford Royal Hospital**, where high levels of staff engagement have helped ensure improved outcomes for both workforce and patients.
- Recognise the role of frontline staff as active participants in developing joined-up care, not passive recipients of top-down plans.

- Empower staff to find the best ways of making change happen (see – Skills for Care **Leadership Qualities Framework**).
- Use networks of professional leaders as a link with frontline staff and to promote the value of joined-up care, e.g. the Adult Principal Social Workers Network has produced an **advice note** that spells out the distinctive contribution of social workers to integrated care.
- Consider the **six building blocks for a highly engaged workforce**.

“There is now an overwhelming body of evidence to show that engaged staff really do deliver better health care. The NHS providers with high levels of staff engagement (as measured in the annual NHS Staff Survey) tend to have lower levels of patient mortality, make better use of resources and deliver stronger financial performance.”

The King's Fund, **Leadership and engagement for improvement in the NHS** (2012)

“Engaged staff are more likely to have the emotional resources to show empathy and compassion, despite the pressures they work under. So it is no surprise that trusts with more engaged staff tend to have higher patient satisfaction, with more patients reporting that they were treated with dignity and respect.”

Improving NHS care by engaging staff and devolving decision-making – Report of the Review of Staff Engagement and Empowerment in the NHS (2014)

“
The value of people from different disciplines and organisations working together across traditional boundaries cannot be over stated. This helps instil person-centred approaches, embracing co-production and a ‘one team’ ethos which focuses on best pathways, with the right blend of care and support services to achieve their outcomes and enjoy best possible quality of life.”

Martin Farran, Corporate Director Health, Housing and Adult Social Care, City of York Council

Frontline staff: the key point of contact

Frontline staff are crucial to successfully delivering good joined-up care. They are the key point of contact between individuals, and carers and families, services and systems, so their perspective, experience and knowledge is indispensable.

Frontline staff need to work together with colleagues from other services, professional groups and organisations. This will involve a shift away from working in separate ‘silos’ and creating effective interprofessional relationships based on collaboration and teamwork.

Joint working may involve a number of changes, including adapting to new team members and styles of working, understanding new terminology and processes, and moving to a new workplace. It can be a difficult and emotional time for staff, who may be anxious about the impact the change will have on them. Strong engagement with staff is important, not just in terms of workforce motivation, but also in terms of outcomes for people using services.

This section explores the range of levers that can be used to support a move to joint working for frontline staff. It takes the perspective of a frontline worker, and people working and interacting with frontline workers. It provides practical advice about how to approach joint working as well as examples of what has worked and why.

Change fatigue

We know that this is a time of significant reform in the sector and that staff may be suffering from ‘change fatigue’. Many staff in health and social care have experienced serial reorganisations throughout their careers. They may not have been involved in shaping the proposals, or they may have limited understanding of the rationale for the changes or the potential benefits. They may even disagree with the changes. Professionals with heavy workloads might see major change as an unhelpful distraction.

When budgets are tight and jobs are at risk, adapting existing working practices to enable joint working may feel like a step too far.

It is important to understand how staff feel about changes to their working arrangements. Some may be excited by the prospect of joint working, whereas others may be apprehensive or worried about the proposed change, and there may be a mix of reactions within the team.

Examples of some common concerns include:

- facing and juggling multiple uncertainties, both personal and organisational

- working in a complex system where no one person or single organisation can come up with a solution on their own
- feeling powerless to influence or be involved in the change process.

Understanding and appreciating these concerns is the starting point for a strategy for addressing them as part of the implementation of joined-up working.

“
An environment in which workers feel safe and confident to raise questions, express concerns, talk about their experiences and make suggestions for service improvement based on their experience and relationships with people they support will create trust and help them and colleagues to feel supported.”
 Skills for Care 2014

I would be really happy to work differently if only someone would think about what I can stop doing within my current workload

This has been done before and it didn't work then

OK, I will play my part but it will change next year, so it doesn't really matter

If only they would stop and listen to me and the people I work with, I could tell them how to do things better – but no one bothers to listen to me



Case study: Salford Royal NHS Foundation Trust

Salford Royal NHS Foundation Trust has consistently high levels of employee engagement and it scored highest out of the 142 acute trusts in England in all of the national surveys of the last three years. Staff satisfaction is high across the board. Out of the 28 key findings in the staff survey, the high levels of employee engagement are matched by exceptional performance. Patient satisfaction is very high at the trust and it performed very well on the inpatient survey. Salford Royal aims to be the safest trust in the NHS and it currently has the fifth lowest mortality in the country.

Devolving decision-making: the whole culture at Salford Royal is focused on involving employees in decision-making. This is reflected in the trust's structure. Unlike many trusts, there is no director of operations or chief operating officer taking major operational decisions at the top of the organisation. Instead, the trust is organised into clinical divisions with responsibility for decision-making, and management devolved to the senior nurses and doctors in those areas. Senior

leaders at the trust understand how important prominent clinical leadership is. Clinical leaders are seen as the experts in their services.

Continuous improvement: there is an established and effective methodology for continuous improvement at Salford Royal. Employees are encouraged to think about how they might be able to deliver their service more effectively and efficiently, to get teams together to work on their ideas collaboratively and then to test them in their services, measuring their impact.

People management: Salford Royal has a real focus on people management, ensuring line managers are really able to engage with staff. The trust invests time and money in leadership programmes for line managers, ensuring they have the skills, capability and confidence to act as effective leaders. The trust comes top of the 142 acute trusts in the country in terms of support from immediate line managers. Appraisals are a key part of this process, ensuring staff have a clear understanding of their personal goals and objectives, and

how they align to those of the organisation.

Leadership: the senior leadership team has been relatively stable, which has helped ensure consistent messages. There is recognition that engagement needs to be a shared priority across the trust, rather than an initiative owned by one individual or team. Senior leaders place great importance on being highly visible around the trust and spend at least half a day a month in a different service, working alongside staff.

Values and purpose: the four values – putting patients at the centre, continuous improvement, respect and accountability – were developed with extensive involvement from employees through focus groups across the trust. The values are mainstreamed throughout the trust, forming a key part in the service delivery strategy and the annual planning process, as well as informing the recruitment and appraisal systems. Increasingly, the trust is looking to align reward and advancement to individual contributions towards these goals and the values of the trust.



How can this learning be applied?

Frontline staff can only change their behaviour if they are empowered to do so. It is vital that frontline staff have defined freedoms to take initiative and test out ways to work across organisational boundaries. This needs to be clearly and consistently communicated by all managers and built into the responsibilities outlines in job descriptions.

Frontline staff need to recognise that when they do this, they assume a leadership role. Such leadership from below is grounded in everyday behaviours and must become a part of the culture in every organisation.



A team needs a champion who can constantly remind us what we are doing and why and can tell us when we are making progress and how we can do even better.



GP representative, Oxfordshire

Tools and resources

- **The Leadership Qualities Framework for Adult Social Care**, National Skills Academy for Social Care, 2012. The Leadership Qualities Framework (LQF) describes the attitudes and behaviours needed for high-quality leadership at all levels across the social care workforce. It focuses on the values and behaviours that provide the foundations for effective leadership in social care.
- **Healthcare Leadership Model, NHS Leadership Academy**. The model aims to help those in the health and care sectors to understand how their leadership behaviours affect the culture and climate they and their colleagues and teams work in. The model is made up of nine leadership dimensions and the online resource describes each dimension – why it is important and ‘what it is not’.
- **The Social Work Professional Capabilities Framework, British Association of Social Workers**. This framework can be used as a benchmark or checklist to build on any existing local approaches.
- **The principles of workforce integration – Skills for Care**. The principles describe the ways in which all workers, practitioners and managers can be enabled to contribute to creating and sustaining a confident and high-quality workforce, and deliver person-centred, excellent integrated care and support.



Example

Skills for Care and Skills for Health have worked with integrated care pioneer programme sites, helping them to engage the workforce in developing new models of care, and **supporting them to develop new ways of working** that enable personalised, joined-up care.

In Greenwich we have developed core competencies for our care navigators to nurture, develop and measure performance. I have found it helpful to distinguish between MDTs and interprofessional practice, which is more conducive to integrated care. One of the key things for us is to incorporate learning from service users, carers and staff all the time. This helps us to identify both subtle and significant service gaps and functions that are not meeting people's needs. My advice would be to challenge, influence and nurture change with commissioners and senior managers to ensure investment and refreshed ideas.

Wendy McDermott, former Integration Lead, Royal Borough of Greenwich

Create a shared agenda

Having started to explore the issues and anxieties surrounding joint working, the next stage is to develop a common understanding about the purpose and objectives of joined-up working. A shared ambition around making things better for local people, developed in open partnership, such as at a team awayday, gives staff from across different organisations the opportunity to come together and start developing relationships, while influencing the design and priorities of the future service.

Use guidance from specialist bodies

Another approach is to refer back to the guidance from the main professional bodies in health and social care who hold a shared view that working across organisational boundaries is crucial to providing effective care and support. This is helpful because clinical and professional staff are influenced by, and work to adhere to the values of their professional group.

“
All professionals have a duty to work collaboratively with patients, families, carers and other teams to deliver person-centred care that meets physical, psychological and social needs. Professionals should work across traditional organisational boundaries in order to coordinate care and meet people’s needs.”

Joint statement from the Royal College of Physicians (London) and the Royal College of General Practitioners supported by the Academy and Medical Royal Colleges

“
The key roles and contributions that social workers make to an integrated health and care system are: to improve outcomes for people; protect people appropriately; and maximise the effectiveness of expenditure across health and care overall by undertaking a rights, strengths, and co-production approach to creative and innovative ways of improving people’s lives.”

Social Work: Essential to Integration
Advice note by Department of Health, Adult Principal Social Workers Network & Association of Directors of Social Services



Engage staff in joint working

In the first instance, the intended changes should be communicated in person, with a clear explanation of their rationale and what the changes are intended to achieve, along with and a clear plan for how staff can co-design the new joint working structure and processes. To overcome the barriers to joint working it is important to harness the energy, ideas and expertise of a range of people across the system, including frontline staff, who should be engaged with the change process from the outset. After this there are a variety of different engagement approaches that can be taken, including:

- Weekly sessions to discuss the change, either run as 'drop-ins' or focused on specific issues, with the option of one-to-one meetings.
- Asking teams to nominate a representative to attend working group meetings, where key issues are discussed and resolved.
- Mass anonymised engagement through surveys and consultation, ensuring a clear feedback loop so that staff understand how their views have informed the new model.

“

The biggest changes I have been a part of have only been delivered by working as a team across boundaries. Moving outcomes for stroke care from bottom quartile performance to top decile in 18 months [in Oxfordshire] was only achieved by GPs working with specialists and both working with nurses, social workers and senior managers. The whole team accepted that what had been happening was not good enough for patients and was frustrating for all parties. There was a real “feel-good factor” when we saw outcomes improve and no new money was required! It felt good when what we had done was shared in big meetings across the region.

‘My patients just do not understand why we are not working as a team on their behalf. Why don't I know the community nurse, the social worker and the specialist? Why can't I just pick up a phone to any of them and make something happen today and not in a month's time?’ ”

Dr Stephen Richards, GP, former Chief Executive of Oxfordshire CCG

Checklist: co-designing change

- Develop clearly documented service pathways in conjunction with staff from all parties.
- Support easy communication by providing a contact list of staff, thereby removing barriers to action.
- Provide a clear map or inventory of organisations and services provided.
- Ensure there is a secure email service in place across local authorities and other stakeholders to prevent any information-sharing barriers.
- Create shared objectives, built into performance management.
- Establish joint team meetings to promote frontline staff coming together to collaborate and problem-solve.
- Make sure any joint teams are co-located as far as possible.
- Ensure all organisational KPIs are recognised and shared openly among teams made up of different organisations. Create an aligned/shared view of what success looks like for the team.

- DON'T expect frontline staff to be enthusiastic or buy into change from the start, but understand that this is not because they don't care.
- DON'T underestimate the differences in the style and culture of organisations and the traditional way in which they do things.

“
As allied health professionals [AHPs] we need to work together towards services that we aspire to provide rather than being constrained by organisational boundaries. We all have common goals in improving care and this needs to work in both acute and community [settings] without being limited by the structure that services are provided in.”
 Dr Stephen Richards, GP, former Chief Executive of Oxfordshire CCG

Source: Direct quote (Anon) from **Allied health professionals into action**, NHS England (2017). **AHPs into Action** commits allied health professionals to supporting integration, emphasising their role in care coordination, rehabilitation and reablement.

“
Failure occurs when staff aren't involved from the beginning in designing how integrated care will be implemented. Imposed change with 'consultation' doesn't enable the necessary relationships to start developing between the different professional groups. The narrative has to resonate with people's everyday work. If it consists of only data and stats and finance it won't. Change also doesn't work if people believe it is just this year's fashion and not here to stay. Integrated care is a necessity for the majority of people we now have to care for, and for the sustainability of the health and care system. That is why every main political party backs the concept and why it will happen irrespective of government.”
 Sir John Oldham, former Chair, Independent Commission for Whole Person Care



Checklist: workforce development

- As new roles, relationships and ways of working develop, have the learning and other needs of individual workers been considered? Is there a system in place to identify learning and development needs? Has the impact of change upon individuals been acknowledged and incorporated into plans?
- Have resources, including funding, been set aside to meet those needs?
- Are there built-in opportunities for workers with different professional backgrounds to share experiences and concerns, and learn from each other?
- Are there built-in opportunities for people from the different parts of the 'system' to come together and talk about the issues from their perspective, so that they can problem solve together? Is there a 'no blame' culture in which individuals can safely express concerns, anxieties and admit to mistakes in a constructive and receptive environment?
- Does supervision provide personal and practice support and guidance?
- Are arrangements in place to enable professional and team supervision?
- Don't assume that senior managers and senior professionals have the knowledge and skills to deliver an integrated workforce – everyone has learning needs. Can you be certain these people are managing well?

Adapted from: **The principles of workforce integration**, Skills for Care, Think Local Act Personal, Skills for Health, the Local Government Association, NHS Employers and the Association of Directors of Adult Social Services (2014)

Listening to each other: including everyone in the conversation

Good workforce development means learning from everyone's experience and valuing what all stakeholder have to say



Source: **The principles of workforce integration**, Skills for Care, Think Local Act Personal, Skills for Health, the Local Government Association, NHS Employers and the Association of Directors of Adult Social Services (2014)

5 Managers

Challenges

- The role of practitioners and managers in joint arrangements can be unclear.
- In a joint team the manager's job is made harder because staff have a wider range of roles and needs and they are going through the uncertainty of transition.
- It's hard to sustain the commitment of time and energy to lead a team through change on top of the day job.

Key actions

- Ensure managers have the time, support and investment they need.
- Provide joint management training and set up joint management meetings. Skills for Care has produced a helpful [Manager induction standards guide](#).
- Ensure clear and consistent communications. For further guidance visit the NHS Confederation's [Reconfigure it out](#) publication for good practice principles for communicating change.
- Explore practical levers, including co-location, joint appraisals, learning and sharing information, as trialled in the [West](#)

Norfolk Alliance Pioneer Programme.

- Implement structural mechanisms, including joint or shared performance frameworks and shared management posts, like the [Joint Accountability Framework in West Dunbartonshire](#).
- Look at sharing money across organisations to underpin joint working, for example, where budgets have been pooled as part of the Better Care Fund.

Translating joined-up strategy to joined-up delivery

Understanding, buy-in and culture shift among operational managers is crucial as they will set the tone and lead their teams in new ways of working. Even if senior leadership is clearly committed to change, managers have to operate in an environment of uncertainty, juggling different and sometimes conflicting priorities. Engaging managers at all levels in a clear vision, demonstrating their particular role and contribution in developing joined-up care, is pivotal to success.

It is really important to have a clear plan as to how this can be done. This section explores the range of levers that can be used with a

range of managerial roles including service managers, commissioning managers, heads of service and team leaders. It provides practical advice about how to approach joint working at an operational management level, as well as examples of what has worked elsewhere and why.

A clear mandate

Managers need a clear mandate and framework that sets out their role in developing joined-up care.

This mandate should describe how much freedom and autonomy managers have to experiment with different ways of working so that they can find the right balance, collectively with their team. Managers need to have the confidence (and implicitly, the support) to leave their traditional comfort zone and test different approaches. An effective joint working system will ensure clear lines of accountability while allowing freedom to innovate at every level.

Empowering staff

Managers need to support frontline staff to focus on outcomes for people, not on tasks or processes. This is a major shift and should be considered as part of their ongoing

development and performance plans. Doing this well will remove some of the perceived threat around new ways of working. Many practitioners will welcome greater freedoms in how they apply their professional skills.



Individual remit within a joint structure

Joint working at a management level (either managing a joint team, or assuming responsibility for managing across organisations in a joint post) requires a new skill set. For example, understanding the priorities and systems of the 'home' organisation or taking on responsibility for the management of different professional groups. This should be acknowledged, and any gaps in training addressed.

Managing a joint team

It's vital to spend time gaining a real understanding of where the people in your joint team have come from and what they have been used to in their previous organisations. Think about what's different for them – the language being used, the place they are working, the IT system they are using, the colleague(s) they sit next to.

Have conversations with staff to understand how they see the changes, and which ones might be more painful than others. Work through them with patience and support. Empathise with the loss that takes place and stress the improved outcomes of the new joint ways of working. Small changes can make a big difference to the way an entire team interacts.

Continuing commitment

The behaviours and skills required from managers for joint working might be hard to maintain in the face of day-to-day priorities. Sustaining energy and effort is essential to ensure that joint working 'sticks' and becomes the cultural norm. Managers should look to allocate a specific percentage of their time to promoting and actively driving this change, and their line managers should support them

in doing so. Bringing together a disparate group of practitioners into one team with a shared purpose is hard. However, there are many tools available to encourage a single team mindset and a focus on outcomes.

Unless the whole system changes, services cannot make a real difference to people who have multiple, long-term conditions. It is about getting the right people together in a room to bring about change and the meetings are based on delivering outcomes. [For us] those partners are: director from KCHT Sue Scott; assistant director West Kent Mary Silverton and integration programme lead from KCC Jo Frazer. Without their commitment and sincerity to deliver the pioneer objectives the work streams would not be as far developed. We are now networked and hash tagged with national partners and sharing best practice through teleconferences.

Sue Excell, Service Manager for West Kent and Clinical Lead for Integration



Effective management of joint teams

Managers need support and investment to manage joint teams effectively, including being allowed the space and time to reflect on what is working (or not!). Establishing joint management meetings will bring to managers' attention the day-to-day problems of creating joint services. Managers should consider the following:

- Co-location: physically bringing people together so they are based in the same office or place. This creates day-to-day interaction and communication which, in turn, generates a new joint culture, e.g. in the **West Norfolk Alliance Pioneer programme**, where integrated operational management brings together community health and social care.
- Use appraisal schemes to ensure consistent joint objectives for managers, and help remove any conflicting targets – focus on shared objectives and outcomes across the management team.
- Pool resources: including staff, offices and management systems.

Managers are often caught in the middle, between people who use services and the strategies and plans of senior leaders. The role of managers needs to be set out clearly in the overall narrative for joined-up care that connects the strategy and plans with the benefits for people with care and health needs.

The role of joint management training is vital. Developing shared common qualifications and joint learning will embed 'jointness' and ensure it is recognised in a common way. Skills for Care's **Manager induction standards** is a good place to start.

Given that many of the most serious risks to service change programmes relate to communication and engagement, the role played by communication and engagement leaders is crucial. Although there are some key themes for strong engagement, such as clear language and consistent messaging, communications should be tailored to meet the needs of different audiences. This can include both the content of the message and the most effective way of communicating it. See **How to ... lead and manage better care**.

The NHS Confederation also provides information on **Good practice principles for communicating service change in the NHS**.

When managing joint teams, remember the following:

- Form joint action learning networks to allow space for reflection and encourage frank and honest dialogue at management level across organisations (e.g. the Scottish Social Services Council's action learning sets were commissioned to bring senior managers, social services and health together to work on the issues that prevent good and improving outcomes for those who use services).
- Spend 'a day in the life' of a manager colleague from another organisation. Actively encourage job swap days across organisations to build insight into other people's roles, responsibilities, priorities and ways of working.
- Use information-sharing platforms that will enable collaboration and the sharing of materials (e.g. **Camden CCG's use of Huddle**).

There are lots of examples of joint or shared performance frameworks which can be drawn upon to standardise an approach, such as the



Joint Accountabilities Framework in West Dunbartonshire.

The Scottish Government has set guidance on the principles for planning and delivering integrated health and social care and a set of core indicators to measure progress.

In Greenwich, joint management posts have been created across health and social care. Integrated management is assured through having a Royal Greenwich assistant manager where there is a NHS manager, and vice versa: see [Innovation in social care](#).

Sharing money can help erase traditional organisational boundaries: pooled operational budgets such as in the [Staffordshire and Stoke-on-Trent Partnership Trust](#) can also support effective joint management.

Shaping the workforce offer

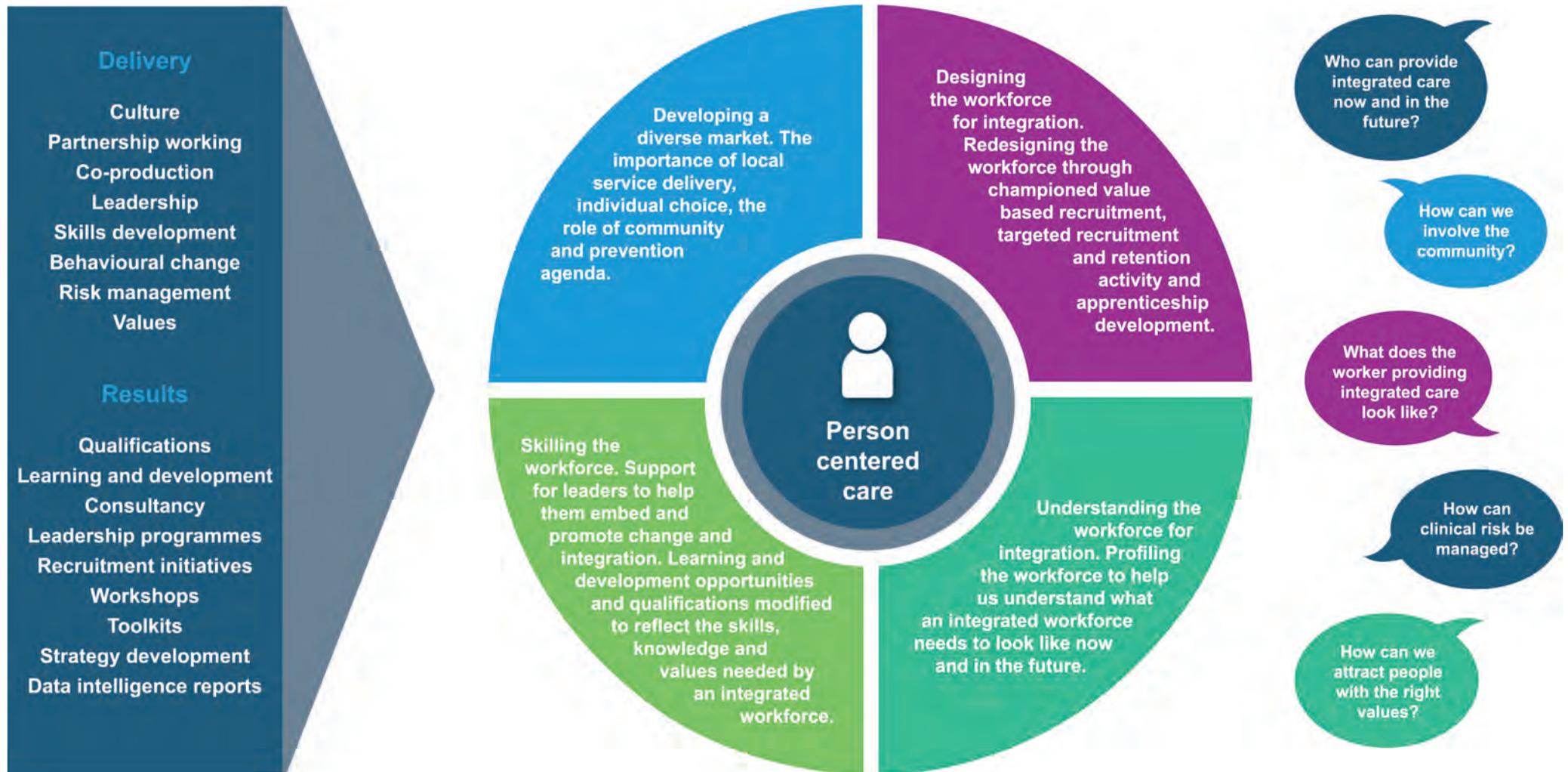
Sites involved in the Skills for Care programme include representatives from the pioneer sites, Health Education England, Public Health England, the Association of Directors of Adult Social Services, Skills for Health and NHS England. They have developed a programme based on workforce needs identified by the sites.

The priorities are:

- understanding the size and shape of the workforce for integration
- designing and redesigning the existing workforce with the right values
- skilling the workforce
- developing a diverse market, focusing on workplace culture.

The group has identified the need to ensure that the focus of work crosses all service areas and is not predicated on older people.

Shaping the workforce offer work programme – an overview



Source: **Shaping the workforce offer work programme (2014)** (Skills for Care, Skills for Health, Public Health England, Mental Health Forum, ADASS, NHS Health Education England, NHS Improving Quality)



How can this learning be applied?

Developing joined-up care is a change process that will only be achieved through managerial behaviours that actively learn from what is happening day-to-day. These include:

- taking a proactive approach and not waiting to be told about mistakes or omissions
- treating complaints as opportunities to learn and improve
- using the insights of local Healthwatch and other groups representing people who use services
- seeking out feedback from staff.

It is always important to share learning. No one is getting this 100 per cent right, and being able to evaluate how things are going with colleagues can help. For example, mentoring across sectors is hugely rewarding from both a mentor and a mentee perspective.

Staff should be encouraged to speak up about their concerns. It is important that they feel able to express their views and highlight any concerns. Whistleblowers should always be protected.

Refer to information about pooled budgets and section 75 case studies in **3: Pooling**

budgets and agreeing risk share in [How to... bring budgets together and use them to develop coordinated care provision](#).

Skills for Care undertook an **evidence review of integrated health and social care** in October 2013, and discovered that:

- effective management of integrated teams is key to successful integration
- team management is different, and should be separated from clinical or professional management
- separate management structures do not support integrated approaches to delivery.

Managers' checklist

- Ask managers to manage positively. Encourage joint working through recognition of behaviours in line with this.
- Consider creating joint management posts or other shared arrangements such as co-location of staff.
- Involve staff in decision-making and proactively seek their views and feedback.
- Encourage shadowing and mentoring opportunities across organisations at managerial level.

- Have the confidence to feel uncomfortable and test new ways of working.
- Build evaluation into the role of managers.
- Consider implementing performance management arrangements across organisations. This should include a single set of tools for objectives and standards, measures, and monitoring arrangements. The Scottish Government has released its **Core suite of integration indicators** in relation to this.
- Consider whether structural integration would be beneficial. The King's Fund report, **Integrated care in Northern Ireland, Scotland and Wales** discusses this.
- DON'T focus on managing tasks and processes – empower the team by managing outcomes.
- DON'T be afraid to highlight poor behaviour and create mechanism to share power.
- DON'T dismiss complaints: turn them into an opportunity to learn.
- DON'T forget that this is about better care for individuals.

We would like to thank the following individuals for their contribution to this publication.



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