Integration 2020: Scoping research
Report to the Department of Health
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- identifying and sharing knowledge about what works and what’s new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.
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1. Introduction

Context

'The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements.'

The government wants to see the integration of health and social care, in every area of England, by 2020. The Department of Health’s recent thinking regarding this is summarised in Figure 1 below, and it includes the establishment of an Integration Standard with associated metrics that enable the performance of each area to be measured by qualitative and quantitative data, giving a clear picture of progress toward integration.

Figure 1 Integration of health and social care, in every area of England, by 2020

It is likely that progress towards the development of integrated services will be based on incentivising local areas, rather than prescriptive legislation.

The Integration Standard

The Department of Health’s initial thinking about the Integration Standard includes the following seven objectives, each of which is underpinned by service user ‘I’ statements.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Digital interoperability (use of NHS number and digital maturity index)</td>
<td>‘I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data).’</td>
</tr>
<tr>
<td>2. Resources targeted at high-risk cohort to prevent crises and maintain wellbeing (use of personal budgets, integrated personal commissioning, risk stratification, capitated budgets)</td>
<td>‘If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital.’ ‘If it would benefit me, I will be able to access a personal budget, giving me greater control over the money spent on my care.’</td>
</tr>
<tr>
<td>3. Value for money (clear plans for making efficiencies/performance against efficiency plans, reduction in total bed days)</td>
<td>‘I receive the best possible level of care from the NHS and my local authority.’</td>
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<tr>
<td>4. Single assessment and care plans (proportion of target cohorts receiving single assessment and integrated care plan)</td>
<td>‘If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care.’</td>
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<tr>
<td>5. Integrated community care (user satisfaction, areas use multidisciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week)</td>
<td>‘I receive more care in or near my home, and haven’t been to hospital for ages.’ ‘My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it.’ ‘Areas use multidisciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.’</td>
</tr>
<tr>
<td>6. Timely and safe discharges (delayed transfers of care from hospital, stronger incentives and mechanisms to reduce delayed transfers of care)</td>
<td>‘If I go into hospital, health and social care professionals work together to make sure I’m not here for any longer than I need.’</td>
</tr>
<tr>
<td>7. Social care embedded in urgent and emergency care (health and social care professionals available when needed/align with seven-day service standard)</td>
<td>‘If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them.’</td>
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About this report

Within this context, this report presents the findings from a programme of scoping research and engagement to better understand what excellent integrated health and social care should look like in 2020; to test out the Integration Standard with national stakeholders and local areas; and to provide feedback and support for further development of the standard. The research, involving engagement with national stakeholders, local areas and people who use health and care services, was undertaken by SCIE on behalf of the Department of Health.

The research will inform the government’s future plans for the further integration of health and social care, including the next phase of the Better Care Fund. This report draws on the following work streams:

1. A rapid evidence scan, focusing on what good integrated care looks like; what role each objective set out in the standard plays in progressing towards integration; and what challenges are associated with each objective.

2. Interviews with stakeholders from across health and social care including, for example, the Department for Communities and Local Government, the Local Government Association, the Care Quality Commission (CQC), NHS providers, the NHS Confederation, Care England, Solace, the United Kingdom Homecare Association and National Voices, about what excellent integrated health and social care should look like in 2020 and to test out the Integration Standard (interviewees listed in Appendix 1).

3. Research with five local case study sites (Dudley, Southampton, Mid-Nottinhamshire, York and Hertfordshire) to explore in greater depth the experiences of local areas with the Integration Standard and the progress they are making towards integration.

4. A workshop, chaired by Lord Michael Bichard, chair of SCIE, and supported by the Policy Lab from the Cabinet Office which brought together experts in health and care policy, stakeholders from across health and social care and stakeholders from the case study sites to inform the emerging research and consider implications for the planning and delivery of this proposed policy initiative.

The remainder of this report prior to the conclusion and appendices is set out as follows:

Chapter 2 Provides a summary of the evolving policy context and its impact on health and social care integration.

Chapter 3 Presents stakeholders’ views about the ambition for integration of health and social care by 2020 and the challenges associated with it.

Chapter 4 Gives an overview of views on the Integration Standard and the objectives outlined in it.
2. The evolving policy context and its impact on health and social care integration

The goal of integration by 2020 is dependent on an evolving set of national policies and circumstances. Driven on the one hand by the need to provide services at less cost, and on the other by the practical need to achieve better outcomes for citizens, there are a plethora of policy frameworks and ideas that are reshaping public services towards a more integrated and person-centred approach. The main policies impacting on health and social care – including the Care Act\(^2\) the Five Year Forward View\(^3\), the New Models of Care Programme\(^4\), the Five Year Forward View\(^3\), the New Models of Care Programme\(^4\), Integrated Personal Commissioning\(^5\) and Sustainability and Transformation Plans (STPs)\(^6\) – all call for more integrated health and social care that is person-centred, seamless and outcome-focused. There are at least five high-level policy changes that are currently driving the reshaping of health and social care.

**Treasury policies and spending reforms**

The government’s spending plans to 2019/20 set tight targets for spending on health and social care, with demand for services exceeding available funding. In social care, reductions to the funding settlements for local authorities have reduced spend on adult social care with the King’s Fund recently concluding that ‘Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help.’\(^7\)

The current funding gap in social care is estimated at £1.1billion,\(^8\) and recent evidence confirms fewer adults are receiving publicly funded social care. Although funding for NHS services has been relatively protected, the pressures associated with growing demand and health care cost inflation have resulted in a very significant pressure on expenditure by NHS providers. About two-thirds of NHS acute trusts in England are in a financially precarious position, which is affecting overall performance. Demand for high-cost, unplanned care continues to grow.

Most worryingly, there is mounting evidence that the financial deficits in the acute sector are driving short-term decisions, shifting funds to bolster hospital care rather than encouraging long-term investments in schemes designed to prevent admissions and to deliver health and social care integration. Across the country, the financial sustainability of local health services has become an overriding concern. Despite this, in many

\(^7\) Richard Humphries et al., ‘Social Care for Older People. Home Truths’ (London: King’s Fund, 2016).
places, the tight fiscal environment has resulted in concerted efforts by local authorities and NHS commissioners jointly to plan and jointly commission health and care services.

Reconfiguration of health care services

The health service’s policy response to the funding pressures has been the Five Year Forward View9 and the introduction of geographic ‘footprints’ in which local health and care economies are required to produce Sustainability and Transformation Plans.10 These efforts promise to build on a number of existing integration initiatives, including NHS England’s Better Care Fund,11 the New Models of Care Programme12 and Integrated Personal Commissioning,13 and they are consistently taking an expanded view of integration beyond health and social care, with an emphasis on shifting as much care as possible into primary and community settings. For example, in many areas, Sustainability and Transformation Plans are proposing new care models and organisational forms, aiming to tackle inefficiencies and the variability in care outcomes.

Prevention and early intervention services are also part of the mix, with many of the Sustainability and Transformation Plans proposing an increase in preventative care and support services such as social prescriptions, care navigation and reablement. In response to unusual geographic size and scope, many plans are promoting locality-based integrated services – often taking the form of integrated care hubs or networks – that target patients at risk of hospitalisation. These plans also propose pooling budgets and joint commissioning in many instances, retaining a very local and positive focus for health and social care integration.

The new organisations resulting from the Sustainability and Transformation Plans will require extensive collaboration across providers (e.g., many are expected to become ‘accountable care organisations’). This bodes well for plans to increase levels of integration, yet the statutory context for providers maintains existing organisational autonomy and accountabilities. This will make it difficult to introduce the payment reforms, financial incentives and the risk-sharing arrangements associated with the new organisational arrangements. Another challenge is the accelerated timetable for delivering the Sustainability and Transformation Plans, particularly the financial savings targets, and this may distort progress in the near-term towards the sustainability elements of the Plans, rather than system transformation (and therefore integration).

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Devolution and local place-shaping

Devolution can broadly be defined as the redistribution of power and funding from central government to a local level. Devolution does not necessarily bring additional funding, but it can galvanise local leaders to further integrate local organisations.

‘In Manchester and Cornwall, health has been caught up in the wider devolution agenda, creating a potentially unstoppable momentum that has brought NHS and local authority leaders together to think about how services could be transformed to better meet the needs of their populations and overcome longstanding barriers to change.’

The most advanced example is devolution in Greater Manchester, for which local partners have taken control of the region’s health and social care budgets. Using Manchester as an example, devolution has prioritised the creation of an integrated system, one with distinctive local provision, furthering the scope for joint commissioning, the pooling of public resources and the creation of provider alliances and new models of care. In other local areas, such as Cornwall, devolution builds directly on the relationships formed through integration. Nonetheless, where devolution has been approved and is getting underway, a mixed picture emerges. Closer collaboration of commissioners ought to break down barriers to integration and encourage ‘place-based’ solutions, but the Sustainability and Transformation Plan process, which does not always cover the same geographic area, can divert attention away from realising the benefits of devolution locally. Complex governance arrangements are also required. Only time will tell whether these experiments are successful at accelerating the system changes that result in fuller integration. Devolution is clearly not a quick solution; Manchester’s efforts have been underway for more than 10 years – some suggest even longer.

Health and social care regulation: protecting the public and ensuring accountability

The regulatory framework for integrated services is also evolving. The remit of the Care Quality Commission is to ensure the quality of services among health and social care providers. However, the regulation is currently designed to inspect and monitor autonomous provider organisations, and not new integrated organisations (such as accountable care organisations or the vanguards). The Care Quality Commission has recognised that there are numerous starting points for integration, and local experiences and successes vary. The regulatory system needs to adapt to account for more complicated and integrated delivery systems, new care models and their

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15 Greater Manchester Combined Authority and NHS in Greater Manchester, ‘Taking Charge of our Health and Social Care in Greater Manchester’ (Manchester: Greater Manchester Combined Authority and NHS in Greater Manchester, 2015).
governance arrangements. The Care Quality Commission’s efforts will need to align with and be supportive of the national Integration Standard.

Better Care Fund

The Better Care Fund\(^\text{17}\) has been the primary lever in recent years to bring health and social care organisations together to plan, fund and commission integrated services (since 2013). The initiative has helped to drive a shift towards more integrated commissioning and an increase in the size of pooled budgets between local authorities and clinical commissioning groups (CCGs), through Section 75 agreements. The Better Care Fund has been used to fund a number of important initiatives that future integration plans and Sustainability and Transformation Plans will reflect, including integrated care hubs, discharge to assess schemes, extra care schemes, integrated information systems, reablement and community navigator initiatives. The Better Care Fund will continue over the next financial year, with guidance published at [https://www.gov.uk](https://www.gov.uk). A new process of ‘graduation’ from the Better Care Fund for local areas deemed to be performing well is expected to be introduced.

3. Integration by 2020

The results of our interviews with both local and national stakeholders suggest that integration by 2020 continues to be a sensible national policy objective, especially for service users, patients, carers and staff. While there is widespread agreement that integrating care is the right thing to do, defining it and describing how it should be achieved is more complicated. In the literature, many commentators use the terms ‘integration’ and ‘integrated care’ interchangeably, with one study identifying 175 definitions of integrated care.\textsuperscript{18}

The Nuffield Trust distinguishes between integration and integrated care, arguing that integrated care ‘… is an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care’.\textsuperscript{19} Similarly, a report published by the King’s Fund argues that the development of integrated care ‘… means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place’.\textsuperscript{20} Despite the challenges associated with defining integrated care it is clear that coordinated and person-centred ways of working are an essential feature.

Some of the national stakeholders we interviewed argued that a national framework is needed that brings health and social care together, and seeks to resolve a number of system-level dilemmas, such as:

- the potential conflicting policies of the Department of Health, NHS England and the Department for Communities and Local Government
- different funding systems.
- different eligibility for health and care (free NHS care vs means-tested social care)
- separate governance.

Further to this, the national framework should include an overarching vision of what integration can achieve, expressed through a coherent and shared narrative. National Voices, working with a number of others, previously created a shared narrative and suggested this as the starting point.\textsuperscript{21} The concise narrative below, which was adopted

\textsuperscript{20} Chris Ham and Nicola Walsh, ‘Making Integrated Care Happen at Scale and Pace’ (London: King’s Fund, 2013, p 1).
\textsuperscript{21} National Voices and Think Local Act Personal, ‘A Narrative for Person-Centred Coordinated Care’ (London: National Voices, 2013, p 4).
by the government in 2013,\textsuperscript{22} has been helpful to those planning and implementing integrated care:

‘My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes.’\textsuperscript{23}

What does ‘good’ look like?

Given the lack of a precise definition of integrated care and the variety of approaches to integration, it is unsurprising that attempting to assess the effectiveness of integration can be challenging. Despite the existence of an extensive literature on integrated care, measuring the effectiveness of integration has proven to be difficult; many studies simply provide descriptions of a service or project. Those pieces of research that do evaluate the effectiveness of integration tend to focus on service outcomes such as hospital admissions, rather than service user outcomes.

Others have taken a different approach and have focused on attempting to assess whether the ‘right’ framework for integration is in place. In June 2016, the Association of Directors of Adult Social Services, the Local Government Association, NHS Clinical Commissioners and the NHS Confederation jointly produced a self-assessment tool called ‘Stepping up to place: the key to successful health and care integration’. This was designed to support health and care communities via their local health and wellbeing board to ‘… critically assess their ambitions, capabilities and capacities to integrate services to improve the health and wellbeing of local citizens and communities’.\textsuperscript{24} The document focuses on the preparedness of areas to integrate and asks:

- whether the ‘essentials for the integration journey’ are in place (shared commitment, shared leadership and shared accountability)
- how ‘ready’ the local health and care system is to deliver integration (shared vision, shared decision-making and shared systems)
- whether effective governance is in place (decision-making authority, clear roles and responsibilities, engagement of stakeholders, managing interfaces and information flow)
- whether there is effective programme management (shared vision, programme planning, planning footprints, programme interdependencies and monitoring of progress).\textsuperscript{25}


\textsuperscript{23} National Voices and Think Local Act Personal, ‘A Narrative for Person-Centred Coordinated Care’ (London: National Voices, 2013, p 3).

\textsuperscript{24} Local Government Association, ‘Stepping Up to Place: Integration Self-assessment Tool’ (London: Local Government Association, 2016, p 3).

\textsuperscript{25} Ibid., pp 6–13.
Our research found that the local context is an important determinant of success with regard to integrated care, with many commentators guarding against a ‘one size fits all’ approach, as made clear in a report by the Nuffield Trust stating that there ‘… is no one model of integrated care that is suited to all contexts, settings and circumstances’.26

‘In the future, integration will look really messy. I expect a diversity of models and variation in approaches. As we are observing, there are lots of different ways in which integration plays out; for example, not every area will have a joint authority, and with Sustainability and Transformation Plans and devolution, different areas are figuring out what they want to do. The rhetoric about integration suggests a number of things. There are more starting points, and therefore more end points’ (national stakeholder).

**Barriers and facilitators to integration by 2020**

Although an understanding of the local context is essential in implementing a programme of integration, a number of barriers and facilitators to integrated care are regularly identified by commentators as important to overcome in order to meet the ambition of integration by 2020. Factors that are regularly cited as having an impact on the success or failure of integration include the following:

**Financial issues**

A number of commentators suggest that the drive towards an integrated health and care system is hindered by the financial foundations that underpin the health and social care sectors. Most obviously, this can be seen in the different approaches to eligibility for care, with NHS services being provided for free at the point of delivery and based only on clinical need, and social care services being rationed by means testing. Separate funding streams and different payment processes further entrench this financial division.

Although the current financial climate provides a strong driver for change, local areas told us that this has also meant that some partners have found it hard to sustain their engagement with the integration agenda when they are dealing with organisational viability – from shrinking budgets and overspends to staff recruitment and retention issues. This has resulted in slowing the pace of change and ‘parking’ integration activities until a later date.

**Communication and information-sharing across agencies**

Communication between different agencies is a central component of integrated care. This is because it enables professionals to coordinate care, enables risk stratification and allows data to be monitored (e.g., activity levels and costs). Some view governance issues as a hindrance to communication and information-sharing, with practitioners reporting that regulatory frameworks can sometimes be confusing.27

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may be better in areas where pre-existing relationships already exist, for example through co-located services.\textsuperscript{28}

**Shared vision and leadership**

Many commentators highlight the importance of leadership when discussing factors that may impact upon the success of integration initiatives. Leaders must be able to clearly communicate the rationale and vision for integrated care in their local area.\textsuperscript{29} Importantly, they must be perceived as being able to do so by their staff. The evaluation of the Integrated Pioneers Programme found that ‘... success was more often reported in pilots where individuals were confident that senior management or team leaders were strongly committed to implementing lasting change’.\textsuperscript{30}

**Organisational culture and professional boundaries**

Health and social care professionals may still be separated by language, ideas about health and wellbeing, perceptions of accountability and preferred ways of working. Local areas we spoke to often cited these as ongoing barriers. They explained the need to break down cultural and professional barriers in order to challenge the traditional ‘us and them’ mind-set and secure ongoing involvement of partners who feel threatened by new models of care, who are risk averse and reluctant to embrace new ways of working.

One of the case study areas highlighted the varying levels of engagement on behalf on some GP practices, which are central to integrated working. Interviewees suggested various reasons for this including legitimate concerns about quality, accountability and governance issues in relation to integrated working; a lack of capacity to attend the engagement activities and events needed to move this work forward; and some GPs viewing integration as a threat to their independent practice.

‘There are no quick wins. You have to put the time and effort into partnership working. You need to be constantly working on this in order to drive change within your own organisation as well as others’ (case study site).

**Workforce**

An additional concern is the availability of a workforce to pursue the integration model fully, including the introduction of new roles; the area is considered under-resourced. It may be difficult to motivate some staff due to previous experiences with initiatives and pilots. Moreover, fostering high levels of engagement can prove difficult, given that the positive results associated with integrated care may only become apparent in the longer term.\textsuperscript{31}

\textsuperscript{28} Tom Ling et al., ‘Barriers and Facilitators to Integrating Care: Experiences from the English Integrated Care Pilots’, International Journal of Integrated Care, vol 12, no 5 (2012), p 4.


Supporting local areas with the integration agenda

Among the areas we spoke to, there was a desire for a better understanding of what ‘good’ looks like. In addition, a number of people said they would find it helpful for the government to identify and share effective/good practice in relation to implementing integrated care. An integration standard may help begin to articulate this.

Interviewees identified a number of ways in which the Department of Health could support and facilitate the integration agenda, including:

- developing and supporting systems leadership
- providing guidance as to how local areas can use financial incentives, such as the Commissioning for Quality and Innovation (CQUIN) framework, to encourage organisations to work more closely together
- encouraging wider partners such as the police, housing and employment services to participate in the integration agenda
- providing guidance on integrated key performance indicators (KPIs) and how these translate into improved outcomes for patients/service users
- resolving data-sharing challenges (this is critical, and national leadership is needed)
- advising clinical commissioning groups about procurement models which best support integrated working, since competitive tendering can be counterproductive when trying to establish relationships between multiple agencies on the ground
- altering the regulatory system so that it is aligned with integrated service provision by multiple organisations
- addressing the challenge faced by local areas which have hospitals weighed down by significant private finance initiative debt.
4. The Integration Standard

Overall, both national and local stakeholders thought that, in terms of democratic accountability, it is right that the Integration Standard involves those aspects of performance that government thinks are important. Nonetheless, it was argued that the Standard, as it stands, presents a confusing mix of measures. It was suggested that there is a need for any standard to more clearly articulate the level of integration it intends to measure and the outcomes gained.

What levels of integration do we need to think about?
- At the level of personal experience.
- In regards to health and social care services.
- In relation to organisations.
- Across local places.

What can be gained through integration?
- Better outcomes and experiences for service users?
- More effective services?
- More efficient services?
- Organisations that communicate and work effectively together?
- Better use of local resources?
- Provider sustainability?

Many stakeholders suggested that the objectives in the proposed standard are a subset of what is essential – so they are necessary but not sufficient. There was a significant level of consensus among national and local stakeholders about the weaknesses of and gaps in the proposed Standard, including the following.

- The Standard appears too focused on structural and process-related measures. For example, a local area might achieve all the elements of the Standard without actually delivering better care. The system and structural measures don’t describe what good integration looks like.
- There was a consistently strong view that person-centred outcome measures are needed, but also that these should address emotional and general wellbeing. The Standard was perceived to lack the patient or service user perspective, including views about their experience of care as well as outcomes.
- The Standard was considered to be too focused on health and the acute sector in particular, and needs to focus on ‘the whole system’ including the input of, and impact on, not only social care but other partners, including the voluntary
and community sector, housing, transport, police, etc. It would be helpful to measure the effectiveness of partnership working, and this might include evidence of joint commissioning arrangements, actual pooling of funds, concordats and data-sharing agreements, co-location of staff, leadership and governance, etc.

- Systems leadership should be defined and measured within the Standard. It was suggested that the leadership characteristics of a well, integrated area would be: mature and well developed relationships at all organisational levels; a culture of shared endeavour throughout organisations; good governance for system-wide decision-making; and a focus on what can be achieved in the future rather than refighting past conflicts.

- Delivering integrated care has significant implications for the workforce and how they are deployed and trained. It would be helpful for this to be recognised in the Standard. Further to this, culture change and improved communication and relationships are vital enablers of integration.

- Finally it was argued that there must be scope within the Standard to include both national and local measures. There should be a degree of local freedom in how the Standard is applied and assessed, as areas have approached integration in different ways, depending on their local health and social care economies. Measurement should also include qualitative measures to give greater confidence that the whole system is evolving.

Below we provide a brief summary of what the evidence says (a more detailed overview of the evidence can be found in Appendix 4) and discuss feedback in relation to each of the specific objectives in the proposed Integration Standard.

Digital interoperability (use of NHS number and digital maturity index)

’I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data).’

What the evidence says

It is widely acknowledged that integrated health and social care models can only be fully achieved and sustained through effective information- and data-sharing within and across sectors, with information travelling with the individual and easily accessible to all the professionals involved in their care. Digital interoperability is the critical enabler of information flow, ensuring that multiple IT systems are able to communicate, exchange data and virtually operate as a whole integrated information system. The Five Year Forward View sets out a vision for harnessing the information revolution, ensuring locally procured information systems meet nationally specified interoperability and data
standards and advocating the use of the NHS number in all settings, including social care.32

This commitment is echoed and further detailed in a comprehensive framework for action produced by the recently formed National Information Board, whose remit is to develop strategic priorities for data and technology use in health and social care. Key elements of the framework include:

- from March 2018 all individuals will be enabled to view their care records and to record their own comments and preferences on their record, with access through multiple routes including NHS Choices
- all patient and care records will be digital, real-time and interoperable by 2020
- the NHS number will be universally adopted across the care systems, including local authorities
- common standards and a single clinical terminology will be implemented.33

The Health and Social Care (Safety and Quality) Act 2015 introduced a new legal duty requiring health and adult social care bodies to share information where this will facilitate care for an individual.

There is broad agreement in the literature and among commentators that information- and data-sharing, supported by an adequate interoperability infrastructure, is the essential building block of successful integrated care models.

Successful implementation of interoperability programmes depends on a whole range of local drivers and enablers. Key themes emerging from the literature and practice include: strong vision and leadership; relationships at all levels, including between strategic leaders from health and social care; communication with relevant stakeholders; engagement with partners, providers and patients; staff training, including addressing staff concerns around the service user consent process; and adopting a phased process, starting small and growing in stages.34

Stakeholder feedback

Digital interoperability was seen as an important ambition, however many stressed that it is an enabler of integration, not an end in itself. Addressing issues relating to information governance and data-sharing was deemed more important than partners all using one system, and this is a significant task in its own right. A lack of digital interoperability should not prevent progress on integration if data-sharing agreements are in place.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

34 Ibid.
• the extent to which data-sharing protocols are in place across the system
• the extent to which information/data is actually being shared across the system
• use of the NHS number as an identifier across all relevant services.
• a description of what a good system looks like – e.g., is it a shared platform or separate systems that share records?
• data intelligence (the use of information) is seen as just as important as data-sharing.
• evidence of local shared systems and information-sharing agreements.

Resources targeted at high-risk cohort to prevent crises and maintain wellbeing (use of personal budgets, integrated personal commissioning, risk stratification, capitated budgets)

‘If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital.’

‘If it would benefit me, I will be able to access personal budget, giving me greater control over the money spent on my care.’

What the evidence says

The evidence base indicates that overall impact is significantly greater when integrated care interventions are targeted at high-risk segments of the population, broadly characterised by high-level, multiple needs and generally requiring input from a range of professionals and services across the health and care sectors.

In their review of the evidence on supporting patients with costly complex needs, Vrijhoef and Thorlby found that ‘… interventions targeted at complex patients achieve more of their goals if they are multifaceted, for example combining a range of professionally focused changes (such as specialist geriatricians or case management) with patient/carer-focused interventions (such as better information or self-management).’ The rationale for this is that ‘… the heterogeneous nature of the needs that arise from complex co-morbidities’ requires coordinated and personalised responses. Similarly, Nolte and Pitchforth argue that ‘… the complexity of needs arising from the nature of multiple chronic conditions, in combination with increasing frailty at old age, involving physical, developmental or cognitive disabilities, with or without related chronic illnesses or conditions, requires the development of delivery systems that bring together a range of professionals and skills from both the cure (health-care) and care (long-term and social-care) sectors to meet those needs.’


36 Ibid.

These findings are echoed in Kasteridis et al., whose analysis of the groups most likely to benefit from integrated care and capitated budgets demonstrates that multi-morbidity is the main driver of health and social costs. While a significant proportion of older people may present multiple chronic conditions, age alone ‘… adds little explanatory power once we have accounted for the number of conditions in analysing costs’. 38 Nonetheless, the prevalence of co-morbidities is growing as a result of demographic changes and the ageing population, with evidence showing that ‘… the majority of people aged over 75 have three or more conditions …’ 39 in a context of growing financial strains both in the health and social care sectors. Against this background, and to contain costs and reduce the disproportionately large demand for services accounted for by a relatively small number of patients, emerging integrated care models are increasingly focusing their efforts on the most vulnerable patients, targeting the ‘super-users’ with early interventions and preventive programmes.

Personal budgets have also been suggested as a means of facilitating the integration of care and are intended to give people with care needs and disabilities greater choice and control over the care and support they receive. The Care Act 2014 requires local authorities to assign a personal budget to all people who are eligible for support and personal budget holders are able to ‘… decide how, who with and where they wish to spend that budget in order to meet their needs and achieve the outcomes of their support plan’. 40

There is a broad consensus that personal budgets have the potential to produce a range of positive outcomes such as increased choice and control, improved health and general wellbeing, quality of life, greater participation and community engagement and cost-effectiveness. However, the evidence base in relation to these outcomes is sometimes uncertain and the strength and quality of the evidence is sometimes contested. While some researchers report that personal budgets increase feelings of choice and control 41 others argue that personal budgets do not represent value for money and in those instances where better outcomes have been achieved this can in part be attributed to funding levels. 42

The use of personal budgets by older people has been relatively well explored. Looking specifically at the costs and benefits of personal budgets for older people, Woolham and Benton (2013) concluded that ‘… compared to younger adults, older people did not greatly benefit from possessing a budget on the outcome measures used, but costs

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41 Ibid.
were higher for budget holders across all care groups'. However it is noted that there may be particular barriers in uptake of personal budgets among older people as they may be ‘… less likely to accept a personal budget and more likely to be dissatisfied with their experience of using one’. In addition, ‘… most councils are finding significant challenges in implementing personal budgets with older people, in particular in achieving good numbers while also being confident that they are making a positive difference’. Similarly, Routledge et al. argue that there is typically a lower level of resources available to older people in their personal budgets which ultimately leaves less scope for personalised outcomes.

The use of personal budgets by people with mental health needs has also been studied and one review suggests that personal budgets for people with mental health problems can have an impact on service use, costs and service user outcomes, including quality of life. However, the review also highlighted the methodological limitations of the studies reviewed and suggested that there is an evidence gap in terms of high quality research. Similarly, a recent qualitative study on outcomes from personal budgets in mental health found that ‘most participants identified positive outcomes across domains interconnected through individual life circumstances, with mental health and wellbeing, social participation and relationships, and confidence and skills most commonly reported’.

The evidence base on personal budgets also includes references which focus on the impact of personal budgets on carers. Larkin (2015) found that just over half of the sample of carers interviewed felt their relationship with service users had been enhanced by the personal budget arrangements. Three quarters reported positive outcomes, such as feeling happier, healthier and having more control over their lives. An independent evaluation of the 2005–2007 individual budgets pilot (IBSEN) arrived at similar conclusions, suggesting that ‘that the receipt of the budget was significantly

associated with positive impacts on carers’ reported quality of life and, when other factors were taken into account, with social care outcomes’.  

More recently, the Integrated Personal Commissioning programme has been targeted at people with complex needs, providing them with more control and choice on the extent and the way in which the financial resources they are entitled to are used, through the enhancement and expansion of personal budget options and the blending of social care and health budgets. The programme aims to achieve integrated care at the level of individual service users, through co-commissioning arrangements between NHS England, clinical commissioning groups and local authorities. However, as the initiative was only launched in 2015 it has not been possible for the programme to be evaluated.

**Stakeholder feedback**

Risk stratification is very useful, however it is only as good as the available data. It is important to include social care and community health data in risk stratification, although this can be harder to access. Several questions were raised about how ‘high risk’ was being defined and it was suggested that the Standard seems to focus on older people and is skewed towards those at risk of hospitalisation rather than other population groups with complex needs. Further, it can’t be assumed that risk stratification is sophisticated enough to pick up all the ‘right’ people – the information systems on which it relies are not perfect. Additionally, clarity about the parameters/timeframe around risk is required – for example, some people have underlying risks such as obesity, which could translate into diabetes in the future.

While targeting is important, many felt that there also has to be an element of integrated prevention/early intervention activity. There are many people who fall below the thresholds for various services. If prevention and early intervention isn’t prioritised, there’s a risk more innovative approaches will not be funded, which could end up costing the system further down the line.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- the extent to which health and social care data are being combined to identify those most at risk, and the proportion of the population that are being targeted (1, 5, 10 per cent etc.)
- description of integrated working around prevention and early intervention, and intended outcomes of this

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• support for other types of ‘high risk’ service users with complex needs, such as children
• comparison of the impact of risk stratification on the investment in care homes (vanguard approach) – which achieves the best outcomes?
• evidence of a shared strategic vision and strategy for medium- and low-risk cohorts
• the proportion of people receiving integrated care through a multidisciplinary team, as well as the categories of people receiving support (e.g., those with physical health needs, mental health, children, young people, etc.)

Value for money (clear plans for making efficiencies/performance against efficiency plans, reduction in total bed days)

‘I receive the best possible level of care from the NHS and my local authority.’

What the evidence says

The Integration Standard sets out a value for money objective, to ensure service users receive the best possible level of person-centred, coordinated care from the NHS and local authorities. Reduction in total bed days is proposed as an indicator of performance; in addition, areas are expected to deliver against a clear plan for making efficiencies across health and care, through integration, contributing to the £22 billion efficiencies programme.

The NHS estimates that ‘… of the so-called “£22bn efficiency requirement”, around £7bn will be delivered nationally, leaving around £15bn to be secured from local efficiencies’. These will be achieved through productivity improvements each year across NHS secondary care providers but also by ‘… moderating the level of activity growth through care redesign, and interventions such as Right Care and Self Care’.52

Arguably, the main expectation underpinning the value for money objective is that integrated care is capable of delivering the so-called ‘triple aim’ – improving health outcomes, enhancing patient experience and reducing the costs of care.53 Better Care Fund guidance adopts a similar approach, recommending that ‘a reasonable range of outcomes and measures should be selected with the aim of delivering the following key impacts: people’s experiences of care; care outcomes in terms of changes to people’s health and wellbeing; and better use of resources’.54

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Measuring the value for money of integrated care is fraught with difficulties. This is reflected in the existing evidence, which in general is difficult to assess and is often conflicting.

In the literature, value for money as a measure of improved health outcomes is generally evidenced through the analysis of the benefits of integrated care ‘… in terms of natural units (cost-effectiveness), such as life years gained, reduction in blood pressure or in a synthetic overall health measure (cost-utility, such as quality adjusted life years (QALYs)).’\footnote{E. Nolte and E. Pitchforth, ‘What Is the Evidence on the Economic Impacts of Integrated Care?’ (Copenhagen: World Health Organisation Regional Office for Europe, 2014).} Cost and utilisation analysis on the other hand capture the third element of the triple aim, with utilisation measuring ‘… the level of use of a particular service over time, such as physician visits; emergency room/accident and emergency department (ED) visits; hospital admissions; length of hospital stay; hospital days’.\footnote{Ibid.}

While it is assumed by many that integrated care is likely to produce cost savings, the literature as a whole does not necessarily reflect this optimism. Although there have been studies that report positive results there are a similar number that report that integrated care is at best cost-neutral. Findings from systematic reviews and meta-analyses are similarly inconclusive. A meta-analysis by Nolte and Pitchforth from 2014 (see note 51) identified 17 studies that explicitly examined cost and/or expenditure data. Although they found some evidence of cost reduction they emphasised that these results were often based on a limited evidence base or on non-controlled studies.\footnote{Ibid.} In contrast, Dorling et al. (2015) conducted a meta-analysis of 53 controlled studies (mostly from the US, although some UK studies were included) investigating the impact of integrated care on hospital admission rates. They found ‘… a statistically significant reduction in the probability of hospitalization for patients in integrated-care programs of 19 per cent when compared with usual care’.\footnote{G. Dorling et al., ‘The Evidence for Integrated Care’ (McKinsey & Company, 2015).}

The evidence base on integrated care in England specifically is rapidly expanding and many localities report positive impacts resulting from an integrated care initiative. However, it is important to treat these findings with caution given methodological concerns such as lack of a control group or the suitability of measures used. Additionally, in the absence of a high quality systematic review or meta-analysis of a generally equivocal evidence base it seems wise to be cautious regarding the likely impact of integration on resource use.

**Stakeholder feedback**

Delivering efficiencies across the system is a primary driver for the local areas we spoke to. Many cautioned that the description reflects a bias towards acute care spending as the basis for determining the value of integration interventions. They suggested that there are other things to look at, such as investment in community-based care; the impact on commissioning; finding efficiencies in care delivery processes (fewer interactions) and pathways; reduced bed days in other residential

\footnote{Ibid.}
\footnote{Ibid.}
\footnote{G. Dorling et al., ‘The Evidence for Integrated Care’ (McKinsey & Company, 2015).}
care; and other service utilisation across the whole system, including primary care, and so forth. From the patient/service user perspective, integrated care consists of much more than avoiding hospital admissions.

Nonetheless, some commented that it would be helpful to distinguish between different types of hospital admission; for example, an admission for a rapid assessment is very different from a long-term admission of an elderly person with high care needs. Yet currently they are considered as a single cohort.

Some interviewees felt that a greater emphasis should be placed on improving outcomes, rather than financial savings, as savings will flow from better patient outcomes. Wellbeing and quality of life were also seen as important considerations. It is very hard to prove value for money in relation to prevention/early intervention activity however, which runs the risk that this will be neglected in favour of ‘quicker wins’.

The payment system in the acute sector engenders protectionism which can impact negatively on efforts to deliver efficiencies across the system. The right incentives need to be in place to encourage all partners to ‘play their part’ in delivering value for money.

Joint commissioning was also seen as producing better value for money, but it is not reflected or measured in the Standard.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- reduction in residential and other care bed days needs to be taken into consideration alongside reduction in hospital beds
- the system requires longer-term indicators that acknowledge the time it takes for prevention/early intervention activity to deliver outcomes and savings
- integrated personal commissioning (personal budgets) is also seen as addressing the value for money indicator – how extensively are local areas using personal budgets, and what is their impact?
- qualitative measures that address quality of life and wellbeing, as well as the personal experience of care, should be factored into value for money considerations.

Single assessment and care plans (proportion of target cohorts receiving single assessment and integrated care plan)

‘If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care.’

What the evidence says

As with many concepts relating to integration, producing a precise definition of a single assessment/integrated care plan is challenging, despite what at first may seem to be a relatively straightforward concept. This is reflected in the array of terms employed in the literature, which variously describe joint approaches to assessment and care planning.
as ‘integrated’, ‘shared’, ‘collaborative’, ‘joint’ or ‘single’. (Indeed, the documentation supplied by the Department of Health on the Integration Standard 2020 makes reference to single assessments, integrated care plan and joint approaches). These concepts, however, are not necessarily used interchangeably in the evidence reviewed; each term seems intended to capture a distinctive model of practice and a varying degree of interprofessional collaboration and service integration.

The principles underlying the single assessment process are reasserted in the Care Act 2014, which requires that in carrying out proportionate assessments for people with complex needs local authorities must consider involving a number of professionals and that care plans should not be developed in isolation from other plans. Where a person has both health and care and support needs, the Act prescribes that local authorities should work in collaboration with the NHS to produce integrated assessments and care plans: ‘To achieve this, local authorities should: ensure healthcare professional views and expertise are taken into account when assessing the care and support services people require; and work with healthcare professionals to ensure people’s health and care services are aligned and set out in a single care and support plan’.59

Partly as a response to these specific provisions of the Care Act, and reflecting the vision set out in the Five Year Forward View, NHS England has produced guidelines for the implementation of personalised care and support planning processes within the NHS. These are defined as a ‘… systematic way of ensuring that individuals living with one or more long-term condition (LTC) and their health and care professionals have more productive and equal conversations, focusing on what matters most to that individual …’,60 and supporting their independence, overall wellbeing and self-management. Key to this approach is a single holistic care and support planning discussion and plan.

For people who need care and support from more than one service, it is important that assessments and care planning are holistic and coordinated. While this is generally seen as a goal for all health and care assessments, joint assessments and care plans are perceived to be particularly effective for those cohorts associated with the greatest use of care, with some researchers suggesting that in the case of older people ‘… multidimensional assessment and multiagency management’ can lead to better outcomes’.61

Single assessments and care plans are also seen as a way to minimise bureaucracy, duplication and administration for frontline staff, which in turn is seen as an important way of conserving resources. Benefits to service user experience are also expected given that the individual will only have to ‘tell their story once’. This is often cited as a key objective of integrated care. The National Voices programme of work selected ‘I tell my story once’ as part of the person-centred coordinated care narrative relating to


60 Coalition for Collaborative Care, ‘Personalised Care and Support Planning Handbook: The Journey to Person-Centred Care: Core Information’ (London: Coalition for Collaborative Care, 2015).

communication. National Voices also makes suggestions regarding the practicalities of person-centred care planning. These include shared decision-making, involvement of families and carers, provision of information and care plans that are linked to health and social care records, and regular reviews of care plans.

Organisational and professional cultural differences, along with setting-specific variations in priorities and approaches to care, remain a key barrier to full interagency and interprofessional collaboration. Local health and care systems and care providers are developing local solutions to the delivery of single assessments and care plans by either improving interorganisational collaboration or ensuring that all the relevant professionals are involved in the process.

**Stakeholder feedback**

Localities all said they have made some progress on developing a single assessment and care planning process, although there is still work to do to refine approaches and make care plans accessible across the system.

Like digital interoperability, this measures process and not outcomes. It cannot be assumed that single assessments and care plans will automatically lead to better outcomes for patients.

Several stakeholders pointed out that single assessment processes and care plans vary in what they contain. This objective is therefore in danger of creating a ‘tick box’ exercise. Instead, the Standard should be measuring how well the care plan is making a difference to patients.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- the extent to which a patient understands their care plan and has control over it
- patient reported outcome measures (PROMS) and patient reported experience measures (PREMS) could be used to understand the extent to which patients feel that a single assessment and care plan has impacted on their care and outcomes.

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Integrated community care (user satisfaction, areas use multidisciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week)

‘I receive more care in or near my home, and haven’t been to hospital for ages.’

‘My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it.’

‘Areas use multidisciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.’

What the evidence says

Community care is about ensuring that people who need care are supported to live with dignity and independence in their communities. As set out in the broader legislation, community care comprises a wide range of services, including: domiciliary care/support services; home help services; day centre provision; respite care; aids and adaptations; community health services; residential and nursing care; supported living placements; hospital discharge arrangements; and meals on wheels services. The increasing incidence of multi-morbidities and long-term conditions, the rising costs of acute care and pressures on hospitals have led to a growing involvement of medical professions and health services in the delivery of community care and the development of a broader range of NHS-led, community-based health service models, designed to bring care closer to home and away from hospital wards. Indeed, health-based community services make up a substantial part of NHS care provision.

Integrated community care aims to ensure that local authorities and the NHS work together, both vertically and horizontally, to offer a comprehensive provision of social and health care services in the community. This is achieved through a better coordination of services and greater interprofessional collaboration, to meet the growing complexity of care needs of local populations, in a cost-effective, personalised and person-centred manner and exploiting the resources, formal and informal arrangements and the social networks available in communities: ‘There is a clear push among commissioners to commission on the basis of a place, overcoming artificial barriers established within the NHS and between health and care.’

64 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’ (London: Local Government Association).

There are variations in the way integrated community-based services are shaped, interorganisational relationships are established, and specific arrangements for interprofessional collaboration are being defined, and both policy and practice are building on the learning from emerging models. There appears to be some consensus that primary care settings remain at the centre of many new integrated systems.
Effective community services are widely acknowledged as a key component of a sustainable health and social care system. Services that prevent health and wellbeing crises by maintaining the independence and wellbeing of people in their local community reduce the need for more expensive forms of care such as that provided in the acute sector. Well designed and coordinated community services, built around multidisciplinary teams and cost-effectively combining the expertise and resources of local actors, including the NHS, local authorities and the voluntary sector, are critical to the successful implementation of the integration agenda and to achieving its core objectives, namely the provision of person-centred care; addressing the holistic needs of people and supporting their independence and overall wellbeing; harnessing individual and communities’ assets; and preventing or reducing the demand for more intensive or emergency care.

Cultural and organisational differences between the health and care sectors and variations in professional behaviours and approaches to care pose significant challenges to integration. Highlighting the critical role played by coordinated care interventions to support enhanced hospital discharge safety, Waring et al. note that ‘… hospital discharge involves a dynamic network of interactions between heterogeneous health and social care actors, each characterised by divergent ways of organising discharge activities; cultures of collaboration and interaction and understanding of what discharge involves and how it contribute to patient recovery’. 65

**Stakeholder feedback**

Stakeholders agreed that integrated community care is a core component of local areas’ integration plans, but some argued that this objective isn’t clear: what is being measured and why?

Many felt there is still some way to go to deliver a seven-day service in the community, which would facilitate more weekend discharges from hospital. More work is needed for social care to provide a 24/7 service, but there is a shortage of social work staff.

Nonetheless, from experience, partners in mid-Nottinghamshire have learned that integrated community care isn’t needed 24/7 in every setting. Other case studies illustrate the important role of primary care and GP services in coordinating and delivering integrated care.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- important to measure the impact of integrated community care on patients and carers
- measure weekend discharges from hospital as a proportion of all discharges
- case studies could be used to illustrate how different parts of the system have worked together to offer a seamless service to patients/service users

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effectiveness of multidisciplinary teams: measure staff and service user experiences

evidence of certain things being in place (e.g., an integrated commissioning plan across health, social care and housing that illustrates how money will flow across the system from acute care into integrated community services).

Timely and safe discharges (delayed transfers of care from hospital, stronger incentives and mechanisms to reduce delayed transfers of care)

‘If I go into hospital, health and social care professionals work together to make sure I’m not there for any longer than I need.’

What the evidence says

Timely and safe discharges are a critical aspect of effective patient flow and, more broadly, high quality care provision – the right care provided at the right time and in the right setting. Underpinning this definition of quality care is the principle that ‘… hospitals should look to admit only those patients whose medical needs require it, and reduce length of stay and the proportion of long-stay patients wherever it is clinically safe and appropriate to do so’.66

NHS England guidance states that a ‘… delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when: a clinical decision has been made that patient is ready for transfer AND a multi-disciplinary team decision has been made that patient is ready for transfer AND the patient is safe to discharge/transfer’.67

The evidence indicates that lengthy stays in hospital, unduly prolonged by factors unrelated to the treatment of an acute episode, are not only costly to the system but also pose significant risks to patient safety and recovery. Remaining in hospital for longer than is clinically necessary can lead to negative outcomes for users. There are risks in relation to hospital acquired infections68 and there can be a detrimental impact on morale. Perhaps most significantly, long hospital stays can lead to rapid functional decline, particularly in the case of older users.

Delayed transfers of care also represent an inefficient use of resources. In 2016 the National Audit Office estimated that there was a cost to the NHS of £820 million resulting from the inappropriate use of acute care beds.69 This figure relates to the care

69 Ibid.
of older people specifically and does not include the costs associated with other groups who may also be at risk of delayed transfers.

Timely and safe discharges are the culmination of complex processes and interdependencies. They are contingent on the contribution and coordination of multiple services across occupational and organisational boundaries and as such provide a good illustration of the benefits of delivering integrated care. Conversely, ‘… the complex interdependencies and non-linear couplings between health and social care agencies can be the latent source of poorly timed, inappropriate or unsafe transition from hospital to community care’. Delayed transfers of care more specifically, are widely seen as a key indicator of the extent to which a local health and care system is integrated. An evidence review produced by NHS Providers stated that delayed discharges are ‘… a measure not just of hospital performance, but of how well the wider health and care system is working’.71

Timely and safe discharges can only occur in well integrated systems of care, with health and social care providers working together to minimise length of stay in hospital and smooth the transition to the appropriate level of care in the community. The Committee of Public Accounts (2016) however finds that ‘… the fragility of the adult social care provider market is clearly exacerbating the difficulties in discharging older patients from hospital …’, suggesting that reduced spending in social care services by local authorities and difficulties in recruiting and retaining staff is hampering the offer of local services.72

Given the increasing complexity of care and support needs and the growth in the numbers of older frail people and those with multiple long-term conditions it is perhaps unsurprising that social care services are increasingly recognised as a vital component of the hospital discharge process. The latest data from NHS England show that in July 2016 a third of total days delayed were directly attributable to the social care sector while 8 per cent were attributable to both the NHS and social care. Causes of delayed transfers attributable to social care commonly resulted from a delay in securing social or community care support services such as a nursing or residential home placement, a home care package or equipment and housing adaptation.73 Strong local leadership to ensure the health and social care sectors work effectively and collaboratively through innovative approaches and clear structures of accountability are highlighted as key enablers of good practice.74

Information-sharing across professional and service boundaries, to enable a full understanding of the whole spectrum of a patient’s health and care needs, is found to be a critical enabling factor of timely and safe transfer of care.

Stakeholder feedback

Delayed transfer as a measure was generally seen as highly relevant (possibly due to the considerable attention it has been given in relation to the Better Care Fund), but not on its own. Because delayed transfers of care are caused by multiple factors, it is important to unpack the indicator to understand what is happening within the system and how to address discharge delays.

Many stakeholders suggested that delayed transfers need to be treated as a shared responsibility across the whole system, with organisations taking collective responsibility for reducing them. The ability of one organisation to levy financial penalties on another is counterproductive to collaborative ways of working, and can engender a blame culture. Fines imposed on social care only reduce the resources available for future activity.

‘Safe’ and ‘timely’ require equal emphasis, so as to avoid a situation where patients are discharged quickly, only to reappear in the system due to unsuitable accommodation or care. Further, it is important that delayed transfers are understood within the wider system of care: focusing on the ‘back end’ of the system is unhelpful, as there is much that can and should be done to prevent some people from needing to attend hospital in the first place.

Local challenges in terms of reducing delayed transfers included: the availability of step-down beds; funding issues (such as free vs means-tested care); insufficient workforce; reduction in social care funding; lack of home-based support; different discharge practices at different providers; and differing expectations from commissioners.

Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- measuring delayed transfers is helpful, but additional metrics are required to understand the system-wide reasons for any increases/decreases in delayed transfers
- how well the system is responding to delayed transfers, i.e. how proactive are partners in managing and/or preventing delayed transfers, as opposed to responding in a reactive way?
- overall length of stay in hospital
- non-elective admissions to hospital
- measuring the place where people are discharged to, or the proportion of people being discharged to home vs care homes.
Social care embedded in urgent and emergency care (health and social care professionals available when needed/align with seven-day service standard)

‘If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them.’

What the evidence says

A more effective and efficient urgent and emergency care network that is appropriately used is perceived as an important tool in alleviating the increasing pressure on accident and emergency departments and reducing the numbers of emergency admissions. Although there is little agreement on a precise definitions of the terms, emergency care is generally understood to indicate an immediate response to a life threatening, time critical health need. Urgent care, on the other hand, is the treatment of conditions that do not pose an immediate threat to life but require treatment within 24 hours or before the next in-hours or routine primary care service is available. The provision and organisation of urgent and emergency care in the UK is highly complex and increasingly fragmented. It comprises a wide range of services, both hospital and community-based, offering a variety of responses and different levels of specialised care, which are often difficult to navigate.

The evolving background against which urgent and emergency care services operate is characterised by a growing prevalence of long-term and multiple conditions and a composite yet disjointed provision of care options. This highlights the need for better, integrated approaches to health crisis management. Setting out an integrated approach to urgent and emergency care, Fernandes observes that ‘… given the complex nature of patient flows across different services, urgent and emergency care services cannot be commissioned in isolation and the process requires a “whole system” and “multidisciplinary” approach across acute, primary and community-based services and social care’.75

The literature acknowledges that social care has a critical role to play in preventing older people from experiencing a health crisis, reducing hospital admissions and readmissions, shortening length of stay and supporting the discharge process.76 The literature acknowledges that availability and access to social care support during a health crisis is time critical, noting that ‘… in managing older people with urgent care needs in the community, the first 24 hours of timely, effective health and social care support is crucial’.77 Indeed, enabling people to access services where and when they are needed has been a key feature of recent government policy. In evidence to the House of Lords Select Committee on Public Service and Demographic Change given in

76 Ibid.
2012, the Health Secretary made clear that the NHS must become a 24/7 service.\(^{78}\)

This was followed in 2013 by a review of seven-day working in the NHS which recommended that social care and other support services ‘… both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken’.\(^{79}\)

While much of the focus has been on 24/7 working in the NHS, it is clear that an effective and integrated urgent and emergency care system necessitates more flexible social care services that are available at the point at which they are needed. When crisis occurs the default position is to access an emergency department, raising a high probability of an emergency admission. The crisis may not necessarily be the result of a health problem, however, and the response that is needed may not require acute care or need to be the sole responsibility of health professionals. By ensuring that social care professionals are accessible as and when needed it may be possible to reduce the need for emergency admissions.\(^{80}\)

**Stakeholder feedback**

Many local stakeholders agreed that this was an important objective, but some argued that it is not entirely clear what is being measured or what the desired outcome should be.

Mental health access in urgent and emergency care was seen as just as important as social care. Other services, such as care navigators, could also have a useful role to play within urgent and emergency care.

Some felt a broader view of the role of social care in the whole emergency care system should be taken, from the role of social care in rapid response teams to working in a more coordinated way with emergency care professionals and out-of-hours services. Fall response cards were described, and the way social workers are working with paramedics, undertaking mini-assessments and avoiding hospital admissions.

Nonetheless, as social work resources have been significantly reduced, it is unclear where the resources to achieve this objective will come from on an ongoing basis. Some local stakeholders said experience demonstrates that scarce social work resources need to be properly targeted to ensure their best use; it is possible that not all urgent and emergency care facilities require social care input seven days a week.

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\(^{80}\) British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’ (London: British Geriatrics Society).
Suggested indicators and/or ways of measuring progress and outcomes around this objective included:

- measuring mental health as part of the emergency care system
- a focus on evidence about how well health and social care are joined up across the system, not just in emergency care
- consideration of the whole of the emergency response system (e.g. rapid response teams, other emergency services), and pathway redesign and referral protocols that prevent unplanned care.
5. Conclusions

This study confirms full support for the ambition of integration by 2020 because bringing together health and social care is universally seen as the right thing to do. A national standard therefore might fulfil several essential functions:

- helping to keep people’s eyes on the ball: continuing to focus local hearts and minds around integration
- adding impetus and urgency: contributing momentum towards local service transformation
- creating a framework for action: providing the Department of Health, Communities and Local Government, NHS England and local areas with a means of measuring and monitoring progress towards integration.

The feedback on the Standard can be summarised as follows.

- The starting point for the Standard should be the patient/service user or citizen.
- The Standard should recognise that integrating care requires a set of complex interventions and behaviour changes at all levels of the health and care system – national agencies, local commissioners and providers, professionals and users.
- Local context matters. Although there are common elements, integration will look different in each local area, and the standard should accommodate this variability, avoiding a ‘one size fits all’ approach.
- The Standard should recognise integration as an enabler of more cost effective care, rather than a key driver for savings.
- The Standard must adapt to, and be consistent with, the wider transformation agenda in health and social care. Government must nonetheless restate its commitment to integration if the ambition is to be realised and explain how different policy drivers, such as Sustainability and Transformation Plans contribute to integration.
- A national framework is needed to address some of the barriers to integration.
- Some specific modifications and additions to the Standard would improve its utility and effectiveness.

There was a significant level of consensus that the proposed Standard:

- is too focused on structural- and process-related measures as opposed to outcomes
- lacks the patient and user perspective
- is too focused on health and the acute sector in particular – it needs to focus on ‘the whole system’ including primary, community and social care
needs to recognise and measure the role of systems leadership

needs to recognise and measure workforce strategy

needs to include both national and local measures.

Developing the Integration Standard further: a framework for action

This study confirms that the journey towards integration is ongoing and evolving. Building on a national consensus for integration, the development of the Integration Standard can prioritise and accelerate the system changes required to achieve the ambition, but concerted efforts are required nationally, locally and at the point of care. We suggest conceptually breaking down metrics into national and local objectives.

- **National level** – shaping the environment for integration at a national level, where the alignment of public policies, financing, regulation and accountabilities is best achieved.

- **Local level** – here, cross-organisational efforts come together to create a local system for integrated care.

- **Frontline level** – the frontline delivery of integrated care and how patients/users experience care.

The national challenges are appropriate for central government agencies and NHS national bodies (e.g., NHS England, NHS Improvement, Care Quality Commission) to lead and resolve. These actions would help remove the policy and contextual barriers to integration related to financing, regulation, system governance and accountabilities, including:

- addressing the different funding strategies for health and social care, including the ongoing eligibility criteria dilemma

- demonstrating how financial incentives (e.g., contractual levers, different payment approaches) can encourage service integration

- addressing the conundrum of the statutory and regulatory environment conflicting with the aims of cross-organisational cooperation and governance

- setting data interoperability standards and data-sharing protocols

- restating a national framework for integration

- providing a range of examples of ‘what good looks like’ in relation to each of the Standard’s objectives.

The local challenges are best defined nationally but applied locally. They specifically reflect the capabilities of partners to deliver integration, and in many respects they are consistent with the proposed Standard. They recognise that local partners may need guidance and practical support in tackling local barriers to change. The refinement to the proposed Standard should include effective indicators for measuring:
• the effectiveness of joint working, joint commissioning, strategic alliances and formal networks, including governance frameworks
• the alignment or pooling of budgets and shared contracts, and the use of capitation or other financial incentives that move away from payments for episodic care
• the strength of leadership at local level – in terms of collaboration, including with the voluntary sector, joint problem-solving, etc.
• how new models of care or integrated delivery organisations are providing integrated care
• the effectiveness of discharge and transfer agreements, and protocols for referrals, risk management and rapid response
• data-sharing (integrated IT or interoperability), and the use of data intelligence to drive change and track costs and activity levels
• poor system working – better systems for detecting risks and early warnings (e.g., rising transfer delays, unplanned admissions, rising costs, etc.)
• the effectiveness of joint workforce training and development, including the development of new roles.

The frontline challenges are best understood as measuring the actual delivery of integrated care. They apply primarily to the workers responsible for care, and focus on the point of care, the management of care and especially individuals’ experience of care. Key issues are:

• the effectiveness of care planning and management, evidence of continuity of care, involvement of users/patients
• the effectiveness of preventative care – put in place support earlier to prevent people’s conditions unnecessarily worsening
• the effectiveness of multidisciplinary teams – how professionals are working together, how well information is shared and communicated, consistent practices and common protocols used
• the benefits from the user’s perspective: breadth and comprehensiveness of services (include mental health), quality of life and wellbeing, maintenance of independence
• personalised care, patient and carer involvement, use of technology
• how well people are supported to manage their own care.
Appendix 1: List of interviewees

As part of our research, we interviewed a number of key experts, leaders and stakeholders. Through semi-structured interviews, we sought to understand their views on the government’s early thinking about a national Integration Standard.

<table>
<thead>
<tr>
<th>Person</th>
<th>Organisation</th>
<th>Role</th>
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<tbody>
<tr>
<td>Alex Lim</td>
<td>Department for Communities and Local Government</td>
<td>Team Leader</td>
</tr>
<tr>
<td>Sally Burlington</td>
<td>Local Government Association</td>
<td>Head of Policy</td>
</tr>
<tr>
<td>Malte Gerhold</td>
<td>Care Quality Commission</td>
<td>Interim Executive Director of Strategy and Intelligence</td>
</tr>
<tr>
<td>Chris Hopson</td>
<td>NHS Providers</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Bev Searle</td>
<td>Berkshire Healthcare NHS Foundation Trust</td>
<td>Director of Corporate Affairs</td>
</tr>
<tr>
<td>Phil McCarvill</td>
<td>NHS Confed</td>
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<tr>
<td>Vic Rayner</td>
<td>National Care Forum</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>David Pearson</td>
<td>Nottinghamshire County Council</td>
<td>Corporate Director of Adult Social Care and Health</td>
</tr>
<tr>
<td>Mark Rogers</td>
<td>Birmingham City Council</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Don Redding</td>
<td>National Voices</td>
<td>Director of Policy</td>
</tr>
<tr>
<td>Martin Green</td>
<td>Care England</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Bridget Warr</td>
<td>United Kingdom Homecare Association</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Debbie Sorkin</td>
<td>The Leadership Centre</td>
<td>National Director of Systems Leadership</td>
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## Appendix 2: List of stakeholder workshop attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
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<tbody>
<tr>
<td>Peter Howitt</td>
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<td>Vic Rayner</td>
<td>National Care Forum</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Varsha Dodhia</td>
<td>North West London Integration Pioneer</td>
<td>Lay Partner Advisor</td>
</tr>
<tr>
<td>Henry Kippin</td>
<td>Collaborate</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Anne Prentice</td>
<td>Home Group</td>
<td>Head of Health and Social Care Development</td>
</tr>
<tr>
<td>Nicola Morrow</td>
<td>Home Group</td>
<td>Health and Social Care Partner</td>
</tr>
<tr>
<td>Don Redding</td>
<td>National Voices</td>
<td>Director of Policy</td>
</tr>
<tr>
<td>Geoff Alltimes</td>
<td></td>
<td>Freelance consultant</td>
</tr>
<tr>
<td>Dr Lesley Godfrey</td>
<td>Priory Medical Group</td>
<td>GP</td>
</tr>
<tr>
<td>Sharon Stewart</td>
<td>Southampton City Council</td>
<td>Service Manager</td>
</tr>
<tr>
<td>David Stockdale</td>
<td>Careline</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Michelle Turton</td>
<td>Mansfield District Council</td>
<td>Housing Needs Manager</td>
</tr>
<tr>
<td>Karen Linde</td>
<td>The Social Work for Better Mental Health</td>
<td></td>
</tr>
<tr>
<td>Fiona Russell</td>
<td>Local Government Association</td>
<td>Senior Adviser</td>
</tr>
<tr>
<td>Donna Chapman</td>
<td>Southampton City CCG</td>
<td>Lead Associate Director</td>
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<tr>
<td>Anna Starling</td>
<td>The Health Foundation</td>
<td>Policy Fellow</td>
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<tr>
<td>Ossie Stuart</td>
<td></td>
<td>Independent Equalities Consultant</td>
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<tr>
<td>Gavin Reid</td>
<td>Scottish Government</td>
<td>Integration Division</td>
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<tr>
<td>Jenny Harland</td>
<td>Department for Communities and Local Government</td>
<td>Senior Policy Advisor, Care and Reform Division</td>
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<tr>
<td>Susan Hart</td>
<td>Department for Communities and Local Government</td>
<td>Senior Policy Advisor, Care and Reform Division</td>
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</tbody>
</table>
Appendix 3: Case studies

Integrated care in Dudley

Vision and model

Dudley’s multispecialty community provider (MCP) programme ‘All Together Better’ is one of NHS England’s new care model vanguards. The programme has three priority themes, which have been developed through extensive engagement with patients, the public and professionals: (1) enhanced access to care; (2) improved continuity of care, particularly for those with long-term conditions; and (3) better coordinated care, most notably for those with multiple co-morbidities, the frail and those nearing end of life.

The programme will transform primary care, which is at the heart of the multispecialty community provider model. Patients will have their care overseen by a multidisciplinary team (MDT) in the community including GPs, specialist nurses, social workers, mental health services and voluntary sector link workers. Outside the team, Dudley Clinical Commissioning Group is also changing the way it commissions secondary care services, moving away from item-of-service payments to commissioning best practice pathways of care.

In essence, partners in Dudley want to do three things: (1) shift care from the hospital to the community; (2) change the relationship between services and the citizen, and (3) ensure the sustainability of its services. Figure 1 illustrates Dudley’s multispecialty community provider model and the logic model for the model can be found at the end of the case study. The multispecialty community provider programme is intended to be operational by 1 April 2018.

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81 Partners include: Dudley CCG, Dudley MBC, Dudley Healthwatch, Dudley Group NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Dudley CVS and Dudley Walsall Mental Health Partnership NHS Trust.
This programme of transformation is overseen by a partnership board comprising Dudley Clinical Commissioning Group, Dudley Metropolitan Borough Council (MBC) and NHS providers. A cross-organisation Clinical Strategy Board ensures clinical input to the design of the model. Dudley benefits from having a coterminous clinical commissioning group and council, as well as a single health and wellbeing board, acute trust and mental health trust operating in the area.

**Main successes to date**

Dudley partners had already made considerable progress on integrating health and social care prior to the programme. This included creating a structure for general practice, where 46 GP practices operate in five locality groups, each with a dedicated GP lead, tasked with developing provision in the locality. Multidisciplinary team working had already begun and all general practices had moved to a single IT system. Devolved commissioning has enabled the reform of quality outcomes frameworks locally to support a focus on long-term conditions.

When asked to comment on the main successes to date, interviewees agreed that establishing multidisciplinary working in all Dudley GP practices was a major achievement. It has led to improved communication and referrals between agencies, greater awareness of and connection to voluntary and community sector organisations, and, anecdotally, improved patient and carer outcomes. One health professional noted: ‘MDTs have revolutionised the way we work. We all know each other now and communicate between meetings. It has opened avenues into other services, and we also now look at family members as well as the patient.’
A recent development is the employment of 10 care coordinators to help administer, monitor and support multidisciplinary working, ensuring that any agreed actions are taken forward and that teams are as effective as they can be. More generally, interviewees pointed to achievements including partners having a greater aspiration towards new, more integrated ways of working; an improved focus on data and evidence to shape future services; a much greater sense of partnership across the different organisations involved, including more involvement of hospital consultants and geriatricians in the community; and extensive and innovative engagement with patients, the public and professionals to shape the multispecialty community provider specification and develop ideas about how to better harness community assets.\(^{82}\)

**Main challenges to date**

In terms of the multispecialty community provider programme, the greatest challenge at the time of the research was establishing a provider with the right mix of expertise, skills and capacity as well as appropriate links to/relationship with general practice. Additionally, there was still work to be done to clarify governance and decision-making processes for the programme, for example the extent to which difficult decisions about finance and decommissioning would be devolved to the programme.

In terms of integration more widely, interviewees identified the following challenges:

- continuing to break down cultural and communication barriers between professionals in order to challenge the traditional ‘us and them’ mind-set
- securing ongoing involvement of partners who feel threatened by the programme and/or are risk averse and reluctant to embrace new ways of working
- implementing joint record-sharing across multiple agencies
- engaging patients and the public in discussions about the programme, as it is a new concept to the NHS and there are few existing examples to draw on.

Additionally, the presence of other vanguards in the Black Country region has meant that some partners are being thinly stretched as they are required to participate in transformation programmes in multiple localities.

The development of the Black Country and West Birmingham’s sustainability and transformation plan provides an opportunity and a challenge for Dudley. As in many other localities, it has led to debates about what can and should be achieved at the regional, sub-regional and local levels, and there is still work to be done to clarify the details of the Sustainability and Transformation Plan. Generally speaking, interviewees were optimistic about the opportunity for Dudley to shape the plan, and were positive

\(^{82}\) This includes a series of ‘listening events’ in over 30 groups in the borough and the development of the ‘All Together Better Activate Pack’ used to stimulate discussions in local communities: see http://www.colabdudley.net/activate/.
Integration 2020: Scoping research

about the wider environment for change in the Black Country which has three outstanding clinical commissioning groups\(^{83}\) and three new care model vanguards.\(^{84}\)

**Measuring progress and outcomes**

Dudley partners are in the process of developing an outcomes framework and metrics for the programme, which reflect the range of outcomes identified in the logic model. These include improved experience and outcomes for patients/users, higher levels of patient activation, increased staff engagement/empowerment, improved capacity and capability across community care and more appropriate use of secondary care. Running across these outcomes is a focus on the financial savings that they will deliver. Additionally, Dudley has also developed a specific outcomes framework for long-term conditions to deliver better outcomes for this group of patients/users.

Interviewees pointed to a wide range of indicators and data that was routinely collected across the system including Better Care Fund indicators, staff surveys, national audits, friends and family tests and patient/user feedback on individual services. Delayed transfers were the most controversial of the current measures, as individual organisations could be held responsible for what is a system-wide responsibility. A new development is the use of PSIAMS\(^{85}\) by link workers to measure patient/user outcomes and social value.

Several interviewees stressed the need for qualitative evidence, alongside hard metrics, to illustrate the benefits and impact of new ways of working. Suggestions included (1) patient stories, which illustrate not only how their care has changed, but how they are taking responsibility for their health, using services differently, participating in their communities etc., and (2) case studies which demonstrate how services are working in a more integrated way to support not only patients/users but also their carers and families with multiple care needs (e.g. elderly couples).

**Views on the Integration Standard**

Interviewees made some general observations about the Standard (see Appendix 1 for description), which may be helpful in further refining it and/or in making decisions about how it is used.

Dudley’s multispecialty community provider programme is much broader than health and social care: it is designed to support and sustain communities in partnership with voluntary and community sector organisations, housing and social enterprises. The Standard does not reflect this ‘whole systems’ approach and is, for some, too focused on the acute sector.

- Culture change and improved communication and relationships are vital enablers of integration: putting processes and systems in place will not, by

\(^{83}\) Dudley CCG, NHS Sandwell and West Birmingham CCG, and Wolverhampton CCG.

\(^{84}\) Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) in the West Midlands; Modality in Birmingham and Sandwell, and Dudley’s MCP.

\(^{85}\) www.psiams.com.
themselves, deliver better and more efficient care. It would be helpful for the Standard to reflect some of these more intangible enablers.

- Delivering integrated care has significant implications for the workforce and how they are deployed and trained. It would be helpful for this to be recognised in the Standard.
- There should be a degree of localised freedom in how the Standard is applied and assessed, as areas have approached integration in different ways, depending on their local health and social care economies.

Interviewees felt that the objectives identified in the standard are reflected in Dudley’s transformation programme, although they ‘don’t tell the whole story’. Interviewees’ specific comments on each of the objectives are set out in the table below.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reflections</th>
<th>Suggested indicators and ways of measuring progress/outcomes</th>
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<tbody>
<tr>
<td>Digital interoperability</td>
<td>Most interviewees see this as vital, and interoperable information systems are at the centre of the delivery mechanism for the programme. The use of the NHS number is embedded in NHS contracts for 2016/17 and 85 per cent of social care records include the NHS number. Having the right driver in place (a quality outcomes framework dashboard for IT) was central to moving primary care onto the same IT system. There is still work to be done to get full interoperability with partners across the multidisciplinary teams and in acute care, and getting the right drivers/incentives in place will be central to this.</td>
<td>Extent to which system-wide information governance is in place to support data/information sharing. Use of NHS number as an identifier across all relevant services.</td>
</tr>
<tr>
<td>High-risk cohorts targeted</td>
<td>Dudley’s teams are targeting high-risk patients/service users. Risk stratification relies on good IT and data from across the system including primary care, secondary care and social care. This data then needs to be made sense of in a multidisciplinary setting. There are many people who fall below the thresholds for various services. If prevention and early intervention isn’t prioritised, there’s a risk more innovative approaches will not be funded, which could end up costing the system further down the line.</td>
<td>Use of social care data as well as health care data in risk stratification. Description of integrated working around prevention and early intervention, and intended outcomes of this.</td>
</tr>
<tr>
<td>Value for money</td>
<td>Delivering efficiencies is one of the main drivers of the multispecialty community provider programme and is evident in the logic model. Some interviewees felt that a greater emphasis should be placed on improving outcomes, rather than financial savings, as savings will flow from better patient outcomes. The payment system in the acute sector engenders protectionism which can impact negatively on efforts to deliver efficiencies across the system.</td>
<td>In addition to measures like non-elective admissions and delayed transfers, the system requires longer-term indicators that acknowledge the time it takes for prevention/early intervention activity to deliver outcomes and savings.</td>
</tr>
<tr>
<td>Single assessment and care plans</td>
<td>Dudley’s model is based on having a lead accountable professional at the practice and locality level. Partners have made some progress on developing a common assessment and care plan, although there is still work to do to refine the approach and make care plans accessible across the system. Several interviewees questioned how much patients actually use care plans, which can become out of date quickly. Others stressed that having care plans in place doesn’t mean that partners across the system will actually use them.</td>
<td>It would be helpful to measure the extent to which patients feel they 'own' their care plan, and how much they use it in practice.</td>
</tr>
<tr>
<td>Integrated community care</td>
<td>The multispecialty community provider programme will deliver the full range of community physical and mental health care, social care and primary care. The health and social care economy is committed to seven-day services and Dudley was a national pilot site for seven-day service transformation. A number of services already operate on a seven-day basis, and support avoidance of unnecessary hospital admissions.</td>
<td>Gathering patient feedback, stories and outcome data will be important in demonstrating the impact of this new way of working, including on their own level of self-care. Case studies could be used to illustrate how different parts of the system have worked together to offer a seamless service to patients/service users.</td>
</tr>
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Timely and safe discharges

Dudley has a delayed transfer of care improvement plan in place to reduce unnecessary admissions, improve patient flow and ensure appropriate community support is in place. The use of integrated care or multispecialty community provider beds in future may reduce the need for acute beds.

It is important that delayed transfers are understood within the wider system of care: focusing on the ‘back end’ of the system is unhelpful as there is much that can and should be done to prevent some people from needing to attend hospital in the first place.

Fines imposed on social care only reduce the resources available for future activity.

Delayed transfers can be a useful measure but need to be viewed within the context of the whole system of care, and the availability of seven-day services in the community which can facilitate discharges.

Social care embedded in urgent and emergency care

Many interviewees see this as essential. GPs and other professionals need to think more broadly about the range of options open to patients, rather than relying on acute beds.

As social work resources have been significantly reduced, it is unclear how this would be funded.

Summary

Partners in Dudley had been progressing integrated care prior to the multispecialty community provider programme, however achieving vanguard status has been a significant vote of confidence in Dudley’s ambitions and plans. The infrastructure is in place to facilitate the programme, and at the time of research, work was ongoing to establish a suitable provider which would be operational by April 2018. In the future, Dudley partners will be taking forward a wide range of activities including: embedding multidisciplinary working, piloting multidisciplinary teams for mental health, introducing lead accountable professionals, delivering the Better Care Fund work streams aimed at the frail and elderly and their carers, developing interoperable information systems and improving discharge pathways, among many other things. Interviewees identified two main ways in which the Department of Health could support their work: (1) identifying and sharing learning from elsewhere, including the lessons learned from integration programmes which have struggled or failed; and (2) addressing the challenge faced by local areas which have hospitals weighed down by significant Private Finance Initiative debt, as is the case with Dudley Group NHS Foundation Trust.
Figure 2: MCP logic model

A: RATIONALE
Changes in the nature and scale of demand, allied to significant resource constraints, have rendered our current models of care unsustainable. Different population groups have different needs, requiring improvements in access, continuity and coordination. Primary care is uniquely positioned to support these changes, leading integration with other services and sectors. Dudley’s MCP has been established to catalyze this.

B: INPUTS
- Changes in ‘mainstream’ CCG investments to implement MCP
- In-kind support from partner organisations and changes in their investments
- Transformation fund

C: PRIORITY THEMES & ACTIONS
ACCESS
- Primary care at scale
  Development programme / locality working; standardise back office; guidance to GPs
  Single patient portal
  Consolidate systems; add in other telephony services / telehealth
  Clinical pathways
  Standardise pathways, supporting protocols and templates; pilot open access services
  Primary and community estates
  Create multi-functional hubs

CONTINUITY
- Long Term Conditions Framework
  Replace QOF / LSS to incentivise pro-active management; use of standardised tools on EMRS
  Telehealth and patient activation
  Unified telehealth solution (Sense.ly); Patient Activation Measure
  Enhanced pharmacy in primary care
  Medicines reviews for complex cases

COORDINATION
- Multi Disciplinary Teams
  Extend and roll out (incl risk stratification)
  End of life care
  Training programme; engage homes; Care Plans
  New types of worker
  Frail elderly ‘team without walls’
- Public / patient engagement
- Better use of digital technology
- Contract development
- Governance
- Evidence / analytics
- Programme management and partnership

D: INTERMEDIATE OUTCOMES
- Improved access to care
- Improved systems and skills in primary care; reduction in back office costs - more efficient use of resources
- Improved estates in primary / community care
- Improved and quicker access to information, advice and guidance (patients and staff); find it easier to do the right thing, sooner
- Reduced unwarranted variation in pathways; more appropriate referrals
- Better care planning; increased patient knowledge of condition(s); increased ability to self-manage
- More proactive, targeted diagnosis and management of higher risk patients; better medicines management
- Improved patient access to holistic support services (e.g. voluntary sector)
- New ‘generalist’ roles: the workforce is better matched to need

E: OUTCOMES
- Increased capacity and capability in primary and community care; more services provided out of hospital (associated savings)
- Reduced (and more appropriate) use of secondary care; improved discharge (associated savings)
- Improved outcomes for higher risk patients; they are more ‘activated’, in control of their care and self-managing; reduction in inequalities (associated savings)
- Improved patient experience of care; reduced patient social isolation; better quality of life - incl at the end of life (associated savings)
- Increased staff empowerment / engagement and reduced ‘burn out’ (associated savings)

F: IMPACTS
- Improved quality and quantity of life for all people in Dudley (Health & Wellbeing Gap)
- An integrated and self-improving system of care based on principles of mutualism (Care & Quality Gap)
- A sustainable – and replicable – ACO-type model founded in primary and community care (Finance & Efficiency Gap)

G: CONTEXTUAL FACTORS
- National policy / regulation / funding; patient / public expectation; support from local partners; supply of appropriate workforce

45
SCIE would like to thank the following people who contributed in some way to the development of the Dudley case study.

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
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<td>Helen Codd</td>
<td>Engagement Manager, Dudley CCG</td>
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<td>Jayne Emery</td>
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<td>Tony Oakman</td>
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<td>Laura Broster</td>
<td>Director of Communications and Public Insight, Dudley CCG</td>
</tr>
</tbody>
</table>
Integrated care in Southampton

Vision and model

Southampton’s City blueprint sets out a vision of integrated health and social care that is: 'delivered across the full life course, is as local as possible, promotes individuals taking control, is person centred, and rooted in their community'.

Southampton partners’ commitment to this vision is evident in its ambitious, five-year Better Care Fund (BCF) Plan, and a pooled budget on behalf of Southampton Council and Southampton City Clinical Commissioning Group of over £130 million, nearly nine times the minimum Better Care Fund requirement. The city benefits from having a coterminous local authority, commissioning group and community health care provider.

To achieve their shared vision, Southampton partners are implementing a number of complementary programmes of work under the banner of ‘Better Care Southampton’. This includes:

- integrated primary, community, social and mental health care teams operating in six geographical clusters across the city
- integrated discharge, rehab and reablement services, which bring together the health and social care community and inpatient rehab and reablement, alongside crisis services
- building community capacity through a range of initiatives including care navigators, increased support for carers, increased access to personal budgets and improving the use of community facilities.

Southampton partners have drawn on the National Voices ‘I statements’ to drive the transformation of care so that it meets what patients/users want – see Figure 1.

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86 Southampton City CCG and Southampton City Council, ‘Better Care Southampton – The Vision One Year On’ (February 2016).

87 Partners include: Southampton City Council, Southampton City CCG, Southampton Voluntary Services, Southampton Healthwatch, University Hospitals Southampton NHS Foundation Trust, Solent NHS Trust, Southern Health NHS Foundation Trust and GP practices.
Main successes to date

Interviewees agreed that leaders across the system are fully committed to delivering Better Care Southampton and that there have already been some notable successes, including the following.

- The establishment of integrated health and social care teams, with integrated management and systems, to deliver discharge, rehab and urgent response services. This has meant improved communication across the system, streamlined processes and quicker and more effective troubleshooting. Non-elective hospital admissions have reportedly reduced as a result, as have delayed transfers of care.  

- The establishment of six clusters (and leadership teams) for integrated working, based around groups of GP practices. These include representation from community nursing, mental health services, housing, social care, primary care and the community and voluntary sector. Work is ongoing to develop shared leadership and management arrangements in the clusters.

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88 Southampton City CCG and Southampton City Council, ‘Better Care Southampton – The Vision One Year On’ (February 2016).
Multiple examples of joint working across the system including: a voluntary and community sector-led care navigator pilot operating in two GP clusters; an integrated health and voluntary team delivering a public health nursing service for 5–19 year olds; specialist nurses working with the over 75s in partnership with cluster teams, and work between accident and emergency and the ambulance service to support those with drug-related issues.

More generally, interviewees pointed to much improved relationships and levels of partnership working across the system, including with the relatively newly formed GP federation.

**Main challenges to date**

The financial climate provides a strong driver for change, but has also meant that some partners have found it hard to sustain their engagement with this work when they are dealing with shrinking budgets as well as staff recruitment and retention issues. This has meant slowing the pace of change at times, ‘parking’ activities until a later date and re-explaining the work to newly recruited members of staff. Another challenge has been varying levels of engagement on behalf on some GP practices, which are central to cluster working. Interviewees suggested various reasons for this, including legitimate concerns about quality, accountability and governance issues in relation to integrated working; a lack of capacity to attend the engagement activities and events needed to move this work forwards; and a wider range of significant pressures with which they are grappling.

More broadly, interviewees pointed to system-wide issues which are subtly counterproductive to fast-paced integration. These include: activity-based funding, block contracts and payment-by-results in the NHS; combined commissioner/provider roles in local authorities; and differing financial and political priorities in health and social care. Interviewees stressed the challenging and long-term nature of this work, with one stating: ‘There are no quick wins. You have to put the time and effort into partnership working. You need to be constantly working on this in order to drive change within your own organisation as well as others.’

Interviewees identified a number of enabling factors for integrated working: being very clear about the function of integrated teams/ways of working before proceeding; changing organisational cultures and professionals’ mind-sets; adjusting professionals’ contracts, terms and conditions so that they support integrated working; involving ‘wider’ partners such as the police, probation service, and employment services who are often working with the same clients/patients as health and social care.

**Measuring progress and outcomes**

Interviewees generally felt that the current Better Care Fund indicators are helpful in measuring progress and outcomes in relation to integration, but that they don’t capture the extent to which services are working in an integrated way on the ground. Many pointed to the need for process measures that ‘sit underneath’ hard metrics, such as avoidable hospital admissions in order to capture the extent to which any changes can be attributed, directly or indirectly, to integrated ways of working.
At the team or service level, interviewees underlined the importance of having jointly owned key performance indicators, targets and outcomes to avoid one partner being ‘blamed’ for low performance or poor outcomes, which are dependent on multiple parts of the system and/or external factors which they can’t directly control. Delayed transfers of care were most commonly mentioned in relation to this.

Interviewees stressed the importance of capturing the experiences and views of patients/users, carers and frontline staff in order to truly understand if and how the system of care has improved and any impact this is having. Southampton partners have done some interesting work to develop a method and tool for capturing patient/user feedback about the system of care (not just individual services), using the ‘I statements’ that underpin its model (see Figure 1 earlier). The approach will continue to be refined over time to ensure that it’s fit for purpose. Other methods of capturing feedback from patients and staff include Southampton HealthWatch’s website, where the public can comment on the care they have received; staff surveys; and the staff family and friends test carried out by relevant NHS organisations.

**Views on the Integration Standard**

Interviewees felt that the seven objectives in the Standard are reflected in the work being taken forward in Southampton, however they made a number of observations which may be used to enhance the Standard or the way that it is used.

- Southampton is taking a ‘total place’ approach to integrated care which involves a range of partners outside of health and social care, such as the voluntary and community sector. This comprehensive approach to integration, and the contribution of partners outside health and social care, should be recognised when assessing Southampton’s progress and success.

- Achieving integrated care is reliant on a number of important factors including: place-based leadership, values and behaviours; good governance for system-wide decision-making; training and development for staff to work in a multidisciplinary way; and developing a shared culture and behaviours within integrated teams. These are implied, but not explicitly mentioned, in the Standard.

- Several stakeholders emphasised the importance of making explicit links between the system-level requirements of the Standard and intended outcomes for patients/users and carers.

One interviewee reflected on the significant workforce implications of delivering the Standard: ‘Implementing the Standard means a move away from single, disease-focused solutions to more generalist solutions. It’s implied but not explicit in the Standard … What I see on the ground is a growing number of people with co-morbidities and social isolation. There are major implications of dealing with this for the workforce, for example having more teams with a generalist focus.’

Another interviewee suggested that the Standard could usefully be turned into ‘I Statements’ for organisations and staff to help filter it through the system, and reinforce
professionals’ responsibilities for working in an integrated way. Interviewees’ reflections on the details of the Standard are summarised in the table below.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reflections</th>
<th>Suggested indicators and/or ways of measuring progress and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital interoperability</td>
<td>This is an ambition for partners across the city, however many stressed this is an enabler of integration, not an end in itself. Some organisations will take longer than others to get to this point.</td>
<td>Indicators could include: extent to which data sharing protocols are in place across the system, and extent to which information/data is actually being shared across the system.</td>
</tr>
<tr>
<td></td>
<td>Addressing issues relating to information governance and data-sharing is an important enabler of integrated care. A lack of digital interoperability should not prevent progress on integration if data sharing agreements are in place.</td>
<td></td>
</tr>
<tr>
<td>High-risk cohorts targeted</td>
<td>Southampton partners are targeting high risk cohorts through cluster working, currently targeting the over 65s, with plans to extend this to the over 55s. While targeting is important, many felt that there also has to be an element of integrated prevention/early intervention activity.</td>
<td>Indicators could include: extent to which health and social care data are being combined to identify those most at risk, and proportion of the population that are being targeted (1, 5, 10 per cent etc.).</td>
</tr>
<tr>
<td></td>
<td>Risk stratification is very useful, however it is only as good as the available data. It is important to include social care and community health data in the risk stratification, however this can be harder to access.</td>
<td></td>
</tr>
</tbody>
</table>
| **Value for money** | Delivering efficiencies across the system is a primary driver for Southampton partners, and there are clear plans for making efficiencies through reducing delayed transfers and bed days.  
It is very hard to prove value for money in relation to prevention/early intervention activity, which runs the risk that this will be neglected in favour of ‘quicker wins’.  
The right incentives need to be in place to encourage all partners to ‘play their part’ in delivering value for money. | Reduction in residential and other care bed days needs to be taken into consideration alongside reduction in hospital beds. |
|-------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| **Single assessment and care plans** | Southampton partners have been working on this for a number of years and there is still some way to go before it is universally applied.  
Developing a single assessment and care plan is an important process, but not an end point. It cannot be assumed that single assessments and care plans will automatically lead to better outcomes for patients. | It is important to assess the extent to which a patient understands their care plan and has control over it.  
Patient reported outcome measures and patient reported experience measures could be used to understand the extent to which patients feel that a single assessment and care plan has impacted on their care and outcomes. |
| **Integrated community care** | Southampton’s partners deliver integrated community care through its multidisciplinary cluster teams, as well as a range of other initiatives.  
There is still some way to go to deliver a seven-day service in the community, which would facilitate more weekend discharges from hospital. | As with the point above, it will be important to measure the impact of integrated community care on patients and carers.  
Could measure weekend discharges from hospital as a proportion of all discharges. |
| Timely and safe discharges | Integrated discharge, rehab, reablement and urgent response services are reportedly reducing delayed transfers in the city. Delayed transfers need to be treated as a shared responsibility across the system, with organisations taking collective responsibility for reducing them. The ability of one organisation to levy financial penalties on another is counterproductive to collaborative ways of working, and can engender a blame culture. ‘Safe’ and ‘timely’ require equal emphasis, so as to avoid a situation where patients are discharged quickly, only to reappear in the system due to unsuitable accommodation or care. | How well is the system responding to delayed transfers, i.e. how proactive are partners in managing and/or preventing delayed transfers, as opposed to responding in a reactive way? An alternative to delayed transfers could be overall length of stay in hospital and non-elective admissions to hospitals, both of which partners are collectively trying to reduce. |
| Social care embedded in urgent and emergency care | Interviewees agreed that this was important and most felt that Southampton was doing well in this respect. Other services, such as care navigators, could also have a useful role to play within urgent and emergency care. | |

**Summary**

Southampton leaders have a clear plan for integrating health and social care at scale, and considerable progress has already been made. The blueprint sets out a range of intended outcomes for Southampton’s residents over the next five years which will be delivered through a range of interdependent programmes of activity. These include (but are not limited to): embedding integrated cluster working and widening the pool of patients eligible for support; developing telecare; identifying lead professionals to help coordinate care; better utilisation of community assets; extending the use of personal health budgets; and further work on integrated care plans.

Interviewees identified a number of ways in which the Department of Health could facilitate this agenda: identifying and sharing effective/good practice in relation to implementing integrated care; providing guidance as to how local areas can use financial incentives, such as CQUINS, to encourage organisations to work more closely together; encouraging wider partners such as the probation and employment services to participate in the integration agenda; advising clinical commissioning groups about procurement models which best support integrated working, since competitive tendering can be counterproductive when trying to establish relationships between multiple...
agencies on the ground; and altering the regulatory system so that it is aligned with integrated service provision by multiple organisations.

SCIE would like to thank the following people who contributed to the development of the case study.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role / Organisation</th>
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<tbody>
<tr>
<td>Dr David Payton</td>
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<tr>
<td>Alex Whitfield</td>
<td>Chief Operating Officer, Solent NHS Trust</td>
</tr>
<tr>
<td>Rob Kurn</td>
<td>Deputy Chief Executive of Southampton Voluntary Services, Manager of Healthwatch Southampton</td>
</tr>
<tr>
<td>Sharon Stewart</td>
<td>Service Manager, Southampton City Council</td>
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<tr>
<td>Moraid Forrest Charde</td>
<td>BCF lead / Integrated Care Transformation Manager, Southampton City CCG</td>
</tr>
<tr>
<td>Jamie Schofield</td>
<td>Senior Commissioner, Southampton City CCG</td>
</tr>
<tr>
<td>Rachel Bailey</td>
<td>IDB Operational Manager, University Hospital Southampton</td>
</tr>
</tbody>
</table>
Integrated care in Mid-Nottinghamshire

**Vision and model**

The ‘Better Together’ programme in Mid-Nottinghamshire is one of NHS England’s vanguard Primary and Acute Care Systems (PACS), announced in 2015. It is intended to deliver a whole-system integration of hospital, community, social and primary care. It is a vanguard site for developing new ways of paying health providers, moving away from paying for each activity completed, towards outcomes-based capitated contracts. This will be enabled through moving from a predominantly reactive hospital-based system of urgent care, to one of home-based proactive care. Social care services and personal budgets will align and run alongside these contracts. Prior to the Primary and Acute Care System, system leaders in Mid-Nottinghamshire had recognised the need for change and established the Mid-Nottinghamshire Transformation Programme in 2013, which laid the foundation for the Primary and Acute Care System. The programme comprises four core workstreams (and associated projects/interventions), summarised below.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Proactive care</strong></td>
<td>Expand integrated health and social care community services (known as PRISM – ‘profiling risk, integrated care and self-management’) to create much improved and proactive care for frail and elderly people and those with complex and/or long-term conditions.</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Provide urgent care services to ensure people receive the right care in the right place from the right professional. A care navigator service will help professionals ensure people can access the right service(s) as quickly as possible.</td>
</tr>
<tr>
<td><strong>Elective care</strong></td>
<td>Review each specialty to ensure that quality, safety and viability standards are met and use existing capacity more effectively, providing care closer to home from specialist professionals.</td>
</tr>
<tr>
<td><strong>Women and children</strong></td>
<td>Provide rapid medical assessments for children and pregnant women, and ensure that children with complex needs have more joined up packages of care and more support within the community setting.</td>
</tr>
</tbody>
</table>

Partners in Mid-Nottinghamshire have developed a Commissioner Provider Alliance Agreement to underpin the Primary and Acute Care System, which means that they are legally bound to work in partnership and make collective decisions on the use of available public funds. Supporting the Alliance Agreement is a set of principles to guide difficult decision-making, based on what’s best for local people and the most effective

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89 Full members: NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, Nottinghamshire County Council, Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, East Midlands Ambulance Service NHS Trust, NEMS Community Benefit Services, Nottinghamshire Healthcare NHS Foundation Trust. Associate members: United Lincolnshire Hospitals NHS Trust, Circle Nottingham, TEAM consortium – voluntary sector special purpose vehicle which includes three district community and voluntary services organisations.
use of public funds. Distinctively in Mid-Nottinghamshire, social care (the responsibility of the county council) is a full member of the Alliance. A process was also developed to select social care providers and partners to join the Alliance. Mears Care Ltd and Mansfield District Council have been successful and are now due to join as associates. An overarching Alliance Leadership Board directs and leads the Alliance and sets its overall strategic objectives.

The system of governance across the whole of Nottinghamshire, which includes the county council, the city council, seven district councils, seven clinical commissioning groups, as well as three acute trusts, two community providers and a mental health trust, adds a layer of complexity to this agenda. There are three different emerging models of integrated health and social care in the county, working to different timescales and expectations. Mid-Nottinghamshire is the most advanced in terms of progressing its plans.

**Main successes to date**

Interviewees pointed to much improved strategic relationships across health and social care as a result of the Mid-Nottinghamshire transformation programme. At the operational level, two main achievements stood out.

- The establishment of local integrated care teams (LICTs) which deliver the PRISM approach in the community. Social care staff work alongside a range of health professionals to identify and support patients at greatest risk of hospital admission. Staff in these teams are felt to have a much better understanding of each other’s roles, and are reportedly improving patients’ experiences of care and reducing non-elective admissions to hospital. The risk factors are due to be broadened so that the teams can also target people at risk of developing high social care needs, to be able to intervene to avoid or delay a trajectory into residential care.

- Innovative, integrated working with Mansfield district where ASSIST housing officers work with county council social care staff and hospital staff to proactively identify and support patients who have housing issues that prevent them from being discharged from hospital. Independent evaluation by Nottingham Trent University has shown significant financial savings (in terms of reduced bed days) as a result.

Other achievements identified by interviewees included the establishment of the Self Care Hub, a ‘single front door’ to King’s Mill hospital and primary care, and the care navigator service. More broadly, interviewees commented that the Alliance Agreement has created an environment in which organisations are increasingly discussing how they could work together to improve services, over and above existing programmes of work. As one interviewee put it: ‘Everyone has terrific enthusiasm for the Alliance and it means we are regularly talking to each other now.’

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90 An MCP in primary care in Rushcliffe, Nottingham city’s enhanced health in care homes, and Mid-Nottinghamshire’s PACS, all of which are new models of care vanguards.
Additionally, some felt that the presence of three integrated care vanguards\(^1\) in the county, and two integrated care pioneers,\(^2\) provided significant opportunities to share learning and effective practice to the benefit of all.

**Main challenges to date**

Interviewees talked about the differences between health and social care that needed to be navigated in order to progress the integrated care agenda, including different governance arrangements, target populations, cultures, terminology, ways of working, tolerance to risk and quality standards. Several interviewees referred to the ‘difficult conversations’ that were a necessary part of the process of establishing the Alliance and the commissioning process, which initially considered the option of a single accountable provider (SAP) as a potential model. Other challenges identified by interviewees included:

- a lack of robust research evidence, nationally and internationally, to prove that integrated care will deliver the kind of financial savings that are required across the system
- linked to the point above, managing stakeholders’ expectations about the scale and timeframe for financial savings to be realised, particularly from the local integrated care teams
- ensuring that integrated services keep the best elements of health and social care professions and services, and ensuring that professional identities (particularly of social workers) do not get subsumed in teams dominated by health care professionals.

Some interviewees felt that the biggest challenges are yet to come, when difficult decisions about resource reallocation and/or decommissioning will need to be made. The principles and behaviours that all Alliance members have signed up to will help to support these discussions.

**Measuring progress and outcomes**

Interviewees stressed the need to develop new metrics which are aligned to the new model of care being implemented in Mid-Nottinghamshire. Partners have developed a single integrated outcome framework for the Primary and Acute Care Systems intended to realign risk and reward within the system. It contains four outcome domains (population health, quality of life, quality of care and effectiveness of care) which were developed through a literature review and extensive engagement with local residents and clinicians. Measures include nationally mandated indicators, including integration metrics, as well as patient/user feedback. Delivery against the outcomes in the framework will be linked to the payment of health providers, and it is expected that this approach will support capitation payments and encourage innovation.

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\(^1\) An MCP in primary care in Rushcliffe, Nottingham city’s enhanced health in care homes, and Mid-Nottinghamshire’s PACS.

\(^2\) Nottingham city and Nottinghamshire county are integrated care pioneers.
Interviewees made two main points about measuring progress and outcomes moving forward: (1) the need to be realistic and open about the time lag between interventions and their intended impact, which can sometimes be significant; (2) the vital importance of capturing service user experiences and perceptions of integrated care in order to understand how care has changed for those who require it and the impact this has had.

**Views on the Integration Standard**

On the whole, interviewees felt that the Standard reflects some potential characteristics of an integrated health and social care system, however these are process- rather than outcome-focused. Interviewees stressed that integration can take many different forms, therefore the Standard will need to allow for local variation. At present, positive outcomes are being delivered, with social care being closely aligned with health through the Alliance, but the two are not structurally integrated. Nottinghamshire County Council's Adult Social Care Committee developed a set of social care guiding principles for any model of integration. Resource intensive structural reorganisation should only be considered if it will achieve better outcomes for the citizens of Nottinghamshire that cannot be achieved without doing this. ‘I do think it’s useful to have the Standard, but the danger is that people see it as “that’s it”. We need to be thinking about the local angle and local variations.’

Interviewees felt there were a number of important elements of integrated care that could be made more explicit in the Standard, including:

- systems leadership, which is one the biggest contributory factors to the success or failure of complex change programmes
- the role that housing, public health and the voluntary and community sector have to play, particularly in relation to prevention and early intervention
- the importance of prevention, patient activation or self-management in helping reduce demands on the system
- recognition that people with mental ill health, children, young adults and others also stand to benefit from integrated care – it shouldn’t be assumed that the Standard only relates to the elderly or those with physical health care needs.

Additionally, some felt that the Standard was too focused on health and the acute sector in particular, and that it needed to focus on ‘the whole system’ including the input of, and impact on, social care and other partners.

Interviewees’ comments on the individual objectives contained in the Standard are set out in the following table.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Reflections</th>
<th>Suggested indicators and/or ways of measuring progress and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital interoperability</td>
<td>Many felt that this is an important ambition and noted that partners have been working on it for a number of years. However, one interviewee stated ‘we need to be really honest and ask ourselves if it is ever going to actually happen’. Others made the point that overcoming barriers relating to information governance and data sharing is more important than partners all using one system, and is a significant task in its own right.</td>
<td>Given the challenge of achieving digital interoperability, it would be more helpful to look for evidence of local shared systems and information-sharing agreements.</td>
</tr>
<tr>
<td>High-risk cohorts targeted</td>
<td>The local integrated care teams have a key role to play in identifying and supporting high-risk cohorts. Currently, risk stratification uses only health data and partners are looking at ways to include social care data alongside this. It can’t be assumed that risk stratification is sophisticated enough to pick up all the ‘right’ people – the information systems on which it relies are not perfect. Additionally, clarity about the parameters/timeframe around risk is required (e.g., some people have underlying risks such as obesity, which could translate into diabetes in the future). A personal budget is not the first port of call for social care, but rather the last option if a person’s needs are not able to be met through first providing ‘front end’ services such as information, reablement, prevention services, assistive technology, etc.</td>
<td>As well as targeted care, it would be helpful to seek evidence of a shared strategic vision and strategy for medium and low risk cohorts. A helpful measure could be the proportion of people receiving integrated care through an multidisciplinary team where the need for more intensive health and/or social care is reduced, as well as the categories of people receiving support (e.g., those with physical health needs, mental health, children, young people etc.).</td>
</tr>
<tr>
<td>Value for money</td>
<td>Value for money needs to be assessed at the system level, as it is possible for one part of the system to benefit at the expense of another. Partners need to be clear about where savings will accrue and what organisations are going to do with any savings (e.g., reducing waiting times). Reduced bed days are a process measure – they don’t say anything about value added.</td>
<td>Need to develop system-wide measures of value for money. Quality of life/wellbeing is an important element of achieving value for money.</td>
</tr>
</tbody>
</table>
There is an inference that less time in hospital is equivalent to better care, which is not always the case.

It would be helpful to distinguish between different types of hospital admission (e.g., an admission for a rapid assessment is very different from a long-term admission of an elderly person with high care needs). Currently they are considered as single cohort.

<table>
<thead>
<tr>
<th>Single assessment and care plans</th>
<th>The local integrated care teams create multi-professional care plans, and a range of different professionals (housing workers and accident and emergency staff) can complete single assessments. Having a single assessment and care plan across health and social care can be challenging, as they fulfil different purposes and some people require social care but no health care and vice versa. The social care assessment process is first focused on supporting the person to (re)gain their independence and, if required, is also used to inform the monetary amount of any eligible personal budget. Completing a single assessment and a care plan does not, in itself, guarantee improved experience of care or better outcomes.</th>
<th>As well as measuring the extent to which patients/users receive a single assessment and care plan, it is important to measure the extent to which they feel it has made a difference to their care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated community care</td>
<td>The local integrated care teams are delivering integrated community care, primarily for those with physical health needs. Several interviewees reiterated the point that those with mental ill health should also be included, as should other groups with complex needs, including children and young adults. From experience, partners in Mid-Nottinghamshire have learned that integrated community care isn’t needed 24/7 in every setting.</td>
<td>Need to be looking for evidence of certain things being in place (e.g., an integrated commissioning plan across health, social care and housing that illustrates how money will flow across the system from acute care into integrated community services).</td>
</tr>
<tr>
<td>Timely and safe discharges</td>
<td>There are a number of interventions being implemented to reduce delayed transfers of care, including housing officers working with hospital discharge teams and the ‘transfer to</td>
<td>Measuring delayed transfers is helpful, but additional metrics are required to understand</td>
</tr>
</tbody>
</table>
assess’ scheme. It is also important to look at internal processes within hospitals to speed up the discharge process (e.g., it can take hours to get the paperwork signed by the range of professionals required to do so).

It is possible to put many things into the system to prevent delayed transfers, but it would make it unsafe. Need to give ‘timely’ and ‘safe’ equal emphasis.

### Social care embedded in urgent and emergency care

Mid-Nottinghamshire does have social workers based in hospital settings. Experience has shown that scarce social work resources need to be properly targeted to ensure their best use: it is possible that not all urgent and emergency care facilities require social care input seven days a week.

Some interviewees questioned how this would be resourced on an ongoing basis.

### Summary

Partners in Mid-Nottinghamshire feel that considerable progress has been made in transforming the health and social care system, but were keen to point out that there is still a long way to go to achieve their vision. Looking ahead, interviewees identified a number of activities, and potential challenges, including: testing the risk and reward framework in practice; implementing capitated payment mechanisms; evidencing the efficiencies delivered through integrated working; collectively shaping the market, particularly in relation to nursing homes and domiciliary care; and establishing primary care hub working, among many other things.

Interviewees identified a number of ways in which the Department of Health could support their transformation work: (1) providing guidance on integrated key performance indicators (KPIs) and how these translate into improved outcomes for patients/users; (2) providing clarity on the purpose of the Integration Standard and how it will be used; and (3) collating and sharing learning from other areas.
SCIE would like to thank the following people who contributed to the development of the case study.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/organisation</th>
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</thead>
<tbody>
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<td>Sue Batty</td>
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<td>Hayley Barsby</td>
<td>Deputy Chief Executive and Director of Communities, Mansfield District Council</td>
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<tr>
<td>Tony Berryman</td>
<td>Chair of the Mid Notts Better Together Citizens Board; Member of the Mid Notts Alliance Board; lay representative on the Mansfield and Ashfield and Newark and Sherwood CCGs</td>
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<td>Interim Director of Public Health, Nottinghamshire County Council</td>
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<td>Amanda Sullivan</td>
<td>Chief Officer, NHS Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
</tr>
<tr>
<td>Jez Alcock</td>
<td>Chief Executive, Healthwatch Nottinghamshire</td>
</tr>
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</table>
Integrated care in York

Vision and model

Integrated services are developing in York from the ground up through a set of pilots. The model’s foundation has been the intensive identification, proactive monitoring and care planning and coordination for at-risk patients, starting from the GP practice and providing an enhanced set of services through multidisciplinary teams, which become a single point of access for users. In effect, this places integration squarely within planned care, rather than primary care. The multidisciplinary teams operate five days a week, and they consist of a GP, a nurse, an administrator or care coordinator, and a social worker from the council. Additional support from therapists and the reablement team is provided, as needed, usually on alternate weeks. Enhanced funding has been dedicated to the rapid response team. The City of York has also funded a hospital-based social worker to assist with identifying patients and supporting their discharge, such that care is provided within two hours of leaving hospital. However, continuing health care is considered to be poorly managed, and there is a lack of step-down beds. The intention is to roll this model out further from the initial pilots, although funding has not been fully agreed. Over the long term, daily care coordination is anticipated. Achieving the standard of fully shared care records continues to be a ‘massive, massive problem’. Governance arrangements between the partners have enabled them to work around data-sharing difficulties for the time being.

While it is early days for integration in York, the ambition for integration is much broader than current provision, but it is directly challenged by a long-standing unstable health economy and now the Sustainability and Transformation Plan. The unwieldy footprint, the ‘top-down’ process, complicated governance and the absence of local community engagement were cited as concerns by local leaders because they do not resonate with their intentions of developing a new operating model, which is community asset based, and complicates their local efforts, which are underway through a dedicated and focused integration transformation board. For the City of York, the solution is to focus on place-based planning, and interviewees commented that the precarious financial position of the local health and care economy has brought partners together. For most interviewees, changing the model of care was considered more important than creating new organisations or structures. The stated ambition is to ‘change the offer’ to local citizens, and it emphasises interventions that shift demand away from public services and reduce existing paternalism, applied to the whole population, not just the frail elderly. These interventions include: better information and advice services, the development of prevention and early intervention services, the inclusion of mental health services and wider community assets, better use of assistive technology and integrated personal commissioning (personal budgets). A joint commissioning strategy and greater pooling of local resources are also planned.

Main successes and challenges to date

It is relatively early days for the delivery of the York integration model; it has not been taken to scale across all GP practices, and it continues to evolve. Relationships and trust are emerging. Silo working persists, and there is a great deal of room for improvement.
One of the main challenges is demonstrating the full impact of the proactive care planning model at the system level. The partners fully recognise that this may be difficult because the time required to shift demand and behaviours, as well as changing culture and behaviours, both in the staff and those in receipt of services, takes time.

For the people served by multidisciplinary teams, the assessment and care planning processes are beginning to show benefits, such as swifter access to urgent care needs and more proactive interventions. The area has not ‘been brilliant’ at reporting and sharing data, or using this intelligence. Data-sharing concerns remain a barrier to the expansion of the model.

An additional concern is the availability of a workforce to pursue the integration model fully; therefore a joint commitment to workforce development is an imperative as an area previously considered to be under-resourced.

**Measuring progress and outcomes**

The clinical commissioning group and local authority are monitoring the required integration metrics, including non-elective admissions, A&E attendances, delayed transfers of care and number of people going into residential care. User experiences are also collected; these consist of satisfaction questions. The impact of integration has been limited so far because not all GP practices have been involved with integration or use multidisciplinary teams. The funding crisis for the clinical commissioning group, which is now in special measures, has been exacerbated by the level of acute sector activity. Several people noted difficulties with the Better Care Fund arrangements and assumptions, citing misunderstandings about the potential of interventions to generate savings, as opposed to stemming the year on year increase in demands.

Without a more sophisticated evaluation, it is difficult to determine the impact (attribution of cause and effect) of the local integration model on hospital activity. The main indicators, such as non-elective admissions and length of stay have been going in the wrong direction, probably due to wider system behaviours rather than the failure of the integration model. Partners are starting to map care pathways to address the various potential causes, and they are actively identifying interventions that have system-wide effects, such as an acute liaison service for mental health.
Views on the Integration Standard

<table>
<thead>
<tr>
<th>Objective</th>
<th>Reflections</th>
<th>Suggested indicators and/or ways of measuring progress and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital interoperability</td>
<td>Digital interoperability is definitely seen as an enabler, but some believe the problem is with the NHS. Using the NHS number makes sense. Digital interoperability is a process and not an outcome. Several people commented that they did not understand what the digital maturity index was or how it was intended to be used.</td>
<td>Define the benefits of digital interoperability to service users and professionals in the system. How well are we achieving these outcomes? Describe what a ‘good’ system looks like (e.g., is it a shared platform or a separate system that shares records?).</td>
</tr>
</tbody>
</table>

| High-risk cohorts targeted       | Risk stratification tools should identify people at risk of high service demands across primary, community, mental health and acute services. This is based on condition as well as previous hospitalisation. The standard seems focused on older people and not other population groups with complex needs. Several questions were raised about how high risk was being defined. As described in the Standard, the measure is skewed towards risk of hospitalisation. In regards targeting resources, there should be some recognition that people’s conditions are variable. It may not be wise to target only the top percentage of users, as people’s health can both improve and decline. | Should we also be measuring support for other types of ‘high-risk’ users with complex needs, such as children? |


<table>
<thead>
<tr>
<th>Topic</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Value for money</td>
<td>Many commented that the description reflects a bias towards acute care spending as the basis for determining the value of integration interventions. This represents limited thinking and a different underlying philosophy, reducing integration efforts to cost-saving priorities, rather than doing what is in the best interests of users. Wellbeing and quality of life were also seen as important considerations. Joint commissioning was also seen as producing better value for money, but it is not reflected or measured in the Standard. Integrated personal commissioning is also expected to expand.</td>
</tr>
<tr>
<td>Single assessment and care plans</td>
<td>Like digital interoperability, this measures process and not outcomes. Nonetheless, effective care planning and care management are core components of the York model. There was more interest in whether care plans make sense, and their effects on individuals, than their impact on bed days. How can we measure outcomes in primary care? The voluntary sector? Self-management?</td>
</tr>
<tr>
<td>Integrated community care</td>
<td>The York model is based on proactive primary care. They see themselves at the beginning of a journey to identify better system outcomes. What would therefore be helpful to them locally are descriptions of what ‘good’ looks like, perhaps defined as a set of stepping stones. Descriptions of the stages of development local areas can achieve, recognising that localities are at different starting points on their journey toward integration.</td>
</tr>
<tr>
<td>Timely and safe discharges</td>
<td>Delayed transfer of care as a measure was seen as highly relevant, but the indicator needs to be analysed in more detail in order to understand what is happening within the system and how to address discharge delays. One local challenge is the availability of step-down beds. Another persistent issue relates to continuing health care, and the issue of free vs means-tested care. Recording where people are discharged to. Also measuring success in diverting people, and reducing demands on primary and secondary care, plus ongoing social care in particular residential care.</td>
</tr>
<tr>
<td>Social care embedded in urgent and emergency care</td>
<td>The discharge to assess scheme exists. Mental health access in urgent and emergency care was seen as just as important as social care. Measure mental health as part of the emergency care system.</td>
</tr>
</tbody>
</table>
Applying the Integration Standard

Although there is support for the Integration Standard, several interviewees commented that its objectives do not correspond directly with either their integration model or their local ambition. Other measures, including qualitative measures, would give them greater confidence that the whole system was evolving. The Association for Directors of Adults Social Services (ADASS) ‘six principles’ were specifically mentioned. In addition, there was a strong reaction to the objectives omitting measures sensitive to users and relevant to professionals delivering the changes. One person wondered if local case studies would be a useful additional way of demonstrating how the Standard is being met.

Some expressed concerns about creating a ‘tick box’ exercise that distracts from the long-term ambitions and place-based working arrangements. It was felt that the Standard would be improved if it were understandable to both users and professionals working in the system. Practical examples should illustrate how the Standard can be used to measure progress and lead to further integration, perhaps as a set of stepping stones.

The Standard appears biased towards quick fixes, rather than sustainable solutions. Integration was seen by the partners as a long-term system transformation.

Summary

York’s commissioning and delivery partners would welcome improvements to the Standard that increase its relevance locally and are sensitive to their local ambition, including:

- keeping the Standard ‘simple and short’ so that it is understandable to both service users and professionals working within the system; many acronyms are not understood outside of the NHS
- including practical examples of how the Standard would apply in practice
- providing a mixture of nationally and locally significant measures, with less emphasis on acute sector activity measures and the inclusion of measures sensitive to their care coordination approach
- including both quantitative and qualitative measures
- focusing on good outcomes for integration from a user perspective, and not just the process or structural elements that enable better integrated care
- avoiding the creation of a ‘tick box’ exercise, i.e., achieving the objectives of the Standard without fully achieving integration
- capturing outcomes that reflect their long-term ambition to reduce dependency and enable people to retain their independence, stay in control and enable choice
- applying a risk-enabling approach to measures, rather than a risk-averse approach, such that there is greater engagement from primary care, voluntary sector providers, service users and their carers
• recognising that effective leadership is an important enabler of change. SCIE would like to thank the following people who contributed to the development of the case study.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/organisation</th>
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<tbody>
<tr>
<td>Martin Farran</td>
<td>Director of Adult Social Care, City of York Council</td>
</tr>
<tr>
<td>Wendy Scott</td>
<td>Director of Out of Hospital Care, York Teaching Hospital</td>
</tr>
<tr>
<td>Dr Lesley Godfrey</td>
<td>GP and CCG Clinical Lead York Integrated Care Team</td>
</tr>
<tr>
<td>Sharon Stoltz</td>
<td>Assistant Director, Public Health, City of York Council</td>
</tr>
<tr>
<td>Fiona Bell</td>
<td>Deputy Chief Operating Officer, NHS Vale of York CCG</td>
</tr>
<tr>
<td>Ruth Hill</td>
<td>Director of Operations, Tees, Esk and Wear Valleys NHS FT</td>
</tr>
</tbody>
</table>
Integrated care in Hertfordshire

Vision and model

Hertfordshire is a county covered by two clinical commissioning groups with a good track record of joint planning and piloting approaches to health and social care integration. Their system leaders report making progress towards joint commissioning and creating pooled budgets, particularly for older people. There are two models of integration that have developed across the county, that have a common set of elements.

- Integrating not only health and social care, but also mental health services, prescribing and voluntary services, for adults and children.
- Providing more care out of hospital, from outpatient care and diagnostics to virtual wards, including the redesign of priority clinical pathways, such as respiratory, cardiology, diabetes, musculoskeletal physiotherapy (falls prevention) and others. This includes common data systems and sharing protocols to support care planning and system ‘intelligence’.
- Use of multidisciplinary and rapid response teams for managing patients with complex needs and at risk of hospitalisation, supported by community navigators (already a Health Service Journal commended effort). Single assessment and care planning, with an increasing emphasis on self-management of long-term conditions.
- Reserving a proportion of funds (5 per cent) to invest in prevention (and demand management).

One of the enhanced health in care home vanguards is also located in Hertfordshire, and it combines many of the elements of health and social care integration, including an incentive (complex care premium) to manage complex care better outside of hospital and reduce unplanned acute care. Evaluation efforts are underway to assess the impact of the new care model and its wider implications for Hertfordshire’s delivery system.

Concerns exist about the impact of the Sustainability and Transformation Plan on local integration plans. The imposition of a footprint that includes parts of Essex has added a layer of complexity to local relationships that requires partners to address a growing financial gap associated with two distressed acute trusts.

Main successes and challenges to date

The interviewees cited a number of significant achievements to date, including:

- reduction in delayed transfers of care
- tangible benefits from the rapid response teams (a Healthwatch report cites positive feedback from service users and GPs)
- good partnership working, with agencies being fully engaged and moving towards joint commissioning and provider alliances
• early successes with the enhanced health in care home vanguard, including admissions avoidance through use of the premium data-sharing agreements.

Several challenges were highlighted, with many seen as the types of problem that require intensive time and attention to address, as follows.

• Clarity around outcome measures. These include describing with greater specificity the expected benefits of the different interventions – developing patient-experience measures that apply to a number of inputs and interventions and developing longitudinal outcome measures.

• Funding constraints and the challenge of delivering savings. These include new community-based schemes. Prevention services need investment at a time social care spending is not protected and funds are likely to be committed to addressing the acute services deficit.

• Data-sharing, interoperability and the real need for better management information.

• Culture challenges. Mainly between and within the NHS and local authority.

• Capacity challenges. Just starting to resolve barriers between providers, but trusting relationships take time to develop (e.g., GP federations are just forming).

**Measuring progress and outcomes**

Care quality-related measures are being used to demonstrate care improvements, but there is a recognition that many outcomes (e.g., diabetes outcomes) are long-term in nature and that better short-term measures are needed. Other existing qualitative measures are collected through:

• staff reported outcomes

• a current survey of social care users, every month and quarter

• existing patient surveys.

The vanguard work has instilled discipline in their thinking. The national team has helped them describe their value proposition and how to evaluate results. In terms of understanding impact, they have used logic models to understand their outcomes, looking at quality of life measures such as feeling safe, as well as quantitative measures. The partners are testing the use of a set of qualitative methods, first looking at the effectiveness of the care navigators and the impact of the carers’ strategy.
Views on the Integration Standard

<table>
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<tbody>
<tr>
<td>Digital interoperability</td>
<td>Many considered digital interoperability to be one of the biggest barriers to progress locally. They are making progress. One solution has been to purchase another overarching system that pulls data from across the partners. One key lesson is that data-sharing agreements and concordats take an enormous amounts of time and energy. In addition, several people commented that, while interoperability is an important goal, using data intelligently to improve care should be the ultimate goal.</td>
<td>Intelligence is as important as data-sharing. Indicators should recognise that both data interoperability and better intelligence should directly affect patient care. National efforts are needed to tackle variations in provider capability.</td>
</tr>
<tr>
<td>High-risk cohorts targeted</td>
<td>General agreement that a focus on high-risk groups is important, especially if this enables prevention and supports care outside of hospital and admissions avoidance. Different approaches are currently being used across the county. Focusing on high-risk cohorts overlooks the challenges associated with integrated personal commissioning (personal budgets and direct payments): there is a need to resolve what can and cannot be purchased, and how this affects service demand.</td>
<td>What are the best outcomes for targeting services? Can we measure what we have prevented from happening? Compare the impact of risk stratification to the investment in care homes (vanguard approach) – which achieves the best outcomes?</td>
</tr>
<tr>
<td>Objective</td>
<td>Description</td>
<td>Further Information</td>
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<td>-----------------------------------------------------</td>
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</tr>
<tr>
<td>Value for money</td>
<td>All agreed that value for money is absolutely critical, but they questioned whether the best measure is bed days. There are other things to look at, such as investment in community-based care, the impact on commissioning, finding efficiencies in care delivery processes (fewer interactions) and pathways, etc.</td>
<td>An ongoing challenge is measuring the value of investment that requires several years to reap benefits. Sustainability and Transformation Plan: savings are unrealistic, expectations for reducing acute care spend and capacity are likely to drive short-term decision-making away from better long-term investments.</td>
</tr>
<tr>
<td>Single assessment and care plans</td>
<td>Several pointed out that single assessment processes and care plans vary in what they contain. On its own, this objective is in danger of creating a ‘tick box’ exercise. Measures should answer the question: how does the care plan make a difference to patients? The effectiveness of the multidisciplinary teams will impact on how care plans are delivered. How well is the care coordinator working? There was a suggestion to look at how mental health uses care coordinators.</td>
<td>Add relevant patient experience measures: how they are experiencing joined up care. Are communications with health and care professionals improving? Other aspects of experience/quality of life measures.</td>
</tr>
<tr>
<td>Integrated community care</td>
<td>This objective isn’t clear: what is being measured and why? How teams should operate, including the role of the care coordinator, could be better described. Staff and service user perspectives are relevant. In regards seven-day working, their rapid response team is already operating 24/7. More work is needed for social care to provide the same level of service, but there is a shortage of social work staff.</td>
<td>Effectiveness of teams: measure staff and user experiences. Related to care planning. Could also look at operational measures, such as attendance at teams by core and non-core members.</td>
</tr>
</tbody>
</table>
**Timely and safe discharges**

Delayed transfers of care have received considerable attention in Hertfordshire (‘we were awful to start with’). So, an important measure. Effective discharge to assess processes are working to a degree, but many of the causes are difficult to sort out: insufficient workforce, reduction in social care funding, lack of home-based support. Some mentioned the different discharge practices at different providers, as well as the differing expectations from commissioners.

One suggestion was to look at the proportion of people being discharged to home and those being discharged to care homes. A model of what ‘good’ looks like might help harmonise the approaches within trusts, many of which are discharging patients from a number of places (different systems in place can cause confusion among staff).

**Social care embedded in urgent and emergency care**

Unclear what is being measured or what the desired outcome should be.

Hertfordshire partners have been embedding social care in accident and emergency for 12 months now; seen as successful, although several raised the issue of taking a broader view of the role of social care in the whole emergency care system. Fall response cards were described, and the way social workers are working with paramedics, undertaking mini-assessments and avoiding hospital admissions. Social workers are also well embedded in rapid response teams.

In contrast, for primary and community services, GPs generally do not think of social care as a first point of call. The redesign of pathways also needs to include social care and be jointly commissioned.

Focus on evidence about how well health and social care are joined up across the system, not just in emergency care. Consider the whole of the emergency response system (e.g. rapid response teams, other emergency services, pathway redesign and referral protocols that prevent unplanned care).

### Applying the Integration Standard

In general, interviewees felt that the proposed Integration Standard described what would be expected of an integrated service but that it neglects to include anything about the people using the services – the benefits to users – or the people delivering the services – the workforce.

The Standard appears to be too focused on structural and process-related measures. For example, a local area might achieve all the elements of the Standard without actually delivering better care. There was a consistently strong view that person-centred outcomes measures were needed, but also that these should address emotional and
general wellbeing. Furthermore, outcomes should reflect the effectiveness and efficiency of care, as well as quality measures.

The objectives in the Standard would be more likely to be achieved if the measures were more specific. This might require clearer descriptions of what ‘good’ looks like. Several interviewees suggested ways the Standard could be improved by thinking in a more strategic, whole-system way.

**Summary**

The Hertfordshire partners expressed a keen interest in supporting the use of a standard as a way of setting out system expectations and strengthening the rationale for local partnership working. It is also important not to lose sight of desired clinical outcomes, as their future plans extend beyond structural and process-driven integration.

The Standard should enable further development of local integration without limiting Hertfordshire’s preference for piloting and evaluating changes. Most important, many expressed a strong message about allowing time for trusting relationships to develop at all levels of the system. Resolving data-sharing challenges is critical, and national support is needed.

An overemphasis on reducing delayed transfers of care diverts attention away from other priorities, such as transforming pathways across primary and community care.

A few additional factors were missing from the draft Standard, as follows.

- Measurement of the effectiveness of partnership working – this might include evidence of joint commissioning arrangements, actual pooling of funds, concordats and data-sharing agreements, co-location of staff, leadership and governance, etc. (Are the partners fully engaged and working towards the same ambition?)

- Monitoring the impact of the Sustainability and Transformation Plan, bearing in mind the footprint challenges, the distorting effects of the financial gap on local decision-making, and the fact that patients and front-line staff have not been involved or consulted to date.

- The importance of the Standard making sense to patients and the public – what are the plans for consultation? Can we have an honest discussion with the public about what ‘success’ looks like?
SCIE would like to thank the following people who contributed to the development of the Hertfordshire case study.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/organisation</th>
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<tbody>
<tr>
<td>Dr Nicholas Small</td>
<td>Chair – Hertfordshire Valleys Clinical Commissioning Group, GP – Hertsmere Locality Commissioning Group</td>
</tr>
<tr>
<td>Beverley Flowers</td>
<td>Chief Executive, East and North Hertfordshire Clinical Commissioning Group</td>
</tr>
<tr>
<td>Iain MacBeath</td>
<td>Director, Health and Community Services (DAS), Hertfordshire County Council</td>
</tr>
<tr>
<td>David Law</td>
<td>Chief Executive, Hertfordshire Community NHS Trust</td>
</tr>
<tr>
<td>Tom Barrossa</td>
<td>Policy and Partnerships Manager, Healthwatch Hertfordshire</td>
</tr>
</tbody>
</table>
Appendix 4: Rapid evidence review

Review methodology

This section outlines the findings of a rapid review into the seven objectives of the Integrated Standard. It presents a selective summary of relevant evidence rather than the findings of systematic review. The search was carried out using a number of bibliographic databases including Social Care Online. This retrieved 863 references and these were screened on title and abstract. As very few of these references were of relevance to the objectives specifically, the search was supplemented by Google searches.

Overall, the evidence relating to integrated care is of a mixed quality. The majority of references can best be described as ‘grey literature’ and while a great deal has been published on the subject, much of this material is in the form of guidance, policy documents or descriptive case studies and offers little analytical insight.

The review was designed to reflect the Department of Health’s early thinking regarding the Integration Standard and the seven objectives. The primary goals were to begin to build an evidence base to understand the importance of each objective and how each contributes to an integrated care system and to map how local areas are beginning to respond.

Review findings: integration 2020

People with complex needs often require support from a wide range of health and social care services. While the care provided by each individual agency may be of a high quality, care can become fragmented where multiple providers are involved. This is thought to lead to poorer health and wellbeing outcomes, frustration for service users, inefficiencies and higher costs.

The English health and social care system is increasingly being subjected to unprecedented levels of strain. The number of people with multiple long-term conditions is increasing and it is estimated that by 2018 there will be 2.9 million people with three or more long-term conditions93 such as dementia or diabetes. These trends have a significant impact on the health and care economy with chronic conditions accounting for over 70 per cent of the health and social care budget.94

Integrated care aims to place service users at the centre of the health and care system and is seen as the solution to care that is fragmented, difficult to navigate and expensive. It is expected to deliver better health and wellbeing outcomes, higher quality care, an improved user experience and cost-savings. While integrated care is not a new concept, unlocking the benefits associated with it remains high on the agenda. The 2013 launch of the Better Care Fund, which required local health and social care budgets to be pooled, was an attempt to incentivise the integration of NHS and local

94 Ibid.
authority services. Similarly, the 2014 Care Act requires that local authorities promote the ‘… integration of care and support provision with health provision and health-related provision …’ and in the same year NHS England announced its new care models programme – a significant part of which focused on integration. The importance of integrated care was underlined further by the 2015 Comprehensive Spending Review which outlined plans for the integration of health and social care by 2020, the achievement of which would ‘… improve services for patients and unlock efficiencies’.

What is integrated care?

While there is widespread agreement that integrated care is the right thing to do, defining it and describing how it should be achieved is difficult. Many commentators use the terms ‘integration’ and ‘integrated care’ interchangeably and the results of a review that identified 175 definitions of integrated care are often cited in reports on the subject.

The Nuffield Trust distinguishes between integration and integrated care, arguing that integrated care ‘… is an organising principle for care delivery with the aim of achieving improved patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care’. Similarly, a report published by the King’s Fund argues that the development of integrated care ‘… means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place’.

Person-centred care

Despite the challenges associated with defining integrated care, it is clear that maintaining a focus on service users is essential; without this, integrated care initiatives are unlikely to succeed. The majority of the literature emphasises that the ultimate goals of integrated care are to improve service users’ experiences of care and support and to achieve better outcomes. In 2012, National Voices collaborated with service users to explore what integrated care meant to them and what they hoped it would achieve. The definition that they arrived at was simple: integrated care meant ‘person-centred coordinated care’. This was further developed into an ‘I’ statement which was adopted by the government in 2013.
‘I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.’

Measuring integration

Given the lack of a precise definition of integrated care and the variety of approaches to integration it is perhaps unsurprising that attempting to assess effectiveness can be challenging. Despite the existence of an extensive literature on integrated care, evaluating effectiveness has proven to be challenging and many reports avoid this question and instead simply provide descriptions of a service or project. Those pieces of research that do explore the effectiveness of integration tend to focus on service outcomes such as hospital admissions rather than service user outcomes.

Others have taken a different approach and have instead focused on attempting to assess whether the ‘right’ framework for integration is in place. In June 2016, the Association of Directors of Adult Social Services, the Local Government Association, NHS Clinical Commissioners and the NHS Confederation jointly produced a self-assessment tool called ‘Stepping up to place: the key to successful health and care integration’. This was designed to support health and care communities via their local health and wellbeing board to ‘… critically assess their ambitions, capabilities and capacities to integrate services to improve the health and wellbeing of local citizens and communities’. This focuses on the preparedness of areas to integrate and asks whether the ‘essentials for the integration journey’ are in place (shared commitment, shared leadership and shared accountability); how ‘ready’ the local health and care system is to deliver integration (shared vision, shared decision-making, shared systems – models, and shared systems – enablers); whether effective governance is in place (decision-making authority, clear roles and responsibilities, engagement of stakeholders, managing interfaces, and information flow); whether there is effective programme management (shared vision, programme planning, planning footprints, programme interdependencies and monitoring of progress).

Barriers and facilitators to integrated care

Much of the literature on integrated care emphasises that local context is an important determinant of success, with many commentators guarding against a ‘one size fits all’ approach, as made clear in a report by the Nuffield Trust: ‘There is no one model of integrated care that is suited to all contexts, settings and circumstances.’

Although it is apparent that an understanding of the local context is essential in implementing a programme of integration, there are a number of barriers and facilitators to integrated care that are regularly identified by commentators. Factors that are

104 Ibid., pp 6–13.
regularly cited as having an impact on the success or failure of integration include issues such as common goals and a shared vision; pooled resources/unified structures; and interprofessional collaboration/status.¹⁰⁶

- **Financial issues.** A number of commentators suggest that the drive towards an integrated health and care system is hindered by the financial foundations that underpin the health and social care sectors. Most obviously this can be seen in the different approaches to means-testing, with NHS services being provided for free at the point of delivery and based only on need, and social care services being rationed by means testing. Separate funding streams and different payment processes can further entrench these issues.

- **Communication and information-sharing.** Communication between different agencies is a central component of integrated care. This is because it enables professionals to coordinate care, enables risk stratification and allows data to be monitored (e.g. costs). Some view governance issues as a hindrance to communication and information-sharing, with practitioners reporting that regulatory frameworks on these can sometimes be confusing.¹⁰⁷ Communication may be better in areas where pre-existing relationships already exist, for example through co-located services.¹⁰⁸

- **Shared vision and leadership.** Many commentators highlight the importance of leadership when discussing factors that may impact upon the success of integration initiatives. Leaders must be able to clearly communicate the rationale and vision for integrated care in their local area.¹⁰⁹ Importantly, they must be perceived as being able to do so by their staff. Researchers reporting on the Integrated Pioneers Programme found that ‘… success was more often reported in pilots where individuals were confident that senior management or team leaders were strongly committed to implementing lasting change’.¹¹⁰

- **Organisational culture and professional boundaries.** Health and social care professionals may still be separated by language, ideas about health and wellbeing, perceptions of accountability and preferred ways of working.


• **Workforce.** It may be difficult to motivate some staff due to previous experiences with initiatives and pilots. Given that the positive results associated with integrated care may only become apparent in the longer term, fostering high levels of engagement can prove difficult.\(^{111}\)

**Progress to date**

The past few years have seen the launch of a range of integrated care initiatives. Of particular interest are three relatively large-scale schemes supported by the Department of Health and NHS England – Integrated Care Pilots, Integrated Care Pioneers and the New Care Models.

• **Integrated Care Pilots.** A two-year pilot launched in 2009, focusing on integration at the primary care level. Sixteen pilots were chosen and five of these included the integration of social care within community services.

• **Integrated Care Pioneers.** The early experiences of 14 ‘pioneers’ were the focus of an evaluation by the Policy Innovation Research Unit. Learning from these areas was to be used ‘... as a means of driving forward change at scale and pace, from which the rest of the country can benefit’.\(^{112}\)

• **New Care Models.** NHS England’s New Care Models ‘vanguard’ programme represents a very recent and high profile example of an integration initiative. There are five types of vanguard (announced in 2014) – integrated primary and acute care systems; enhanced health in care homes; multispecialty community providers; urgent and emergency care; and acute care collaborations. In 2015, 50 areas were selected to be trial sites.

**Integration 2020: The seven objectives**

**Digital interoperability (use of NHS number and digital maturity index)**

> ‘I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data).’

**Policy overview**

It is widely acknowledged that integrated health and social care models can only be fully achieved and sustained through effective information- and data-sharing within and across sectors, with information travelling with the individual and easily accessible to all the professionals involved in their care. Digital interoperability is the critical enabler of

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information flow, ensuring that multiple IT systems are able to communicate, exchange data and virtually operate as a whole, integrated information system.

The Five Year Forward View sets out a vision for harnessing the information revolution, ensuring locally procured information systems meet nationally specified interoperability and data standards and advocating the use of the NHS number in all settings, including social care. This commitment is echoed and further detailed in a comprehensive framework for action produced by the recently formed National Information Board, whose remit is to develop strategic priorities for data and technology use in health and social care. There are a number of key elements to the framework. From March 2018 all individuals will be enabled to view their care records and to record their own comments and preferences on their record, with access through multiple routes including NHS Choices. All patient and care records will be digital, real-time and interoperable by 2020. The NHS number will be universally adopted across systems, including local authorities, and common standards and a single clinical terminology will be implemented.

The Health and Social Care (Safety and Quality) Act 2015 has introduced a new legal duty requiring health and adult social care bodies to share information where this will facilitate care for an individual.

In response to the National Information Board framework and as part of the Forward View implementation plan to facilitate the accomplishment of digital interoperability in health and social care, in 2015, under the lead of each relevant clinical commissioning group, local health and care organisations, including NHS trusts, general practices, local authorities, health and wellbeing boards and New Models of Care, have joined forces to form local health and care systems known as ‘Local Digital Roadmap Footprints’. Each ‘footprint’ was tasked to submit a local digital roadmap by 30 June 2016, setting out how they are planning to achieve ‘paper-free at the point of care’ processes by 2020. The local roadmaps provide a system-wide perspective on plans and priorities for digital technology deployment and optimisation, identifying ‘new capabilities for all frontline health and care professionals, including medics, nurses, midwives, AHPs, social workers and care staff’.

Setting out a five-year vision for the digitally enabled transformation of each local health and care system, the roadmaps, which will be published locally in autumn 2016, comprise: an outline of the baseline position and information maturity; a readiness assessment; a capability deployment schedule; intended steps to ensure information-sharing and implementation of interoperability principles; and plans to further develop the infrastructure and to improve collaboration between professionals from different organisations within the local health and care system.

The requirement that roadmaps provide a description of the initial baseline position and a readiness assessment was partly informed by the Digital Maturity Assessment, which ‘... supports the National Information Board’s commitment to achieving a fully

interoperable health and care system by 2020 that is paper-free at the point of care.\textsuperscript{115} NHS providers, including acute, mental health, community health and ambulance services, submitted their self-assessment in January 2016. The data are now available on the ‘My NHS’ website, enabling members of the public to look see how a particular trust scores in the three areas of ‘digital readiness’, ‘capability’ and ‘infrastructure’, and to view a number of more specific measures held for each of these topics.

Following in the NHS England’s footsteps, the Local Government Association has also developed and piloted a social care digital maturity self-assessment specifically designed to help local authorities appraise their digital readiness and ensure the local digital roadmaps can provide a comprehensive picture of health and social care digital maturity. The social care digital maturity self-assessment mirrors the NHS form, although the topic areas have been tailored to social care. The first wave of submissions, on a voluntary basis, closed in May 2016, but future iterations are planned. The Social Care Digital Maturity Index has not yet been published.\textsuperscript{116}

\textit{Role and benefits of digital interoperability}

There is broad agreement in the literature and among commentators that information- and data-sharing, supported by an adequate interoperability infrastructure, is the essential building block of successful integrated care models. More broadly and across the whole spectrum of public services, well integrated digital tools can ‘link processes within and between organisations, providing customers with a smooth and consistent end-to-end experience of a service, with feedback and updates at each stage, while avoiding rekeying of data by staff; capture ongoing and up-to-date insight about how services are being used, helping service providers to monitor performance, share this information with customers and continuously improve service design; enable organisations, with appropriate customer consent, to share information early, online and in real time for both operational and strategic purposes [ … ]; provide infrastructure and capabilities that can be built once and used many times by different organisations, reducing costs and risks, facilitating quicker deployment and achieving greater reliability and consistency’.\textsuperscript{117}

More specifically, information flow has the potential to play a key role at every step in the delivery of integrated care, from identification and assessment of care needs, to care planning and care coordination, optimisation of hospital admission and discharge, the provision of social care packages and planning and use of resources.\textsuperscript{118}

The final report of an early evaluation of the Integrated Care and Support Pioneers Programme highlights three broad functions of data-sharing that are particularly important to the pioneers: it enables health and care professionals to coordinate the


\textsuperscript{118} Ben Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’ (London: Local Government Association, 2016).
provision of care; it supports risk stratification, case finding, business intelligence and a shared understanding of needs; and it supports the implementation of pooled and capitated budgets by tracking costs across services.\textsuperscript{119}

In addition, the literature suggests that joined-up working between health and social care services through data-sharing eliminates duplication, including multiple assessments, maximising resource allocation and as a result enhancing the care experience of service users.\textsuperscript{120}

A case study reporting on the implementation of integrated digital care records, as a part of a wider programme of integrated health and social care, describes the impact of information-sharing and digital interoperability in four local areas and provides some evidence of the various functions that integrated information systems may perform.

A more efficient use of health care services, including diagnostic services, increased safety and more time spent on clinical care is highlighted as one of the benefits. More specifically (and drawing on the results of the pilot stage of ‘Connecting Care’, an interoperability programme that brings together service users’ medical and social care information from several systems), the case study estimates that in Bristol, North Somerset and South Gloucestershire annual savings associated with admission prevention could equate to £1,036,288; annual savings associated with better use of time by professionals would equate to £155,278; and £68,000 annual savings could be made from a reduction of unnecessary home visits (based on 10,000 people using Connecting Care).

While specific and supporting data is not provided, the case study suggests that there is evidence that the implementation of integrated digital care records has led to reduced delays in treatment and safer care. Risks to patients, for instance, are reduced when health and care services, including out of hours or urgent care services, are able to access service users’ medication data, allergy details or existing concerns.\textsuperscript{121}

In addition, practitioners are reported to value the role of interoperability and shared care records in smoothing transitions, ensuring all relevant parties have simultaneous access to patient information, supporting hospital discharge and facilitating the joint work of multi-disciplinary teams. Social care access to patient records in Leeds, for instance, is specifically aimed at ensuring ‘timely reactions to patients’ emergency admission, enabling care packages to be halted during hospital stays, and re-started on discharge’.\textsuperscript{122}

‘The virtual ward development for the Leeds Care Record has really helped my practice prepare for our patients being discharged from hospital. With one quick simple view I


\textsuperscript{120} Vicky Sargent, ‘Redesigning Health and Social Care: Challenges and Opportunities from an IT and Digital Perspective’ (Northampton: Socitm, 2015).

\textsuperscript{121} Centre of Excellence for Information Sharing, ‘Integrated Digital Care Records: Enabling Information Sharing’ (Centre of Excellence for Information Sharing, 2015).

\textsuperscript{122} Ibid.
can understand where patients that I’m directly involved in caring for are [and] what their likely needs will be when they return to the community’ (general practitioner).123

Critically, the ability to share information is highlighted as a driver of further integration, increasing the appetite for more collaborative work and attracting the interest of a broader range of services and professionals (e.g. pharmacists).124

**What are the enablers and barriers to good digital interoperability?**

The guidance for developing local digital roadmaps sets out the 10 universal capabilities (four of which are directly relevant to social care professionals) that local health and care systems need to deliver over the next two years. They build a picture of what digital interoperability should achieve. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions. Clinicians in urgent and emergency care settings can access key GP-held information for those service users previously identified by GPs as most likely to present (in urgent and emergency care). Patients can access their GP record and GPs can refer electronically to secondary care. GPs also receive timely electronic discharge summaries from secondary care and social care receive timely electronic assessment, discharge and withdrawal notices from acute care. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly, and professionals across care settings can be made aware of end-of-life preference information. GPs and community pharmacists can utilise electronic prescriptions, and patients can book appointments and order repeat prescriptions from their GP practice.125

Good digital interoperability is defined by and depends on the effective implementation of technical and semantic interoperability (i.e. the ability of systems to communicate with each other and understand the information they exchange) and information governance. NHS England has produced an interoperability handbook outlining the strengths and limitations of a range of technical interoperability options for information exchange.126 In addition, the ‘Interoperability Toolkit’ sets out common specifications, frameworks and implementation guides to support interoperability within local organisations and across local health and social care communities.127 Systems may be linked using a point-to-point architecture, which allows each system to connect to every other system. Alternatively, multiple systems may connect to a central hub (hub and spoke architecture) or a combination of point-to-point and hub and spoke models may be used. Information can be exchanged by sharing the same application between organisations, by exchanging pre-formatted documents through a message broker (or

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123 Ibid.

124 Ibid.


through a shared repository), or by sharing data (again using a point-to-point portal, a message broker or a shared repository).

The case studies reviewed for this report indicate that at a local level a variety of IT solutions are being implemented. The ‘Adapter Project’, for instance, brings together five London boroughs, the NHS, GP practices and software suppliers. Through a piece of ‘middleware’ that easily adapts to the changing requirements of the network of applications, local health and social care agencies can exchange patient-identifiable information, including GP referrals, hospital admissions and discharges, needs assessment and care plans. The Lancashire Health Record allows GPs, district nurses and social care teams to share information using a registry/repository pattern. A central index (registry) enables search and retrieval of user records from the local systems (repositories). In Leeds, “… partners opted for a digital care record where key information from separate IT systems would be integrated into a web-based application view”. While not recommending a specific technical solution, current guidance does provide advice on available options, how different architectural patterns support specific processes and the range of business needs, and the steps to take to implement an interoperability programme.

Replacing the existing, fragmented infrastructure of local systems with a single, shared information system would avoid the requirements for interoperability. However, the literature cautions that the implementation of a single system programme could prove expensive and disruptive and that the risks of failure could be significant. While acknowledging that there is no consensus on what solution is most effective in supporting digital interoperability within the NHS, Imison et al. observe that ‘a single system will always be the second-best option compared to a purpose-built solution for a particular specialty’, even though it may be more likely to support integration. Nonetheless, achieving effective technical interoperability by linking existing systems poses significant challenges. While a number of case studies give examples of successful implementation, a less rosy picture emerges from other studies, suggesting that at the local level there may be some appetite for a single system approach, as the following quotes from members of clinical commissioning groups demonstrate.

‘I think it would be very helpful though to just have some more control over joining up of systems, so RiO versus Cerner versus EMIS versus Adastra versus System One, you know, that’s five systems that we have to join up … in the locality, and each system does a different thing.’

‘Put a million quid into it [IT system]. It didn’t work. The simple message is: you can’t do a bolt-on onto something else for integrated care. Actually, you’ve got to get your entire

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129 Ibid.


IT platform to be about integrated care, because there’s a huge amount you need to know and nearly all of it is somewhere else."^{133}

‘I’ve been in disagreement with a number of people on this, but I have a strong view that you need, in a CCG, to just have one system. You might have interoperability between systems but it’s just adding complication, it’s going to make it difficult."^{134}

Information governance and the interpretation of current legislation pose a further challenge to digital interoperability and information-sharing. Between 2011 and 2014 the NHS suffered 7,000 breaches of data.\(^\text{135}\) Robust information governance is critical to the successful implementation of interoperability programmes to ensure both service users and professionals are confident that personal data can be shared safely across sectors. Imison et al. note that ‘… at present, there is a tension between the Health and Social Care Act 2012, which encourages data transparency, and the Data Protection Act 1998, which seeks to guard and inhibit access to patient data’.\(^\text{136}\) The lack of clarity about lawful practice is found to foster a culture of risk aversion where services within and across the health and care sectors are reluctant to share data and collaborate.\(^\text{137}\)

The evidence emerging from the experience of the Integrated Care and Support Pioneers confirms these concerns, with stakeholders reporting that the regulatory framework is complex and advice contradictory. Key barriers to implementing workable information governance include a lack of national and strategic coordination, insufficient support and lack of specific advice from national bodies, along with the role played by an ‘… obstructive and risk adverse information governance “industry” being allowed to set the agenda’.\(^\text{138}\) ‘Is it technical or is it also because of the legal framework in terms of sharing data? I get such different messages, I don’t even think the government knows what the message is. Some people say we can’t share, others say they we can’ (acute provider).\(^\text{139}\)

Both the latest evaluation of the Integrated Care and Support Pioneers Programme and a number of case studies, however, highlight examples of good practice where localities have been able to work out practical solutions to ensure robust and shared information governance is in place. To support the implementation of their interoperability programme, for instance, Bristol, North Somerset and South Gloucestershire partners developed a combined interpretation of the legislation, liaising with the Information Commissioner’s Office and Health and Social Care Information Centre for guidance and

\(^{133}\) Ibid.


\(^{135}\) Imison et al., ‘Delivering the Benefits of Digital Health Care’.

\(^{136}\) Ibid.


\(^{139}\) Ibid.
advice. Information-sharing agreements and local protocols are increasingly used to set out what data can be shared and how. The evidence shows that the process of developing information-sharing agreements in partnership, while often lengthy and complex, sets out the conditions for building trust and gaining support from stakeholders and is critical to the success of digital interoperability programmes.

Successful implementation of interoperability depends on a whole range of local drivers and enablers. Key themes emerging from the literature and practice include: strong vision and leadership; relationships at all levels, including between strategic leaders from health and social care; communication with relevant stakeholders; engagement with partners, providers and service users; staff training, including addressing staff concerns around the service user consent process; and adopting a phased process, starting small and growing in stages. Conversely, the Care Quality Commission thematic review of integrated care for older people in eight areas in England, reporting that information was not systematically exchanged between staff and providers, found that barriers to data-sharing included: staff shortages and lack of effective linkages between staff in different organisations; staff attitudes and a lack of awareness of data-sharing tools; and poor information governance, IT incompatibility or concerns over data security and confidentiality.

Resources targeted at high-risk cohort to prevent crises and maintain wellbeing (use of personal budgets, integrated personal commissioning, risk stratification, capitated budgets)

‘If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital.’

‘If it would benefit me, I will be able to access personal budget, giving me greater control over the money spent on my care.’

Targeting high-risk cohorts

The evidence base indicates that overall impact is significantly greater when integrated care interventions are targeted at high-risk segments of the population, broadly characterised by high-level, multiple needs and generally requiring input from a range of professionals and services across the health and care sectors. In their review of the evidence on supporting patients with costly complex needs, Vrijhoef and Thorlby found that ‘... interventions targeted at complex patients achieve more of their goals if they are multifaceted, for example combining a range of professionally focused changes (such as specialist geriatricians or case management) with patient/carer-focused interventions (such as better information or self-management)’. The rationale for this is that ‘...
heterogeneous nature of the needs that arise from complex co-morbidities …’ requires coordinated and personalised responses. Similarly, Nolte and Pitchforth argue that ‘… the complexity of needs arising from the nature of multiple chronic conditions, in combination with increasing frailty at old age, involving physical, developmental or cognitive disabilities, with or without related chronic illnesses or conditions, requires the development of delivery systems that bring together a range of professionals and skills from both the cure (health-care) and care (long-term and social-care) sectors to meet those needs’. These findings are echoed by Kasteridis et al., whose analysis of the groups most likely to benefit from integrated care and capitated budgets demonstrates that multi-morbidity is that main driver of health and social costs. They point out that while a significant proportion of older people may present multiple chronic conditions, age alone ‘adds little explanatory power once we have accounted for the number of conditions in analysing costs’.

Nonetheless, the prevalence of co-morbidities is growing as a result of demographic changes and the ageing population, with the evidence showing that ‘… the majority of people aged over 75 have three or more conditions …’ in a context of growing financial strains both in the health and social care sectors. Against this background, and to contain costs and reduce the disproportionally large demand for services accounted for by a relatively small number of service users, emerging integrated care models are increasingly focusing their efforts on the most vulnerable patients, targeting the ‘super-users’ with early interventions and preventive programmes.

There are significant variations in the size and characteristics of the population cohorts targeted by integrated care programmes currently being implemented. Assessing progress in the journey to integration in seven localities in England, Richardson found that ‘… places have initially focused on a scope of 1 to 2 per cent on the basis that this is an area of acute need, while others have broadened their focus. This represents around just 12 to 15 per cent of the total healthcare spend (£4,700 to £8,000 per head) and requirements of these complex patients are very different from others. Others have targeted about 20 per cent of the population and 60 per cent of spend in total (£3,500 to £4,000 per head)’.

Older people and those with long-term care needs are found to be the main focus of integrated care interventions, but groups with specialist needs, including diabetic patients and people with mental health problems, are also increasingly targeted. The latest evaluation of the Integrated Care and Supported Pioneers Programme provides a similar picture, with groups more commonly targeted including older people with multiple long-term conditions, and to some extent people with mental health conditions or

145 Ibid.
148 Vrijhoef and Thorlby, ‘Developing Care for a Changing Population: Supporting Patients with Costly, Complex Needs’.
149 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’. 
people with learning disabilities, with a smaller number of pioneer sites prioritising families and children.  

Crucially, the literature cautions against restricting too narrowly the focus of interventions to the highest risk segment of the population, arguing that this may not lead to a significant reduction in service utilisation and associated costs. Roland and Abel have demonstrated that targeting the top 0.5–1 per cent highest risk patients may have a modest impact on overall emergency admissions, showing that even if all the emergency admissions of the 0.5 highest risk group were avoided, the overall reduction in unplanned hospital admissions would be less than 10 per cent.  

In addition, the evidence indicates that risk scores in the highest risk cohort fluctuate significantly and as a result turnover in this group is extremely high. ‘Approximately 30 per cent of patients move out of the very complex risk band (0.5 per cent of the population) within one month; 50 per cent after five months and 80 per cent after one year.’ As a result, targeting such a changeable group with preventive interventions may prove ineffective. In contrast, a case could be made for broadening the targeted segment of the population, to include people at lower risk, preventing them from joining the highest risk cohort in the future. Similarly, Richardson states that ‘... pursuing a broader range of patients than the top 1 or 2 per cent allows local communities to implement an integrated care model which shifts the focus to prevention and maintaining wellbeing and independence’.

The evidence emerging from current practice, reflected in the views of Integrated Care and Supported Pioneers, confirms that the identification of a cost-effective risk threshold and manageable and meaningful size of target cohorts remains a key challenge for integrated care providers. ‘But it’s that – that’s what we’re trying to work out. That’s the bit we’re really working out at the moment is, where is our cohort of people? How big a chunk do we take in this coordinated approach?’

**Population segmentation and risk stratification**

A number of approaches are employed to identify people at high risk, including clinical knowledge, threshold modelling and population segmentation (through risk stratification or, alternatively, segmentation by age and type of condition).

Clinical judgement is the default approach in the NHS. However, subject to cognitive biases, professional knowledge is shown to have little predictive capability.

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151 Martin Roland and Gary Abel, ‘Reducing Emergency Admissions: Are We on the Right Track?’ (2012).
154 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.
157 Lewis, ‘Next Steps for Risk Stratification in the NHS’.
Nonetheless, both current guidance and practice suggest that clinical expertise and, more broadly, professional knowledge and local intelligence from a whole range of settings, including social care, have a role to play in offsetting some of the limitations of existing risk stratification and case finding tools, which current guidance states are not intended to replace but rather complement professional judgement and local intelligence.\textsuperscript{158}

Threshold modelling uses a simple set of rule-based criteria to identify high-risk patients (e.g. people with repeated emergency admissions as a marker of high risk of future admission). The validity of this approach is however questioned, not least because of ‘… the statistical phenomenon called regression to the mean, which holds that patients who experienced an extremely high frequency of hospital admissions in one year will tend to have fewer admissions the following year, even without intervention’.\textsuperscript{159}

The identification of high-risk groups is more commonly achieved through risk stratification and segmentation. Risk stratification is a systematic process that divides a population into different strata of risk for a specified outcome (e.g. unscheduled admission to hospital).\textsuperscript{160} Commonly used risk predictors include age and previous acute care admissions, but sociodemographic characteristics are also included.\textsuperscript{161,162} In the NHS, risk stratification models are generally used to predict unplanned hospital admissions in the next 12 months because of their costs to health services but also because they may be an indicator of poor care.

As an alternative to risk stratification, the population can be segmented on the basis of age and type of health condition and a whole range of relevant and related information, including social care data. Pioneered in the UK by North West London, effective segmentation by age and type of health condition relies on the judgement of multiple professionals, including health and social care commissioners, and an in-depth analysis of the integrated health and social care data set.\textsuperscript{163} While there is a clear conceptual distinction between risk stratification and population segmentation, in practice predictive tools may use a combination of the two; indeed, it has been noted that ‘applying a risk stratification to the segmentation will yield a more precise understand of the needs of each segment’.\textsuperscript{164}

Crucially, ‘… both population segmentation and risk stratification can be performed with patient de-identified data as well as patient-identifiable data. De-identified data can be used to make commissioning plans while patient-identifiable data is essential for direct


\textsuperscript{159} Lewis, ‘Next Steps for Risk Stratification in the NHS’.


\textsuperscript{162} Purdy, ‘Avoiding Hospital Admissions: What Does the Research Evidence Say?’


\textsuperscript{164} Ibid.
patient contact by providers and in both cases is protected by robust information governance.\(^{165}\)

More specifically, population segmentation and risk stratification are employed to: help to understand the distinctive needs of different parts of the population; help define the main combinations of care that people might need, supporting integrated, personalised care; support prioritisation and a phased approach to implementation; allow the modelling and tracking of how integrated care interventions affect different patient groups; and allow the implementation of capitated budgets and new payment models.\(^{166}\) In addition, predictive models support planning and commissioning and where social care data is available, ‘… support an approach which aims to identify the health AND social care determinants of risk admission to hospital, or other adverse social care outcomes. In certain cases this may be, for example, permanent admission to a care home.’\(^{167}\)

Several predictive models and tools are currently available, mainly designed to calculate the risk of future emergency admission, although tools designed to predict future social care needs are also being developed. Current guidance does not recommend a specific approach or tool but does give advice on how best to implement risk stratification/population segmentation programmes.

A number of studies have attempted to assess, and have often questioned, the predictive accuracy of existing tools. Reviewing the evidence on risk prediction models for hospital readmission, Kansagara et al. concluded that the 26 models analysed had poor predictive ability, suggesting that ‘… patient level factors such as medical comorbidities, basic demographic data, and clinical variables are much better able to predict mortality than readmission risks’.\(^{168}\) One of the studies examined in their review found that a model ‘… incorporating sociodemographic factors such as drug use and housing discontinuities was more predictive than comorbidity-based models.’ These findings are consistent with the broader evidence base on factors associated with an increased risk of unplanned hospital admission, which indicates that key drivers are age, social deprivation, morbidity levels, area of residence, ethnicity and environmental factors.\(^{169}\)

The modest predictive accuracy of some of the tools currently in use is partly down to the quality of data they rely on and poor-information sharing practices, within and across sectors, including the insufficient inclusion of the social and social care data as a result of the current fragmentation of health and social care. Reviewing 27 risk prediction models for predicting emergency hospital admission in community-dwelling adults, Wallace et al. found that only a third of the models incorporated non-medical factors such as functional status, social support and self-rated health and ‘… less than half

\(^{165}\) Ibid.

\(^{166}\) Ibid.


\(^{169}\) Purdy, ‘Avoiding Hospital Admissions: What Does the Research Evidence Say?’
considered a specific measurement of multi-morbidity, which is surprising considering the impact the presence of multiple conditions has been shown to have on health care utilization. The technical aspects of interoperability and the legal aspects of data sharing continue to inhibit the full potential of risk stratification and case finding. The ambition for the future is to be able to share primary care, community health, mental health, secondary care, social care and ambulance service data in a secure, whole system approach.

In addition, there are inherent methodological limitations to predictive risk models. While acknowledging the role that risk stratification can play in the identification of patients at risk, Lewis stresses the importance of assessing the adverse impact of false positives (patients wrongly identified as at risk, who may be offered unnecessary treatment) and false negatives (patients incorrectly excluded from the at-risk cohort, who could benefit from early and preventive interventions). Although the sensitivity of predictive tools can be adjusted according to the specific context and business requirements, there is an unavoidable trade-off between precision and sensitivity, whereby fewer false negatives can only be obtained by allowing for a larger number of false positives.

Richardson found that localities currently implementing integrated care programmes are commonly using risk stratification tools to segment the population but are increasingly incorporating additional intelligence to reflect not only the medical but also the social care needs and context. Crucially, he argues that ‘... a segmented approach is more attractive than risk stratification in pursuing integration because it [brings] together a total picture of health and care spend, engaging frontline staff in understanding the needs of specific segments and designing care to meet their need, and ultimately provides an obvious new link to new payment models, such as capitation.’

The literature warns that even when cohorts of people at risk are identified correctly, targeting those groups indiscriminately may not alone lead to a reduction of waste or to a more efficient use of limited resources. Not all true positives (people correctly identified as potential beneficiaries of interventions) will respond to preventive programmes and may still experience unplanned hospital admission. A number of impact models can be used to identify, within each high-risk cohort and population segment, the subgroups that are most likely to be responsive to preventive interventions, for instance focusing on conditions that are shown to respond better to care or excluding the highest risk individuals. In addition, a significant number of frail older people may only have one long-term condition, or even none, and as a result may not be identified by risk stratification tools based on such conditions. The literature

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170 Emma Wallace et al., ‘Risk Prediction Models to Predict Emergency Hospital Admission in Community-Dwelling Adults: A Systematic Review,’ Medical Care, vol 52, no 8 (2014).


172 Lewis, ‘Next Steps for Risk Stratification in the NHS’.

173 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.

174 Lewis, ‘Next Steps for Risk Stratification in the NHS’.
recommends the use of validated tools to identify people with frailty but also to maximise the use of local intelligence increase the understanding of people at risk.  

Integrated personal commissioning and personal budgets

The Integrated Personal Commissioning Programme is targeted at people with complex needs, providing them with more control and choice on the extent and the way in which the financial resources they are entitled to are used, through the enhancement and expansion of personal budget options and the blending of social care and health budgets. ‘Through joint personal budgets people are able to join-up their own services in a personalised way that makes sense to them, ensuring integration from the bottom up.’ In addition, a broader range of services and care and support options, including non-traditional community-based services, built around user preferences, is made available.

Specifically, the Programme aims to join up health and social care for adults, and health, social care and education for children, to improve the experience of care for children and young people with complex needs, people with multiple long-term conditions, particularly older people with frailty, people with learning disabilities with high support needs, and people with significant mental health needs.

Targeting these demographic groups, the Programme provides person-centred, holistic, and preventative interventions to address the health and social care and more broadly the wellbeing needs of people, enabling access to what matters most to them. The Programme has a strong focus on community resources and solutions, including social prescribing and peer support, in addition to, and beyond, statutory services. Critically, while a number initiatives and programmes, operating at system level and often using a top-down model, including pooled budgets and the Better Care Fund, are already in place and are taking forward the integration and personalisation agenda, the Integrated Personal Commissioning Programme specifically aims to achieve integrated care at the level of individual service users, through co-commissioning arrangements between NHS England, clinical commissioning groups and local authorities.

Personal budgets are intended to give people with care needs and disabilities greater choice and control over the care and support they receive. ‘Local authorities have had the option to make direct payments to service users since 1996. More than 600,000 people in England now have a personal budget and 24 per cent of these receive a direct payment.’ The Care Act 2014 requires local authorities to assign a personal budget to all people who are eligible for support. ‘By law, personal budget holders can decide

176 NHS Confederation, ‘Joining up Health and Social Care Personal Budgets: Key Points on Implementation, Briefing; Issue 280’ (London: NHS Confederation, 2015).
177 Sam Bennett, ‘Getting Serious About Personalisation in the NHS’ (London: Think Local Act Personal, 2014).
178 NHS Confederation, ‘Joining up Health and Social Care Personal Budgets: Key Points on Implementation’.
how, who with and where they wish to spend that budget in order to meet their needs and achieve the outcomes of their support plan. Since October 2014 any person eligible for NHS continuing healthcare (or continuing care for children) has the right to “have” a personal health budget. From April 2015 people with a long-term condition also had an option to hold their own personal health budget.

There is a broad consensus that personal budgets have the potential to produce a range of positive outcomes such as increased choice and control, improved health and general wellbeing, quality of life, greater participation and community engagement, and cost effectiveness. A recent small study on the experience of people using personal budgets found that 83 per cent of people with a direct payment and/or a managed account valued having more choice and control over their care and support and were able to find tailored care and support. However, 28 per cent of people said they were unsure where to look for care and support and nearly one in three felt that the financial value of their personal budget did not meet their care and support needs.

The strength and quality of the evidence is sometimes contested, occasionally leading to increasingly polarised views. A number of studies suggest that personal budgets do not deliver better outcomes for less money and argue that where better outcomes do occur, better funding levels are a factor. Arguably, however, many current analyses of direct payments and personal budgets ‘… are based on an imperfect understanding of the principles at stake; on a failure to apply the same burden of proof to the old system as well as the new; on prior attitudes to state services and to current social care; and on a potentially limited adherence to more traditional forms of evidence-based practice’.

If there is mixed evidence that personal budget objectives are achieved in practice ‘… this is especially so in respect of older people who are less likely to accept a personal budget and more likely to be dissatisfied with their experience of using one’. In addition, ‘…most councils are finding significant challenges in implementing personal budgets with older people, in particular in achieving good numbers while also being confident that they are making a positive difference’.

However, Routledge et al. drawing on the 2013 and 2014 National Personal Budget Surveys and informed by the Personal Budgets Outcomes and Evaluation Tool (POET), and other studies, argue that there is evidence to support the view that older people do experience positive benefits from having a personal budget, although these are not as

180 NHS Confederation, ‘Joining up Health and Social Care Personal Budgets: Key Points on Implementation’.
181 Hestia, ‘Personal Budgets: A Lived Experience’.
marked as for other groups. They also note that there are typically lower levels of resources available to older people in their personal budgets, leaving less scope for personalised outcomes. Factors linked to positive outcomes, and which are to an extent now incorporated into the Integrated Personal Commissioning Programme include getting help to plan the budget; feeling their views were included in the support plan; the council making all aspects of the personal budget process easier; getting third party support with a personal budget; using a personal budget flexibly on community and leisure activities rather than on formal services; and employing a personal assistant.\(^{186}\)

Drawing on a survey of local authorities’ senior managers, older people and carers, Woolham found that while personal budgets had the potential to give more choice, control and independence to older people, take-up was low due to a lack of suitable services and information, low expectations and the stress of arranging care at a time of crisis. Informal carers of older people with direct payment also reported higher levels of stress, possibly associated with the responsibilities of organising and managing care services.\(^{187}\)

Rabiee and Glendinning found that the level of choice and control older people using council-managed personal budgets ‘… felt able to exercise to tailor home care services to their personal needs and preferences was restricted to low level choices. Other choices were constrained by the low levels of older people’s PBs and council restrictions on what PBs can be spent on. Older people’s understanding of limitations in public funding/pressures on agencies and their reluctance to play an active consumer role including willingness to “exit” from unsatisfactory care arrangements appeared to further challenge the potential for achieving greater choice and control through council-managed PBs’.\(^{188}\)

Looking specifically at the costs and benefits of personal budgets for older people, Woolham and Benton concluded that ‘compared to younger adults, older people did not greatly benefit from possessing a budget on the outcome measures used, but costs were higher for budget holders across all care groups. These findings support evidence from an earlier study (…) and raise important questions about the suitability of PBs as a means of achieving personalised services for older people and the implications for social work practice’.\(^{189}\) However, Woolham et al. suggest that these concerns may be addressed at policy level through a renewed emphasis on person-centred care, rather than personalisation.\(^{190}\)


Equally, an evaluation of direct payments in residential care trailblazers shows modest positive outcomes. A few service users and families acknowledged that direct payments had allowed them access to a care home or to activities that had not been previously available to them. The findings also show that the costs of implementing the scheme were high compared to the modest outputs.\textsuperscript{191}

A key issue emerging from the literature is whether the use of personal budgets for older people may lead to an increased risk of certain types of abuse, including financial abuse. However, there does not appear to be strong evidence to suggest higher levels of safeguarding referrals among people using personal budgets, although ‘… in three councils studied in depth there was a statistically significant higher proportion of referrals for financial abuse and abuse by home care workers among people using PBs’.\textsuperscript{192}

The evidence of a positive impact of personal budgets on people with mental health care needs is somewhat stronger. Indeed, personal budgets have been shown to support recovery thinking and to mobilise suitable resources in mental health settings. Crucially, the research shows that this is better achieved through co-production and peer-supported processes of assessment and planning.\textsuperscript{193}

A systematic review of the effectiveness of personal budgets for people with mental health problems found that positive outcomes included greater choice and control, quality of life, service use and cost-effectiveness. However, the review also highlighted the methodological limitations of the studies reviewed and suggested that there is an evidence gap in terms of high quality research.\textsuperscript{194} ‘A key factor enabling personal budgets to support empowerment and recovery was reported to be the quality and continuity of the professional relationship’, suggesting that external factors such as organisational culture and processes significantly impact on the success of personal budgets and the experience of people with mental health problems.\textsuperscript{195}

Similarly, a recent qualitative study on outcomes from personal budgets in mental health found that ‘… most participants identified positive outcomes across domains interconnected through individual life circumstances, with mental health and wellbeing,


\textsuperscript{193} Jerry Tew et al., ‘“And the Stuff That I’m Able to Achieve Now Is Really Amazing”: The Potential of Personal Budgets as a Mechanism for Supporting Recovery in Mental Health’, British Journal of Social Work (2015).


social participation and relationships, and confidence and skills most commonly reported'.

The literature has also examined the impact of the use of personal budgets on carers. Larkin found that just over half of the sample of carers interviewed felt their relationship with users had been enhanced by the personal budget arrangements. Three quarters reported positive outcomes, such as feeling happier, healthier and having more control over their lives. An independent evaluation of the 2005–2007 individual budgets pilot (IBSEN) drew similar conclusions, suggesting that ‘… that the receipt of the budget was significantly associated with positive impacts on carers’ reported quality of life and, when other factors were taken into account, with social care outcomes. These outcome gains were achieved despite no higher costs being incurred to the public purse, thus suggesting that IBs for service users are cost-effective for carers’.

There is however evidence that inadequate funding and restrictions on how personal budgets/direct payments may be used can inhibit choice and control. These are limitations that the Integrated Personal Commissioning Programme intends to address and evidence is needed to ascertain whether the Programme is successful in tackling them.

Findings from the Personal Outcomes Evaluation Tool (POET) survey 2015 provide an overall positive picture of the impact of personal health budgets, with over 80 per cent of personal health budget holders stating that their budget has had a positive impact on their quality of life, independence and the way they arrange support. In addition, over 75 per cent of carers said that having a personal health budget had a positive impact on day-to-day stress, their ability to continue caring, quality of life and choice and control.

Personal health budgets have been found to work best for people with the highest needs and can help join up health and social care the level of the individual. Personal health budgets for people with learning disabilities and autism are found to ‘… lead to better support for individuals who may otherwise end up in high cost, poor quality residential care’.

A longitudinal study of people with a range of conditions found that ‘… the use of personal health budgets was associated with a significant improvement in the care...


198 K. Jones et al. ‘Can Individual Budgets Have an Impact on Carers and the Caring Role?’, Ageing and Society, 34, no 1 (2014).


related quality of life and psychological well-being of patients. However, in this study personal health budgets did not appear to have an impact on health status per se over the 12 month follow-up period.  

**Value for money (clear plans for making efficiencies/performance against efficiency plans, reduction in total bed days)**

*I receive the best possible level of care from the NHS and my local authority.*  

**Policy overview**

The Integration Standard sets out a value for money objective, to ensure service users receive the best possible level of person-centred, coordinated care from the NHS and local authorities. Reduction in total bed days is proposed as an indicator of performance; in addition, areas are expected to deliver against a clear plan for making efficiencies across health and care, through integration, contributing to the £22 billion efficiencies programme.

The NHS estimates that ‘… of the so-called “£22bn efficiency requirement”, around £7bn will be delivered nationally, leaving around £15bn to be secured from local efficiencies’. These will be achieved through productivity improvements each year across NHS secondary care providers but also by ‘… moderating the level of activity growth through care redesign, and interventions such as Right Care and Self Care’.  

Arguably, the main expectation underpinning the value for money objective is that integrated care is capable of delivering the so-called ‘triple aim’ – improving health outcomes, enhancing patient experience and reducing the costs of care. Better Care Fund guidance adopts a similar approach, recommending that ‘… a reasonable range of outcomes and measures should be selected with the aim of delivering the following key impacts: people’s experiences of care; care outcomes in terms of changes to people’s health and wellbeing; and better use of resources’.  

In the literature, value for money as a measure of improved health outcomes is generally evidenced through the analysis of the benefits of integrated care ‘… in terms of natural units (cost-effectiveness), such as life years gained, reduction in blood pressure or in a synthetic overall health measure (cost-utility, such as quality adjusted life years (QALYs))’. Cost and utilisation analysis on the other hand capture the third element of the ‘triple aim’, with utilisation measuring ‘… the level of use of a particular

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204 Nolte and Pitchforth, ‘What Is the Evidence on the Economic Impacts of Integrated Care?’


206 Nolte and Pitchforth, ‘What Is the Evidence on the Economic Impacts of Integrated Care?’
service over time, such as physician visits; emergency room/accident and emergency department (ED) visits; hospital admissions; length of hospital stay; hospital days.\textsuperscript{207}

**Demonstrating value for money**

Measuring the value for money of integrated care is fraught with difficulties. This is reflected in the existing evidence, which in general is difficult to assess and often generates conflicting results.

Both in research and practice, integrated care is understood in a variety of ways, and studies frequently fail to provide a clear definition of integrated models which they examine. These can vary significantly in terms of their focus, degrees of integration, processes and types of intervention. In turn, the impact an intervention can make depends on a whole range of factors, including its specific characteristics, the population it targets and the delivery model it uses. As a result, attribution between the interventions implemented and the outcomes they produce may be difficult to determine. Indeed, the literature on integrated care tends to relate to a variety of very different approaches, many of which are complex and multidimensional, and may include multidisciplinary teams, case management, hospital at home, early supported discharge, care coordination, individual care plans and a whole range of preventive programmes, including patient education and empowerment.

In addition, the timeframe for the assessment of integrated care interventions plays a critical role. Measures of impact will reflect the stage in the lifecycle of an intervention in which the evaluation is carried out, with a number of outcomes requiring the full maturity of a programme to materialise. ‘Certain measures (such as improvements in life expectancy, trends in hospital utilisation, or changes in quality of life) may be legitimate long term goals of integrated care, yet attribution becomes conflicted due to a myriad of other factors influencing the outcome. For this reason, measures of quality for integrated care should probably not include variables that are unlikely to be amenable to change within 3–5 years.’\textsuperscript{208}

Some commentators question ‘… whether the concept of “integrated care” lends itself to evaluation in a way that would allow for clear-cut or definitive evidence, given its polymorphous nature’.\textsuperscript{209} This point is echoed by Dorling et al., who note that ‘… integrated care is, by definition, not a single intervention that can be isolated from other elements of practice’.\textsuperscript{210}

In addition, a number of measures and a whole range of approaches, including cost analysis, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis, are employed to measure value for money. These may not be easily comparable and may produce conflicting results. For instance, cost-effective interventions, shown to produce positive outcomes for users may lead to an increase in service utilisation and

\textsuperscript{207} Ibid.

\textsuperscript{208} Better Care Fund, ‘Implementation Support Programme, How To ... Understand and Measure Impact’.

\textsuperscript{209} Nolte and Pitchforth, What Is the Evidence on the Economic Impacts of Integrated Care?’

associated costs, in the short and medium term at least, to meet needs which had previously gone unmet.

The robustness of the evidence also varies significantly according to the research methods employed. Commonly used methods include experimental studies, randomised control studies, matched comparison group design and before and after methods.\textsuperscript{211} The evidence base suggests that studies measuring the impact of integrated care interventions are often small and lack a strong controlled design or comparison strategy.\textsuperscript{212}

**Utilisation and cost reduction**

Utilisation analysis measures the impact of integrated care on service use, generally in terms of reduced hospital admissions and bed days. However, the evidence on the ability of integrated care interventions to reduce bed days is patchy and contradictory. In their meta-review on the economic impact of integrated care, focusing on utilisation, cost-effectiveness and cost reduction, Nolte and Pitchforth found that levels of utilisation, including admission and readmission rates, length of stay and visits to the emergency department, and associated costs, were the main economic outcomes assessed in the reviews they examined. However, findings were on the whole inconclusive, even within each review. For instance, one of the reviews, examining the impact of case management for mental illness, revealed that of the six studies analysed, two showed a decrease in number of admissions, three reported no change, and one an increase. Meta-analyses on the impact of early supported discharge or discharge planning also produced conflicting results, with one study finding no evidence of significant change in readmissions and two studies reporting significant lower readmission rates compared to usual care. Hospital at home services, designed to reduce hospital admissions, were found to produce a non-significant increase in admissions in another study.\textsuperscript{213}

The impact of integrated care in utilisation of emergency departments is also patchy. Nolte and Pitchforth report that in one review only one randomised controlled trial out of three showed that interventions aimed at frequent emergency department users led to a significant reduction in utilisation of emergency services. Most before and after studies, however, reported a significant reduction (six out of eight), and one found a significant increase. In contrast, another review of six studies on chronic care programmes for patients with chronic obstructive pulmonary disease found that only two studies reported a significant reduction in emergency department use as a result of the intervention.\textsuperscript{214}

Nolte and Pitchforth’s 2014 meta-review identified 17 reviews that explicitly examined cost and/or expenditure data. They found some evidence of cost reduction in a number

\textsuperscript{211} Better Care Fund, ‘Implementation Support Programme, How To ... Understand and Measure Impact’.

\textsuperscript{212} Nolte and Pitchforth, ‘What Is the Evidence on the Economic Impacts of Integrated Care?’

\textsuperscript{213} Ibid.

\textsuperscript{214} Ibid.
of reviews of integrated care interventions. However, they concluded that findings were often based on a limited evidence base or on studies that lacked controlled design.\textsuperscript{215}

In contrast, Dorling et al.’s meta-analysis of data from 53 controlled studies (the majority of which were US-based but the analysis did include some UK studies) investigating the impact of integrated care on hospital admission rates, found ‘… a statistically significant reduction in the probability of hospitalization for patients in integrated-care programs of 19 percent when compared with usual care’.\textsuperscript{216} Crucially, their analysis identifies a number of specific integrated care interventions that are shown to make the greatest impact in terms reduced hospital admissions. These include patient education and empowerment; multidisciplinary teams; proactive care coordination and case management; and personalised care planning.

There is a growing and emerging evidence base on the impact of integrated care approaches in England, with some localities reporting significant improvements in relation to patient and staff experience, service utilisation, cost savings and outcomes, although the strength of the evidence is often unclear. Richardson suggests that the Northumberland Frail Elderly Pathway produced a significant reduction in emergency admissions between April 2011 and July 2013, with the decrease expected to equal 36 per cent compared to usual care. Torbay is reported to have demonstrated a 33 per cent reduction in daily average number of occupied beds between 1998 and 2008, and, in 2009/10, it ‘… showed 19 per cent lower average length of stay and 29 per cent lower emergency bed use for the population over 65 versus South West Strategic Health Authority (SHA peers)’.\textsuperscript{217}

Similarly, an earlier evaluation of the Partnerships for Older People Projects (POPPs), which provide a person-centred, integrated response for older people through prevention and early intervention, found that ‘… when compared with non-POPP sites, POPP sites had significantly fewer emergency bed days in hospital. This reduction in emergency bed days resulted in considerable savings; for every extra £1 spent on POPP services per month, there is a £1.20 reduction on required spending on emergency bed occupants’.\textsuperscript{218} However, Steventon et al. examined eight selected interventions, part of the Partnerships for Older People Projects, four of which were expected to have a high likelihood of reducing hospital admissions, and compared POPP participants to matched controls. They found ‘… no evidence of a reduction in emergency hospital admissions associated with any of the POPP interventions studied. In some instances, there were more admissions in the intervention group than in the control group. One intervention reduced the number of bed-days, but overall we found that the interventions we studied did not appear to be associated with a reduction in the use of acute hospitals’.\textsuperscript{219}

\textsuperscript{215} Ibid.

\textsuperscript{216} Dorling et al., ‘The Evidence for Integrated Care’.

\textsuperscript{217} Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.


\textsuperscript{219} Adam Steventon et al., ‘An Evaluation of the Impact of Community-Based Interventions on Hospital Use’ (London: Nuffield Trust, 2011).
Cost-effectiveness and service user outcomes

Hospital use and costs are not the only impact measures and changes in clinical markers of health, patient-reported health status or care experiences, and staff perceptions may be as important. Bardsley et al. observe that, as a result of the current narrow policy focus and financial incentives to reduce avoidable hospital costs, hospital admission targets are inappropriately included in business cases even for programmes that are not likely to meet the targets. ‘The result is that pilots comprise interventions that are more likely to influence outcomes other than admissions (at least in the short term), but are evaluated primarily in terms of impacts on admissions. It is generally easier to evaluate the impact of interventions on hospital use than other outcomes, as data are readily available. A more honest approach towards specifying impacts from the outset might help with the long-term sustainability of schemes.’

Economic evaluations of integrated care use cost-effectiveness analysis to measure the extent to which interventions maximise resources to improve outcomes for service users. Nolte and Pitchforth’s meta-review found some evidence of cost-effectiveness of selected integrated care interventions but concluded that overall the evidence was inconclusive. A trial examining the impact of case management on high frequency emergency department users did report improved clinical and social outcomes at costs comparable to usual care. In contrast, another review, while acknowledging the cost saving potential of structured home-based health promotion, reported that one study found little evidence of quality-adjusted life year improvement over usual care. ‘Six reviews reported on cost per QALY as a measure of cost-utility, suggesting increased cost associated with the integrated care approach in question in some studies but not others.’

Measuring patient outcomes rather than outputs, such as reduction in hospital admissions, poses a number of challenges. Outcome indicators of integrated care programmes such as quality-adjusted life years may require many years to yield meaningful measures. The evaluation of the Integrated Care and Support Programme found that ‘… it was common for interviewees to point out that transforming services will not lead to instant results, and that considerable time will be needed before improvements in outcomes can be measured as opposed to changes to resource use and outputs. Five years was the sort of timeframe often mentioned before results could be expected.’

‘We talk about the Pioneer being a five to seven year programme. It’s about transformation of change. We will struggle to see some of the results in five to seven years if we are truly transformational’ (local authority).

While data on the outcomes so far demonstrated by the Pioneers Programme is not yet available, the latest evaluation of the Programme summarises the views of pioneers on

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220 Martin Bardsley et al., ‘Evaluating Integrated and Community-Based Care: How Do We Know It Works?’ (London: Nuffield Trust, 2013).

221 Nolte and Pitchforth, ‘What Is the Evidence on the Economic Impacts of Integrated Care?’


223 Ibid.
what constitutes success for them. A common theme is a commitment to work towards achieving all of the three goals of the ‘triple aim’, to which they explicitly or indirectly refer, although they are also clear that programmes should primarily focus on service user outcomes and experience.224

‘… although we talk about having the triple aim in balance, actually, we know if you do the first two things [improving health and wellbeing; improving experience of care and support] you get the third [reducing the per person cost of care and support], but if you focus just on cutting contracts or … on increasing volume, and you try and do that in a contractual way rather than in a relationship way, you very rarely get the first two …’ (voluntary sector).225

**Single assessment and care plans (proportion of target cohorts receiving single assessment and integrated care plan)**

“If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care.”

**What is a single assessment/integrated care plan?**

As with many concepts relating to integration, producing a precise definition of a single assessment/integrated care plan is challenging, despite what at first may seem to be a relatively straightforward concept. This is reflected in the array of terms employed in the literature, which variously describe joint approaches to assessment and care planning as ‘integrated’, ‘shared’, ‘collaborative’, ‘joint’ or ‘single’. (Indeed, the documentation supplied by the Department of Health on the Integration Standard 2020 makes reference to ‘single assessments’, ‘integrated care plan’ and ‘joint approaches’.) However, these concepts are not necessarily used interchangeably in the evidence reviewed, and each term is often intended to capture a distinctive model of practice and a varying degree of interprofessional collaboration and service integration. They do however all share common features and are underpinned by similar aims and principles.

The concept of single assessments and care plans as part of an integrated, person-centred care approach to services was first introduced nationwide by the National Service Framework for Older People (2001). Standard 2 of the framework, the implementation of which began in 2004, requires that the NHS and social care services ‘… treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services’.226 As the Framework explains, the single assessment process for health and social care needs also comprises the individual care

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224 Ibid.
225 Ibid.
plan, ‘… which should be used by all agencies for managing the care and treatment of older people including those with mental health problems’. 227

The principles underlying the single assessment process are reasserted in the Care Act 2014, which requires that in carrying out proportionate assessments for people with complex needs, local authorities must consider involving a number of professionals and that care plans should not be developed in isolation from other plans. Where a person has both health and care and support needs, the Care Act prescribes that local authorities should work in collaboration with the NHS to produce integrated assessments and care plans. ‘To achieve this, local authorities should: ensure healthcare professionals views and expertise are taken into account when assessing the care and support services people require; and work with healthcare professionals to ensure people’s health and care services are aligned and set out in a single care and support plan.’ 228

Partly as a response to these specific provisions of the Care Act and reflecting the vision set out in the Five Year Forward View, NHS England has produced guidelines for the implementation of personalised care and support planning processes within the NHS. These are defined as a ‘… systematic way of ensuring that individuals living with one or more long-term condition (LTC) and their health and care professionals have more productive and equal conversations, focusing on what matters most to that individual …’, 229 and supporting their independence, overall wellbeing and self-management. Key to this approach is a single holistic care and support planning discussion and plan. The guidance recommends that ‘… personalised care and support plans should be developed in conjunction with other plans that the individual may have, for example where the person is receiving both Local Authority provided care and support and NHS health care’ and that ‘attempts should be made to combine plans (and the planning process) to support the individual and avoid duplicating processes or introducing multiple monitoring regimes’. 230

As the integration agenda moves forward, new evidence of joint approaches to assessment and care planning is emerging, providing examples of specific local solutions and good practice. The Integrated Personal Commissioning Programme, for instance, is a new voluntary approach joining up health and social care for adults and aiming to improve the experience of care for people with complex needs. It places personalised care and support planning at its heart. It views the care planning process as ‘… holistic, covering all health and wellbeing needs and leading to a coordinated assessment and a single personalised plan, owned by each individual and geared towards maximising their personal potential for self-management’. 231 A single assessment and care plan is delivered by the Integrated Personal Commissioning

227 Ibid.
230 Ibid.
Programme support teams, which bring together a range of clinical and professional experts, including GPs, nurses, social workers and mental health specialists but also the voluntary sector.\textsuperscript{232}

Taylor argues that integrated assessments do ‘… not mean that professions are regarded as if they could do each other’s jobs … Nor is the term used here to mean arrangements whereby an assessment undertaken by one professional is accepted by others …’. For Taylor the ‘… aim is to coordinate specialist assessments into a holistic picture’.\textsuperscript{233} The author goes on to argue that a tool to integrate these specialist assessments could be designed.

Why is this objective important?

For people who need care and support from more than one service it is important that assessments and care planning are holistic and coordinated. While this is generally seen as a goal for all health and care assessments, joint assessments and care plans are perceived to be particularly effective for those cohorts who are associated with the greatest use of care, with some researchers suggesting that in the case of older people ‘… multidimensional assessment and multiagency management. …’ can lead to better outcomes.\textsuperscript{234}

Single assessments and care plans are also seen as a way to minimise bureaucracy, duplication and administration for frontline staff which in turn is seen as an important way of conserving resources. Benefits to service user experience are also expected given that the individual will only have to ‘tell their story once’. This is often cited as a key objective of integrated care and the National Voices programme of work selected ‘I tell my story once’ as part of the person-centred coordinated care narrative relating to communication.\textsuperscript{235}

The literature indicates that integrated assessments and care plans also have a direct, positive impact on health outcomes for service users, arising from the comprehensive, holistic understanding of care needs they afford and the coordinated, multidisciplinary approaches to interventions they support. Summarising early evidence, Challis et al. (2010) suggest that key benefits of a comprehensive assessment, as part of the single assessment process, undertaken by both health professionals and social workers include ‘… reduced functional decline, improved carer wellbeing, and reduced care-home admissions and health-care costs.’\textsuperscript{236}

These findings are further corroborated in Clarkson et al. (2011). Re-analysing data from an early randomised controlled trial of integrated assessment between specialist

\textsuperscript{232} Ibid.


\textsuperscript{235} Think Local Act Personal and National Voices, ‘A Narrative for Person-Centred Coordinated Care’ (Redditch: NHS England, 2013).

clinicians and social services care managers in England, they found that patients receiving the integrated assessment experienced reduced deterioration in their physical functioning, delay in care home admission or more appropriate admission for those most frail. Their analysis indicates that integrated assessments resulted in an 11 per cent cost reduction to the NHS, associated with reduced use of acute care services. The paper suggests that ‘… to realise wider benefits integrated assessment may necessitate integration at a higher level of coordination, where explicit structures require organisations to work together through the use of single assessment documentation or shared decision making.’

An early review of progress against the National Service Framework for Older People, while acknowledging that the implementation of a single assessment in the localities reviewed had been limited, noted that ‘… older people emphasised the importance of receiving services that are well coordinated, or joined up.’ When older people had undergone a single assessment, they reported some initial benefits, including ‘being able to keep their shared record with them at home.’ Furthermore, ‘… the inspections of local communities indicated that a single assessment process for older people was also thought to be bringing other benefits, in particular: more consistent and regular reviews of care and support; greater coordination of systems to safeguard older people; better systems to review prescribed medication.’ The report goes on to argue that ‘… multiple assessments mean that older people are likely to be asked the same questions repeatedly, while other important areas remain ignored. A shared approach reduces the likelihood of confusion and means that critical issues are more likely to be jointly understood and acted on. In addition, older people wanted their unique combination of experiences, aspirations and hopes for the future to be recognised, rather than have uniform solutions imposed on them that focused only on problems.’

Empirical evidence suggests that coordinated approaches to assessment and care planning has the potential to improve patient experience of services by increasing their understanding of how the processes work, their ability to participate in the decision making and their confidence that all their needs are adequately addressed. Drawing on the results of a survey of patient views in the North West London Integrated Care Pilot, Mastellos et al. (2014) found that service users valued the integrated approach to care planning and felt involved in the process. Ninety-four per cent of respondents with knowledge of their care plan status agreed that all care professionals involved in the management of their care should share information with one another.

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239 Ibid.

240 Ibid.

241 Ibid.

Enablers, barriers and challenges

The role played by multidisciplinary approaches as enablers of effective assessments and care planning was made clear by national conditions for the Better Care Fund which require that plans should provide confirmation of a ‘...joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional …’.\(^{243}\)

Furthermore, it has been argued that effective multidisciplinary comprehensive assessments are best achieved when a multidisciplinary team is led by a single manager.\(^{244}\) Indeed, the emerging evidence suggests that the role of care coordinator/care manager, who may come from a range of professional backgrounds, may be key to the achievement of care integration and the facilitation of multidisciplinary team.\(^{245}\)

Challis et al. (2010) acknowledge the prevalent consensus around the key role that multidisciplinary teams play in the delivery of integrated assessments to older people, whose complex conditions may require the input of a range of professionals with different levels of expertise and skills. Analysing early data from a national survey of local authorities on the implementation of the single assessment policy, and looking specifically at the extent to which a multidisciplinary component was used in the assessment of people with complex needs, they found however that ‘... two years and more after the introduction of the Single Assessment Process in England, such teams were not the norm’ and assessments were more often undertaken by a single professional. The absence of a systematic approach to comprehensive assessments, the lack of mandatory procedures, prescriptive guidelines and agreed protocols between agencies and professional groups are identified as a possible reasons for the initial tentative accomplishments of the single assessment process.\(^{246}\)

In 2006, The Healthcare Commission highlighted additional factors deemed to hinder the implementation of a single assessment process – the lack of a shared electronic system for keeping records; difficulties in ensuring participation for multidisciplinary training of staff; insufficient engagement of staff in hospitals and in GP surgeries; disagreements about what information could be shared between partners; insufficient understanding of the need for a change in culture; and a full commitment to person-centred care.\(^{247}\)

Reviewing how care is integrated across health and social care, the Care Quality Commission recently found that when standardised assessment tools were available


\(^{244}\) Challis et al., ‘Comprehensive Assessment of Older People with Complex Care Needs: The Multi-Disciplinarity of the Single Assessment Process in England’.


\(^{246}\) Challis et al., ‘Comprehensive Assessment of Older People with Complex Care Needs: The Multi-Disciplinarity of the Single Assessment Process in England’.

\(^{247}\) Healthcare Commission, ‘Living Well in Later Life: A Review of Progress against the National Service Framework for Older People’.
their potential was not exploited, with separate assessments being undertaken in different settings and information not being routinely shared, failing to trigger a coordinated response and early intervention. Among GPs, there was uncertainty about the certified status of the assessment tools and some doubted their usefulness and effectiveness. In addition, ‘… it was common for older people to have multiple care plans, with the type and detail of information varying across plans’ and occasionally conflicting, while health and social care professionals struggled to produce single care plans and support. As a result, users’ had little understanding of what they should expect from services and were not effectively involved in the production of plans that meaningfully addressed the full range of their care needs.248

While noting that the fragmentation of IT systems was reported as the main obstacle to the production of single coordinated plans, the Care Quality Commission report observes that as a result ‘… providers often made decisions about the care plan according to their own priorities, accountabilities and professional cultures, instead of providing people with coordinated care, designed with the person and their carer(s), and aligned to meaningful outcome measures’.249 ‘Professionals should sit around a table to discuss a patient’s care plan and have a key document that is available to everyone. This is about health talking to social care but also about health talking to health’ (older person).250

Organisational and professional cultural differences, and settings-specific variations in priorities and approaches to care, remain a key barrier to full interagency and interprofessional collaboration. Local health and care systems and care providers are developing local solutions to the delivery of single assessments and care plans by either improving inter-organisational collaboration or ensuring that all the relevant professionals are involved in the process. A recent study on social care for older people by the King’s Fund reports on the complex process of discharging, with hospitals having to navigate through the intricacies of differing social care arrangements and multiple local authorities. The report observes that ‘…one NHS acute provider was in the process of trying to get agreement among the local authorities in their area for a single, generic social work assessment that would, in their view, reduce length of stay ….’. This was reported to signal a return to the role of the in-house social worker who would undertake the assessments instead of social services but encountering some resistance from local authorities concerned about the impact on their resources. Another area was trying ‘to stimulate more efficient ways of managing assessment and discharge by colo-locating hospital and social care staff members in order to improve communication. What was previously described as ‘quite fragmented and quite distant’ was now ‘much improved’ because of this change’.251

248 Care Quality Commission, ‘Building Bridges, Breaking Barriers’.
249 Ibid.
250 Ibid.
Integrated community care (user satisfaction, areas use multi-disciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week)

‘I receive more care in or near my home, and haven’t been to hospital for ages.’

‘My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it.’

‘Areas use multidisciplinary integrated teams and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.’

What is integrated community care?

Community care is about ensuring that people who need care are supported to live with dignity and independence in their communities. The NHS and Community Care Act 1990 gives overall responsibility for the provision of community care services to local authorities, which are required to produce and publish community care plans, carry out the needs assessment, produce written care plans and arrange for the provision of care. As set out in the broader legislation, community care comprises a wide range of services, including: domiciliary care/support services; home help services; day centre provision; respite care; aids and adaptations; community health services; residential and nursing care; supported living placements; hospital discharge arrangements; and meals on wheels services.

The increasing incidence of multi-morbidities and long-term conditions, the rising costs of acute care and pressures on hospitals have led to a growing involvement of medical professions and health services in the delivery of community care and the development of a broader range of NHS-led, community-based health service models, including intermediate care, designed to bring care closer to home and away from hospital wards. Health-based community services make up a substantial part of NHS care provision. Edwards estimates that ‘around 100 million community contacts take place each year, ranging from universal public health functions such as health visiting and school nursing to targeted specialist interventions in musculo-skeletal services, chronic disease management and intensive rehabilitation’.252

Integrated community care aims to ensure local authorities and the NHS work together, both vertically and horizontally, to offer a comprehensive provision of social and health care services in the community. This is achieved through a better coordination of services and greater interprofessional collaboration, to meet the growing complexity of care needs of local populations, in a cost-effective, personalised and person-centred manner and exploiting the resources, formal and informal arrangements and social networks available in communities. ‘There is a clear push among commissioners to

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commission on the basis of a place, overcoming artificial barriers established within the NHS and between health and care. 253

The Better Care Fund, the Integrated Care and Support Pioneers Programme, the New Care Models Vanguards and a number of programmes resulting from recent devolution arrangements provide growing evidence of emerging models of integration at place level.

Outlining case studies from seven leading localities, Richardson examines some recent examples of integrated approaches to community care. These include: community health services and social care team integration in partnership with acute care (Northumberland); integrated health and social care teams (Torbay); primary care hubs with acute, community mental health and social care (Tower Hamlets); multidisciplinary neighbourhood groups with acute, community, mental health and social care and central coordinator role (Salford); real time integrated health and social care record deployed in neighbourhood (Leeds); psychiatric liaison team in acute care – rapid assessment interface and discharge (Pennine Care); multidisciplinary neighbourhood groups with acute, community, mental health and social care and central coordinator role. 254

A common feature of these models is the extent of interprofessional collaboration and the critical role played by multidisciplinary teams. NHS England describes a multidisciplinary approach as one which draws on ‘… skills and best practice from multiple disciplines and across service provider boundaries (e.g. health, social care or voluntary and private sector providers) to redefine, re-scope and reframe health and social care delivery issues, and reach solutions based on an improved collective understanding of complex patient need(s)’. 255

There are variations in the way integrated community-based services are shaped, inter-organisational relationships are established, and specific arrangements for interprofessional collaboration are being defined, and both policy and practice are building on the learning from emerging models. There appears to be some consensus that primary care settings remain at the centre of many new integrated systems. A 2014 report by the Royal College of General Practitioners argued that ‘… no models of care provision would be truly integrated without general medical services at their heart, as general practice remains the central point for cradle to grave care and has responsibility for the registered list of patients’. 256

In a separate report focusing on improving the care provided by general practice, the King’s Fund further suggests that their research demonstrates that there is ‘… a need for general practice to work more closely with hospital and community services in order to co-ordinate care – particularly for those with long-term conditions … For those with complex needs, including more serious mental health problems, general practice needs to see itself as the hub of a wider system of care, and must take responsibility for

253 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.
254 Ibid.
coordinating and signposting to services beyond health care – in particular, for social care, housing and benefits’.\textsuperscript{257} Similarly, a report by BASW and the RCGP published in 2014 argued that through collaboration ‘… social workers and GPs are ideally placed to shift the balance of care from acute to community settings’.\textsuperscript{258}

\textit{Why is this objective important?}

Effective community services are widely acknowledged as a key component of a sustainable health and social care system. Services that prevent health and wellbeing crises by maintaining the independence and wellbeing of people in their local community reduce the need for more expensive forms of care such as that provided in the acute sector.

Well designed and coordinated community services, built around multidisciplinary teams and cost-effectively combining the expertise and resources of local actors, including the NHS, local authorities and the voluntary sector, are critical to the successful implementation of the integration agenda and to achieving its core objectives, namely: the provision of person-centred care; addressing the holistic needs of people and supporting their independence and overall wellbeing; harnessing individuals’ and communities’ assets; and preventing or reducing the demand for more intensive or emergency care.

Evidence on the impact of integrated community care, and of the emerging new schemes in particular, is somewhat inconclusive. This is not surprising, due to the novelty of some of these models, the varying nature and aims of the schemes examined, their maturity in their journey to full implementation, the robustness of the delivery arrangements in place, and the outputs and outcomes measured. Focusing on use and costs impact of a range of integrated and community-based services, Bardsley et al. found little evidence of reduction in emergency admissions. They note however that an earlier evaluation of the Department of Health funded integrated care pilots ‘found that the integrated care interventions led to process improvements such as an increase in the use of care plans and the development of new roles for care staff’.\textsuperscript{259}

In contrast, examining examples of emerging integrated community programmes in seven leading localities, which use a multidisciplinary approach and close collaboration across health and social care, Richardson found that ‘Northumberland has had significant reductions in emergency admissions; Tower Hamlets has achieved significant success in terms of prevention for various chronic diseases across the entire borough; Torbay has shown significant impact in terms of reducing cost growth and several outcomes related to discharge facilitation; and Pennine Care’s Rapid Assessment Interface and Discharge (RAID) model has displayed impact in terms of cost and activity.’\textsuperscript{260}

\textsuperscript{257} Nick Goodwin et al., ‘Improving the Quality of Care in General Practice’ (London: King’s Fund, 2011).


\textsuperscript{259} Bardsley et al., ‘Evaluating Integrated and Community-Based Care: How Do We Know It Works?’

\textsuperscript{260} Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.
Similarly, and more broadly comparing integrated care interventions with usual care, in their meta-review of integrated care programmes for adults with chronic conditions examining 27 systematic reviews and meta-analyses, Martinez-Gonzalez et al. found ‘beneficial effects of integration of care on several outcomes, including reduced mortality, reduced hospital admissions and re-admission, improved adherence to treatment guidelines and quality of life’.261

Using simulation modelling, Monitor has attempted to estimate the cost benefits of delivering care through community-based schemes, including integrated services delivered by multidisciplinary teams, and compared them to an acute setting. Their findings show that ‘in the long run, the costs of delivering care in the community may be lower than those of delivering care in acute hospitals’.262 For instance, enhanced step-up services, providing rapid multidisciplinary assessment, diagnosis and treatment in a centralised community setting, are found to reduce acute inpatient stays by 80 to 90 per cent. ‘In addition, these patients’ ongoing social care needs are likely to reduce as they avoid deconditioning in acute hospital beds, but there is insufficient data to quantify these impacts’.263 Around 65 to 85 per cent of patients using rapid response and early supported discharge services provided by multidisciplinary teams in their own homes avoid admissions into acute inpatient settings. Reablement schemes are found to result ‘in a 50 per cent to 70 per cent reduction in the intensity of social care for a year following discharge’.264

Moving care ‘closer to home’ is also viewed as beneficial to service users and the importance of preventative care provided in community settings was emphasised in a 2014 Department of Health paper that argued that the NHS Transforming Primary Care programme was ‘… the next step towards safe, personalised, proactive out-of-hospital care for all’.265 A similar goal was most recently articulated in the Five Year Forward View which states that ‘far more care’ will be delivered locally in the future.266

Specific evidence on the impact of the multidisciplinary component of integrated approaches to care, including community care, is also emerging. In 2015 the King’s Fund identified ‘care co-ordination through integrated health and social care teams’ as one of 10 priorities for commissioners, arguing that although ‘robust evidence’ is limited there is evidence that more coordinated care and ‘highly’ integrated primary care can have a positive impact on quality of life, patient experience and cost-effectiveness.267

In an earlier paper the King’s Fund argued that community-based services had the potential to ‘transform’ care through the provision of ‘… locality-based teams that are

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263 Ibid.
264 Ibid.
266 NHS England et al., ‘Five Year Forward View’.
grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services'.

According to Stokes et al., assessing the effectiveness of case management for patients in primary care ‘at risk’ of hospitalisation and in particular older people with multiple morbidities, the evidence shows that the effectiveness of case management may be increased when delivered by a multidisciplinary team, and when a social worker is involved.

Similarly, the Commission on Improving Urgent Care for Older People, setting out the principles for redesigning services that better meet the needs of older people, supports greater use of multidisciplinary and multi-agency teams, both hospital and community based, suggesting that for frail patients ‘there is evidence that comprehensive geriatric assessment – underpinned by a multidisciplinary approach – leads to better outcomes’. Examining the impact of the Westminster Falls Service, which provides a multidisciplinary falls risk assessment and targeted intervention for people referred following a fall, or who are at risk of falling, the Commission reports that people followed up a year post-discharge reported a 60 per cent reduction in falls, 55 per cent fewer fractures, 92 per cent fewer accident and emergency admissions, and an 80 per cent reduction in GP appointments compared to the year prior to intervention.

Enablers, barriers and challenges

Cultural and organisational differences between the health and care sectors and variations in professional behaviours and approaches to care pose significant challenges to integration. Highlighting the critical role played by coordinated care interventions to support enhanced hospital discharge safety, Waring et al. note that ‘hospital discharge involves a dynamic network of interactions between heterogeneous health and social care actors, each characterised by divergent ways of organising discharge activities; cultures of collaboration and interaction and understanding of what discharge involves and how it contribute to patient recovery’.

These cautionary notes are echoed in a recent review by the Care Quality Commission on the state of integrated care for older people across health and social care. The Commission found evidence that in some localities a range of services with overlapping remits (reablement, falls prevention, rehabilitation and enablement, and rapid intervention) operate in a disjointed and uncoordinated manner. As a result, navigation across the system becomes cumbersome for users and duplication of services results in an inefficient use of resources. The review identifies key barriers to integration in terms of limited understanding of staff about other providers and a lack of appreciation of ‘their

268 Edwards, ‘Community Services: How They Can Transform Care’.


different priorities, pressures and accountabilities. People working in primary and social care expressed strong views about the way in which staff in hospitals focused on what they needed to do and did not pay sufficient attention to others. Hospital staff said the same about primary and social care providers.272

The Commission recommends two approaches to addressing these challenges: at a strategic level, local health and social care leaders should agree a shared understanding of what integrated care means in their local context and work towards delivering the shared aims; and commissioners and providers should ensure users are helped to navigate through the local offer of services and are provided with adequate information about the services available and how to access them.273

Richardson, drawing on the learning from seven case studies, suggests that a key enabler of integrated care in localities is the development of a fully integrated workforce plan, through engagement and co-production. In addition, the author observes that ‘several sites have indicated how critical to success it is to identify a small number of pivotal roles and invest in making these happen. Care coordinator roles within MDTs are cited by many sites, with many making use of non-clinical backgrounds to deliver this role. Some of the other key roles that have been developed are clinical leads, care planners, and management support roles. Community matrons and nurse practitioners have been discussed and experimented with in some areas, including taking on a wider role than GPs. The placing of geriatricians in the community setting has also been discussed: significant innovation is clearly possible’.274

A recent report by the King’s Fund acknowledges the potential of a number of new professional roles such as care navigators, community facilitators, enablers or link workers, currently being developed in community care settings to smooth the service user’s journey through services and across care boundaries. However, the report cautions that there is a lack of robust evidence on the specific contribution of these roles to the success of emerging integrated care programmes; new roles are only effective when they are part of a system-wide process of integration, are accompanied by a change in organisational and professional culture and are supported by stakeholders; building effective relationships and establishing a shared commitment to developing care around an individual’s needs may be more important than developing new professional roles; the skills needed to support integrated care may already exist within the workforce – interdisciplinary training and cross-organisational placements may help ensure that existing expertise is better shared, distributed and exploited; and new models of integrated care may be best achieved by ensuring existing staff learn to work in different ways rather than through the creation of new roles.275

The literature identifies a number of additional factors supporting interdisciplinary collaboration, particularly between social workers and health professionals. These include acknowledgement of colleagues’ expertise; recognition of roles; positive level of

272 Care Quality Commission, ‘Building Bridges, Breaking Barriers’.
273 Ibid.
274 Richardson, ‘The Journey to Integration: Learning from Seven Leading Localities’.
communication; and mutual respect. Theoretical differences, varying professional perspectives, lack of knowledge and poor communication, on the other hand, are perceived as barriers to effective integrated care team work.\textsuperscript{276}

For Mackie and Darvill, who critically examined existing evidence on factors that enable the successful implementation of integrated health and social care and effective integrated teamwork, key enablers are: co-location of staff, communication, leadership, resource and capacity, national policy framework and information technology systems. Crucially, they observe that ‘the opinion that integrated teams take a number of years to become established and start realising the benefits of an integrated care approach is widely acknowledged’.\textsuperscript{277}

More specifically, exploring system characteristics associated with higher and lower increase in unplanned admission rates in those aged 85 years and over in six sites in England, Wilson et al. found that ‘the most striking difference between improving and deteriorating sites was not the presence or absence of specific services, but the extent to which integration within and between types of service had been achieved’.\textsuperscript{278} They recommend maximising integration, leadership and adopting a system-wide approach to reconfiguration.

**Timely and safe discharges (delayed transfers of care from hospital, stronger incentives and mechanisms to reduce delayed transfers of care)**

‘If I go into hospital, health and social care professionals work together to make sure I’m not there for any longer than I need.’

**What are timely and safe discharges?**

Timely and safe discharges are a critical aspect of effective patient flow and more broadly high quality care provision – the right care provided at the right time and in the right settings. Underpinning this definition of quality care is the principle that ‘hospitals should look to admit only those patients whose medical needs require it, and reduce length of stay and the proportion of long-stay patients wherever it is clinically safe and appropriate to do so’.\textsuperscript{279}

NHS England guidance states that a ‘… delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when: a clinical decision has been made that patient is ready for transfer AND a multi-


\textsuperscript{278} Andrew Wilson et al., ‘Establishing and Implementing Best Practice to Reduce Unplanned Admissions in Those Aged 85 Years and over through System Change [Establishing System Change for Admissions of People 85+(ESCAPE 85+)]: A Mixed-Methods Case Study Approach’ (2015).

disciplinary team decision has been made that patient is ready for transfer AND the patient is safe to discharge/transfer'.

However, the literature views hospital discharge as a highly complex process, which does not occur as a single or isolated event at the end of acute or emergency treatment but rather through a composite, multifaceted series of situations and opportunities. These begin with admission to hospital, and early identification of needs, and continue throughout hospital stay, involving multiple stakeholders and operating in various settings within and across acute, intermediate, primary and social care. For many patients, their discharge from hospital does not represent the end of their journey through care but rather a critical and potentially vulnerable point in the transition from one form of care to another.

The evidence indicates that lengthy stays in hospital, unduly prolonged by factors unrelated to the treatment of an acute episode, are not only costly to the system but also pose significant risks to patient safety and recovery. Remaining in hospital for longer than is clinically necessary can lead to negative outcomes for service users. There are risks in relation to hospital acquired infections and there can be a detrimental impact on morale. Perhaps most significantly, long hospital stays can lead to rapid functional decline, particularly in the case of older people. This was emphasised by the 2014 National Audit of Intermediate Care, which reported that a delay of seven days or more is associated with a 10 per cent decline in muscle strength.

For older people, in particular, and for people with long-term, multiple conditions, a smooth and safe transition from hospital to community care is too often hindered by the fragmentation of services, unavailability of adequate and easily accessible social care packages and poor communication within and between secondary, primary and community care settings. The National Audit Office estimates that, in 2015, 85 per cent of delayed patients were aged 65 and over, with the majority of bed delayed days recorded in acute care (1.15 million).

Delayed transfers also represent an inefficient use of resources. In 2016 the National Audit Office estimated that there was a cost to the NHS of £820 million resulting from the inappropriate use of acute care beds. This figure relates to the care of older people specifically and does not include the costs associate with other groups who may also be at risk of delayed transfers.

284 National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.
285 Ibid.
The available data provide some indication of the magnitude of the problem and the extent to which the picture nationwide is deteriorating. NHS England’s delayed transfer data show that in 2015 there were 1.75 million days delayed, a 12 per cent increase on previous year, confirming a long established trend of year on year rise on both number of patients delayed and total days delayed.\textsuperscript{286}

Despite widespread focus on delayed transfers as a key performance indicator it is apparent that the understanding of this measure and use of data relating to it is inconsistent. In 2015 NHS providers reported that there was still ‘confusion and variation’ in the counting, recording and signing-off of delayed transfers.\textsuperscript{287} The authors also emphasise that in mental health settings the ‘absence’ of a clear definition of both a delayed transfer and an out of area treatment ‘… makes meaningful comparison impossible and weakens efforts to identify and share best practice’.\textsuperscript{288} Moreover, official data does not capture the full extent of delays occurring during the whole stay in hospital and before a final decision to release a patient has been made. The National Audit Office estimates that ‘the number of older patients in hospital who are no longer benefiting from acute care to be approximately 2.7 times the figure for reported delayed transfer of care’.\textsuperscript{289}

While the majority of evidence relating to timely and safe transfers of care focuses on delays in the system and much energy has been expended in trying to address this problem, the literature emphasises that it is just as important that service users should not be inappropriately discharged before it is clinically safe to do so as this in turn may increase the risk of readmission. Premature discharge is shown to make a significant contribution to unplanned readmissions to hospitals.\textsuperscript{290} A recent study found that older people that felt they had been released from hospital before they felt well enough to go home were significantly more likely to be readmitted to hospital within three months.\textsuperscript{291}

\textit{Timely and safe discharges through care integration}

Timely and safe discharges are the culmination of complex processes and interdependencies. They are contingent on the contribution and coordination of multiple services across occupational and organisational boundaries and as such provide a good illustration of the benefits of delivering integrated care. Conversely, ‘the complex interdependencies and non-linear couplings between health and social care agencies can be the latent source of poorly timed, inappropriate or unsafe transition from hospital to community care’.\textsuperscript{292}

\begin{itemize}
  \item \textsuperscript{287} Paul Burstow et al., ‘Right Place, Right Time: Better Transfers of Care: A Call to Action’ (London: NHS Providers, 2015).
  \item \textsuperscript{288} Ibid.
  \item \textsuperscript{289} National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.
  \item \textsuperscript{290} Ibid.
  \item \textsuperscript{291} Royal Voluntary Service, ‘Going Home Alone: Counting the Cost to Older People and the NHS’ (Cardiff: Royal Voluntary Service, 2014).
  \item \textsuperscript{292} Waring et al., ‘An Ethnographic Study of Knowledge Sharing across the Boundaries between Care Processes, Services and Organisations: The Contributions to Safe Hospital Discharge’.
\end{itemize}
Delayed transfers of care, more specifically, are widely seen as a key indicator of the extent to which a local health and care system is integrated. An evidence review produced by NHS Providers stated that delayed discharges are ‘… a measure not just of hospital performance, but of how well the wider health and care system is working’.293

The latest NHS England data shows that in July 2016 a third of total days delayed were directly attributable to the social care sector and 8 per cent to both NHS and social care. Even when the responsibility for late discharges lay with the NHS, the drivers for delayed transfers were mostly associated with the need to secure social or community care support and services (awaiting nursing or residential home placement or availability, awaiting care package in own home, awaiting community equipment and adaptations, housing).294

The true impact of poor integration between health and social care is not fully captured by the official data on delayed transfers, which focus on the final phases of the discharge process. Reviewing the literature on safe transition of care from hospital, Waring et al. observed that effective discharge planning is the result of a complex range of collaborative activities and procedures, carried out by well integrated teams and services, throughout the whole patient care pathway. These include: preparation of accurate patient records and setting of estimate date of discharge on admission; regular multidisciplinary assessments to identify opportunity for discharge during hospital stay; the activation of a whole array of activities at least 48 hours prior to discharge, including liaising with multi-disciplinary teams, initiating referrals to community health care providers and social care agencies and undertaking social work/care assessment and referrals, making arrangements for equipment installations or house adaptations and putting in place a post-discharge care package; confirming follow-up arrangements with family and carers and issuing a discharge letter to the GP on the day of discharge; and provision of follow-up care after discharge.295

Focusing on the key broad principles emerging from current guidance, specifically in relation to the discharge planning process for older patients, the National Audit Office notes that ‘hospitals should identify the needs of older patients as quickly as possible to decide whether they are best met in hospital; where an older patient needs to be admitted, health and social care staff should work together to maintain the momentum of treatment and discharge planning; and health and social care staff should start the assessment and rehabilitation of patients as soon after admission as possible and in the home wherever possible’.296

Assessing hospital discharge best practice, the National Audit Office found that while nearly all hospitals in their case studies reported that their multidisciplinary teams reviewed older patients on a daily basis, this did not happen at weekends. Only 43 per cent said their multidisciplinary teams started planning and assessments on or soon


295 Waring et al., ‘An Ethnographic Study of Knowledge Sharing across the Boundaries between Care Processes, Services and Organisations: The Contributions to Safe Hospital Discharge’.

296 National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.
after admission and ‘only 21 per cent of local authorities and 13 per cent of community providers said they were involved at this point’. In addition, the report finds that a lack of knowledge and understanding of community-based services, which are often inconsistently described and subject to variable referral criteria and the need for untrained hospital staff to negotiate with local authorities added a level of complexity to the discharge process.

A clear focus on delayed transfers at a policy level and a broad consensus that these are one of the clearest indicators of an integrated system, have fostered significant levels of innovation. There have been a number of new service models that have been implemented including ‘discharge to assess’, which NHS England guidance recommends should become the default pathway. In South Warwickshire, for instance, the service enables patients to be discharged earlier from acute inpatient wards by coordinating care in alternative settings. An emphasis is placed on trusted assessments between health and social care, and the service includes the use of a care coordinator who supports patients and their families throughout the discharge process. Findings from a survey of hospitals on discharging arrangements for older people reveal that 52 per cent of hospitals had ‘discharge to assess’ schemes although only 39 per cent of schemes were available to all or most patients.

**Enablers, barriers and challenges**

Timely and safe discharges can only occur in well integrated systems of care, with health and social care providers working together to minimise length of stay in hospital and to smooth the transition to the appropriate level of care in the community. However, in 2016, The Committee of Public Accounts found that ‘the fragility of the adult social care provider market is clearly exacerbating the difficulties in discharging older patients from hospital’, suggesting that local authorities reduced spending in social care services and difficulties in recruiting and retaining staff is hampering the offer of local services. Strong local leadership to ensure the health and social care sectors work effectively and collaboratively through innovative approaches and clear structures of accountability are highlighted as key enablers of good practice.

Information-sharing across professional and service boundaries, to enable a full understanding of the whole spectrum of a patient health and care needs, is found to be a critical enabling factor of timely and safe transfer of care. NICE guidelines on transition between inpatient hospital settings and community or care home settings for adults with social care needs emphasise the importance of ensuring effective communication and information-sharing and interprofessional collaboration at all stages.

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297 Ibid.


299 National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.

of a patient journey through care, from admission to discharge.\textsuperscript{301} The National Audit Office’s report on older people’s discharges, however, found that ‘patient information was still not consistently shared across health and social care providers. This applied particularly to information provided to hospitals, and from primary and community healthcare providers to local authorities’.\textsuperscript{302}

These findings are echoed by the Committee of Public Accounts which observes that ‘the absence of widespread and effective sharing of patient information remains a significant barrier to the effective discharge of older patients’.\textsuperscript{303}

Financial incentives may have a role to play in encouraging timely and safe discharges. Under the Care Act 2014, local authorities may incur a fine by the NHS if discharge delays are caused by a failure to provide timely assessments or social care arrangements.\textsuperscript{304} However, only 23 per cent of councils were fined for delayed transfers in 2014/15 to a total of £2 million.\textsuperscript{305} The National Audit Office observes that ‘the financial incentives to discharge older patients as soon as possible from hospital are not aligned across health and social care systems’.\textsuperscript{306} While hospitals have a clear incentive to free up beds for elective admissions, community-based services often operate under a block contracts, which provide no financial incentive to take on new patients.

Social care embedded in urgent and emergency care (health and social care professionals available when needed/align with seven-day service standard)

‘If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them.’

The changing landscape of urgent and emergency care

A more effective and efficient urgent and emergency care network that is appropriately used is seen as an important tool in alleviating the increasing pressure on accident and emergency departments and reducing the numbers of emergency admissions.

Although there is little agreement on a precise definitions of the terms, emergency care is generally understood to indicate an immediate response to a life threatening, time critical health need. Urgent care, on the other hand, is the treatment of conditions that do not pose an immediate threat to life but require treatment within 24 hours or before the next in-hours or routine primary care service is available.


\textsuperscript{302} National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.


\textsuperscript{306} National Audit Office, ‘Discharging Older Patients from Hospital: Report by the Comptroller and Auditor General’.
The provision and organisation of urgent and emergency care in the UK is highly complex and increasingly fragmented. It comprises a wide range of services, both hospital- and community-based, offering a variety of responses and different levels of specialised care, which are too often difficult to navigate. They include: accident and emergency departments, general practices (estimated to provide the majority of urgent care), out-of-hours primary care, urgent care centres (walk-in and minor injuries units), NHS 111 and emergency ambulance services. New schemes such as rapid response, crisis response teams and care-at-home services are increasingly playing a critical role in the provision of urgent care. These new forms of care grew by 30 per cent between 2003/4 and 2011/12, responding to the growing demand for urgent care, but have not resulted in a reduction in accident and emergency attendances and emergency admissions.\footnote{307}

While the emergency and urgent care system was designed to deal with acute illnesses, demographic change has seen a shift towards complex, long-term conditions, including dementia, associated with old age. An increasing number of older people are attending accident and emergency departments or requesting urgent care. 'The older population continues to grow, with over 11.6 million (17.8 per cent of the population) aged 65 and over and 1.5 million (2.3 per cent of the population) aged 85 and over in mid-2015.'\footnote{308} Between 2003/04 and 2013/14 there was a 32 per cent increase in the number of accident and emergency attendances, from 15.5 to 21.8 million, resulting on a 27 per cent increase in emergency hospital attendances over 10 years. 'A total of 43 per cent per cent of people admitted to hospital non-electively are over 65, accounting for 53 per cent of all bed days; people over 65 also account for 80 per cent of hospital admissions that involve stays of more than 2 weeks. There is a more than threefold variation between areas in rates of emergency admission and occupied bed days for people aged over 65.'\footnote{309}

It is estimated that the average length of stay for emergency admissions for all ages is 5.6 days, increasing ‘to 7.5 days for emergency admissions for ages 65–74, 9.3 days for ages 75–84, and 10.9 days for ages 85+.’\footnote{310} Imison et al. also recognise that age is the main driver of variation in the use of emergency beds, noting that ‘in 2009/10, the average length of stay was approximately three days for patients under 65, but nine days for patients over 65. Among over 65s, the average length of stay varied from seven days (for those aged 65–74) to 11 days (for those aged 85 and over).’\footnote{311}

The evidence also shows that ‘older people are more likely to call an ambulance from home, more likely to be taken to hospital, and then more likely to be admitted than...'}
younger people. People under 65 use an average of 0.2 emergency bed days per year, while people over 85 use an average of 5 bed days.\textsuperscript{312}

The role of social care in urgent and emergency care

The evolving background against which urgent and emergency care services operate, characterised by a growing prevalence of long-term and multiple conditions and a composite and yet disjoined provision of care options, highlights the need for better, integrated approaches to health crisis management. Setting out an integrated approach to urgent and emergency care, Fernandes observes that ‘given the complex nature of patient flows across different services, urgent and emergency care services cannot be commissioned in isolation and the process requires a “whole system” and “multidisciplinary” approach across acute, primary and community-based services and social care’.\textsuperscript{313} The Silver Book on quality care for older people with urgent and emergency care needs similarly argues that ‘a whole systems approach with integrated health and social care services strategically aligned within a joint regulatory and governance framework, delivered by interdisciplinary working with a person-centred approach provides the only means to achieve the best outcomes for frail older people with health and social crises’.\textsuperscript{314}

The literature acknowledges that social care has a critical role to play in preventing older people from experiencing a health crisis, reducing hospital admissions and readmissions, shortening length of stay and supporting the discharge process.\textsuperscript{315} Assessing the existing evidence on urgent care for older people, Appleton and Miller observe that ‘there is a definite awareness of the challenge of getting the right skill mix to deliver older people's care well, and in doing so, building the right multidisciplinary teams across acute, primary, social and community care. Factors such as workforce/skill mix, competence in working with older people and awareness of their particular needs, integration, appropriateness of admission, pre-admission support, effective and safe discharge, the role of social care and capacity all feature highly as influencers upon the effectiveness of urgent care delivery for older people’.\textsuperscript{316}

Examining local variations in emergency bed use by older people, Imison et al. found that while the impact of community services such as GPs, community nursing and social care on bed use are unclear, ‘areas that have well-developed, integrated services for older people have lower rates of hospital bed use. Areas with low bed use also deliver a good patient experience and have lower readmission rates’.\textsuperscript{317} The broader evidence appears to confirm these findings. A recent literature review examining the impact of a

\textsuperscript{312} Oliver, Foot and Humphries, ‘Making Our Health and Care Systems Fit for an Ageing Population’.


\textsuperscript{314} British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’.


\textsuperscript{316} Steve Appleton and Robin Miller, ‘What the Evidence Tells Us About Improving Urgent Care for Older People: A Literature Review to Support the Independent Commission on Improving Urgent Care for Older People’ (London: NHS Confederation, 2016).

\textsuperscript{317} Imison, Thompson and Poteliakhoff, ‘Older People and Emergency Bed Use: Exploring Variation’.
range of interventions targeting the elderly population to reduce emergency department utilisation concluded that ‘some key elements including multidisciplinary team, integrated primary care and social care often existed in effective interventions, while were absent in all significantly ineffective ones’ and concludes that ‘interventions seem to achieve the most success with integration of multi-layered elements, especially when incorporating key elements such as a nurse-led multidisciplinary team, integrated social care, and strong linkages to the longer-term primary and community care’.  

Urgent and emergency care episodes provide an important window, albeit one fraught with vulnerabilities and challenges, for the identification and assessment of multifactorial needs, including social care needs, which frequently are either the primary or a significant contributing factor to a health crisis. Indeed, ‘while most health and social care professionals come into contact with older people in a variety of settings, it is often in the acute situation, often out of hours or when traditional office hour services are not available, that the challenges are most pressing’, providing a critical juncture during which health and social care needs can be detected. In addition, ‘all too often older people are referred to ED or admitted to hospital because of a lack of timely social care rather than there being a clinical indication for this level of care’.  

A few papers have focused specifically on the impact of involving social workers in the delivery of emergency care, suggesting that social workers can contribute to improvements in health outcomes and transitions for older people in emergency care. More specifically, a US study assessing the value of the presence of social work in emergency rooms found that social workers were often referred the most complex cases but only 16 per cent of patients seen by social workers were admitted to hospital, 54 per cent were sent home and 8.4 per cent were referred to a nursing facility. The study concludes that ‘these findings support the cost-effective nature of social work in the emergency room setting and the importance of finding alternatives to hospital admissions’.  

A growing number of policy papers and current guidance further acknowledge and support the role of adult social care in responding to urgent and emergency care needs. Oliver et al. have argued that ‘social work expertise and social care capacity are important elements in multidisciplinary initiatives such as rapid response, crisis response teams, and care-at-home services. As with primary care, appropriate social care services should be available out of hours, and should enable swift assessment of an individual’s care and support needs with the aim of stabilising the situation and  

319 British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’.  
320 Ibid.  
assembling a care plan that avoids clinically unnecessary admission to hospital or to long-term residential care’. 323

The literature acknowledges that availability and access to social care support during a health crisis is time critical, noting that ‘in managing older people with urgent care needs in the community, the first 24 hours of timely, effective health and social care support is crucial’. 324 Indeed, enabling people to access services where and when they are needed has been a key feature of recent government policy. In evidence to the House of Lords Select Committee on Public Service and Demographic Change given in 2012, the Health Secretary made clear that the NHS must become a 24/7 service. 325 This was followed in 2013 by a review of seven-day working in the NHS which recommended that social care and other support services ‘… both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken’. 326 National conditions for the Better Care Fund require that plans should provide confirmation ‘… of agreement on how plans will support progress on meeting the 2020 standards for seven-day services …’ 327

While much of the focus has been on 24/7 working in the NHS it is clear that an effective and integrated urgent and emergency care system necessitates more flexible social care services that are available at the point at which they are needed by an individual and work efficiently. When crisis occurs the default position is to access an emergency department and there is a high probability of an emergency admission. However, the crisis may not necessarily be the result of a health problem specifically and the response that is needed may not need to be one of acute care and may not need to be the sole responsibility of health professionals. By ensuring that social care professionals are accessible as and when needed it may be possible to reduce the need for emergency admissions. 328 ‘As with primary care, appropriate social care services should be available out of hours, and should enable swift assessment of an individual’s care and support needs with the aim of stabilising the situation and assembling a care plan that avoids clinically unnecessary admission to hospital or to long-term residential care.’ 329

The Silver Book on urgent care recommends that ‘a 24/7 single point of access (SPA) including a multidisciplinary response within two hours (14 hours overnight) should be commissioned. This should be coupled to a live directory of services underpinned by

323 Oliver, Foot, and Humphries, ‘Making Our Health and Care Systems Fit for an Ageing Population’.
324 British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’.
328 British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’.
329 Oliver, Foot, and Humphries, ‘Making Our Health and Care Systems Fit for an Ageing Population’.
consistent clinical content (NHS pathways). Discharge to an older person’s normal residence should be possible within 24 hours, seven days a week – unless continued hospital treatment is necessary’. Similarly, ‘the new Better Care Fund in England requires local authorities and clinical commissioning groups (CCGs) to provide seven-day services to support hospital discharge and prevent unnecessary hospital admissions’.

The evidence indicates that to some extent policy recommendations and guidance are reflected in current practice and that some progress has been made to embed social care in urgent and emergency care settings. The NHS Benchmarking Network suggests that 62 per cent of trusts have rapid access to social workers in accident and emergency to assist with admission avoidance of older people, with an average social care skill mix comprising bands 26–30 (56 per cent); bands 31–38 (33 per cent); and bands 39–41 (11 per cent).

Summarising the findings from the first UK national survey of emergency department based social care initiatives, Bywaters et al. found that of the 208 EDs across the UK, 35 per cent (n=73/208) had social care interventions located within the department. The remainder 65 per cent (n=135/208) reported that social care interventions were available through links or referral pathways to resources outside the ED. Eight of the 73 EDs with in-house social care interventions had multiple social care initiatives. Five EDs had two and three EDs had three interventions. The majority of interventions, 67 per cent (n=56/84), were solely located in the ED, with 28 per cent (n=24/84) co-located within the hospital or local community. Emergency department-based interventions comprising a social care component included admission avoidance, early discharge and prevention programmes.

The survey highlighted significant variations, particularly in terms of the responsiveness of services and their 24/7 availability, ‘with only 12 per cent offering 24-hour access. The majority of the interventions were not providing an out-of-hours service and operated only within normal working hours. Of the remainder, 34 per cent offered some out-hours provision in addition to in-hours provision although the extent varied greatly and one service only operated out of hours’.

New models of urgent and emergency care, integrating physical and mental health and social care, are being piloted across the country. The Greater Nottingham System Resilience Group, for instance, is developing a ‘clinical hub which will deliver an integrated urgent care pathway offering a viable alternative to A&E for patients; supporting clinical navigation and referral of patients to appropriate settings offering an alternative to urgent hospital admission or direct admission into specialties without the

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330 British Geriatrics Society et al., ‘Quality Care for Older People with Urgent and Emergency Care Needs: The Silver Book’.
331 Oliver, Foot and Humphries, ‘Making Our Health and Care Systems Fit for an Ageing Population’.
334 Ibid.
patient going through A&E’. Barking and Dagenham and Havering and Redbridge System Resilience Group are planning to transform local urgent and emergency care services by removing barriers between health and social care and between organisations, ensuring health and social care professionals are able to share and update patient care records, and using digital technology to ensure people have access to the right advice and community-based rapid response before they go to hospital. Leicester, Leicestershire and Rutland System Resilience Group are reshaping and integrating their services to ensure ‘patients can access urgent health and social care 24 hours, seven days of the week through enhanced clinical navigation, both via NHS 111 and a “single front door” at Leicester Royal Infirmary.’

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336 Ibid.
Appendix 5: Bibliography


Jones, K., et al. ‘Can Individual Budgets Have an Impact on Carers and the Caring Role?’, Ageing and Society, vol 34, no 1, pp 157–75.


SCIE support for integrated health and care

The Social Care Institute for Excellence, and our partners, are helping to transform systems around the lives, skills and needs of local people.

We work with local authorities, clinical commissioning groups, health and wellbeing boards, care and health providers, service user and carer networks to:

- review existing relationships and joint working arrangements
- develop and implement plans, including Sustainability and Transformation Plans and Better Care Fund plans
- evaluate progress on and the impact of integration plans
- facilitate discussions with local stakeholders
- co-produce plans and implementation with local citizens
- share knowledge and best practice
- inform policy and planning, including prevention.

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Integration 2020: Scoping research

This report presents the findings from a programme of scoping research and engagement to better understand what excellent integrated health and social care should look like in 2020; to test out the Integration Standard with national stakeholders and local areas; and to provide feedback and support for further development of the standard. The research, involving engagement with national stakeholders, local areas and people who use health and care services, was undertaken by SCIE on behalf of the Department of Health.

The research will inform the government’s future plans for the further integration of health of social care, including the next phase of the Better Care Fund.