Commissioning Care Closer to Home

Final Report

Gerald Wistow
Eileen Waddington
Iain Kitt

April 2010
Contents

Foreword .............................................................. 2

Executive summary ................................................... 3

1. Introduction ..................................................... 10

2. Our findings ..................................................... 11

3. Implications of Findings ...................................... 17

4. Conclusion: Key Lessons ..................................... 27

5. Local case studies ............................................. 27
   1. Blackpool .................................................. 27
   2. Hampshire ................................................. 31
   3. Islington .................................................... 35
   4. Knowsley ................................................... 39
   5. Leeds ....................................................... 45
   6. Oxfordshire ................................................ 50
   7. Sandwell ................................................... 55

Acknowledgements

We would like to thank ADASS and the Department of Health for commissioning this project. Our particular thanks to Ruth Eley of DH and James Reilly of ADASS for leading the work on behalf of the commissioners and to the members of the steering group who provided support and encouragement. We are also immensely grateful to colleagues in our seven local sites for their willingness to share their experiences and learning with us and with a wider audience at a time of many competing calls on their time.

Gerald Wistow,
Eileen Waddington
and Iain Kitt
November 2009
Foreword

The idea for this project was conceived following the publication of the White Paper “Our Health, Our Care, Our Say – a new direction for community services” and as Lord Darzi embarked on his review of the NHS. It arose out of a desire from ADASS and CSIP’s Older People’s programme to explore and describe the commissioning practice that leads to the development of services that achieve the aspiration of this White Paper to deliver care closer to home. Our expectation (perhaps naively) was that we would be able to pin down the various models of commissioning that lead to exemplar services, producing good outcomes for older people within the explicit policy frameworks for the NHS and social care.

Three years later, the result has turned out to be very different, but no less useful. The project has confirmed that as far as care closer to home is concerned national policy is not always as coherent as we think it is. Local commissioners and providers often struggle to make sense of the various policy strands, resulting in different interpretations in different places according to local needs and circumstances. Service development often remains a provider led rather than commissioner led process. More importantly, the study has highlighted the ways in which a broader model of care closer to home is emerging that embraces the community wellbeing and social inclusion agendas and the responsibilities of local authorities beyond social care.

The report raises some important issues. To what extent are commissioners at local level able to make the strategic shifts necessary – which include the de-commissioning of ineffective or inappropriate services – using the existing system of incentives and levers, for example Payment by Results tariffs? What evidence do they look for to justify these changes? Is the burden of proof more rigorous for new services, while commissioning more of the same can appear to carry on regardless?

The report includes a suggested framework for commissioning care closer to home that encompasses place and personalised purchasing as well as whole system strategic commissioning.

As we move increasingly in to the world of improving quality through efficiencies and productivity, we hope that the report and accompanying case studies will give some pointers about approaches that can work.

Ruth Eley  
National Programme Lead – Older People and Dementia  
Department of Health (Formerly Care Service Improvement Partnership)

Jenny Owen  
President ADASS  
Executive Director – Adults, Health and Community Wellbeing  
Essex County Council
and service settings. While not sharing a single understanding of ‘care closer to home’, they had common features:

1. The goal of shifting towards services delivered as close as possible to a person’s own home and in as normal a setting as possible to obtain better outcomes for individuals;
2. The alignment, but not necessarily the formal integration, of NHS and local government services;
3. A more rounded view of an individual’s needs focused not just on a specific condition but on their overall wellbeing in the places and networks where they live their lives;

The last point seemed to be associated with developments being driven from social care, public health and the wider local authority perspective. Thus a broader model of what constitutes care closer to home was emerging which embraced community wellbeing, social inclusion and health inequalities agendas with more engagement from a wider range of services.

None of the sites was, however, engaged in a change programme badged “Care Closer to Home”. Commissioners and providers were mostly struggling to work with and connect a multiplicity of different policy and system reforms of which care closer to home was a component.

In addition, they were still trying to apply effective commissioning capabilities consistently across all services. Often what we witnessed was a process of provider led service development seeking sustainability by winning the support of local commissioners.

### 1. Executive summary and Key Messages

ADASS and the Care Services Improvement Partnership (CSIP) funded this project in July 2007 to promote better commissioning by social care and partner agencies of care closer to home for older people. This report is the outcome of a process of coproduction by the research team, its ADASS and DH commissioners, local field sites and participants in three seminars at which emerging findings were presented and refined.

An initial scoping exercise identified two principal foci for fieldwork:

1. The commissioning implications for adult social care, its local authority and community sector partners of the strategic shift from care in acute hospital settings;
2. More effective commissioning arrangements for older people with mental health (OPMH) needs.

Seven local sites agreed to participate in the fieldwork, three of which were working on the first theme (Blackpool, Islington and Sandwell) and four on the second (Hampshire, Knowsley, Leeds and Oxfordshire). Case studies were written up by the team, agreed with the sites and are published at the end of this report.

### Case Study Findings

The sites were chosen partly because of their willingness to participate rather than their representativeness. However, they covered a wide range of organisational and service settings. While not sharing a single understanding of ‘care closer to home’, they had common features:

1. The goal of shifting towards services delivered as close as possible to a person’s own home and in as normal a setting as possible to obtain better outcomes for individuals;
2. The alignment, but not necessarily the formal integration, of NHS and local government services;
3. A more rounded view of an individual’s needs focused not just on a specific condition but on their overall wellbeing in the places and networks where they live their lives;

The last point seemed to be associated with developments being driven from social care, public health and the wider local authority perspective. Thus a broader model of what constitutes care closer to home was emerging which embraced community wellbeing, social inclusion and health inequalities agendas with more engagement from a wider range of services.

None of the sites was, however, engaged in a change programme badged “Care Closer to Home”. Commissioners and providers were mostly struggling to work with and connect a multiplicity of different policy and system reforms of which care closer to home was a component.

In addition, they were still trying to apply effective commissioning capabilities consistently across all services. Often what we witnessed was a process of provider led service development seeking sustainability by winning the support of local commissioners.
At least four factors were inhibiting such progress. These were:

- Widespread organisational change, including structural and systems reform
- A lack of local commissioning frameworks
- A lack of understanding of the different ways in which commissioning works in social care and the NHS
- The underdevelopment of commissioning capacity and capability generically

Integration

As with care closer to home, integration can mean many different things and our sites were characterised by different degrees of formality and organisational integration. The chart below shows a range of partnering opportunities that might be adopted.

The different categories are not necessarily mutually exclusive and the table is not intended to be viewed as a hierarchy; we are not proposing a journey to be travelled from a low level of integration to a higher one, rather we are highlighting the partnering options that could be available depending on local contexts and objectives. Furthermore, care closer to home was not necessarily better developed in those localities where functional or organisational integration was apparently further advanced. For instance we found joint projects in localities where there was little formal integration at a structural level and vice versa. Some services need to be operationally unified to operate effectively (for example intermediate care) but in other cases effective responses to need can be delivered successfully by separate services provided they are sharing information appropriately and working to a single care plan.

<table>
<thead>
<tr>
<th>Form of integration</th>
<th>What it means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-location</td>
<td>Staff from different organisations share the same offices</td>
</tr>
<tr>
<td></td>
<td>Often seen as the easiest form of integration and one which builds shared trust and understanding and can, therefore, act as a basis for more ‘developed’ forms.</td>
</tr>
<tr>
<td>Joint appointments</td>
<td>A post works across two or more organisations on behalf of both and reporting into both</td>
</tr>
<tr>
<td></td>
<td>Seen as useful for developing specific areas of work that themselves cross organisational boundaries e.g. intermediate care</td>
</tr>
<tr>
<td>Integrated teams/units</td>
<td>A single team comprising staff from two or more organisations delivering a shared service. Usually accountable within one organisation</td>
</tr>
<tr>
<td></td>
<td>Best developed in more specialist areas where staff already work closely together e.g. older people’s mental health</td>
</tr>
<tr>
<td>Joint strategies and plans</td>
<td>Where two organisations will remain separate but agree joint plans</td>
</tr>
<tr>
<td></td>
<td>Becoming increasingly common as a means of aligning organisational objectives and resources</td>
</tr>
<tr>
<td>Shared budgets/resources</td>
<td>Organisations share, or ‘pool’, their resources</td>
</tr>
<tr>
<td></td>
<td>Not as common as might be expected as one of the more difficult aspects of integration. Often so called pooled budgets aren’t</td>
</tr>
<tr>
<td>Joint commissioning unit/policy unit</td>
<td>Organisations develop a shared commissioning function – often for specific groups such as older people and people with mental health problems</td>
</tr>
<tr>
<td></td>
<td>Recognises the overlap between the commissioning of health and social care services for specific groups</td>
</tr>
<tr>
<td>Functional and/or organisational unification</td>
<td>Full organisational integration to create a single organisation out of two or more</td>
</tr>
<tr>
<td></td>
<td>Few successful examples as requires a high degree of trust and confidence.</td>
</tr>
</tbody>
</table>
Justifying investment in care closer to home

By definition care closer to home implies a shift in the balance of resources from hospital and other institutional settings towards home and the community. Most of the sites were grappling with how such shifts could be justified in commissioning processes and had been able to gather a range of evidence including:

- Formal evaluations e.g. as part of the POPPs programme
- Quantitative indicators e.g. service utilisation and activity data
- Qualitative data collected through a variety of methods including focus groups, public surveys, case studies, individual case reviews and audit and video interviews
- Comparative data pre and post intervention in both quantitative and qualitative forms

Much of this information demonstrated good outcomes in terms of public satisfaction and positive impacts on peoples’ quality of life and reinforced the messages from the national POPPs evaluation. However it was sometimes the case that despite such evidence, continuing investment was not forthcoming. The bar for what constitutes ‘good enough’ evidence for such new services seemed higher than for more traditional ones.

In addition, payment by results failed to support shifts towards community provision and senior management was sometimes concerned about destabilising the local health economy by shifting funds from historical service patterns even when activity had been moved to the community.

Implications of Findings

Our fieldwork findings and workshop discussions led us to identify four key issues:

- The clarity and completeness of policy about care closer to home
- The coherence and competence of commissioning for this outcome
- The extent to which investment in implementing the policy can be justified and secured
- How far integration is a separate objective or a dimension of all the above

The nature of the policy

The term care closer to home, itself, was adopted and endorsed by the 2006 White Paper ‘Our Health, Our Care, Our Say’ as the centrepiece of its ‘new direction for community services’:

“Our longer-term aim is to bring about a sustained realignment of the whole health and social care system. Far more services will be delivered – safely and effectively – in settings closer to home; people will have real choices in both primary care and social care; and services will be integrated and built round the needs of individuals and not service providers. Year on year, as NHS budgets rise, we will see higher growth in prevention, primary and community care than in secondary care, and also resources will shift from the latter to the former.”

However, our experiences in the local sites led us to question its status and especially how far it could be described as:

- A coherent policy and implementation framework awaiting better commissioning
- An aspect of many different and more or less coherent policies and implementation frameworks
- A desirable policy aspiration

In practice, the answer seemed to lie between the last two. In the absence of specific objectives and with many other priorities to deliver, however, it is unsurprising to find limited progress being made.

Consequently, we concluded that central government should consider how to demonstrate higher profile ownership of, and accountability for, the policy of care closer to home nationally and locally. A key consideration should be how far the policy is to be managed in its own right or as an aspect of other policies. Which implementation dimension is adopted is less important than that one is given greater priority than is currently evident for either of them.

---

1 Department of Health ‘Our Health, Our Care, Our Say: a new direction for community services’, Cm. 6737. London: The Stationery Office, para. 1.28
A framework for commissioning care closer to home

Our findings suggested care closer to home remained more of a service development than a commissioning activity. A more bespoke commissioning framework is required to deliver care closer to home, albeit one built on the foundations provided by, for example, World Class Commissioning and ‘Putting People First’. The figure below identifies the principal elements of such a commissioning framework.

Framework for commissioning care closer to home

- Cross cutting Themes
  - √ Strategic shift in resources
  - √ Proactive agent of change
  - √ Coherent place based strategy for wellbeing
  - √ Voice and choice for all citizens
  - √ Working in partnership with providers

- Aspects of commissioning
  - Sustainable community
  - Whole systems strategic commissioning
  - Costed medium term strategies
  - Personalised purchasing

- Implementation

- Integration
  - Securing resources
  - Holistic care pathways

Care closer to home
Cross cutting themes: the things that need to underpin effective commissioning

Aspects of commissioning: the different levels of commissioning care closer to home

Implementation: the mechanisms that are needed to deliver effective commissioning of care closer to home

Whole systems strategic commissioning

Locating care closer to home within the Sustainable Communities Strategy and its health and wellbeing theme identifies it as a major strategic direction for a locality and a contributor to its overall economic, environmental and social vision. As a result, it can adopt its proper position as a major element in the locality’s ‘story of place’

Costed medium term strategy

The medium term strategy provides the framework for setting out specific service development programmes based on local needs and resources within the broader local visions for people and places. Organised around holistic care and support pathways (see below), it specifies the inputs needed to extend care closer to home within agreed timescales. These will include the building blocks for independent living provided by the sustained strategic shift to prevention and empowerment envisaged in ‘Our Health, Our Care, Our Say’

Personalised purchasing

Care and support will increasingly be delivered through opportunities for personalised purchasing. This third component of our commissioning framework comprises the processes by which personalised care and support is procured by, or directly on behalf of, individuals (including those who are carers). They include personal budgets in social care, personal health budgets, GP purchasing of ‘non health’ as well as health interventions, and traditional mechanisms for assessment and case management in social care and health. In addition, services such as children and families, employment, financial support and housing also operate their own processes for identifying individual needs and allocating resources.

Forms of personalisation, including personal budgets and the right to control, are increasingly being adopted in these services too but there is currently little evidence of thinking about how they might all be coordinated at the level of the individual. However, the Common Assessment Framework (CAF) could create new opportunities not only to put the individual at the heart of such assessment and resource allocation processes but also to ensure that they are co-ordinated around their own needs and across organisational boundaries.

Implementation mechanisms: holistic care and support pathways

Holistic care and support pathways entail a process which is both longer and wider than traditional care pathway planning. It is longer because such pathways are ‘end to end’ (or home to home) planning tools.

- They begin conceptually with people living relatively independent lives in their communities
- They move on to address the risks to continuing health and wellbeing in specific places and circumstances
- Their end point is with individuals (back) in their communities having been re-enabled (where necessary) to live as independently as possible and participate as fully as possible in the life of their communities.

Such pathway planning is wider as well as longer than traditional care pathways. The focus on prevention and early intervention directs attention to the underlying determinants of health and wellbeing, many of which lie outside the NHS and social care responsibilities (though not the local authority as a whole). It similarly extends to a wide range of local authority and other services (including education, housing, leisure and social inclusion) which can substitute for traditional community health and social care services.

Implementation mechanisms: securing resources

There is little to be gained from developing service models and commissioning frameworks or skills if they cannot be supported by appropriate resource streams. The field sites that had reached the point of seeking to fund models of care closer to home had encountered some significant difficulties in aligning resource flows with their service models. To oversimplify slightly, these difficulties could be categorised as:

---

2Department of Health (2007), ‘Practice based commissioning – Budget setting refinements and clarification of health funding flexibilities, incentive schemes and governance’. London: Department of Health

3See, for example, Common Assessment Framework for Adults: A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning

4See Wistow G. (2008), Integrating Practice Based and Social Care Commissioning, Eastern Regional Pilot Network, Final Report, Integrated Care Network, Department of Health. The concept of end to end care pathways is not employed here as necessarily implying that an individual follows the whole pathway. The route may fork in different locations according to needs, preferences and choices. However, the concept should be explicit in mapping out potential routes from ‘beginning, to ‘end’ and planning possible stopping points along the way.
Providers in search of commissioners
Commissioners in search of budgets
Budget holders in search of evidence

In practice, these characterisations represent points on a continuum rather than descriptions of specific sites. Neither winning support from commissioners nor developing services in partnership with them guaranteed access to funding, however. Some commissioners reported limited success in securing budgets through existing NHS business planning processes. This experience was understandable in terms of senior managers’ need to maintain stability across service systems in an environment with a low tolerance of failure.

There is a need for greater clarity about what constitutes ‘good enough’ evidence for commissioning the shift from institutional services to care closer to home. While the destabilisation of service delivery systems should be minimised, unrealistically high standards of evidence applied only to new service models reinforce current service and power structures.

Commissioning processes must be capable of securing shifts in the balance of investment as well as the balance of care. In turn, commissioning organisations and partnerships must be strong enough to manage the power structures that underpin existing service configurations. The underlying uncertainty is whether sufficient commitment has been demonstrated nationally to the design and delivery of a financial strategy consistent with the White Paper’s ‘new direction for community services’ to secure greater public value, including better outcomes for end users.

The issue here is how these benefits can be realised through a managed financial strategy. Ultimately, the challenge is one of ‘political’ will (with both a small and large ‘p’) and a preparedness to recognise that decommissioning is an inevitable dimension of better commissioning.

Our analysis of implications for future resource flows and investment decisions highlights the importance of a comprehensive place based approach to commissioning, investment and benefits realisation. Care closer to home is as much about where and how people live - the community wellbeing agenda - as it is about the re-configuration of health and social care services.

**Implementation mechanisms: integration**

Integration has many local faces, as was evident in the different patterns of formal and informal arrangements in our field sites. Moreover, there is no reason why such arrangements should not vary with local contexts so long as they are delivering better outcomes.
Two further aspects of the integration agenda should also be noted:

1. It is no longer one for health and social care alone. Care closer to home should be implemented as an integral part of that ‘single community based support system focussed on the health and wellbeing of the local population’ that ‘Putting People First’ said every locality should seek to establish.

2. In the past, it has been seen as a way of closing gaps and removing blockages at the interface of organisations. In effect, the focus has been on building bridges and crossing borders. It has been seen as a way of engaging with the needs of citizens, particularly the more vulnerable and complex needs, and driving improvement and transformation. The integration challenge is to ensure mainstream business processes line up with each other and line up behind whole system outcomes rather than seeking to compensate for flaws in organisational systems and processes by trying to join them up at what are often their weakest points.

‘Putting People First’ contains something approximating to this approach in its description of a single community based support system being delivered through a process of ‘binding together’ the responsible agencies, a process which will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens. Two approaches have been identified here with potential to bind together different organisational systems: holistic care and support planning could be developed as a building block for whole system re-design based on individual needs and outcomes, and a Comprehensive Assessment Framework (CAF) might fulfil the same purpose at the level of self directed support for individuals.

Conclusion: Key Lessons

It quickly became clear that ‘care closer to home’ lacked some degree of identity and clarity as a policy direction. Many projects and services could be seen to fall under its banner and were seen locally as making a difference to the care and support of individuals in their own homes and communities.

However, we found limited evidence of a strategic whole systems approach to commissioning a different balance of care for specific populations and places.

Consequently, we designed a commissioning framework to help structure that task.

At the same time, however, we are acutely aware that this policy cannot be delivered by better commissioning alone. Getting an effective balance between technically more competent commissioning, clarity of policy objectives and sufficiently powerful implementation mechanisms remains the core task for commissioners throughout the relevant policy and delivery chains.

More specific lessons are summarised below:

- Care closer to home is being interpreted and implemented in a variety of ways. A developing feature, however, is the growing linkage of the initiatives in our sites with the community wellbeing agenda.
- It is not clear whether care closer to home is seen as a specific objective of central government policy or a dimension of other policies. Which side of the policy matrix it occupies is less important than being clear that it will be more proactively managed along one of the two dimensions.
- There is a corresponding lack of clarity about where ownership and accountability lie locally and nationally for its implementation and how its success will be measured.
- Commissioning competencies are being addressed through national and local development programmes but should be complemented by a bespoke framework for commissioning care closer to home which incorporates:
  - Whole Systems Strategic Perspective
  - Costed Medium Term Strategy
  - Personalised Purchasing
- Holistic care and support pathway planning should be developed as a key tool which combines the concept of an ‘end to end’ pathway with that of the personalised customer journey. The development of the CAF could offer a mechanism for helping to achieve the integration of these different approaches.

- As care closer to home has been increasingly understood to include wellbeing and inequalities in health and place, it should be dealt with as a cross cutting and cross sectoral issue rather than the exclusive province of social care and health.
- The implementation of care closer to home could be reinforced if it is seen as a key component of the local ‘story of place’ and, therefore, a shared objective for all partners including politicians and the public.
- Funding for care closer to home would benefit from re-visiting the approach to resource shifts identified in ‘Our Health, Our Care, Our Say’. This approach will require financial systems reform to payment by

---

2. Ibid.
results and other mechanisms so that services can be decommissioned and resources re-invested in whatever part of the health and care economy necessary.

- We suspect we may need less rather than more integration, certainly of the traditional bureaucratic kind on the margins of mainstream organisational structures and processes. Rather, we should be looking at how to develop and harness mainstream structures and systems to support the goal of care closer to home within that ‘single community based support system focussed on the health and wellbeing of the local population’.

- If care closer to home is to be understood in the context of the strategic shift to prevention, inclusion and personalisation, integration mechanisms must be fit for such purposes and not merely joining up specialist health and social care services at the point of service delivery.

- Realistic expectations should be clarified about the nature of evidence needed to justify new service patterns and reduce the risk of failure and destabilisation of health economies.

- There may be scope for ADASS and DH as the commissioners of this project to begin a dialogue to clarify the objectives of and accountability for delivering care closer to home policy alongside other policy objectives.

1. Introduction

The Association of Directors of Adult Social Services (ADASS) and the then Care Services Improvement Partnership (CSIP) commissioned this project in July 2007 to support the improvement of commissioning care closer to home for older people. It was designed to address three core questions:

1. What are the features of an exemplar service for older people that, via integrated commissioning, successfully delivers care closer to home?

2. What is the commissioning process that involves practitioner staff in securing this type of change?

3. How can the alignment of practice-based commissioning and social care commissioning deliver these service changes?

The commissioning brief specified that these issues should be addressed through the creation of learning networks focussed around authorities which had already developed ‘exemplar services’ and thus had pre-existing good practice which could be shared more widely. Two principal themes were also identified by the commissioners:

- the implications for adult social care and its partners, of the strategic shift from care in hospitals settings proposed in Our Health, Our Care, Our Say and

reinforced by the then recently published Darzi review in London.

- more effective commissioning arrangements for older people with mental health (OPMH) needs following a recent National Audit Office Report and the announcement of plans to publish a national strategy for dementia.

These themes and the identity of possible sites had been identified through a CSIP scoping exercise. However, the project team experienced substantial difficulties in making contact with, and securing commitment from local authorities. The explanations offered to the team for reluctance to engage in them at that time included:

- General pressure of work and perceptions of being ‘over-researched’

- Volume of national/regional development activities and network events being promoted

- Scepticism about the value of learning networks in this context in terms of whether individual local authorities have:
  - sufficiently well-developed service models to offer or from which to learn
  - sufficient in common for there to be value in collaborating

- ‘Tool kit fatigue’

Authorities also expressed a preference for development support targeted on the individual needs of authorities rather than engagement in learning networks. Most particularly, potential field sites suggested they were not ready to offer ‘exemplar services’ to a learning network. Consequently, the project steering group agreed that team members should spend 3-4 days with each locality helping to reinforce the development of service models and/or assisting them to engage effectively with commissioning arrangements capable of delivering those models locally. Ultimately, 7 sites signed up to participate in the project, each of which brought with them a local development agenda and a range of support needs that were translated into a short focussed work programme with the project team:

Blackpool were developing and implementing a programme of work designed to reduce hospital admissions by people with long-term conditions

Hampshire were engaged on work to develop a joint commissioning strategy for OPMH and wanted to develop an outcomes based implementation plan

Islington had identified the need to reprovide slow stream intermediate care currently provided outside the borough

Knowsley wanted to build upon their POPPs learning to influence the commissioning of OPMH services

Leeds identified the need to use learning from its
Partnerships for Older People Projects (POPPs) and LinkAge Plus pilots to shape the development of more holistic pathways for OPMH services.

**Oxfordshire** wanted to further develop their approach to commissioning services for OPMH based on a social inclusion model.

**Sandwell** had identified intermediate care as a key feature of acute sector redesign and needed to plan to develop their services accordingly.

The project steering group also agreed that opportunities for shared learning should be pursued as the project developed. This ongoing dissemination has included:

- An initial workshop for sites and the Department of Health (DH) in September 2008 to facilitate cross site learning and draw out emerging messages for policy.
- A presentation at the National Children and Adults Conference in October 2008 to share the work with a wider audience.
- A policy seminar in April 2009 between the sites and DH colleagues to:
  - Discuss progress on implementing care closer to home.
  - Share the project findings and ‘test’ their implications.
  - Identify and discuss how current progress might be built upon.

This approach has meant that the practical learning from the sites has been shared with policy colleagues as the project has developed and our finding and their implications have been refined iteratively through a co-production process based on continuing dialogue between policy and practice communities.

This report describes the overall findings from the project and provides an analysis of the implications for the further development of Care Closer to Home. We also include 7 short case studies, describing the work undertaken in each of our sites.

### 2. Our findings

In this section we draw out the findings from our fieldwork in the seven sites.

As we explained in the introduction, the sites were chosen partly because of their willingness to participate rather than being selected on any representative basis. They exhibited a variety of different characteristics in
terms of type of authority, geography, deprivation and population profiles, and had chosen to work on a range of different topics. Those topics included the development of strategies for older people’s mental health services, intermediate care, modernisation of older people’s mental health services, development of more holistic care pathways, and long-term conditions. Notwithstanding these differences, our fieldwork and workshops suggested that the localities not only faced similar challenges but also that their experiences were not uncharacteristic of those facing many others in England at the present time.

Exemplar models of care closer to home

The original tender document was predicated on the notion that there existed models of care closer to home that would exemplify good practice and serve as an example for other areas to follow. It quickly became clear in our discussions with the different authorities that no such models existed – certainly not in their minds. What there were, were examples of services and developments that in themselves could be cited as examples of good practice but did not necessarily constitute a comprehensive model.

To a considerable extent this reflects a lack of a clear definition about what constitutes care closer to home. The concept may have been a part of health and social care policy for a number of years but there is currently no single policy statement setting out in clear and unambiguous terms what it is health and social care agencies are expected to achieve to deliver this aim and within what timeframes.

Thus, we found different understandings of what was meant by care closer to home and different drivers of developments at a local level. In some cases the approach was being developed as an alternative to hospital based provision, in others it was less about building a different system than about the transition between hospital and community. In other field sites it was about modernising services traditionally delivered in the community and providing them in new, less institutional ways. For some sites it was about promoting social inclusion and wellbeing through helping people rebuild their networks or develop new ones in their communities. All of these approaches can be seen as different facets of the same concept in that they share some of the same features, namely:

- A shift towards services that are delivered as close as possible to a person’s own home and in as normal a setting as possible in the belief that this is more likely to lead to better outcomes for the individual;
- The alignment of services from both health and social care even if these were not formally integrated;
- A more rounded view of an individual’s needs focused not just on a specific condition but on their overall wellbeing in the places and networks where they live their lives;

The last point seemed to be associated with developments being driven from social care, public health and the wider local authority perspective. Thus a broader model of what constitutes care closer to home was emerging which embraced community wellbeing, social inclusion and health inequalities agendas with more engagement from a wider range of services.

A blueprint for change or multiple developments?

Allied to the notion of an exemplar model is the implicit assumption that authorities would be working to implement some sort of blueprint or overall vision of care. Again this was not our experience. Rather the different sites were often responding to specific issues that had arisen affecting one or more services that necessitated some change.

This is not to say that sites were not thinking strategically – often they were – but this was in response to a particular local set of needs or in response to a specific policy imperative rather than a general approach to developing care closer to home. In none of the sites was there a comprehensive change programme badged as “Care Closer to Home”.

In most places both commissioners and providers were struggling to work with and connect a multiplicity of different policy and system reforms. Care closer to home is a component of a range of different policies including, but not limited to:

- The management of long-term conditions (LTCs);
- A strategic shift towards prevention and early intervention;
- The personalisation of, especially, social but also health care;
- The reform of community health care services;
- The (forthcoming at the time we carried out the fieldwork) launch of a national strategy for dementia care;
- The redesign of acute care and a shift towards more community based provision;
- The development of intermediate care and other new ways of delivering services such as telecare;
- New methodologies in commissioning including practice based commissioning, payment by results and World Class Commissioning;
- The Darzi ‘Next Stage’ review;
- Disease specific initiatives around, for example, coronary heart disease and cancer;
- Policies to reduce health inequalities.

These are not always well connected either at a national
or a local level and sites often struggled to make the links between them. So, for example, it may be that a practice based commissioning group is developing an initiative to respond to the needs of people with a specific long-term condition but this will not be connected locally with another development, led by social services, to redesign home care to promote reablement. Meanwhile a local provider has developed a service which would meet both objectives but does not know how to get this taken up as a commissioned service. This is an issue that we will return to in the section on ‘Implications’

We found commissioning organisations in both local authorities and the NHS were aware of some of these issues and at the time that we began our fieldwork were beginning to develop responses and to try and produce a more coherent local framework for the development of care closer to home through:

- Developing new/refreshed systems wide commissioning strategies
- Developing unified commissioning frameworks and methods across LTC and acute services.

In some cases we were able to help with these processes but it felt very much that localities were feeling their way with little sense of any central direction or unifying framework available to help them along the way.

Commissioning in the context of health and social care dates from reforms introduced in the early 1990s. This saw the introduction of the purchaser/provider split in the NHS and the development of local authority’s responsibilities for funding care in the independent sector. However for many years commissioning was seen as being synonymous with contracting and only recently has the notion of “strategic” commissioning as a much broader activity become more widespread.

By strategic commissioning we understand a process that has several different components and stages that can be illustrated by the following diagram.

### The strategic commissioning cycle

What we tended to see was that authorities were still developing the capabilities to apply this model consistently across all services. Often what we witnessed was a process of service development that was being led by providers seeking to respond to issues arising from their daily activities of service delivery rather than the initiative coming from commissioners. Indeed in a number of sites one of the issues that the people we worked with were finding difficult was how to engage with the relevant commissioning organisation and move from a situation where a service had been developed through a provider led initiative but now needed to fit into overall commissioning frameworks if it was to be sustained.

It seems that there are at least 4 issues in addition to the different policy and systems reforms that we described above that inhibit this process. These were:

- Widespread organisational change

**Commissioning or service development?**

The focus of our work was on the commissioning of care closer to home and the distinctive characteristics of that activity.
Practice based commissioning

Practice based commissioning (PBC) had been identified at the beginning of our work as a development that local authorities felt was not fully connected to their commissioning processes and our fieldwork confirmed this perception to be the case. The spread and development of PBC was very patchy and nowhere was a local PBC group an active player in the development of the initiatives that we were looking at. It very much felt to the people we were working with that PBC was something that was happening ‘over there’ and there was concern that the care closer to home agenda was poorly understood by GPs and/or was conceptualised in overly medicalised terms – for example as being purely concerned with the management of long-term conditions. Even within PCTs, those managers involved in PBC often did not seem to be engaged in taking forward developments in care closer to home. At the very least this risks fragmentation and, at worst, there is the potential for differing and contradictory approaches to be developed to the same group of people.

Community health services

The 2007/08 Operating Framework for the NHS, current at the time we started this work, required PCTs to:

reach early decisions about the best way to take forward the shift of care into community settings. 7

PCTs were encouraged to take forward reviews of community based services and develop new models that would support this shift. In practice, this became conflated in some places with the policy of separating the PCT’s provider services from its commissioning arm. Concerns were raised that the development of these plans was being carried out separately from discussions about the development of care closer to home and that, generally, the separation was unlikely to be helpful because:

- It risked weakening commissioner knowledge and understanding of the agenda and the capacity to innovate
- It introduced a further element of organisational and relationship uncertainty
- Where integrated working arrangements did exist these risked being disrupted.

Understandings of commissioning

The different ways in which commissioning as an activity takes place in local authorities and the NHS continues to inhibit better joint commissioning and the development of a shared understanding of how to commission care closer to home.

7 Annual Operating Framework for 2007/08, para 3.11, Department of Health, December 2006
There are several ways of describing this difference. In social care, the separation of commissioning from provision operates down to front line service delivery where care managers undertake assessments and commission services on behalf of individual service users. These activities are more likely to be described as care planning in the NHS and take place within provider services. Until relatively recently commissioners in the NHS have largely been concerned with commissioning from a few, large NHS Trusts rather than from many, often small, independent sector providers which is the case in local government. Commissioning of community health services has been especially weak, something that has been recognised in the ‘Transforming Community Services Initiative’.

Commissioning frameworks and capacity

A further issue we encountered was the general lack of commissioning strategies and plans. Sometimes there might be overall strategies – say for services for older people – but they had not been translated into commissioning plans to deliver those strategies and drive spend at a local level. This made it difficult for service providers – and indeed for commissioners – to know whether a particular service development would fit with the overall strategy, its relative priority and, therefore, its chances of securing sustained funding.

There was also a sense that commissioning as an activity was underdeveloped. Local authorities have developed strong contracting functions to deal with the independent sector since the early 1990’s but this is only part of the commissioning cycle. Local authority and PCT Joint Strategic Needs Assessments were also in their very early stages of development and were not contributing significantly to commissioning. World Class Commissioning in PCTs was just being launched and, whilst it promised to deliver a stronger focus on commissioning frameworks and competencies, there was also a concern in some areas that it was very focussed on the NHS and did not pay sufficient regard to the need for joint commissioning across health and social care – never mind housing or other services important for wellbeing and social inclusion. So organisations were having to grapple with a number of different initiatives around commissioning in general – and commissioning care closer to home in particular – that came down to them through different routes and did not feel particularly ‘joined up’.

Integration

Another major strand of the original brief was to look at integration as a major driver of change and its significance in developing successful models of care closer to home.

Integration has also been something of a touchstone in health and social care policy over the same period as care closer to home. The general assumption has been that better integration of health and social care services will lead to more effective and efficient service delivery with corresponding benefits for both service users and providers.
In practice the experience of integration had been more mixed; while it can bring benefits it also has its risks. As with care closer to home, integration can mean different things to different people. Our sites had approached partnership working across health and social care in different ways characterised by different levels of formality and organisational integration. We have developed the chart below based on our observations of the sites and other work we have undertaken to show the range of partnering opportunities that are available.

We found it was very much the case that what worked in a particular area was largely a product of what had been right or possible at a specific point in time. Efforts to force the pace of integration sometimes foundered because the underlying conditions were not right. The different categories of integration are not necessarily mutually exclusive and the table is not intended to be viewed as a hierarchy; we are not proposing a journey to be travelled from a low level of integration to a higher one, rather we are highlighting the partnering options that could be available depending on local contexts and objectives.

<table>
<thead>
<tr>
<th>Form of integration</th>
<th>What it means</th>
<th>Reasons for integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-location</td>
<td>Staff from different organisations share the same offices</td>
<td>Often seen as the easiest form of integration and one which builds shared trust and understanding and can, therefore, act as a basis for more ‘developed’ forms.</td>
</tr>
<tr>
<td>Joint appointments</td>
<td>A post works across two or more organisations on behalf of both and reporting into both</td>
<td>Seen as useful for developing specific areas of work that themselves cross organisational boundaries e.g. intermediate care</td>
</tr>
<tr>
<td>Integrated teams/units</td>
<td>A single team comprising staff from two or more organisations delivering a shared service. Usually accountable within one organisation</td>
<td>Best developed in more specialist areas where staff already work closely together e.g. older people’s mental health</td>
</tr>
<tr>
<td>Joint strategies and plans</td>
<td>Where two organisations will remain separate but agree joint plans</td>
<td>Becoming increasingly common as a means of aligning organisational objectives and resources</td>
</tr>
<tr>
<td>Shared budgets/resources</td>
<td>Organisations share, or ‘pool’, their resources</td>
<td>Not as common as might be expected as one of the more difficult aspects of integration. Often so called pooled budgets aren’t</td>
</tr>
<tr>
<td>Joint commissioning unit/policy unit</td>
<td>Organisations develop a shared commissioning function – often for specific groups such as older people and people with mental health problems</td>
<td>Recognises the overlap between the commissioning of health and social care services for specific groups</td>
</tr>
<tr>
<td>Functional and/or organisational unification</td>
<td>Full organisational integration to create a single organisation out of two or more</td>
<td>Few successful examples as requires a high degree of trust and confidence.</td>
</tr>
</tbody>
</table>

Care closer to home was not necessarily better developed in those localities where functional or organisational integration was apparently further advanced. Certainly some measure of systems integration and/or alignment between stakeholders seems necessary to develop successful services that deliver care closer to home. However our experience of the local sites led us to conclude that it was not a sufficient condition.

It is also our experience that different forms of integration could co-exist at different levels of formality. For instance we found joint projects in localities where there was little formal integration at a structural level and vice versa. In other words high formal levels of integration, say at a strategic commissioning level, do not necessarily translate into integration in service delivery and high levels of integration can exist in services with little at a formal structural level. However it often seemed to be in the middle – at operational management level – that integration was weakest.

What we do conclude is that integrated assessment and
care planning and co-ordination are keys to delivering services that provide a holistic response to the needs of the service user. This does not, however, imply that services also need to be formally integrated to ensure the delivery of that holistic response. Some services need to be operationally unified to operate effectively (for example intermediate care) but in other cases effective responses to need can be delivered successfully by separate services provided they are sharing information appropriately and working to a single care plan.

Justifying investment in care closer to home

It is becoming increasingly important for new policy and service developments to be able to demonstrate evidence of their effectiveness – both in terms of their cost effectiveness but also that they deliver good outcomes for service users. In particular, for care closer to home, there is often a requirement to show that developments are more cost effective and produce at least as good outcomes as the more traditional alternatives they could supplant.

By definition care closer to home implies a shift of resources from hospital and institutional settings towards home and the community. What is the evidence base that would suggest such a shift in resources will deliver outcomes that are at least as good as those achieved by other ways of delivering services?

This was something that most of the sites had to grapple with to some extent. Developments in two of the sites had initially been funded as part of central government initiatives, such as the POPPs and LinkAge Plus, and had access to ring-fenced funding. As this came to an end they had to justify continued investment in the services. In other cases promoters of care closer to home found themselves looking for increased investment in the face of competing demands for services that, perhaps on the face of it, had a more immediate impact on people’s health.

In fact the evidence that would justify investment for care closer to home is often there. The evaluation of the POPPs programme, for example, has concluded that not only can the programmes demonstrate reduced costs compared with acute hospital care, they can also show a wide range of other, beneficial outcomes in terms of:

- users reporting improved quality of life – both specifically health related but also overall
- wider cultural change with a greater recognition of the importance of including early intervention and preventative services focused toward well-being
- strengthened and accelerated developments around joint commissioning. In particular, there has been recognition of the value of involving voluntary and community organisations in service planning and delivery.
- greater involvement of older people in the planning and delivery of services

The sites had been able to gather a range of different types of evidence about the services they were providing or looking to develop. This included:

- Formal evaluations e.g. as part of the POPPs programme
- Quantitative indicators e.g. service utilisation and activity data
- Qualitative data collected through a variety of methods including focus groups, public surveys, case studies, individual case reviews and audit and video interviews
- Comparative data pre and post intervention in both quantitative and qualitative forms

Much of this information demonstrated good outcomes in terms of public satisfaction and positive impacts on people’s quality of life and reinforced the messages from the national POPPs evaluation. One site, for example, was able to demonstrate a clear reduction in acute bed days as a result of a shift to community based services. In some cases such evidence was enough to convince commissioners of the merits of investment in the services concerned.

However it was sometimes the case that despite such evidence, investment was not forthcoming and there is a suspicion that the bar for what constitutes ‘good enough’ evidence is set higher for these types of services than it is for more traditional ones. In addition, mechanisms, such as payment by results, that were supposed to support shifts in commissioning to more community alternatives did not always do so. Sites also reported that it was proving difficult to get resources shifted out of hospital into the community even when the activity had already shifted because of concerns about potential destabilisation of the local health economy.

We now move on to explore the implications of these findings for the development of care closer to home.

3. Implications of Findings

Our fieldwork findings and workshop discussions led us to identify four key policy issues that need to be addressed in order that initiatives to provide care closer to home can have a broader and deeper impact:

- The clarity and completeness of policy about care closer to home

---

The coherence and competence of commissioning for this outcome.

The extent to which investment in implementing the policy can be justified and secured.

How far integration is a separate objective or a dimension of all the above.

In what follows we explore each of these issues in the light of our findings and our brief to support the improvement of commissioning care closer to home for older people.

The nature of the policy

The objective of providing ‘care closer to home’ is scarcely a new one. It has underpinned policies for care and health for at least half a century, albeit under different labels. These terms have included community care, care in the community, intermediate and continuing care, long term care, managing long term conditions, hospital at home and modernising primary care. Each has had different orientations and life cycles in policy fashion and implementation. At their heart, however, is the goal of enabling people to live in or near their own homes and communities ‘wherever feasible and sensible’. The corollary, and for some, the key driver has been to reduce dependence on hospital and other institutionally based services for delivering both immediate and longer term responses to need. However, this implication for institutional services has rarely been given the same degree of prominence, not least because the closure of beds and hospitals remains controversial and tends to be vigorously opposed by local interests.

The term care closer to home, itself, was adopted and endorsed by the 2006 White Paper ‘Our Health, Our Care, Our Say’ as the centrepiece of its ‘new direction for community services’ based on sustained whole systems change. The White Paper summarises this approach and recognises the need for it to include an appropriate funding stream:

‘Our longer-term aim is to bring about a sustained realignment of the whole health and social care system. For more services will be delivered - safely and effectively - in settings closer to home; people will have real choices in both primary care and social care; and services will be integrated and built round the needs of individuals and not service providers. Year on year, as NHS budgets rise, we will see higher growth in prevention, primary and community care than in secondary care, and also resources will shift from the latter to the former.’

Elsewhere, it articulates the aims of this strategic realignment in terms of:

- a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity
- a strategic reorientation towards promoting health and wellbeing, investing now to reduce future ill health costs
- a stronger focus on commissioning those services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

The phrase continues to occupy a key place in NHS policy. It appears, for example, in the Operating Framework for 2010/11 as one of the defining characteristics of a system that will deliver both improved quality and outcomes and save money.

Our experience in the field sites suggests, however, a need to consider whether the policy and implementation frameworks are sufficiently well developed to support such change across the boundaries of health, social care and other services or sectors. For example, the seven local sites put forward a wide range of initiatives as examples of success in providing care closer to home and engaging frontline staff in the commissioning process. As the descriptions of the sites have indicated, these various service models and initiatives displayed different understandings of care closer to home as a focus for service development and commissioning across the health and social care boundary.

It is important to recall at this point that the starting point for our brief was to focus on commissioning care closer to home from the perspective of social care and its interface with the NHS. The kinds of initiatives identified by sites in volunteering to work with us covered a broad range including:

- a comprehensive strategy for OPMH strongly informed by user and carer views;
- intermediate care as a key feature of acute sector re-design;
- more comprehensive locally provided intermediate care;
- the management of long term conditions at home through case management;
- developing a wider range of home based options for older people with mental health issues.

In addition, as the local case studies demonstrate, the initiatives put forward were not being implemented as

---

10Department of Health ‘Our Health, Our Care, Our Say: a new direction for community services’, Cm. 6737. London: The Stationery Office, para. 1.28
11Department of Health Annual Operating Framework for the NHS in England 20010/11, p27
part of a unified strategy for providing care closer to home. Rather, they were aspects of the wide range of policies we identified above. It is not necessarily a problem if care closer to home is pursued as an aspect or consequence of other policies and purposes. Indeed, one of our sites was explicit that it was expecting a wide range of other implementation programmes to identify and deliver their own contributions to the care closer to home strategy for older people with mental health needs. Nonetheless, the range of initiatives and approaches identified for inclusion in our project does help to make the point that we are not dealing here with an integrated national policy programme, despite the prominence of the issue in ‘Our Health, Our Care, Our Say’.

If it was understandable in these circumstances that the sites did not share a single interpretation of care closer to home, it is also important to note that the case studies were all concrete joint initiatives between local government and the NHS (especially public health and community health services). They were distinctly not part of the unilateral re-drawing of boundaries between hospital and other services that has sometimes characterised relationships between social care and the NHS in, for example, the field of continuing care. Moreover, and despite their different starting points, there was a strong tendency for them to be arriving at a common focus on the contribution of the community, wellbeing and social inclusion agendas to the extension of care closer to home. One consequence of this journey was that the policy was no longer being seen as merely the province of specialist social care and health services. It also needed to involve the wider local authority and community sectors.

A second and more fundamental consequence was to emphasise the importance of place and community alongside the more traditional concerns of social care and the NHS for individual users and carers. Understandings of care closer to home were moving on from a relatively simplistic conception of community as the physical location for care delivered outside hospital. Instead, there was a growing recognition of the central importance of place to better outcomes: levels of social capital, cohesion and inclusion in the places where people lived were being seen as critical to both the provision of genuine opportunities to live a good quality of life ‘at home’ and also to avoiding unnecessary hospital admissions, extended lengths of stay and re-admissions. This reflects the broader focus set out in a number of policy documents including the Government’s strategy for ageing ‘Building a Society for All Ages’ and the ADASS/LGA document ‘All Our Tomorrows: Inverting the Triangle of Care’. In this context, the Local Strategic Partnership and its thematic sub partnerships were emerging as an important framework for developing initiatives influenced by thinking about the promotion of health and wellbeing as well as more traditional alternatives to institutional services.

We described above how our initial remit required us to identify ‘exemplar’ services and explore how they might be effectively commissioned with particular reference to the role of front line staff. This task appeared to contain an implicit assumption that there was a recognised policy for care closer to home of which such services were exemplars. In practice, this discussion of the nature of policy in the local sites challenges such an assumption and led us to question how far care closer to home is, in fact:

- A coherent policy and implementation framework awaiting better commissioning
- An aspect of many different and more or less coherent policies and implementation frameworks
- A desirable policy aspiration.

In practice, our findings suggest that the answer lies somewhere between the latter two. Given the frequency with which the term appears in policy documents, it is perhaps surprising to discover that there is no specification of the pace and extent of change attached to the strategic re-alignment described in the White Paper. It is, of course, for consideration whether the most effective way of delivering more care closer to home is as a separate policy stream supported by the implementation of the many other policy objectives identified above or as specific aspect of those policies. The issue is effectively one of how the policy matrix is constructed and managed. At the present time, however, neither approach is well developed. We found it difficult to locate approaches to care closer to home as a coherent whole across local government and health. Local ownership tended to be condition, care group or service-based and initiatives tended to be project rather than strategy focussed (though the balance was shifting in the latter direction in some localities).

Despite the clear articulation of the goal at the core of the White Paper, therefore, it lacks the implementation focus and drive accorded to other objectives set out there, such as prevention and early intervention or self directed support. Against this background and with many other priorities and performance measures to deliver, it is expecting a great deal of local agencies to deliver a coherent policy on their patch. Consequently, central government should consider how to demonstrate higher profile ownership of, and accountability for, the policy of care closer to home nationally and locally.

**Implications for commissioning**

Findings from the sites showed that the extension of care closer to home remained more of a service development than a commissioning activity. To some extent, this was unsurprising. Our fieldwork was largely conducted during the spring and early summer of 2008 and, in the main, covered developments which predated

12Perhaps reflecting the growing influence of jointly appointed Directors of Public Health in many areas. See I&DeA ‘Perspectives on Joint Director of Public Health Appointments’, 2008
our project by some time. In all cases, they predated the launch of World Class Commissioning and the separation of PCT provider and commissioning arms. On the social care side, they also pre-dated the ‘Putting People First’ concordat, its implications for more personalised commissioning and the possibility of enhancing links between personal budgets and practice based commissioning.

It would be only a partial exaggeration to suggest that, if we had found well-developed and firmly established arrangements for commissioning care closer to home, the above initiatives would have been unnecessary or certainly less necessary. As indicated above, recognition of the timelines for both our work and the initiatives being undertaken to develop commissioning capacities and competencies is critical to the interpretations of our findings. In what follows, therefore, we assume that initiatives now in place to improve the effectiveness of commissioning generally will begin to enhance local capabilities for commissioning care closer to home. In addition, however, we suggest that these general initiatives should be tailored to support the specific requirements of the latter and built on the foundations provided by such initiatives as World Class Commissioning and ‘Putting People First’. We outline the possible components of such a meta commissioning framework below. In many respects, this suggestion and the earlier discussion of the policy framework are co-dependent. To the extent that the policy framework is incomplete or unclear, improvements in technical commissioning capabilities will be of limited value. Technically competent means cannot compensate fully for weaknesses in the specification of ends, though they can help to make the latter more apparent.

Before outlining a possible meta framework, however, we highlight a number of cross cutting themes that different sites identified and which we suggest should strongly inform its design and implementation:

- The current range of initiatives to strengthen commissioning in local government and the NHS would have a greater impact on care closer to home if they could be combined/aligned in a framework specifically targeted on achieving the necessary strategic shifts in services and resources.
- Commissioning should be understood and developed as essentially a proactive agent of change, designed to transform people’s lives.
- Commissioning care closer to home should be identified as a coherent place based strategy oriented towards promoting community wellbeing rather than limited to the reconfiguration of specialist social care and health services.
- The involvement of users and citizens at all stages in commissioning provides energy and focus in support of better outcomes for individuals and communities.
- Service development is not commissioning but commissioning is not just for commissioning organisations. The important role of service users and citizens has already been noted. In addition, providers have a necessary and legitimate role working in a partnership rather than adversarial relationship with their commissioners. This message is better understood in local government than the NHS where experience is more limited and especially in community services.

- A closely related issue is the identification of the point at which the purchaser/provider split ends. In particular, how far are front line staff expected to operate as commissioners on behalf of individuals in micro commissioning processes as well as the employees of providers and what are the implications for this in organisational design, multi disciplinary team work and self directed support? This issue was addressed in social care when the purchaser/provider split was implemented nationally from 1993. It is assuming more importance in the NHS, though receiving less attention, as PCT provider arms are separated from their commissioning counterparts.

- The introduction of self directed support similarly challenges the assessment and care management roles developed by local authorities since 1993.

A framework for commissioning care closer to home

We have argued that care closer to home is not simply a well developed policy and implementation strategy awaiting more effective commissioning infrastructures and skills. Nor, however, do such commissioning capabilities universally exist. However, they do need to be developed within the context of the implementation requirements for delivering more care closer to home. They also need to be informed by the cross cutting themes identified above including the newly emerging emphasis on place based planning and resource allocation.

Figure 1 identifies the principal elements of such a meta commissioning framework. This is composed of a set of cross cutting themes, commissioning aims and implementation mechanisms. In particular the core of the framework is provided by four different aspects of commissioning each of which is described more fully below.  

Whole systems strategic commissioning

Locating care closer to home within the Sustainable Communities Strategy and its health and wellbeing theme identifies it as a major strategic direction for a locality and a contributor to its overall economic, environmental and social vision. This approach will help make a reality of, for example, the planning, employment, learning and transport dimensions of the shift towards care closer to home. It could also provide a vehicle for bringing political and public engagement to the development of the commissioning vision from an early stage. As a result, it can help all stakeholders to understand care closer to home as a re-balancing of the
whole care and support system in order to produce better outcomes for local people. Care closer to home can be more readily understood, therefore, as part of a more transparent process of whole systems change rather than separate projects which develop some services and withdraw others in apparently unrelated ways. From this more holistic perspective, care closer to home can adopt its proper position as a major element in the locality’s ‘story of place’.

**Costed medium term strategy**

The medium term strategy provides the framework for setting out specific service development programmes based on local needs and resources within the broader local visions for people and places. Organised around holistic care and support pathways (see below) as the basic planning and development tool, it specifies and marshals the inputs, including finance, needed by local partnerships to extend care closer to home within agreed timescales. These will include the new configurations of services necessary to provide the building blocks for independent living through the ‘sustained strategic shift’ to prevention and empowerment envisaged in ‘Our Health, Our Care, Our Say’. Such a costed and comprehensive strategy would also help to build local confidence that a managed process of change is taking place as it provides the place where the commissioning, delivery and performance management plans for different services are aligned or combined in support of care closer to home objectives. Thus, the focus of the medium term strategy is on using service or agency based commissioning mechanisms to deliver shared goals within a shared vision of how a different balance of services, support and investment can deliver better outcomes for local people and places.

**Personalised purchasing**

The processes by which individual service users access care closer to home remain key to achieving those better outcomes. Personalised purchasing comprises the processes by which care and support is procured by, or directly on behalf of, individuals (including those who are carers). They include personal budgets in social care, personal health budgets, GP purchasing of ‘non health’ as well as health interventions, and traditional mechanisms for assessment and case management in social care and health. In addition, services such as

---

Commissioning Care Closer to Home

children and families, employment, income support, housing and leisure operate their own processes for identifying individual needs and allocating resources. Forms of personalisation, including personal budgets, are increasingly being adopted in these services too.

If we are to ensure that these arrangements do not become another labyrinth for individuals to navigate (or not), horizontal integration arrangements will be necessary at the level of individuals as much as whole systems. Traditionally this function has been fulfilled by different forms of multidisciplinary assessment and team work, including most recently the single assessment process (SAP) for older people. In the context of self directed support and other approaches to personalisation, this function is arguably ever more imperative. There seems little point in a multiplicity of personalisation, this function is arguably ever more imperative. There seems little point in a multiplicity of personalisation, effective holistic care and support pathways requires more discussion since they imply a process which is both longer and wider than traditional care pathway planning. In essence, it should bind together the elements of the commissioning framework outlined above through a process of co-design involving users, carers and community interests as well as professional stakeholders. It is longer because such pathways are ‘end to end’ (or home to home) planning tools. That is to say, they start conceptually with people living relatively independent lives in their communities and move on to identify and address the risks to their continuing health and wellbeing in the context of the places and circumstances in which they live. Their end point is with individuals (back) in their communities having been re-enabled (where necessary) to live as independently as possible and participate as fully as possible in the life of their communities. In between these end points, the objective is two fold: first, through prevention and early intervention to target threats to health and wellbeing; and second, to provide any necessary care and support close to home wherever feasible at different stages in their journey. An as yet underdeveloped aspect of pathway planning, with its origins in NHS processes, is how it can be integrated with the social care concept of planning customer journeys based on the ‘seven steps to personalisation’. The Personal Health Budget and CAF pilots could provide opportunities for bringing together these different approaches.

Such holistic pathway planning focussed on wellbeing, home based care and personalisation, is wider as well as longer than traditional care pathways because a focus on prevention and early intervention directs attention to the underlying determinants of health and wellbeing. Many of these factors lie outside the influence the NHS and social care (though less so of the local authority as a whole). Prevention similarly focuses on interventions capable of substituting for hospital and other institutional services by providing a combination of accommodation, care and support in people’s own homes and other community settings. Again a wider range of local authority and other services (including education, housing, leisure and social inclusion) potentially has a role to play alongside or instead of traditional community health and social care services.

As a planning tool, the holistic, end to end pathway serves a number of critical bridging roles across the whole care and support system. Thus, it can provide a framework within which to align:

- Prevention, early intervention, care, treatment and enablement
- Personalisation, including self directed support
- Public health, primary care, community health and acute services
- Social care and the wider local authority responsibilities for social inclusion, safer, stronger communities and community wellbeing more generally
- Local government, the NHS and other sectors

Implementation mechanisms: holistic care and support pathways

The concept of holistic care and support pathways requires more discussion since they imply a process which is both longer and wider than traditional care pathway planning. In essence, it should bind together the elements of the commissioning framework outlined above through a process of co-design involving users, carers and community interests as well as professional stakeholders. It is longer because such pathways are ‘end to end’ (or home to home) planning tools. That is to say, they start conceptually with people living relatively independent lives in their communities and move on to identify and address the risks to their continuing health and wellbeing in the context of the places and circumstances in which they live. Their end point is with individuals (back) in their communities having been re-enabled (where necessary) to live as independently as possible and participate as fully as possible in the life of their communities. In between these end points, the objective is two fold: first, through prevention and early intervention to target threats to health and wellbeing; and second, to provide any necessary care and support close to home wherever feasible at different stages in their journey. An as yet underdeveloped aspect of pathway planning, with its origins in NHS processes, is how it can be integrated with the social care concept of planning customer journeys based on the ‘seven steps to personalisation’. The Personal Health Budget and CAF pilots could provide opportunities for bringing together these different approaches.

Such holistic pathway planning focussed on wellbeing, home based care and personalisation, is wider as well as longer than traditional care pathways because a focus on prevention and early intervention directs attention to the underlying determinants of health and wellbeing. Many of these factors lie outside the influence the NHS and social care (though less so of the local authority as a whole). Prevention similarly focuses on interventions capable of substituting for hospital and other institutional services by providing a combination of accommodation, care and support in people’s own homes and other community settings. Again a wider range of local authority and other services (including education, housing, leisure and social inclusion) potentially has a role to play alongside or instead of traditional community health and social care services.

As a planning tool, the holistic, end to end pathway serves a number of critical bridging roles across the whole care and support system. Thus, it can provide a framework within which to align:

- Prevention, early intervention, care, treatment and enablement
- Personalisation, including self directed support
- Public health, primary care, community health and acute services
- Social care and the wider local authority responsibilities for social inclusion, safer, stronger communities and community wellbeing more generally
- Local government, the NHS and other sectors

16 See, for example, Common Assessment Framework for Adults: A consultation on proposals to improve information sharing around multi-disciplinary assessment and care planning
15 See Wistow G. (2008), Integrating Practice Based and Social Care Commissioning, Eastern Regional Pilot Network, Final Report. Integrated Care Network, Department of Health. The concept of end to end care pathways is not employed here as necessarily implying that an individual follows the whole pathway. The route may fork in different locations according to needs, preferences and choices. However, the concept should be explicit in mapping out potential routes from ‘beginning, to ‘end’ and planning possible stopping points along the way
Thus pathway planning is itself potentially an important mechanism for integration within and between agencies. In addition, it can provide a framework for public and professional interests to co-design services around the needs of the former.

**Implementation mechanisms: securing resources**

There is little to be gained from developing service models and commissioning frameworks or skills if they cannot be supported by appropriate resource streams. The field sites that had reached the point of seeking to fund models of care closer to home had encountered some significant difficulties in aligning resource flows with their service models. To oversimplify slightly, these difficulties could be categorised as:

- Providers in search of commissioners
- Commissioners in search of budgets
- Budget holders in search of evidence

In practice, these labels represent points on a continuum rather than descriptions of specific sites. However, they reflect tendencies which could be identified on the ground, sometimes more fully than others.

One of the features of provider led initiatives was that they were looking for commissioners to adopt their models and identify resources to fund them. Where commissioning remained underdeveloped, this could be a continuing search, especially in respect of arrangements for practice based commissioning. The separation of PCT commissioning and provider arms tended to reinforce this problem and some providers experienced difficulty in adapting to the new rules of the game. In at least one site, PCT providers were still seeking to understand their future role and how resources were allocated in market and quasi market arrangements. Such uncertainties were absent in the social care sector where market roles and rules had become the norm.

Neither winning support from commissioners nor developing services in partnership with them guaranteed access to funding, however. The tendency for practice based commissioning to be developed separately from other forms of commissioning, created further uncertainties. Established joint commissioning were not always clear how resources would be committed in future, including the routes by which such decisions would be taken and the respective influence of PCTs and PBC consortia in making them. In social care, there was a similar lack of clarity and understanding of how self directed support would impact on funding decisions at and between different levels of commissioning. Some commissioners’ experience of seeking to secure budgets through existing NHS business planning processes was not always successful. In particular, the demands from resource allocators (and existing providers) for evidence of the value and effectiveness of new service models were difficult to satisfy. It sometimes seemed that the bar was set unrealistically high for investing in new developments compared with the case for maintaining spending on existing service patterns, if indeed such a case were ever required.

This experience was understandable in terms of senior managers’ need to maintain stability and minimise uncertainty across service systems in an environment with a low tolerance of failure. At the same time, there is a need for greater clarity about what constitutes ‘good enough’ evidence for commissioning the shift from institutional services to care closer to home. While the destabilisation of service delivery systems should be minimised, unrealistically high standards of evidence applied only to new service models reinforce current service and power structures. To some extent, these difficulties and uncertainties can be seen as transitional problems which would resolve themselves as systems reform became embedded in both social care and the NHS. In addition, the evidence base for care closer to home is accumulating and can be expected to become stronger in the medium term.

However, it would be prudent to consider whether such an evolutionary approach to funding is consistent with the *Our Health, Our Care, Our Say: a new direction for community services*’, Cm. 6737. London: The Stationery Office, para. 1.28

Mechanisms like personal budgets, practice based commissioning and payment by results are intended to help secure such shifts between service models, providers and users. Leaving aside, for the moment, the still developing nature of such mechanisms, the underlying uncertainty is whether sufficient commitment has been demonstrated nationally to the design and delivery of a financial strategy consistent with the White Paper’s ‘new direction for community services’. The White Paper, itself, set out the basis for such a strategy in its statement that ‘year on year, as NHS budgets rise, we will see higher growth in prevention, primary and community care than in secondary care, and also resources will shift from the latter to the former’. It further stated that, from the 2008 planning round”, PCT Local Delivery Plans would not be approved unless they

---


18. ibid
The unanswered question is how such benefits can be realised through a managed but tightly focussed financial strategy. The White Paper’s proposed requirement to shift resources from secondary to community services suggests it was not seen as possible to fund care closer to home purely out of differential growth rates. More robust systems and financial modelling is now required to help underpin place based commissioning decisions about care closer to home. A benefits realisation model (which is already being used in the NHS) could usefully contribute to such processes if deployed on a whole systems basis. Ultimately, however, the challenge is one of ‘political’ will (with both a small and large ‘p’) and a preparedness to recognise that decommissioning is an inevitable dimension of better commissioning with all the challenges to rooted power structures that this implies.

There seems to be continuing commitment to delivering more care closer to home as evidenced in, for example, the NHS Next Steps Review and Putting People First. The 2009 Budget Report’s additional target for reducing lengths of stay is an indicator of its continuing relevance in hard times. There remain questions about means and ends, however. How far are reductions in hospital use to be ‘sweated out’ of current service structures, perhaps only at the margins, and how far can they be realised through fundamentally different service models of the kinds being developed in our field sites and elsewhere? How far are they seen as means for balancing hospital budgets, including improvements in quality, and how far as a necessary route to fund community services?

Perhaps more than anything, however, this analysis of the implications from our project for future resource flows and investment decisions highlights the importance of a comprehensive place based approach to commissioning.
investment and benefits realisation. As we have argued above, care closer to home is as much about where and how people live, the community wellbeing agenda, as it is about the re-configuration of health and social care services. As ‘Putting People First’ recognises, better outcomes depend on bringing together the four pillars of prevention and early intervention, stronger social capital, universal services and self directed care and support. In addition, the logic of care closer to home as a process of whole systems realignment is that it should be planned and funded on that basis using all the resources of a locality to fund it. This is the underlying logic of the LSP, LAA and sustainable community planning and accountability frameworks that many of our sites were beginning to adopt, if only partially. It is even more the logic of the total place pilots, now being established, and care closer to home would form a natural focus for one of their thematic initiatives.

As we noted above, the place based planning and accountability frameworks also offer a vehicle for what might be termed ‘whole system transparency’. They offer the opportunity for strategic systems realignment to be laid out in toto so that all partners, including the public, can see how it is intended to improve access and outcomes, together with the tradeoffs that are being made to secure such benefits. This does not overcome the necessity for difficult decisions (especially around decommissioning) but it could help to instil the greater confidence and trust needed to make them possible. It also provides a context within which Lord Darzi’s tests of service reconfigurations can be transparently conducted and the benefits to the public demonstrated. In practice, some form and level of decommissioning is an almost inevitable consequence of new service models. Given the attachment of the public to existing institutions, the opportunity for developing an understanding of all aspects and dimensions of implementing care closer to home may not be being fully exploited by LSPs. In this respect, however, it could be said that local policy for care closer to home is simply reflecting the absence at national level of sufficient clarity and transparency, about the decommissioning dimensions of the policy.

### Implementation mechanisms: integration

We have deliberately left the implications of our work for integration to last. The remit for this project was explicit in seeking to identify service models first and then the arrangements necessary to commission them. Again it is a question of securing a proper balance between ends and means. In this case, it involves avoiding the trap into which much joint working has historically fallen of treating integration as an end in itself, dominated by the design of joint structures and processes in relative isolation from the outcomes they are expected to deliver for local people. As we noted above, integration has many faces and this was evident in our field sites in their respective degrees of formal and informal arrangements. We also suggested that it was appropriate for the nature of those arrangements to vary with local contexts so long as they are delivering better outcomes. We do not intend to adopt a more prescriptive position now. We would simply add two points by way of elaborating our findings.

First, to re-emphasise the breadth of the integration agenda as being no longer one for health and social care alone; in truth, it never has been. However, a wider range of universal services and community resources becomes ever more central to its implementation as many of the case study sites are recognising. In practice, they are implementing care closer to home as an integral part of that ‘single community based support system focused on the health and wellbeing of the local population’ that ‘Putting People First’ said every locality should ultimately seek to have. That document saw local systems embracing ‘local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training’. As the case studies demonstrate, many of these services were part of the models and approaches they were delivering or developing as part of a place based wellbeing agenda within the sustainable community plan.

A corollary is that closer integration between some of these functions could create new barriers with others. For example, integration of health and social care outside local government would create new boundaries between social care and other local authority functions. This might be a price worth paying if the objective of integration is to help manage immediate demands on hospital and other health services. However, a different calculus would apply if the objective were one of promoting independent living through prevention and the social model of disability, as under the terms of ‘Putting People First’. Neither approach is inherently correct or incorrect. These observations simply point to the crucial importance of designing integrating means to deliver specific policy ends; which, itself, is merely another way of underlining the point made by Leutz to the effect that one person’s integration is another’s fragmentation.

---

22 See Communities and Local Government (2009), ‘Strengthening local democracy: Consultation paras 21-22

23 The focus of the total place pilots in Dorset, Poole and Bournemouth (older people) and in Gateshead, South Tyneside and Sunderland (health inequalities and empowerment) may generate some relevant learning


26 Ibid

ensuring mainstream business processes line up with each other and line up behind whole system outcomes rather than seeking to compensate for flaws in organisational systems and processes by joining them up at what is often their weakest point. Putting People First also contains something approximating to this approach in its description of its single community based support system being delivered through a process of ‘binding together’ the responsible agencies, a process which will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens.”

At the service delivery level the Comprehensive Assessment Framework (CAF) can be seen as having the purpose of binding together different operational systems so that individual needs and preferences can be met more holistically. These reflections take us back to our starting point in terms of the proper relationship between ends and means which underlay the commissioning of this project. As ends develop and are re-defined, so means, themselves, have to be adapted to meet new circumstances. If care closer to home is to be understood in the context of the strategic shift to prevention, inclusion and personalisation, integration mechanisms must be fit for such purposes and not merely joining up specialist health and social care services at the point of service delivery.

Finally, and from the perspective of the meta framework for commissioning outlined above, our discussion of integration has been as an external process capable of ‘binding together’ the activities and systems of different organisations with different kinds and levels of responsibility for care closer to home. A second perspective on integration is also critical to commissioning better outcomes: the extent to which the processes contained in our meta framework for commissioning are themselves integrated with each other in support of defined outcomes. Traditionally, the emphasis in local partnership working has been on developing forms of horizontal relationships across organisational boundaries, an emphasis which almost inevitably defines integration in structural terms. If, however, it is also understood in terms of vertically integrating the different layers and levels of commissioning activity identified in our framework, the importance of systems integration to deliver outcomes becomes more evident. It is, of course, important to recognise that vertical, like horizontal, influences operate in more than one direction. Vertical integration can be both top down and bottom up as the diagram indicates: the key is to establish the appropriate balance of such forces to re-shape local care and support systems.

The second implication for integration that we draw from our findings relates to the means themselves. We consider it legitimate for the centre not only to be more prescriptive about ends than means but also about the requirement to demonstrate that local needs are being met appropriately and cost effectively. Equally, however, we think it right that central and local government should demonstrate how their mainstream commissioning, development and funding systems are positively contributing to the delivery of those outcomes. In the past, integration has been seen as a way of closing gaps and removing blockages at the interface of organisations. This focus has been reflected in the terminology of building bridges, demolishing walls and crossing borders. It has been seeking to design integration into the day to day activities of some (primarily health and social care) organisations but at their margins rather than into the core operating systems of all of them.

We suspect we may need less rather than more integration certainly of the traditional bureaucratic kind on the margins of mainstream organisational structures and processes. Rather, we should be looking at how to develop and harness mainstream structures and systems to support the goal of care closer to home within that ‘single community based support system focussed on the health and wellbeing of the local population’. Our Health, Our Care, Our Say effectively adopted that approach with, for example, its support for a single performance assessment system through the LAA, the shift in the balance of mainstream investments referred to above and the requirement that this shift be demonstrated in local systems wide commissioning strategies and as part of the core business of LSPs and other place based planning arrangements. From this perspective, the integration challenge becomes one of ensuring mainstream business processes line up with each other and line up behind whole system outcomes rather than seeking to compensate for flaws in organisational systems and processes by joining them up at what is often their weakest point. Putting People First also contains something approximating to this approach in its description of its single community based support system being delivered through a process of ‘binding together’ the responsible agencies, a process which will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens.”

At the service delivery level the Comprehensive Assessment Framework (CAF) can be seen as having the purpose of binding together different operational systems so that individual needs and preferences can be met more holistically. These reflections take us back to our starting point in terms of the proper relationship between ends and means which underlay the commissioning of this project. As ends develop and are re-defined, so means, themselves, have to be adapted to meet new circumstances. If care closer to home is to be understood in the context of the strategic shift to prevention, inclusion and personalisation, integration mechanisms must be fit for such purposes and not merely joining up specialist health and social care services at the point of service delivery.

Finally, and from the perspective of the meta framework for commissioning outlined above, our discussion of integration has been as an external process capable of ‘binding together’ the activities and systems of different organisations with different kinds and levels of responsibility for care closer to home. A second perspective on integration is also critical to commissioning better outcomes: the extent to which the processes contained in our meta framework for commissioning are themselves integrated with each other in support of defined outcomes. Traditionally, the emphasis in local partnership working has been on developing forms of horizontal relationships across organisational boundaries, an emphasis which almost inevitably defines integration in structural terms. If, however, it is also understood in terms of vertically integrating the different layers and levels of commissioning activity identified in our framework, the importance of systems integration to deliver outcomes becomes more evident. It is, of course, important to recognise that vertical, like horizontal, influences operate in more than one direction. Vertical integration can be both top down and bottom up as the diagram indicates: the key is to establish the appropriate balance of such forces to re-shape local care and support systems.

26 Ibid.
4. Conclusion: Key Lessons

It quickly became clear that ‘care closer to home’ lacked some degree of identity and clarity as a policy direction. Many projects and services could be seen to fall under its banner and were seen locally as making a difference to the care and support of individuals in their own homes and communities.

However, we found limited evidence of a strategic whole systems approach to commissioning a different balance of care for specific populations and places. Consequently, we designed a commissioning framework to help structure that task.

At the same time, however, we are acutely aware that this policy cannot be delivered by better commissioning alone. Getting an effective balance between technically more competent commissioning, clarity of policy objectives and sufficiently powerful implementation mechanisms remains the core task for commissioners throughout the relevant policy and delivery chains.

More specific lessons are summarised below:

- Care closer to home is being interpreted and implemented in a variety of ways. A developing feature, however, is the growing linkage of the initiatives in our sites with the community wellbeing agenda.
- It is not clear whether care closer to home is seen as a specific objective of central government policy or a dimension of other policies. Which side of the policy matrix it occupies is less important than being clear that it will be more proactively managed along one of the two dimensions.
- There is a corresponding lack of clarity about where ownership and accountability lie locally and nationally for its implementation and how its success will be measured.

Commissioning competencies are being addressed through national and local development programmes but should be complemented by a bespoke framework for commissioning care closer to home which incorporates:

- Whole Systems Strategic Perspective
- Costed Medium Term Strategy
- Personalised Purchasing
- Holistic care and support pathway planning should be developed as a key planning tool which combines the concept of an ‘end to end’ pathway with that of the personalised customer journey. The development of the CAF could offer a mechanism for helping to achieve the integration of these different approaches.

- As care closer to home has been increasingly understood to include wellbeing and inequalities in health and place, it should be dealt with as a cross cutting and cross sectoral issue rather than the exclusive province of social care and health.
- The implementation of care closer to home could be reinforced if it is seen as a key component of the local ‘story of place’ and, therefore, a shared objective for all partners including politicians and the public.
- Funding for care closer to home would benefit from re-visiting the approach to resource shifts identified in ‘Our Health, Our Care, Our Say’. This approach will require financial systems reform to payment by results and other mechanisms so that services can be decommissioned and resources re-invested in whatever part of the health and care economy necessary.
- Realistic expectations should be clarified about the nature of evidence needed to justify new service patterns and reduce the risk of failure and destabilisation of health economies.
- We suspect we may need less rather than more integration, certainly of the traditional bureaucratic kind on the margins of mainstream organisational structures and processes. Rather, we should be looking at how to develop and harness mainstream structures and systems to support the goal of care closer to home within that ‘single community based support system focussed on the health and wellbeing of the local population’.
- If care closer to home is to be understood in the context of the strategic shift to prevention, inclusion and personalisation, integration mechanisms must be fit for such purposes and not merely joining up specialist health and social care services at the point of service delivery.
- There may be scope for ADASS and DH as the commissioners of this project to begin a dialogue to clarify the objectives of and accountability for delivering care closer to home policy alongside other policy objectives.

5. Local Case studies

Blackpool

The Local Context

Blackpool is a well known holiday resort on the Lancashire coast. Its 2008 Sustainable Communities Plan suggests the town is ‘synonymous with fun and enjoyment’.

Winter Gardens, annual illuminations and other attractions drawing some 10 million visitors annually. Behind this tourist façade, however, it is a town facing major and growing challenges. For example:

- Visitor numbers have fallen by two million since 2002
- The town experiences extreme levels of deprivation as evidenced by a fall from 24th to 12th in the 2007 Index of Multiple Deprivation.

This deprivation was particularly severe in localised pockets with 58,500 residents (41% of total population) living in the 20% most deprived Super Output Areas and 38,529 residents in the most deprived 10% (27% of the population).

With a resident population of around 143,000 living along a seven mile long coastal strip, it is the second most densely populated area outside of London. There is a high proportion of multi occupancy properties and a large private rented sector accommodating a transient population.

Its workforce earns the lowest average wage in UK in a highly seasonal labour market. There are high levels of worklessness (23% population of working age claiming a work related benefit including 13% on incapacity benefits)

Life expectancy for males is 73.2 and for females 78.8 (2nd and 12th worst in England and Wales, respectively)

While improving overall, the gap between mortality rates in Blackpool and the rest of England continues to grow and there is a trend for Blackpool to export good health to its more rural and affluent surrounding neighbourhoods while attracting new residents with poorer health30.

The town is served by a coterminous Unitary Council and Primary Care Trust who are externally seen to have a positive record of working together through the local strategic partnership. The PCT shares offices in the football stadium with the Council’s Adult Social Care and Housing Department and there are a small number of joint appointments. Co-location ensures that relevant commissioning and provider staffs are ‘rubbing shoulders daily’ and, in turn, facilitates effective working relationships. Their outcomes are reflected in joint strategies, shared investment programmes and integrated arrangements for service delivery.

Older People in Blackpool

Blackpool’s population is ageing and, as an established retirement area, already had an above average proportion of older residents. The number of over 85s is expected to grow from 3,300 in 2004 to 5,700 in 2029.

The 2008 LAA refresh31 emphasised that older people’s issues are more pronounced in Blackpool than elsewhere. In particular, it suggested that the

30 ibid. page 7
31 the Local Area Agreement Refresh June 2008 http://www.idea.gov.uk/idk/aio/8512814 p.7
vulnerability of adults over 85 years of age were exacerbated in Blackpool by the higher proportion of single pensioner households, 17.4% compared with 15.1% of the North West and 14.4% for England and Wales (Census 2001).

In addition, it argued that the general pattern of poverty, high levels of alcohol consumption, and general ill health among the population in Blackpool meant that the older people’s population under 85 exhibited many of the characteristics and needs of those associated with the over 85 years of age group such as accelerating age related debility, vulnerability and dependency. The overarching strategy for reducing the health gap between Blackpool and the national average is, therefore, of direct relevance to the health and wellbeing of older people more particularly. It forms a direct expression of the focus in World Class Commissioning on ‘adding years to life and life to years’.

Blackpool’s strategic approach to Older People is aimed, therefore, at improving both the morbidity rates and the quality of life experienced by its older residents. Its corporate strategy for older people for 2007-2017 is based on a vision for older people developed by the Senior Voice Forum, a self selected group of over 200 older people which identified the following core requirements:

- We want to live in our own homes for as long as possible, preferably right to the end;
- We want to feel safe in our homes;
- When we need help we want a single point of contact to sort out our problems; and,
- When we have a problem we want help to get over it quickly and get back to normal life.

This vision with its emphasis on such concepts as ‘safety’, ‘access’ and ‘sense of community’ took the agenda for older citizens way beyond the narrow remit of health and social care. For example, the Council’s one-time Community Alarm Service has been remodelled and expanded to work across Age Concern, NHS Blackpool, the North West Ambulance Service, Sheltered Housing, Registered Social landlords and Council wide services. Delivering a 24/7 personal response service it delivers a range of Telecare and Telehealth provision targeted at individuals with chronic illness, disability and frailty whilst also providing basic safety features for socially isolated older people.

Joint Strategy for Long Term Conditions

The introduction of community matrons in the NHS and its associated processes of case management for people with long term conditions (LTC) was a catalyst for new ways of working with older people and between agencies. This national development was intended to provide the key mechanism through which the NHS would deliver its Public Service Agreement (PSA) with the Treasury to reduce non-elective hospital admissions. One of the first steps prescribed in implementing NHS case management was the identification of a local quota of very high intensity service users with repeated hospital admissions (the then so-called ‘frequent flyers’). This exercise, in itself, was a stimulus to joint working since it raised questions about how far this population overlapped with that known to social care and how far their respective populations of service users would benefit from a more integrated approach to case management.

Similar initiatives include those based on an extended Home Improvement Agency, a town Heritage Strategy and a Sports, Nutrition and Physical Activity Alliance. The overall framework within which such initiatives are being delivered is through the vehicle of integrated care pathways for individual older people. These are being implemented through the locality management of integrated Health and Social Care Teams and, the further development of preventative and rehabilitative services. It was the development and delivery of such integrated care pathways for long term conditions that first attracted the care closer to home project team to Blackpool’s work.


33 the Local Area Agreement Refresh June 2008 http://www.idea.gov.uk/idk/aio/8512814 p. 35

34 Jaynes J. (2009) Celebrating Age: Experience and Aspiration p. 1

35 Ibid. p. 2
Commissioning Care Closer to Home

As a result, the NHS and social care adopted a version of the ‘Kaiser Pyramid’ to segment the population into different categories and to identify a range of responses appropriate to each level of need. An important aspect of the Blackpool approach was the focus on the whole population level of need as well as higher levels. In this respect, it was also consistent with the ADASS/LGA report All Our Tomorrows and its emphasis on inverting the triangle of care so that there was a better balance of investment across the health and care system as a whole. This whole systems joint approach is depicted in Figure 1 which illustrates the comprehensive nature of the initiatives deployed to reduce hospital admissions and the extent to which they drew on contributions outside the traditional, statutory social care and community health services.

Figure 1 shows that these initiatives ranged from information, advice and health promotion to increasingly more targeted services. For example, the ‘Foul weather service’ provided advance warning of climatic changes associated with hospital admissions for an identified group of residents with breathing difficulties. Community matrons were able to use telehealth services to monitor specific patients at home (and enable them to self-monitor) who would otherwise have required observation in hospital or nursing home settings.

A number of the initiatives shown in Figure 1 have been commissioned by the PCT from the Borough council. These include: exercise on referral, physical activity and diet schemes; monitoring service for telecare and telehealth; cold weather warnings for COPD patients; environmental security improvements and a falls pick up service. Such investment in local authority services have been made possible by the established history of partnership working in Blackpool and the robust financial position of the PCT.

The Blackpool seminar presentation provides other examples of how these initiatives have operated, including feedback from local people about their positive experiences of using them. The same source also contains some early data about the impact of the joint LTC strategy on hospital admissions. In particular, the two slides on the ‘outcomes’ of the community matrons’ work suggest that, in their first six months, 218 people were able to avoid hospital admission, producing a notional saving of approaching £2m. Whether and how far these can be realised as cashable savings remains uncertain.

The project team’s work with the Blackpool site suggested that a strength of the latter’s approach was the way all these different initiatives were conceived as a set of potentially interlocking interventions to be accessed at appropriate points in a planned and integrated care pathway. They were, therefore, an extended repertoire of interventions for case managers, tangible resources for them to deploy to the right people at the right time. In other words, Blackpool’s approach to meeting its PSA target for reducing hospital admissions was to appoint community matrons and introduce NHS case management processes as part of an integrated NHS and local authority strategy using the services of the wider council as well as those of the social care and community sectors. We can speculate that an important aspect of its value locally lay in a n approach to case management which was embedded in a wider joint service system, an approach which was not merely ‘administrative’ or even clinical but one which incorporated the resource mobilisation, deployment and coordination elements of the case management role.

The Blackpool example of care closer to home described here essentially originated in the local joint response to the introduction of case management in the NHS and its role in reducing ‘unnecessary’ hospital admissions by people with long term conditions, most of whom were older people. In this form, care closer to home was also supported by the public health drive to reduce the substantial inequalities of mortality and morbidity both within the town and between it and other parts of the country. A further important driver was the development of an older person’s strategy based on a vision developed with an older people’s forum which extended well beyond the bounds of traditional health and social care services. This approach further reinforced the public health focus on the wider determinants of ill health and disability.

With the exception of this contribution from older people, the development of the LTC care initiatives were provider led at least as service design responses to the national PSA target. At the initial implementation stage, local targets for bed reductions were effectively allocated by DH in the form of SHA and, then, PCT ‘shares’ of the overall PSA figure using a relatively crude national formula. The associated initiatives in NHS case management led by community matrons placed a significant responsibility on PCT provider arms and, ideally, operational partnerships with social care to address these targets.

More recently the balance has begun to swing nationally towards commissioners with the separation of commissioning and providing arms of PCTs and the promotion of World Class Commissioning competencies. Locally in Blackpool, the strengthening of the analytical base for commissioning has been associated with the identification of above average elective and non elective admissions as well as relatively high rates of readmissions. At the same time, projected demand modelling has shown an overall decrease in in-patient activity as a result of, for example more preventive care and disease management.

The current commissioning strategy sees a key challenge as being to reduce reliance on secondary care through developments which include

36 ADSS and LGA (2003). All our tomorrows: inverting the triangle of care
an urgent care centre and three primary care centres.\(^\text{38}\) The latter have been the subject of a public consultation on expanding care closer to home through a changing balance of hospital and community services.\(^\text{39}\) In addition practice based commissioning has been charged with the redesign of care pathways so that more patients can be managed in primary care and to prevent admissions to hospital.\(^\text{40}\) The streamlining of urgent care services and linked developments are planned to reduce A&E admissions by 25% and non elective admissions by almost 26%.\(^\text{41}\) The LTC experience described here and in the Blackpool seminar presentation would appear to be a valuable building block in this respect.

### Conclusions

Blackpool was initially included in this project because of its work in developing a joint strategy for long term conditions. The roots of this aspect of its work on developing care closer to home can be seen to have had the following analytical components:

- A joint approach to the implementation of NHS case management and the work of community matrons as vehicles for reducing non elective hospital admissions
- A whole systems approach to the adoption of the Kaiser pyramid and integrated care pathways as the key conceptual framework for implementation.

As a result, population and pathway planning became broader and longer: broadened out from traditional health and social care contributions to those of the wider local authority and community sectors; and lengthened at both ends to include primary prevention, early intervention and, where necessary, reintegration into independent living to reduce readmissions (what we have termed elsewhere ‘end to end pathway planning’\(^\text{42}\)).

This whole systems approach was supported and reinforced by two further factors: the priority given to:

- addressing the wider determinants of health and wellbeing as part of the reduction of nationally very high levels of mortality and disability
- a vision for older people generated by older people and based on the full range of what was important to their quality of life rather than merely health and social care

- A shared investment programme which included the PCT commissioning from the council a significant body of ‘non health’ services to make possible the implementation of wider and longer integrated pathways
- Integrated locality teams to deliver services

All of these features were facilitated by a shared recognition that the town’s problems of poor health, economic and social deprivation were interdependent and required concerted action among the ‘family’ of partners in the LSP.

The initial development of the joint approach to integrated care pathways was primarily led by provider services. However, this phase and focus of development for care closer to home shows signs of becoming incorporated into a broader and yet more strategic commissioning agenda for shifting the balance of care between hospital and community settings. In making this shift to a more strategic commissioning focus, it will be valuable to build on the whole systems initiatives and understandings identified here. In particular, it seems relevant to consider how far it is possible and necessary to design and implement a new configuration of health services based on a shared pathway design and investments programme across the LSP as a whole.

### Hampshire

#### The local context

Hampshire County Council serves a population of approximately 1.25 million and covers an area of around 1,428 square miles. The County Council and PCT have been coterminous since October 2006 following the merger of 7 PCTs, and the PCT is now the largest in the country. The partners work with 11 District and Borough Councils; 5 Acute Trusts, 2 of whom are Foundation Trusts and a further 2 Mental Health Trusts which introduces a significant level of complexity in strategic planning and commissioning.

Hampshire has a mixture of rural, semi rural and urban geography. Overall, health outcomes in Hampshire are good compared to regional and national outcomes. However, there are some areas of high deprivation and health inequality, which are most marked in the Havant, Gosport and Rushmore districts. One of the key challenges facing Hampshire is the changing demography with a projected rise of nearly 15% in the number of people over 65 by 2012. Cardiovascular disease and cancer are the key causes of premature death within Hampshire. Smoking remains a major cause of morbidity and rising rates of obesity, sexually transmitted infections and alcohol related harm in both young people and adults create challenges and it is felt locally that they can only be addressed through effective partnership working and targeting of interventions and services.

---

\(^{38}\) Ibid. p.11  
\(^{39}\) Ibid. p.13  
\(^{40}\) Ibid. p.52  
\(^{41}\) Ibid.  
Locally partners recognised that there was a limited history of working jointly to commission and provide services for older people with mental health needs and information about the priorities of older people and their carers was patchy. There was also recognition that the health and social care economy was under pressure and that planning to meet the needs of this group of people would need to rely on smarter more integrated commissioning rather than the availability of more resources.

Hampshire County Council and PCT were enthusiastic to join the project as it coincided with work they were undertaking to develop a county wide joint commissioning strategy for older people’s mental health and they welcomed the opportunity to share learning with other sites and the opportunity to access consultancy time to support their initial implementation planning. The Care Closer to Home project team felt that working with Hampshire offered the opportunity to learn lessons from managing change across a large geographical area; observe and contribute to the development of an outcomes based strategy implementation process and increase understanding about the services and approaches that are important to older people with mental health needs and their carers.

Commissioning services to promote older people’s mental health

At the time the project commenced, Hampshire was consulting upon a draft joint commissioning strategy for older people’s mental health 2008-13. This strategy was developed through an inclusive process drawing heavily on priorities which had been articulated by service users, carers and voluntary sector organisations. It included mapping of current services and work to develop needs led care pathways linked to relevant performance indicators.

The development of the strategy had included significant engagement with service users and carers facilitated by the Alzheimer’s Society. This engagement, together with wider stakeholder workshops had provided a clear set of priorities around which the strategy has been constructed and which it is intended will drive commissioning intentions in the future. Hampshire identified their priorities as:

- Support for Carers
- Promoting independence, prevention and well-being
- Balancing specialist and mainstream services
- Ensuring people only go into hospital when they really need to and that they are helped to do as much for themselves as possible when they leave
- Agencies and individuals working together towards shared goals.

These priorities were broadly supported in the formal consultation that took place and the strategy has now been adopted by the County Council and PCT. The partners recognised that the challenge was then to move towards an implementation plan that secured wider ownership for the detail of the priorities, focussed more
clearly on the outcomes to be achieved and the steps which needed to be taken, allocating clear accountabilities with agreed time frames. It was around these areas that the consultancy support was targeted.

Linking outcomes and implementation

Lead staffs in the County Council and the PCT have worked hard to ensure that the strategy demonstrates transparent links between, user and carer priorities, needs and service mapping and national policy requirements. They also believe that it is important to be clear and explicit about the outcomes they are seeking to achieve through their joint commissioning strategy and how they will measure progress. A small working group came together with the consultant to develop an outcome and implementation framework for each of the priorities which identified the outcome the priority would deliver (i.e. how it would be experienced by older people and their carers) and a set of objectives and tasks that would need to be addressed in order to achieve the outcome. It is these objectives and tasks that then became the key stages of the implementation plan. The next step was to allocate responsibilities for leading the work on these tasks and agree timescales.

The advantage of this approach is that it allows individuals who are contributing to the implementation of the overall strategy to understand where “their piece of the jigsaw fits” and how it contributes to the overall strategy to understand where “their piece of the jigsaw fits” and how it contributes to the overall strategy to understand where “their piece of the jigsaw fits” and how it contributes to the overall strategy to understand where “their piece of the jigsaw fits” and how it contributes to the overall strategy. It is these objectives and tasks that then became the key stages of the implementation plan. The next step was to allocate responsibilities for leading the work on these tasks and agree timescales.

The priority outcomes frameworks also demonstrate very effectively the contribution of other strategies in helping to deliver outcomes for older people with mental health needs; where links need to be made and “deliverables are required”. The intention is to identify OPMH “deliverables” in a number of other key strategies such as those for carers, health and wellbeing, primary care mental health, end of life, extra care housing and to ensure the particular needs of this group are recognised in local initiatives to introduce more personalisation and choice.

This was seen as both strengthening the belief that older people with mental health needs are “everyone business” and also ensuring that there is a holistic approach to meet needs.

Gaining wider ownership and securing contribution

A second part of the consultancy support focussed on helping to facilitate a launch conference that used the priority outcomes framework to begin to secure commitment to the implementation plan and also gave participants, including older people and carers, the opportunity to contribute their ideas about how tasks might best be approached. The County Council and PCT have appointed a project manager to oversee the implementation process.

Conclusions

The approach in Hampshire has been to develop and seek agreement to the overall high level strategic direction for services for older people with mental health needs, an approach heavily influenced by the complexity of the organisational geography of the county. The work to develop the strategy has built on and extended the engagement with older people with mental health needs and the implementation process further reinforces this. Service mapping has also highlighted examples of effective and valued service models which need to be shared more widely across the county. The strategy development work will put Hampshire in a strong position to respond to the National Dementia Strategy which was published as local work was progressing.

Partners recognise that it will be a huge and complex task to develop and reshape services across the county. The decision has therefore been taken to phase implementation with detailed work taking place first in the Winchester, Eastleigh and Test Valley health and social care system. This will allow the implementation work to inform and be informed by other work taking place in the locality including a review of unscheduled care pathways and a “year of care” exercise to examine the use/misuse of acute care beds as well as development work with new practice based commissioning consortia.

In reflecting on the learning locally in preparation for the two national events (September information sharing and the National Children and Adults Conference) Hampshire partners have identified the importance of the building blocks on which their strategy and its implementation have been constructed:

- Engaging with a broad range of stakeholders including older people and their carers
- Gaining ownership of OPMH as “everybody’s business”, by constructing care pathways which are holistic and extend from promoting mental health and wellbeing through to end of life care and identifying the contribution of different stakeholders
- Linking into other change agendas/strategic commissioning decisions
- Developing clear governance arrangements including project management methodology, outcome and priority framework, evaluation and metrics.
- In addition lessons have emerged around developing stronger partnerships to deliver changes including:
- Securing senior level sign up

63 Hampshire joint Commissioning Strategy for Older People’s Mental health 2008-13
64 Hampshire Outcome and Priority Framework for OPMH Strategy Implementation
Having a plan but also being opportunistic

Recognising the importance of champions at different levels in the organisations

The importance of communication

Recognising that progress might be slow but still should be able to demonstrate it is happening!

Translating the strategic priorities into jointly agreed commissioning intentions remains a challenge but there is commitment to delivering this through the implementation process. Hampshire has recently undertaken a review of progress against agreed outcomes and have identified that there is still considerable work necessary to secure sufficient OPMH focus in generic work being undertaken.

During the course of this work Hampshire was also undertaking its inquiry into the future needs of adults requiring support and care, Putting People First - Shaping your future, choosing your care. The Commissioners took evidence from individuals, carers and other experts in the field who told them what has not been working well for them and what they want for the future. Hampshire now believes it has a clear direction for a model for adult social care that it wants to be a national benchmark.

The inquiry found that “in order to achieve personalisation that truly promotes improvement in the lives of people in need of care and support, it is necessary to create a system that:

- shifts from an eligibility-based model providing limited silos of support to only those in the worst crisis, to one in which everyone who needs support is entitled to something that prevents crisis;
- is fairer, clearer, accessible, and inclusive to all;
- is adequately and sustainably resourced to give people the support they are entitled to;
- is the joint responsibility of the government, individuals and the people that support them;
- is person-centred and works with individuals to determine their support;
- takes into account the connections between care, benefits, housing, finance and other aspects of people’s lives rather than considering personal budgets in isolation.”

The “Hampshire model” arising from the inquiry and which is currently being developed resonates with many of the issues raised during the consultation on the OPMH Joint Commissioning Strategy and there is now a commitment to develop the use of integrated health and social care personal budgets for older people with dementia.

45 See http://www3.hants.gov.uk/adult-services/aboutas/consultation-involvement/commission-personalisation.htm
46 Ibid Summary Report
The Hampshire partners have acknowledged that there is a danger that by producing a high level strategic plan, people might believe more appropriate services will magically result. However they felt that locally the work on developing the strategy was an appropriate first step as it offered the opportunity to:

- Cement and make more explicit the need for partnership working particularly across HCC and PCT
- Identify and address some of the equity issues across a big geographical area
- Secure agency and public sign up to a vision and future direction for the service whereas currently the service tends to be driven by local opportunistic action on the part of providers
- Develop better engagement with older people and carers as the strategy is constructed around their priorities.

The Hampshire case study also shows how elements of the commissioning process can be brought together; needs assessment work, service mapping and user and carer engagement to identify a set of priorities. Hampshire are also going for a phased implementation which does allow this work to be set in the wider system reshaping work which is being initiated in Winchester.

Islington

Local Context

Islington is an Inner London Borough with a coterminous PCT and an established range of joint structures. These have included joint commissioning posts, pooled budgets and joint locality managers for care management and community health services. It had a population 185,500 in mid 2006, an increase of approximately 3.5% from 2001. Further increases are predicted of 12.9% between 2006 and 2016 and 9.8% between 2016 and 2026, with the greatest proportional increases being in the 45 to 64 age group.

Three of the features that define Islington are:

- Its size as the geographically smallest London Borough but one of the most densely populated, with a lack of green space, affordable housing and space to develop local health and social services
- The socioeconomic polarisation of people and place in an area of great contrast with neighbourhoods showing some of the country’s worst deprivation alongside considerable wealth.
- The diversity of its population, 60% of which is white British, and 5-10% of residents are refugees. There are significant numbers of disabled residents and residents from the lesbian, gay, bisexual and transgender communities.

The 2008 LAA refresh summarises the Borough as one ‘of stark contrasts and aspirations in which poverty plays a central role’. It further identifies ‘the economic divide between rich and poor in Islington… (as) the critical issue facing the borough. It is reflected in the patterns of housing, employment and lack of work, educational attainment, health, well-being and life expectancy, and crime’.

Against this background, the Sustainable Community Plan (SCP) identifies three key objectives as areas where the Strategic Partnership could target its resources where they are most needed to make a real impact on people’s lives:

- Reducing poverty
- Improving access for all
- Realising everyone’s potential

Part of the SCP’s vision for 2020 is that people will ‘have good mental and physical health, and better quality, longer lives’. This goal reflects the impact of social disadvantage and exclusion on health and wellbeing in a borough with:

- the lowest life expectancy rate for men and the third for women in London
- a death rate 34% higher than the rest of England and 17% higher than London as a whole
- life expectancy of 74.6 years for men and 79.6 years for women compared with 76.9 years and 81.1 years, respectively, for England
- life expectancy varying within the Borough from 76.4 to 71.7 years for men and 82.3 years to 77.7 years for women
- 17.9% of the population reporting a long term limiting illness, almost a quarter above the national rate when adjusted for Islington’s age and sex structure.

Older People in Islington

Islington has a relatively young population: around 10% of people are aged over 65. The 2005 joint commissioning strategy anticipated a decrease in the number of ‘younger old’ people over the following five years.
years but an increase in the number of “older old”. While the number aged 65 plus would decrease by 4%, those over 85 would increase by 6%. In addition, the proportion of older people from minority ethnic communities was also rising and would be about 14% by 2011.

The health and wellbeing of the general population was reflected in that of older people: for example, around 26% of people aged over 50 reported they were not in good health and 45% reported they had a long term limiting illness, compared to 19% and 38% in London as a whole. Healthy Ageing is, therefore, an essential aspect of reducing health inequalities in Islington. Indeed, promoting independence and enabling older people to stay at home for as long as possible is a public health agenda no less than a ‘care and support’ one.

Older people played a central role in developing ‘Live Long and Prosper’, Islington’s Quality of Life Strategy for people over 55. This plan has provided a strong framework for promoting healthy and active ageing since its publication in 2003. (It has recently been refreshed as the Prosper and Live Longer Strategy). Based on a vision for older people by older people, it seeks to promote their empowerment and independence through healthy ageing and better opportunities to be active members of the wider community. It has also contributed to a recognition that improving older people’s quality of life depends on many organisations, including mainstream health promotion and local authority services working together within a whole systems perspective.

One indication of its influence is in the substance of the three overall objectives of the joint commissioning strategy:

- Help people “age well”.
- Promote people’s independence better and give people more choice and control over their lives.
- Support more people at home for longer.
- Commissioning against these objectives was seen to require:
- Services planned and delivered as a whole system, as represented by the ‘triangle of care’ (Figure 1).
- ‘Inverting’ the triangle and investing relatively more in promoting healthy ageing, preventing avoidable escalations in people’s needs and actively helping them recover from illness and injury.

The document also emphasised the role of the strategy in reducing pressure on hospital beds through shorter lengths of stay, fewer admissions (especially, emergency admissions) and fewer re-admissions. A health and social care Implementation Group had been established to oversee the continuing development of a successful range of Intermediate Care Services and a pooled budget created to provide services focused on delayed and early discharges. The majority of the PCT’s budget for continuing care was spent on beds outside the Borough at St Pancras Hospital, which meant there was limited choice for where their care is provided. Consequently, the PCT was de-commissioning some of the beds and using the money to pay for continuing care in other settings, such as nursing homes and people’s own homes.

This action was not only expected to increase choice but also allow more individualised and cost effective responses to people’s needs. In addition, existing nursing and residential care was to be re-configured by modernising council premises and increasing the supply of nursing care beds, especially in dual registered homes and resource centres to increase choice, reduce reliance on out of borough placements and reduce pressure on hospital beds. A further strand of the strategy was the need to stabilise the market and secure local provision of nursing and residential care through the increased use of block rather than spot contracts with the independent sector.
By contrast, it saw the introduction of ‘Payment by Results’ as an opportunity to strengthen services outside hospital through a shift from block to cost and volume contracts based on Islington patients treated, thereby increasing efficiency and patient choice. At the same time, however, it also noted that the Audit Commission had identified a number of associated risks that would need to be mutually managed, including uncertain income for hospitals.59

Commissioning Intermediate Care Services Locally

Islington’s interest in participating in the ADASS/CSIP Care Closer to Home project focussed on its experience of seeking to implement this commissioning strategy and particularly to secure more rehabilitation/intermediate care services closer to home. Although some significant achievements had been made, the exercise had been less successful than anticipated and joint commissioners wanted to learn what features of service design and commissioning might have enabled them to be more successful.

Slow Stream Rehabilitation services had historically been provided through 32 beds at St Pancras Hospital. Funding was part of an overarching Service Level Agreement (SLA) with Camden Primary Care Trust (CPCT) Provider Services. In light of the commissioning objectives described above, an audit of Islington admissions was undertaken in May 2006 to explore whether rehabilitation could have been provided in alternative settings. The audit covered 88 rehabilitation case records, equivalent to some 68% of all Islington admissions in one year. The audit concluded that:

- 32% could have been supported in slow stream rehabilitation
- 32% could have been supported at home through the established community rehabilitation service
- 36% could benefit from intermediate care in nursing homes, residential homes, sheltered housing or an EMI interim care placement. 60

The findings were not fully accepted by St. Pancras hospital but Islington interpreted them as meaning that the same needs could be met in a mix of community and slow stream rehabilitation settings within the Borough. A joint project team was established in Islington to develop:

- Locally delivered community services using a care pathway designed by Islington community health services
- Borough based in patient slow stream rehabilitation to be commissioned from the private sector

The initiative was consistent with the agencies’ formal strategies and was expected to deliver more care at or closer to home. In practice, however, only the first of the above objectives was secured. A wider range of community services was developed, a single point of access for all intermediate care services created, the number of St Pancras beds commissioned by Islington reduced from 32 to 23 and average lengths of stay reduced from 15 to 8 weeks.

However, the Borough based independent sector inpatient service was not developed and the majority of the St Pancras beds were retained. A more detailed case study was prepared for this project by Andrew Gawthorpe, one of the Islington joint commissioners61 and some of its key elements are highlighted in the Islington seminar presentation. The aim here is to use those materials, together with information gained through meetings and a workshop with key Islington stakeholders, to gain an understanding of some of the influences which shaped this mixed pattern of implementation outcomes.

In the first instance, the successful re-provision of out of borough, bed based slow stream rehabilitation by community based rehabilitation services in Islington was a less radical change than re-provision through independent sector inpatient facilities. The former was effectively an incremental extension of established services using a proven model and known, in house providers. The PCT’s provider arm had already played a critical role in leading the audit and developing proposals for systems change in response to its findings. It had up-to-date knowledge of the different patient categories, their needs and relevant clinical responses. Its capacity to deliver the extended service model was also a significant advantage in terms of trust, clinical governance and, if necessary, direct managed controls.

A further advantage of the in house provider role was seen to be in giving senior management confidence in local capacity and capability to deliver the re-provided service since it was rooted in the former’s professional reputation and expertise. Indeed, one of the concerns arising from the subsequent requirement to establish a more formally separate PCT provider arm was precisely the anticipated loss of its professional expertise in the commissioning process. Without that professional input, it was felt the commissioning function would be significantly weakened when required to make the case for the safety and effectiveness of care closer to home in negotiations with current providers and also in public consultations.

At the same time, however, the leading role of the in house providers for service design, clinical leadership and service delivery was seen by commissioners as tending to cast them in support role. As a result, the commissioning

59 Ibid. pp. 48 and 82

60 Elderly Rehabilitation Services: Shifting the balance of provision to deliver services closer to home. Andrew Gawthorpe, Senior Commissioning Manager Older Adults, Islington Primary Care Trust & Islington Council (Housing & Adult Social Services) para. 3.2

61 Ibid
function tended to be reactive rather than proactive in setting the strategic direction.

The second element of the proposed package of local services, local in-patient rehabilitation services, was not successfully commissioned. Following a ‘soft’ market testing exercise, the PCT prepared a draft business case and consulted on a model comprising a form of public/private partnership. It envisaged the discontinuation of the use of the St Pancras hospital service and the decommissioning of a six bedded interim residential care service provided at a council residential home (6-beds) and funded under a S31 Agreement. The PCT would commission from the independent sector a specialist 19-bedded nursing care unit providing locally based rehabilitation, intermediate and interim care services. In addition, its provider arm would supply in reach services to deliver and lead rehabilitative and therapeutical inputs, whilst also having lead responsibility for co-ordination, administration; admissions & discharges, and outcome/goal setting.62

A number of concerns were raised during the consultation process about whether this partnership model could be delivered effectively. The issues focused on a lack of confidence in the private sector which was a relatively untested and unknown quantity in terms of, for example, staff skills and experience compared with those of the in house provider of the community rehabilitation services. While that provider would deliver similar services into the nursing care unit, concerns were raised about potential weaknesses in clinical governance and medical cover inherent in the public/private partnership compared with the integrated nature of the existing inpatient hospital service. In addition, the proposed reconfiguration raised issues about TUPE rights and redundancy costs.

A further concern was that the withdrawal of Islington support for the Camden PCT hospital services might lead to a destabilization of the wider local health economy. The Islington proposal envisaged that it would enable the local PCT to meet its responsibilities for reducing delayed discharges as well as patient well-being and satisfaction.63 However, if the end result was instability in other parts of the local health system, the original objective might be compromised either directly for Islington patients or indirectly for others. It is possible to interpret such claims in terms of the self interest and defensive behaviours of existing inpatient providers. Yet, it would also seem that there could be little advantage in shooting oneself in the foot or being perceived to shoot one’s colleagues in the back.

The PCT’s senior management team considered that a complete withdrawal from St Pancras hospital facilitated by the proposed partnership between its community providers and a private sector nursing care unit was a step too far. It concluded that the business case was not in the best interests of either patients or organisations.64 Nonetheless, while the PCT retained the majority of the St Pancras beds it had historically used, the continuing development and management of community based rehabilitation services tilted the balance to care closer to home.

62 Ibid. para 4.4
63 Ibid. para 4.6
64 Ibid. para 5.1
Conclusions

The Islington site provides an example of implementing care closer to home as the re-provision of traditional rehabilitation beds located outside the borough to more actively therapeutic intermediate care services delivered at, or closer to, home. It carries echoes of the re-provision of services from the former long stay hospitals. It also took place right at the cusp of NHS and social care systems reform. Practice based commissioning and personal budgets were not live factors, nor were payment by results and provider plurality. In fact, a continuing preference for in house providers and lack of trust in the private sector were continuing and significant influences on commissioning outcomes.

Market reforms appear to have been perceived as risks rather than opportunities especially if they might be seen to threaten at that time more immediate targets for senior managers. In some respects the complete re-provision of out of borough beds was an idea ahead of its time in terms of a rational risk/benefit calculus. If the PCT was prepared to more than dip its toes in the care closer to home waters, it made a perhaps not unreasonable judgement that it was still too early to risk the uncertainties of market reforms in this area.

It also proved difficult to withdraw money from the St Pancras contract. Savings were difficult to realise and were effectively swept up in the end of year negotiations between PCTs. Comparatively small sums were found for investment in community services but these funds were important contributions to their expansion. They were secured at least partly because of the existence of an alternative service model backed up by experience and evidence of it effective operation. By contrast, there was no local evidence that the public/private partnership would be successful in clinical terms.

At a workshop reviewing the case study, commissioners felt it questioned the extent to which they were then able to operate proactively and implement the agreed joint commissioning strategy. They had been unable to shift radically either the existing balance of services or the balance of power which underpinned it. While more effective commissioning might require improved technical competences, it also depended on the ability to operate in the worlds of power and politics. Moreover, the relatively high degree of formal joint structures and processes in Islington, while perhaps necessary, were an insufficient condition for realising integrated commissioning plans. There were no magic bullets to produce better commissioning outcomes.

Finally, the joint commissioners were aware of differences in approach between themselves and acute sector counterparts. One interpretation of these differences is that the focus of the latter tended to me more on evidence based, integrated care pathways for different categories of patients, their own was more on the wider population, client groups and broader issues of service principles and design. There may be scope to bring together these two approaches by lengthening and extending care pathway planning so that it addresses the whole person in their community and the risks to their health and wellbeing rather than merely the period when they are the responsibility of acute services.

Knowsley

The Local context

Created by local government re-organisation in 1974, Knowsley Borough is two-thirds countryside or open space. There are four main urban areas, Kirkby, Huyton, Halewood and Prescot / Whiston, together with the more rural areas of Cronton, Tarbock and Knowsley Village. The first three of the urban areas were considerably expanded between the 1930s and 1960s, principally to accommodate families moving out from clearance areas in central Liverpool. It is one of 5 metropolitan districts of Merseyside, covering an area of 33 square miles and is located on the outskirts of Liverpool. The population of Knowsley is approximately 151,300 people, while this represents a decline in the resident population of 12.8% over the last quarter of a century, the decline has been slowing and the latest Office of National Statistics suggests that the numbers of residents has actually risen over the last two years.

Knowsley has a relatively young population, with a proportionally higher number of people under 25 years of age when compared with the national average, the lower than average proportion of people in the 25 to 34 age group is probably indicative of residents moving out of the Borough, to look for employment elsewhere. The higher proportion of people in the 65-79 age groups in the Borough is thought to be linked to the influx of people to the overspill estates described above. As is the case in many parts of the UK, the number of older people (over 65) in the Borough has steadily increased over the last 20 years, rising by 25% between 1985 and 2006. Population forecasts predict further increases in the population aged 50 plus, including a 75% increase in men aged over 85. At the same time, it is anticipated there will be decreases in younger age groups, notably those aged 35-44. This is likely to impact on the dependency ratio within the Borough 65.

The challenges facing Knowsley are significant and include:

- High levels of deprivation; the borough is the 5th most deprived area in the country, although this is an improvement from 2004 when it was ranked third.

- Data suggests that high levels of deprivation and issues of lifestyle have a high impact on the health of residents. Life expectancy for women is on average 10 years lower than the national average and for men 3 years lower. This masks variations of approximately 10 years within the Borough for both sexes.

- The Borough has significantly higher numbers of residents who die from lung cancer, liver, respiratory and coronary disease.

Emergency admissions to hospital are increasing in Knowsley and are significantly higher than the average for England. One explanation for this is that many people in Knowsley do not seek help at an early stage and therefore reach a crisis needing hospital care.

There is a strong history of partnership working in Knowsley to address these challenges and the Sustainable Communities Strategy 2008-2023 identifies a number of opportunities that will be available to help achieve the vision of creating “Knowsley – the borough of choice.” These include:

- Proximity to the Liverpool – Manchester economic corridor
- Increase in housing provision locally
- Forecast growth in the service sector
- Investment in community health and social care premises

Knowsley was one of the first areas to take the step of integrating its executive functions across the Council and the Primary Care Trust through a Section 31 agreement under the 1999 Health Act. The PCT Chief Executive is also Executive Director for Health and Social Care for the Council, with a joint management team established for the last 7 years. Within the last year responsibility for leisure and culture has been added to her remit to create an integrated Health and Wellbeing Directorate.

Knowsley Health & Wellbeing is a unique partnership between NHS Knowsley and Knowsley Council’s Directorate of Wellbeing Services, incorporating social care, leisure and culture. Operating together, but with dual accountability to the Board and Cabinet the partnership has a single unified leadership structure, with integrated budgets and commissioning arrangements in place. The additional benefits of a close partnership with the wider local authority have led to a strong political and executive commitment within the Council to tackling the wider determinants of poor health, disability and inequality. This extends across the whole spectrum of local authority responsibility including children’s services, planning and regeneration, direct service delivery and investment.

The Health and Wellbeing Partnership has a jointly agreed vision to ensure:

The local communities we serve will be more informed and involved in decisions that affect them and experience better health and wellbeing and improved health and wellbeing services through:

- **Prevention** – outcomes with an increasing emphasis on proactive prevention rather than emergency / crisis services
- **Empowerment and engagement** – enabling people to take control of their own health and to become involved in local decisions about health and wellbeing services

---

66 “Knowsley, the borough of choice”: Sustainable Communities Strategy 2008-2003
67 Strategic commissioning Plan “Health and Wellbeing for All” 2008/9-2012/13, NHS Knowsley
• **Services Closer to home** – providing services in the appropriate setting but closer to home and in neighbourhoods where possible.

• **Providing quality services** – that are personalised and focussing on outcomes that deliver improved quality of life.  

**Older People in Knowsley**

The over 65 population of Knowsley is set to rise steadily with the most marked increases in the 65 to 69 age group and those aged over 80 as shown in table 1. These very significant increases need to be viewed within the context of an overall population reduction in Knowsley which means that the older age group will increase as a proportion of the total population and there will be fewer young people from which both paid and unpaid carers will be drawn.

Knowsley has a proven track record of engaging with its older residents. Knowsley Older Peoples Voice (KOPV) was launched in July 2003 and the numbers of older people involved has grown steadily, providing an important local mechanism to ensure older people are able to have their say and influence service planning and development. Members are actively engaged in a wider agenda representing the voice of older people, both locally and nationally.

During 2007, Knowsley Older People’s Voice ran a series of consultation events to identify the priorities older people want to see addressed to improve their quality of life and wellbeing. The themes identified have been used to shape a strategy for ageing positively in Knowsley with a strong emphasis on addressing:

• Crime and safety
• Health and social care
• Finance and pensions
• Transport
• Housing and environment
• Learning and education
• Effective communication.

Intergenerational work is seen very much as a cross cutting theme reflected in the development of each of these individual themes.

It is against this demographic and engagement background that partners in Knowsley successfully bid to become part of the Department of Health’s Partnerships for Older People Projects (POPP) programme. The Knowsley POPP work has 3 key aims:

• To tackle the entrenched social and cultural factors that lead to poor health, and a high level of emergency admissions to hospital, facilitate access to services and ensure that by the end of two years, well-being and prevention will be everybody’s business.

• Build on existing, well established partnership arrangements and extend the approach and services already developed in Knowsley. It targets older people and carers proactively, including excluded groups, in the most deprived areas of the Borough bringing the issues of health and well being to their doorsteps.

Table 1 Population aged 65 and over, in five year age bands, projected to 2025. (Source: Projecting Older People Population Information System)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2008</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>People aged 65 - 69</td>
<td>6,300</td>
<td>6,200</td>
<td>7,400</td>
<td>7,600</td>
<td>8,800</td>
</tr>
<tr>
<td>People aged 70 - 74</td>
<td>6,300</td>
<td>6,200</td>
<td>5,500</td>
<td>6,700</td>
<td>6,900</td>
</tr>
<tr>
<td>People aged 75 - 79</td>
<td>5,100</td>
<td>5,000</td>
<td>5,100</td>
<td>4,700</td>
<td>5,700</td>
</tr>
<tr>
<td>People aged 80 – 84</td>
<td>3,200</td>
<td>3,500</td>
<td>3,700</td>
<td>3,900</td>
<td>3,600</td>
</tr>
<tr>
<td>People aged 85+</td>
<td>2,100</td>
<td>2,200</td>
<td>2,700</td>
<td>3,100</td>
<td>3,600</td>
</tr>
<tr>
<td><strong>Total population 65 and over</strong></td>
<td><strong>23,000</strong></td>
<td><strong>23,100</strong></td>
<td><strong>24,400</strong></td>
<td><strong>26,000</strong></td>
<td><strong>28,600</strong></td>
</tr>
</tbody>
</table>

68 Ibid page 7

To develop a system of prevention and care where different interventions work together in a synergistic way so that the total effect on health and well-being is greater than the sum of the separate interventions.

Partners have worked to deliver these aims through 4 programmes of work namely;

1. The IKAN project which has brought together a multi-agency team including health and social care, the fire service, pharmacy and leisure, aims to identify people "upstream" and offer a range of services that will support and empower them, without formally bringing them in to the health and social care system, unless this is indicated by their circumstances. The approach was promoted through a social marketing and has consistently targeted the harder to reach groups in the Borough. Strong links have been made with the neighbourhood PRIDE teams and local health forums.

2. Age Concern Peer Mentoring/Befriending Scheme which supports befrienders to identify key goals with service users which aim to aid independence and provide planned support to help achieve these. For example, if an individual's isolation was due to lack of confidence of going out alone, they would be supported by the befriender to help them build confidence and link into community activities or other social networks. One of the key challenges and achievements for Age Concern from this aspect of the project has been the development of a new approach that is very much about empowerment, social inclusion and an outcome focused approach.

3. Transitional Adult Placements for older people with mental health needs; prior to POPPs there was no formal provision in intermediate or transitional care services for older people whose primary need relates to their mental health. In the absence of such services the options for people with a high level of need were severely limited. Rather than invest in traditional mainstream services POPPs has developed and tested alternative approaches, aimed at maintaining independence and preventing admission to, or facilitating swifter discharge from hospital, or preventing admission to a care home. One of the approaches was the creation of a transitional Adult Placement Scheme provided by PSS which is a voluntary organisation with extensive experience of managing such services.

4. The Flexible Worker Support Service built on an existing service within Knowsley for older people with mental health needs. This service provides flexible support to older people in their own home and has the ability to respond to crises and sudden or fluctuating changes in need. The workers liaise with Care Managers to monitor the health and well-being of individuals to ensure timely interventions that enable people to remain independent. Through POPPs this service was expanded and developed to provide an ‘in-reach’ service to the hospital in order to support effective discharge and provide support to older people with mental health problems access mainstream intermediate care and rehabilitation services.

It was these latter two service developments which were of particular interest to the Care Closer to Home project team given the team’s remit to consider commissioning and provision of services to older people with dementia.

New Service Models for OPMH

Knowsley were particularly interested in contributing to the Care Closer to Home project as they wanted to explore how best to use the learning POPPs had offered to influence commissioning intentions.

One of the aims of the National Dementia Strategy is the provision of higher quality care for individuals and their carers and recognition that services should be developed which will meet needs as they develop and change over time.70 Two of the developments in the POPPs programme allowed Knowsley partners to test out and evaluate new models of care to promote care closer to home for people with mental health needs; to support people through crises and help individuals maintain their independence and provide support to carers. The two developments have provided different opportunities and challenges, each providing valuable learning which is can taken forward into local commissioning arrangements.

---

70 Living well with dementia; A National Dementia Strategy, Department of Health February 2009
**Transitional Family Placement**

The development of this service took place in partnership with a known voluntary sector provider with experience in other parts of Merseyside of providing family placements for older people. Personal Social Services (PSS) worked with the POPP steering group to develop a local family placement service that could provide care for up to 8 weeks in a professional carer’s home to avoid hospital admission or admission to long term care and to facilitate early discharge from hospital. The emphasis of the service was on helping individuals to regain or maximise their skills and to facilitate their return to community placements, a form of specialised community reablement/intermediate care for older people with mental health needs.

Difficulties were encountered during the first year of the development of the new placement scheme, these centred around resistance to utilising short term care placement in a professional carer’s home from both service users and their carers. This stemmed from concerns that the move would be disruptive to the individual concerned, and that the time-limited nature of the service would result in further disruption upon the individual’s return home.

Through the evaluation process and ongoing dialogue with care managers and service users, it was agreed that the family placement model would be developed to provide day care for people who would not or could not be accepted into traditional day care. The 24/7 service would still be available for respite, step up or step down if required. The service was able to offer more flexibility than existing mainstream services as it was available evenings and weekends. This has been a great help to families and those caring for older people with mental health needs as it provides them with greater options to enable them to continue supporting at home. For example, one service user was alone late afternoon and early evening due to the primary carer being at work; adult placement provided the flexibility for the service user to have tea with the adult placement carer and then be collected by the family when they were returning home from work.

This has resulted in a more flexible person-centred service that is now better able to respond to individual needs of service users. The new service has removed the initial time constraint of 6-8 weeks and is offering a longer term service whilst still focusing on promoting and maintaining independence.

Adult placement carers work with the service users and families to ensure daily life skills, activities and hobbies can be continued in the adult placement. The flexibility of the service which also includes the appointment of carers from different backgrounds and with different home/family circumstances means that service users can be matched with carers who can offer a suitable environment as well as day to day care.

“With a family environment, it’s not just one-to-one as well, it’s the whole family. So you might get a… single carer living on her own, but she might have grandchildren visiting, it’s just a home-from-home.”

“We’ve seen a lot of people who lack confidence and they had been very introverted before the service started. Now, they’re actually laughing and singing and doing things that perhaps they wouldn’t do before.”

The development of this service has relied heavily on the flexibility of the provider; PSS, to respond to the emerging learning and to reshape the service accordingly. While the evaluation has demonstrated positive outcomes in individual cases particularly for those individuals where traditional day care has proved unsatisfactory, the service is relatively expensive and so is now spot purchased in order to meet specific needs and can offer a wider range of choice for individuals.

**Flexible Care Support Scheme**

Unlike the family placement service, Knowsley already had experience of running a flexi care service but wanted to use the opportunity of POPP programme to extend its remit to provide an ‘in-reach’ service to the hospital in order to support effective discharge and provide support to older people with mental health problems to access mainstream intermediate care and rehabilitation services as well as exploring other opportunities for its use.

The achievements of the service and its overall development have been impressive.

**Development of hospital in-reach:** The Flexi-care Service is able to offer a unique service by accepting referrals whilst individuals are still in hospital and getting involved in their care and discharge plans way before discharge. Continuity and trust in staff is often particularly important to a successful discharge for older people with mental health needs; the Flexi-care Worker will visit them whilst still on the ward, getting to know them and building up a relationship and will follow them into the community. Depending on the circumstances, the Flexi-care Service will support service users in various ways whilst settling back home, on occasions this may only be very short term until the individual has stabilised and is back in a routine; on other occasions, this may take much longer if a new mainstream care package needs to be introduced or the older person has been in crisis.

**Preventing hospital admissions:** although the Flexi-care service is not formally a crisis response team they do have the ability to quickly respond to changing and fluctuating needs. They are also very skilled in working with service users with complex mental health problems and who are particularly resistant to accepting mainstream services which then leaves them extremely vulnerable and at risk of emergency admissions.

**Supporting return to independent living from residential care:** as the service has developed, flexi
workers have supported 3 people in returning to the community from residential care. Due to the flexibility of the team they have been able to work with individuals, their families and care management teams to provide intensive and varied support tailored to each case. This has included providing personal care and support, undertaking and supporting visits back to the home environment, support with building daily living and social skills, and in one case arranging new accommodation when a previous tenancy had been relinquished.

**Catalyst for Change and Service Development:** the success of the flexible care model in the areas identified above also encouraged partners to consider other ways in which it might be developed. This led to the piloting of a Care and Support Programme (CASP). The aim of CASP was to provide a short term programme for older people with mental health needs (and their carers if they wished) who had been referred for day care at one of the Borough’s day care centres. It aimed to support individuals to identify how they could maintain their independence, social inclusion and good mental health. The programme included things such as an introduction to Age Concern’s befriending scheme and luncheon clubs, the role of the older person’s health visitor and other preventative services and an introduction and assessment for assistive technology. The focus of the programme was on supporting the older person and their carer to access information, services and support that are available both through formal and informal channels. Initially the programme was aimed at older people with mental health needs, however, it was so well received it was quickly extended and is now offered to all older people who have been referred for day care at the centre. The evaluation of the first year of the pilot demonstrated that 36 people had been through the programme, but only 19 of these went on to have a day care placement. The rest of the cohort were introduced to other services such as befriending, luncheon clubs or other community groups that they felt would better meet their needs. CASP has been so successful that it is being continued and has now become a mainstream service offered at one of the day centres in the Borough and plans are now underway to roll the programme out across other Council run day care facilities.

There have been significant challenges in maximising the potential of the flexible support model not least the culture changes necessary in mainstream services. Introducing this type of transitional care has challenged the traditional pathways and the working practices of Care Management Teams. There was potential for this service to become blocked with people receiving long term packages of flexible care. Although original plans for the service was to act as a 6-8 week intermediate care service, learning from the project has shown that this is not always possible. While some service users have had much longer periods of input, particularly where transition from residential back to community, the emphasis in care planning has been more outcome focused. Initially the emphasis was on social care workforce skills but now the workforce brings together both health and social care skills.

> “The way that service is used from one perspective is that the service would normally be entered into where there was difficulty in an individual accepting Social Services; someone with dementia, for example, who was obviously struggling but in denial that they were struggling. From a Social Services perspective, we commission the Flexi-care Service to go in and discover what was happening on a day-by-day basis, and they would report back to us. And gradually form a sort of therapeutic relationship with the service user” 72

**Conclusions**

Contributing to the POPP programme offered health and social care partners opportunities to explore and evaluate new ways of working with older people. The IKAN project was able to engage a more whole system approach to identify and provide support to people who might be at risk of losing their independence and or becoming socially isolated. Through the involvement and co-location of IKAN Team members with the neighbourhood PRIDE Teams innovative partnership have been developed around the needs of older people with the fire service and neighbourhood wardens playing a key role. Gaining a wider ownership for promoting a quality old age was seen locally as an important step in managing an increasingly ageing population as was developing pathways where older people could access non statutory services often in very local locations. The links between the impact of things such as fear of crime, poor housing, social exclusion, etc on health and well-being has become much more understood by other agencies locally.

72 Ibid page 23
The local development of new service responses to the needs of older people with mental ill health preceded the publication of the National Dementia Strategy and has offered some interesting learning about the services valued by older people and their carers. These developments were initially led by provider thinking and experience and there were concerns about how far experiences would influence commissioning intentions. The integrated structure within Knowsley offered both opportunities and threats to this happening. The governance for the project was set up through the Health & Well-being Partnership Board which is chaired jointly by the PCT chair and the Leader of the Council. POPP presentations have regularly been provided through the duration of the project to both the Health and Well-being Management Board and the Full Board; this has ensured that both the Council and the PCT have taken joint responsibility for sponsoring the project. However during the course of the programme further work was underway to more fully integrate commissioning and it was not always clear where the responsibility for OPMH would rest and what the capacity would be for developing clear commissioning intentions. There is now a clearer commissioning structure in place. This aims to ensure that a holistic view of the local population needs for both Health and Social Care Services is taken with a greater focus on prevention, early intervention and targeted services. Commissioning is now clustered around four Lead Commissioning roles. These are:

Commissioning of Treatment Services including Secondary, Specialist and Practice Based Commissioned Services. This is led by the Director of Finance and Commissioning.

Community Services led by the Director of Health and Social Care

Wellbeing Services – Director of Public Health

Primary Care Services – Medical Director

A commissioning post for OPMH has now been identified and Knowsley is working with neighbouring boroughs (Halton, St Helens and Warrington) to agree a shared commissioning strategy.

“We aim to work collaboratively across the 4 Borough Alliance to deliver a system of care that is effective, valued and person centred. We will achieve this within a context of recovery, social inclusion and choice. Our aim is to improve quality of life and promote independence.”

Experiences in Knowsley have also shown the value in working with older people in developing new service models and in reviewing and redesigning them in the light of experience. Working with a new service provider as in the case of PSS was often challenging on both sides, but by recognising and building on the experience they brought, greater levels of trust were developed and it was more possible to reshape services to better meet needs.

Leeds

Local Context

Leeds describes itself as ‘a city of contrasts, comprising a built up urban city centre and rural hinterland with market towns. With a population of 750,000 it is the second largest authority in the country and has all the challenges of a big city not least of which are the 1 in 5 residents who live in poverty’. The Leeds Strategic Plan (2008) portrays the city as ‘a quality place to live, work and raise families’. It says Leeds ‘is recognised as one of UK’s most successful cities’, having transformed itself over the last 20 years ‘from a mainly industrial city into a broad based commercial centre, the most important financial, legal and business service centre outside of London’. The city has attracted the country’s largest absolute increase in the country (4.8% since 2001). Its economic progress is illustrated by the creation of 59,000 new jobs between 1996 and 2006 together with an increase of 36% in Gross Value Added, (a measure of wealth creation).

Alongside this economic growth, the 2008 plan also recorded some significant social advances. Life expectancy had grown by over a year during the previous decade; crime had fallen by approximately 30% since 2003/04, the second highest fall in the country, more children were doing well at school than ever before as a result of an approach that aimed both to engage children and young people and also put schools and children’s centres at the heart of their communities.

Nonetheless, the Plan identified significant continuing challenges: some neighbourhoods and communities had not shared in the city’s economic success, significant numbers of people remained unable to work due to illness or injury; and many local people were excluded from job opportunities or career development due to a mismatch between their skills and aspirations and the skills now required. Only 65% of the Leeds workforce...
had level 2 skills (equivalent to five A* to C GCSEs) against a national skills target of 90% by 2020.

The growing population had put pressure on the housing market and health inequalities persisted. For example, children born into the most deprived neighbourhoods could expect to live almost 12 years less than those in the least deprived ones. The growing proportion of people over 60 was seen as raising issues about how older people’s health, independence and contributions to the life of the community would be supported into the future.

The city is a single tier authority and places emphasis on a devolved approach to neighbourhoods and areas. The views of its communities were ‘central to the development of the Vision for Leeds, and we have continued to work hard to empower and engage with all sectors’. Community empowerment was the city’s selected area as one of the eleven LAA demonstration areas nationally.

Leeds has been successful in winning external recognition for its work. For example, it is the only Local Authority to have won Beacon Awards in all 9 rounds up to 2008/09, when it secured Beacon status for its Local Area Agreement and Local Strategic Partnership (the Leeds Initiative). The LSP was founded in 1990, is led by Leeds City Council, and was developed with the private and voluntary community and faith sectors. The Sustainable Community Strategy (The Vision for Leeds 2004-2020) sets out three high level aims for the city to:

- Go up a league
- Narrow the gap between the most deprived parts of the city and the rest
- Develop our role as a regional capital

The interlinking of these aims was considered fundamental to the city’s recent success. For example, economic development and growth allowed it to narrow the gap and the Local Area Agreement 2006-9 was used as the mechanism for accelerating improvements in the lives of local people. A key challenge for the LSP and LAA remains the co-ordination of an ambitious improvement agenda across such a large and diverse city and effectively involving over 500 partner organisations.

Older People in Leeds

Some 20% of the Leeds population is aged 60 and above. The Leeds Strategic Plan envisages that ‘rising life expectancy and the growing number of older people will increase the need for additional services or support to maximise the capacity of elderly or vulnerable people to continue living independently.’ The principal strategic framework for the population of older people in Leeds at the time of this project was the document ‘Older Better: a strategy to promote a healthy and active life for older people in Leeds 2006 - 2011’. The strategy was prepared by the multi agency healthy and active life group for older people, widely consulted on and launched in May 2006. Its vision was expressed in the following terms.

79 Leeds Strategic Plan 2008 to 2011, p.23 http://www.leedsinitiative.org/uploadedFiles/Local_Area_Agreement/Content/Documents/PDF/LSP%202008%20to%202011%20INTERNET.pdf
A life worth living for older people in Leeds is one where: they are respected and included, their contributions are acknowledged, and they are enabled to remain independent and enjoy as good mental and physical health as possible."

It was explicit that its approach was to ‘shift from the tradition of developing specialist health and social care services for older people in Leeds to a move towards recognising the value and importance of health promotion and illness prevention work targeting the broader determinants of health.’ To this end, it was based on three principles:

1. **Reduce health inequalities** by focussing on:
   a. social and economic factors (poverty, housing, gender, ethnicity, isolation)
   b. access issues (transport, information, technology, mobility, safety, discrimination and ageism in service provision)
   c. power issues (public involvement, decision making and ageism)

2. **Promote active citizenship:** older people should be regarded as active citizens, making a positive contribution to society and not passive recipients of services

3. **Involve older people at all levels:** older people want to play their part in the wider society and in planning for their own futures.

The breadth of this agenda and its implications the wider system of care and support were reflected in its aspirations for specific changes so that by 2011 all older people would:

- Have access to comfortable and secure homes
- Have an adequate income
- Live in safe neighbourhoods
- Be able to get out and about
- Have the opportunity to develop and maintain friendships
- Have access to learning and leisure
- Be able to keep active and healthy
- Have access to good relevant information

Older People with Mental Health Needs

‘Older Better’ provided a universal, inclusive framework for addressing the needs of people with mental health problems. The level of need was identified as significant. For example, the 10-15% prevalence rate for depression in older people and the 1-2% rate for schizophrenia meant that approximately 15,500 and 2,200 people, respectively, were affected in Leeds. An Older People’s mental health strategy plan had been produced in 2005 based on Standard 7 of the NSF for older people and especially its statement that “mental health services for older people should be community-orientated and provide seamless packages of care and support for older people and their carers”. Consequently, it emphasised the need to focus on:

- Rooting out age discrimination
- Providing person centred care
- Promoting older people’s health and independence
- Fitting services around people

The plan gave particular priority to health promotion, mental health promotion, early intervention, social inclusion and better diagnosis. In addition, the city has invested in Intermediate Care since 2000 as a means of reducing hospital admissions and lengths of stay. The development of Intermediate Care and Joint Care Management Teams were at the core of the local Reconfiguration of Older Peoples Services which preceded the National Service Framework (NSF) for Older Peoples Services.

By 2008, its local vision was for an intermediate tier, comprising ‘a set of support services available to all, in time of personal, physical, psychological and emotional need. It is time-limited, community or home based, focused on good health and well-being and encourages independence with personal choice.”

---

80 Older Better p.2
http://www.leedsinitiative.org/assets/0/694/716/778/784/974/02660F30-FC95-4C93-AE56-BC223D07424ADE.pdf

81 (DH 2001)

The same source also emphasised the radical nature of impending change: with a greater emphasis on personal choice, independence and control, responsibility needed to be shifted to “the wider community health and social care services, taking intermediate care “upstream”, where possible, away from crisis towards greater prevention and proactive care planning. Through intelligent commissioning, resources will also need to shift in the same direction”.

This thinking also led to the advocacy of a whole systems approach geared to commissioning an intermediate tier function rather than a service and requiring an increased level of integration, including a commitment to joined up commissioning. A number of indicators of success were identified for the 2003-2007 period, including reductions in care home admissions, acute hospital lengths of stay, delayed transfers of care and older peoples mental health bed numbers. However, progress was considered inconsistent and limited by the absence of ‘universal support’ for the intermediate tier strategy across the city.

For example, the focus had been on physical needs and mental health had, ‘to a certain extent, been excluded, despite the previous expectation that the intermediate care requirements of older people with mental health needs will be commissioned for within the whole system. The existence of five PCTs and the ad hoc development of national policies, such as those for reducing delayed discharges and introducing community matrons, also contributed to fragmented implementation which the 2008 strategy sought to rectify.

As a result, there continued to be inequities of access to services for older people with mental health needs and gaps remained between PCT community services and specialist mental teams as well as between mental health services for adults of working age and older people. In addition, older people with mental health needs remain the longest delays from the acute trust.

Partnerships for Older Peoples Projects (P0PP) and LinkAge Plus

Nonetheless, there had been considerable developments in services for people with mental health needs as a result of the city’s success in winning pilot funding from central government. An application to the P0PP programme, for example, based on its Older Peoples Mental Health Strategy Action Plan, received the largest investment (£4.1mover two years) of all the national pilots. Several of the Leeds schemes were within the Intermediate Tier:

- Liaison Psychiatry
- Rapid Response Intermediate Care (Older Peoples Mental Health)
- Community Support for Older People
- Community Intermediate Care beds for dementia
- Dementia outreach
- After hospital care.

In addition, Leeds was a pilot site for the Department for Work and Pensions Link Age Plus initiative. This programme was designed to tackle exclusion faced by older people (including those with mental health needs) and to implement integrated approaches to promoting older people’s health, wellbeing and independence. The Leeds pilot had a budget of one million pounds over two years from 2006-08 and aimed to develop:

- A single accessible gateway to a wide range of services and information promoting health independence, wellbeing and quality of life work.
- Capacity building within the innovative voluntary sector for older people in Leeds, to support the development of preventative services and to promote the contribution of older people and active ageing
- Further work on streamlined assessment building on participation by Leeds in the original Link Age initiative which led to the integration of the visiting services of Leeds Benefits Agency and Pension Service.

Both these pilots provided national recognition and funding for local initiatives. The latter effectively located care closer to home as an integral part of delivering other national priorities including: reducing inequalities in health and wellbeing; promoting active ageing; building community capacity; extending choice and control, increasing social inclusion, strengthening the intermediate tier, and removing unnecessary burdens on health services, especially hospital beds. Yet the local leads for the pilots were experiencing real difficulties in securing long term funding. What follows focuses particularly on sustainability in relation to elements of the P0PP programme.

As noted, POPP was being used to kick start an older people’s mental health strategy with a particular emphasis on substantial investments in intermediate care and delayed discharge services. Part of its purpose was to bring together partners who had not always been in agreement to support strategic planning, joint commissioning and joint care management. Thus, it was recognised to be the start of a whole systems process of service and organisational development which would generate learning to inform decisions about longer term funding by the council and NHS. Moreover, it aimed explicitly to test out ways of implementing national and local policy agendas including such ‘key drivers’ as:

- Promoting health, wellbeing and independence.

83 The document cited the British Geriatric Society’s description of intermediate care as having “a clear function (admission prevention and/or post-acute care), incorporate comprehensive (multi-disciplinary) assessment, have an enablement process, offer time-limited contact (to differentiate I.C. from maintenance services) and involve multi-agency working.”
Reducing the use of bed based solutions

Extending the range of home based services

Re-aligning systems and resources to support earlier intervention and prevention

Putting older people at the centre of planning, assessment and delivery of services

Partnership working

In addition, it was accepted that POPP supported and benefitted other work streams and change programmes in Leeds. These included the carers’ strategy; intermediate tier review; telecare; Linkage Plus; new type of worker project and; Adult Social Care Transformation Programme, the reduction of health inequalities and promotion of wellbeing for older people. In other words, POPP in Leeds was described as a significant contributor to the implementation of policies at the heart of national and local visions for health and social care. It was a large scale development building the city’s early development of intermediate and specifically aimed at bringing older people with mental health needs from the margins to the mainstream.

Implementing and sustaining POPP

At the time of our fieldwork, the major issue confronting the POPP project team was how to secure long term funding by integrating it with the other local strategies to which it had contributed. The team believed that it was delivering a successful programme. The quality of OPMH service delivery had improved as a result of POPP. Much more of its activity was at the front end so that people could be seen earlier and quicker. It was also drawing in people who had previously ‘been invisible’ including people from hard to reach groups. A high proportion of the people seen were aged 80+, living in rented accommodation, isolated, with financial difficulties and not seeing primary care services until they experienced a crisis event. Liaison psychiatry and rapid response services were reducing hospital admissions and locally based services were offering a wider range of choices and opportunities for people in or near their homes.

While there was some feeling that the intermediate tier was still too health focussed and the in house home care team was still to be re-focussed from cleaning to reablement, the growing infrastructure of community networks and carer support was beginning to change the balance of provision. LinkAge Plus and other community development approaches were building on an established pattern of neighbourhood networks and localised voluntary sector projects, some of which owed more initially to citizenship, community safety and health inequality agendas than those in social care and health services for older people with mental health problems. However, such services were complementary to more specialist outreach, community team and community resource centre models delivered by the latter.

POPP projects were being shown to be responsible both for avoiding hospital admissions and reducing lengths of stay as a result of using POPP to reinforce the intermediate tier. Care home admissions were similarly being avoided or delayed. All told the team claimed it had identified £6m in savings from its £2m POPP grant. It had also developed an integrated locality model in which it was seeking to interest commissioners including GPs (Figure 1).

Figure 1

---

84 Presentation to ‘Keeping Leeds Well Workshop, 14th September 2007.

However, PBC was still at an early stage and seemed to have ‘a life of its own’. PCT commissioners were seeking hard evidence of savings (which was still being collated at the beginning of our project) as acute providers would not begin to agree service changes without it. In addition, organisational change was leading different players (for example, GP consortia, PCT providers) to seek to position themselves in the new market. They were looking for their own market niches rather than contributing to a systems wide process of re-design that might put them at a disadvantage in terms of their continuing business.

Proving the impact of particular interventions within a large and complex system like Leeds was inevitably problematic but a financial modelling exercise was being undertaken. In addition, the Team was learning that financial systems were not supportive of sustaining POPP investments and, therefore, activity. The PBR rules meant that reductions in length of stay before the trim point produced no savings for commissioners and the reduction in admissions was capable of producing savings only if beds were not filled by other patients. At the same time, the arrangements for dividing savings between the PCT and PBC consortia also reduced the volume of savings potentially available to sustain POPP projects. The Leeds team had been asked to look at the potential of PBR to provide funding to sustain projects pump primed by the national POPP grant. It reviewed how, in theory, the PBR mechanisms might operate in such circumstances. Its analysis suggested that, in principle, it appeared that for every £1m ‘saved’ in acute budgets, only £180,000 would be available to them for re-investment in the services which had made those savings.

Conclusion

The Leeds site provided important learning for this project in relation both to service models and their longer term commissioning. First, it provided an example of a well developed service model organised around an enhanced intermediate tier (rather than service) increasingly linked to generic neighbourhood networks and community services based on citizenship and aiming to support health and wellbeing, reduce inequalities and increase choice. As a result, Leeds was delivering care closer to home within a wider corporate wellbeing context as well as more traditional health and social care models. Indeed, the city had developed nationally recognised LSP and LAA mechanisms within which a city wide approach could come together.

Second, although the POPP pilot was designed within and clearly reflected this wider context, it was proving difficult at the time of our fieldwork (spring 2008) to secure long term commitments to long term commissioning of the POPP projects. This partly reflected the difficulty of securing a whole system focus on care closer to home at a time of organisational change and system reform in both social care and the NHS. A more fundamental difficulty demonstrated by the Leeds case is that without financial systems reform designed to enable money to be transferred more readily within and between the local government and health economies, the opportunities to invest in successful care closer to home initiatives will remain unjustifiably limited.

Oxfordshire

Oxfordshire County Council was identified as an organisation that might be willing to take part because of work they were doing to develop services for older people with a mental health problem using a ‘social inclusion’ approach. This was in partnership with Oxfordshire Primary Care Trust and Oxfordshire and Buckinghamshire Mental Healthcare Partnership NHS Trust.

Oxfordshire

Oxfordshire is a relatively prosperous county with a growing population estimated to be 652,000 in mid-2006. The largest settlement is Oxford itself with a population of just under 150,000 almost one-third of whom are students. However it is a very rural county with over 50% of the population living in settlements of less than 10,000. There is virtually full employment (this was pre the current recession) Health is generally good. However despite its overall prosperity there are pockets of deprivation in some of the more urban areas such as Oxford and Banbury.

86 ‘Oxfordshire 2030’ which is the County’s Sustainable Community Strategy. At http://www.oxfordshirepartnership.org.uk/wps/wcm/connect/OxfordshirePartnership/Oxfordshire+Partnership/Oxfordshire+2030/
Oxfordshire 2030 is the County’s Sustainable Community Strategy. It sets out a long-term vision for Oxfordshire’s future. This is to

- “Create a world class economy for Oxfordshire building particularly on the high tech sector.”
- Have healthy and thriving communities. We want to sustain what is good about our city, towns and villages but also respond to the needs of the 21st century including the impact of demographic and lifestyle changes.
- Look after our environment and respond to the threat of climate change and the potential for more extreme weather conditions.
- Break the cycle of deprivation by addressing the regeneration needs of disadvantaged communities; reducing the gap between the best and worst off and supporting people to maximise their talents and raise their aspirations.”

**Older people in Oxfordshire**

Older people currently make up just less than 15% of the total population, slightly less than the national average. Between 2006 and 2026 whilst the total population of the County is forecast to grow by over 12%, the number of people aged 75 and over is projected to grow by 60%. This trend is similar to that expected nationally and is driven by increasing life expectancy and the current age profile of the county.

Older people are unevenly distributed, with most concentrated around the urban conurbations and the southern half of the county. The increase in the older population will also fall unevenly across the county, with the southern half expected to show the largest increases.

Oxfordshire does not have an older people’s strategy. However in 2007 the County Council and PCT published two specific joint strategic needs assessments (JSNA) for older people. One was for the general population and the second looked at the needs of older people with mental health problems.

The JSNA for the general population concluded that:

- Older people in Oxfordshire are generally healthier that the national average. There was one noticeable exception to this – osteoarthritis. The reasons for this were not clear
- Within the county there are differences in the incidence of ill health. These are frequently aligned to the more deprived areas of Oxford City and Banbury. However, in some instances e.g. cancer there is no clear explanation for differences across the county.

Mental illness, especially dementia, was identified as an increasing problem. Prevalence data amongst the population over 65 showed that the incidence of the disease in primary care was the same as that of cancer. However the prevalence is much higher in population over the age of 85, which is the group that is expected to increase at the fastest rate over the next decade.

The needs assessment goes on to state:

“No strategy has been put forward to address this issue locally and few resources are currently devoted to preventing this imminent problem. The mental health needs assessment has also demonstrated that the current management of older patients with mental illness both in primary and secondary care is far from ideal, with drug costs for dementia in primary care doubling over the past four years and with the number of bed days consumed by patients with dementia being second only to patients with fractured neck of femurs. Mental illness is also a consistent reason for the readmission. There is clear evidence from service users and carer’s (which points to the inconsistency of care across the PCT leading to an urgent need to standardised care pathways for older people with the most common mental health problems.”

The JSNA for Older People with Mental Health Needs estimated that:

- There were 2,406 older people with a diagnosis of dementia.
- This was projected increase by 3,800 by 2026 (63%).
- 719 older people experiencing mental ill health received support from social care.
- Of these two-thirds (493) were supported in their own homes.

The assessment concluded that:

- The most common conditions associated with mental ill-health in older people are depression and dementia.
- These two conditions are the 2nd and 6th most important contributors to acute inpatient bed days in Oxfordshire, despite lower admission rates for these conditions than the national average.
- Recently discharged patients with dementia also manage more poorly in the community and are more commonly readmitted than patients discharged with any other condition.

---


88 Ibid pp 35-36

89 This was published in October 2007. See http://portal.oxfordshire.gov.uk/content/public/oxfordshirepartnership/Partnerships/health_and_wellbeing/published_reports/Older-People-Mental-Health-HNA-2008.pdf
Although there is a considerable range of statutory and voluntary services provided for older people with mental health problems, there are notable gaps in the current provision of mental health services for older people. These include the absence of any mental health promotion programs for older people across the county and the lack of psychological services in primary care for those over the age of 65 suffering with mild to moderate mental illness.

Specialist mental health services for the elderly, including Community Mental Health Treatment services, day hospital, and nursing home beds are currently evenly distributed across the county.

An analysis of current and projected service use suggests that the majority of the burden of increasing mental illness, especially amongst the very frail will fall on geriatric medical services and psychiatric community services rather than old age psychiatry services.

The needs assessment identified five priority areas for services for OPMH

1. Agreeing care pathways for older people with mental health problems
2. Developing and strengthening the health, and social care workforce locally, particularly to increase expertise in older peoples mental health issues
3. Developing a wide range of health and social care services that offer timely, appropriate and high quality care closer to home for older people with mental illness
4. Acknowledging the needs of carers and the supportive unit around older people with mental health problems
5. Implementing strategies to prevent mental illness in older people by promoting and supporting healthy ageing and active citizenship.

The approach to services for OPMH

By the time we undertook the fieldwork the County Council and PCT were co-terminous. Oxfordshire PCT had, however, only been in existence since October 2006 when five PCTs were merged into one. The Mental Health Trust provides services throughout Oxfordshire but also in the neighbouring county of Buckinghamshire.

Whilst there may not have been a written strategy for services for OPMH there was a clear sense of direction. The overall approach was described as one of ‘social inclusion’. That is wherever possible to integrate OPMH into mainstream services for older people. It was recognised that OPMH did need access to specialist mental health services at specific points but that on most occasions they had similar needs to other vulnerable older people and a shared a need for generic support and care services.

At a workshop organised as part of this project the model for OPMH care was set out as made up of 4 elements:

- Integrated CMHT with Social Care and Mental Health
- Integrated Day Care with Social Care and Voluntary Sector
- Integrated Intermediate Care with PCT, Social Care and Mental Health
- Integrated Crisis Intervention Team with Social Care and Mental Health

Intermediate care

Oxfordshire have developed an intermediate care service for all older people including those with mental health problems. Within the service there is a specific element providing specialist support for OPMH with staff from

90 Ibid pp 44-46
the Mental Health Trust working as part of the staff team. The service targets older people with mental health needs in hospital (either acute mental health or general acute) who meet a set of generic criteria for intermediate care. The service is provided in a person’s own home, which can include residential care.

Day services

A traditional hospital based day care service for OPMH has been de-commissioned and the resources used instead to develop a more social care focused approach. This involves older people with mental health problems being given a service in local authority resource centres and voluntary sector provided day services. Staff from the Mental Health Trust worked in the centres providing specialist support. This included running group sessions and providing training and support to staff so that older people with more severe mental health problems could attend.

This shift was taking place within the context of a more general review of day services which sought to promote a re-enablement approach linking people back into mainstream council, NHS and voluntary sector services in the community.

Home care

There is a very effective joint home support service. This provides support through 4 levels up to, and including, NHS continuing care in a person’s own home. It includes staff from both the Council and PCT with Council staff being on honorary contracts with the PCT.

Commissioning

Commissioning social care services for OPMH was aligned with commissioning for older people rather than adult mental health. A pooled budget had been set up that was held within social care. This included all social care funding and some NHS funding e.g. for continuing care. The budget is currently approximately £70m and is expected to grow to £100m with the inclusion of funding for intermediate care, home care and day care.

There were reports that the Mental Health Trust sometimes struggled with this approach. This was because their relationships tended to be with people in the PCT commissioning services for working age adults rather than those people commissioning services for older people.

Commissioning was described as relatively under developed as an overall strategic process. There were strong contracting and procurement process within the Council and care managers worked closely with contracting staff to help shape and influence what services are procured. Most service developments have been provider led. There were joint service specifications for intermediate care and end of life care. The creation of a single PCT was beginning to pay dividends, making it easier to develop closer joint working.
Involvement in project

Initial discussions identified two possible areas of work:

- Developing a commissioning strategy for services for dementia
- The role of extra care housing in supporting older people with dementia

Extra care housing

There was currently only one extra care scheme in the County. This was a state-of-the-art development but there were concerns that it would not take single people with mental health problems and there was reluctance to take couples where one person has dementia. The Council was about to embark on a large-scale development of extra care housing but want to ensure that its social inclusion model applied to that type of provision.

Commissioning strategy

With the publication of the JSNA there were discussions taking place about developing a joint strategy for services for older people with mental health problems. It had been agreed that this would be produced by March 2009. It was agreed that it would be useful to broaden the range of people who could input into the strategy through holding an event which a member of the project team would facilitate. The focus of the event would be on how to develop further their approach to commissioning services based on a social inclusion approach.

The event

The event brought together a wide range of people from statutory and voluntary sector organisations and people with dementia and their carers. It developed a vision for services in the County and identified priority areas for development. There was strong support for changes which made it easier for people with dementia to use ‘normal’ services – especially through increasing awareness of dementia amongst, for example GPs and other health professionals. A need for much better information was identified and for a more co-ordinated approach from agencies towards the provision of services. The event was attended by the lead commissioners from both the Council and PCT charged with developing a commissioning strategy. They assured everyone that the outcomes would be fed into the strategy when it was developed.

Conclusions

Oxfordshire were included in this project because of their approach to developing services for older people with mental health problems that was integrated across health and social care and based on a social inclusion model.

The approach in the County illustrates one of the themes that has run through this work, that is how service developments are often initially driven by the needs of providers rather than specifically being ‘commissioned’ by commissioners.

For example the development of integrated day care services and intermediate care came about to an extent because of cost pressures in the Mental Health Trust arising from high use of acute mental health beds and the need to make efficiency savings in the Trust. However there was also recognition that there was a service gap which needed to be filled, especially for intermediate care. Because of the integrated approach between the Trust and the County Council there was an opportunity to use this to develop new models of service. In the case of day care this included not just the Council and the Trust but also a partnership with the voluntary sector to deliver a service that cost less but delivered a better model of care.

This integration did not flow from an overall strategy but was based on recognition of the operational benefits that closer joint working could bring. Again this is a common theme. Integration works best when it is responding to the local context and is driven by local needs rather than top-down approach. Based on past success Oxfordshire was able to move ahead in a systematic but incremental way rather than feeling it necessary to adopt an ‘all or nothing’ approach. So the pooled budget for older people with mental health problems was initially set up with limited NHS funding incorporated but this was being increased as confidence grew in the way it was being used and managed.

Oxfordshire also demonstrated that it is possible to release resources from acute care settings and reinvest these into community services. A total of £1.2 million was saved by reducing the number of acute mental health beds and all of this was re-invested into intermediate care services. In relation to the provision of day care moving from a hospital based service to one integrated into existing services enabled additional investment in those services of £750,000 whilst delivering savings to the Trust of £350,000.

This shows that when there is a partnership between commissioners and providers it is possible both to reshape and improve services and deliver savings. This can be much more difficult when such a partnership approach is lacking.

91 Oxfordshire is now one of 22 national demonstrator sites for dementia advisors. See http://www.direct.gov.uk/en/Nl1/Newsroom/DG_179088
In terms of service models the intermediate care and day care services both demonstrate that it is possible to develop services that do not segregate older people with mental health problems from other older people. This has been the traditional service model in the past and it is questionable whether it is the most effective or efficient. Whilst neither of these developments has been formally evaluated there is clear evidence that they are cheaper than providing separate services and, at least anecdotally, the view in Oxford was that they delivered at least as good, if not better, outcomes for users and carers. Apart from intermediate care this is an aspect of services for people with dementia that is rather overlooked by the National Dementia Strategy.  

Sandwell  

The local context  

Sandwell is a unitary metropolitan borough in the West Midlands. It is overwhelmingly urban in character and is made up of six main towns – Oldbury, Smethwick, Rowley Regis, Tipton, Wednesbury and West Bromwich. Sandwell’s population experienced a sustained decline from the 1970s onwards, but is now beginning to increase again and in mid 2007 was estimated to be 287,600 people. 15% of the population are from black or minority ethnic groups.

Sandwell is one of the most uniformly deprived boroughs in the country. Nearly 60% of the population live in areas that fall in to the most deprived quintile in the country. There are no areas in the borough in the least deprived quintile. Life expectancy is increasing but is lower than for England as a whole and there are significant variations within the borough. Men from less deprived areas can expect to live 8.8 years longer than those in more deprived areas. For women the difference is 6.7 years. Whilst death rates have been declining over recent years the gap between Sandwell and the rest of the country has increased in the period 2004/2006  

There have been significant improvements in some areas however, for example deaths from circulatory diseases. The Standardised Illness Ratio for limiting long term illness (LLTI) shows Sandwell as being 21 points higher than the national index figure and also significantly higher than regional averages.

The 2001 Census recorded just over 60,000 people aged 60 and over living in the Borough – amounting to 21.5% of the population. The number of people aged 60 and over is expected to increase by 31% (18,600) between 2006 and 2031. The greatest increase within this category is expected to be those aged 85+ with a rise of 81% (+4,600). However the rate of increase in the numbers of older people is predicted to be lower than for England as a whole.

In common with many other metropolitan boroughs, therefore, Sandwell faces the challenge of an ageing population with high levels of poverty and ill health leading to a high demand for health and social care services.

The Council and the PCT are co-terminous and have a history of good joint working. A joint policy unit between the Council and the PCT was set up in 2003 to help develop a joint approach to improving health in the borough. Within the Unit there is a post with specific responsibility for older people and it was with this person that we initially made contact. She was keen to get involved once we had been able to renegotiate our methodology and offer some specific support to Sandwell.

Commissioning intermediate care services

The area chosen for the work was to look at developing the commissioning of intermediate care services. A new post of joint intermediate care manager had recently been created working across the Council and PCT reporting in to both the PCT’s Commissioning Directorate and the Council’s Adult Services Department. The post had just been filled and this was seen as a good opportunity to help launch some work on developing intermediate care. A strategy had been developed in 2006 but had never been effectively implemented and in the meantime things had moved on and it needed updating. It was hoped that our involvement would help the new manager.


93 Sandwell Health Profile 2009, Department of Health
Commissioning Care Closer to Home

- develop a strategic approach to intermediate care planning and joint commissioning
- tap into market leaders and regional/national networks
- develop effective delivery strategies – programme management, pathways, and contracts.
- providing more care in people's own homes and in their local communities and
- making sure people have access to the highest quality of care and support from skilled staff working from the best possible buildings.

The Towards 2010 programme was based upon the following model

Opportunities and Challenges in Sandwell

Sandwell had developed a comprehensive joint commissioning strategy for Health and Wellbeing in Later Life which covered the period 2007-2010. This already identified care closer to home as one of three top priorities along with Wellbeing and prevention and integrated and person centred care.

This strategy itself formed a part of the ‘Towards 2010’ programme. http://www.towards2010swb.nhs.uk/ This is an ambitious set of changes in the way that local health and social care services are delivered with the aim of:

- helping people stay healthy and avoid becoming ill,
Linking outcomes and implementation

Discussions with key players locally suggested a number of reasons why the development of intermediate care was being held up and not progressing as quickly as was hoped. These included:

- A lack of a shared agreement about what was meant by the term ‘intermediate care’
- Changes in key personnel
- A lack of dedicated management time to drive forward the desired changes
- A sense that intermediate care was seen by many people as a bed based approach that was separate from mainstream services
- A lack of clarity about how intermediate care could contribute to delivering the outcomes in 2010

Developing intermediate care was seen as the specific responsibility of the joint manager rather than being recognised as an essential component of a whole system approach and an integral part of a shift towards care closer to home.

The Commissioning Strategy provided an overall framework within which the development of intermediate care could take place. The 2010 programme provided much of the delivery framework for driving the changes in health and care services that the strategy had identified as required. It was agreed that was needed was a process that brought the two together explicitly and provided a wide range of people with the opportunity to understand the links better and identify the contribution that they could make to developing intermediate care – making it everyone’s business. This would then form the basis for identifying those priority areas where the intermediate care manager could focus her energy in making the system work more effectively and move forward.

Gaining wider ownership and securing contribution

Our consultancy support then focussed on developing and facilitating a mechanism to start this process off. It was agreed that we would help develop and facilitate a workshop that would pull together a wide range of people who had a potential contribution to make to developing intermediate care in Sandwell to engage them in developing plans for the future. It would explicitly involve senior managers from the Council and PCT and the Programme Director for 2010 to highlight the links between intermediate care and mainstream plans of both organisations. The aims of the workshop were agreed as being to:

- agree how intermediate care can help care closer to home and promote independence
- understand the current state of intermediate care services in Sandwell highlighting successful initiatives and identifying the current gaps in services
- agree shared priorities for future development and investment
- engage key players in developing an action plan to take forward work

We adopted a ‘whole systems approach’ to the
A workshop in order to engage a wide range of people with the potential to make a contribution and to build capacity in the local health and social care system. ‘A whole systems’ mean exactly that – an inclusive approach that recognises the contribution that all partners make to the delivery of high quality care and ensures that all stakeholders are involved in both planning and delivery. A wide range of people were invited to the workshop which was designed to be highly participative and make maximum use of the knowledge that resided in the room.

Outcomes

The approach in Sandwell has been to help the organisations develop an approach to intermediate care that supports their local approach rather than seeking to work within a definition developed nationally that was not seen to be terribly helpful. The following model was developed by the intermediate care manager and presented at the workshop as providing a model that linked together all the different elements of reshaping acute care, personalisation and care closer to home.

This brings together the contribution of different services and interventions into a single model of intermediate care that highlights the range of approaches that contribute to delivering care closer to home. This then allowed the people present – users and carers, front-line professionals, clinicians and managers to define the contribution that they currently made – and could make in the future – and the outcomes that intermediate care had the potential to deliver.
Out of this has come a clear set of priorities for the further development of intermediate care services. These cover:

- integration of mental health support into intermediate care including developing a model for crisis avoidance
- development of an integrated care pathway for intermediate care with 24/7/52 point of access and which link to other pathways for stroke, falls etc
- flexible and responsive access to respite care across health and social care services
- flexible and responsive access to 24 hour care including crisis intervention, home support and night sitting and hospital at home
- Roll out predictive risk modelling and proactive case finding
- Develop a model for ‘enhanced’ intermediate care services to provide an opportunity for better assessment of care needs in a ‘re-abling’ environment outside of hospital

An action plan with objectives, milestones, timescales and responsibilities all identified has been developed and agreed and is now being implemented.

Conclusions

Sandwell in common with many authorities is faced with a need to make significant changes to the way that health and social care services are delivered. There are several drivers for this including the need to deliver efficiency savings, to respond to changing expectations and demands as well as meeting the requirements of government policy. Often what this leads to is a myriad of different programmes and initiatives which are not always connected at a local level.

As we have seen Sandwell had made good progress in a number of areas. Its commissioning strategy for older people covers commissioning services for wellbeing as well as the provision of health and social care services. It has integrated structures and staff at a number of different levels – managerial, policy and operational. It has developed a major reform programme to reshape health and social care services in the borough. In contrast to some areas there is a strong lead from commissioners in all these areas.

Care closer to home is an element of all of these but in some way its very ubiquitiveness makes it difficult to commission in a consistent way. It has been a policy objective for many years but interpreted differently at different times and in different places. In Sandwell, in the context of the 2010 programme and a major
reshaping of health services it had perhaps come to be seen as what it was not – care in hospital – rather than what it should be – delivering better outcomes for people because it links to the wellbeing and social inclusion agendas.

Intermediate care is only one of a number of initiatives developed in recent years that can contribute to the delivery of care closer to home. It was initially seen as a solution to the issue of delayed discharges or ‘bed blocking’ – only gradually perhaps has it been appreciated as a positive opportunity to focus on maximising independence and reintegrating people back into community networks. This has led to a shift away from bed based models that predominated in its early days towards a more holistic approach that focuses on assessment and active enablement that can take place in a variety of settings.

This shift in emphasis has been helpful in Sandwell in enabling them to reposition intermediate care within the context of a whole system approach to change. It has enabled the Council and the PCT to move away from a focus on how many intermediate care beds were needed and in what part of the borough to think through how the development of intermediate care can contribute to delivering outcomes related to health and wellbeing recognising that many different services contribute to this process.

The Sandwell case study shows that even apparently discrete elements of the care closer to home agenda, such as intermediate care, are, in fact, intimately linked to broader developments and need to be thought about in that context. Commissioning such services is not a purely technical task but needs to be part of a wider framework for commissioning health and wellbeing. Specifically intermediate care should be aligned to and combined with a comprehensive approach to delivering strategic shifts in services and resources delivered through a range of different services.
Inside Back cover