Available Support for Integrated Care

What is needed for better integrated care?

The Better Care Support Team has identified six key building blocks for better integrated care:

1. Developing excellent system leadership
2. Delivering excellent on-the-ground integrated care
3. Developing integrated datasets and information systems
4. Aligning financial incentives, and sharing benefits and risks
5. Effectively measuring success
6. Developing an integrated workforce and culture

What support is on offer?

These slides will help you to identify what support and resources are available to assist you in developing each of these key building blocks.

The Better Care Support Team
Developing excellent system leadership

What are the issues we need to address?

Implementing better integrated care involves changing not only what we do, but how we do it. It’s about changing not just systems and processes, but cultures and behaviours. Success can be achieved through strong, shared and collaborative leadership, grounded in the way we behave in our everyday working lives, and focussed on outcomes that matter to people.

Leadership can be looked at on two levels:

- **within your organisation**, in front-line, middle management and senior roles
- **beyond your organisation**, with people in other places and sectors, i.e. Systems Leadership.

Having good governance in place is essential, so that responsibilities and accountabilities are clear, and so that systems and processes are in place to ensure high quality service delivery. We know that it is difficult to identify and understand the key success factors in transition planning, and that engaging and communicating effectively across the system is often challenging.

Locality Case Studies and Key Contacts

- The South East CSU leadership programme is designed to inspire and equip NHS leaders to put patients and communities at the heart of their planning and commissioning, and deliver the objectives of Patient and Public Participation (PPP) and Person Centred Care (PCC). Their website contains links to several local case studies.

- The LGA have produced a value case exploring how North West London progressed from local integrated care initiatives, to a radical whole-system of integrated care for 2 million residents.
## Developing excellent system leadership

### Interactive Support and National Contacts

- **The LGA Health and Wellbeing Challenge** is a key part of the LGA’s HWB systems improvement support, involving bespoke teams of peers working on site with the council and its partners to deliver a peer led review.

- **Systems Leadership: Local Vision Programme** aims to achieve system change through leadership development. Run by the Leadership Centre, Local Vision sites are matched with an Enabler with a coaching/systems leadership background, who can spend up to 1 day/week supporting system leadership. An interim evaluation of the first place-based programmes for Systems Leadership: Local Vision is available [here](#).

- If you have questions regarding the development of system leadership, please contact Debbie Sorkin at the Leadership Centre at [Debbie.Sorkin@localleadership.gov.uk](mailto:Debbie.Sorkin@localleadership.gov.uk)

### Further Resources

- **The Better Care Support Team** has produced a [How to Lead and Manage Better Care implementation Guide](#).

- The **CCG Learning Environment** includes development support offers and good practice case studies for CCGs.

- **The Leadership Centre** website has a number of useful resources, including publications such as ‘The Art of Change Making: tools and resources for effective and sustainable change’.

- A paper by the King’s Fund draws on [three years' development work with leaders in health care systems in north-west England](#).

- **NHS Interim Management and Support (IMAS)** offers NHS organisations that need short or medium term support the means to access the management expertise that exists throughout the NHS. Its teams are made up of experienced senior NHS professionals and independent consultants who undertake assignments to support NHS organisations. Support is tailored to the needs of the client and can include elements of interim capacity and capability, organisational renewal, intensive support, consultancy or any combination of these.
Delivering excellent on-the-ground integrated care

What are the issues we need to address?

We are all working towards the shared objective of delivering world-class, person-centred, integrated care in a sustainable manner.

Moving closer to this aim will require us to define a new, patient-centred narrative, and get better at enacting and managing individual care plans. We will need to find ways to operate effectively and efficiently as a joined up system (for example in multi-disciplinary teams), focusing on keeping people out of hospital where possible for as long as possible, and on ensuring effective integrated discharge and re-ablement.

We need to make sure that the service user's journey is central to all our thinking, and that their voices are heard throughout.

Locality Case Studies and Key Contacts

- The King's Fund have created a map which pulls together a range of case studies to help showcase integrated care in action.
- The LGA have produced a value case looking at how integrated teams in Greenwich supported patients leaving hospital and helped to reduce hospital readmissions.
- Kent have produced a case study on operating an integrated discharge team.
- Southend on Sea have produced a case study on developing a single point of referral.
- The LGA have produced a value case examining how using multi-disciplinary teams in North Devon dramatically improved health and wellbeing outcomes for stroke victims.
- The LGA have produced a value case exploring how 10 local areas in Manchester came together to maintain and improve the quality of patient care.
- Birmingham have a useful Better Care website, which includes case studies and links to additional resources.

The Better Care Support Team
Delivering excellent on-the-ground integrated care

### Interactive Support and National Contacts

- **Webinar Series** – NHSIQ hosts a series of Long Term Conditions Improvement Programme webinars.

- **Monthly Bulletins** – NHSIQ also publish monthly bulletins which signpost to free online learning resources and opportunities to connect with each other on the Long Term Conditions Improvement Programme.

- The **Coalition for Collaborative Care** brings together people and organisations from across the health, social care and voluntary sectors who are committed to making person-centred care a reality for people living with long-term conditions. C4CC can be contacted at info@coalitionforcollaborativecare.org.uk

- If you have any questions about the **National Breaking the Cycle Initiative**, or about improving the emergency care pathway more generally, Pete Gordon from the **Emergency Care Intensive Support Team** can be contacted at pete.gordon@nhs.net

### Further Resources

- The **Emergency Care Intensive Support Team (ECIST)** have produced the [SAFER patient flow bundle](#), a combined set of simple rules for adult in-patient wards to improve patient flow and prevent unnecessary waiting for patients.

- NHS England has a dedicated **personal health budget (PHB) delivery support programme**. A [FAQ document](#) has been published which underpins their planning guidance.

- **Care Act 2014: Care and Support Statutory Guidance** provides guidance to practitioners and managers on implementing the Care Act. At Annex G (page 457 of the guidance) it sets out a clear process for managing transfers of care from hospital for patients with care and support needs.

- The **Social Care Institute for Excellence** website includes guides, tools and e-learning to support people who plan, commission and provide care and support services.

- **Towards Excellence in Adult Social Care** is a programme to help councils improve their performance in adult social care. Their webpage includes a toolkit which helps support councils to make the best use of their resources.
Delivering excellent on-the-ground integrated care

Further Resources

- The CCG Learning Environment website includes development support offers and good practice case studies for CCGs.
- The TLAP website provides examples of best practice for person-centred care.
- The Coalition for Collaborative Care website provides links to resources for implementing person-centred, coordinated care.
- The NHS Improving Quality website contains guidance for palliative and end of life care.
- LTC Handbooks provide practical support for good long-term conditions management.
- The Long Term Conditions Commissioning Toolkit is a live resource that brings together national guidance, published evidence, local case studies and information for patients and their carers about how to access services.
- ADASS have published Commissioning For Better Outcomes: A Route Map, outlining 12 standards for person-centred, outcome-focussed commissioning.
- The National Framework for NHS Continuing Care and NHS-funded Nursing Care sets out the principles and processes for NHS continuing healthcare and NHS-funded nursing care. It is supported by a checklist and decision support tool.
- Age UK’s Integrated Care Programme provides a good example of how the voluntary sector can play a key role in helping to deliver integrated health and care on a local level.
- TransformLDN aims bind together all community practitioners in London to realise a community-led revolution in health and social care. Their site contains an ‘Inspiration Landscape’: a map detailing numerous inspirational integration projects taking place across London. For more information please email viccie.nelson1@nhs.net

The Better Care Support Team
Developing integrated datasets and information systems

What are the issues we need to address?

Providing person-centred integrated care requires **high quality information to be shared in a timely, secure manner**, for a variety of purposes, including:

- Ensuring that service users receive a seamless service, without having to give the same information more than once
- Monitoring and measuring the impact of integrated care
- Identifying cohorts and individual service users that could benefit from integrated care interventions (known as risk stratification)
- Designing integration initiatives targeted at different population cohorts
- Designing new commissioning and payment systems

*This requires good quality data, interoperable IT systems that ‘talk’ to one another, underpinned by strong information governance, so that the necessary safeguards are in place when using patient and personal information.*

Locality Case Studies and Key Contacts

- The LGA has produced a value case exploring how the **Isle of Wight** is **developing new approaches to information sharing** that put the patient at the heart of the process.
- **West Norfolk** have produced a case study on their **Eclipse Live information sharing project**.
- **Worcestershire** have produced a case study detailing how they approached **profiling their population**.
- **North West London** have produced a case study detailing how they **profile their population according to need**.
- **Warrington** have created an Information Sharing Framework, including an **information sharing toolkit**.
- **Cheshire** have produced a case study on setting up a **pan-Cheshire integrated digital care record**.

The Better Care Support Team
Developing integrated datasets and information systems

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<thead>
<tr>
<th>Interactive Support and National Contacts</th>
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<tbody>
<tr>
<td>• Information Government for London (IGfL) is a networking and support group for all IG Managers in Local Authorities. They will be meeting on 14th July 2015 at 18:00 for 3.5 hours in Lambeth Town Hall. For further information, or to register your interest in attending, please contact Andrew Babicz at <a href="mailto:Andrew.Babicz@scimg.org.uk">Andrew.Babicz@scimg.org.uk</a></td>
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<tr>
<td>• The ADASS Informatics Network offer support and guidance in regards to developing information systems. You can contact them by emailing <a href="mailto:Andrew.Babicz@scimg.org.uk">Andrew.Babicz@scimg.org.uk</a></td>
</tr>
<tr>
<td>• The Centre Of Excellence for Information Sharing in partnership with the ESRC and KITE have a series of academic seminars looking at information sharing. Their next seminar is “Information Sharing for Smart Places: What kinds of Information Sharing for What Kinds of Places?”, which will be held at University of East Anglia Norwich on 2nd July 2015. For further information and to register your interest in attending, please click here.</td>
</tr>
<tr>
<td>• If you have any questions about data sharing, The Centre of Excellence for Information Sharing can be contacted at <a href="mailto:info@informationsharing.org.uk">info@informationsharing.org.uk</a></td>
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<td>• Monitor will be publishing “Meeting local information needs for integrated care: a technical guide” in June. It will be available on the Better Care Exchange.</td>
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<tr>
<td>• The Centre of Excellence for Information Sharing website has a wide range of resources, including case studies.</td>
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<td>• The Health and Social Care Information Centre website provides support and guidance on collecting and sharing information. It also provides information about the Information Governance Alliance (IGA).</td>
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<tr>
<td>• The Ripple community is focused on taking a collaborative, innovative and open approach on the journey towards an Integrated Digital Care Record.</td>
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Aligning financial incentives, and sharing benefits and risks

What are the issues we need to address?

In order for integrated care to work, we need to find ways to effectively align financial incentives between providers, the wider local system, performance management organisations, regulators and national partners. We need to make sure that all of these are working towards shared goals of desired whole system outcomes.

Both risks and benefits need to be evenly shared between the organisations working together, and budgets need to be brought together using clear and easily understandable processes and mechanisms.

Moreover, sector feedback indicates that the current forms of payment do not always support the delivery of more person centred co-ordinated care. The payment system holds potential to provide better support for innovations in patient centred, co-ordinated care. In particular, new payment approaches using capitation and gain and loss sharing are currently being developed and tested.

Locality Case Studies and Key Contacts

- The LGA have produced a case study looking at how in Waltham Forest, East London And City (WELC) risk stratification has helped health and social care professionals see beyond organisational boundaries.

- The North West London Whole System Integrated Care toolkit contains the chapter How can commissioners align provider incentives?

The Better Care Support Team
## Aligning financial incentives, and sharing benefits and risks

### Interactive Support and National Contacts

- If you have questions regarding aligning financial incentives, and sharing benefits and risks, Monitor can be contacted at [pricing@monitor.gov.uk](mailto:pricing@monitor.gov.uk)

### Further Resources

- **The Better Care Support Team** has produced a [How to bring budgets together and use them to develop coordinated care provision guide](https://www.bettercareexchange.org.uk/resource/how-to-bring-budgets-together-and-use-them-to-develop-coordinated-care-provision-guide).

- **Monitor** have produced several guidance documents, which are available on the [Better Care Exchange](https://www.bettercareexchange.org.uk);
  - [Reforming the payment system for NHS services: supporting the Five Year Forward View](https://www.bettercareexchange.org.uk/resource/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view)
  - [Capitation: a potential new payment model to enable integrated care](https://www.bettercareexchange.org.uk/resource/capitation-a-potential-new-payment-model-to-enable-integrated-care)
  - [Care Spend Estimating Tool](https://www.bettercareexchange.org.uk/resource/care-spend-estimating-tool)
  - [Guidance on mental health currencies and payment](https://www.bettercareexchange.org.uk/resource/guidance-on-mental-health-currencies-and-payment)

- **Monitor** will also be publishing further guidance documents over the course of the next few months. These will be made available on the [Better Care Exchange](https://www.bettercareexchange.org.uk);
  - Urgent and emergency care: A potential new payment model
  - Mental health: Outcome based payment with risk share
  - Secure and forensic mental health services: a new payment approach
  - Multilateral gain/loss sharing: a potential new payment model

- The [Personalisation Outcome Evaluation Tool](https://www.bettercareexchange.org.uk/resource/personalisation-outcome-evaluation-tool) was developed in social care as a way of measuring individuals’ experiences with personal budgets, it is now also used by some CCGs to monitor personal health budgets.

Effectively measuring success

What are the issues we need to address?

To meet our goal of providing world-class, person-centred, integrated care we need to be able to measure how effective and efficient our interventions are.

Effectively measuring such success (in terms of financial performance, system performance and service user satisfaction) requires us to develop new metrics, new evaluation criteria and frameworks, and reliable feedback mechanisms.

Developing the right outcomes, measures, evaluation frameworks and reports will be an evolutionary process and you may have to find local solutions in addition to the on-going national approach.

Locality Case Studies and Key Contacts

- The North West London Whole System Integrated Care toolkit contains the chapter How Do We Define Outcomes and Metrics?
- South Tyneside have produced a case study exploring their evaluation framework for the self-care programme.
Effectively measuring success

### Interactive Support and National Contacts

- Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) are collaborative partnerships between universities and surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research. Each CLAHRC aims to improve patient outcomes across the geographic area covered by the Collaboration through three key interlinked functions:
  - Conducting high quality applied health research;
  - Implementing the findings from research in clinical practice; and
  - Increasing the capacity of NHS organisations to engage with and apply research.

There would be value in contacting your local CLAHRC to understand what work may already be underway on integration.

- **Better Care Atlas** - As part of the Better Care Fund, NHS England have developed a tool which allows HWBs to monitor and benchmark their performance against key measures and national performance. This tool also provides an opportunity to see how peers are performing, which should enable HWBs to proactively reach out to other areas for good practice.

### Further Resources

- The Better Care Support Team has produced a [How To Understand and Measure Impact Guide](#).

- **The LTC Dashboard** contains a summary of metrics that will support intelligent commissioning for long term conditions across health and social care (in particular across five areas; risk factors, prevalence, quality of care, quality of life and economic activity).

- **The Patient Activation Learning Set** will capture and spread learning about how to implement a person-centred measure. This builds on work done by the Health Foundation to measure what really matters to people. More information can be found at [http://www.health.org.uk](http://www.health.org.uk)

- **The NHS England monthly situation report** collects data on the number of patients delayed on the last Thursday of each month, and the total delayed days during the month for all patients delayed throughout the month. The guidance document provides information on how to count, record and report delayed transfers.

- The Policy Innovation Research Unit (PIRU) provides advice on measures of integrated care for individual and collective progress monitoring using routine data.

- The Nuffield Trust undertook a series of evaluations looking at case studies of integrated and community based care. The report summarises a series of ‘key points’ that can help systems when developing and assessing their integrated care models.

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**The Better Care Support Team**
Developing an integrated workforce and culture

What are the issues we need to address?

The quality of any service is directly linked to the skills, knowledge, expertise, values and attitudes of the people who make up the workforce. These employees have a very significant role to play in any transformation that takes place. Developing a workforce which has the right skills and training, not just for today but for the future, is very challenging but crucial.

Positive workplace cultures are also central to an organisation’s success or failure, and are never more important than when the service is providing people with care and support. Positive workplace cultures not only address productivity and the health and wellbeing of staff, but also look to improve outcomes for those who need care and support services.

Bringing together individuals from different backgrounds and organisations, who may be used to working and communicating in very different manners, and moulding these into an effective, collaborative team, with strong relationships and high levels of trust, is also incredibly challenging. Creating collaborative, cross-cutting teams, who trust and understand one another despite having different backgrounds and experiences, is crucial for successful integrated care.

Locality Case Studies and Key Contacts

- The LGA have produced a case study looking at how Torbay used the patient journey to break down organisational boundaries and focus on the service-user perspective.

- The LGA have produced a case study exploring how Cumbria linked up 30 different voluntary organisations to improve the connection between health and social care and the wider community.

- The LGA have produced a case study outlining how health and social care commissioners harnessed technology and worked together with providers to help the elderly to remain independent in Northamtonshire.

- The End of Life Partnership in Cheshire have done some fantastic work bringing together 23 partner organisations in order to facilitate excellent, person-centred palliative and end of life care.

The Better Care Support Team
Developing an integrated workforce and culture

Interactive Support and National Contacts

• On July 9th 2015 at 10:00, at the Holiday Inn Bloomsbury London, there will be a Shaping the Workforce Offer Programme national event; “Supporting leaders to embed and promote workforce change”. This event explores designing the workforce for integration, and developing a diverse market, with the aim of exploring how leaders can be supported to embed and promote change and integration in the workforce. Click here for further information and to register.

• To contact Skills for Care with questions about workforce integration, please email; integration@skillsforcare.org.uk

Further Resources

• The Better Care Support Team has produced a How To Work Together Across Health, Care and Beyond Guide

• The Skills for Care website offers workforce learning and development support, and practical resources.

• The King’s Fund have recently published Staff engagement: Six building blocks for harnessing the creativity and enthusiasm of NHS staff.

The Better Care Support Team