

# Integration

## A report from the NHS Future Forum

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# CONTENTS

Foreword .....	3
Summary.....	6
The Case for Change.....	9
• Meet Mrs Crabtree from number 3 .....	9
• The “burning platform” for change .....	10
• Complex needs .....	11
• Barriers and Enablers to integration .....	12
Principles & recommendations to make integration commonplace .....	14
• Integrate around people, not pathways .....	14
– Patients and carers are key drivers of integration .....	15
– Patients and communities are part of the solution.....	16
– Make it easier to navigate and coordinate care.....	16
– Information: a key enabler of integration .....	18
• The quality of outcomes.....	19
– Align the NHS, social care and public health outcomes frameworks .....	19
• Commissioning and pooling budgets for people and populations.....	20
– Ensure integration reduces inequalities and promotes equality .....	21
– Health and wellbeing boards must become a crucible for integration .....	22
• Providers play a key role .....	24
– Make the most of general practice as providers of care.....	24
– Incentivise interoperability.....	26
– Free up third sector providers .....	27
– Clarifying the rules on choice, competition and integration.....	28
• Freedom and flexibility to “get on and do” .....	29
– Allowing time and space to develop new models of care .....	29
– Allow the money to follow the patient.....	31
– Make best use of personal budgets.....	32
• National support for local leadership.....	33
– Professional bodies should set the example .....	34
• Share lessons and provide support .....	36

# Foreword



Integration is a vitally important aspect of the experience of health and social care for millions of people. It has perhaps the greatest relevance for the most vulnerable and those with the most complex and long-term needs. We have services to be proud of, and patients in the England already receive some of



the most joined-up services in the world. However, too many people fall through gaps between services as they traverse journeys of care which are often too difficult for them to navigate themselves. This lack of integration results daily in delays and duplication, wasted opportunities and patient harm. It is time to “mind the gaps” and improve the experience and outcomes of care for people using our services.

In a relatively short space of time, we have learned a great deal about the current state of integration in health and social care in England. We have seen that excellent progress is already being made by many, at the level of commissioners, providers and individuals. Whether we were listening to patients, carers, charities, professionals or managers, there was almost universal welcome for the current focus on integration in health and social care. However, we saw and heard that it is currently too hard to make progress, particularly towards the huge gains promised by joint commissioning by the NHS and local government. Enabling more patients to experience a smooth, effective and safe care journey is not simply a matter of trying harder – a number of changes in the system are necessary. There is no “silver bullet”, but with action at various levels of leadership, management and regulation, care for people with complex needs can be dramatically improved.

One of the key themes people raised with us was that, while many encounters between individual patients and professionals are patient-centred, the system as a whole is not. Too many patients and carers feel that they are required to fit their needs and lives around the services on offer, rather than experiencing flexible and responsive services. Our public services are deeply precious, but no more so than the people we are called to serve. There is a clear commitment from staff working across health and social care to build systems and services which are increasingly designed around people. Commissioners have a central role in ensuring we integrate around the patient, not the system.

Another theme in our listening was a call from across health and social care to regard the people who use these services as a key asset to be embraced, rather than a burden to be endured. Patients, carers and community groups expressed a strong desire to be more involved in decisions about their care and the design of their services. In many instances, they also wished to be a bigger part of the solution to

their own needs. Through greater shared decision-making by professionals, training and support for self-care, and radical new asset-based community development projects, some localities are already making this vision a reality. They reported that, as individuals and communities begin meeting more of their own needs, they make less use of statutory services, people and staff are more satisfied, and care journeys are smoother. Supported by easy access to information and new telehealth solutions, approaches such as this hold much promise.

The greatest current challenge facing the NHS is the need to balance financial “grip” with local “freedom”. Throughout the country, frontline professionals and managers expressed a desire for greater freedom to design locally responsive services. However, they also described how innovation, clinical engagement and the development of locally sensitive services were stifled by a tendency towards centrally imposed change and micro-management. We were concerned by the number of clinical commissioning leaders who told us that local multi-professional engagement in the new NHS architecture was being lost as a result of this. Local authority leaders described their challenge in collaborating with NHS colleagues, because of the greater restrictions placed upon the local NHS. The Government has signalled a major policy shift towards greater freedom and responsibility for frontline staff to create a patient-centred, clinically-led NHS. We will watch with interest to see how the NHS Commissioning Board establishes a new way of working, which balances the imperative for local freedom and flexibility with the need to maintain financial control and sustainability.

It has been a tremendous privilege for us to be involved in this piece of work. Our team of 16 has done an amazing amount of work, travelling the length and breadth of England, meeting with thousands of people and giving their time, effort and wisdom to collating and interpreting all we have heard. We are grateful for the commitment the team have made, despite their busy jobs, to achieving this.

We are also hugely grateful to the enormous number of people who have taken the time to write to us, phone, join web seminars, attend meetings, submit reports and, in many cases, welcome us to their neighbourhoods. We would like to thank the Nuffield Trust, King’s Fund, National Voices and the Standing Commission on Carers for their bespoke work for the Forum. It is inspiring and humbling to see the deep commitment to continuing to improve our public services amongst patients, carers, communities, charities, professionals, managers and local councillors.

As co-leads of the Integration workstream for the NHS Future Forum and the social care White Paper engagement, we come from very different worlds. Geoff has a wealth of experience in social care and local government, most recently as chief executive of a London borough council. Robert is a GP in inner city Manchester and a trainer in healthcare quality improvement. Our journey in leading this listening exercise has provided us with an invaluable lesson in the strengths of collaboration across traditional public sector boundaries. We have had to take the time to understand one another’s culture and professional language, but the result has been a broader perspective and better range of ideas. To local leaders embarking on new

cross-boundary partnerships or looking to deepen existing ones, we offer our encouragement to invest in building open and trusting relationships which can stand the test of the challenges ahead. It will be time well spent. You will rapidly discover that you share values and commitment, and can forge solid partnerships built on a shared vision for your local community. You may even make new friends.



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Hammersmith and Fulham  
Council**



**Dr Robert Varnam**

**Chair, Integration group and  
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# Summary

We heard from many places that although the case is clear for more integrated care, there are many barriers and disincentives to integration that make it difficult for local areas to come together to re-design care that everyone knows is better. Some of these barriers were to do with a lack of shared leadership, culture and vision at local level between health and local authorities, or within health itself. Others were to do with the centre being seen to have too much control - issuing guidance, rules and restrictions that made it difficult to produce more locally appropriate solutions. More were cited around financial incentives, which were misaligned and often made it impossible to integrate care. But, we also heard great stories from communities on the ground who have managed, despite the system's barriers, to create solutions that work for people and for the public purse. And we didn't hear from anyone who didn't want to at least try – and for them, we want to make it easier to do. Below are our key recommendations to make integration happen.

**Integrate around the patient, not the system.** Integration is not about structures, organisations or pathways – it is about better outcomes for patients. The entire health and social care system should embrace a definition of integration that truly puts people at the centre. The NHS Commissioning Board should therefore focus its commissioning guidance on supporting clinical commissioning groups to commission for people not specific diseases.

**Make it easier for patients and carers to coordinate and navigate.** NHS commissioners should ensure that every patient with long-term or complex needs has easy access to a named person or team who can act as the coordinating point for all of their care, taking into account their personal preferences.

**Information is a key enabler of integration.** Information belongs to the individual. Care records should be electronic and accessible at the point of care throughout the whole care journey, regardless of sector or provider.

**You can only improve what you measure.** The Department of Health should urgently support the development of a new generation of patient reported experience measures that evaluate patients' experiences across whole journeys of care, and within and between services. The aim should be to start reporting against these measures from April 2013. These should be incorporated into the national and local outcomes frameworks for the NHS, social care and public health as soon as possible and should form part of the Mandate set for the NHS Commissioning Board. The Department of Health should seek to achieve greater alignment and coherence between the national outcomes frameworks for the NHS, public health and adult social care.

**Health and wellbeing boards must become the crucible of health and social care integration.** All local commissioners must fully and properly explore the potential benefits of joint commissioning and pooled budgets in health and social care for key

populations requiring integrated approaches; such as frail older people, people with mental health problems, people with learning disabilities, children with complex needs and the socially excluded. Emerging health and wellbeing boards should consider the allocation of £1bn of NHS funds already earmarked by the Government towards delivering social care services in partnership with health as one of the first major decisions they make. PCT clusters and local authorities must facilitate this.

**Providers need to be able to work with each other to improve care.** The NHS Commissioning Board should develop and test innovative approaches to incentivise care outside hospital settings. The NHS Commissioning Board should work with local commissioners to introduce measures of service interoperability in contracts, to drive integration. These could include measures of the efficiency and reliability of admission and discharge processes, patient understanding of their care plan, and patient experience measures.

**Clarify the rules on choice, competition and integration.** Monitor and the NHS Commissioning Board should urgently support commissioners and providers to understand how competition, choice and integration can work together to improve services for patients and communities – in particular they should explain how this fits with the principles and rules for cooperation and competition and UK and European competition law. Guidance should be jointly published as soon as possible in 2012.

**Freedom and flexibility to “get on and do”.** Monitor and the NHS Commissioning Board need to jointly signal as soon as possible during 2012/13 their methodology for establishing and policing prices (tariff, currencies) within and for markets in order to provide stability and predictability for commissioners and providers. This should include a proportionate, transparent and consistent approach to local price variations and adjustments where this is needed to enable more integrated care, and a clear and simple account of the rules. Clinical commissioning groups should be allowed the freedom and flexibility to develop innovative local integrated solutions, including variations to tariffs and contracts, while these new funding models are developed. The NHS Commissioning Board should, as far as possible, build on the principle of certainty around under- and over-spends (including multi-year settlements) in order to allow clinical commissioning groups the ability to plan across multiple years to design, commission and invest in longer-term, sustainable solutions with their local partners, for example local authorities who already receive multi-year settlements from central government.

**Allow the funding to follow the patient.** The NHS Commissioning Board and Monitor should develop new funding models which support and incentivise integration, and share with commissioners examples of how others have used such models. This should accelerate progress already made on the Year of Care funding model (based on need and not on single conditions).

**National level support for local leadership is essential.** National level leadership and collaboration are essential to supporting local efforts to design and deliver integrated services for patients. There should be a national level forum to support this and oversee an enabling programme of work beginning in 2012. This could be

provided by the National Quality Board with extended membership to include the Local Government Association and local representation from clinical commissioning groups and local authorities.

**Sharing best practice and breaking down barriers.** The NHS Commissioning Board working with local government through the Local Government Association, should make available a responsive facility providing advice and support to local commissioners on practical implementation issues of integration. This support could include practical support (model tariffs, contracts and tools), best practice and peer-support, and training for leading change jointly for clinical commissioning groups and local government.

# The Case for Change

## Meet Mrs Crabtree from Number 3

We are all aware that we have an ageing population and an increased prevalence of chronic illness and disability. We have been told repeatedly that the system, as it stands, does not meet the needs of individuals who access services or achieve their desired outcomes.

Integration is a term that we hear more and more, but what does it actually mean? Perhaps the best way to explain is to introduce Mrs Crabtree.

Mrs Crabtree at Number 3 is an 88 year-old widow and a former housewife who lives alone. She has had diabetes for 15 years and has suffered cardiac failure for the past three years, leading to ankle swelling, breathlessness on exertion and once ending up in hospital in the middle of the night very short of breath. She has become increasingly forgetful over the past year or two though it hasn't until recently affected her ability to cope. She has occasional urinary incontinence, leading her to be nervous about going out to the shops and to deliberately miss the water tablets prescribed for her heart failure. She fell in the garden a few months ago and struggled to get up and back into the house. She ended up being taken to hospital, and stayed for 10 days because of delays in arranging additional home care for her. After another recent fall, when the ambulance crew came out, she refused to go into hospital, even though she needed some help from the crew just to get back into her chair and had clearly suffered some urinary incontinence when on the floor. Although she likes to play her symptoms down and doesn't want to "worry my son" or "bother the doctor", she is secretly concerned that if too much is made of her problems, she might be put under pressure to leave her house and "put into a home".

In an ideal world, Mrs Crabtree's care would be preventative, proactive, joined-up and centred around her preferences. She would be well known to her GP and other primary care staff. They would be fully aware of all of her needs, including the falls and early memory impairment, and she would have a clear diagnosis and medical management plan for each of her conditions. She would be fully involved in developing her care plans. The information about her medical problems and medication, her physical impairments and care needs and her recent admissions to hospital would be shared across agencies, so she wouldn't have to repeat the same information to multiple professionals. She might be on the books of a case manager, such as a community matron, to help improve her awareness of her medical conditions, what she could do to manage her own care, including recognising signs of deterioration, and when to contact professionals for help. When she did suffer a crisis such as a fall, a loss of mobility or a deterioration in her memory, she would only remain in hospital for a short time, or better still be offered a full diagnostic assessment outside hospital. She would receive any rehabilitation or short-term

social support (e.g. befriending) in her own home. The key local agencies would meet regularly to ensure that they had the right pathways and resources in place to ensure similar care for all the other patients like Mrs Crabtree in their locality.

## The “burning platform” for change

In the next 20 years, the percentage of the population over 85 years old in England is forecast to double<sup>1</sup>. There will therefore be many more people with complex health and care needs like Mrs Crabtree. Around the world, people are facing the combined challenge of rising need and severe financial constraints. There is a growing consensus that healthcare systems need to deliver improved value, through simultaneously improving outcomes and cost-effectiveness. This cannot be achieved without significant changes to our systems of care, improving integration, providing more care closer to home and enabling people and communities to care for themselves more often.

Sadly, in our listening exercise across England we have been told repeatedly that the system, as it stands, often does not deliver the integrated package of care that people like Mrs Crabtree need. It doesn't deliver their desired outcomes either. There are often wide gaps between services, particularly between primary and secondary medical care, and between health and social care. The often inefficient and unreliable transitions between services result in duplication, delays, missed opportunities and safety risks. Designing and delivering more joined-up and patient-centred services offers the hope of improving patient experience, safety, quality, outcomes and value. We have heard about the challenges faced by the sector regulators and we know the recent scandals in hospitals, home care, and care homes will not go away if we don't change the way the system works.

The huge financial challenge that all areas of the system are trying to tackle is not something that those we heard from are ignoring. Everyone we spoke to, be they service user, carer, patient, commissioner or service provider, is conscious of the real difficulties that current cuts to local authority budgets are bringing. Similarly, no one is blind to the year on year efficiencies that the NHS is required to make to meet the value challenge – to save 4% a year, every year for four years.

We have also heard that while the evidence is still emerging, there may be significant potential for efficiency gains from integration through pooling resources, shifting towards more proactive care for those with complex needs and a multidisciplinary approach across primary, community and secondary care. Some localities, such as Birmingham, have already saved £4 million per year from pooling budgets and resources between health and social care. Others such as inner North West London are re-organising services to provide care management for frail older people and those with long-term conditions. They have projected savings of up to £10 million per year – which, if scaled up London-wide (8 million population), could result in savings of £470 million annually.

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<sup>1</sup> ONS population projections

We have heard these challenges (financial and demographic) referred to as the dual “burning platforms”. The status quo is not an option. The case for integration is clear.

## Complex needs

Mrs Crabtree is someone professionals might define as having “complex needs”. She may be described as having “multi-morbidity” or “co-morbidity” which means that she has several health conditions at once, such as diabetes, heart failure, incontinence and dementia. Mrs Crabtree will also be considered as someone with long-term or chronic conditions, i.e. we have not yet found a way to cure Mrs Crabtree of her diabetes or her dementia, so she will need to live with these conditions for the rest of her life. Mrs Crabtree also has issues with her activities of daily living, such as with getting in and out of bed, getting dressed, going to the toilet and other daily tasks. Healthcare professionals might refer to her as a patient, social care professionals as a service user. In this report, we use many of these terms, and we also refer to Mrs Crabtree as being on a “care journey” – one that may involve lots of different professionals in lots of different settings (hospital, community, care homes). These differences in terminology only go to show how difficult it is for people like Mrs Crabtree to navigate the system and get the care they need.

But we are not just talking about older people. Integration is an aspect of any care journey, but it is a particularly important one for people with complex and long-term needs requiring input from multiple different agencies. We heard that improving integration can especially benefit the following groups:

- children and young adults with complex needs;
- people with enduring mental health problems;
- homeless people;
- frail older people and their carers;
- people at the end of their lives receiving palliative care.

These people are intensive users of services, repeatedly crossing traditional organisational and sector boundaries. Gaps, duplication or poor reliability of care are therefore multiplied as their journeys progress, and they are disproportionately vulnerable to suffering as a result of their complex needs. We heard that these people are also more likely to experience difficulty in understanding or navigating their often tortuous care journeys, compounding these problems and, ironically, making it harder for them to exercise choice or control, or to manage their own care.

We heard that people’s needs are often not conveniently confined to just health and social care. We heard that, for children and young people, education plays a key role, and must be integrated with health, social care and other services for children and their families. We also heard how the justice system needs to link in better with traditional care and health services. Similarly, we have heard that there is little

understanding of the dependencies between health, social care, housing and other services, especially in relation to the effectiveness of housing in preventing, delaying, reducing or diverting demand on more costly health and social care services. For example, the NHS spends £600m treating people every year because of ‘category 1’ (the most severe) hazards in poor housing, the vast majority being associated with falls.

### **Jim and the London Homeless Pathway**

Jim was brought into A&E at University College Hospital (UCH) in London with alcohol withdrawal seizures and malnutrition, having been found by paramedics collapsed in the ground floor common room of his hostel where he had been unable to climb the stairs to his room for two days. Upon admission, it was discovered that he also had alcoholic fatty degeneration of the liver, cerebral atrophy and symptoms of cerebellar ataxia and peripheral neuropathy (alcohol related brain and nerve damage); he also had many old scars of self-harm. The usual practice would be to get Jim back to his “baseline” and discharge him as rapidly as possible back into the community. Since 1995 Jim had attended A&E at UCH 155 times; had been admitted to hospital 11 times and spent a total of 62 days as an in-patient. Usually this had been related to self-harm or alcohol-related damage. Having been homeless for the last seven years with periods of rough sleeping, he had never been deemed to have social care needs and medical care had been reactive. All of his mental and physical health problems were dismissed as alcohol-related.

The London Homeless Pathway integrated service team befriended Jim, and arranged to replace his soiled clothes. Talking to him, it was clear that much of his agitation was due to ongoing alcohol withdrawal symptoms and an increase in the dose of his medication was negotiated. His hostel key worker was contacted and the story of his steady deterioration clarified. Instead of the usual rapid discharge, assessments were arranged with an occupational therapist and a physiotherapist. Jim was supported on a daily basis and involved in decisions about his care. His medical history and current findings were summarised in a report by the Pathway team GP and a referral to social services was made. The accumulated information clearly showed significant care needs and he was placed by the local authority in a residential unit, where he settled well and considerably reduced his alcohol consumption. Jim has not needed to attend A&E at UCH for over 12 months.

## **Barriers and enablers to integration**

Across the country, we heard from many patients, carers, commissioners and clinicians about the barriers and enablers to integrated care. Although the places we visited were different, many of the issues were the same – to do with culture, incentives, regulations and relationships. Below is a summary of what we heard, which we explore in our recommendations and principles in the next section.

### **Enablers to integrated care**

- A shared vision of the case for change between GPs, local authorities, and other partners
- Strong, courageous and persevering leadership, particularly from local professionals
- Sufficient time spent building relationships, developing a shared culture and governance between organisations
- Involvement of people and communities as key partners in designing services
- Proactive provision of information and support to help people make decisions about their own care
- Sharing information between all providers involved in an integrated journey of care
- Joint commissioning between health and social care based on shared vision and budgets
- Using flexible funding models and innovating around existing incentives
- Alignment of governance procedures, staff management and training
- Leadership investment in supporting behavioural change and shared ambitions within providers
- Responsiveness to feedback of frontline staff
- Strong commissioners prepared to follow through on a vision to integrate around the needs of patients
- Sharing of activity and performance data between commissioners and providers
- Anticipation and mitigation of side effects of service changes, such as initial 'double-running' of services

### **Barriers to integrated care**

- Repeated structural change prescribed centrally
- Lack of clear shared vision among all parties involved
- Lack of strong leadership or organisational alignment
- Lack of attention to issues of culture, staff engagement, behaviour and training to deliver change
- Lack of interest from local GPs, local authorities or other organisations in new ways of working
- Lack of shared culture, language, governance and operating procedures between organisations and sectors
- Insufficient investment in service improvement and project management
- Failure to remove or address conflicting incentives
- Existing payment regimes and information systems
- An expectation that integration of providers will always improve care or reduce costs
- Disparities between commissioners in funding available – particularly between health and local authorities
- Reluctance among providers to share performance data
- Lack of high quality premises in the community for new services
- Provider financial models which disincentivise integration

# Principles & recommendations to make integration commonplace

We call on everyone involved in shaping, planning, delivering and receiving care to consider how they might contribute to improving the experience, outcomes and value of care journeys. We heard that there is a tremendous will across England to do this, but it needs to be easier to achieve. Drawing on all we heard and saw, we have identified the following principles and actions. This is a complex issue, and we do not believe there is a “silver bullet”. Many of our recommendations are interdependent, and none will be sufficient in itself to enable the scale and scope of integration our patients and communities deserve. Therefore, this is not a menu but a recipe, in which we regard most, if not all, the ingredients to be essential.

We call on national and local politicians, professional leaders and managers to create and spread a national narrative to promote collaboration to create a more seamless experience, integrated around the patient.

The following principles and recommendations for action are grouped around key themes. These themes, while not necessarily mutually exclusive, are intended to assist the reader.

## **Integrate around people, not pathways**

The Forum heard a consistent message from patients, service users, carers, clinicians and managers that integration is only valuable insofar as it improves experience and outcomes for the individual. It is not a virtue in its own right, but one important aspect of the quality of care. Integration is valuable where it reduces the problems created by gaps in the infrastructure or processes of the person’s journey. Poor integration results in delays, duplication and defects in care, and impacts on the quality, safety, productivity and the patient’s and carer’s experience of the journey of care. Given that patients with the most complex journeys are often those with the greatest need, poor integration places a significant and unnecessary burden on them, their families and the system.

We heard from many people (and those who care for them) about how important it is to be treated as a whole person – i.e. not “the stroke in bed 5”. People told us how they may have more than one condition, and sometimes have physical, mental and social needs all at the same time. They also told us that it was frustrating when the different professionals and services they dealt with were not able to coordinate with each other, and that where specialised input was needed for a specific condition, it was sometimes hard to join it up with the other services they were

already receiving. Assessments were often repeated and both patients and their families experienced bureaucracy and delays in accessing treatment or care and support.

We heard that integration means different things to different people, and that clarity is needed. We therefore defined our focus very simply: **integration is a means to achieving better outcomes for people**. It is not about structures, organisations or funding – although all of those things may be involved. Places we visited that were forging ahead with integration all had the same vision at the heart – integration as a means of providing better care, better services and better systems for all the Mrs Crabtrees.

**Recommendation: The entire health and social care system should embrace a definition of integration that truly puts the patient at the centre.**

### *Patients and carers are key drivers of integration*

It was clear from what we heard around the country that patients and carers are often the most passionate advocates of integration, and the most effective agents for delivering it. Patients and their families live with and manage their conditions day-in and day-out, unlike professionals. Every day, patients and their carers navigate and improve their complex care journeys. They obtain information, seek explanations, make choices, chase lost appointments and fill gaps in data. Carers, patients and non-professionals can become a greater part of the solution and their contribution and input should be recognised. We heard that where care is designed in an “asset-based” approach, i.e. looking first at what is already available – from patients themselves or from communities, better solutions can often be found. This includes a greater focus on reablement and self-care, which could allow more people with complex long-term needs to receive more integrated services and regain greater independence and wellbeing. It also involves including patients and communities themselves as key partners throughout the process of designing and commissioning services. Integrating around patients rather than providers will involve an unprecedented depth of partnership and trust between professionals, managers and the people they serve. Staff and the system as a whole need to embrace this new way of working with patients and carers, which will include sharing knowledge, decision-making and responsibility.

We heard a clear message that people want integrated journeys of care to become the norm for people with complex or long-term health and social care needs. For these patients, poorly integrated care cannot be regarded as good care. We believe that every patient with complex or long-term needs has the right to expect:

- to receive care as close to home as possible;
- to be informed about the options available to them;
- the opportunity to discuss their options with a professional skilled in shared decision-making;

- easy access to a named care coordinator who knows them and is able to provide a tailored level of support to navigate their care journey and make choices at appropriate junctures;
- to know what to expect at each step of planned care journeys;
- to have an integrated care plan and where appropriate be offered an integrated budget;
- every provider involved in the individual's care to have access to their care record;
- transitions between professionals, teams and organisations to be safe, smooth and efficient;
- to understand clearly and simply what care and support they are eligible for and how they might pay for it if they are not eligible for state-funding; and,
- to be confident that appropriate information, training and support are available for any carers.

### ***Patients and communities are part of the solution***

The principles of shared decision-making, self-care and control should be at the forefront of commissioners' minds, in particular in relation to people with complex and long-term needs – and they should contract for and measure providers' ability to deliver this. Such information must be available in a range of languages and formats, and not solely written in English. We would also look to the professional bodies to take the lead in championing shared decision-making with clinicians and incorporate it into best practice.

The principles of self-care, control and shared decision-making can also be applied at the level of the local community. We heard of community-led schemes where local communities are supported to design and deliver their own solutions to local needs, and where people have been involved in the design and evaluation of services in their communities. We need to make it easier for patients and families to fill in their own gaps in services, and support them to do so. Where this is done, communities feel empowered to make the most of their own resources, providing highly innovative solutions to plug gaps in existing services, reduce inequalities and help more people to receive care closer to home.

**Recommendation: The NHS Commissioning Board should focus its commissioning guidance on supporting clinical commissioning groups to commission for people not specific diseases.**

### ***Make it easier to navigate and coordinate care***

We heard from many people that the biggest obstacle to receiving excellent care lay not in the services they receive but in the challenge of navigating the health and social care system and coordinating the input of multiple different services. Having access to someone to help them navigate the system and coordinate their care made a considerable difference to their experience as well as the effectiveness of their

care. There are many places around the country that we visited where a nurse, physiotherapist, social worker, family member or volunteer went out of their way to link together all the different pieces of the system for patients and their families. Where this worked well, people saw the impact in better care, more control and better experience for themselves, their carers and families.

However, just having a care coordinator or navigator isn't always enough – the system needs to be intuitive and develop a culture that encourages coordination to happen. We heard many stories of frustration from individuals and their care coordinators, where the access to the bits of the system weren't available, or where professionals wouldn't allow the sharing of information or respond to coordinators' requests.

**Recommendation: NHS commissioners should ensure that every patient (and their carer) with long-term or complex needs has easy access to a named person or team who can act as the coordinating point for all of their care, taking into account their personal preferences.**

#### **Ben and his mum, his key worker**

Ben (who is now almost four) was born full term by caesarean section. He had feeding difficulties due to a throat malformation, which resolved at around six months. He was always very floppy and it was not thought that he could see. Then at eight months he had infantile spasms, which stopped after treatment at 12 months and he hasn't had a fit since. Eventually, after many investigations and meetings with paediatricians and genetics doctors, Ben was diagnosed with a brain disorder which explained all of his problems. In Ben's life we see a portage home visitor, paediatrician, occupational therapist, physiotherapist, sensory support teacher of the visually impaired, the Eye Opportunity Group, Scope (until Christmas 2010), nursery, speech and language therapist, and an early years support teacher.

It was difficult to keep everyone on the same page of what was happening with Ben, developmentally and emotionally. Ben's family were introduced to the key worker scheme when Ben was two, through an early support parents group. This involved having regular meetings to bring all the professionals together to talk about what Ben was doing and where he was going, so everyone knew what was going on.

At first, Ben was assigned a key worker. **After she left, Ben's mum decided to take on the role of Ben's key worker** with the help and support from the key worker service coordinator. Ben's mum feels that this really works as she is able to proactively find out information regarding Ben's needs.

Ben started nursery in April 2010 and his mum used the key worker meeting to prepare for the transition. Having the professionals meet and someone from the

nursery attend made the move to nursery so much easier and reassuring for Ben's family. His mum feels that since Ben has had a key worker, his care has been more straightforward and less complicated and his transitions better organised.

### *Information: a key enabler of integration*

We heard time and again that, without information, integration will only ever be a pipe dream. Full and accurate information about a patient's needs and care must be available throughout the care journey to everyone involved, including the patient themselves. Where possible, patients and carers should be provided with information about their progress and options in advance of consultations with professionals to discuss these and make plans for the future.

We also heard from commissioners and providers that they do not have access to the kind of information they need to provide integrated care journeys. Delays, inaccuracies and gaps are commonplace. Too often, patients turn up for their appointment, or have a visit from a nurse or care worker, only to find there is no information available about them.

One of the major causes of the current poor state of information transfer across health and social care is the incompatibility of their IT systems. There are many system providers, most of which use different applications for entering, storing, analysing and sending information. Often, these systems do not talk to each other, and commissioners and providers alike are unable to share information. We also heard that there are times when providers and clinicians are reluctant to share information. The problem is not a lack of information, it is the lack of a clear vision and will to ensure information is useful for patients and populations.

The NHS Future Forum's information workstream have been considering the same messages and we support their recommendations, in particular those that state that:

- the data belongs to the patient and service user;
- every patient should always receive a copy of discharge or referral letters;
- the Department of Health must ensure the universal adoption of a unique identifier (NHS Number) across health and social care by 2013;
- progress must be made on electronic care records;
- All providers should make information available to allow patients to make decisions about their options, with or without support.

We know that collecting and sharing appropriate information is vital if we are going to improve outcomes for patients. But you can only improve what you measure. Measuring outcomes for patients and populations has a large part to play in improving quality.

## The quality of outcomes

Although we heard resounding support for integrated care that improves the experience and outcomes of patients, we also heard that not enough has been done to understand how to plan new integrated services or assess the results of better integrated care. The current set of outcomes data for the most part looks at care within and not across organisations. There is also not enough focus on outcomes for patients' experiences across a whole journey of care. Methods should be developed and promoted by which commissioners can model potential options for improving integration. This should include evaluating and benchmarking population needs for integration and predicting the impact of different service configurations changes. Use of this kind of modelling should become commonplace. Monitor and the NHS Commissioning Board are well placed to promote and support this.

**Recommendation: The Department of Health should urgently support the development of a new generation of patient reported experience measures that evaluate patients' experiences across whole journeys of care, and within and between services. The aim should be to start reporting against these measures from April 2013. These should be incorporated into the national and local outcomes frameworks for the NHS, social care and public health as soon as possible and should form part of the Mandate set for the NHS Commissioning Board.**

### *Align the NHS, social care and public health outcomes frameworks*

We heard frustration from local commissioners and frontline healthcare professionals that having different priorities for objectives and management meant that it was much more difficult to align their work and integrate services for patients. Some didn't understand why there are separate outcomes frameworks for the NHS, social care and public health when the outcomes that matter most to patients cannot be delivered by one sector acting alone. Many told us that if local commissioners are to develop shared priorities and plans, they need to be answerable to similar sets of outcomes. The report on the NHS's Role in the Public's Health considers in particular the greater use of shared outcomes across the NHS and public health systems. These outcomes should also reflect local need, not central accountability. Much of this alignment at local level can be supported by the transformed public health system's population-level understanding of priorities. We believe, therefore that it is imperative that both the NHS and local authorities fully benefit from strong public health leadership and expertise.

People also asked for a simple way to understand which outcomes are relevant locally for particular populations; i.e. which outcomes are relevant for older people, mental health, etc, across all three outcomes frameworks.

**Recommendation: The Department of Health should seek to achieve greater alignment and coherence between the national outcomes frameworks for the NHS,**

**public health and adult social care. As part of this, it should set out in one place how the outcome indicators across the three frameworks work together to support collaboration and integration for different population groups.**

**Recommendation: The Department of Health, the NHS Commissioning Board and Public Health England should agree “baskets” of outcome indicators which health and wellbeing boards can draw upon to support the measurement of shared goals as identified through the Joint Strategic Needs Assessment and set out in the joint health and wellbeing strategy.**

## **Commissioning and pooling budgets for people and populations**

In the first NHS Future Forum report we recommended that all commissioners (including new clinical commissioning groups) should be taking a population health approach. This means looking at the needs of everyone within a community and proactively planning services in cooperation with local authorities, community groups, the voluntary and community sector and patients and service users. Commissioners in the NHS and local authorities should address the design of local systems and pathways from the perspective of needs and trends in the population, rather than the configuration of current services. This will make it more likely that new services serve the interests of patients rather than providers. It will also help commissioners achieve the joint goals of the outcomes frameworks for their local population, and address the cost savings expected of them.

Too often, we heard commissioning described as contracting and procurement, not as a strategic way to assess the needs of a population in order to create a platform for procurement. We believe that commissioning is the key vehicle for integration. The culture and priorities created by commissioners set the tone and context for all provision within a locality. Clinical commissioning groups and local authorities have a major role in ensuring swift progress is made towards integrating around patients and making it easier for providers to play their desired part in integrated care journeys. Commissioners should ensure that patients and carers, as well as the wider community, are involved as partners throughout the commissioning process. We heard repeated calls to move away from traditional “decide first, ask later” approaches, and there is encouraging evidence that some commissioners are already discovering the contribution people and communities can make to improving innovation, effectiveness and efficiency.

### **Pooling budgets for joint outcomes and joint savings in Birmingham**

Birmingham is England’s second largest city, with a population of just over one million. In March 2010 the three PCTs and the City Council signed a section 75 agreement establishing the largest pooled budget in the country of £313 million (per year). The joint commissioning board has an independent chair and co-located health and social care commissioning staff in order to share intelligence, use single contracts and to take advantage of different styles of commissioning.

There is a single commissioning strategy based on a joint needs assessment. Through a joint approach using a care cost calculator, market development and single contracts, the team was able to balance the pooled budget for the first time in many years at the end of 2010/11 and is on balance for 2011/12, as they were able to find efficiency savings of £4 million (per year).

The percentage spent on residential care has fallen, with more people receiving support in different housing options. A programme of quality assistance visits, including assessments by non-professionals, is underway.

Commissioners are also working with providers on a proposed joint framework agreement for April 2012. This and open book negotiations are helping to shape a more effective and sustainable service.

The service won the regional 'Good Commissioner' Award at the Great British Care Awards.

### ***Ensure integration reduces inequalities and promotes equality***

If a population health approach is used, it should be easier for local commissioners to ensure that socially excluded groups are included in the commissioning process. This should also hold true for ensuring equality for excluded groups – in access, quality of care and outcomes.

Travelling across England we heard from many people in socially excluded groups. We heard about their complex health and social needs and their problems accessing care and their experiences with poorly integrated services. When the homeless, Gypsies and Travellers have complex long-term needs spanning different sectors, they are even more likely to fall through gaps in current provision and to receive fragmented care. They require a sophisticated coordinated and flexible response from services. The cost of failure is great not only in their individual life chances but also to the economy, and the communities and services that have to deal with the consequences.

Health and wellbeing boards should be well placed to evaluate the needs of those marginalised groups within their populations, and ensure that their clinical commissioning groups commission innovative models of integrated systems of care. This will require the use of a range of proactive and flexible community engagement strategies in addition to generic patient and public engagement activity. It will also require a focus on prevention and early intervention and wider health and wellbeing services, not just the delivery of care.

## *Health and wellbeing boards must become a crucible for integration*

Many of the people with the greatest need in the community require multiple services from multiple agencies, often simultaneously. Furthermore, deficiencies in one service often impact on the other, i.e. in the case of 'bed blocking' where people are forced to stay in hospital not because they need intensive healthcare but because the appropriate community, social or housing services are not in place for them at home.

Health and wellbeing boards should be the drivers to ensure better value for money across the whole system, recognising that additional spending in one area could achieve greater savings in another area and overall better use of resources in the system, e.g. reducing need for hospital admissions. We heard about some clinical commissioning groups, local authorities and health and wellbeing boards who were using public health, risk-stratification and prioritisation tools to identify and agree the needs of their communities.

We heard from many local areas across the country that health and wellbeing boards have great potential to also influence the key determinants and influencers of health and wellbeing, such as housing, environment, access to sport and leisure, employment, nutrition, enforcement and licensing (smoking, drugs, alcohol) through the involvement of local authorities, and wider engagement of other partners such as schools and JobCentre Plus. For example, we heard of areas where greater use of extra-care housing improved prevention and early intervention as well as enabled more integrated services for older people.

Health and wellbeing boards should become meeting places for genuine partnership and productive collaboration for a whole community. We heard some concerns that they might function merely as "talking shops", debating chambers or political arenas. To this end we believe that clinical commissioning groups and local authority commissioners must urgently invest time in building open and trusting relationships, taking practical steps to understand one another's culture, language, priorities and expertise. They should also meet in public and provide opportunities for the wider community to engage in their work.

Health and wellbeing boards should ensure that all commissioning partners actively contribute, to shape and agree the Joint Strategic Needs Assessment and joint health and wellbeing strategy, which is key to managing resources across the system, building relationships and meeting the needs of local populations in the most effective way.

Health and wellbeing boards can also play a key role in ensuring integration between nationally and locally commissioned services. In some services, especially rarer conditions, where a well-integrated service is best commissioned regionally or nationally. The Health and Social Care Bill therefore gives the NHS Commissioning Board powers to commission certain services, which include specialised services, such as children's heart surgery, and other services such as primary care. It is vitally

important that these regionally and nationally commissioned services are integrated with locally commissioned services and are accountable to local communities.

Health and wellbeing boards offer a new opportunity to actively engage patients and carers themselves as strategic partners in the design, development and review of local services. Both will be key populations for the health and wellbeing boards and their engagement (as is already happening in some health and wellbeing boards) should have a positive effect on local commissioning arrangements. Additionally their active involvement in the health and wellbeing boards would contribute to achieving the Government's vision of 'building capable communities' and 'clear partnership between the state, communities, families and individuals.'

Health and wellbeing boards should therefore become the strategic decision-making body for all local health and wellbeing services, including how health, social care and public health budgets are spent for the benefit of the community and the system as a whole. We were very encouraged by what we heard from areas that used the reablement and NHS transfer funds to social care as a catalyst for joint decision-making across health and social care and how it grounded the partnerships in a real, financial partnership for a population.

**Recommendation: All local commissioners must fully and properly explore the potential benefits of joint commissioning and pooled budgets in health and social care for key populations requiring integrated approaches, such as frail older people, people with mental health problems, people with learning disabilities, children with complex needs and the socially excluded.**

**Recommendation: Emerging health and wellbeing boards should consider the allocation of £1bn of NHS funds already earmarked by the Government towards delivering social care services in partnership with health as one of the first major decisions they make. PCT clusters and local authorities must facilitate this.**

**Recommendation: PCT clusters should ensure as soon as possible that health and wellbeing boards have strategic oversight of public health transition and transformation, to ensure a shared local vision is in place for public health.**

**Recommendation: The NHS Commissioning Board should use the authorisation process to test the will and capability of clinical commissioning groups to collaborate in the design of more integrated systems and services before granting them their full statutory powers.**

**Recommendation: The Department of Health and the NHS Commissioning Board must ensure that the proposed arrangements for commissioning support will not jeopardise the establishment of effective joint-commissioning locally. Local commissioners should be encouraged and allowed to choose the commissioning support that best meets their needs. If there are concerns, these should be considered at their local health and wellbeing board.**

**Recommendation: When directly commissioning services, the NHS Commissioning Board must work with local commissioners to ensure their commissioning decisions complement the delivery of local priorities. The NHS Commissioning Board must be prepared to provide an account to the local health and wellbeing boards for their decisions.**

## **Providers play a key role**

Patients and carers told us that services need to be coordinated and to interact smoothly with one another, but this does not necessarily mean they should be provided by the same provider. While much has been achieved by providers offering more integrated services, we heard bigger gains can be made when commissioners collaborate with providers to design whole systems and pathways focused on providing a more seamless patient experience. These systems may include providers that are themselves integrated, and some providers may continue to merge to meet their own needs. However, we understand that what matters most is that all providers involved in a person's care cooperate effectively, delivering services which are both coordinated within their own organisations and with outside providers – for example through sharing key information and responsibility smoothly and safely. It is therefore key that all providers are fully aware of the existing regulations around integration as set out in the Care Quality Commission guidance about compliance.

For provider organisations and the staff who work in them, the imperative to contribute to a smooth integrated care journey will have a number of implications. In many cases, this will simply involve providing great care, through adopting best practice in patient safety, access and patient-centredness. To ensure sufficient progress is made, however, we call for providers and their staff to be much more mindful of how their service sits within patients' journeys and more proactive in improving their contribution to the journey as whole – particularly transitions into and out of their care.

### ***Make the most of general practice as providers of care***

Many people commented to us that, in general practice, England already has access to a body of providers close to people's home, which are able to provide accessible, flexible, holistic care. This aspect of England's NHS is admired and increasingly copied throughout the world. General practice registers cover most of the population, and provide an easy means of identifying people who would benefit from better integrated care. We heard of new methods for improving integration which do not require major service reconfiguration, but which make general practices a hub for integration and coordination. They rely on practices taking a much more proactive approach to care, which allows interventions to prevent deteriorations and exacerbations. They usually involve greater multidisciplinary working, with new frontline partnerships between the practice, community nursing teams and home care staff. They also involve the whole community team supporting greater shared decision-making and self-care by patients themselves.

We heard from people of all ages that easy access to general practice and primary healthcare is an essential ingredient of smooth journeys and can help to avoid inappropriate use of emergency services. However, particularly for those with complex needs, it is access to a clinician (such as a GP) who knows them that confers the greatest benefit. Experience and efficiency appeared best where patients and carers knew how to contact their own GP, and it was made easy for them. Where this was not the case, there was greater demand for additional coordination services, which were often perceived to provide better personal continuity.

GP practices that adopt more proactive and integrated multidisciplinary approaches often develop collaborative arrangements with neighbouring practices while others have adopted a more formal legal structure. Closer collaboration at a strategic and operational level has been promoted by the Royal College of General Practitioners for a number of years, in their 'Roadmap' and then in their model of Primary Care Federations.<sup>2</sup> This promises enhanced opportunities to share ideas and learning, build shared expertise and expand the multi-professional primary care team to meet the new challenges ahead. A federation of practices acting together enjoy economies of scale that lead to valuable efficiency gains which allow them to deliver a wider range of services for their patients, and are able to play a much greater part in delivering accessible integrated care for the local population. There is growing evidence that groups serving a population of approximately 40,000 to 70,000 will be best placed to realise the benefits of the federated model.

In recent years, general practice has also played a much expanded role in managing complex conditions. Patients who, 15 or 20 years ago, would have attended one or more specialist clinics, can now receive all of their care from their GP practice. The improved continuity and efficiency afforded by this more holistic approach was welcomed by the patients and professionals we heard from. We also heard from patients, carers and GPs themselves that some patients (especially ones with complex needs) need longer with their GP or others in the primary care team, as there is more to do in each consultation.

We heard from many GPs who themselves were taking the lead in re-designing better care - by understanding which of their patients had the most complex needs, and taking a pro-active approach to managing their care. They also told us of the benefits of coordinating care for their patients with long-term conditions and of providing them with a named staff member or team to contact with any concerns.

The NHS Commissioning Board can play a key role in supporting local commissioners to design more flexible general practice services that provide better access, continuity, information and shared-decision making for patients, and in sharing best

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<sup>2</sup> The Future Direction of General Practice: A roadmap Lakhani M, Baker M & Field SJ RCGP: London 2007

Primary Care Federations: Putting Patients First Field SJ, Gerada C, Baker M, Pringle M & Aswani K RCGP: London 2008

practice across the country. There will also be a need for training and support for general practice to change and to improve their services. In its commissioning role for primary care it will be important for the NHS Commissioning Board to work with professional bodies and clinical commissioning groups to ensure that primary care contracting takes account of local priorities, plans and partnerships.

**Recommendation: The NHS Commissioning Board should promote and support the implementation of innovative approaches to incentivise integrated care outside hospital settings.**

**Recommendation: The NHS Commissioning Board in negotiating the General Medical Services contract should explore how best to improve general medical services contracts to incentivise integrated care and continuous quality improvement.**

### *Incentivise interoperability*

Interoperability describes the way in which a service interacts with other services around it. It is a good description of the kind of services we were told contribute to an integrated experience for patients. Interoperable services are aware of their place in the patient's journey and are able to facilitate safe and timely transitions into and out of care settings. They use open or common ways of working to reduce the chance of delays or duplication, and common information and information technology standards to ensure continuity of information across the whole care journey. In the world of computing, interoperability means the user is able to transfer their work from one program or computer to another, and it will "just work". This is how patients should experience healthcare – regardless of how many different providers they use, the process of caring and transferring should be smooth and transparent. It is not sufficient for commissioners to incentivise great care from local providers, they should drive continual improvements in transitions as well.

This requires careful design of care processes, particularly transitions into and out of services, and the reliability of the processes. It also requires the use of common information standards, interoperable information systems, effective systems for collaborating with other providers in the care journey, and continual mindfulness of what happens after the patient leaves the service. We fully endorse the recommendations arising from the Future Forum's Information workstream with regard to the value of common, open standards for coding, storing and transmitting information in health and social care, as a vital means of achieving interoperability and local flexibility.

We heard from patients, carers and professionals (especially GPs and social care professionals) that there is a need for hospital care to integrate better into the whole package of care received by patients with complex needs. Additionally, we heard and saw that organisational integration is not a guarantee of a smooth patient journey, as patients frequently experience gaps and duplication, even within a single provider.

We welcome the recommendations from the Information Workstream in this area:

- The NHS Commissioning Board should ensure that the national specimen contracts it develops include specifications addressed at interoperability, such as the management of access, information and handover.
- Commissioners should collaborate with providers, patients and carers to understand the local issues impacting on service interoperability, and to make it easier for providers, patients and coordinators to improve it.
- Providers themselves should ensure that departments across their organisation are fully interoperable with one another, minimising delay, duplication and defects in handovers between sites, wards or teams.
- Commissioners and providers should work to improve the reliability of outpatient care processes, identifying and reducing problems such as failure to coordinate investigations or to arrange timely follow-up for patients.

**Recommendation: The NHS Commissioning Board should work with local commissioners to introduce measures of service interoperability in contracts, to drive integration. These could include measures of the efficiency and reliability of admission and discharge processes, patient understanding of their care plan, and patient experience measures.**

### *Free up voluntary and community sector providers*

There is widespread support for expanding the role of voluntary and community sector organisations in designing pathways and providing services. For some services, such as community palliative care, counselling and support, and home care, the third sector is already a major provider in most parts of the country. The sector is also frequently innovative, able to demonstrate new ways of supporting patients and carers in community settings. However, we heard from many voluntary and community sector providers that it can be difficult for their services to be commissioned due to boundaries between commissioners. For example, if the services the organisation provides do not fit neatly into health, social care or other services. This means that the provider must bid for multiple contracts across different commissioners – and for smaller providers, this is often very costly and difficult. There is a great opportunity for the voluntary and community sector to work with the Department of Health and the NHS Commissioning Board to clarify the offer that they can make to commissioners and to identify barriers to providers.

Designing new integrated services and procuring them will be a very important aspect of the transforming system. Those working within health and social care organisations told us that it will be important for providers and commissioners to have clear guidance about how they can do this. Much of what we heard was that it was often difficult to understand the rules of the game – in particular in relation to policies on choice and competition.

## *Clarifying the rules on choice, competition and integration*

A better “story” needs to be told on how choice, competition and integration can sit alongside each other to improve outcomes, experiences and value. We were told that the requirement to deliver choice and the increased emphasis of competition may stifle integrated care. What we heard from patients and carers is that what matters most is having control over their own care; where, when and how that care was delivered rather than necessarily a simplified choice of providers.

Commissioners should focus on helping patients and users take control - and competition can help make this happen. This can occur through offering new services which fill gaps between existing services, increasing the options from which patients can choose, introducing new providers with experience in providing more flexible personalised care, and reducing the impact of financial protectionism on the part of some existing providers.

The present systems of financial targets and financial flows have consistently been cited as major barriers to the provision of integration for patients, and both should change. Commissioners expressed concerns that central imposition of rules regarding plurality of providers could force them to break effective local integration. A number of NHS foundation trusts said that, although they shared commissioners’ desire to see more care provided close to patients’ homes, they were fearful that Monitor would penalise them for reducing their income in this way.

The Forum spoke to Monitor who were pleased to have the opportunity to clarify for the NHS Future Forum their position on competition:

“In order to make sure competition develops in a measured way, the emphasis has been shifted towards protection rather than promotion. This means, amongst other things, that there will be an increased burden of proof required where additional competition is used to promote patients' interests. Another key difference is that previously, there was a presumption that competition would be the right tool for Monitor to use to help drive up efficiency and quality on behalf of patients. The Health and Social Care Bill has made it much clearer that competition is a means to an end and not an end in itself. Under the amended proposals, Monitor would have to consider all of the options before reaching a decision on the best approach. This means, amongst other things, that Monitor will need to look closely at costs and benefits where competition is used to promote patients' interests and these will always have to be evaluated against other ways of promoting and protecting patients’ interests. However, Monitor’s position has always been that we support competition only where it’s appropriate and can deliver benefits for patients, rather than for its own sake.”

**Recommendation: Monitor and the NHS Commissioning Board should urgently support commissioners and providers to understand how competition, choice and integration can work together to improve services for patients and communities – in particular they should explain how this fits with the principles and rules for**

**cooperation and competition and UK and European competition law. Guidance should be jointly published as soon as possible in 2012.**

Clarifying the rules of the game will be key to unlocking integration – but most importantly, we heard a plea for freedom to allow local communities to create the solutions that work for them and their populations.

## **Freedom and flexibility to “get on and do”**

We heard frustrations that unlike local authorities, who are seen to be freer to develop local solutions through genuine engagement with their communities, the NHS appears less able to experiment and innovate locally. Many that we spoke to, particularly GP commissioners, said that they were ‘always looking over their shoulders’, worried that they would be told they weren’t allowed to do what they were doing or that there would be a new rule or requirement from their PCT, PCT cluster or SHA cluster or from the Department of Health, which would mean they would have to stop or change their plans. Local areas asked for stability, certainty and a level of freedom to “get on and do” what they all knew needed to happen – provide more integrated, effective and efficient care for their populations. This section looks more at what central bodies need to stop doing, to allow new models of services to flourish.

## ***Allowing time and space to develop new models of care***

Travelling around England, we experienced a growing sense of urgency to deliver a more integrated health and social care system, which we welcome. However, we heard from those who had been successful, that integration takes time to become successful and sustainable. The international evidence supports this. Whether at the level of commissioning or provision, the development of shared goals, culture, plans, governance, procedures and practices is a complex and difficult task, often requiring years of effort from leaders and staff.

There appears to be considerable appetite among clinical commissioning groups to foster clinically-led collaboration and innovative solutions for local people. However, many are devoting much, if not most, of their time to considering issues of organisational form and governance. In the context of the upheaval caused by frequent structural changes, such as the recent SHA and PCT clustering, this is not necessarily surprising. However it is essential that urgent action is taken by PCT clusters to protect clinical commissioning groups' progress in building their own partnerships and focussing on improving patient pathways. We have heard consistent concerns that the opportunity will be lost to create a clinically-led and innovative NHS if the bureaucratic and structural agenda does not rapidly give way to one focussed on improving patient outcomes using locally agreed solutions.

We heard that sometimes the joint commissioning of integrated care systems may take a year or more before patients and communities are reaping the benefits. Where we heard about successes, it was where commissioners and providers took a

longer-term view – of outcomes and of relationships with each other and with their communities.

We also heard that it was difficult for local commissioners within annual cycles to show benefits or value from new commissioning arrangements, for example by being able to vary contract length to allow them to plan ahead, or to rapidly road-test new models of care.

**Recommendation: Monitor and the NHS Commissioning Board need to jointly signal as soon as possible during 2012/13 their methodology for establishing and policing prices (tariff, currencies) within and for markets in order to provide stability and predictability for commissioners and providers. This should include a proportionate, transparent and consistent approach to local price variations and adjustments where this is needed to enable more integrated care, and a clear and simple account of the rules. Clinical commissioning groups should be allowed the freedom and flexibility to develop innovative local integrated solutions, including variations to tariffs and contracts, while these new funding models are developed.**

**Recommendation: The NHS Commissioning Board should, as far as possible, build on the principle of certainty around under- and over-spends (including multi-year settlements) in order to allow clinical commissioning groups the ability to plan across multiple years to design, commission and invest in longer-term, sustainable solutions with their local partners – for example, local authorities who already receive multi-year settlements from central government.**

**Recommendation: PCT clusters must ensure that sufficient funds and time are released for leaders of clinical commissioning groups to fulfil their role as pathfinders, including full participation in health and wellbeing boards. This must happen as a matter of urgency.**

**Recommendation: PCT clusters should delegate decision-making responsibilities and budgets to local clinical commissioning groups as soon as possible during 2012/13, and where this is not possible, PCT clusters should ensure that clinical commissioning groups are supported to lead health commissioning arrangements locally.**

#### **Developing an integrated care system in inner North West London**

In June 2011, partners in inner North West London launched an ambitious pilot (currently being evaluated by Imperial College and the Nuffield Trust) to provide better, more integrated care for over 500,000 registered patients. The pilot focuses on case managing elderly patients and diabetics (half of which have multiple conditions) to improve patient outcomes, reduce the need for hospital admissions and enable a more effective use of resources. The integrated care system has a governance arrangement that brings together partner organisations from primary, community, secondary, social care and mental health, as well as patients' groups and the voluntary sector.

Case management is at the heart of the approach. A single patient registry enables patients to be identified and risk assessed. GP practices are then responsible for ensuring patients have integrated care plans that are delivered across all settings of care. These care plans are shared electronically with all providers in the system. The most complex patients are discussed in a monthly case conference by Multi-Disciplinary Groups (MDGs), which also review the performance of the integrated care system on a quarterly basis.

Providing more proactive, high quality integrated care is expected to reduce attendances at A&E, emergency admissions and length of stay, resulting in expected annual savings for commissioners of up to £10m. It is important to note that to achieve these savings, significant investments – such as in MDGs and integrated information systems – are required to ensure proactive care can be delivered and supported.

If this approach is rolled out to capture further patient groups for whom case management would be an effective way of supporting their care, an estimated £28m could be saved by commissioners in inner North West London. Applying such an approach across multiple integrated care systems covering an 8 million population – i.e. the whole of London – up to £470m could be saved.

### *Allow the money to follow the patient*

Much of the difficulty in re-structuring models of care for patients is that the funding mechanisms currently disincentivise integration. We heard that it is particularly important that there are payment mechanisms that support new integrated pathways, so that the money can follow the patient to the best type and setting of care.

The NHS Commissioning Board should support clinical commissioning groups and local authorities to ensure that budgets for integrated patient journeys are allocated fairly, taking particular care that where care is provided closer to home, that money follows the patient into the community. There should also be an expectation that services traditionally funded by local authorities should be used more often by the NHS as a means to meet an individual's needs in an holistic and joined-up way. Any part of a care journey which is relevant to the individual must be seen as relevant to the commissioner.

We heard from areas where commissioners are developing models of funding that cover the entirety of care for individuals, which span multiple contacts with providers across multiple different settings.

We also heard that the current financial governance regime made it difficult to operate total budgets rather than being constrained within pre-set budget lines.

**Recommendation: The NHS Commissioning Board and Monitor should develop new funding models which support and incentivise integration, and share with**

**commissioners examples of how others have used such models. This should accelerate progress already made on the Year of Care funding model (based on need and not on single conditions).**

#### **The Year of Care Funding Model – funding for patients, not pathways**

The Department of Health are developing a new “Year of Care” funding model for long-term conditions, to actively encourage the integration of health and care services and ultimately improve quality of care for those with complex health needs.

The funding model will look to incentivise organisations to manage care jointly and invest in preventative care. It encourages organisations to reduce unnecessary A&E admissions, by focusing instead on a strong role for primary and community care. It will therefore depend on the continued development of high quality community services, to help people to avoid hospital admissions and support those who have been discharged to maintain and improve their health and wellbeing.

Under the “Year of Care” model, local health economies would assess the likely health and care needs of their whole local population (risk stratification), so that they can understand and manage local needs and identify those not being met. The Department will explore opportunities to support clinical commissioning groups and local authorities to do this through the indicators the NHS Commissioning Board sets in the Commissioning Outcomes Framework, as well as other contractual levers.

#### ***Make best use of personal budgets***

Recent trends towards the use of personally-held budgets for social care, and current pilots for their use in healthcare, pose new challenges and opportunities for both commissioners and providers of services in both sectors. As the use of personal budgets and direct payments expand within adult social care (the Government’s target is that 100% of users should hold their own budget by 2013) and the range and scope of personal health budgets expand in the NHS, the impact of personalisation and “micro-commissioning” will become clearer. What is important is to understand how it can make difference on the ground and improve outcomes, especially for those people who require both health and social care services and may therefore need to integrate their budgets.

We heard from patients who told us how well-planned personal budgets gave them more control over their own care – from whom, when and how they received it. For example, one mum spoke about how a personal budget helped her daughter receive the care she needed at home and then get back to school sooner (as she was able to use some of her local authority budget for the home help, whereas before it was only allowed to be used at school). The evidence to date is that personal budgets are welcomed by patients and carers, as they have more control and flexibility over their care, and in some cases, can even act as their own commissioner. They provide

a way to fill in gaps between existing services. In social care, where many services are paid for by users already, personal budgets are often used to create highly personalised packages, exactly tailored to an individual's circumstances. We welcome the early findings of the pilot programme in health, which also suggest that giving patients and carers freedom and responsibility to design their care package results in greater joining up of services for their health and care needs, and a greater sense of control.

#### **Louise's personal health budget**

Louise, 90 and from West Sussex, has Alzheimer's disease. Her personal health budget, as a direct payment for health care, pays for personal assistants to care for her at home.

Louise's Alzheimer's was diagnosed fifteen years ago. She has immense trouble communicating her needs and she is difficult to understand. She also has chronic physical health problems. As a result she is totally dependent on others for her personal care and day-to-day needs. Before having a personal health budget, Louise required frequent stays in residential homes. But her daughter Mary felt that these homes tended to rely on agency staff who were often poorly-trained and overworked, and couldn't give Louise the attention that was necessary to maintain her health. Louise went to live with Mary and her husband, as she wanted spend her final months at home, rather than in a nursing home.

A team of personal assistants now cover shifts from 8am-6.30pm every day, and Mary and her husband look after Louise during evenings and nights. Louise's diet is planned and monitored and, as she can't move on her own, the personal assistants help move Louise's arms and legs to ensure her joints remain supple and to help her take her medications. Mary feels that Louise is really benefiting from personalised care and says "Since my mother has had the personal health budget we have never looked back. Her quality of life has increased exponentially, and she is so much happier." Vitaly, because of the expert care she receives, Louise has been able to remain at home and has not needed to visit the hospital.

### **National support for local leadership**

Flexibility and freedom are essential to allowing local commissioners to "get on and do" – but more needs to be done to support local leadership at a national level.

We heard about success stories where local GPs, the local authority and elected members worked together to make the best decisions for their communities, and with local support were able to reconfigure services to provide better services closer to home. However, we also heard of other examples where there was shared commitment from local partners to re-design services, but the reconfigurations were blocked.

We heard about how local authority elected members (many of whom may now sit on health and wellbeing boards) and MPs have a great opportunity to actively

engage with commissioners throughout the process of redesigning systems and care journeys, and to champion the decisions made by communities on the priorities and strategies for their populations. Many clinical commissioning group leaders we heard from were already proactively forming positive working relationships with local people, politicians and the media. We were also very encouraged at the potential for health and wellbeing boards as a coalition of local voices, to speak up in favour of appropriately developed local plans, and to defend them where necessary.

We also heard that national leadership and collaboration are essential to supporting the development of services that are more integrated for patients. The NHS Commissioning Board and Monitor in its new role can either strongly signal their support for more integrated models of care, or can leave local commissioners without clarity on priorities or expectations. We hope that they will do their utmost at a national level to support local leaders in promoting better, safer, more effective, integrated care for patients.

**Recommendation: National level leadership and collaboration are essential to supporting local efforts to design and deliver integrated services for patients. There should be a national level forum to support this and oversee an enabling programme of work beginning in 2012. This could be provided by the National Quality Board with extended membership to include the LGA and local representation from clinical commissioning groups and local authorities.**

### *Professional bodies should set the example*

We have heard that more attention should be given to the behaviours necessary to improve integration. In particular, continued investment is needed in developing clinical leaders and ensuring managers promote cultures of quality and innovation.

We heard from many clinicians and frontline professionals about their passion for more integrated care for their patients and users. When we met with professional bodies and organisations, they too whole-heartedly supported the principles of integrated care as a best practice, for patient experience and for effective outcomes. Professional bodies need to use their influence to promote integrated care for people – and to disseminate best practice to their members. We were therefore very heartened to speak to healthcare professionals, including many allied health professionals and representatives of the British Geriatrics Society (BGS), the Royal College of Surgeons, Royal College of Physicians and Royal College of General Practitioners, who were passionate about improving care from a clinical and professional perspective, and were strongly in favour of professionals taking a leadership role in driving integrated solutions for patients.

**Recommendation: We challenge the Academy of Medical Royal Colleges, the Royal College of Nursing and ADASS to develop a shared vision for how professional leadership can drive more integrated care for patients and to communicate this to their members. They should do this in collaboration with other national professional bodies, the voluntary and community sector and patients.**

**Recommendation: Professional bodies should gather evidence from their members regarding challenges and successes for clinicians, to be shared more widely, including with the NHS Commissioning Board. This may be supported by the development of “communities of practice” where clinical leaders can share ideas and best practices.**

**Recommendation: The Department of Health and, in future, the NHS Commissioning Board should commission new national clinical audits that span whole journeys of care for key patients groups such as frail older people. As well as measuring outcomes relating to the effectiveness and safety of care, these should also measure the patient reported experience of care.**

### **The Association of Directors of Adult Social Services (ADASS) and the British Geriatrics Society (BGS) –partners in integrating care for older people**

ADASS represents directors of adult social services in local authorities in England. The BGS is a multi-disciplinary professional membership association (the majority of members are doctors and consultants) that promotes better health and care for older people.

The partnership aims to encourage social care professionals and BGS members to engage in joint leadership at the local level to influence service commissioning and delivery through sharing best practice and building local networks. It also seeks to develop evidence-based approaches to high quality service delivery in a financially constrained environment to meet the increasing challenges presented by an ageing population.

The agreement was based on a joint commitment to the policy priorities of promoting integration between health and social care services and encouraging a focus on early intervention, prevention and health promotion.

To promote this joint approach, ADASS and the BGS held a joint conference in June 2011 to disseminate examples of integration and partnership in practice, to discuss the research evidence and honestly explore the challenges in the face of new health and social care reforms and the current financial situation.

ADASS and the BGS are currently focusing on three strands of work:

1. A joint conference on commissioning for older people – to be held in summer 2012. This seeks to empower BGS and ADASS members to engage constructively and proactively with the emerging commissioning architecture of the new health and care system.
2. Information governance – looking at how information can be shared appropriately, effectively and efficiently between health and social care professionals. It will also look at potential obstacles and enablers to information sharing and best practice (e.g. policy issues, IT compatibility, protocols, service level agreement and confidentiality issues).

3. Care home resident “empowerment” – so that residents, friends, family and carers and public and patient organisations know what type of health and care support they can expect to receive or advocate for.

We also heard that the attitudes and behaviours of professionals are an important element of integrated care. We challenge professionals to look at what they do and focus on the patient and service users’ needs. If patients, families and non-professionals are to become a bigger part of the solution, their clinicians and professionals will need to change the way they work too. This new way of working, in integrated, multi-professional teams, needs to be taught through education and continuing development. We strongly support the Education and Training workstream’s recommendations around multi-disciplinary working, inter-professional training and also the involvement of patients and service users in training. This training needs to be up-front, but also ongoing through continuing professional development.

## Share lessons and provide support

Many front-line health and social care professionals and managers told us that more should be done to facilitate the sharing of learning, tools and knowledge throughout and across the NHS and local government. We found that, where local areas heard about others’ successes, they were encouraged to attempt their own integration projects. However, it was clear that the most readily transferable lessons related to the process of planning and implementing change for integration, rather than the details of the specific solution arrived at and how this achieved the outcomes and benefits expected. Many of the actual service configurations were highly contingent on the local context, building on pre-existing relationships, services and geographies. We also heard that often there was insufficient investment in service improvement and project management expertise. Sharing lessons based on the endpoints of integration projects is therefore likely to be less useful than describing and analysing the means by which success is achieved. This should be reflected in the focus of future research and analysis.

We were encouraged to see the peer-networking support already being provided to members of health and wellbeing boards by the government. A growing number of clinical commissioning group leaders are also taking advantage of peer support opportunities. However, we were concerned that too many leaders and local organisations lack expertise in planning and leading large-scale change. Many leaders will benefit from training and coaching in successful methods for leading sustainable change. The NHS and local government already have access to improvement and leadership support, and greater use should be made of these expert resources, with learning and development undertaken jointly where possible.

The NHS Commissioning Board should support the development of models facilitating evidence-based options appraisal, prioritisation and planning by commissioners considering new integrated pathways or services. The NHS

Commissioning Board should ensure that appropriate and effective guidance around procurement is available and used by clinical commissioning groups and PCT clusters.

**Recommendation: The NHS Commissioning Board working with local government through the Local Government Association should make available a responsive facility providing advice and support to local commissioners on practical implementation issues of integration. This support could include:**

- **practical support such as consulting, strategic advice (for example about: tariffs/currencies, competition and choice (informed by Monitor where relevant), tools (such as specimen contracts and legal agreements);**
- **helping local commissioners understand the latest in best practice and peer-networking**
- **training for planning and leading large scale re-design and change across clinical commissioning groups and local authorities (jointly with local government).**