Achieving integrated care

15 best practice actions

Foreword

We must "break down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care".

That is the ambition set out in the NHS Long Term Plan.

However, there are many hurdles to overcome if the ambition is to become reality. For example; cash and workforce shortages; healthcare free at the point of use, social care means-testing; different regulatory regimes; incompatible IT systems; differences in professional cultures and approach. Collectively, this set of challenges has plagued policy makers for more than 30 years.

Nonetheless, progress has been made to bring services together and create more integrated person-centred care, albeit on small-scale and in pockets. If implemented properly, we know that a range of interventions can make a difference, such as personalised care plans, social prescribing and multi-disciplinary teams.

We also know more about what system-wide conditions need to be in place for integrated care to flourish: effective systems leadership; coproduction and citizen involvement; joint commissioning and integrated workforce strategies.

However, knowing what works, and knowing how to implement it locally are very different things; often we may understand the research evidence, but struggle to translate it into meaningful actions on the ground.

That is why we have developed this new resource 'Achieving integrated care: 15 best practice actions'. The resource seeks to translate the best available evidence – as set out in Shifting the centre of gravity – into clear actions for local systems leaders, commissioners and practitioners.

The material proposes a range of actions on topics as diverse as risk stratification, access to information, resource allocation and integrated commissioning. For each action we explain why it is important, how to achieve it and who needs to own it. It also provides links to the latest evidence, tools and resources. To demonstrate what is possible, case studies are provided as exemplars.

Delivering person-centred integrated care remains one of the greatest policy and implementation challenges facing health and social care; but it is a prize worth working for. We hope that this resource can contribute to making that task more achievable.

Rt Hon Paul Burstow, Chair, SCIE

Councillor Ian Hudspeth, Chairman, LGA Community Wellbeing Board

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Introduction

The Local Government Association (LGA) and the Social Care Institute for Excellence (SCIE) have joined to produce an accessible and practical resource that supports local systems in fulfilling their ambition of integration. From experience working with local systems, we know that the journey towards integrated care takes time, energy and resources from all local partners. Change can be slow, with setbacks common, but there are a handful of actions local leaders can take to accelerate progress.

The 15 actions prioritised in this resource draw on evidence about what works from international research, emerging best practices and engagement with our own stakeholders and partners. The actions are deliberately aligned with national policy, legal frameworks and regulatory guidance, but most importantly, they allow for local variety in system design and service delivery to flourish. Although voluntary, they also complement the existing tool; the High impact change model.[1]

Purpose

We envisage a 'whole system' approach in taking these actions forward, involving system leaders, health and social care commissioners and providers, front-line professionals, local communities and local people. By applying these actions, local partners will be able to focus on three key elements:

- delivering person-centred coordinated care – ie the core objective of integrated care

- building local 'place-based' care and support systems

- system leadership for integration

For each action, the resource sets out the rationale, 'How to' tips, and signposts to the underpinning evidence and examples of good practice.

The principles underpinning the actions

A number of core principles underpin the 15 actions. First, integration is not the end goal in and of itself. Instead, it is a means towards achieving the goal of better, joined up care. Integration creates opportunities for transforming people's experiences of care from disjointed to coordinated, reactive to proactive, and service-orientated to personalised. Effective integration should enable people to live healthy and independent lives. Care planning and coordination should build on an individual's strengths and preferences. We have adopted some of the 'I/We' statements from Think Local Act Personal's 'Making it real' framework. This will further highlight the way in which a particular action relates to the expected outcomes for both people who use ('I' statements) and people who provide ('we' statements) a service.

Integration should also support the building of community capacity for prevention, early intervention and 'place-based' care and support. 'Place' is an integral aspect of the best practice actions, but we recognised that the concept of place will mean different things in different contexts. Therefore, we suggest 'place' be defined by local partners and used flexibly to accommodate a range of geographic footprints and population sizes. For example, in some instances, place may mean as small as a neighbourhood; in others it will reflect the political boundaries of a local authority; and in some instances place will be defined as regional.

1   www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

The principle for defining place should be one that optimises collaboration between local partners – and where there is a clear purpose for working and across organisational or institutional boundaries.

Finally, this tool is designed to support improvement and not performance management. Our consolidation of key sector research and best practice examples is intended to help local systems identify areas for improvement and introduce sound approaches for accelerating progress or tackling the barriers to better care. In particular, the resource draws on:

- SCIE Logic model for integrated care[2]

- Shifting the centre of gravity[3]

- 'Making it real' framework[4]

- NHS Long term plan[5]

- NHS England integrating better[6]

- NHS Comprehensive personalised care model[7]

- Better care fund guidance[8]

- The care act 2014[9]

2   www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

3   www.local.gov.uk/shifting-centre-gravity-making-place-based-person-centred-health-and-care-reality

4   www.thinklocalactpersonal.org.uk/_assets/MakingItReal/TLAP-Making-it-Real-report.pdf

5   www.england.nhs.uk/long-term-plan/

6   www.scie.org.uk/?res=true

7   www.england.nhs.uk/wp-content/uploads/2019/02/comprehensive-model-of-personalised-care.pdf

8   www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2019-to-2020

9   www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Fifteen best practice actions

Realising person-centred coordinated care	Building place-based care and support systems	Leading for integration
1. Risk stratification Identify the people in your area that are most likely to benefit from integrated care and proactive support, and preventative support.	**6. Operational framework** Create an integrated care operational framework that is right for the local area, and which aligns service delivery and service changes to a clear set of benefits for local people.	**11. Common purpose** Agree a common purpose and a shared vision for integration, including setting clear goals and outcomes.
2. Access to information Ensure individuals and their carers have easy and ready access to information about local services and community assets. Also, that they are supported to navigate these options and to make informed decisions about their care.	**7. Integrated commissioning** Use integrated commissioning to enable ready access to joined-up health and social care resources and transform care.	**12. Collaborative culture** Foster a collaborative culture across health, social care and wider partners.
3. Multidisciplinary team training Invest in the development and joint training of multidisciplinary teams (MDTs) to transform their skills, cultures and ways of working.	**8. Shared records** Identify and tackle barriers to sharing digital care records to ensure providers and practitioners have ready access to the information they need.	**13. Resource allocation** Maintain a cross-sector agreement about the resources available for delivering the model of care; including community assets.
4. Personalised care plans Develop personalised care plans together with the people using services, their family and carers.	**9. Community capacity** Build capacity for integrated community-based health, social care and mental health services, focusing on care closer to home.	**14. Accountability** Provide system governance and assure system accountability.
5. Rapid response Provide access to integrated rapid response services for urgent health and social care needs through a single-point.	**10. Partnership with voluntary, community and social enterprise (VCSE) sector** Foster partnerships to develop community assets to provide easy access to a wide range of support.	**15. Workforce planning** Lead system-wide workforce planning to support delivery of integrated care.

Realising person-centred coordinated care

1. **Risk stratification**: identify the people in your area who are most likely to benefit from integrated care and proactive and preventative support

'Making it real'- I/We statement

"I can live the life I want and do the things that are important to me as independently as possible."

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services for information or advice if needed."

Why take this action?

To increase the effectiveness and efficiency of integrated care and proactive support.

Who?

Integrated care leads, supported by public health and data analysts – (GPs, care coordinators, nurses and other social care practitioners – to apply needs assessment criteria reliably).

How to achieve it

- Use local population information from health and social care databases to identify cohorts of people 'at risk' of dependency, often with multiple or complex long term conditions, and/or with high needs for care and support. Risk stratification and population management tools categorise people according to the severity of their needs.

- Usually, these individuals will be known to multiple agencies, and can be identified through need assessments; for example frailty, or because they frequent A&E, hospital discharge or other services. Consider offering training to ensure assessment criteria are applied reliably.

- Informal information from voluntary services can also enhance local knowledge about people's needs.

- Analytics and modelling, using good quality data, also generate insights into demand or potential for early intervention services, from falls prevention to tackling social isolation.

Evidence and tools

The transition to integrated care: Population health management in England (Deloitte, 19) is a discussion about the building blocks and success factors of public health management in England – including population targeting and segmentation. Draws on examples of good practice.

www2.deloitte.com/content/dam/Deloitte/uk/Documents/public-sector/deloitte-uk-public-sector-population-health-management.pdf

Using case finding and risk stratification (NHS England, 2015) provides practitioner insights into case finding and risk stratification to support personalised care and support planning.

www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14-FINAL.pdf

Next steps for Risk Stratification in the NHS (NHS England, 2015) explains how to use risk stratification as a way of improving the targeting of preventive care.

www.england.nhs.uk/wp-content/uploads/2015/01/nxt-steps-risk-strat-glewis.pdf

Risk Stratification Assurance Statement (NHS England, 2016) is an action plan template, to be completed by CCGs/GPs. Demonstrates their risk stratification tool for providers on how they meet the CAG approval conditions; as set out in the Risk Stratification Assurance Statement.

www.england.nhs.uk/wp-content/uploads/2016/10/risk-stratification-assurance-statement-template.pdf

Enhancing risk stratification for use in integrated care (BMJ, 2016) highlights findings of a retrospective cohort study showing that segmentation can help tailor and target integrated care programmes.

https://bmjopen.bmj.com/content/6/12/e012903.short

Case studies

Risk stratification: Learning and Impact (NHS England, 2017) describes how a selection of vanguards have used risk stratification and predictive models in ways that are broadly consistent with the national policy direction.

https://imperialcollegehealthpartners.com/wp-content/uploads/2018/07/ORE__Risk_stratification_learning_and_impact_study.pdf

Use of social care data for impact analysis and risk stratification: Sunderland CCG (NHS England, 2014) is a discussion about work completed by Sunderland CCG and others in the use of social care data, in combination with health data, for risk stratification of patients and impact analysis for proposed changes.

www.england.nhs.uk/wp-content/uploads/2014/09/bcf-cs-sunderland.pdf

2. **Access to information**: ensure individuals and their carers have easy and ready access to information about local services and community assets; and that they are supported to navigate these options and to make informed decision about their care

'Making it real'- I/We statement

"I can get information and advice that is accurate, up to date and provided in a way that I can understand."

"We provide information to make sure people know how to navigate the local health, care and housing system, including how to get more information or advice if needed."

Why take this action?

One of the challenges in any care system is to link people to the local services that matter most to them, especially in a complex system that can be difficult to navigate.

Providing good access to information, and navigation support, will facilitate people's involvement in their own care planning. As well as informed decision-making, prevention and social prescribing, and the personalisation of care.

Who?

Local commissioners should lead the development, working with a variety of local community partners.

How to achieve it

- Good, accessible information systems should include:

  ○ a single database for the directory of local services

  ○ comprehensive listings of a variety of local services, from statutory to voluntary, and that offer care at home and in the community

  ○ an easily accessible "front door", or single point of access, combining both telephone and online portals

  ○ resources for maintaining and updating the directory on a regular basis.

- 'Navigators' or 'community link workers' can offer support and guidance for those seeking services to help them to make an informed decision about their care.

- Creating a comprehensive directory requires a shared commitment across the local community with a broad range of partners. This includes commissioning its development and delivery, and the commissioning and training of care navigators.

- It is critical to think beyond statutory services and to map the full range of local community assets, from housing support to prevention services offered by the voluntary and community sector.

Evidence and tools

Social prescribing and community-based support (NHS England, 2019) focuses on social prescribing, which enables all local agencies to refer people to link workers, as well as connect them with community groups and agencies for practical and emotional support.

www.england.nhs.uk/wp-content/uploads/2019/01/ social-prescribing-community-based-support- summary-guide.pdf

The Community Mapping Toolkit (Preston City Council) helps community groups map assets in their local area and develop their own neighbourhood action plans.

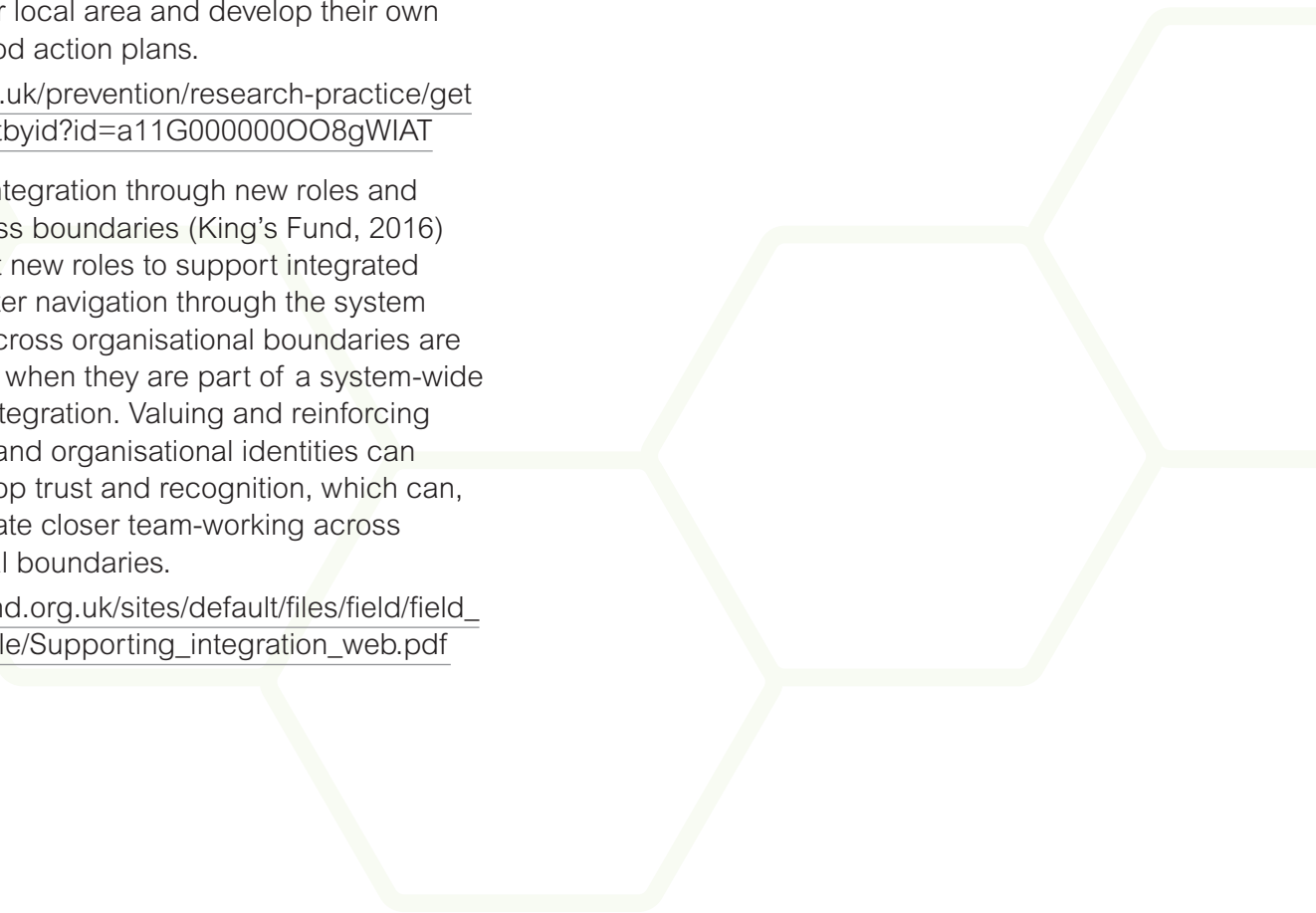www.scie.org.uk/prevention/research-practice/get detailedresultbyid?id=a11G000000OO8gWIAT

Supporting integration through new roles and working across boundaries (King's Fund, 2016) suggests that new roles to support integrated care and better navigation through the system by working across organisational boundaries are only effective when they are part of a system-wide process of integration. Valuing and reinforcing professional and organisational identities can help to develop trust and recognition, which can, in turn, facilitate closer team-working across organisational boundaries.

www.kingsfund.org.uk/sites/default/files/field/field_ publication_file/Supporting_integration_web.pdf

Case studies

Wigan community link worker service evaluation (Innovation Unit, 2016) is an evaluation of Wigan community link worker service, suggesting the service has made a difference to the lives of its clients. The difference – as client stories suggest – is that CLWs help people 'get back on track', feel supported and become involved and able to contribute in their community.

www.innovationunit.org/wp-content/ uploads/2017/05/Wigan-CLW-service-evaluation. pdf

3. **Multidisciplinary team (MDT) training**: invest in the development and joint training of MDTs to transform their skills, cultures and ways of working

'Making it real'- I/We statement

"I have care and support that is coordinated and everyone works well together and with me."

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services."

Why take this action?

Team members work across organisational and professional boundaries, so they need to acquire new skills, adapt their ways of working and facilitate communication. Joint training facilitates a shared culture and practice.

Effective MDTs develop over time and with experience. Collaborative cultures, trusting relationships and reflective team learning are at the heart of team working.

Who?

Local commissioners to arrange the training; MDTs to participate.

How to achieve it

- A sustained investment in team development and joint training is essential, as it helps foster and secure the practices and protocols that underpin delivery of integrated care and better care outcomes.

- Topics for joint training include:

  ◦ standardised approaches for joint assessment, care planning, care coordination, care management, and crisis response

  ◦ making the shift from reactive to proactive and preventive care

  ◦ working with shared care records, and information sharing

  ◦ understanding and accessing the resources available for personal care plans, including personal budgets

  ◦ personalisation and co-production methods, including shared decision-making

  ◦ team development to improve working relationships and behaviours, joint problem-solving, shared accountability

  ◦ involvement of link workers (care navigators) to support self-care and social prescribing.

- Co-location of team members has been shown to enhance the ability of teams to communicate and collaborate.

Evidence and tools

Delivering integrated care: the role of the multidisciplinary team (SCIE, 2018) outlines the role of MDTs as effective means to deliver holistic, person-centred and coordinated care. Includes examples of good practice.

www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team

What are the key factors for successful multidisciplinary team working? (CordisBright, 2018) identifies common features of successful multidisciplinary teams working in integrated care.

www.cordisbright.co.uk/admin/resources/05-hsc-evidence-reviews-multidisciplinary-team-working.pdf

MDT development: Working toward an effective multidisciplinary/multiagency team (NHS England, 2014) draws together information about multi-disciplinary and integrated teams, and looks at the types of teams that need to be in place to deliver integrated care.

www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

Integrated primary care and social work: a systematic review (JSSWR, 2018) systematic review of evidence suggesting integrated primary care provided by interprofessional teams – including social workers – improves the behavioural health and care of patients.

www.journals.uchicago.edu/doi/full/10.1086/697567

Case studies

Delivering integrated care: MDTs case studies (SCIE, 2018) shows that there are different ways to support groups of professionals and practitioners to collaborate successfully. Lincolnshire and Manchester have brought together those working within an identified locality into an MDT. Stockport has instead maintained single-discipline teams but enabled collaboration through shared principles, joint training and an emphasis on innovation and improvement.

www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team#casestudies

Integrating Better – 10. Case Studies. Leeds: Multidisciplinary community approach (NHS England, 2019) explores how Leeds has developed multidisciplinary community teams and how they located them into local communities to achieve a better experience for people who use services, their families and their carers.

www.scie.org.uk/?res=true

Multidisciplinary Teams (MDTs)

MDTs are the health and social care professionals who are jointly responsible for assessing, planning, managing and coordinating the care and support that best meets the needs of individuals. These teams tend to include a local social worker, nurse, doctor/GP, and therapists – and possibly others such as care navigators or link workers.

4. **Personalised care plans**: develop personalised care plans together with the people using services, their family and carers

'Making it real'- I/We statement

"I have a co-produced personal plan that sets out how I can be as active and involved in my community as possible."

"We talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans"

Why take this action?

Care planning that directly involves individuals and those who care for them is more likely to produce plans that build on the person's own strengths and assets, support shared decision-making, and meet the person's care goals.

Who?

Integrated care leads, clinical leaders and 'users by experience' (to co-develop standards and practices).

- Commissioners to facilitate learning programmes for MDTs and other assessors.
- Local system leaders to tackle barriers.

How to achieve it

- When care is personal, the focus is placed on the individual at the centre – the whole person – and understanding that they know best what their needs are and how to meet them.

- The starting point is the person's own strengths and goals, with care planning directly involving the person in the process. Whoever is assessing needs and developing plans must adopt this guiding principle.

- Realising the ambition of personalised care requires a cultural shift. As covered in action three, training of multi-disciplinary teams and other assessors is needed to ensure that the expected standards and practices become adopted and second nature. Learning programmes should cover:

  ◦ best practices for involving people in care planning and setting care goals

  ◦ how to plan for prevention and self-care along with traditional services

  ◦ supporting shared decision-making, patient activation, motivational interviewing, and other techniques

  ◦ how to involve people's families and caregivers in the planning process.

  ◦ personalised care planning is best facilitated by an effective and accessible system of shared care records, one that incorporates standardised documentation practices.

- A personalised care plan is more than just the technical output of an assessment – it should encompass the quality of these plans from the perspective of the person. Finding ways for practitioners to receive feedback will support better care and improvements in future planning.

- Plans must be reviewed on a regular basis, since people's needs and goals will change over time as their underlying conditions and personal circumstances change.

Evidence and tools

Personalised care and support planning (TLAP) is a series of case study scenarios and the tool that shows what different journeys through personalised care and support planning could look like – when delivered through integrated and person-centred arrangements.

www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/

Personalised care and support planning (LGA and NHS England, 2017) is practical guidance on how to develop and implement a single personalised care and support plan, develop multidisciplinary approaches and put in place a single, named coordinator.

www.england.nhs.uk/publication/personalised-care-and-support-planning/

What to expect during assessment and care planning (SCIE and NICE, 2018) is a description of what is to be expected from social care staff during assessment and care planning. Includes topics such as making decisions, support from an advocate, needs assessment; and care planning.

www.scie.org.uk/person-centred-care/care-planning/what-to-expect

Using conversations to assess and plan people's care and support (Skills for Care, 2018) outlines key principles of conversational assessment; aligned with principles and values of Think Local Act Personal, and support the Making it Real framework.

www.skillsforcare.org.uk/Documents/Leadership-and-management/Workforce-commissioning/Conversational-assessment/Using-conversations-to-assess-and-plan-peoples-care-and-support.pdf

Case studies

Assessment and care planning: three conversations (SCIE, 2017) is a description of the 'three conversations' model, an innovative approach to needs assessment and care planning which focuses primarily on people's strengths and community assets.

www.scie.org.uk/future-of-care/asset-based-places/case-studies/three-conversations

Digital care and support plan standard: case studies (PRSB, 2018) are examples of implementation of a standard for digital care and support plan, so that care plans can be effectively shared between patients, carers and all the health and care professionals involved.

https://theprsb.org/wp-content/uploads/2018/08/Digital-care-and-support-plan-standard-case-studies-v2-post-endorsement.pdf

5. **Rapid response**: through a single-point of access, provide access to integrated rapid response services for urgent health and social care needs

'Making it real'- I/We statement

"I know what to do and who I can contact when I realise that things might be at risk of going wrong or my health condition may be worsening."

"We work with people to write a plan for emergencies and make sure that everyone involved in supporting the person knows what to do and who to contact in a health or social care emergency. We make sure that any people or animals that depend on the person are looked after and supported properly."

Why take this action?

Having an effective crisis response in the community helps to stabilise changing conditions, keep people at home and avoid unnecessary emergency hospital attendances and admissions.

Who?

Commissioners, working with local partners.

- As described in the NHS Long Term Plan, all CCGs within an Integrated Care System should be aiming for a single approach to urgent community care.

How to achieve it

- Commissioning an effective single point of access with 24/7 hour coverage enables an effective rapid response system to be deployed for people whose care needs require urgent attention:

  ○ a clear model of care and agreed protocols, including referral and escalation pathways, for handling urgent and emergency care needs that arise from the targeted population. This should apply whether they are people living at home, in care homes or elsewhere in the community

  ○ a fully integrated rapid response team, ideally available 24/7. Delivered by a range of health and social care professionals with access to specialist medical expertise, as needed, who can triage and attend to the individual's urgent needs

  ○ a single point of access – usually telephone triage in a physical hub – from which to coordinate the rapid response, and which is linked to a shared care record system.

- The community-based urgent care system is suitable for any person at high risk of entering a crisis. This includes anyone receiving integrated care at home or in the community, care home residents, those who frequently attend hospital emergency care, or people recently discharged from hospital.

Evidence and tools

Urgent and emergency care consolidated channel shift model: user guide (NHS England, 2018) is a description of channel shift model whereby urgent and emergency care interventions shift activity to the most appropriate setting of care, and away from less appropriate settings of care.

www.england.nhs.uk/wp-content/uploads/2017/03/uec-channel-shift-model-user-guide.pdf

Achieving better access to 24/7 urgent and emergency mental health care (NICE & NHS England, 2016) is guidance around 24/7 urgent and emergency mental health care.

www.england.nhs.uk/publication/achieving-better-access-to-247-urgent-and-emergency-mental-health-care-part-2-implementing-the-evidence-based-treatment-pathway-for-urgent-and-emergency-liaison-mental-health-services-for/

Case studies

Learning the lessons from integrating urgent response, short term rehabilitation and reablement services to create Intermediate Care Southward (IPC, 2018) is a summary of challenges and lessons learned during the development of a new service which brings together, under shared management arrangements, four separate services: Southwark Enhanced Rapid Response Service, Southwark Supported Discharge Team, Reablement Service and the social work urgent response function.

https://ipc.brookes.ac.uk/publications/pdf/Learning_the_Lessons_from_Integrating_Urgent_Response.pdf

Avoiding A&E through Rapid Response teams and See and Treat models (NHS, 2016) brings together 12 case studies from both the UK and internationally, and provides details of quantified impact.

www.healthylondon.org/wp-content/uploads/2017/11/Rapid-review-Rapid-response-teams-and-see-and-treat-models.pdf

Rapid Response Service: Central and north west London NHS foundation trust (Monitor, 2015) is a description of how the service enables patients who are entering crisis to remain supported in their home or the community, rather than be admitted to hospital, or return home as soon as possible.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/459191/CNWL.pdf

Building place-based care and support systems

6. **Operational framework**: create an integrated care operational framework that is right for the local area, and which aligns service delivery and service changes to a clear set of benefits for local people

'Making it real'- I/We statement

"I have care and support that is coordinated with me, and everyone works well together."

"We work in partnership with others to make our local area welcoming, supportive and inclusive for everyone."

Why take this action?

Moving from a shared vision for the new local system to real change requires collaborating with providers to have a shared operational framework and performance goals.

Who?

Joint commissioners and integrated care leads, working with local providers.

How to achieve it

- Operational frameworks translate system leaders' vision and strategy for integrated care to local place-based care and support systems. An operational framework will be unique to each local area; it is not a 'one size fits all' approach.

- Aiming to meet the needs of local people, and staying people-centred in focus, the framework should describe: how care will be organised and provided; how outcomes will be achieved, such as through local care networks and care pathways; the range of services available; and how prevention and early intervention are incorporated into the offer.

- It should be co-produced by local providers, frontline staff and local people, so as to ensure:

  ◦ the framework maximises the potential and capacity of local assets and resources, including the voluntary and community sector

  ◦ prevention and early intervention services are incorporated into the plan

  ◦ engagement with frontline staff and local people maintains a focus on the development and innovation of local services

  ◦ there is support for new ways of working, and any structural or behavioural changes are understood

  ◦ frontline staff will have the autonomy and freedom to work together.

Evidence and tools

Shifting the centre of gravity: making place-based, person-centred health and care a reality (LGA, 2018) sets out a vision and the actions that will help local systems and places to progress their work on system-wide transformation.

www.local.gov.uk/sites/default/files/ documents/1.84%20-%20Shifting%20the%20 centre%20of%20gravity%20WEB_0.pdf

NHS operational planning and contracting guidance 2019/20 (NHS, 2019) includes system planning, the financial settlement, full operational plan requirements, and the process and timescales around the submission of plans.

www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting/

Case studies

Frimley System Operating Plan 2019/20 is a description of collective priorities and actions for providers, commissioners and local authorities that make up the Frimley Health and Care Integrated Care System (ICS).

www.frimleyhealthandcare.org.uk/media/1143/ frimley-ics-operating-plan-2019-20-final-11th-april-submission-20190411-2-00000002.pdf

Integrating health and social care: Rotherham case study (LGA, 2018) is a description of Rotherham's progress developing integrated care arrangements; including an Integrated Health and Social Care Place Plan.

www.local.gov.uk/integrating-health-and-social-care-rotherham-case-study

Integrating health and social care: North East Lincolnshire case study (LGA, 2018) is a description of North East Lincolnshire's progress developing integrated care arrangements at place level through the Union's Partnership Board, which provides single strategic leadership across the CCG and the council.

www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

Integrating health and social care: Dorset case study (LGA, 2018) is a description of Dorset's progress developing a joined up approach to providing care for the local population.

www.local.gov.uk/integrating-health-and-social-care-dorset-case-study

7. **Integrated commissioning**: use integrated commissioning to enable ready access to joined-up health and social care resources and transform care

'Making it real'- I/We statement

"I can live the life I want and do the things that are important to me as independently as possible."

"We work in partnership with others to make our local area welcoming, supportive and inclusive for everyone."

Why take this action?

The experience of care is more likely to be seamless where local providers and practitioners share accountability for care outcomes, the best use of joint resources and the management of risks.

Integrated or joint commissioning enables shared accountabilities and practices to work effectively.

Who?

Commissioners.

How to achieve it?

- A single team of joint commissioners, ideally co-located, can better leverage the co-ordination, pooling or alignment of local resources to create improved outcomes and experiences from integrated health and social care. (See also action 11 and action 13.). Their work is underpinned by the local integrated care vision.

- The options for integrated commissioning are:
  - section 75 agreements between CCGs and councils that create permission to pool or align NHS and social care funds
  - contracts with providers, including lead providers, which include risk-reward incentives and clear outcomes and performance metrics.

- Commissioners cannot work solely in a transactional way. Instead, dialogue with local providers, clinical professionals and service users should be used to shape the delivery of the service model and full range of integrated care services, from prevention to urgent care in the community.

- Commissioners may need support to develop their negotiation, influence and engagement skills.

Evidence and tools

Cabinet Office: The Commissioning Academy: framework document (Cabinet Office, 2013) is a high-level summary of commissioning.

www.gov.uk/government/publications/the-commissioning-academy-framework-document

Options for integrated commissioning (King's Fund, 2015) is an assessment of evidence of past joint commissioning attempts. Study of current policy framework and local innovations in integrated budgets and commissioning. Also considers which organisation is best placed to take on the role of single local commissioner.

www.gov.uk/government/publications/the-commissioning-academy-framework-document

Integrating funds for health and social care: an evidence review (JHSRP, 2015) is an examination of whether integrated funds facilitate coordinated care.

https://journals.sagepub.com/doi/pdf/10.1177/1355819614566832

Health foundation: need to nurture is an examination of outcomes-based commissioning to date.

www.health.org.uk/sites/default/files/NeedToNurture_1.pdf

The Personalised health and care framework is a guide for local authorities and CCGs showing how they can use integrated personalised commissioning and personal health budgets as key ways for providing people with a more personalised approach to their health and social care.

www.england.nhs.uk/personalisedcare

Case studies

Integrating Better – 10 case studies. Wirral: Joint Commissioning – Teletriage (NHS England, 2019) is an exploration of how the joint commissioning of a 24/7 clinical teletriage service helped to increase both health and social care outcomes.

www.scie.org.uk/?res=true

North East Lincolnshire CCG: Strategic plan 2014-2019 acts as lead commissioner for all health and social care services (section 75 agreement).

www.northeastlincolnshireccg.nhs.uk/data/uploads/publications/nelccg-narrative-strategic-plan-dec-14.pdf

Sheffield Council and CCG have established a joint commissioning and management structure utilising the section 75 agreement for some service pathways.

www.sheffieldccg.nhs.uk/our-projects/integrated-commissioning-programme.htm

Salford Integrated Care Programme is where the council, CCG and NHS trust formed an alliance bringing together commissioners and providers to enable the provision of more integrated care and services, and to share risk.

www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n572.pdf&ver=864

8. **Shared records**: identify and tackle barriers to sharing digital care records to ensure providers and practitioners have ready access to the information they need

'Making it real'- I/We statement

"I know how to access my health and care records and decide which personal information can be shared with other people, including my family, care staff, school or college."

"We get permission before sharing personal information."

Why take this action?

Information sharing supports care planning, care coordination, proactive and urgent care management. Futhermore, it also supports the personalisation of care, and workforce and service planning. What gets in the way are behaviours and assumptions about how to share data legally and functionally.

Who?

System leaders.

How to achieve it

- Access to shared care records is an important enabler of integrated care. A relentless focus on eliminating the barriers to data access and data sharing will accelerate local progress. To do this well, requires:
  - committed leadership, supporting culture change, openness and collaboration – beyond just introducing new technology – to reimagine work processes, professional interactions and the engagement of service users
  - strong information governance, including formal information-sharing agreements and partnerships – acknowledging that users of services generally assume information is already shared
  - interoperability and standardisation, ensuring IT systems are able to communicate across settings and organisations
  - a focus on the relevance and quality of data
  - staff skills development and clear guidance to ensure consistent compliance with data protection laws and the wider regulatory framework
  - processes in place to ensure customisable sharing, tailored to the person's consent and service needs
  - user-centred design, developing the facility for people to have access to their own records
  - analytic capacity and capability to extract insights and monitor outcomes.

Evidence and tools

NHS Digital: Information governance alliance are publications to enable effective information sharing.

https://digital.nhs.uk/

Centre of Excellence for Information Sharing resources are a series of tools to help local areas address the cultural barriers to information sharing.

http://informationsharing.org.uk/

Case studies

Leeds and Bristol/South Gloucestershire/North Somerset utilise shared care record approaches and improved sharing of information for the direct care of individuals.

www.leedscarerecord.org/ and http://informationsharing.org.uk/policy-areas/health/

Harrow and Living Well Essex use platform approaches and digital channels by which citizens can engage in care and health services.

www.adass.org.uk/media/5284/chris-greenway.pdf

Leicester, Leicestershire and Rutland share information to analyse the journeys taken by local people across the whole health and care system to help inform commissioning.

www.lsr-online.org/uploads/full-report-of-launch-event.pdf

9. **Community capacity**: build capacity for integrated community-based health, social care and mental health services, focusing on care closer to home

'Making it real'- I/We statement

"I can live the life I want and do the things that are important to me as independently as possible."

"We have a clear picture of all the community groups and resources in our area and use this when supporting people and planning services."

Why take this action?

To support people to maintain their independence and prevent unnecessary hospital or institutional care, it is important that there is capacity within community-based services to support prevention, early intervention, rehabilitation and reablement.

Who?

Commissioners, leaders from local statutory providers, including clinical leaders, and local people (as described in the NHS Long Term Plan, the evolution of Primary Care Networks (PCNs) should align with these principles).

How to achieve it

- An objective of integrated care is to provide services to people closer to home – or at home. This means developing a greater array of preventive, therapeutic and rehabilitative services in the community.

- This requires the redesign of care pathways and the creation of new or expanded community-based services. Some services could be designed for delivery at home. Other services might be accessed at a neighbourhood 'hub', which could provide primary care, community health, mental health, social care and voluntary sector services all in one place. Access to specialist care would support the management of long term conditions and urgent care, while an expanded offer of reablement would help people prevent unnecessary admission to hospital or care settings.

- Commissioners should involve local people, their families and carers, as well as health and social care providers, in their planning efforts. This would ensure the resulting services are better tailored to local context and priorities.

Evidence and tools

Reimagining community services: Making the most of our assets (King's Fund, 2018) focuses on services in the community, comprising both services commissioned by the NHS and local authorities, as well as related services delivered by the third sector, private sector, carers and families. The report proposes 10 design principles that should inform the future planning and provision of community-based care.

www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf

Primary care home and social care: working together (NAPC and ADASS, 2018) is a description of the importance of closer integration of social care with primary care to achieve better outcomes for users of services and local populations. Highlights the value of the primary care home model as a framework for making this happen at scale and consistently throughout the country. Includes case studies.

https://napc.co.uk/wp-content/uploads/2018/11/NAPC-Social-care-guide.pdf

Case studies

Integrated care for older people with frailty: innovative approaches in practice (RCGP & BGS, 2016) are case studies providing innovative and interesting ideas about the care of older people. The studies are set in a range of locations across the UK, including urban and rural populations, and a range of settings, including services based in the community, GP practices, care homes and hospitals.

www.bgs.org.uk/sites/default/files/content/resources/files/2018-10-09/RCGP-Integrated-care-for-older-people-with-frailty-2016.pdf

Primary care home and social care: working together case studies (NAPC and ADASS, 2018) are four case studies illustrating how partnerships between health and social care work in practice, the impact they have and their success factors.

https://napc.co.uk/wp-content/uploads/2018/11/NAPC-Social-care-guide.pdf

10. **Partnership with voluntary, community and social enterprise (VCSE) sector**: foster partnerships to develop community assets that offer a wider range of services and support

'Making it real'- I/We statement

"I feel welcome and safe in my local community and can join in community life and activities that are important to me."

"We invest in community groups, supporting them with resources: not necessarily through funding, but with things like a place to meet or by sharing learning, knowledge or skills."

Why take this action?

Actively cultivating partnerships with local voluntary services, housing associations and other community organisations will broaden the range of services people are able to access to keep them independent and well, such as services that support prevention, self-care and social prescribing.

Who?

Commissioners working with the VCSE sector and local people.

How to achieve it

- An objective of integrated care is to provide services to people closer to home – or at home. Limiting these services to statutory health and care ignores the often rich 'assets' of the local voluntary, community and social enterprise (VCSE) providers, often already serving local people.

- Think broadly about how to partner with the VCSE sector to develop community-based services, support and interventions that focus on prevention, self-care, independence and wellbeing.

- Commissioners, working in partnerships, can:

  ◦ reframe the narrative about people and communities – shifting the emphasis from deficits and needs, to strengths and assets, creating the right environment for community engagement

  ◦ reinforce an ethos of co-production, taking a co-design approach to develop the services people want, and focusing on wellbeing, prevention and self-care

  ◦ include voluntary-led services in local service directories to support personalised care planning

  ◦ connect people to the wealth of local community resources and initiatives through clear and intuitive signposting, social prescribing, peer mentors, link workers and care navigators

  ◦ support and encourage the full offer of schemes and programmes run by the voluntary sector, including Shared Lives, community circles, time banks, etc.

Evidence and tools

Asset-based places: a model for development (SCIE, 2017) is a suggestion of a framework for local areas to enable asset-based approaches to thrive.
www.scie.org.uk/future-of-care/asset-based-places

The asset-based area (TLAP, 2017) introduces 10 key features of an asset-based area and suggests a number of planning and support models that can help areas to make progress.
www.thinklocalactpersonal.org.uk/_assets/Resources/BCC/AssetBasedArea.pdf

Strengths-based approach: Practice framework and practice handbook (DHSC, 2019 is an introduction of a practice framework for strengths-based practice for social work with adults.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778134/stengths-based-approach-practice-framework-and-handbook.pdf

Social prescribing and community-based support (NHS England, 2019) enables increased understanding of what good social prescribing looks like and why social prescribing improves outcomes, commissioning of local social prescribing connector schemes, and collaborative working amongst all local partners at a 'place-based' local level.
www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf

Commissioning community development for health (Coalition for Collaborative Care, 2018) aims to help local authorities, CCGs, federations and sustainability and transformation partnerships' (STPs) footprints to commission community development.
www.healthempowerment.co.uk/wp-content/uploads/2018/01/COMMISSIONING-CD-FOR-HEALTH-C4CC-2018-1.pdf

Case studies

Integrating Better – 10 case studies. Bracknell Forest: Changing care (NHS England, 2019) is a case study looking at what has made system change successful, particularly: the 'Help Yourself' portal; changes to the social care market; and the 'Community Connector' role.
www.scie.org.uk/?res=true

Integrating health and social care: Coydon case study (LGA, 2018) is a description of Croydon's progress developing integrated care arrangements. Including the creation of Local Voluntary Partnerships which will be vital in organising and supporting the voluntary and community sector offer, so that initiatives such as social prescribing and the Integrated Community Networks know where to signpost and refer people to for help in their communities.
www.local.gov.uk/integrating-health-and-social-care-croydon-case-study

ConnectWELL (SCIE Prevention Research and Practice) is a description of a social prescribing service in Rugby, which provides health professionals with just one, straightforward referral route to the many voluntary and community sector organisations, groups and activities that can help manage or prevent compounding factors of ill-health.
www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a11G000000PWDv7IAH

Leading for Integration

11. **Common purpose**: agree a common purpose and a shared vision for integration, including setting clear goals and outcomes

'Making it real'- I/We statement

"I have care and support that enables me to live as I want to. I am supported as a unique person with skills, strengths and personal goals."

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services."

Why take this action?

A clear, shared vision and common goals help develop integration and support the necessary behavioural changes for achieving better health and wellbeing outcomes.

Who?

System leaders, building on current local arrangements.

How to achieve it

- Without a common purpose and shared vision, integrated care will fall at the first hurdle, with commissioners and providers not working collaboratively towards the same goals.

- It is vital for local system leaders to re-affirm their local vision for integrated care and the goals and outcomes expected for their local systems. This involves:

  - working together to align priorities and responsibilities, including overcoming cultural and performance challenges to establish a common language and set of objectives

  - co-designing and co-producing goals and solutions with those who receive health, care and support

  - building commitment, ensuring leadership is shared and rooted deeper within organisations, engaging middle managers, multidisciplinary team leads and frontline staff in their thinking

  - setting medium and long-term milestones, ensuring vision and goals are tangible, well-defined and measurable.

Evidence and tools

Stepping up to the place: integration self-assessment tool (LGA, NHS Confed, ADASS, NHSCC, 2016) is a self-assessment tool designed to support local health and care leaders to critically assess their ambitions, capabilities and capacities to integrate services to improve the health and wellbeing of local citizens and communities.

www.local.gov.uk/sites/default/files/documents/stepping-place-integratio-f0b.pdf

The King's Fund: Population health systems: Going beyond integration care (King's Fund, 2015) aims to challenge those involved in integrated care and public health to 'join up the dots'. Viewing integrated care as part of a broader shift away from fragmentation towards an approach focused on improving population health.

www.kingsfund.org.uk/sites/default/files/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

The King's Fund: Place-based systems of care (King's Fund, 2015) proposes that organisations need to establish place-based 'systems of care' in which they collaborate with others to address challenges and improve the health of the populations they serve.

www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

The journey to integration: learning from seven leading localities, p51-54 (LGA, 2016) is a paper displaying that development and ownership of a vision is critical across the area. Also, that strong leadership across the area's organisations is essential to maintain focus and mitigate against the risk of change in leadership and loss of momentum.

www.carnallfarrar.com/media/1111/the-journey-to-integration_learning-from-seven-leading-localities_by-ben-richardson.pdf

Case studies

NHS Providers: Birmingham community healthcare NHS trust: healthy villages and the complete care model – Complete Care is a new model of delivering integrated services for older adults, and is part of the wider Healthy Villages programme.

http://nhsproviders.org/media/1814/birmingham-final-p.pdf

Integrating health and social care in Torbay: Improving care for Mrs Smith (Kings Fund, 2011) shows how integration evolved from small-scale beginnings to system-wide change.

www.kingsfund.org.uk/sites/default/files/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf

Integrating Better – 10 case studies. Croydon: Bringing organisations together to deliver integration (NHS England, 2019) is an assessment of partnership working in Croydon and the role of relationships, cultural changes and organisational development in creating the One Croydon Alliance Agreement, and a new, integrated, model of care.

www.scie.org.uk/?res=true

Bexley's local care partnership MOU sets out the vision and values for partners coming together in a local care partnership.

https://future.nhs.uk/connect.ti/system/login?nextURL=%2Fconnect%2Eti%2FHome%2Fview%3Fobjectld%3D45629253

12. **Collaborative culture**: foster a collaborative culture across health, care and wider partners

Making it real'- I/We statement

"I have care and support that is coordinated and everyone works well together and with me."

"We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them."

Why take this action?

Integrated care systems require people to work across organisational and professional boundaries to achieve success. This requires significant culture change.

A system-wide organisational development strategy that fosters collaboration at all levels is suggested.

Who?

System leaders.

How to achieve it

- Without a common purpose and shared vision, for system leaders, creating a joint strategy for organisational development will set the parameters for the culture changes expected at all levels of the system. How system leaders act and behave will demonstrate these expectations in practice.

- The focus should be to develop mutual understanding and collaborative ways of working. This would include building capacity for tackling seemingly unpassable challenges that arise when different organisations or groups of people work together.

- System leaders have the power to address:

  ◦ accountability for decision-making at the most appropriate level – system, place, neighbourhood or individual

  ◦ sharing accountability for the use of joint resources

  ◦ facilitating opportunities for staff from different disciplines to understand each other's roles and professional identities, building trust, relationships and joint ways of working – including through co-location where appropriate

  ◦ creating opportunities for professionals from multiple settings and agencies to learn from each other, and plan solutions and interventions together

  ◦ developing integrated training opportunities, including offering rotational placements in different sectors

  ◦ facilitating information sharing, including shared access to care records.

Evidence and tools

Developing a competent workforce for integrated health and social care: what does it take? (International Journal of Integrated Care, 2016) is a paper discussing workforce competencies needed for integration and ways to support staff to work in an interdisciplinary and integrated environment.

www.ijic.org/articles/10.5334/ijic.2533/

System wide collaboration? Health and social care leaders' perspectives on working across boundaries (Journal of Integrated Care, 2019) is a paper to understand the experiences of working across organisational and sectoral boundaries for the benefit of the population.

www.emerald.com/insight/content/doi/10.1108/
JICA-06-2018-0042/full/html

Stepping up to the place. Part B Evidence review (IPC, 2018) looks at barriers and enablers of integrated care practice, including the roles of cultures and behaviours.

https://ipc.brookes.ac.uk/docs/Part%20B%20-%20
Evidence%20Review%20October%202018%20
WEB.pdf

Case studies

Integrating Better – 10 case studies. Gloucestershire: housing and partnership working (NHS England, 2019) demonstrates how building strong relationships and partnerships has allowed Gloucestershire to improve health outcomes through housing approaches.

www.scie.org.uk/?res=true

Thanet Health Community Interest Company Primary Care (NHS Confederation, 2017) is a description of how health and social care organisations in Thanet came together to pool resources on a voluntary basis and build an integrated, accountable care organisation to improve care for frail elderly people, as well as reducing demand.

www.nhsconfed.org/resources/2017/06/thanet-
health-community-reducing-hospital-admissions

Integrating Better – 10 case studies. Croydon: Bringing organisations together to deliver integration (NHS England, 2019) is a look at partnership working in Croydon and the role of relationships, cultural changes and organisational development in creating the One Croydon Alliance Agreement and a new, integrated, model of care.

www.scie.org.uk/?res=true

Dorset Council: getting providers working as one (LGA, 2019) is a description of how providers working for Dorset Council are working collaboratively. The result of this has been less fragmentation, improved services for patients and greater emphasis on prevention.

www.local.gov.uk/dorset-council-getting-providers-
working-one

13. **Resource allocation**: maintain a cross-sector agreement about the resources available for delivering the model of care, including community assets

'Making it real'- I/We statement

"I have care and support that is coordinated and everyone works well together and with me."

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services."

Why take this action?

Commissioning should be underpinned by firm shared agreements for how resources will be allocated in relation to outcomes, and how outcomes will be monitored. This should help to reduce or resolve competing financial incentives within the current system.

Who?

Systems leaders and commissioners of health and social care.

How to achieve it

- Some of the barriers to integrated care are financial, namely how resources align with the expected model of care; how they are made available to local providers through contracts; how joined up they are in terms of outcomes and contractual incentives; and whether the lines of accountability for delivery of value and outcomes are clear.

- System leaders that actively address resource challenges and maintain cross-sector agreements will create greater scope for success. They need to:

  ◦ define the shared budget available for the population groups targeted in each local place, and in line with the model of care

  ◦ agree how resources will be aligned or pooled, along with the legal and governance arrangements, including cross-sector agreements

  ◦ identify types of contractual models and financial incentives that will be used for managing provider contracts

  ◦ ensure incentives within the contracts correspond with the outcomes and service changes expected.

Evidence and tools

Stepping up to the place. Part B Evidence review (IPC, 2018) highlights barriers and enablers of integrated care practice, including financial arrangements, shifting money across the system and budget sharing mechanisms.

https://ipc.brookes.ac.uk/docs/Part%20B%20-%20 Evidence%20Review%20October%202018%20 WEB.pdf

Integrating funds for health and social care: an evidence review (JHSRP, 2015) is an examination of whether integrated funds have the potential to facilitate coordinated care, noting that integration may uncover unmet needs – offering value for money even with additional costs.

https://journals.sagepub.com/doi/ full/10.1177/1355819614566832

Case studies

Integrating health and social care: Dorset case study (LGA, 2018) is a description of Dorset's joined-up CCG and county council approach to proactive care market management, integrated commissioning, brokerage and a contract framework – the 'Dorset Care'. Initial focus was on home and community services for older people and it is now being extended into learning disability and mental health services.

www.local.gov.uk/integrating-health-and-social-care-dorset-case-study

Integrating health and social care: North East Lincolnshire case study (LGA, 2018) – offers an example of an advanced whole system approach, underpinned by a shared vision for the 'place' and led by the 'union' of the council and CCG. This union drives a joint approach to commissioning, service delivery and financing to the point that integrated working is seen as business as usual.

www.local.gov.uk/integrating-health-and-social-care-north-east-lincolnshire-case-study

14. **Accountability**: provide system governance and assure system accountability

'Making it real'- I/We statement

"I am treated with respect and dignity."

"We make sure that our organisational policies and procedures reflect the duties and spirit of the law and do not inadvertently restrict people's choice and control."

What take this action?

As part of their public governance role, system leaders should regularly be monitoring progress and evaluating the outcomes and benefits of integrated care.

Demonstrating that integrated care is making a difference to local people and that resources are being used appropriately is key.

Who?

Local system leaders.

How to achieve it

- Most local systems have good foundations for assuring system accountability, but the continued evolution of integrated care systems will challenge these foundations and require strengthening. An example of this would be working over geographies larger than those for local political accountability for social care. Forging productive, trusting working relationships, building on existing arrangements, will continue to be an important activity for local system leaders.

- Effective governance structures and processes will need to enable local priorities to be met by high-quality services and adequate resources; that decision-making is transparent and publicly accountable; that local populations have equitable access to care and support; and that the cultural changes associated with integrated care are fully realised.

- Local systems may need to stress test their current governance arrangements and introduce important changes, reviewing the following important factors:

  ○ governance arrangements that are lean, transparent and not overly burdensome or bureaucratic

  ○ clarity about where decision-making and resource allocation powers lie within the system. Also how different decision-makers will be held accountable – and to whom

  ○ an accountability framework that focuses on monitoring progress, assuring quality, delivering better outcomes and value for money for local people

  ○ agreed ways of working for tackling barriers to integration, solving joint problems such as workforce planning, and sharing resources. Any new ways of working should build on existing legal agreements and other formal arrangements (eg data sharing)

  ○ clarity about local people's influence and involvement in governance and decision-making.

Evidence and tools

Governance and accountability for integrated health and care (NHS Clinical Commissioners and Centre for Public Scrutiny, 2019) is an explainer for the NHS and local authorities outlining some of the key governance and accountability challenges that these organisations may face when seeking to work more collaboratively, as well as potential solutions.

https://445oon4dhpii7gjvs2jih81q-wpengine.
netdna-ssl.com/wp-content/uploads/2019/02/
NHSCC-governance-and-accountability_web.pdf

New care models: Emerging innovations in governance and organizational form (King's Fund, 2016) takes a look at the approaches being taken by the NHS vanguards to contracting, governance and other organisational infrastructure.

www.kingsfund.org.uk/sites/default/files/field/field_
publication_file/New_care_models_Kings_Fund_
Oct_2016.pdf

North West London Whole systems integrated care: integration toolkit governance tools (NHS, 2019) is a blueprint for developing a governance model for an accountable care partnership.

www.healthiernorthwestlondon.nhs.uk/news-
resources/information-sharing/wsictoolkit

Case studies

Taking charge of our health and social care in Greater Manchester (Greater Manchester Combined Authority, 2015) is a strategic plan for health and social devolution.

www.gmhsc.org.uk/wp-content/uploads/2018/04/
GM-Strategic-Plan-Final.pdf

Warwickshire and Coventry's health and wellbeing alliance concordat was developed as the basis for joint working across the two boards.

https://apps.warwickshire.gov.uk/api/documents/
WCCC-644-400

Leicester, Leicestershire and Rutland: The better care together are overview documents for this partnership which spans three health and wellbeing board areas.

www.bettercareleicester.nhs.uk/the-bct-plan/

15. **Workforce planning**: lead system-wide workforce planning to support delivery of integrated care

'Making it real'- I/We statement

"I have considerate support delivered by competent people."

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services."

Why take this action?

A system-wide workforce strategy will ensure there is appropriate capacity and capability across all local settings to meet the ambition and goals of the local integrated care system.

Who?

System leaders, local providers from the public, independent and voluntary sectors.

How to achieve it

- System leaders should undertake workforce planning in partnership - and not in isolation - working with local provider organisations across health and care.

- Local workforce strategies should be cross-sectoral in nature; including public, independent and voluntary sectors. They should address:

  ◦ existing and future recruitment needs and retention challenges

  ◦ the state of the local labour market

  ◦ the skills and training required to work in new settings and in new ways

  ◦ the advent and roll-out of new roles, such as link workers or care navigators

  ◦ the availability of local resources for workforce development and training.

- Using a whole-system approach to workforce planning will ensure local providers and commissioners are working in partnership to address workforce shortages. This would include developing innovative and shared opportunities for recruitment and retention – and avoiding competition for staff. Including the independent sector in social care is of particular importance to the growth of home-based and community care and reablement.

- The strategy should reflect the need to develop an integrated workforce by creating opportunities for professionals from multiple settings and agencies to learn from each other, and plan solutions and interventions together. This is likely to produce integrated training programmes and rotational placements in different sectors.

- Involvement of local education providers in the development of the workforce strategy recognises that they too play an important part in building local workforce capacity and capability.

Evidence and tools

LGA workforce redesign provides useful information on how to develop new ways of working to support an integrated workforce.

www.bettercareleicester.nhs.uk/the-bct-plan/

Defining the role of integrated care systems in workforce development: a consultation (NHS Confederation, 2019) is a discussion of the role of ICSs in workforce decision-making based on roundtable sessions.

www.nhsconfed.org/-/media/Confederation/
Files/Publications/Documents/Defining-the-
role-of-integrated-care-systems-in-workforce-
development-A-draft-manifesto.pdf

Specialists in out-of-hospital settings: findings from six case studies (King's Fund, 2014) is a report exploring the role of specialist consultants in supporting the delivery and co-ordination of out-of-hospital care. Includes information about redesigning the workforce.

www.nhsconfed.org/-/media/Confederation/
Files/Publications/Documents/Defining-the-
role-of-integrated-care-systems-in-workforce-
development-A-draft-manifesto.pdf

Supporting integration through new roles and working across boundaries (King's Fund and LGA, 2016) is a report looking at the evidence on new roles and ways of spanning organisational workforce boundaries to deliver integrated health and social care.

www.kingsfund.org.uk/publications/supporting-
integration-new-roles-boundaries

Skills for care: workforce integration offers is a support offer from Skills for Care, including 'Principles of workforce integration'.

www.skillsforcare.org.uk/Leadership-management/
commissioning-and-planning-workforce/
integration/integration.aspx

SCIE: integrated care workforce resources offers useful information and resources to provide support around enabling multi-disciplinary teams (MDTs).

www.scie.org.uk/integrated-care/workforce

Case studies

Lessons learned from local systems reviews support programme (SCIE, 2018) are insights and learning from local systems reviews, including around system workforce planning and development.

www.scie.org.uk/integrated-care/leadership/
learned/local-systems-reviews-support-
programme

How to meet population health needs through workforce redesign (NHS England, 2017) provides learning about workforce integration from vanguards, integration pioneers and primary care homes. Includes 17 case studies showing the strength and richness of the journey towards workforce integration.

www.scie.org.uk/integrated-care/leadership/
learned/local-systems-reviews-support-
programme

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