integrating care in the South West

FOR HEALTH, WELL BEING AND INDEPENDENCE

A handbook for improvement

introduction

Social and health organisations across the South West have been working in partnership looking at how to improve the interface between health and social care. Benefits of this approach include improvements to health and wellbeing and increased independence for people in our communities, more rewarding employment opportunities for staff and better use of resources across health and social care economies.

The scale of the opportunity for health and social care organisations is clear. In the South West, there are currently[1]:

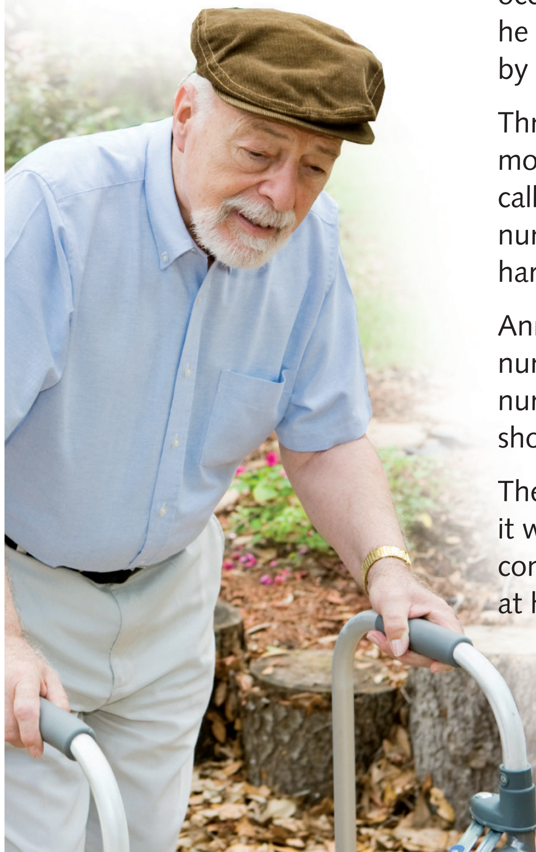
- ~ 10,000 elderly people suffering from preventable fall-related hip and femur fractures
- ~ 15,000 potentially preventable COPD/influenza/pneumonia related admissions
- ~ 30,000 people with undiagnosed dementia who are provided with no or little specific services
- ~ 550,000 excess hospital bed days for people aged 65+

This handbook brings together the work that PCTs and LAs have been leading together over the past 3 months. Supported by ADASS, the SHA and CSIP, these partners have been working together to understand local, national and international best practices in commissioning integrated care. From this understanding, as well as pilots across the region, this group of partners have developed a set of key enablers or "Golden Rules" for the commissioning of integrated health and social care.

This handbook is one element of a toolkit which is being published to support PCT and LA partnerships who are interested in improving the interface between health and social care in their areas. The toolkit has three elements: (1) First, this handbook with the "10 Golden Rules" for commissioning integrated care; this includes a self-assessment tool for LAs and PCTs who would like to understand their current capabilities and set themselves individual goals for improvement. (2) Secondly, there are three "how-to" guides for specific integrated initiatives which LAs and PCTs may use as a starting point for commissioning specific programmes. (3) Finally the toolkit includes a set of benchmarks across health and social care metrics that can be used to understand local improvement opportunities.

[1] References on pages 5 and 6

part 01
Why move towards integrating care?



Joe's story

Joe is 85 years old. Up until three months ago, Joe was being cared for at home by his 80 year-old wife, Annie. Joe was physically frail and would occasionally become confused. He often forgot things but was clear that he wanted to remain at home. Annie was determined to look after him by herself.

Three months ago, Joe developed a low-grade infection, which made him more confused than usual. Annie became very worried about Joe and called their GP. Joe's GP diagnosed a urinary infection and sent a district nurse to check in on Joe each day, but Joe became more confused and harder to look after in the evening when he was alone with Annie.

Annie wondered whether she could get more help and asked the district nurse what kind of carer support they might be eligible for. The district nurse told Annie that the council dealt with home care and that she should call them.

The council needed to assess Joe's eligibility for social support and said it would take some time to sort out the paperwork. Meanwhile, Joe's confusion was making it increasingly difficult for Annie to look after him at home.

On the third night, Joe got up to go to the toilet. He slipped on the bathroom floor and broke his hip. Annie called an ambulance and Joe was admitted to hospital. The unfamiliar environment in hospital made Joe unhappy, and his confusion became even worse. Annie found it difficult to visit – she was extremely upset about Joe's condition, and she found it hard to get to the hospital on a bus.

Joe needed surgery on his hip. Although the operation was a success, he had become frailer and was still confused by the unfamiliar environment. Joe was discharged to a community hospital, but he was unable to cooperate fully with rehabilitation programme prescribed by the physiotherapist and as a result did not regain the mobility he had before his fall. Annie was unable to look after him at home any more, so he was eventually discharged to a nursing home.

What does Joe want?

"Ideally, I'd like to ...

... have a say in what happens to me

... know all the facts and what my choices are

... stay healthy and independent as long as possible

... have one person I can go to who knows me and my story

... be listened to and have my wishes respected

... continue living at home"

How could we have done better for Joe as social and health care organisations?
We are jointly responsible for commissioning the health and social care Joe needs. Our goal is to help him make the right choices for him, helping him stay healthy and living independently as long as possible. His story illustrates how much better we could do if our services were more closely coordinated.

If one of Joe's service providers had noticed his confusion, he might have had access to a memory assessment service, which could have helped Joe recognise he and Annie needed some practical advice and help. For example, early support would have helped Annie and Joe indentify potential adaptations to their home to enable them to deal with Joe's confusion.

The GP could have alerted a rapid-response team, which would have assessed Joe within 2 hours and provided up to 7 days care in the home while Joe recovered from his infection. This team would have included the district nurse as well as personal carers to help with washing, dressing and night-sitting, and would have helped Annie to cope. The night-sitter would have been available to help him to go to the toilet, reducing the danger of falling and breaking his hip.

Even if the hip fracture itself was unavoidable, closer links between health and social services (for example, a co-ordinated, multi-disciplinary approach to discharge, involving medical, nursing and social work professionals), might have helped ensure Joe was discharged quickly to his home rather than the community hospital, with a package of domiciliary care and support for Annie that might have helped Joe avoid the need for a nursing home.

This coordinated approach would have made it much more likely that Joe would recover from his infection and be able to continue living at home as he wanted. We would have achieved our goal and carried out our responsibility to provide Joe with choice and the best possible health and social care. The integrated care toolkit is aimed to help us do this.

There are national and international examples of how integrated care provides better outcomes for people like Joe and Annie:

- A rapid response service in a UK GP practice led to a 14% reduction in elderly patient admissions and a 31% reduction in average length of stay compared to control practices.
- A falls prevention scheme across three sites in the UK achieved a 37% reduction in falls in people aged 65+.
- In Denmark, 25% of older people receive home based care compared to 4% in the UK.
- In Sweden, an incentive scheme for local authorities and health payors reduced the number of 'bed blockers' (unnecessarily retained hospital beds) from 15% to 6%.

There is great scope for improvement across the South West
Improving our services to people like Joe across the South West could result in major benefits. These include:

- More early diagnosis, prevention and/or early intervention: includes significant reductions in the number of
  - Undiagnosed dementia patients (currently it is estimated that 50% of the dementia patients are not diagnosed[2]; this translates to ~ 30,000 people in the South West[3])

[2] National Audit Office (2007). Improving services and support for people with dementia. London: TSO.

[3] Prevalence of dementia in the UK is estimated at 700,000 ("Dementia UK": A report into the prevalence and cost of dementia, London School of Economics and King's College London). Mid-2006 population data (ONS) for the UK and South West used to project UK prevalence to the South West

– Elderly people with fractures (there are currently around 10,000 hip and femur fractures per year in the South West)[4]

– Pneumonia related hospital admissions of elderly people (there are currently around 15,000 COPD/influenza/pneumonia related admissions per year in the South West)[5]

- Quicker hospital discharge

– There are around 550,000 excess bed days for people aged 65+ every year in the South West costing acute trusts and PCTs over £95m per year [6]

- Improvement in patient/user feedback

Who benefits from these improvements?

The main beneficiary of these improvements is Joe - patients and users should experience a more seamless journey through health and social care where they only have to tell their story once and they are given the support they need to be as healthy and independent as possible.

In addition, there are benefits to both the health and social care economies. These changes could free up to £150 million per year for the NHS and local authorities, allowing us to make further investments in service improvement. In addition, improvement in the quality of experience for patients and users should correlate with greater public satisfaction with their local services.

[4] HES, total inpatient cost under tariff for 65+ age group by PCT (£k), 2006-07, all hip and femur fractures cases

[5] HES, total inpatient cost under tariff for 65+ age group by PCT (£k), 2006-07, all COPD/influenza/pneumonia cases

[6] HES, excess bed days for people 65+ age group after average length of stay built in tariffs (trimpoints), 2006-07

What will it take to achieve this?

In order to develop the best possible care for Joe, many PCTs and LAs may need to improve the way they work together to commission and deliver integrated care. This requires leaders to come together and, while recognising each other's differing cultures and histories, develop a shared vision of how to deliver seamless care. Strong leadership will be needed to develop an organisational culture which encourages working together with counterparts in PCTs/LAs to deliver excellence in integrated care.

Shaping an integrated service also means involving a wide group of staff who serve Joe. On Joe's journey through the health and social care systems he is likely to encounter nurses, social workers, doctors, physiotherapists, occupational therapists, voluntary sector workers and others. We as health and social care organisations need to ensure that each of these groups is fully involved in the design and implementation of any integrated care programme. We must also consult the service users themselves to ensure we are meeting their needs as we intended.

Our responsibilities to the public also mean that we have to consider the financial implications of integrated care delivery. Each programme should be supported by a robust business case and have mechanisms in place to assess its financial outcomes as the programme progresses.

Providing the best care for Joe should be encouraged and rewarded by both the PCT and the LAs. We need to work together to make sure that Joe does not 'slip through the net', and continue to improve our services for individuals who require both health and social care support.

So what needs to change?

To do the best for Joe, all local resources, both health and social care, must work together to identify issues early, provide timely and effective service, and allow Joe to make choices for himself.

Over the last 3 months PCTs and LAs, supported by ADASS, the SHA and CSIP, have researched local, national and international examples of best practice at the interface between health and social care. They have identified potential initiatives and tested three of these in pilots across the South West, bringing together staff from healthcare, social care and the voluntary sector.

In Bath and North East Somerset the focus was on early identification of dementia and support for those affected. In Devon a new approach was taken to commissioning rapid responses services to optimise individuals independence by preventing acute admissions. In Torbay the focus was on how health and social care can work together to ensure timely, safe and effective discharges to the home where possible.

In each of these robust business cases and metrics were developed to allow PCTs and LAs to measure the impact of these initiatives.

Key features of a collaborative approach may include:

- A single point of access
- An integrated assessment and case management for potential high-intensity users
- A system for early identification of key conditions such as dementia and falls, sharing information between the NHS, social services, providers and the community
- A step up and step down support mechanism (e.g., a joint rapid response team, like the one described above)
- A coordinated discharge process to ensure people like Joe are discharged from hospital in a timely way, and to their own home if possible.

How will we make this change happen?
PCTs and LAs have the opportunity to help make the South West the best region in England for Joe by working together to commission seamless services.

The proposed approach to integrating care has 5 components: setting goals, diagnosing ways to improve, delivering change, monitoring progress and providing support.

1. Setting goals

PCTs and LAs may work to develop a series of local goals for service quality and outcomes. For example, in one region, the PCT and LA might commit to reducing avoidable hospital admissions by 30% over 3 years.

2. Diagnosing ways to improve

Individual PCTs and LAs may work together to understand their current organisational capabilities and set individual targets for improvement, making use of the competencies framework found on page 14.

3. Delivering change

PCTs and LAs are encouraged to work together to implement the changes necessary to achieve their goals relating to the commissioning of integrated care.

4. Monitoring progress

PCTs and LAs can decide to regularly monitor their progress against their stated goals.

5. Providing support

To accelerate the integration, a regional integration board will be established from representatives of both PCTs and LAs to support local joint commissioning through knowledge sharing and providing direct support to partnerships that are facing particular difficulties.

What are the next steps for PCTs and LAs?

The development of the Golden Rules creates the opportunity for PCTs and LAs to meet and diagnose their current capabilities for commissioning integrated care with the help of the self-assessment tool. This could lead to an agreement about a set of local priorities for improving the interface between health and social care, which could form the basis for a development plan and a roadmap for delivering improvements to local communities.

The regional government office for social care, ADASS and the SHA will support this process by providing PCTs and LAs with a toolkit for integrating care. This toolkit has three elements:

1. The self-assessment tool found at the back of this booklet to understand local current competencies in commissioning integrated care
2. "How-to" guides for commissioning the work started in the pilots should these prove to be local priority areas, e.g.,
   - Identification and support for people with early-stage dementia
   - Joint rapid response services to address acute health or social care needs and keep people out of hospital, nursing or residential care
   - A co-ordinated discharge process to ensure timely discharge to the home wherever possible
3. Benchmarking data across health and social care metrics to understand local gaps

part 02

The “10 Golden Rules” for commissioning integrated care

To help you carry out your self-assessment and support your development, we have developed the “10 Golden Rules” for commissioning integrated care.

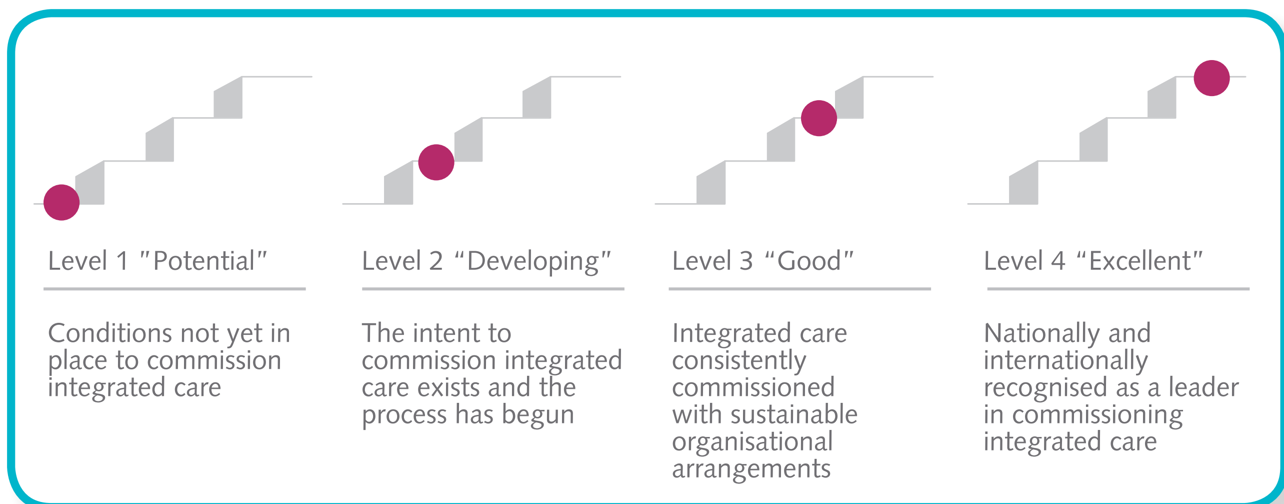
Where did the “10 Golden Rules” come from? Throughout spring 2008, PCTs and LAs, supported by ADASS, the SHA and CSIP studied local, national and international best practice to understand the key enablers, or Golden Rules, of integrated commissioning.

The NHS is striving to improve its commissioning abilities through World Class Commissioning. The Golden Rules for commissioning integrated care are aligned with the World Class Commissioning competencies. To learn more about World Class Commissioning please go to: www.dh.gov.uk/worldclasscommissioning

The Golden Rules form the basis of the self-assessment tool which describes 4 levels of competency against each of the “10 Golden Rules”. The Golden Rules and the competency levels are described in detail on the following pages.

	Integrated care competency indicators - the 10 Golden Rules
1	**Demonstrate joint leadership:** Agree a common vision and goals between the NHS, local authorities and other partners
2	**Develop strong partnerships:** Demonstrate a commitment to partnership working by promoting integrated care
3	**Learn from service users and carers:** Actively engage users of both health and social care to understand how the systems interface and develop integrated services
4	**Involve all staff:** Involve multi-disciplinary frontline staff from both health and social care in the design and the management of integrated services
5	**Share knowledge and data:** Generate insights from bringing together health and social care data and predict future needs based on collaborative analysis
6	**Produce robust business cases:** Conduct thorough analysis of costs and benefits of integrated care to both health and social care systems before investing in joint initiatives
7	**Stimulate the market:** Signal the importance of integration and work with high-quality providers to ensure seamless integrated care from the user's perspective
8	**Promote innovation in integration:** Research national and international best practice examples of integrated services and encourage the adoption of relevant innovations
9	**Foster talent:** Develop an understanding of the skills and capabilities required for integrated commissioning and manage talent appropriately
10	**Manage performance of joint services:** Ensure there is a single point of accountability for the performance management of jointly commissioned services

the four levels of competency in commissioning integrated care



COMPETENCY 1
DEMONSTRATE JOINT LEADERSHIP

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	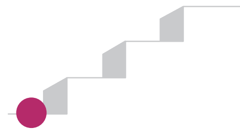	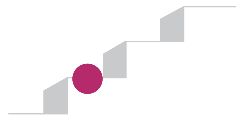	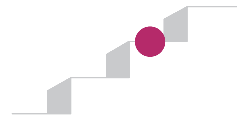	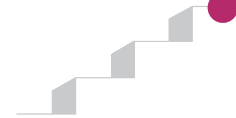
Agree a common vision and goals between the NHS, local authorities and other partners	• Does not meet Level 2 requirements	• PCT and LA proactively work together to drive change (e.g. through joint strategic needs assessment and LAA) • PCT and LA have agreed priorities and set goals for delivering a joint vision • Health and social care staff and key stakeholders are aware of the vision for integrated commissioning and care delivery	• PCT and LA have developed a shared vision for integrated commissioning and care delivery and have full agreement from the PCT board and the LA cabinet • PCT and LA have agreed priorities, have set goals for delivering this vision, and are consistently achieving these goals • Staff identify PCT chief executive and LA DASS as leaders regarding integration	• PCT and LA have developed a shared vision for integrated commissioning and care delivery and have established governance and financial arrangement to sustain the commitments • PCT and LA revisit and refresh goals annually, and set higher aspirations each year for the delivery of integrated health and social care and these goals are consistently met • National peers recognise PCT chief executive and LA DASS as leaders on integration

COMPETENCY 2

DEVELOP STRONG PARTNERSHIPS

Demonstrate a commitment to partnership working by promoting integrated care

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	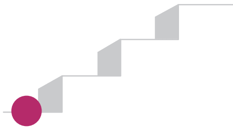	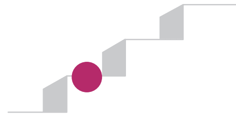	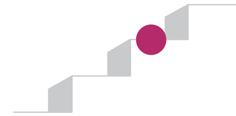	
Demonstrate a commitment to partnership working by promoting integrated care	• Does not meet Level 2 requirements	• PCT and LA proactively work together to drive change (e.g. through joint strategic needs assessment and LAA) • PCT and LA acknowledge each others' history and their cultural differences and are actively working to overcome these • PCT and LA have developed shared posts where appropriate	• PCT chief executive and LA DASS meet regularly (e.g. monthly) to discuss strategic and tactical aspects of partnership • PCT and LA leadership promote partnership working at all levels of the organisations • PCT and LA have a track record of surfacing and solving difficult issues	• PCT chief executive and LA DASS meet regularly (e.g. monthly) to discuss strategic and tactical aspects of partnership and have created forums for management to come together • PCT and LA work effectively together with other partners e.g. from third sector or from private sector where appropriate • Staff at all levels and service users agree that PCT and LA form strong partnerships for ensuring the delivery of integrated care • PCT and LA are nationally recognised for their development of effective partnerships for integrated care

COMPETENCY 3

LEARN FROM SERVICE USERS AND CARERS

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	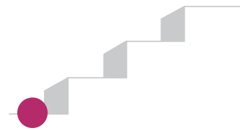	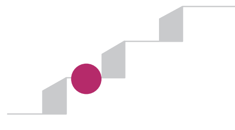	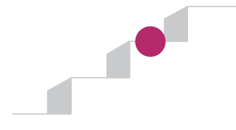	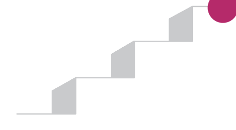
Actively engage users of both health and social care to understand how the systems interface and develop integrated services	• Does not meet Level 2 requirements	• PCT and LA regularly listen actively to users to understand their perspective and the difficulties at the interface of health and social care • Users and carers agree that the PCT and LA listen to their views and act in their interest • Users and carers are involved in the development and commissioning of integrated care	• PCT and LA have joint tools and infrastructure in place to listen to the experiences of users and carers regularly and understand the difficulties at the interface of health and social care • Users and carers strongly agree that the PCT and LA listen to their views and act in their interest	• Joint user feedback culture is so strongly embedded in PCT and LA culture that staff continuously seek out user and carer input on the interface of health and social care together and improve the commissioning of services as a result • PCT and LA are internationally recognised for their commitment to generating user and carer insights

COMPETENCY 4

INVOLVE ALL STAFF

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	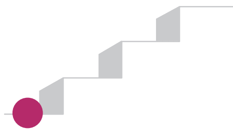	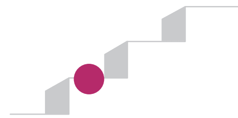	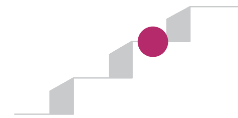	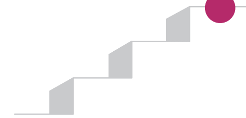
Involve multi-disciplinary frontline staff from both health and social care in the design and the management of integrated services	• Does not meet Level 2 requirements	• PCT and LA bring together multi-disciplinary groups of professionals to agree design of integrated services and solve problems • Staff from multi-disciplinary backgrounds agree that their views have been incorporated into service specifications • PCT and LA jointly communicate broad changes as well as specific initiatives to health and social care staff	• PCT and LA bring together multi-disciplinary groups of professionals to actively contribute to the design of integrated services (e.g. create opportunities for different professions to be involved in planning) • PCT and LA have a track record of surfacing and solving difficult issues between staff members from different professions	• PCT and LA actively and regularly shape a collaborative culture between all service providers (e.g., encourage problem-solving and experience sharing between different professions) • Staff agree that there is a culture of mutual respect between health and social care professionals

COMPETENCY 5

SHARE KNOWLEDGE AND DATA

Generate insights from bringing together health and social care data and predict future needs based on collaborative analysis

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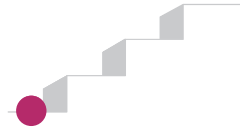	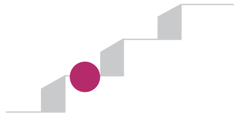	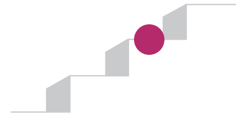	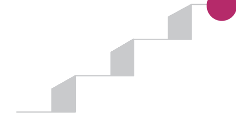
• Does not meet Level 2 requirements	• PCT and LA bring together in a systematic way their independent benchmarks, analytics, and understanding of trends/needs to generate insights for integrated care • Health and social care staff are aware of how to access and share information with staff from other professions	• PCT and LA meet regularly (e.g. monthly) to bring together in a systematic way their independent benchmarks, analytics, and understanding of trends/needs to generate insights for integrated care • PCT and LA staff actively work together to develop approaches to improving the access and sharing of information in order to best meet the needs of patients and service users	• PCT and LA meet regularly (e.g. monthly) to bring together in a systematic way their independent benchmarks, analytics, and understanding of trends/needs to generate insights for integrated care and relevant insights are communicated to appropriate staff groups for their feedback • PCT and LA are constantly improving their data set to include external data sources e.g. national and international data, data from the third sector • PCT and LA staff work from fully compatible systems, enabling them to best meet the needs of patients and service users

COMPETENCY 6

PRODUCE ROBUST BUSINESS CASES

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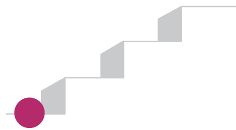
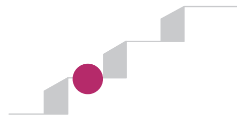
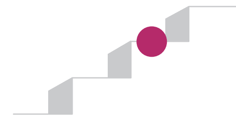
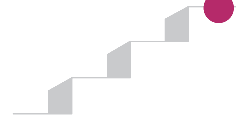
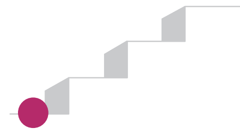
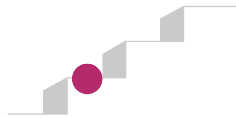
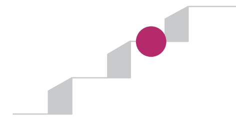
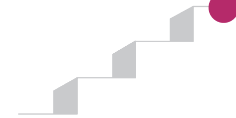
				
Conduct thorough analysis of costs and benefits to both health and social care systems (develop a business case) before investing in joint initiatives	• Does not meet Level 2 requirements	• PCT and LA develop an understanding of costs and benefits of integrated services independently	• PCT and LA collaborate to establish costs and benefits of their integrated care services to both the health and social services systems • PCT and LA have allocated the cost of integrated care services in line with the financial benefits received from each programme	• PCT and LA collaborate to establish the costs and benefits of their integrated care services to both the health and social services systems and receive external challenge on these models e.g. from localities nationally recognised for best practice • PCT and LA have allocated the cost of integrated care services in line with the financial benefits received from each programme and have made a sustainable long term commitment to commission programmes beyond a single budget cycle (if milestones are met)

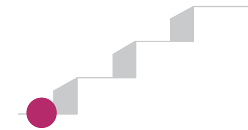
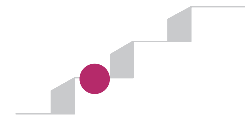
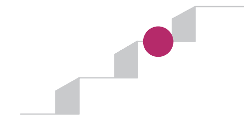
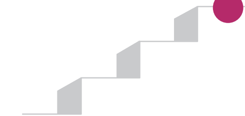
COMPETENCY 7

STIMULATE THE MARKET

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
				
Signal the importance of integration and work with high-quality providers to ensure seamless integrated care from the user's perspective	• Does not meet Level 2 requirements	• PCT and LA have jointly developed commissioning specifications which stress the importance of integrated care provision • PCT and LA understand which providers are considered national innovators	• PCT and LA have jointly developed commissioning specifications which require provision of integrated care including patient choice where applicable • PCT and LA discuss integrated care with providers who are considered national innovators • PCT and LA commission services from providers who can demonstrate a track record of integrated care provision • The local market involves healthy competition between providers of integrated care • Joint commissioning specifications lead to better contracts, e.g. through economies of scale	• PCT and LA have jointly developed commissioning specifications which require provision of integrated care including patient choice where applicable and which are flexible to change based on user and carer feedback • PCT and LA learn from nationally innovative providers and use this knowledge to shape the local market • PCT and LA commission services from high quality providers who can demonstrate a track record of integrated care provision • The local market involves healthy competition between providers of integrated care and is considered to be an attractive market for new entrants

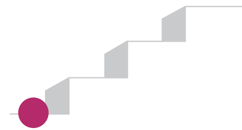
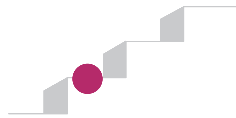
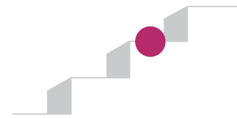
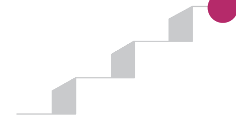
COMPETENCY 8

PROMOTE INNOVATION IN INTEGRATION

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
				
Research national and international best practice examples of integrated services and encourage the adoption of relevant innovations	• Does not meet Level 2 requirements	• PCT and LA consider international, national and local examples of innovation in integrated care which demonstrate clear user benefits • PCT and LA are trying to implement the innovative approaches which are relevant to their locality	• PCT and LA proactively research international, national and local examples of innovation in integrated care which demonstrate clear user benefits • PCT and LA have implemented these best practices and have seen a measurable improvement in their services as a result, including the development of some of their own national best practice examples	• PCT and LA proactively research international, national and local examples of innovation in integrated care and annually share learnings with these innovators • PCT and LA have implemented these best practices and have seen a measurable improvement in their services resulting in national and international recognition as a hub of innovation in integrated care

COMPETENCY 9

FOSTER TALENT

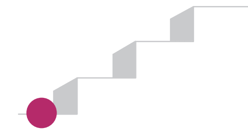
	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
				
Develop an understanding of the skills and capabilities required for integrated commissioning and manage talent appropriately	• Does not meet Level 2 requirements	• PCT and LA joint commissioners have a good understanding of health and social care needs and health, social and third sector providers in the market • PCT and LA are aware of the required skills and capabilities of integrated care commissioning staff • Staff are recruited from a diversity of backgrounds based on individual merit	• PCT and LA joint commissioners have a thorough understanding of health and social care needs and health, social and third sector providers in the market • Senior management are actively involved in ensuring that commissioning staff receive high quality training on the skills needed to commission integrated care • Personal development plans recognise the importance of commissioning integrated care	• PCT and LA joint commissioners have a thorough understanding of health and social care needs and health, social and third sector providers in the market and act on it • PCT and LA are able to attract the top global talent who demonstrate an appropriate mindset regarding the commissioning of integrated care • Personal development plans are built on the importance of commissioning integrated care • Staff from this locality are actively recruited by other PCTs or LAs wishing to improve their integrated care commissioning

COMPETENCY 10

MANAGE PERFORMANCE OF JOINT SERVICES

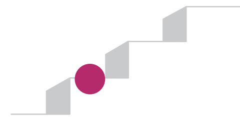
Ensure there is a single point of accountability for the performance management of jointly commissioned services

LEVEL 1



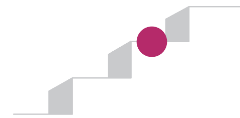
- Does not meet Level 2 requirements

LEVEL 2



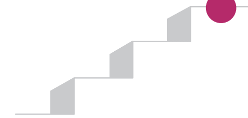
- PCT and LA assign an individual as the single point of commissioning accountability for the performance management of each integrated service
- Providers are assessed on a single set of key performance indicators across health and social care

LEVEL 3



- PCT and LA assign an individual as the single point of commissioning accountability for each integrated service who is empowered to provide performance incentives and to enforce contracts in order to do the best thing for service users
- Providers are assessed on a single set of annually reviewed key performance indicators across health and social care
- Feedback from users and carers demonstrates that they have a single interface when excessing services

LEVEL 4



- PCT and LA assign an individual as the single point of commissioning accountability for each integrated service who is empowered to provide performance incentives and to enforce contracts in order to do the best thing for service users - which has resulted in a continuous improvement culture becoming embedded integrated care providers
- Providers are assessed on a single set of annually reviewed key performance indicators across health and social care which have been challenged by nationally recognised commissioners of best practice

■ "Where we are"

■ "Where we would like to be"

"10 Golden Rules" scorecard

		Level 1	Level 2	Level 3	Level 4
1	Demonstrate joint leadership	○	○	○	○
2	Develop strong partnerships	○	○	○	○
3	Learn from service users and carers	○	○	○	○
4	Involve all staff	○	○	○	○
5	Share knowledge and data	○	○	○	○
6	Produce robust business cases	○	○	○	○
7	Stimulate the market	○	○	○	○
8	Promote innovation in integration	○	○	○	○
9	Foster talent	○	○	○	○
10	Manage performance of joint services	○	○	○	○