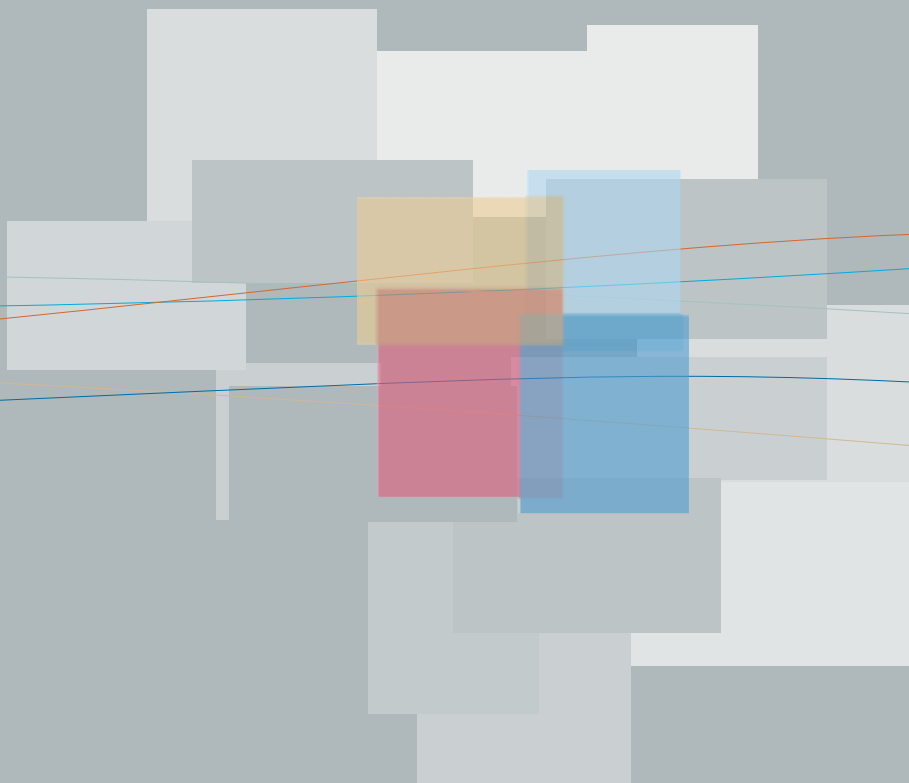


BRINGING THE NHS AND LOCAL GOVERNMENT TOGETHER

Integrated working: a guide



YOUR FEEDBACK

This guide seeks to examine key issues and signpost possible resources and routes for health and social care communities wishing to progress integration; it is not intended to be prescriptive or the final word.

The Integrated Care Network welcomes comments about the guide (feedback@integratedcarenetwork.gov.uk) to inform both the future development of this guide and the wider work of the Network.

If you wish, you can share examples of innovative integrated practice by uploading them to the Network's website:

www.integratedcarenetwork.gov.uk/additem.php

FURTHER COPIES

You can obtain electronic copies of this document from the Integrated Care Network's website: www.integratedcarenetwork.gov.uk

The homepage will point to the link.

Should you require hard copies of the guide, please email publications@integratedcarenetwork.gov.uk

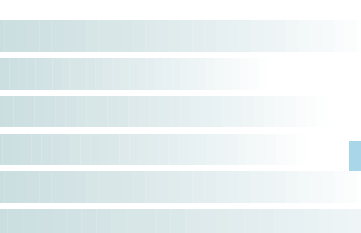
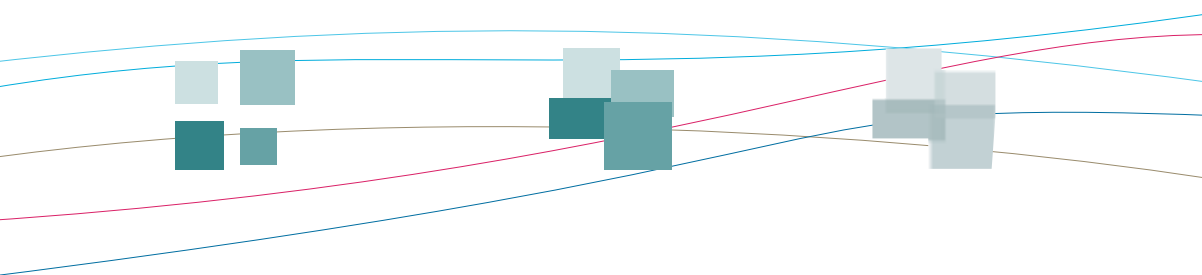
with details of :

- a contact name
- your organisation name and address
- your contact telephone number or email address.

Please note there is an order limit of 20 copies.

BRINGING THE NHS AND LOCAL GOVERNMENT TOGETHER

Integrated working: a guide



www.integratedcarenetwork.gov.uk



Acknowledgements

The contents of the guide were conceived and drafted by Peter Thistlethwaite, who is Honorary Fellow at Exeter University, editor of the Journal of Integrated Care (Pavilion, Brighton) and secretary of the Centre for Social Policy, Warren House Group at Dartington.
Contact: peter@whg.org.uk 01752 840752

Editing and design by DeMo, a communication design studio which is also part of the Warren House Group.
www.de-mo.org.uk www.whg.org.uk

Printed by Short Run Press, Exeter

First published June 2004 ©Integrated Care Network

We have twin girls aged five, both have a moderate learning disability. Jenny also has autism. We're totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we deal with on a regular basis:

GP, counselling nurse, speech and language therapist, occupational therapist, psychiatrist, psychologist, teacher, classroom assistant, ophthalmologist, audiologist and administrators to name but a few. We're so confused sometimes.

We don't understand the different roles and have so many appointments that clash.

Can nobody or no system sort it out?

Parents 'Olive and Peter'
quoted in *Developing a Model
for Integrated Primary,
Community and Continuing
Care in the Midland Health
Board*, Executive Summary,
June 2003
[www.mhb.ie/mhb/Publications/
IntegratedCareOneNetwork](http://www.mhb.ie/mhb/Publications/IntegratedCareOneNetwork)
ICON/

Foreword

Those of you who work in Local Government and the NHS provide a wealth of services to support and foster the well-being of the communities in which we live. In carrying out your work, you and your services regularly need to work across the Local Government and NHS interface in order to plan and deliver services that are effective in meeting the needs of your users, patients and carers.

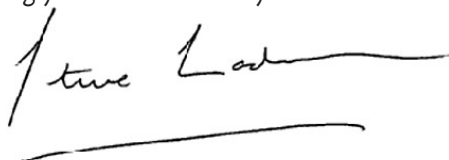
Experience tells us that working across this boundary can be challenging. Government has taken action to support Local Government and the NHS in meeting this challenge; the introduction of the Health Act Flexibilities, Care Trusts and Children's Trusts being just three examples of this support.

Another aspect of this support was the formation of the Integrated Care Network in 2002. Since its inception I know that the Network and its products – website, national meetings, briefing papers, action learning networks and now this guide – has become a key support to you in your work to provide effective and integrated services across the Local Government and NHS interface.

This guide describes in a concise and yet comprehensive manner the issues that face one when integrating service planning and delivery and signposts potential solutions and resources.

I am sure that you will find this guide invaluable.

Wishing you all success in your work.



Dr Steven Ladyman MP

Parliamentary Under Secretary of State for Community
Department of Health



Part One: Knowing more about integration

1	2	3	4
From fragmentation to integration: agreeing what integration means	From autonomy to integration: recognising where you stand	How evidence of what works can help	Understanding the potential benefits
P Defining integration and building a common language L	P The continuum of collaboration	P Research and integration	P Benefits from improved coordination
The transition to integration	The World Health Organisation (WHO) framework W	Bristol University review of joint working	Added value from integration L
Integration or better co-ordination?	Analysing patterns of collaboration	What helps: a checklist L W	ICN's five areas for development W L
Addressing complex, multiple or special needs		The use of 'partnership flexibilities'	Part One in summary
		Using flexibilities: the findings L	

Part Two: Making it happen

5

Planning and governing the whole system

P

Leadership and strategic support

The implications of a whole systems approach

Case studies [1](#) and [2](#)

Evaluating current [L](#) [R](#) patterns of collaboration

If things are not working out well...

Assessing your partnerships [W](#)

Section 5 in summary

6

Taking the lead through strategic partnerships

P

Clarifying local aspirations

Key questions of strategic partnerships: a checklist

Service governance arrangements

Seizing opportunities for change [R](#)

Case studies [3](#) [4](#) and [5](#)

Using the partnership flexibilities [R](#)

Section 6 in summary

7

Implementing the strategy and planning specific services

P

Towards integrated leadership [R](#)

Project plans [L](#) [W](#)

Project planning: The Department of Health checklist

Organisational development and 'cultural' issues [W](#)

Monitoring and evaluation [W](#)

Variations on a theme

Improving access to services

Case studies [6](#) and [7](#) Partnerships

Case study [8](#) Setting up a Trust

Case study [9](#) Transferring staff employment

Section 7 in summary

8

Putting integrated care into practice

P

Creating the climate for integrated practice

The integrated practice environment [L](#)

Tools and protocols

Teamwork [L](#)

Case studies [10](#) and [11](#)

Four steps towards integrating care [R](#)

The Guide in summary

Contents

What the guide is for	6
How to use the guide	8
Part One: Knowing more about integration	11
1 From fragmentation to integration: agreeing what 'integration' means	12
2 From autonomy to integration: recognising where you stand	16
3 How evidence of what works can help	19
4 Understanding the potential benefits	24
Part One in summary	27
Part Two: Making it happen	29
5 Planning and governing the whole system	30
6 Taking the lead through strategic partnerships	38
7 Implementing the strategy and planning specific services	46
8 Putting integrated care into practice	58
The Guide in summary	68
The Integrated Care Network	70



What the guide is for

Integrating organisations and services is a daunting task and there is plenty of evidence that outcomes can be poor if services are delivered in a fragmented way to people who need access to care. With that in mind, Government has placed a duty of partnership on the main statutory bodies and integration remains a major aspect of its 'modernisation' plans for public services. The main purpose of this guide is to offer practical help to all those responsible for integrating services for children and for adults of all ages, but fundamental to the approach will be a search for greater clarity about how integration can directly benefit service users. The guide presents integration as a means to this end, and not as an end in itself. Another of its objectives is to try to give readers an awareness of the wider picture, where a range of organisations can work together to improve community well-being and population health.

Some form of integration is likely to have been attempted in every locality in one service or another: intermediate care for older people, for example, has received special funding, and youth offending teams are well established as part of a national strategy. There are pockets of innovation and highly developed practice in many parts of the country, and, in a smaller number of places, newly acquired powers have been used to establish Care Trusts and to pilot Children's Trusts. **Integration can therefore be contemplated at the level of organisation, service or professional team, and can be initiated on grand or small scales.**

Given this complex pattern of local development and opportunity, the guide provides a means of evaluating progress as well as offering assistance with the practicalities of integration. It also acknowledges the fact that wherever partnership is being advanced it involves asking what scale of integration may be needed to achieve local goals and to

satisfy national expectations. The guide does not advocate any particular endpoint, but it urges clarity about local intentions. Uncertainty is seen as likely to damage partnership working.

The guide should help you to gather a picture of where you stand locally with this important agenda, so that you can map out and sustain your own development process. It isn't a text book, but rather a carefully ordered combination of background information, practical guidance, case histories and references to policy and research all designed to improve understanding and to help public representatives, managers and practitioners to find their bearings. All the way through, the guide seeks to dispel any idea that a 'top-down' managerial approach to integration might ever be thought enough, and section 8 suggests steps to facilitate a 'bottom-up' approach. **Only by enabling all stakeholders to engage with one another will the benefits be felt by service users.**



How to use the guide

This is meant to be a short guide; it shouldn't take long to read it all. Some people in some jobs will need to go through it methodically from cover to cover; some of them may do so once and never need to look at it again. Rather like a city guide, it should show those readers where they are and how to get to where they want to be, and then suggest what form the journey might take. Others will pick from it what they need at any point, referring back to it periodically for new ideas or to check things out.

There is no single path to follow. In some services frontline practice may actually be ahead of official local policy and strategy. Different ways of dealing with the combination of permissive legislation, government policy guidance, and messages from local and national research will continue to lead to wide local variation. Please be aware then that the guide will encourage you to work with the grain of local conditions, recognising that integration is bound to be an idiosyncratic process. Providing stimulus and ideas, the guide supports local choices about integration: there is no prescription.

L Integration means that organisations will change together. A shared process of organisational development (OD) is seen to be at the heart of successful integration. It is likely to be helpful to involve all the stakeholders in the process from the time integration is first being thought about. It will help to identify the tasks and learning needs to be addressed in the final OD programme

You will be encouraged to think about a continuum of co-operation, with integration at one extreme, and you will be helped to identify the most appropriate position on that continuum for your service or locality. You will need to be ready to promote communication across and between organisations, to make plans in response to local needs and, in the best sense of the word, to improvise. Also important is the need to support collective learning and development – hence the learning together **L** elements included throughout. Your task can be seen as helping integrated care to emerge from existing local practice and systems by engaging practitioners and users in the development process from the start.

The guide is presented in two parts, each with four sections. The sections are identified and mapped out so that they can be consulted as and when they seem to be most relevant, but the whole of **Part One: Knowing more about integration** should be read by everyone because it is the foundation for all that follows. Its main purpose is to help build critical capacity about integration, sharpening debate and so informing subsequent decisions. **Part Two: Making it happen** aims to move local thinking beyond the small scale integrated project to considering how integration in mainstream services can be approached simultaneously at several different organisational levels. It starts by reflecting on the importance of **whole system thinking**, and then, while urging a shared understanding of user needs, deals in turn with the **strategic, operational** and **practice levels**. Most emphasis is placed on how questions of vision, trust, culture, learning etc. can be woven into any change process – structural solutions are regarded as having limited potential. Aspects of Part Two will inevitably be familiar to many involved in one or other aspect of integration, but there will always be new issues to address and the guide should give readers confidence that answers can be found.

For those who would like to work in more detail on any particular aspect of the guide, the web version includes downloadable exercises to help with self-assessment. It also includes a form for recording your conclusions from each section so that they can be carried forward, reviewed and turned into action points. The simplest way to access other sources of information about integration is to use the ICN website. Apart from providing up-to-date news, there are sections on policy, research, organisational development, governance, performance and evaluation, and inclusion. A number of key references are given in the margins of the guide.

‘LAWS’ OF INTEGRATION?

There will be regular references to the work of Walter Leutz, an American academic who studied integrated care in the USA and Britain, comparing underpinning concepts and developments. In presenting his findings he has proposed five ‘laws’ of integration. They are not truly scientific laws, but, like a Japanese haiku, they provide a lot of meaning in a few words – rather entertainingly, too.

Leutz, W (1999) *Five laws for integrating medical and social services: lessons from the US and UK*. *Milbank Quarterly*. 77(1): 77-110



Part One

Knowing more about integration

Part One aims to develop the critical capacity necessary for making good decisions about local integration, based on an understanding of which users will benefit and how services will improve.

Firstly, it challenges preconceptions about integration and clarifies the basic concepts and vocabulary. It then asks localities to consider where their current policies, practices and services might fit on a continuum of collaboration, and introduces some important messages from research. All this is designed to highlight where progress might be needed, to identify likely obstacles and to determine what might help.

1 From fragmentation to integration: agreeing what 'integration' means

P *The fragmentation of services between and within organisations, and between different professions is a key obstacle to effective care. A simpler, more user-friendly system is wanted, with a single point of access wherever possible and greater continuity: integration is seen as the means to this end. Consequently, the NHS Plan called in 2000 for 'a radical redesign of the whole care system'; more recently, the Green Paper Every Child Matters stated that 'the Government's long term vision is to integrate key services within a single organisational focus'. Integration is regarded as the remedy for fragmentation.*

Defining integration and building a common language

This section tries to bring some clarity to the use of language so that an understanding of key concepts can be shared by all the partners in the process. Without it, there is an obvious danger that effective communication and collaboration will be undermined, no matter how good the policies and systems. Even the word 'integration' needs to be handled with caution, because different professionals habitually use it in different ways, and it is likely, too, that the same people may come to use it differently over time. Don't be afraid to challenge colleagues about what they mean by integration: openness will help. To arrive at a 'common language' would be an significant achievement.

We will follow our own advice and try to be clear right from the start. In its completest form integration refers to **a single system of service planning and/or provision put in place and managed together by partners** (parent bodies) who nevertheless remain legally independent. A single system for a particular service would for example unite mission, culture, management, budgets, accommodation, administration and records, and would apply at any level of integration (team, service or organisation). This is absolutely differentiated from an approach which aims to **co-ordinate** separate systems.

This concept will be useful in the project planning process commended in Part Two.



A partnership is needed to create an integrated system; but a partnership is not the same as integration. Partners are not tied to a partnership for ever; it can be varied or ended by agreement. This applies even to a Care Trust – which is a local choice and not a statutory requirement like a Primary Care Trust or a Social Services Department.

Inconsistency in the use of terms can also belie some of the cultural obstacles likely to be encountered as organisations and services try to become more integrated. To keep things simple, the guide uses the generic term **service user** but we know that it will not find favour everywhere. It also relies on the word **care** acknowledging that while it works well across health and social services, it is less appropriate in the sphere of education, which is going to play an increasingly central role in the development of integrated children's services.

The transition to integration

Government aims to eliminate the problems attributable to the fragmentation of services among professions and organisations by encouraging the creation of single organisational or service entities. By that reckoning, the necessary transition might be described as a journey from **fragmentation** to **integration**.

To drive the necessary change Government is depending on the combined energy of partnerships between what are fundamentally independent bodies. Establishing partnerships will naturally have the side effect of curtailing to varying extents the freedom of action of the individual partners. Another necessary shift therefore can be represented in a transition from **autonomy** towards **integration**.

L Are there any words you opt to use or avoid for any reason? Can this partiality be observed in other people's usage? For example, is there a difference between 'partnership' and 'integration' which affects how you or your colleagues use the terms? Are you more comfortable with a neutral word like 'collaboration'? Does government advocacy of the benefits of integration inspire mixed emotions: at one moment enthusiasm for putting the service user at the heart of things, at another anxiety about a threatened loss of independence? This guide advocates bringing these issues to the fore, and urges you to try to use the vocabulary of collaboration more carefully to help shared meanings to emerge. Confused definitions will complicate things and hold you back. You should also help create the climate for integration in your locality by encouraging staff involved in joint working to think these questions through together.

FRAGMENTATION

The fragmentation of services between and within organisations, and between different professions is seen by Government as a key obstacle to effective care.



PARTNERSHIP

Partnerships have been the main means of dealing with fragmentation so far.



INTEGRATION

The integration of organisations or services into single entities is a further development which allows potential for greater transparency between partners and enhanced benefits for service users.





Integration or better co-ordination?

It is acknowledged that better co-ordination, while not the same as integration, can also result in gains for service users. In fact, it has palpable merits:

- it can deliver many, if not most, of the benefits to users of an integrated system
- it can be a positive, facilitating step towards an integrated system.

Indeed, a co-ordinated approach, in which service delivery staff form an informal co-operative network to meet user needs, or use integrated care pathways to structure their work, has undeniable advantages as a means of overcoming fragmentation. It is also visible in the alignment of policy making, commissioning, training and similar management activities. The question is whether co-ordination is possible to sustain and optimise over time. So, one of the key strategic decisions which localities will later be encouraged to face concerns the extent to which any single integrated system is likely to be more suitable than the co-ordination of existing separate activities. In this context, the decision to proceed as far as integration may have as many symbolic benefits as practical ones.

An integrated system might be said to demonstrate minimal fragmentation between providers and minimised autonomous action by their people, but there are many other possibilities, incorporating sustainable degrees of autonomy and tolerable fragmentation. The guide acknowledges the necessary breadth of this spectrum and tries to set it in the context of varying local needs and conditions.

Addressing complex, multiple or special needs

Messages from international research suggest that integration is most needed and works best when it focuses on a specifiable group of people with complex needs, and where the system is clear and readily understood by service users (and preferably designed with them as full partners). The converse of this is also important: the vast majority of people with non-complex needs will continue to be well served by their GP or school, acting more or less independently of other services. The degree of complexity of individual needs should determine the requirement and context for integration.

LEUTZ'S FIRST LAW

You can integrate some of the services all of the time, all of the services some of the time, but you can't integrate all of the services all of the time.

This is a strong research message about the need to target (expensive) integrated approaches on people with complex needs – he argues that it would be hopelessly inefficient not to discriminate in this way.

AUTONOMY

There is no holistic view of user needs; actions and decisions are arrived at independently and without co-ordination.



CO-ORDINATION


There is a shared view of user needs: actions and decision making are co-ordinated.



INTEGRATION

Fragmentation between providers and autonomous action are minimised. Working practices become transparent. Integration is of greatest benefit to those with complex needs.





2 From autonomy to integration: recognising where you stand

P *'Person-centred care needs to be supported by services that are organised to meet needs. The NHS and councils should deploy the 1999 Health Act Flexibilities to ensure an integrated approach to service provision, such that they are person-centred, regardless of professional or organisational boundaries.'* National Service Framework for Older People.

'Weak accountability and poor integration' are cited in Every Child Matters as aspects of the underlying problem: 'Our systems for supporting children and young people who are beginning to experience difficulties are often poorly co-ordinated and accountability is unclear. This means that information is not shared between agencies so that warning signs are not acted upon. Some children are assessed many times by different agencies and despite this may get no services. Children may experience a range of professionals involved in their lives but little continuity and consistency of support.'

The continuum of collaboration

It may be helpful to think of a continuum of organisational and professional relationships passing from **autonomy**, through **co-ordination** towards **integration**. When it comes to dealing with people with complex care needs, it is firmly part of UK policy and culture that professions and organisations should not act autonomously, so communication and mutual understanding are minimum requirements (Leutz calls this process 'linkage', a step before co-ordination or integration). But even in the high profile world of child protection, communication failure occurs, highlighting the fragility of the co-ordinated approach and the inherent dangers of fragmentation. Government has not surprisingly concluded that a more integrated set of local arrangements might, for example, reduce the risk of a repetition of the events underlying the Victoria Climbié tragedy. Nothing should be taken for granted: a review of current practice is an important preliminary to seeking better partnerships.

The guide maps out steps to more integrated care systems, knowing that, wherever integration is being contemplated, services will almost certainly have evolved towards it at

different rates, perhaps because of the existence of a National Service Framework or the tenacity of a local champion. No preconceived outcome is advocated here because the solution will always need to be arrived at in the local context of what people consider best for those they serve. Clarity of vision and transparency of purpose in all localities and services are the key objectives.

The World Health Organisation (WHO) framework

The World Health Organisation framework considered next attempts to identify the features likely to be associated with integration, and to distinguish them from autonomous working or a co-ordinated approach. Developed by the Organisation's Regional Office for Europe, the authors state: 'Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency'. They tease out four main elements:

- **horizontal integration** relates to strategies linking similar levels of care (eg overcoming professional and departmental boundaries)
- **vertical integration** pertains to strategies linking different levels of care (eg primary, secondary, tertiary)
- **continuity of care** is understood to imply a user perspective, highlighting the patient's experience
- **integrated care** is a broader term encompassing, for example, technological, managerial and economic aspects of services.

LEUTZ'S THIRD LAW

Your integration is my fragmentation

This may well explain why many people resist new approaches. It suggests that as much attention needs to be given to what may be lost through integration as to what is likely to be gained.

A CONTINUUM OF PARTNERSHIP/CO-ORDINATION

A degree of co-operation between **autonomous** bodies – they have a relationship but there is no transparency or sense of coherence, nor shared point of contact with service users.



A **co-ordinated**, user-centred network, embodying some alignment of policy making, service commissioning and management and practice.



A transparent relationship between **integrated** bodies – the point of connection is a clear focus on the needs of users.





Find the framework in its original form at:
www.euro.who.int/document/ihb/Trendicrefconissue.pdf

W The framework is also available as a web-based exercise. It is intended for groups of people who might find themselves needing to work as a team in an integrated system of provision for service users with complex needs. For example, they might be primary health and social care staff responsible for undertaking common assessments, or be providing services to children with disabilities, or be treating older people with mental health problems. If they can be allowed time to learn together, it should help to create a more helpful climate.

	AUTONOMY	CO-ORDINATION	INTEGRATION
VISION OF SYSTEM	individual perception	shared commitment to improve system	common values, all accountable
NATURE OF PARTNERSHIP	own rules, occasional partnership	time limited or similar co-operative projects	formal mission statements, legislation
USE OF RESOURCES	to meet self determined objectives	to meet complementary objectives, mutual reinforcement	used according to common framework
DECISION MAKING	independent	consultative	authority delegated, single process
INFORMATION	used independently	circulates among partners	orients partners work towards agreed needs

Analysing patterns of collaboration

The WHO framework can help localities to map current approaches by looking for themes and patterns, rationales and directions, as well as by being precise in the use of words. You should consider where your locality or service might fit on the matrix. If you have a developed organisational structure like that of an NHS Partnership Trust, is it genuinely meeting the standard for integration suggested? If there are partnership agreements, can elements highlight particular strengths and weaknesses? If you are a 'late adopter' what immediate goals are suggested? Try to take a broad view at this stage, considering the picture across a range of services or groups. Don't worry about generalising: you tackle the detail later.

3 How evidence of what works can help

www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/fs/en

P *Government has been actively promoting evidence-based policy and practice for over a decade. The challenge for local implementers is implicit in the following quotation from Aims and objectives - health and social care research in the Department of Health:*

The Department needs research and development to ensure that:

- *policy for health, health care and social care is based on reliable evidence of needs and of what works best to meet those needs*
- *improved interventions are developed to promote health, treat ill-health and provide social care*
- *information is available to those responsible for health and social care services on what works and what does not, and on known ways of improving quality, access and efficiency.'*

W There are references to research studies throughout the guide; more sources are to be found at:
www.integratedcarenetwork.gov.uk/themes/research.php.

Research and integration

Messages from research have a place in the guide for the light they can shed on the underlying complexities of local circumstances. They are not put forward because they are thought to have universal applicability. The methodology of most current studies is too limited to produce solid findings for general commendation; and what might be useful in one place may be inappropriate in another.

There are also many things other than research evidence to consider when deciding how to improve services: for example, resources, legislation, timescales, public opinion and professional experience must all be taken into account. Decision making about integration can nevertheless be usefully informed by research; it would be negligent not to look for and apply relevant knowledge alongside the other factors.

**LEUTZ'S FOURTH LAW**

You can't integrate a square peg and a round hole.

A timely reminder that certain things may remain permanent challenges, eg charging for social care when health care is free at the point of delivery. Such matters have to be carefully managed in practice.

Cameron, A, Lart, R, Harrison, L, Macdonald, G, and Smith, R (2000) *Factors promoting and obstacles hindering joint working: a systematic review*. Bristol: Policy Press

Most researchers in the field would agree that certain messages about joint working are both reliable and enduring and, if heeded, can help people to understand local issues better and to avoid some pitfalls. The two studies selected here provide a simple introduction, but remember – we give the headlines only; they are not meant to be comprehensive summaries.

The Bristol University review of joint working

The findings opposite are derived from a systematic review of the literature on joint working undertaken between 1983 and 2000 by Ailsa Cameron and her colleagues in the School for Policy Studies at Bristol University. A careful methodology was used to ensure that conclusions were drawn only from well-constructed studies. The review revealed four main patterns of joint working: strategic, ie joint planning, joint commissioning; multi-agency teams (notably in mental health); care management; and placement schemes (mainly link workers in primary care). It then analysed the issues into three categories: organisational, cultural and professional, and contextual. In their conclusion, the authors remarked that over the years the same problems kept coming up, indicating that there had been a failure to learn from research.

On the next page, the findings of the review are translated into a series of statements which might be said to be associated with successful joint working. Take time to consider how each of the research messages might bear on your locality's or your service's approach to integration. The idea is to pinpoint strengths to build upon, and risks to attend to.

- 1 **The political climate is favourable.**
Is there a shared vision at Board/ Cabinet level and a history of collaboration? Problems here can easily undermine progress elsewhere.
- 2 **Friction between councils, NHS bodies, general practice, independent sector is being minimised.**
Differences in cultures, processes and basic goals should be accepted but not ignored. Anticipate difficulties and plan organisational development programmes accordingly.
- 3 **Senior managers and professional leaders are supportive.**
It is harder to overcome barriers in the absence of good leadership or links between planning processes.
- 4 **Overall objectives are clear and realistic.**
The risk of failure is greater where objectives are unclear or over-ambitious.
- 5 **Resources, including staff skills and time, are adequate to the task.**
Uncertainties concerning funding will jeopardise progress and make staff feel insecure.
- 6 **The negative impact of continuous change is being minimised.**
It cannot always be avoided, but organisational instability can undermine relationships, team work, concentration, and planning. Attention to organisational development will minimise the problem.
- 7 **The clash of professional philosophies and language and the risk of professional tribalism are being minimised.**
Divided loyalties and stereotyping are harmful. Try to establish a basis of shared values and collective trust from the start.
- 8 **The right people with the right skills are involved.**
Risks of failure will increase unless all stakeholders have a say, and leaders can emerge. Personality clashes need attention.
- 9 **Communication in and between teams and units is good at all levels.**
Communication failure has been shown to be at the heart of many problems.
- 10 **Staff have 'ownership' of the development.**
An obviously important consideration which managers and staff must actively sustain.
- 11 **The roles and responsibilities of staff are clear and understood.**
Uncertainty here is a common cause of failure in joint work: clear policies and procedures help.
- 12 **Management accountability is clearly delineated and professional support routines are in place.**
Multi-disciplinary teams are prone to problems in this area.
- 13 **Accommodation and IT are shared.**
Co-location of staff is strongly associated with successful joint working, but the absence of shared IT is a common failing.
- 14 **Joint training has been provided and team building is supported.**
Both can help overcome engrained misunderstandings, prejudices and other differences. They can be applied to all levels of management, to non-executive directors, members, specialists and practitioners.
- 15 **Monitoring and evaluation strategies are built in.**
It is good practice to learn about the impact of your changes.

L These findings and those on page 23 have been included to increase general awareness among partners about some important factors which will need constant attention – many, especially the cultural ones, will not go away in the short or medium term. The subjective conclusions reached in reflecting on the research should serve you well in planning and action.

W There is an exercise based on the Bristol findings to download.



National Primary Care
Research and Development
Centre (NPCRDC) (2002)
National Evaluation of
Notifications for Use of the
Section 31 Partnership
Flexibilities in the Health Act
1999. For the final Project
Report, see
www.npcrdc.man.ac.uk/PublicationDetail.cfm?ID=79

The use of ‘partnership flexibilities’

In 1999, Government introduced the Health Act which sought to promote collaborative working by removing legal and other barriers, and by explicitly encouraging **lead commissioning**, **integrated service provision** and **pooled budgets**. Early use of these new ‘flexibilities’ was evaluated by researchers at Manchester and Leeds Universities, who identified issues that help or hinder partnership development. The findings have much in common with those in the Bristol Review.

The table on the next page lists the more tangible benefits identified in the study, but the researchers pointed to other ‘intangibles’, for example, the removal of ‘hiding places’ and the replacement of ‘silos’ by ‘whole system’ thinking. These messages are relevant to any form of partnership working, not merely those formalised under the Health Act.

The researchers acknowledged that implementation had not always been easy and that barriers to partnership persisted, not least the different financial planning and performance management systems for the NHS and local government. They also counselled against barriers ‘rooted in cautious local relationships’.

What were partners trying to achieve?

- improved efficiency
- seamless, more flexible patterns of service
- equitable redistribution of services across a locality
- enhanced experience on the part of service users.

The methods used

- integrating existing services (eg co-location of staff, community equipment services)
- developing new services
- re-prioritising/refocusing existing services (for example, by diverting resources from hospital or residential care to community services).

What helped?

- high and broadly equal levels of commitment
- local organisational stability (eg coterminous boundaries)
- ‘dense’ networks of people
- perceived financial equity among partners
- senior managers with vision, skills and time to develop the partnership.

What took the time?

- legal frameworks spelling out respective responsibilities, especially in order to safeguard financial commitments and manage risks (being careful to deepen trust, not displace it)
- finance – disaggregating mainstream budgets and deciding a fair basis for contributing to a pooled budget
- human resources – joint training and secondments (more rarely the transfer of staff)

- IT – resolving widespread system incompatibilities to deal with matters of confidentiality and professional access
- sectoral differences - harmonising financial planning cycles, audit systems and performance management between NHS and local authorities.

What were the benefits?

- thinking governed less by blame and more by shared vision
- better commissioning processes, greater readiness to engage users and carers
- transparency necessary for setting up a pooled budget also contributed to the pattern of strategic development and was visible in:
 - simplified lead commissioning
 - improved community equipment services
 - increased opportunities for investment and external grant funding
 - sharing buildings
 - innovative service packages
- synergy and added value, eg improving ‘Cinderella’ services, staff morale, communications
- new legal and financial arrangements geared towards partnerships, signifying a shift from margin to mainstream.

L Thinking about these questions will help managers and clinicians/practitioners to appraise thinking about integration in a new light. It is also an important bridge between the worlds of management and of frontline service delivery. Conclusions should therefore be published widely in the locality or service.

4 Understanding the potential benefits

P *The White Paper Valuing People: A New Strategy for Learning Disability for the 21st Century published in March 2001 – the first White Paper on learning disability for thirty years – sets out an ambitious programme of action based on four key principles: civil rights, independence, choice and inclusion. It takes a life-long perspective, beginning with an integrated approach to services for disabled children and their families and then providing new opportunities for a full and purposeful adult life. It has cross-party backing and its proposals are intended to result in improvements in education, social services, health, employment, housing and support for people with learning disabilities and their families and carers.*

Benefits from improved co-ordination

The many exhortations from government, user groups and professional staff to provide more integrated services will not count for much when it comes to motivating people to change their established working routines, unless a clear message can be given about the intended benefits.

Among the general findings to emerge from evaluations and similar studies and reports is an indication that a more co-ordinated approach may benefit users by:

- improving the speed of response to identified needs
- simplifying the decision-making processes by involving fewer people
- ensuring better use of resources
- reducing communication failure
- increasing satisfaction with services.

LEUTZ'S FIFTH LAW

S/he who integrates calls the tune.

This looks like a comment on relative organisational and professional power. However, Leutz principally argues that ways should be found for users and carers to determine the shape of services and their integration: Direct Payments are an important policy option in this context.



Added value from integration

There is as yet no clear cut or uncontested evidence that the integration of services brings users greater benefits than improved co-ordination, but there are indications that integration may be able to add value in the following ways:

- by changing the identity or branding of a service to create more positive user responses and staff allegiances, suggesting a clearer break with the past
- by securing organisational efficiencies, for example in the shape of shared support services, integrated management, innovative administrative processes, emerging hybrid roles
- by defining a focus for action that includes clearer processes of accountability and is less prone to distraction by wider organisational concerns
- by introducing more robust arrangements for teamworking and leadership – pulling together when the going gets tough
- by creating new opportunities for investment, for example in IT systems and opening access to new sources of funds
- by having a greater capacity to advocate and negotiate powerfully on behalf of users, for example with regulators or policy makers.



Do any of these benefits seem appropriate to your local area or service? Can you think of more? This is an important task for managers to consider, but it will also be relevant for stakeholders at the front line of service provision, including users and carers. Clarity about the intended benefits for users should then begin to influence planning, teamwork and professional practice.

The challenge for each locality or service is to be able to state clearly in advance exactly what improvements will be sought and how they will be put in place.



The Integrated Care Network's five areas for development

The Integrated Care Network has indicated five areas where integrated approaches should begin to demonstrate improvements for users:

- 1 access to care
- 2 reshaping of care services
- 3 greater engagement with local communities and those experiencing social exclusion
- 4 reshaping of financial and other resource flows
- 5 developing and redesigning workforce patterns.

Consider in relation to each of the above:

- how satisfactorily can user benefits be demonstrated in existing partnerships, projects and services?
- how should user benefits be specified in new plans and proposals?



This has been made available in downloadable form as a more structured exercise for groups.

Part One in summary

Before contemplating integration in relation to any aspect of current provision, or when reviewing what has already been implemented, it would be wise to check:

- the extent to which understanding of key concepts and words, especially the word 'integration' itself, is shared
- your position on a continuum of collaboration
- the implications for your circumstances of messages from research
- your capacity to identify particular groups of service users with complex needs as the focus for integration, and the specific benefits you intend for them.

building critical capacity



Part Two

Making it happen

Integration can be initiated and developed at any organisational level (strategic, operational, or practice) and on any scale. Part Two recommends a simultaneous and balanced engagement at all levels.

It starts by introducing ideas about raising awareness of the 'whole system' and goes on to examine what might be needed at the strategic, operational and practice levels to achieve sustainable results. Illustrations of what has been achieved elsewhere are included as case studies, but the nature, scale and processes of integration are left to local decision making.

It should be possible to use the sections flexibly, in any order, to meet specific local needs. At every point, the engagement of all stakeholders in the search for the best solutions to meet user need is central.

The levels are therefore interdependent and effective integration will require paying some attention to them all.

5 Planning and governing the whole system

P 1 Local authority duties to enhance the economic, social and environmental well-being of their populations are often expressed in terms of promoting social inclusion or community regeneration and addressing inequalities in health. Widely representative Local Strategic Partnerships are formed for this purpose, and a Community Strategy is a key requirement.

2 The government requires a number of regular formal service plans from NHS bodies and local authorities. One of the most important is the Local Delivery Plan, the preparation of which is led by Primary Care Trusts and which relates to the national planning and priorities guidance issued by the Department of Health. Such guidance is binding on social services authorities and on the NHS. Successful planning depends heavily on shared intelligence; there is therefore a clear case not only for collaboration on particular plans, but also for integrating the planning function overall.

See 'Improvement, expansion and reform'

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/PlanningFramework/fs/en

This section begins with a discussion of the context for partnerships across the whole system, since by taking a broad view of corporate and strategic collaboration the right backdrop can be created for action to improve the provision for vulnerable people. It goes on to offer an approach to evaluating current arrangements against the characteristics of four possible levels of co-operation inside any locality.

Leadership and strategic support

Fragmentation will be visible institutionally at the strategic level. Tackling 'wicked issues' such as **social exclusion** will call for community-wide partnerships, while more specific arrangements will be needed to **improve care for individuals and families**. In every case, success will depend on local politicians, non-executive directors of NHS bodies, senior managers, lead professionals and other partners sharing a clear vision, being willing to bring their resources to bear collectively, and being able to demonstrate consistent leadership of the process. They will need to reach across

1 **ICN**

This is one of the Integrated Care Network's key areas for development.

existing divisions and to manage joint planning and commissioning processes.

Wherever boundaries are not neat, for example in some urban areas and in large counties with multiple District Councils, Primary Care Trusts and NHS Trusts, imaginative collaborative processes are needed: the advantages of coterminosity and stable networks of people identified by researchers may not apply so readily.

Without strategic vision and support, collaboration at the front line of service delivery will be impossible to optimise, however well intentioned the professional practitioners. The impact of policy can be improved by planned support to the efforts of frontline staff. This is a key output for strategic collaboration. Conversely, in the absence of wholehearted collaboration at the front line, strategic vision may count for nothing.

The implications of a whole systems approach

In recent years, the phrase ‘whole systems approach’ has become commonplace as a description of this type of collaboration, implying that in any community there should be a concerted attempt to bring harmony to the relationship between all public bodies and the populations they serve, and that it should be reflected formally in a Community Strategy.

The Office of the Deputy Prime Minister (ODPM) is a good source of background material. See [Social Exclusion Unit and Sustainable Communities](#) www.odpm.gov.uk/stellent/group/s/odpm_control/documents/homepage/odpm_home_index.htm

See also [ODPM Strategic Partnering Taskforce](#) www.odpm.gov.uk/stellent/group/s/odpm_localgov/documents/page/odpm_locgov_605708.hcsp which covers decision-making guidance, practical advice, risk assessment, and includes an assessment tool.

The Improvement and Development Agency (IDeA) provides support to local government in all aspects of change. www.idea-knowledge.gov.uk/

The ICN website has other useful material and links. www.integratedcarenetwork.gov.uk/themes/inclusion.php



Audit Commission (2002)
Integrated services for older people: Building a whole system approach in England.
London: Audit Commission.
See also from the Audit Commission, (2002)
A Fruitful Partnership.
www.audit-commission.gov.uk/

The NHS Modernisation Agency website is a good source of material on all aspects of improving care. For a comprehensive resource about 'working in systems' for people leading change.

www.modern.nhs.uk/improvementguides/systems/

The Audit Commission contends 'whole system working takes place when:

- services are organised around the user
- all the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere
- the following are all shared: vision; objectives; action, including redesigning services; and risk
- users experience services as seamless and the boundaries between organisations are not apparent to them

This method requires everyone to agree direction and approach. They must then act flexibly to deliver it. The strategy does not lend itself to rigid central planning. Senior staff and politicians must endorse the broad vision, which should have been developed in partnership with users, but service providers and practitioners from all organisations will be the ones to adjust and adapt how they work in order to translate this vision into actions that in turn support the needs and wishes of the individual user.'

This quotation summarises the most important elements of strategic responsibility for integration. Note, nonetheless, that:

- shared knowledge of community and user need is the starting point
- partnership with users is a key process
- communication of strategic vision can empower action in services and teams.

There is no single way to put this into practice: two examples of existing local approaches are given in the case studies on the facing page.

integration case studies 1 and 2

B A R N S L E Y

A Beacon Council, Barnsley has adopted a highly positive approach to partnership across the board. All key agencies participate in One Barnsley, which, as the main strategic decision-making body for the Community Plan and Neighbourhood Renewal Strategy, is responsible for:

- setting the over-arching strategy, framework and priorities for improving the Borough's economic, social and environmental well-being
- ensuring delivery, monitoring progress and reviewing performance of the Community Plan and Neighbourhood Renewal Strategy.
- ensuring that priorities and actions remain in touch with the concerns of the wider community.

The Forum has four Strategic Goal Groups, one of which aims for a Safer and Healthier Community. In turn this Group has a Partnership in Action programme involving the council and all local NHS bodies: it has established a Joint Agency Panel which co-ordinates planning and priorities, ensuring full user and independent sector participation through a formal process, funded by a S31 pooled budget.

H E R E F O R D S H I R E

Before the introduction of the most recent restructuring of the management of the NHS (which changed the situation), the then Director of Herefordshire Social Services was additionally appointed Chief Executive of the Health Authority. It was one of the earliest examples of opportunistic organisational integration. Although the statutory responsibilities of each body did not change, their approaches were inevitably brought closer together. One of most interesting consequences was the decision to merge the planning functions of both bodies.

www.barnsley.gov.uk/council/partnership/forum/exec2.asp

www.integratedcarenetwork.gov.uk/downloads/local_government_the_nhs_humphries1.ppt



While these issues are most relevant for politicians and managers at the top level, frontline managers and staff are often unaware how their organisations or agencies operate, make plans, and take decisions. This can lead to inefficiencies and confusion, and sap morale. Integrated services are also likely to make the organisational context even more complex. Look to create opportunities to explain and consult widely.



Evaluating current patterns of collaboration

As a prelude to integration, or as a way of checking progress, it makes sense to consider how far your locality matches up to the principles of whole system working put forward by the Audit Commission. Since a complete ‘whole system’ view will inevitably be complex to assemble and understand, four ‘levels’ and their associated outcomes are proposed here. They may not fit perfectly in every circumstance, but they should make it possible to get a sense of what an integrated whole system might feel like in practice. Keep in mind the conclusions reached in Part One about the centrality of the users who are likely to benefit from integration and of the actual improvements being sought.

Community-wide governance should ensure the overall infrastructure of support, eg in housing provision, public health, lifelong learning and economic security.

Formal strategic partnerships should make it possible to co-ordinate health, social care, education and related responsibilities, and develop a shared vision.

Joint governance and management arrangements should plan, commission and redesign service provision and the way it is supported.

Multi-disciplinary teams should be the main means of collaboration between practitioners, and of ensuring the collection and distribution of information on needs and outcomes.

Key questions to ask are:

- What arrangements are in place locally at each level?
- Are they working satisfactorily, or could their impact be improved?
- Are goals clear at each level, and to what extent have they already been achieved?
- How well are goals supported in practice by local bodies and key individuals?
- What changes could be made?

Different arrangements for democratic accountability in the NHS and local government are a likely source of uncertainty as new governance arrangements come to the fore. For example, if an elected council member is to sit on the Board of a new partnership body, should his or her principal allegiance be to that body or to the council? Tensions are inevitable.

research messages

For a closer look at governance issues, see the ICN publication *Integrated Working and Governance: A discussion paper*.

The authors make the important point about corporate governance that it is the responsibility of Boards to set parameters for executives, to provide advice, and to act in crisis situations. They see the role of Boards as equally instrumental and symbolic.

The paper also includes the following quotation from Sullivan and Skelcher:

‘Partnerships present a challenge to the principles of public sector corporate governance. They are located at arm’s length from the processes of representative democracy yet have a key role to play in delivering improved public services...They can have extensive public involvement mechanisms but also be governed by boards whose operations demonstrate a considerable democratic deficit. Their legal forms can vary considerably, as can their statutory base and financial relationships. Overall, the governance of partnerships is an area of considerable complexity and potential confusion.’

Investment in the development of Partnership Boards and the well-being of their members may be a major success enhancing factor.

www.integratedcarenetwork.gov.uk/resources.php?id=609

Skelcher C and Sullivan H (2002) *Working Across Boundaries: Collaboration in Public Services*, Palgrave: Basingstoke



ASSESSING YOUR PARTNERSHIPS

Several tools have been developed in recent years to help localities appraise and then develop partnership working; some are available online.

The Employers Organisation for local government provides self-assessment tools and further ideas and exercises.

www.lgpartnerships.com

The Partnership Assessment Tool was created from research into health and social care by the Nuffield Institute at Leeds University. It is evidence-based and highly relevant to integration: it has also been developed for ODPM for use in other service areas.

www.integratedcarenetwork.gov.uk/downloads/pat_final.doc

The Health Development Agency has also published The Working Partnership which includes an assessment process.

www.hda-online.org.uk/documents/working_partnership_1.pdf

If things are not working out well...

This guide is unlikely to be of much practical use if you are finding it impossible to get strategic dialogue going, or if partnerships are stagnant, unproductive, or patchy. In these conditions, change will depend on finding individuals who are willing and confident enough to try to break the spell. Here are some suggestions of what to do if you are stuck, or are lacking direction or effective organisation.

The first step is to be honest with yourself and ask if a better contribution from your own organisation might have led to a better outcome. Facing up to this reality might be enough to spur you on. Since problems of this sort are not unique and may have been solved elsewhere, consider the following possibilities:

- make individual contacts in relevant government departments and take specific advice, eg from Office of the Deputy Prime Minister (ODPM), Department for Education and Skills (DfES), Department of Health (DH), NHS Modernisation Agency, Strategic Health Authority (SHA)
- get in touch with someone with the power to intervene, and go over the perspectives obtained from the WHO framework, and the research messages in section 1 of the guide
- get together informally with like-minded people in partner agencies and try to create momentum for a joint 'away day', with an independent facilitator and clear goals
- propose turning a scheduled business meeting or joint planning forum into a special review with an independent facilitator
- use an inspection report, Best Value review, or new policy guidance as a platform for wider engagement of partners
- learn from others, by making contacts through the Integrated Care Network

- consider using specific tools to assess partnership strengths and weaknesses and to generate an action plan
- create opportunities for the voice of users and carers to be heard strategically
- watch out for the cultural factors that can create resistance to partnership and block communication: this may warrant outside attention
- be on the lookout for evidence that individuals' anxieties about upheaval are blocking progress – be willing to invest in skilled and sensitive handling
- think about what might add up to a win-win outcome – how a partnership might be the only way of ensuring individual objectives are met.

LEUTZ'S SECOND LAW

Integration costs before it pays.


This is a good reminder that success is likely to depend on wise, pump-priming investment of time for planning and resources for training and systems development. Always plan for the long haul.

Section 5 in summary

Taking the widest possible view of integration, this section has examined the concept of a 'whole systems' approach, given examples of good practice and provided encouragement to face up to obstacles to progress.

Crucially, it also offers a process for considering aspects of planning for the integration of health, education, housing and social care at four main levels. It has concentrated on the first level, community-wide governance; in the next three sections the remaining three levels will be considered in turn.





6 Taking the lead through strategic partnerships

P *1 Local authorities and NHS bodies are expected to make use of the 'flexibilities' introduced by S31 of the Health Act 1999, which permit the appointment of one agency as 'lead' commissioner of a specific service, the pooling of budgets and the integration of service provision. The Act goes beyond the power in s28A and s28BB of the National Health Service Act 1977 which allowed money transfers (joint finance) between the NHS and local authorities. The new provisions can be used very broadly in accordance with locally determined priorities, and should therefore link to all current joint planning processes.*

2 Opportunities have been created for new forms of organisation. For example, Care Trusts can now be established within the NHS system, but under governance arrangements that include the local authority. Similarly integrated, but operating within local authority structures, Children's Trusts are being piloted and are expected to be in place everywhere from 2006. It is also possible for social care services to be provided through an NHS Trust (often named 'NHS Partnership Trusts' and so far used most commonly for mental health and learning disability services) and for health services to be managed by a local authority (achieved most notably among learning disability services).

Clarifying local aspirations

Some form of strategic partnership of all relevant agencies is likely to be required to deal with the issues raised in this section. The partnership will need to settle standing arrangements for working together and to establish the overarching policies that will ultimately determine the shape of integrated services.

It also means returning to the big issue raised at the beginning – the nature and likely pattern of local partnerships – and asking a number of more specific questions about the vision for particular services. There is a clear advantage in establishing and communicating the values and objectives of any new service in advance (see Northumberland Care Trust on page 55) in a form which clearly describes the benefits for service users and the community as a whole.

Key questions for strategic partnerships: a checklist

- How will partnerships with users be established and maintained?
- How will the planning and commissioning processes be used to promote improved services and user outcomes?
- What new resources, and what existing ones, will be made available for each of the services to be integrated? Who will be accountable for ensuring that the resources are used to improve the experience of service users?
- Will opportunities exist for new joint appointments at the most senior level?
- Will options for large-scale integration be considered, for example a Care Trust, an NHS Partnership Trust, or a Children's Trust. If so, when; if not, what other arrangements will be put in place using the Health Act Flexibilities?
- Will there be Joint Boards or management teams for particular services, geographical areas or functions? If so, what will be their delegated roles and responsibilities?
- What will be the overarching policy on transfer/employment of staff, ownership of buildings, financial management regimes, etc.?
- How will the process of change be resourced and managed?

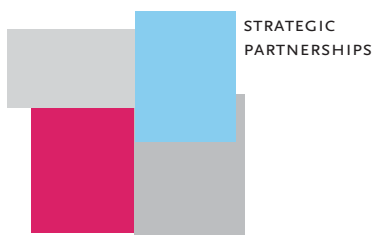
Avoid any lingering uncertainty on any such questions. Giving a clear lead will help operational and practice staff and other stakeholders to respond more readily.

Responses are bound to differ from place to place, and the pattern inside a locality may vary if it encompasses several Primary Care Trusts and District Councils. For the early adopters of integrated approaches, the prompts above may present an opportunity for review. Where progress has been patchy, they may be an opportunity to ensure more even development. For those who have been stuck, one step forward here may constitute the 'giant leap'.

For a closer look at decision making on these issues, including case studies, see Glasby J and Peck E (Eds.), *Care Trusts: Partnership Working in Action*, Abingdon: Radcliffe Medical Press.

You can also download a copy of the ICN booklet *Integration and Children's Services: structure, outcomes and reform*.

www.integratedcarenetwork.gov.uk/downloads/icn_childrens_services_pdf_version_for_web_base_d_dis.pdf





None of these matters should be left to chance or allowed to go unresolved. Major decisions will need to be taken at Cabinet and Board level after much formal and informal deliberation, but smaller-scale initiatives may emerge by local management agreement. The leadership of the development process should be defined in terms of which individuals (or groups) are responsible, and to which bodies or management teams they will report. Once partnership arrangements are in place they are likely to evolve, and any initial agreement will also need to be kept under review by the partners.

Service governance arrangements

There is a case for establishing joint governance and management arrangements across the range of user groups, even if particular services might be integrated over different timescales or in different ways. Although this is usually done by user group (eg children, mental health, learning disability, adult services), they can all be further subdivided (eg early years, children with disability) and, in some cases, linked (eg older people and mental health). These are vital considerations in identifying services where a single system of planning and provision might work better than improved co-ordination.

Seizing opportunities for change

The three case studies in this section demonstrate the importance of quick or creative responses when new opportunities arise. In the case of Knowsley, it resulted in innovative arrangements to fill a senior post and so to signal local intent about integration. The others reveal more conventional opportunism. In South Tyneside an invitation to bid for a project resulted in a new joint approach to commissioning children's services in order to modernise and integrate the system. In Hertfordshire a major decision about the structure of the council's services paved the way to a comprehensive commissioning partnership with Primary Care Trusts.

integration case studies 3 and 4

HERTFORDSHIRE

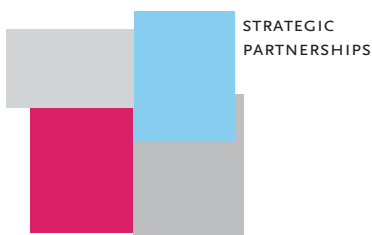
Hertfordshire County Council has separated the responsibilities of its social services department between a Children and Families Service Department (with Education) and an Adult and Community Services Department, and has entered into partnerships with NHS bodies to provide specific services. An NHS Partnership Trust provides mental health, including Children and Adolescent Mental Health Services (CAMHS) and drug and alcohol services. Joint Learning Disability services are managed by the council. The council and the eight Primary Care Trusts have set up a Joint Commissioning Partnership Board, comprising council members and PCT Board members and they have pooled their commissioning budgets (£160m) for these services. A Joint Commissioning Team has been established and management appointments are also being made jointly.

KNOWSLEY

The Director of Social Services has simultaneously been appointed Chief Executive of the Primary Care Trust to permit the integration of Health and Social Care. A leadership team of senior managers from across the Social Services Department and the Primary Care Trust has been formed, and there will be a joint headquarters for both organisations (as part of a joint estate improvement strategy). A 'Go Integral' project has been launched to integrate social care services and community health services for adults and older people. Occupational Therapy services are being integrated to assist with performance and the recruitment and retention of staff, and there is a pooled budget for dealing with learning disability. A significant number of health staff are working with social work teams to develop services for children and there are plans to introduce an integrated service for children with disability.

www.integratedcarenetwork.gov.uk/downloads/experiences_in_hertfordshire_ppt.ppt

www.knowsley.gov.uk/social/lo_index.html



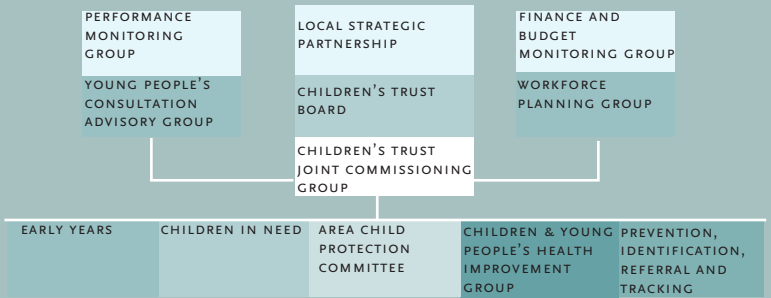


www.children.doh.gov.uk/childrenstrusts/southtyneside.htm

integration case study 5

SOUTH TYNESIDE CHILDREN'S TRUST

This example outlines initial arrangements for one of the 'Pathfinder' Children's Trusts which were approved in the autumn of 2003. South Tyneside Council is developing a Commissioning Children's Trust in partnership with South Tyneside Primary Care Trust and South Tyneside Health Care NHS Trust. The Trust will build on the strengths of the existing Children and Young People's Strategic Partnership and shift the focus from joint planning to joint commissioning. The change will involve establishing a Children's Trust Executive Board and a Joint Commissioning Group. (The model below uses the elements of the 'balanced scorecard' approach to quality management.)



Using the partnership flexibilities

Commissioning is a key process here, but it needs to be linked to a determination to *align* or *pool* existing budgets, and to redesign service provision. It is not always helpful to see the flexibilities as separate entities: if the purpose is to achieve specified benefits and outcomes for users, the whole process of needs assessment, planning, resource use and service design will have to be brought together. It will not fall into place overnight, but that is the ultimate goal.

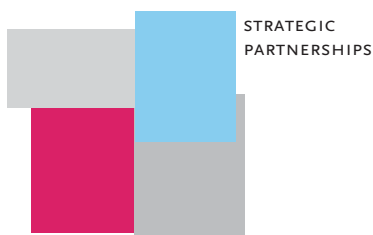
The Integrated Care Network has acknowledged that the **reshaping of financial and other resource flows** is a desirable objective. It is natural enough for bodies to be cautious about the control of finance, which may appear likely to be too remote in an integrated service, but in some places such anxieties seem to have inhibited pooling to an unnecessary extent. There are also specific technical areas to cope with, for example concerning VAT. However, the guidance and regulations now in place and the fruits of local experience mean that progress can be made with confidence. The NPCRDC research quoted in section 1 indicates that some immediate financial benefits are possible. The delegation of budget management responsibility can empower small-scale integrated teams and services and generate innovative responses to individual needs. It may feel like a risky undertaking, but an over-cautious, controlling regime will never unlock the undoubted potential. Similarly, integration and partnership can improve efficiency by encouraging the creative use of available property and land.

4 I C N

There is no substitute for considering the regulations and guidance in their raw state. The simplest access is via the following link established to help the new Children's Trusts, but which includes across-the-board information on partnerships under the Health Act 1999 www.children.doh.gov.uk/childrenstrusts/toolkit.htm

There is also a helpful checklist at www.dh.gov.uk/assetRoot/04/07/07/22/04070722.pdf

The ICN website has archived a workshop session on pooled budgets with a presentation from Southend. www.integratedcarenetwork.gov.uk/eventmanager/uploads/workshop_finance_pooled_budget_stepney.ppt





Johnson P et al 'Interagency and interprofessional collaboration in community care: the interdependence of structures and values', *Journal of Interprofessional Care*, Volume 17, Number 1 February 2003

research messages

This section is about strategic vision, but try to avoid any tendency for thoughts to turn to organisational structures. Researchers at the Nuffield Institute at Leeds University remind us that the vision must always be wider than that.

The research team drew on empirical and theoretical literature from the US and UK to construct a framework for analysing theories of joint working. Supplemented and supported by local case studies, their report highlights the vital importance of integrated systems of local needs assessment, goal setting, funding, training, devolved financial management, and multidisciplinary service delivery as opposed to any narrower focus on structural integration.

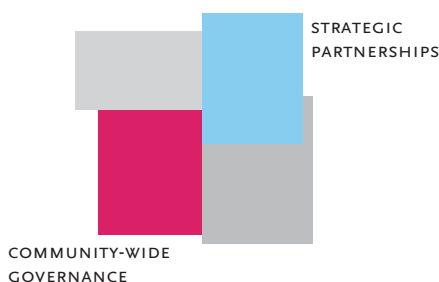


Section 6 in summary

This section has highlighted the importance of robust arrangements for working in strategic partnerships and for clear thinking about the sub-division of responsibilities and associated governance arrangements. This is summarised below and will be considered further in section 7.

Formal **strategic partnerships** can include NHS Acute Trusts, NHS Specialist Trusts, Primary Care Trusts, Social Services Departments, Education, Housing, Police, Probation: they make it possible to co-ordinate health, social care, education and related responsibilities, and develop a shared vision. Partnerships should:

- settle standing arrangements for working together
- consult and involve other stakeholders, such as other governmental bodies, independent sector, users
- decide the nature of partnerships needed
- set up a commissioning process
- secure resources and establish priorities
- frame expectations
- review agreements/partnerships over time.



7 Implementing the strategy and planning specific services

46

INTEGRATED WORKING: A GUIDE

see

www.modern.nhs.uk/scripts/default.asp?site_id=40

P 1 Government has invested significantly in supporting change in public services, for example by creating the NHS Modernisation Agency, the Strategic Partnership Taskforce (within ODPM) and the Integrated Care Network, as well as a new NHS project in the process of being piloted called Pursuing Perfection, which is seeking to link improvement to integration in a broad and challenging way.

2 Staff employment policy is a key issue to be faced everywhere. The Guidance on Children's Trusts, which is broadly applicable to other situations, explains: '...a decision will have to be taken as to the best means of drawing staff together to work in truly integrated teams. This could be through co-location, secondment, or transfer... Wherever any movements of staff are proposed, whether in terms of location only or to a different organisation, it is essential to involve staff, unions and other staff-side organisations as early as possible and throughout. The best possible starting point is where staff themselves recognise that bringing staff from different organisations together will improve process and outcomes for children and families.'

Towards integrated leadership

Responsibility for action indicated in this section should be handled by the specific partnership board, joint management team or any similar body set up to plan, commission and oversee a particular service, whatever its scope or size. Everything that follows assumes that such an arrangement is in place and, ideally, that it will report to the strategic partnership. Accountability for any joint service must always be made explicit.

Since service users will only feel the benefits of integrated leadership when those who are in regular direct contact with them – doctors, social workers, teachers and therapists – work well together, the strategic intention must be to support operational staff. Professionals are frequently enthusiastic



JOINT GOVERNANCE
AND MANAGEMENT
ARRANGEMENTS

about integration and some have done conspicuously well in making the promised advantages a reality, but elsewhere they have been made to struggle by a lack of practical support, manifest for example in negative attitudes or a lack of training, IT or resources.

research messages

A review of integration initiatives in community care in a number of countries has been undertaken by a US academic, Denis Kodner. He argues in favour of 'vertically integrated systems of care', and has identified seven factors associated with successful outcomes:

- care management across time, place and discipline, spanning both medical and social care
- multi-disciplinary or inter-disciplinary teamwork
- GP involvement, with application of geriatric philosophy and methods
- formal organised networks of providers
- use of clinical support tools (eg guidelines, protocols) to facilitate co-ordination and continuity
- appropriate targeting
- financial mechanisms to encourage flexibility and efficiency.

This presentation also includes interesting data and ideas about 'consumer-directed care' which relates directly to the Direct Payments policy in the UK.
www.integratedcarenetwork.gov.uk/eventmanager/uploads/denis_kodner_presentation.ppt



Dedicated management time is a key factor identified in research as a predictor of success in joint working. See page 23.

L This is an important stage, which it should be possible to reach either as a result of strategic decision-making (top-down) or as a considered local response to 'user needs' (bottom-up) or as a combination of the two. Weaving together political and managerial will, practitioner enthusiasm and user support for change will help to establish a benign climate for integration.

Consider:

- who needs to be involved?
- where are good practice models to be found?
- are there local champions of integration?
- how could stakeholder involvement be resourced?
- what specific learning opportunities can be created to enable people to come together to consider their roles and future contributions?

W

A self audit exercise about how to resource project planning is available to download.

Project plans

The first step is to commission and resource a project management process including milestones and realistic timescales. Whatever model of integration is envisaged, it will take dedicated management time to develop, and the more ambitious it is, the more likely it will be to warrant appointing a project manager and project team. The preliminaries should deal with how the project is to be funded by the partners, how staff are to be seconded or appointed to undertake the work and how specialist advice about finance, information technology and human resources is to be obtained. Lines of accountability and performance expectations will also need to be clearly defined.

The proposal should allow ample time for consulting key stakeholders, for example users and carers, referring agencies, professional bodies, unions and legal advisers; and for creating the right climate for change, particularly in its sensitivity to the anxieties of personnel whose jobs may be disappearing or changing, or whose working environment will be altered. This is not just a task for the project team but for all managers. Practical support for staff should be explicit and careful attention given to methods of communication with and between staff throughout. Local managers and practitioners may already have established patterns of good practice and they may have good ideas to contribute.

Project planning: the Department of Health checklist

- What are the aims and intended outcomes of the partnership?
- How will the partnership lead to improvements in services as defined by local delivery plans?
- Who has been consulted, and how has this been done? If there is to be a movement of staff, have staff and their unions been consulted?
- How is/are the local authority functions going to contribute to a health outcome through this partnership?
- How will existing local joint working be promoted?
- Who will be the services users, eg defined in terms of client group, age range, NHS and Local Authority areas?
- In financial terms, how much resource is to be committed by each partner?

Following consultation, are the signatories satisfied that arrangements for the following are robust?

- governance, including, decision-making processes, monitoring, accounting and auditing, operational and management arrangements
- when the partnership will be reviewed
- human resources, including staffing, terms and conditions, policies
- information sharing
- identification of functions
- eligibility criteria and assessment processes
- complaints
- financial issues such as charging, accountancy and VAT implications
- how disputes will be resolved, and how partners will resolve changes or dissolve the partnership altogether.

The Department of Health has introduced a form of notification for S31 Agreements. It provides a good checklist of issues needing to be considered in any partnership.

www.dh.gov.uk/assetRoot/04/02/04/99/04020499.rtf

A planned programme of organisational development is recommended, emanating from the project plan and running alongside it.



JOINT GOVERNANCE
AND MANAGEMENT
ARRANGEMENTS



For a more detailed and creative look at this topic, see Hudson, B 'Interprofessionalism in health and social care: the Achilles heel of partnership?' *Journal of Inter professional care*, Vol 16, Number 1, 2002.

See the Changing Workforce Programme for more ideas about workforce issues www.modern.nhs.uk/scripts/default.asp?site_id=15

For ideas and links, consult the ICN website www.integratedcarenetwork.gov.uk/themes/performance.php

Organisational development and 'cultural' issues

Successful delivery of the project plan will to an extent depend on how well the organisational implications are examined and remodelled, and how far staff can be helped to understand and adopt them. In the light of the research evidence outlined earlier, cultural barriers to integrated working resulting from separate methods of professional training, varying management styles and differing political environments should also be anticipated. The creative interaction between different schools of thought may bring benefits, but in the short run the tension between them is more likely to stand in the way of any more unified culture. There is no substitute therefore for recognising the risks, for planning how to reduce them and for staying alert to specific problems arising from ignorance, prejudice and self-protection. Leutz's third law [Your integration is my fragmentation](#) provides a good cautionary backdrop.

Attention will also need to be given to a range of employment issues and to staff learning needs, all amounting to a demand for specialist human resources advice and for formal negotiations. The process will need planning and resourcing: a major initiative like a Care Trust application will require substantial investment in continuous dialogue with staff and unions. (See the Sandwell case study on p 56.)

Monitoring and evaluation

It is pointed out in section 1 that evaluation and feedback are associated with effective joint working. This is the right time to establish the framework for monitoring user outcomes and for establishing baseline measures from which progress and impact will be judged. The purpose of an integrated service is to improve outcomes and services for users: what they are and how they will be measured should be agreed from the

start. This has implications for performance management measures, too: think how the monitoring you are having to undertake anyway can be fed into the development process. Wiltshire has invested significantly in this sort of evaluation over the years, and used the feedback to underpin phases of development.

Variations on a theme

Four case studies are included in this section: each sheds light on a different approach to integration – a large PCT-based Care Trust, a smaller mental health Care Trust, a set of s31 Agreements transferring social care management to PCTs, and a partnership to integrate information systems. The stories underline the importance of a cumulative local dynamic, taking opportunities for increasing degrees of collaboration as they arise. The outcomes vary, even down to solutions relating to staff employment and financial responsibility.

Three of the studies include examples of formal, single management arrangements, but it should not be inferred that they are a recommended option. Any partnership arrangement that has been given governance responsibility for a specified service, having established a binding inter-agency plan covering objectives, roles, processes, training, etc., could operate just as well through co-ordinating processes and joint accountability. Elements of such a model have been common in many parts of the country, and could also be a legitimate forerunner of more integrated management arrangements. In many localities such an evolutionary approach has helped to channel the energy for change. Whether a ‘network’ is likely to be as robust and sustainable as a ‘merger’ as the vehicle for delivering the benefits of integration to users should be settled by the project plan.

For more detail, see Brown L et al (2002), *The impact of integrated health and social care teams on older people in the community*, University of Bath and Wiltshire Research and Development Partnership.



JOINT GOVERNANCE
AND MANAGEMENT
ARRANGEMENTS



www.integratedcarenetwork.gov.uk/eventmanager/uploads/works_hop_presentation__integrated_childrens_services_in_liverpool1.ppt

Improving access to services

Access strategies are an important focus for integration and can include everything from general information giving through to redesigning the point of entry to specialist services. It is a topic worthy of attention at this point, because significant innovation may be achievable if it is well planned and can be properly resourced. IT systems and investment are obviously central, and opportunities for partnership may be fruitful. This is why access features in the ICN list of development areas.

A long-term project in Liverpool being led by the city council is a good example. Involving partners including NHS bodies, it was triggered by the acknowledgement of poor access arrangements in the past. The opportunity was nevertheless taken for a collaborative, rather than departmental approach to developing the IT system and, like the Telford and Wrekin example quoted later, this will help overcome what research has shown to be one of the key barriers to collaboration.

integration case study 6

THE WILTSHIRE S31 AGREEMENT

Wiltshire's proposal was based on a history of joint working, especially between social services teams for adults and primary health care teams. The Health Act was seen as an opportunity to extend the model more radically. The three Primary Care Trusts responded positively to an approach from the Council to integrate adult social care provision (the county had simultaneously merged children's social services into its Education Department). Funding for a project team was obtained, reporting to a sub-group of a joint Board.

Negotiations resulted in three S31 Agreements to provide integrated management and commissioning of health and social care for adults from April 2002. The Agreements were developed after wide consultations and in conjunction with specialists (lawyers, accountants, human resources advisors, etc).

Locality Team Managers were appointed jointly across the county to manage care managers, occupational therapists and district and community nursing together. If an existing social services employee was appointed to one of these posts, they were seconded to the PCT. Social services area managers were seconded to PCTs to manage the new Locality Team Managers and all normal SSD functions. They continued to be accountable on financial matters to an Assistant Director of Social Services.

For more detail, see Jones, R 'Bringing Health and Social Care Together for Older People: Wiltshire's journey from independence to interdependence to integration', *Journal of Integrated Care*, Volume 12, Number 1. 2004, Pavilion: Brighton.



JOINT GOVERNANCE
AND MANAGEMENT
ARRANGEMENTS



For more details see
www.aware-project.info

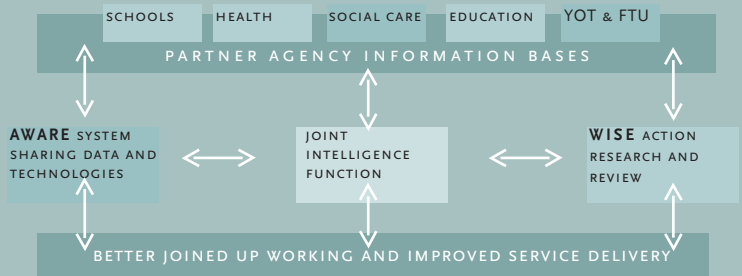
integration case study 7

TELFORD AND WREKIN

Investment in information systems is now perceived as a key element in delivering integrated services, and lack of investment has been highlighted in research findings as likely to be detrimental to success in joint working, with initiatives often foundering on the issue of confidentiality.

Telford and Wrekin council's 'Aware' project has created a shared database on children and young people, which enables partner agencies to share non-sensitive data.

- The data includes name, date of birth, address, school, services (and practitioners) involved – which assists consistent co-ordination of support services
- The system has a series of 'alerts' that will enable services to share their level of concern or involvement about individual children – which helps in the earlier identification of children and young people in need, at risk, and potentially at risk
- It is backed up with secure messaging and a document library



setting up a Care Trust or Children's Trust integration case study 8

THE NORTHUMBERLAND CARE TRUST

The existence of an inter-agency Policy Group and a Strategic Partnership, which led directly to the formation of a Health Action Zone, meant that there was a strong foundation for integrated development. A Whole Systems Review Group was established in 2000 to improve responses to local needs and this step coincided with consultations about options for Primary Care Trusts.

The NHS Plan gave scope for integrating commissioning and provision into a Care Trust and in 2001 the Northumberland PCT/Care Trust Project Board was established to replace the Review Group, and a vision for health and social care for children and adults was published. Initial consultations supported the Care Trust option. Elected members gave their support after reviewing governance and accountability proposals.

A project team was set up to work to the Board on various aspects covering, for example clinical and care governance, locality management and organisational development. With UNISON's support, the Care Trust for services for adults was established in April 2002 (children's services remained outside; and mental health services are integrated into a specialist NHS Trust).

The Northumberland Care Trust is PCT-based, with the Director of Social Services managing the relationship under a S31 Agreement. It has oversight of care management for older people (including those with mental health needs), for those with learning and physical disabilities, for integrated rehabilitation teams and for support services for adult social services. The council's 'provider' services have not transferred although management is via the Care Trust.

Adapted from O'Leary, L 'The Northumberland Experience' in Glasby and Peck (referenced on page 39). See also www.northumberlandcaretrust.nhs.uk/site.htm

For the detailed regulations and guidance on establishing Care Trusts, see www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/TertiaryCare/CareTrusts/fs/en It covers not only the issues needing attention, eg finance, buildings, but also the application and approval process.

The process for establishing Children's Trusts is to be finalised after evaluation of the current pathfinder (pilot) Trusts in a selected group of localities, but a comprehensive toolkit has already been prepared. www.children.doh.gov.uk/childrestrusts/toolkit.htm



JOINT GOVERNANCE
AND MANAGEMENT
ARRANGEMENTS



transferring staff employment integration case study 9

SANDWELL MENTAL HEALTH NHS
AND SOCIAL CARE TRUST

From the start of consultations, the intention in Sandwell was to transfer staff employment from the Borough Council to the new Care Trust. The change called for a massive programme of collaboration, which exposed cultural divides not only between the NHS and local government but also within the two sides of UNISON. Ultimately the employment of all staff except Approved Social Workers was transferred.

The Trust worked from the principle that there would be 'no detriment' in pay and conditions for any individual. The process unearthed a lengthy agenda of human resources issues for 'harmonisation', the most vital of which, for example relating to pensions and continuity of service, were settled early on. A programme to tackle other issues, linked to initiatives such as *Agenda for Change*, is now in train. Established in April 2003, the Care Trust is now seen as delivering real benefits to users through a more coherent, fully integrated organisation and by a well motivated and cohesive staff group.

See

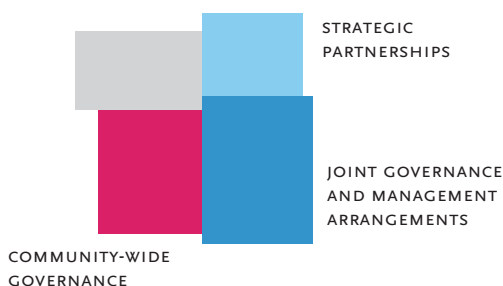
www.integratedcarenetwork.gov.uk/eventmanager/uploads/works_hop__human_resources_warner_davies.ppt

Section 7 in summary

This section has concentrated on the creation and implementation of plans for more co-ordinated or integrated working, giving illustrations of the processes followed in four localities and highlighting the possible content of a project plan. It underlines the benefit of establishing secure governance arrangements and clear management accountability within integrated services as outlined below.

Joint governance and/or management arrangements should plan, redesign and commission specific services to meet user needs. In doing so it should:

- maintain dialogue with stakeholders, including users
- identify needs, estimate demands, settle priorities in consultation with users, pool resources, set strategy
- set out service structure and management accountabilities
- set out the mission and goals to be delivered
- commission services, monitor progress (including user satisfaction), ensure compliance, manage risks
- allocate resources, support implementation, manage performance.



8 Putting integrated care into practice

P This extract from Every Child Matters sets out some of the challenges all integrated working poses at the front line of service delivery:

'A number of those currently working with children have roles which overlap in some important respects. For example, an educational welfare officer, a Connexions personal adviser or a learning mentor may all play the key worker role with a child who truant from school. But current training, as well as pay and conditions, are very different for each role. Within the more integrated structures and working practices... it will remain the case that some children and families need support from a range of professionals. We need to establish new cultures in the workplace so that individual professionals work horizontally across professional boundaries rather than vertically in professional hierarchies.'

Everyone working with children needs to be trained to do their own job well. They also need to know how their role fits with that of others. They need the skills to work positively with, and draw on the expertise of, other professionals and support staff. Among other things this will avoid unnecessary and unproductive referrals. This is true not only for those working with children, but also for teachers and GPs who can be the first to spot emerging problems.'

It is possible to start using the guide here – adopting a 'bottom up' approach. Strategic and operational support are vital in resourcing and sustaining practitioner initiatives, but the practices and ideas which will most impact on service users are likely to be rooted in service delivery.

Creating the climate for integrated practice

This is the fourth level of planning integrated care, but it can be progressed in tandem with or in advance of the other levels. It considers how practitioners can form multi-disciplinary teams or specialist services to deal with people with complex needs, and how such teams and services should dovetail with universal services such as primary health care and schools. This key aspect of any project plan should address the Integrated Care Network's target of **reshaping care services** and **redesigning workforce patterns**, both in terms of how **care management systems** are conceived and designed and how **care provision** can be reconfigured to improve the user's care experience.

MULTIDISCIPLINARY
TEAMS



The need to engage people other than managers in the development process is one of the guide's themes. The essence is open dialogue about national policy requirements and local professional practice, and a willingness to generate and debate ideas about integration at the front line, creating the sense of a common pursuit between management and practice. Without it, even a major step, such as the creation of a Care Trust, may have little impact on established routines and communication methods.

The integrated practice environment

As more integrated forms of service delivery are conceived for particular groups of people with complex needs (eg children with disabilities, or older people with mental health needs), teams from the range of existing backgrounds and agencies will need to be formally or informally assembled for the purpose. This is easy enough when starting a new service from scratch with new funding, but changing established mainstream ways of working can be more difficult.

In a highly co-ordinated, networked, or integrated system all practitioners and clinicians will consider user needs simultaneously and act on them as members of a team, rather than sequentially along a chain of cross-agency referral. Doing so is both more efficient and makes life easier for users, but the implication is that the daily routine of everyone at the frontline will have to change, even in a small way. Research has suggested that investment in facilitating change at this level will increase the chance of success.

Many factors come into play in developing the integrated practice environment. Two are singled out here for particular attention: **tools and protocols** which facilitate communication and decision-making processes; and **teamwork**.

L Confidentiality is a recognised source of difficulty. The activity connected with preparing guidelines and bringing professionals together to perfect and approve them may in itself create the climate for multi-disciplinary working.



For an overview of thinking about integrated care pathways, a good link is provided by the electronic library for health, see

www.nelh.nhs.uk/carepathways/

For more information about protocol based care, see the Modernisation Agency website, see

www.modern.nhs.uk/protocolbasedcare/

Tools and protocols

A number of national initiatives have sought to make integration practical and visible in frontline practice, including at a general level the *National Service Frameworks*, as well as more specific approaches to assessment practice, such as the *Assessment Framework* for children, and the *Single Assessment Process* for adults. Certain other initiatives such as **user-held records** and the design of **integrated care pathways** represent aspects of the practical response by professionals to national goals and user needs. All serve to create common ground and more effective communication between historically divided practice. Any initiative which seeks to distil the work of different agencies or professionals into a 'protocol' governing individual contributions has a place in the bigger scheme of things.

However, it is one thing to create a new approach, but realising the desired effects can be tantalisingly difficult. Successful implementation requires anticipating the likely obstacles (see section 1 of the guide). For example, a well-conceived assessment system supported by introductory training is an important component of an integrated approach, but it may well not be sufficient without longer-term support to teamwork development. IT is another example: research has demonstrated that the lack of supportive IT is regarded by practitioners as a common obstacle to integrated practice.

The interdependence of the strategic, operational and practice elements of the integration process is highlighted by such situations: change needs investment as well as vision.

Teamwork

Teamwork is an antidote to fragmentation, and co-locating staff from different services is sometimes used as an informal preliminary step towards integration. Identifying possible teams and setting about building them can nevertheless amount to an important strategic means to ‘a radical redesign of the whole care system’. This is often easier said than done: researchers have found that teamwork is underdeveloped and that multi-disciplinary teams can often struggle to be cohesive. Resources from an organisational development programme would be well invested in team building: there is good research evidence about what can work.

Most attention in this area has been given to the **care management process**, eg managing hospital discharges and decision-making in child protection, but there is an equivalent scope for more integrated teamwork in **care provision**: good examples are intermediate care services and Sure Start schemes which have flourished as a result of dedicated funding. Integrated ‘hands on’ services should directly improve the user’s experiences: can this be achieved in mainstream services by merging or systematically linking established working groups, such as District Nursing Teams and Home Care services, or Health Visiting and family support workers? This is an important challenge.

To co-ordinate or to integrate is the question that matters most at the practice level. Much can be done for users by creating and sustaining more informal networks, but formal team development with budget devolution and easy access can be more focussed and creative: any project plan for an integrated service will need to consider the balance very carefully. The Cornwall illustration over the page demonstrates the benefit of face to face contact, empowered teams and a creative approach to levels of assessment.

For a good introduction see Borrill C et al ‘Team Working and Effectiveness in Health Care’, *British Journal of Health Care Management*, August 2000
See also, Ovretveit, J (1993) *Co-ordinating Community Care: Multidisciplinary teams and care management*, Open University Press

L If relations between partner services are poor at practitioner level, or if the staff groups do not really know one another, time and effort should be invested in remedying the situation. Shadowing schemes, joint away days and training programmes are all worth contemplating. A good focus would be the WHO categories: vertical and horizontal integration, and continuity of care. Can current practice be reshaped along these lines? The exercises in the web version of the guide may help, but some investment in team building is likely to be required. Research shows that obstacles at this level can be very deep seated. Do not neglect the risks, therefore.

MULTIDISCIPLINARY
TEAMS





See Thistlethwaite, P (2002) *Primary Health and Social Care in Cornwall: Evaluation of the Carrick Integration Project*. Partnerships in Practice Project, CEBSS, Exeter University.

adapted from
www.youth-justice-board.gov.uk/YouthJusticeBoard/YouthOffendingTeams

integration case studies 10 and 11

CORNWALL

For over ten years basic social care services for adults have been organised through case co-ordinators linked to, or based in, GP surgeries. Each has a considerable budget for service purchase and the aim is to provide practical services with the minimum of assessment (using the knowledge of the primary health care team) in the quickest possible time. More complex situations are identified through screening, and referred on for specialist OT or social work intervention, also linked to groups of surgeries in the locality. All financial transactions are handled via a laptop computer linked to the council's system. There is no history of over-spending!

YOUTH OFFENDING TEAMS

YOTs provide an established model for integration across the country, and it would be worthwhile to examine local arrangements whilst considering wider integration. The Youth Justice Board explains the principles as follows:

There is a Youth Offending Team in every local authority in England and Wales made up of representatives from the police, Probation Service, social services, health, education, drugs and alcohol misuse and housing officers. Each Team has a manager who is responsible for co-ordinating the work of the youth justice services. Because the Team incorporates representatives from a wide range of services, it can respond to the needs of young offenders in a comprehensive way. It identifies the needs of each young offender by means of a standard assessment. It identifies the specific problems that make the young person offend as well as estimating the risk they pose to others. This enables the Team to identify suitable programmes to address the needs of the young person with the intention of preventing further offending.

Four steps towards integrating care

A similar approach has been used and tested in one locality, and is explained in their report. 'In order to maximise the contributions from staff, non-statutory organisations and national bodies, interviews were offered to key personnel. Sixty-three questionnaires were completed by individuals or groups of staff and were analysed in order to provide a body of knowledge about the current level of integration and suggestions for future action. Six client-specific workshops were held, followed by a collective workshop. These stakeholder events gave an opportunity to share good practice, be creative about future models and to network. In themselves, the events have prompted further integrated working.' from *Developing a Model for Integrated Primary, Community and Continuing Care in the Midland Health Board*, Executive Summary June 2003

www.mhb.ie/mhb/Publications/IntegratedCareOneNetwork
ICON/

There may be considerable scope for self-organisation among practitioners and other key stakeholders if they can be made to feel they are partners in determining how a collaborative approach might work, and how it will benefit service users and carers. What follows is one possible route to achieving this. Potential members of each multi-disciplinary team or integrated service should be involved.

STEP 1 BRAINSTORMING

Bring groups of staff together to map out how they currently communicate with each other and how they deal with the needs of individual service users. Gradually brainstorm ideas for doing things in a more integrated way. Application of Leutz's first law suggests the creation of frontline multidisciplinary teams and specialist services focussing on people with complex needs. However, those teamworkers will need at times to interact with primary care or universal services (eg schools and GP practices), which in turn will have access routes of their own to specialist support services, such as residential schools and acute hospitals. A clear place for integrated teams and the provision of integrated services will have to be established, and the work empowered and supported.

MULTIDISCIPLINARY
TEAMS





see page 15 in Part One on addressing complex needs

STEP 2 LOOKING AT NEEDS

The key task here is to separate current service demands on the basis of the complexity of the needs they are designed to meet, and to agree new joint processes in relation to each level of service. Always keeping the benefits being sought for users in mind, the consultation should deal with:

- the basis for distinguishing between needs, ie what do the different levels of complexity encompass and who is involved in addressing them
- ideas for a better model for dealing with the most complex needs, setting out the extent of integration required and estimating the caseload;
- the support needed from partner bodies to implement the models and to translate strategic objectives into routine practice.

STEP 3 GIVING RESPONSIBILITY

Ultimately, all new arrangements for working together in service delivery will require a leader. Responsibility for the quality and effectiveness of the new arrangements should therefore be delegated to someone who can act on behalf of all stakeholders: it may be a single manager in an integrated system, a designated co-ordinator or a senior clinician. It has also long been advocated by the Audit Commission that the delegation of budget management to local service managers is likely to increase the potential for service responsiveness to individual needs.

see page 50 on support for frontline staff.

Depending on the scale of change introduced, continuous support for frontline staff involved will need to be made available, eg in budget and human resource management, training, IT, etc.

STEP 4 FINALISING PROJECT PLAN

A recommended model and a picture of organisational development requirements should eventually emerge from the mapping process. Conclusions should be written into reports (for example those of the integration project team) and should be reflected in service redesign.

[see page 48 for more on project planning](#)

Practitioners might also begin gradually to introduce aspects of the new approach into their routines and to establish a process for monitoring and evaluating the benefits for service users.

MULTIDISCIPLINARY
TEAMS





Challis D et al. 'The value of specialist clinical assessment of older people prior to entry to care homes.' *Age and Ageing* Volume 33, Number 1 2004, pp 25-34

research messages

There are limits to how much one can generalise from the findings of many studies on joint or integrated working, but the guide can end on a more positive note about a study by David Challis and colleagues at the Personal Social Services Research Unit (PSSRU), Manchester University, and published in *Age and Ageing* in January 2004. It is important because the research design was experimental, with a large sample size, which suggests some measure of confidence can be placed on the findings. It is to be hoped that more research of this type will be undertaken.

The objective was to ascertain through a randomised controlled trial the value of Social Services obtaining a specialist NHS clinical assessment before placing an older person in a residential home, and redesigning the decision-making process accordingly.

A partnership between NHS clinicians and care managers was established at the heart of the project. A sample of 256 older people at risk of care home entry was randomly allocated to either a control group, who received the usual care management assessment, or to an experimental group who, in addition, received a clinical assessment by a geriatrician or old age psychiatrist.

The clinical assessments uncovered covert morbidity previously unknown to care managers particularly in respect of cognitive impairment, opening up alternative treatment and management options. Those receiving the clinical assessment went on to experience less deterioration in their physical functioning, had less contact with nursing homes and emergency services and their carers experienced reduced levels of distress. Overall, the costs of care for those receiving the assessment were no greater, with NHS costs actually lower. Both partners benefited from pooling expertise, establishing a new protocol, and opening direct communication; and improved outcomes for users and carers resulted.

Section 8 in summary

By identifying services whose quality and effectiveness can be improved by integration, and by clarifying the numbers of potential users with complex needs who in particular can benefit, a basis for redesigning the care system can be established. Specialist multi-disciplinary teams and services can be created with clear links to more universal health and community services. The engagement of frontline staff in these processes, and purposeful support to team and organizational development, will assist the process of change.

Multi-disciplinary teams or **co-ordinated networks** are the main means of collaboration between practitioners to commission and deliver services, and ensure the collection and distribution of information on needs and outcomes.

They should:

- have a single manager (or co-ordinator)
- include a mix of staff appropriate to role of team
- have a single point of access, single assessment process, record system, administration
- work within a delegated budget
- commission individual care programmes.

They must link easily and coherently with universal services, such as GPs and schools, and with more specialist secondary care services, eg hospitals and residential schools.





The guide in summary

In Part One the guide introduced the idea of a continuum of co-ordination, from fragmentation to integration, and from autonomy to integration. In considering action to achieve integration, Part Two has emphasized the interdependence of various levels within a whole system of governance and care provision. The complex system that they represent together, and some of the main issues involved, are brought together here.

building critical capacity

plotting where you are and where you want to be on the continuum of care

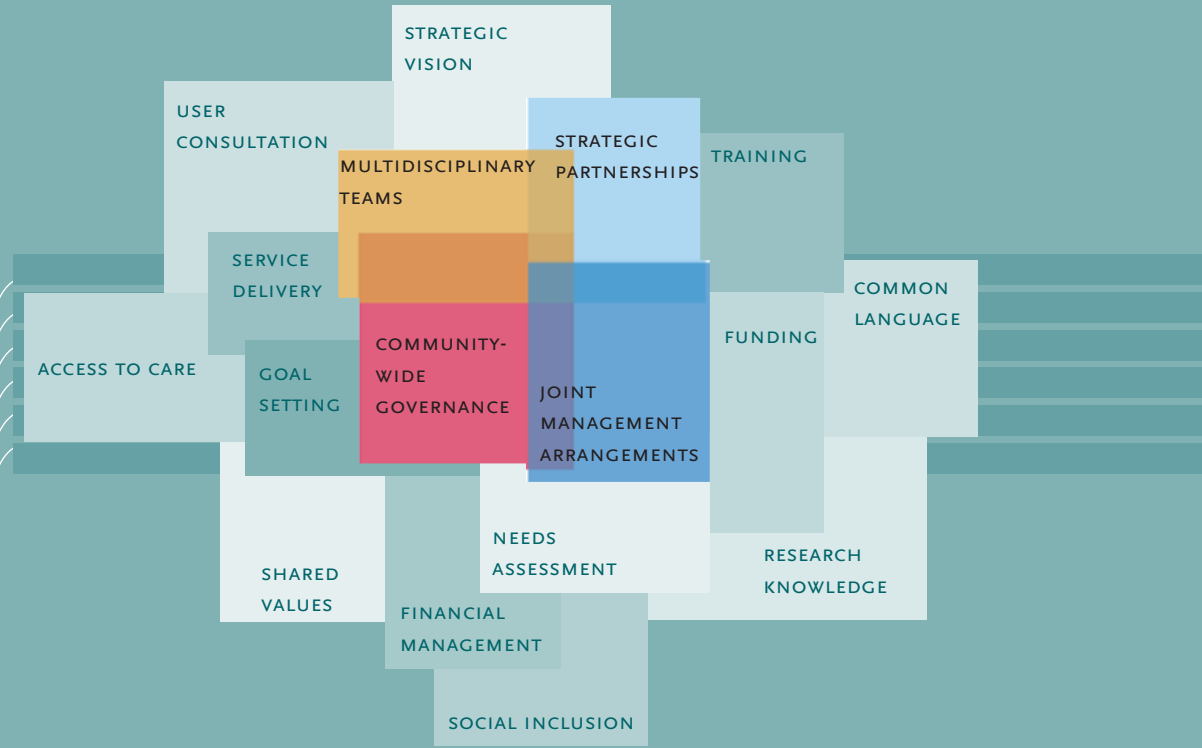
deciding the single system of care required for specific groups

keeping the intended benefits for users at the heart of all developments

responding to the Integrated Care Network's five target areas for development

investing in organisational development programmes







We can now move on from referring to Integrated care as a project and consider it as our established way of working.

participant in the Midland Health Board project described on page 63
www.mhb.ie/mhb/Publications/IntegratedCareOneNetworkICON/



BRINGING THE NHS AND LOCAL GOVERNMENT TOGETHER

What is the Integrated Care Network?

The Integrated Care Network (ICN) provides information and support to organisations using the integration of the planning and delivery of NHS and Local Government services to improve the quality of provision to users, patients and carers.

Key to the role of the ICN is the facilitation of communication between frontline organisations and central government, so that policy and practice inform each other effectively.

What does the Integrated Care Network do?

The resources that the ICN provides include:

- interactive website
- national meetings for the sharing of information (see website events' page for dates)
- local and regional initiatives that promote integrated working
- learning networks to share knowledge and enable organisational development
- discussion and briefing papers
- support to organisational development programmes
- consultation, facilitation and brokerage
- evaluation and sharing of good practice
- publications
- applied research and academic links.

The ICN measures its effectiveness through the impact it has upon the following five areas:

- access to care
- re-shaping of care services
- greater engagement with local communities and those experiencing social exclusion
- reshaping of financial and other resource flows
- developing and re-designing workforce patterns.

Who uses the Integrated Care Network?

The users of the ICN are primarily senior and middle managers, non-executive directors and elected members drawn from frontline organisations or those with a responsibility to support frontline organisations, together with academics.

Who sponsors the Integrated Care Network?

The ICN is sponsored by a range of representative bodies and government departments:

- Association of Directors of Social Services
- Local Government Association
- Improvement and Development Agency
- NHS Confederation
- Health and Social Care Change Agent Team
- National Primary and Care Trust Development Programme
- Department of Health
- Office of the Deputy Prime Minister.

This combination of sponsors uniquely positions the ICN both at the front line and within central government.

How to find out more about the Integrated Care Network

Go to our website -

www.integratedcarenetwork.gov.uk

To keep up to date with the ICN specifically and the integration agenda generally register online to receive regular updates, by email.

Contacting the Integrated Care Network

email: go to **Contact us** on the website

tel: 0113 254 6806

fax: 0113 254 5299

post: Integrated Care Network

Room 1N35C

Quarry House

Quarry Hill

Leeds

LS2 7UE

www.integratedcarenetwork.gov.uk



OFFICE OF THE
DEPUTY PRIME MINISTER

