Integrating Better: Sharing Practical Examples of Integration
<table>
<thead>
<tr>
<th>Time</th>
<th>What</th>
<th>Who</th>
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<tbody>
<tr>
<td>11:53 – 12:13</td>
<td>Perspectives on integration from national actors – what does quality health and social care look like</td>
<td>Jane Silvester, Associate Director for Social Care, NICE; Fiona Russell, Senior Advisor, LGA</td>
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<tr>
<td>12:15 – 12:25</td>
<td>How to launch and run a social prescribing service (Leeds)</td>
<td>Lindsey Bell, Primary Care Commissioning Manager, Leeds CCG</td>
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<tr>
<td>12:25 – 12:35</td>
<td>The challenges facing integrated community teams and how to overcome them (Wirral)</td>
<td>Phil Forester, Integrated Commissioning and Urgent Care, Wirral CCG and Borough Council</td>
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<tr>
<td>12:35 – 12:45</td>
<td>Home first from hospital – challenges, successes and lessons learnt (Somerset)</td>
<td>Tim Baverstock, Strategic Commissioning Manager, Somerset County Council</td>
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<tr>
<td>12:45 – 12:55</td>
<td>Beyond social care services – how you can involve the Fire Service and housing partners (Gloucestershire)</td>
<td>Donna Miles, Lead Commissioner Health and Social Care, Gloucestershire CCG</td>
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Integrating Better Project

Keir Shillaker
Strategy Group
NHS England
Aims
➢ To build on existing work
➢ To capture and share best practice
➢ To accelerate whole-system integration
➢ To improve services and support for individuals

How?
➢ Working collaboratively
➢ 16 local sites
➢ Interviews and workshops
➢ Understand barriers and how to overcome

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Common Themes

1. Theme 1
   Prevention and wellbeing – promoting self care and independence

2. Theme 2
   Ongoing care – maximising independence and wellbeing at home

3. Theme 3
   Care and support in a crisis

Integrating Better How-to Guide
- Practical approaches and lessons learnt
- Check Lists
- Case Studies
- ‘Starting Point’ documents

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What does quality health and social care look like?

Jane Silvester
Associate Director for Social Care
NICE
Unlocking capacity: smarter together

Jane Silvester – Associate Director, Social Care & Leadership, NICE (Quality Matters partner)
Quality Matters: shared focus areas for improvement

**Quality Matters** – a shared commitment by partner organisations to high-quality, person-centred adult social care

**Shared focus areas for improvement** (priority 5) – promoting collaborative working between health and social care to:

- improve quality
- support people to live the lives they want

**Priority 5 partners:** NICE, Skills for Care, Care Provider Alliance, CQC, LGA, ADASS, NHS England & the National Dignity Council
Unlocking capacity: smarter together – new resource

Digital resource developed by priority 5 partners for local system leaders

Designed to inspire and support local areas to take the next step in their journey of collaborative working.
Navigating adult social care – animation

- Unlocking Capacity: Smarter Together
- NHS
- Local authority
- Care providers
7 local case studies

Surrey Heartlands
Health and Care Partnership (an integrated care system - ICS)

Isle of Wight Local Care System (LCS)

Rising to the challenge

A local care board was set up, including senior representation from the local authority, CCG and integrated NHS trust. This has recently been expanded to include voluntary sector and GP Federation representation.

The local care board provides the strategic impetus for collaborative changes and has seen a significant positive change in key system indicators.

System achievements from the last year include:

- Permanent admissions into residential care reduced by over 50%.
- Delayed transfers of care across the system reduced by over 30%.

Frimley Health and Care Integrated Care System (ICS)

A history of collaboration

When the ICS was established it included a mix of local authority and health leaders on the board from the start.

The areas covered by Frimley ICS have a history of good collaborative working between health and local authorities.

Of the 7 strategic ICS workstream boards, 2 include care provider representation.

System leaders attribute improving trends in key performance areas to their ability to work as a cohesive system.

Integrated care model

To improve seamless access to care and support, Frimley ICS have introduced an integrated care model in Surrey.

Lincolnshire Sustainability and Transformation Partnership (STP)

Building trust and relationships

Lincolnshire STP describes itself as a single system, united around local people.

There is good collaboration between health, the local authority and care providers, through the Lincolnshire Care Association.

Trust-based relationships have been actively developed between local leaders.

While differences in culture and language still exist, they’ve proved their ability to work through difficult conversations and remain seated at the table together.

Steps for effective collaboration

A senior executive team, with executive members of the local authority, 4 CCGs and 3 NHS trusts meets once a week to address strategic issues affecting the local population.

In the short video below, the local authority director of adult services, the CCG chief clinical officer and the Lincolnshire Care Association chair discuss effective collaboration.
High level steps to support collaboration

9 steps for collaborative working

Based on our case studies

Can be applied on a big or a small scale
OUR OFFER TO YOU

Our collective offer to support collaborative working between health and adult social care.

The national partner organisations involved in developing this resource have a range of offers and resources to support local systems with collaborative work to improve quality. We have listed links to each of these below.

Tell us about your local work
If this resource has inspired you to take your next step in developing collaborative working between health and social care, please let us know. We’ll help raise the profile of your local collaborative work and share your experiences with the Quality Matters board.

Download elements of this resource
Animation (YouTube)
Local Partner STP video (YouTube)
Individual case studies (PDF files)
Full ‘unlocking capacity, smarter together’ resource (PDF)

• NICE
• Skills for Care
• CPA
• CQC
• LGA
• ADASS
• NHS England
• National Dignity Council
Over to you.....

People accessing services want seamless care and support, it makes a huge positive difference to their quality of life.

- **Use this resource in your local area** to inspire action and to take your next step.
  

- Look out for our **regional events** later in the year – designed to help you with your local collaborative work.
Unlocking Capacity: Smarter Together
What does quality health and social care look like?

Fiona Russell
Senior Advisor
Local Government Association
Perspectives on integration

Fiona Russell,
Senior Adviser,
Local Government Association

6 September 2018
What does ‘good’ look like?

• Integration vision developed by LGA, NHS Confederation, NHS Clinical Commissioners and ADASS in June 2016
• Ten characteristics grouped as three broad principles
  – **Shared commitments**: person-centred, preventative, focused on ‘place’ and the communities’ strengths
  – **Shared leadership and accountability**: collaborative leadership, trust, local accountability to place not organisation, subsidiarity principle
  – **Shared systems**: integrated commissioning, provision, workforce, IT
• Currently reviewing vision and the evidence base
• These highlight progress, barriers and enablers – and are mirrored in the good practice we’ll see from today’s examples
What have we learnt since 2016?

• Local, shared ownership and leadership, with a common purpose and vision around improving outcomes
• Essential this drives a new working culture, shared by all
• Shifting culture from dependency to one of empowerment
• Focus on wellbeing, keeping people well and diverting from formal or statutory services where possible
• Integration is about better health and wellbeing for people, not structures or targets
• Co-producing everything with service users and the community; building care (in all its guises) around them
Practical Examples of Integration

Keir Shillaker
Strategy Group
NHS England
How to launch and run a social prescribing service

Lindsey Bell
Primary Care Commissioning Manager
NHS Leeds CCG
Key themes

1. Purpose of the service
2. Influence of deprivation
3. Integrating general practice from the start and throughout
4. Integration with wider networks
Social Prescribing in Leeds

Based in **South & East** of the city. Run by Leeds Mind in partnership with Barca-Leeds, Better Leeds Communities, Hamara, Leeds Irish Health and Homes and Touchstone.

Based in the **North** of the city. Run by Community Links in partnership with Feel Good Factor, Age UK Leeds and One Medical Group. The service also include 7 practices who directly employ their Wellbeing Co-ordinator.

Based in the **West** of the city. Run by Barca-Leeds with Better Leeds Communities, MIND and Touchstone.
Purpose of the service

- **Case management**: Patients with highly complex conditions. 5% of patients = 70% of costs.
- **Disease management**: High risk patients requiring specialist disease management.
- **Supported self care**: 70-80% of people with less complex conditions.
- **Population-wide prevention**: Signposting, lifestyle advice and guidance.

[Website Link] [Twitter Handle] [Hashtag]
Influence of deprivation

Leeds Health and Wellbeing Strategy 2016-2021

Health inequalities
Improving the health of the poorest the fastest
Weighted support within social prescribing services to 10% most deprived communities

Wider determinants of health
Good work, money & resources, housing, education & skills, food, transport, our surroundings, family, friends & communities.

Social isolation and loneliness
Supporting independent living, reducing falls and reducing excess deaths during the winter.

Community resilience
Using relationships and resources in communities as building blocks for good health.

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• Piloted with a number of local practices
• Main aim of service to support better management of demand in general practice
• Maximising use of the GP/Nurse as a trusted professional
• Maximising use of the Doctors Surgery as a safe space
• Social Prescribing directly linked to one or a group of practices
• High levels of practice satisfaction and ownership with the service
Integrating with wider networks

Current emphasis of resources and focus
- Prevention
- Self Care
- Primary Care
- Secondary Care

Leeds Left Shift

Future emphasis of resources and focus
- Prevention
- Supported Self Care
- Enhanced Primary Care
- Secondary Care

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Integrating with wider networks

Local Care Partnership

Primary Care Team
- GP
- GP
- GP
- GP

Practice Nurse Team

Hospital Specialists
- Consultants and Specialist Nurses

Single Integrated Teams based around General Practices
- Community Care Teams
- Adult and Older Person’s Mental Health Team
- Social Care Services
- Social Prescribing Services

New Extended Multispecialty Team

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Shared learning

• Reductions in primary care activity with statistically significant reductions in attended appointments and did not attends
• Service users predominately lower risk, low intensity users – frees up capacity to allow GPs to address more complex patients
• Some evidence of a reduction in the number of non-elective inpatient bed days in hospital
• Statistically significant improvements in SWEMWBS scores across all three projects
• Evidence of improved confidence to self-manage through greater support
• Improved health and wellbeing, ability to manage relationships and social connectedness
• High levels of patient satisfaction across the three services
The challenges facing integrated community teams and how to overcome them

Phil Forester
Integrated Commissioning and Urgent Care
Wirral CCG and Borough Council
Integrated Commissioning & Roles/Approaches which made a positive impact

• Integration of CCG & Council Commissioning (Adults, PH, Children's)

• Joint Executive led by CCG Chief Officer and Director of Adult Social Care

• Pooled Budgets

• Committee in Common

• Joint roles which have influenced change;
  - AD for Unplanned Care & Community Care Market Commissioning

• Joint QIPP & Recovery Plans
Integrated Community Teams – Lessons Learnt

- Set clear contractual arrangements
- Set clear KPIs and activity measures
- Assurance to elected members
- Partnership approach (not contracted out and leave)
- Importance of ‘mature’ relationships between commissioners and providers
Home First from Hospital: challenges, successes and lessons learnt

Tim Baverstock
Strategic Commissioning Manager
Somerset County Council
4 Simple Integration Tips

- Identify key joint drivers

- Challenge is healthy (at all levels) – the “PDF” methodology

- Mechanisms for joint decision making

- Provide training differently across acute and social care services.
Identifying key joint DRIVERS

• Important to have shared interest and gains. Shared change is more effective than isolated change.

EG:
• Patient/Person experience and outcome – using the evidence that prolonged hospital stays give poor outcomes for people. This created common ground and a concept of doing the right thing for the people we care for.
• Benefits are judged system wide rather than by organisation
• Visible senior buy in to the change and partnership across organisations
• Having to work at pace to solve an urgent issue helped. Integrated working is easier in a practical setting focussed around the person
CHALLENGE is healthy – “PDF”

• Encourage discussion across teams, departments, structures and professions – allow challenge with no fear.

EG:
• Practice Development Forums (PDF) were established, to allow joint discussion, challenge, shared decision making and ownership
• Difficult conversations initially but that was needed. Support of leaders made challenge acceptable and encouraged joint problem solving.
• “This work has enabled and encouraged a challenge to traditional thresholds of decision making, attitudes to risk and established patient pathways”
• Challenge across systems is difficult e.g. “Who are you to question my clinical judgement?”
• Community Agents – whole different perspective to conversation
JOINT decision making mechanisms

• Joint decision making (facilitated by joint posts) is crucial to change

EG:
• Used joint posts (LA and Acute) to create joint buy in and trust across organisations
• Did not spend ages trying to integrate structures, let them evolve and test and learn
• Lack of oversight and clear authorisation across all organisations causes hand offs and delays for the person. It also means organisations work against each rather than with the person at the centre
• Multi-disciplinary teams
• Encouraged clinicians/therapists to experience life outside of a hospital – follow people home – understand the difference it can make to peoples presentation and wellbeing
• Joint data solution – one version of the truth
Different TRAINING

- Providers traditionally have training and regulation in isolation and specific to their own provision

EG:

- Social Care providers were trained in reablement alongside hospital therapists and HCA's
- Acute staff support pathway settings – momentum, ownership and continuity but also learning on all sides
- Our Home First Social Care providers feel part of the system solution not part of the problem – engaged and valued.
DToC have improved markedly (-75%)
Beyond social care services: how you can involve the Fire Service and housing partners

Donna Miles
Lead Commissioner Health and Social Care
Gloucestershire CCG
### Gloucestershire – Integrated working with Glos Fire & Rescue Service

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<tr>
<th>What is the model of care and how was it developed?</th>
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<td>Vulnerable and elderly people were prevented from returning home from hospital if they lived alone and were unable to nominate a ‘responder’ for the Telecare (Community Alarm) service – with the alternative being a care home placement, either short or long term. By working with GFRS retained fire fighters, we piloted and quickly rolled out as a county wide service, GFRS being responders for these people enabling them to return to their own home and act as their ‘friend or family member’.</td>
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<th>What is the structure and composition of the team?</th>
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<td>The processes were developed from the initial pilot between GFRS' Prevention Manager and her team, the Telecare service, Commissioning and the call monitoring centre. This service is embedded as BAU.</td>
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<th>What changes to pathways have been made?</th>
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<td>GFRS are automatically assigned people who fit the above criteria when referred into Telecare. In addition, GFRS use their ‘Safe &amp; Well’ visits to signpost to Telecare and / or when they respond they will carry out a visit which includes falls assessment, supported self assessment for basic equipment, encourage flu vaccinations, tackling social isolation, referring into other appropriate agencies and / or report any safeguarding concerns.</td>
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<th>What were the results (Impact and outcomes)</th>
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<td>c450 people are currently being supported by GFRS. This service has enabled a significant number of people over the last two years to return to their own home, supported and signposted to relevant services. The SORI was calculated as £2.9m per year to our system. A refresh of this will be available during 2018. GFRS have included this role within their recruitment campaigns and helping people in their local communities has in turn led to an improved retention rate. GFRS are also working with SWASFT as co-responders and cardiac care. We are exploring how GFRS can support non-injurious falls pick up to release valuable capacity to respond to emergencies.</td>
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Extent of integrated working with GFRS

GLOUCESTERSHIRE FIRE & RESCUE SERVICE

Assessment & Installation
On going discussions around contracts
Allows self assessment
On Station Clinic Rooms
Skillzone Clinic Room
SMART CLINICS
EYE HEALTH INEQUALITY
Early Prevention
Early intervention & Identification
Eye Clinics on Station

Use Statistical Data to profile those most at risk of having a fire and offer a Safe & Well check
Safe & Well visits for the most vulnerable (top 2%)
Response Service
RISK STRATIFICATION
TELE CARE
Stability Classes
Early Prevention & Assessment
Falls Follow Up Visit
Equipment, Assessment & Fitting
Community Support Teams
Hospital Discharge
Link to longer term Support Agencies Age UK, Village Agents

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Extent of integrated working with GFRS
Questions for the panel?
If you would like more information on our guide please email:

england.integrating-better@nhs.net