FOR HEALTHCARE LEADERS
HSJ INTEGRATION
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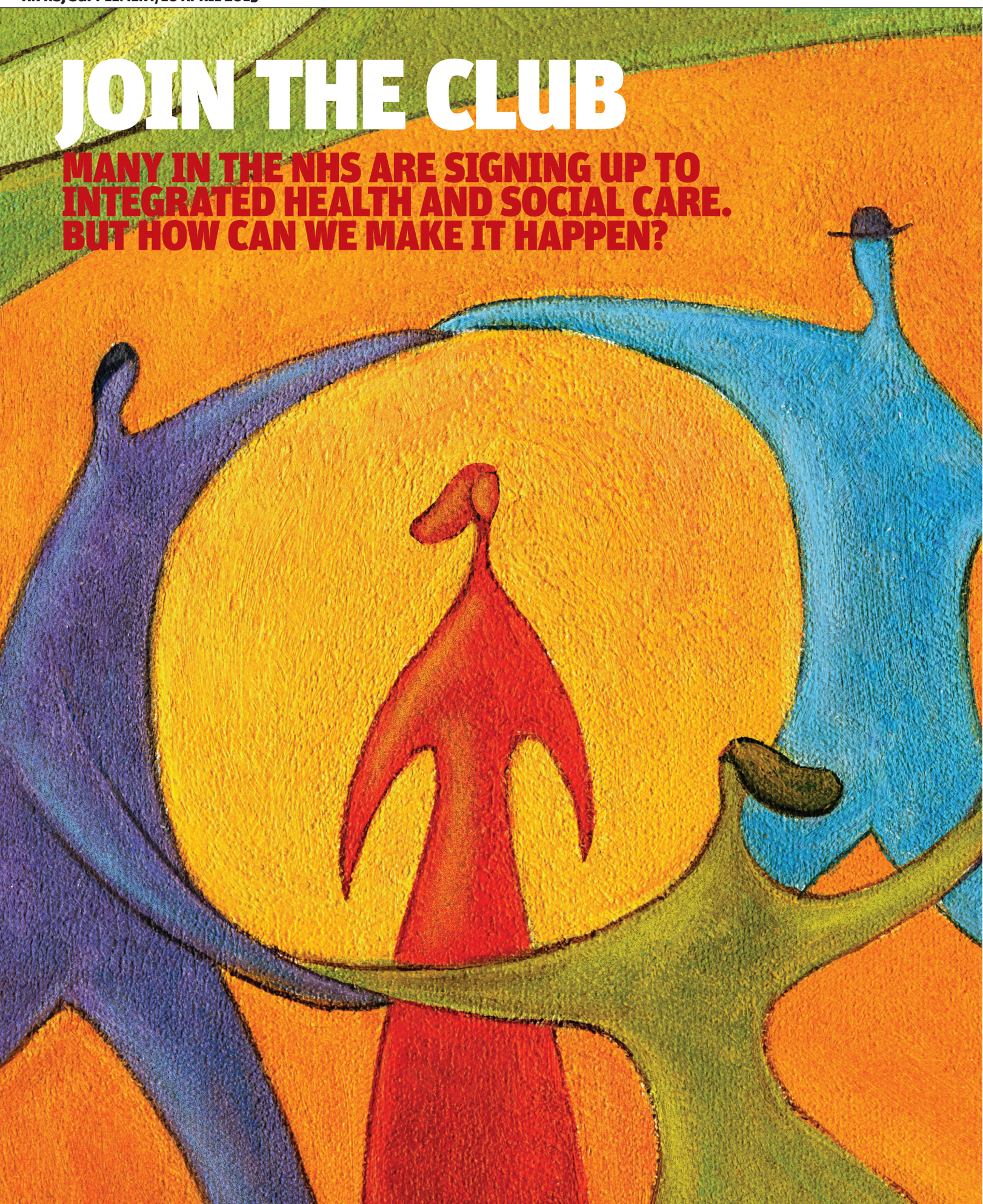
MANY IN THE NHS ARE SIGNING UP TO INTEGRATED HEALTH AND SOCIAL CARE. BUT HOW CAN WE MAKE IT HAPPEN?



OVERVIEW

‘EVERYBODY’S TALKING ABOUT IT’

Integrated care has been a goal for the NHS almost since it was founded. Now that it is finally top of the agenda, can local and national leaders seize the opportunity to deliver it? Jennifer Trueland reports

When Jo Webster first read the *NHS Five Year Forward View*, there was a lot in it that she recognised. As chief officer of Wakefield Clinical Commissioning Group, she was already a strong advocate of the themes in Simon Stevens’ vision document, not least around integration.

“We’ve been working on breaking down traditional barriers for some time,” she explains. “We recognised at a strategic level that we needed to do something dramatically different, something that had strong public engagement, and involved partnerships with teeth. We decided that the best way forward was to take a collaborative approach to allow providers to work with us and with each other.”

Last month it was revealed that Wakefield CCG was one of 29 organisations that successfully bid to become a vanguard site for the New Models of Care Programme.

Making the announcement, NHS England said it was one of the first steps towards delivering the forward view and supporting improvement and integration of services.

It is clear that there is high level political support for integration. Not only is it a focus of the forward view but it is also backed by serious resources: almost two years ago, the government announced establishment of the better care fund, a £5.3bn investment intended to incentivise the NHS and local government to work more closely together.

Although this fund has been accused of being too bureaucratic, even its critics recognise that it is well intentioned.

But will it be enough?

Hugh Alderwick, programme manager for integrated care at the King’s Fund, says that, while there are reasons to be optimistic, action is needed.

He is joint author of a King’s Fund report, published in February, *Population Health Systems: Going Beyond Integrated Care*, which calls on policy makers and leaders to go beyond integrated care to improve population health.

“People have been talking about the need for integration almost since the health service was founded, and certainly since the 1960s,” he says.

“It’s something that we’ve been trying to do for a very long time, but people have found it very difficult. There’s a political will to make it happen and there’s general acceptance that it’s a good thing, but the policy barriers still exist.”

The barriers he lists are familiar, and include payment systems that disincentivise joint working and fragmented commissioning arrangements.

Nevertheless, Mr Alderwick points out that there are areas in the UK, such as Torbay and Wigan, where integration is working well. “But that doesn’t mean it’s the norm,” he says.

So what are commissioners and providers doing to make integration a reality?

Wakefield CCG is a vanguard site in the category of enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.

But the local health economy’s approach to integration does not stop at the care home door. Rather, health services, social services and others are working together to provide better joint services across the board.

‘There are areas in the UK such as Torbay and Wigan where integration is working well’

The new processes are being led by an integration executive group, headed by Ms Webster and Andrew Balchin, the Wakefield Council corporate director for adults, health and communities.

Commissioners and providers – including social enterprise, community and third sector representatives – are equal partners in the group, which is also responsible for the area’s £42m pooled budget from the better care fund.

Early work as part of a joint health and social care “Connecting Care” programme has united specialist community nurses, social workers, therapists and workers from voluntary organisations, such as Age UK, in single teams. The teams are in hubs tied to networks of GP practices.

Shift to prevention

Mr Balchin would like to see this go further. “We’re looking to a systems shift from delivering care to prevention,” he says. “We talk about things like ‘better care’ and the Care Act, but I think that’s only half the picture – we want to stop people needing care in the first place.”

There is no silver bullet to make integration work, says Ms Webster, but a key element is ensuring commitment to collaboration at every level, from leaders to frontline staff; investing in strong strategic leadership was key.

“There’s lots more to do but we are delivering,” she says.

It is not only the vanguard sites that are taking a lead on integration. City and Hackney CCG, for example, is taking an innovative approach to integration and collaboration for frail older people and those at the end of life.

The One Hackney Alliance is made up of a

Thinking together: integration demands collective leadership and decision making

group of local providers including acute, community and mental health trusts, the local authority, voluntary sector, GP confederation, and out of hours provider.

Last year the CCG charged this alliance with designing joined up services for the local population. Payment is contingent on outcomes suggested and agreed by the alliance itself.

"The health and social care economy was already performing quite well but we wanted to better support collective leadership and shared decision making across the local provider community," says Mark Scott, programme director for integrated care and urgent care at the CCG.

"Essentially, we set out the commissioning challenges and then put the responsibility on the providers to work together to find solutions. It's a recognition that no single part of the system is solely responsible for reducing hospital admissions, or getting people out of hospital, – everyone has their part to play."

There are good relationships with the local authority, which has been supported by the preparation for the better care fund, he adds.

"I think the benefit of this approach is that it encourages local provider ownership of both the problems and of the solutions."

Paul Jenkins is chief executive of Tavistock and Portman Foundation Trust, one of the providers in the alliance. He also chairs the One Hackney programme board. He believes that taking time to build trust and relationships has been vital.

"Don't underestimate the time it takes," he says. "It's also been important to have dedicated project resources. Too often these initiatives are done by busy people in their spare time, but dedicated project resources are crucial to making things happen."

Sharing information remains a challenge, Mr Jenkins says, pointing out that if the systems allowed better sharing of care plans, for example, it could prevent hospital admissions at end of life.

The trust came into the alliance as a specialist provider of psychotherapy in primary care, but he believes that its wider involvement has helped to ensure a strong focus on mental health and has helped foster an ethos of reflection.

From a provider perspective, he says he is a fan of the alliance system. "It's an attractive model to get providers to work together," he says. "It's in everyone's interests to make it work."

Mr Alderwick hopes national and local leaders will seize opportunities to build on integration to improve population health.

"The language battle has been won – everybody is talking about integration," he says.

"It's great that it's becoming an established thing. But we need to be clear about what we actually need.

"Integration isn't an end point in itself: it's part of the journey, and should be part of a broader shift to improving population health and wellbeing." ●

IN THIS SUPPLEMENT

ALAMY

BritishRedCross

PARTNERSHIPS

IT'S A HOME RUN

They ensure vulnerable patients reach their homes comfortably, make follow-up calls and can provide up to six weeks social support. Daloni Carlisle on how British Red Cross volunteers are supporting A&E discharge

If you had been waiting in the accident and emergency at Leighton Hospital in Crewe this winter, you would have seen a couple of friendly faces atop bright red uniforms: that of the British Red Cross.

The BRC volunteers have been working in this busy A&E since mid November, helping patients who do not need a hospital bed, but rather to get home quickly and safely. By late January they had helped over 200 patients home.

Amanda Palin, A&E discharge service manager for the BRC at Leighton Hospital, explains how the service works.

"We have a small team working in the discharge lounge in A&E and in the patient intervention unit," she says. "We are on duty from noon until 8pm. We work with the discharge team at the hospital to identify vulnerable patients who could be discharged home safely with our support."

They use their own cars to drive the patients home, settle them in and follow them up for 24 hours.

"We make sure the house is warm and safe and give the patient an information pack about local services," says Ms Palin. "We fill in a patient passport if that's needed, with details such as what has happened to them, how they like to be addressed, what is their favourite food and so on. This is crucial if people cannot speak for themselves."

If a patient has left hospital before take home medication has been dispensed, the BRC delivers them.

On day two, they make a follow-up phone call. If all is well, great. If not, the volunteers can refer patients to the BRC's Home from Hospital scheme that provides up to six weeks social support, such as help with shopping and befriending (see box, right).

Both Ms Palin and Denise Frodsham, chief operating officer at Leighton Hospital, describe the service as "incredibly successful".

"It has amazed us how the service has become part of the team within such a short time," says Ms Frodsham. "Patients recognise the Red Cross uniform and they trust it. They look smart and professional and always have big smiles on their faces. I see them holding elderly patients' hands and comforting them."

Often a new service needs time to bed down but Mrs Frodsham says this has not been the case.

"It's gone like a dream," she says. "I cannot tell you how smooth it has been. You see them talking to the discharge team like they have always been here."

Part of the success is that the volunteers do the important caring jobs that are now beyond the capacity of busy clinical staff in an A&E department receiving one-third more ambulances than last year and an increasing number of very elderly patients aged over 90. They make tea, they hold hands, they listen and reassure and then they do something very practical. The clinical staff know the impact this has on patients.

"The hospital discharge team bought the Red Cross workers a box of biscuits at Christmas to say thank you," says Ms Frodsham.

Leighton Hospital kept the A&E open this winter and did not declare a major incident. Undoubtedly, the BRC's role complementing NHS services was crucial in this.

Ms Frodsham is reluctant to say the service has prevented x number of admissions or saved y number of bed days,

Shirley Green says her experience of the Red Cross volunteers was 'just like having friends over'

Guiding hand: Red Cross volunteers help patients get home and settled in, and follow up with them over the next 24 hours

recognising that it is just part of the jigsaw of services.

It is a jigsaw assembled by Cheshire's Health Economy Operational Resilience Group that brings together the hospital trust, community services, GPs, social services and the CCG.

Last summer this group put together their bids for winter funding, top slicing some money to commission third sector services, of which the BRC A&E discharge service was one.

The fact that the set up, integration and operation of the service in Crewe was so smooth comes as no surprise to Sue Collins, head of independent living at BRC. "We were asked to set up a service by Worcester CCG this winter," she says. "We managed to get it up and running in 24 hours."

The Red Cross now runs 26 such A&E discharge services alongside 86 Home from Hospital schemes and has another 19 contracts with ambulance trusts. Last year BRC supported just short of 500,000 people with independent living services.

Ms Collins gives four key characteristics of the BRC's approach. "Local and national leadership is crucial – having the right conversations with the right people at the right time," she says.

The approach is proactive – they go to chief executives of trusts and CCGs not with a bid for funds but with a practical solution to a problem. They provide evidence – for example, she has been able to demonstrate over £100,000 savings at one hospital alone.

'Given winter pressures, it is no surprise there is interest in what the third sector can do to support the NHS'

"We have a shared value base," she adds. "Like the NHS, we are focused on service user dignity and put the patient at the heart of what we do."

Finally, the BRC is a "can do" organisation, with a clear mandate to provide a crisis response and able to call on 30,000 trained volunteers. "This solution is scalable," says Ms Collins.

Given the winter A&E pressures in 2014-15 it is no surprise that there is now national political interest in what the third sector can do to support the NHS.

In January, Sir Jeremy Heywood, the cabinet secretary and head of the civil service, and Una O'Brien, permanent secretary at the Department of Health, met with a delegation from the Red Cross, Age UK and Royal Voluntary Service, led by the Association of Chief Executives of Voluntary Organisations, to consider the matter.

Now more winter funding has been allocated to these organisations, not just for A&E discharge but also to help hospitals prevent delayed transfers of care.

Back in Crewe there is a real sense of pride at what has been achieved in a few short months.

Ms Palin describes her team as "proud" to work alongside the NHS.

Mrs Frodsham, meanwhile, is busy working to extend the service beyond the winter and into spring. Would she recommend other hospitals work with BRC to develop similar services? "Absolutely yes," she says. "I just wish someone had recommended it to us sooner." ●

PATIENT'S STORY: 'THEY GAVE ME UNLIMITED TIME'

"My name is Shirley Green and I'm an 81-year-old widow living in Woodbridge, near Ipswich, where I've lived for 25 years. On 16 December I was walking my greyhound Psyche when I had a fall. I'm usually very active and walk her for at least an hour a day, so it was a shock.

I had to stay overnight at Ipswich Hospital to have a scan of my head to make sure I was OK. The next day I was nervous about getting home on my own after being in hospital, but the Red Cross came up trumps.

Their volunteers took me home from hospital and made sure I was fine on my own, gave me information on schemes and how they could help, and asked if there were any practical things I needed around the house, such as mobility aids.

They also helped by checking that everything was safe and warm for the winter. And when I needed to get my Christmas food, Amy, one of the Red Cross volunteers, helped me with that as well.

My only daughter, who lives in Wales, visited me the next day and was pleased to see I was being cared for so well at home by the Red Cross. She's said she has peace of mind now I'm being looked after like this.

It would have been completely different being on my own without the Red Cross's help, and I gave them a donation to show my gratitude.

The two Red Cross ladies who supported me to get back home were charming, extremely helpful and caring.

They gave me unlimited time, and I was not rushed.

They carefully checked I would be able to manage everything, without making me feel a liability.

There's nothing as good as being at home. It was even better when the Red Cross ladies rang the next day and the day after that to see if there was anything else I needed, and Amy helped me to the hospital for my checkups. The volunteers are just like friends coming round.

My daughter and her husband are also coming round to stay and help me with a few things around the house, which I'm really looking forward to, and I've been shopping with friends and feel much better now."

BRITISH RED CROSS, ALAMY

PHILIPPE HOUSSIAU ON PREVENTION

One of the most significant challenges facing healthcare in the 21st century is the growing prevalence of diabetes. A recent Health Survey for England found that up to a third of the population is in a pre-diabetic state.

This represents a huge burden on the NHS – with NHS England estimating that diabetes care accounts for approximately 10 per cent of total health resources, predicted by others to rise to over 17 per cent in the next 20 years.

It's because we are focusing on traditional disease treatment, rather than prevention.

Research has shown that active management can halve the number of people transitioning from a pre-diabetic stage into a diabetic stage. Minimise the number of people who transition into a diabetic stage, and many would never need an acute care facility. This is where active population health management comes into play – designing care pathways that cross primary, secondary and tertiary care and into lives, topped with a health analytics framework providing relevant, accurate and predictive data – at the point of care.

How can we make this work? Awareness is key – most of those with diabetes or pre-diabetes are not aware of their condition. Early detection is vital – once people are identified as being at risk, interactive tools can be provided, allowing individuals to monitor their vital

'If diabetes can be managed across a region, that's when we will see the real value'

conditions, and preventative and care programmes can be fine tuned to help maintain or even reverse their condition. If we then capture data – making it relevant for monitoring, risk stratification and predicting outcomes – that will really make the difference. That is exactly what coordinated care is about.

The real power is that it can be scaled to health economies, analysing details on a population level. If diabetes can be managed across a region, that's when we will see the real value in this approach. I believe that this move to early wellness and disease prevention will have as profound an impact on healthcare economies in the 21st century as the ability to treat certain diseases did in the 20th century. It's the model that the most forward looking health economies are moving towards, as the Trafford Clinical Commissioning Group's Patient Coordinated Care Centre will illustrate (see case study, overleaf). Ultimately, it's a model that will help sufferers of chronic diseases remain in a pre-clinical stage, allowing them to live better quality lives.

Philippe Houssiau is vice president of healthcare and life sciences at CSC.
www.csc.com

EMPOWERMENT

FOCAL POINT

Putting patients at the centre of coordinated care is the foundation of the integration agenda. But how can we turn that ambition into practice? Daloni Carlisle reports

Now that integrated care is truly on the agenda and a must-do item for NHS organisations, the question is: are they really putting the patient at the centre?

The notion that integrated care must be person centric is one that has bubbled up slowly to the point where it is an accepted doctrine.

It is there in all the policy documents, from the King's Fund and Nuffield Trust's work as well as that of National Voices.

All of these have influenced the *NHS Five Year Forward View*, which in turn is driving new models of integrated services.

As Don Redding, director of policy for National Voices, says: "It is encouraging that the defining narrative that we produced on person centred, coordinated care has been enthusiastically adopted by the systems leaders and pioneers."

He sees a wide range of organisations starting their integration journey by developing vision statements based on this narrative of putting patients, families and carers at the centre of services.

The conversation has moved beyond policy forums and out into the NHS.

"The advent of clinicians in commissioning has enabled that," he says. "It is a way of thinking that enables some common ground to be established in terms of setting goals between commissioners and providers and what each wants for patients, what people want for themselves and what commissioners want of multiple providers."

He is cautious, though, about how quickly these vision statements can be translated into truly innovative, person centred services.

"To try to achieve the things that are envisaged, you have to take on system and structural processes," Mr Redding says.

"You need to change to produce the outcomes you want."

And that is hard work with the rewards often some way down the line. It is easy to lose sight of the vision in the process.

"It's a five or 10 year process," he says. "We are by no means secure in our confidence that the reconfiguration of local jigsaws of services is going necessarily to produce better services for service users."

Overcoming barriers

Nicola Walsh, assistant director for leadership at the King's Fund, agrees that the defining narrative of integration is person centred care.

That is partly because it is the way in which organisations on the integration journey have overcome barriers, she says.

"When you talk to the people who have already set up integrated care, they say that whenever they came across barriers they always went back to the patient because that was the shared goal around the organisations."

It is a lesson others are taking on board, Dr Walsh argues.

But again, she agrees it is not easy. "Health policy for the last 10-15 years has created independence at an organisational level and we have a mindset in health that identifies with organisations. When leaders in this system say they want to take risks and work in a different way, they may well agree in principle but at the end of the day, those individuals still report back to their individual boards."

She argues that the shift to patient centred care will require system leadership with some incentives that support leaders to take much more of a place based approach. It will also be beneficial to devolve some of

CASE STUDIES OVERLEAF ▶

Joined up: organisations are increasingly working on models that put patients, families and carers at the centre of their services

their leadership to patients and service users.

To support this, the King's Fund has recently appointed two patient leaders and developed the Leading Collaboratively with Patients and Communities programme.

At the coalface, Mel Pickup, chief executive of Warrington and Halton Hospitals Foundation Trust, says thinking in her area is firmly informed by patient centric care. "I think as a starting point it is absolutely right," she says.

"We are working here on a model that is about patients and families and carers at the centre, with services that wrap around them in concentric circles."

But fine words will surely butter no parsnips. Delivering the vision means using a new way of thinking altogether to inform choices about organisational form (mergers into a few providers or many collaborating with each other, for example), understanding where accountability lies and investing in the right means to integrate healthcare (for example, in IT that delivers shared information).

'The hospital's role in this model is really to examine and question the services we provide'

Taking responsibility

In Warrington, partners are working on a population based model in which GPs responsible for the care of around 30,000 people cluster and orient services around that population.

Within each conurbation, GPs stratify patients by risk to identify those most vulnerable, who are offered targeted support by multidisciplinary community based teams. "What we are talking about is an accountable healthcare system based around the GP list," says Ms Pickup.

Where is the hospital in all this? She explains: "We see our future role in this model being really to examine and question all the services we provide and ask: does this have to be provided in secondary care by virtue of clinical co-dependencies, critical mass, economies of scale or of equipment – or can it be provided out in the community?"

If services can be provided in the community, then what are the means? Telehealth and shared patient records will likely be key components – and recently the local authority procured a new IT system with a view to this in future: its unique identifier for residents is their NHS number.

But coming back to Ms Walsh's point that putting the patient at the centre is what helps organisations overcome barriers, Ms Pickup says: "It has brought GPs together into a community interest company. What we are now finding as acute providers is that we have a relationship with them that is outwith the CCG and is one of fellow providers.

"If we can come together with a range of providers to take more patient oriented decisions, this can be a catalyst for describing what the future will look like and how we will get there." ●

EMPOWERMENT: CASE STUDIES

AMBITIOUS MOVES

Daloni Carlisle looks at two pioneering health communities where integrated care is putting the needs of patients centre stage

Traffic control: Trafford CCG is working on a project that tracks patients as they move through the system

TRAFFORD CCG

Trafford Clinical Commissioning Group is aiming to revolutionise the way its local residents are cared for by embarking on an ambitious integrated care project.

Its working title – the Patient Care Coordination Centre (PCCC) – does little to convey the notion behind this venture between the CCG and consulting and IT services company CSC. This ambition takes a bit of explaining.

Gina Lawrence, chief operating officer of Trafford CCG, starts at the beginning. Trafford, she says, is a financially constrained health economy and for the last few years has been developing community services that could deliver better outcomes for patients and better value for money.

"We developed a whole series of community integrated services that work very well," she says. "But we found that the more things we introduced, the harder it was to navigate around the system. People were becoming confused about what was where."

So Trafford CCG came up with the concept of a service that would operate like an air traffic control system, tracking patients as they move through the system and guiding them to different services.

With no preconceived ideas of what such a service might look like practically or how it might be achieved, the CCG started a dialogue with providers. This conversation generated a great deal of interest and resulted in the appointment of CSC as the partner in creating and operating the PCCC, under a five year contract worth approximately £12m.

The vision for the innovative centre is to provide a single point of contact, both for patients and their families and for clinicians. Each patient's journey will begin with their GP making a referral by phone. A discussion with clinicians will result in the patient's onward journey being mapped out on a patient pathway. Pathways will be based on the Map of Medicine, a clinical tool that enables clinicians to plan care according to the best available evidence.

Once the patient is assigned to a particular care pathway, their ongoing management will be overseen by a care coordinator who makes the practical arrangements such as booking outpatient appointments and X-rays or arranging transport or social care support. Each care coordinator has a whole host of interfaces with different service providers available to them.

The model envisages patients being flagged up in the system as they move along patient pathways, enabling the PCCC to proactively coordinate discharge plans, for example. "We will know where everybody is in the system and can coordinate care around them," says Ms Lawrence.

In this model, there is no need for individual GPs to have information about the plethora of services available to their patients or how to contact these services. There is no need for patients or their relatives to know which number to call as there is just the one number.

The data sharing and information technology are clearly going to be crucial to the project's success. With most GPs on the EMIS system, there is a potential for creating a shared care record held within the PCCC. This is the foundation of care coordination, with individual patient data forming that air traffic control view.

The PCCC vision is now close to becoming a reality with a full go live planned for September 2015. For CSC, the development has been more than just another project. "We recognised from our

initial dialogue with Trafford that this would be a unique, first of type service and that we wanted to be their partners," says Kevin McMonagle, CSC's coordinated care lead. "We are making significant investment as we see this model as being entirely replicable elsewhere."

He envisages a series of ways in which patients, clinicians and care coordinators will view and interact with information. CSC is building in health analytics that allow functions such as patient risk stratification. These tools could, in future, allow the CCG to carry out health population management. It could put the CCG in a position where it can meaningfully support patient held budgets.

CSC is working with Orion to build portals and will use Microsoft's CRM (client relationship manager) to track patients.

Colin Henderson, Orion's general manager in UK and Ireland, says: "This is patient experience focused. How do we set this up so that the right services are made available to patients at the right time? That means setting up around the person and sharing information."

Another crucial part of this project will be finding the right people with the right skills to work in the PCCC. Here the partner is Care UK, which will recruit the clinical staff.

"From our perspective we see a connection between high quality care and value for money," says Care UK deputy managing director for secondary care John O'Brien. "One of the central tenets is tailoring services to individuals. That way you do not build in resources to pathways that are not needed by individuals." This is a key element of what the Trafford PCCC is all about, he adds.

"We have a long history of working with clinicians in Manchester," he adds.

It is easy to get swept along by the ambition and vision of people involved in this project. But all partners are wary of overselling it and admit that there are risks and challenges.

For example, is this really just another complicating organisational layer? It is a question that Mr McMonagle acknowledges must arise ahead of the go live date. "This has never been tried before so there are risks," he says. "But it is an attempt to break out of the existing model of care by bringing silos together to improve patient care and outcomes, and move integration forward."

Back at Trafford CCG, Ms Lawrence and Paul Hulme, head of implementation for the PCCC, agree that yes, there are risks, but none so great as doing nothing.

"One of our biggest challenges has been keeping people on board, with them saying this is taking too long or we should start with something smaller," says Mr Hulme. "But this is a system approach and must be for it to work."

They are clear what success will look like and will be benchmarking against other CCGs, particularly on patient experience measures.

There is a way to go yet – and in many ways it is unusual for a CCG and its partners to be this open about such an ambitious project so early. In Trafford, it is all systems go in order to get the system ready for autumn. Watch this space.

SHEFFIELD

Another example of integrated care being built firmly around the needs of patients is developing in Sheffield. Three foundation trusts (the teaching hospital, children's hospital and mental health trust) along with the city council, the Sheffield-wide CCG and all 400 GPs in 87 practices now work collaboratively.

The overall aim is to help vulnerable people live independently. The starting point was risk stratifying patients to identify those most at risk of losing that independence – some 16-18,000 of them – and developing care plans and care coordinators for them.

GPs have coalesced into 16 associations so they can work at scale and pace more effectively; meanwhile, community health services have aligned with local authority short term intervention teams under the management of the acute trust. Health and social care have pooled £260m in a better care fund.

These structural changes have supported more fundamental shifts in the way people are cared for, with the aim of avoiding unnecessary admission and assisting safe discharge.

For example, vulnerable patients are no longer assessed for discharge in the hospital but at home. "The bed stays open but the discharge processes happen at home," says Sir Andrew Cash, chief executive of Sheffield Teaching Hospitals Foundation Trust.

GPs no longer simply admit patients into the hospital but call an assessment service that visits the patient and looks for alternatives.

The next phase will be setting up three new out of hours hubs that will extend access in primary care. Like Trafford, this is part clinical services wrapped around patients and part IT with a shared patient record at its heart.

This is just a snapshot of Sheffield's work, which Sir Andrew describes as "light years" ahead of much of the NHS. Even so, he says Sheffield is still "in the foothills" of integration. "We have good partnership and we are innovative, but it is risky," he says. "It has been a massive organisational development programme where we have to train and retrain and change behaviours."

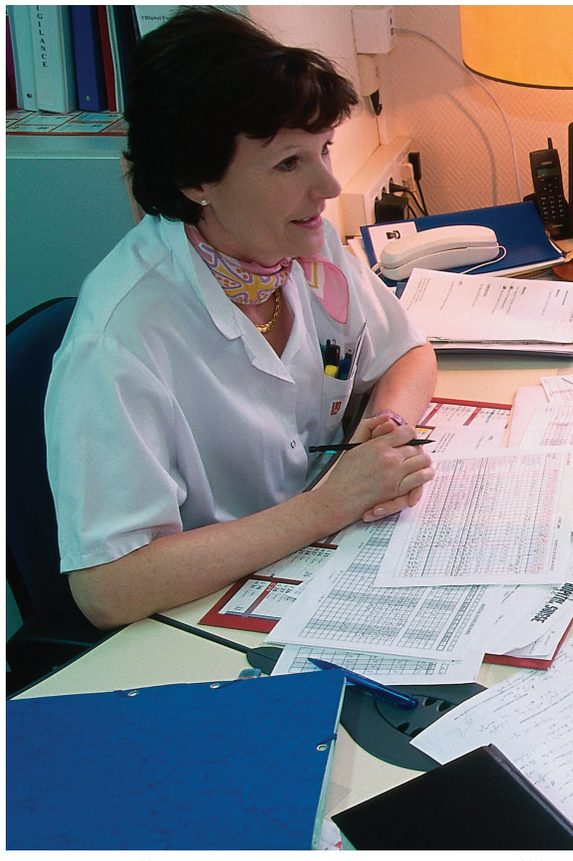
Yes, the results are starting to show. Yes, there is a long way to go. But always, this is about putting the patient at the centre. ●

ALAMY

WORKFORCE

SEAMLESS SYNERGY

Health and social care integration cannot be complete without the right skills in the right place. Daloni Carlisle talks about bringing people together, as well as building skills and competencies



Harmonising efforts: once they are in the same room, staff from

The rise and rise of the integrated health and social care agenda highlights an important question: what is being done to integrate the workforce and its planning?

This is, perhaps not surprisingly, a question uppermost in the minds of Skills for Health and over the last year the organisation has begun a new programme of work to develop thinking and practice.

Andrew Lovegrove, senior consultant for Skills for Health, believes that little emphasis has been placed on this important topic so far.

"It's the perennial problem," he says. "There are numerous examples where organisations have got it wrong and ended up without the right sort of workers in the right place. It is something the sector has battled with."

The cross-party consensus on integrating health and social care coupled with tight public finances make this an ever more pressing issue, he adds. It is a point highlighted in the planning documents that accompany Simon Stevens' *NHS Five Year Forward View*, which lists "plans to invest in and make better use of the current workforce" as one of the key conditions for future transformations. As the document notes: "The provision of health and care is mainly about people, not buildings or infrastructure."

As Mr Lovegrove notes: "An organisation spends 60-70 per cent of its revenue on the workforce. So, as models of care change and services reorganise and integrate, workforce planning and development becomes something we must do."

Over the last year, Mr Lovegrove and Skills for Health associate Christine Mullen have been working in London to develop some tools that could be used more widely by the NHS and social care sector.

Both have worked on local, regional and national level workforce planning and they agree: integrated workforce planning is tough but worth the effort.

"It's hard enough to do it with your own organisation," says Mr Lovegrove. "But when you are planning across several organisations and two sectors with different cultures, there is another layer of complexity."

The work so far is embedded firmly in Skills for Health's proven Six Steps Methodology; there is no need to reinvent the wheel, they say.

THE ISLINGTON STORY

Health and social services in Islington, north London, are already well integrated, with the local Whittington Health Trust working closely with Islington social services.

Now partners are involved in a major piece of workforce planning and development with Skills for Health to develop an innovative strategy that will provide a lead for other inner city areas.

In the tradition of all good NHS projects, it already has an acronym attached: IWAMP, which stands for the Integrated Workforce Assessment Modelling Programme.

Kim Sales, the former deputy director for leadership, talent and organisational development at Whittington, led the early work on IWAMP. She is now associate director for workforce, education and development at Birmingham Women's Foundation Trust.

She says: "If we spend 70 per cent of our cash envelope on people then we need to have a grip on developing our workforce around the integration agenda. We need a collective leadership approach."

She was keen from the start to work with Skills for Health, whose consultants not only have wide experience of working with NHS organisations but also have links to Skills for Care and a proven model for workforce planning.

The work started with a look at the data to build up a local footprint of public health needs, changing demographics, consumer data, existing service provision and current workforce.

This data was then examined jointly by health and social care service leaders brought together by Skills for Health. They segmented the data to come up with four themes that are priorities for Islington: mental health; children and families; older people; and long term conditions.

Using Skills for Health's Six Steps Methodology, multisector groups began to identify the skills and the gaps and put together recommendations around care pathways. Skills for Health is developing reports and recommendations in each area.

"We have been co-creating recommendations of what we would need for these different pathways," says Ms Sales.

It is still a work in progress but, says Ms Sales, it is already proving powerful.

The process of working together to create solutions has brought managers together and helped them to understand each other better. The plans are aligned closely with the priorities of the local clinical commissioning group, health

from different services need to work together to discuss their workforce priorities and their solutions

Mr Lovegrove explains this overall approach and where it differs from traditional workforce planning. "I would argue that, historically, the approach to workforce planning has been very input based. How many doctors and nurses do we need? How many physiotherapists? Then we look at the number of patients in beds or chairs and ask how are we going to get that patient better or discharged," he says.

"What we advocate is an outcomes based approach that starts by asking: what does the service user or patient need and how best can we deliver that?"

This moves away from numbers and whole time equivalents of different professionals and workers and towards a discussion about the competencies and skills needed.

It is a discussion that opens up new possibilities for new types of roles and new ways of working.

If this is the theory, how do Skills for Health apply it? "With integrated care, we start with the patient journey or experience. We look at the points in the pathway and what needs to happen in terms of an intervention or experience," says Mr Lovegrove.

"From that we can look at the skills and competencies that the workforce needs and ask: what do we want the workforce to do? And what are the gaps? Then we can start to look at the options for reconfiguring or reprofiling the workforce.

"It gets away from a uniprofessional approach and moves towards a more multiprofessional approach."

This, he says, is the key to unlocking productivity gains. One such possibility would be in a situation where a vulnerable patient at home needs visits from a nurse, a physio, social worker and an occupational therapist.

Currently, each is usually done separately. In an integrated interdisciplinary team there could possibly be one professional who could deliver a range of interventions: one visit, not four; better use of the workforce and a better patient experience.

"It does not mean people are more busy but that you are making more productive use of your workforce," says Ms Mullen. "It makes sense to better align health, social and voluntary services and it enables staff to broaden their portfolios."

It is an approach now being tested in Islington and other areas of London (see case study, below) where managers from different organisations have come together to examine population, workforce and other data to develop their priorities and solutions.

Easy to say, hard to do. Ms Mullen and Mr Lovegrove agree it is challenging.

"People's natural reaction is to be protective," says Ms Mullen.

"It must be supported and enabled through good leadership and organisational development."

It requires commitment and time from busy senior practitioners and managers from health and social services.

"We find people need at least eight weeks notice to free up their time from work to attend events," says Ms Mullen.

Once in the same room, time needs to be allocated to enabling the group to work together and understand each other's contribution.

"There has to be a synergy developed within the group and, more importantly, the organisations need to have a supportive culture that is ready to accept change and challenge," says Mr Lovegrove.

It has to have senior backing if the solutions co-created by these groups are to gain traction.

'It must be supported and enabled through good leadership and organisational development'

"It's about organisational development and leadership and thinking beyond hierarchy," says Mr Lovegrove.

Ms Mullen adds that there is often an unexpected benefit to such work: the process of bringing people together to talk about workforce planning and development traditionally done separately in itself can help integrate organisations.

"In London we have been bringing together people who often did not know each other and did not necessarily understand each other's roles or organisations.

"Through working together they are gaining a deeper understanding and by co-creating the future they are taking integration to the next step." ●

and wellbeing board and providers, building further consensus.

Practically, discussions are starting around how new roles might develop – for example, a new care navigator role.

A simulation training centre is being developed where integrated care staff can train in a mocked up sheltered housing and community clinic setting.

The hard part, she says, was getting people together to do the work. "It has to be the right people with the right commitment and that requires leadership."

Ms Sales sees Islington as a trailblazer in this work. Other areas of London are now using the model to explore their own workforce planning and she has been invited to speak at events across the country.