Introduction

The year 2014/15 has been a landmark one for the concept of an integrated health and social care system. This year, key principles of integration, being patient-centred for example, and focusing on prevention and where possible caring for people at home and avoiding the need to go into hospital where possible have become the cornerstones of health and wellbeing and are the foundations for any developments.

The work, of course, is far from complete and areas such as direct payments for health patients and stepping up the support for patients to look after themselves out of hospital are really just beginning to gather a head of steam, and also we are still in relatively early days in some areas of developing those levels of trust between health and social care organisations which is so crucial for successful and game-changing collaboration and joint working.

All organisations are beginning to realise that they have a responsibility to acknowledge that they are part of the problem and the solution, and must accept some responsibility for the fragmented and siloed working to date and do something about this. Articles during the year illustrate the need for organisations in different sectors to meet and discuss their work, and concerns and goals around integration and actual projects out there show what can be achieved when this happens.

The World Health Organisation states that the social determinants of health are, in order of importance: social connections, clean water, nutritious food, the means of accessing these necessities of life and, finally, healthcare services or, in other words, the prevention of illness and accident, diagnosis, treatment and care, and rehabilitation.

If we are to achieve all these things in a cost efficient and effective way all organisations must be prepared to work together for the wider public benefit.

Chris Brophy, partner, Capsticks
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Nobody can suggest that integration is a bad idea. Why would anyone not want services to be joined up across institutional, geographical and professional boundaries?

The idea is so obvious that the average citizen would want to know why this is not already the case. Why has it been necessary to introduce new statutory duties and a designated funding stream to achieve this?

The answer is history. We are where we are because of how public services have evolved over the past 100 years; how successive governments have sought to reform them; how statutory bodies and institutions have evolved; how scientific knowledge, academic theory and best practice have developed; how economic and social factors have affected priorities; and how those involved in delivering those services have done their jobs.

There are two major factors driving the integration agenda and challenging fragmentation and mistrust. The first is economic: austerity is here to stay. Wherever services are fragmented, the result is duplication, gaps, poorer outcomes, increased costs and wasted money. We can no longer afford inefficiency.

The second is our ageing population. With people living longer, many with long-term and complex conditions, the pressures on services will increase, which means the money must be spent more effectively.

What is integration?
It is primarily about ensuring services are organised and delivered in a co-ordinated way. It is prominent in the context of health and social care and fundamental in reforming the NHS, but it goes much further in terms of bringing together the delivery of housing, education, economic regeneration, culture and leisure.

This series of articles
This is the first of a series of 12 monthly articles which will explore integration, considering some of the bigger questions it raises, the challenges and barriers it encounters, and some hopes for the future. They will explore two themes.

Why aren't you doing it anyway?
The first will be the citizen wondering at the fuss about addressing obvious inefficiency. Taxpayers can be justifiably indignant about reforms that should be happening anyway.

However, we should be alert to reorganising without really transforming anything apart from distracting practitioners, incurring substantial professional fees and disrupting services. We should ask: how will these changes make a real difference now and lead to continuing improvement thereafter as a norm?

What about me – where am I involved?
The second theme concerns the role of citizens. Integration should mean not just that organisations involved collaborate. It should also build in the right role for patients, service users and carers. Local government and the NHS cannot meet the future challenges alone; they need to collaborate with those accessing services.

In May 2013, the Integrated Care and Support: Our Shared Commitment project (www.gov.uk/government/publications/integrated-care) set out a definition of integrated care and support. Co-developed by National Voices, it says: “I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me.”

This idea is given statutory force in the Care Act which says the starting point for a local authority is that the individual is best-placed to judge their own wellbeing. Patients, service users and carers must have a permanent and audible voice within organisational structures and the reform process.

We must remove barriers between local government and the NHS, primary and secondary care, physical and mental health, and health and health-related services such as housing, and between a wide range of other public service providers. We must also remove the barrier preventing the citizen from playing a part in influencing, shaping and ultimately controlling the services.

Next time
The next article will explore the overarching framework of integration: namely the wide range of new statutory duties including the duty to integrate, the NHS Mandate and key policy initiatives.

If you want to put a question to us, email chris.brophy@capsticks.com

A longer version of this article appears at LGCPlus.com/capsticks-integration

Chris Brophy, partner, and Cliff Mills, consultant, Capsticks Solicitors LLP
A key element of the integration policy initiative is the introduction of statutory duties – for the NHS to secure that health services are provided in an integrated way, and for local authorities to ensure the integration of care and support provision with health and health-related services.

While some might argue that this is just yet more government interference dressed up differently, in reality it is requiring something which ought to be done anyway – but arguably isn’t. So will imposing duties on institutions achieve anything and will they be enforced?

The reality is that it is people that do things, not institutions. Unless those in leadership roles (chief officers, elected members, service heads) personally embrace a collaborative approach with their peers in other organisations, and cascade a change of culture throughout their organisation so that it takes effect on the front line, it is unlikely that significant change will happen. Integration is not a box-ticking exercise.

For local authorities, the new duty to integrate reaches across a wide spectrum of services which include health, social care and housing services, so these duties extend similar duties which have already existed, for example in relation to crime, education and children services.

Local authorities therefore have plenty of experience to draw on. However, what is different now is that in addition to acting in an integrated way within local government, local authorities must collaborate with NHS bodies and assess whether services can be provided in a better way through integration; this means learning the language and culture of the NHS and understanding that their counterpart NHS organisations need to do the same. This is no small feat.

At the heart of all this is the role of health and wellbeing boards. This is where the instinct and drive for integration is intended and needs to take root. But how widely is that happening?

We can see very good reasons why local government is subject to the key duties under the 2012 Act as to hosting HWBs. The first is local government’s extensive experience in partnership working in terms of taking leadership and dealing with change.

The second is the potential for citizens to have a say in influencing change through access to open decision making and the local democratic process. But local government and HWBs cannot and should not try to go it alone without pulling on the resources from the leaders of all relevant organisations to support success.

Perhaps the first real challenge for leaders is to learn to collaborate and understand each other before moving on to integrate healthcare services.

Where are the results?
The key issue for service users is whether the new duties change things for them, and they will only believe it when they see better and more joined-up services. Certainly, it is at the point of delivery where lack of integration becomes most obvious. Where fragmentation continues, the existence of statutory duties will be of little comfort or use to service-users.

So to conclude, integration really is about what happens on the frontline. Change has to be driven from the top, but working collaboratively – both horizontally and vertically. This requires some brave leadership; but the benefits will be worth it.

Where am I involved?
Here again, new duties have been imposed – on NHS England to promote the involvement of patients and carers, and on local authorities requiring the promotion of patient involvement and the potential for engaging Healthwatch or service users on HWBs.

Once more, the danger is of a tokenistic response, rather than a whole-hearted embrace of the principle of citizen participation which is inevitably challenging.

Perhaps the first real challenge for leaders is to learn to collaborate and understand each other before moving on to integrate healthcare services.

The next article in the series will consider how the benefits of integration can increase if we widen the net when considering partners. For example, engaging housing providers to help with preventative measures, such as adaptations within the home that reduce the risk of falls in the elderly. This truly joined-up approach could result in significant reductions in the health and social care bill further down the line.

Alison Richards, senior lawyer, Capsticks LLP

- This is the second in a 12-part series – for the other articles visit LGCplus.com/capsticks-integration
One of the reasons for the historic lack of integration is the natural desire to minimise risk. The more I can separate my service from what others are doing, the greater the control I have over the likely outcomes. Knowing I am accountable, the last thing I really want is to rely on others who are pursuing their own agenda and who might let me down. And it might be better for their objectives than mine. So splendid isolation is a strategic option which makes a lot of sense.

But this is where the citizen or taxpayer is left, head in hands, justifiably angry at the wasted expenditure and missed opportunities. The problem is that integration – long-term and committed collaboration – involves risks for a service and its leadership. But that is the challenge we all now face in adopting a holistic approach, justifying our decision-making in building relationships and trusting others.

Let’s look at this in one particular context – housing. There are several reasons why public service providers should explore opportunities to work collaboratively with housing providers. Early intervention, for example for drug and alcohol misuse, has significant cost-saving impacts and housing providers can be best placed to identify needs. It is also recognised that housing is an important determinant of health, particularly mental health. Improvements in housing may have significant cost-saving impacts in health and social care terms.

The following are examples of integration we have seen:

- Working with local government and/or the health sector to provide step-down accommodation, e.g. for those with mental health needs or for homeless people. Hospital stays can be reduced or avoided altogether.
- Housing vulnerable people in appropriate accommodation allowing them to live independently, while accessing the support services they need.
- Partnerships to reconfigure and update care homes to meet Care Quality Commission standards, funded in part by developing housing on surplus parts of sites where appropriate.
- Helping needy individuals to access support. Housing providers have an established and trusted relationship with residents and can help facilitate introductions and access to those individuals.
- Training programmes organised through housing providers to increase their reach (e.g. healthy eating education).
- Investment in ‘lifetime homes’ that are flexible enough to meet the future needs of service users with only minor adaptations. Such properties will allow individuals to live independently for much longer.
- Housing providers looking beyond housing and using their expertise to support wider community projects.
- In future, the potential to get involved in the management of personal budgets. With the proposals for integrated personal budgets for health and social care, there is increased scope for housing providers to give assistance to individuals. We may also find that groups of tenants living in close proximity may want to combine their resources to increase their buying power, and there is likely to be a role for their landlords in facilitating this, for example in retirement villages.

These are all examples of the use of an opportunity, available to a housing provider, to do things that go beyond traditional housing services; they all help to improve the quality of life of the landlord’s customers. They all produce benefits elsewhere in the system, so achieve benefits taxpayers would expect. But they all require working collaboratively with other service providers.

Opportunity and imperative

The introduction of statutory duties we discussed last month not only provides cover to those willing to take the risk to integrate, but also creates an imperative to do so.

And what are those risks? Essentially, they are to form relationships of collaboration and trust; to build relationships between individuals in equivalent roles; and through those relationships to strive – collaboratively – for improved results for individual citizens. Risky. But not as risky as splendid isolation.

In next month’s column we will look at overcoming some of the language and other barriers between different parts of the public sector.

This is the third in a 12-part series – for the other articles visit LGCplus.com/capsticks-integration

Susie Rogers, partner, Capsticks
In the previous article in this series, Susie Rogers mentioned the temptation for organisations to avoid the risks of collaboration with other organisations and instead to choose the apparently safer course of splendid isolation. There are various factors that are potential disincentives to collaborative relationships and are, in practice, barriers to integration, and one of these is the problem of language.

There are differences of language between different parts of the public sector. These are not just questions of semantics, but often go deeper to differences of decision-making, approval and other basic processes. Having to deal with the unfamiliar does not make establishing collaborative relationships and trust easy but neither are they the most difficult problems. They require patience and a willingness to recognise that there is more than one way of doing things.

Such differences within the public sector commonly go back to the various ways in which particular services have evolved over time. Modern services reflect the way generations of practitioners and managers have delivered services and how they have been affected by continual change, driven by new legislation, technology, practice or science. This constant shape-shifting can make services hard to pin down.

A good example of this is the creation of clinical commissioning groups (CCGs). As reported in the Times recently, although the government had promised to give GPs more control over organising care and patients more choice over treatment, the then health secretary Andrew Lansley “abolished almost every organisation that allocated NHS budgets, and gave £63bn to hundreds of new GP-led bodies to spend on services as they saw fit”.

CCGs are very different from their predecessors, and their GP-led composition means a whole new style and culture is evolving as people find their feet in new roles. In the midst of all this, others are seeking to build up collaborative relationships and to work together. Integration is, without doubt, a long-term strategy. This means that what is good for integration may well conflict with what seems the right thing to do in the short term. You must be braver, more confident and stronger to press for long-term benefits when they are different from the short-term expedient. The temptation for councils is not to look significantly outward and towards co-operation and joint working with other sectors because it is difficult, costs might be challenging, and it is distracting from other goals. But is this really what is best for citizens in the long term?

The impatient taxpayer will have no sympathy with any of these barriers of language, culture or time horizons. At the point of delivery, lack of long-term thinking and a preference for short-term convenience are often very obvious, and nothing can be more likely to cause anger than a cultural inability to work together.

But these things are easy to say, and hard to do. Giving citizens a more prominent role within the process of reform can be helpful in overcoming these barriers. It is not just their impatience to secure change where there is really no excuse not to; it is also a longer-term view based on the fact that they do not expect to be moving any time soon.

In next month’s column we will look more closely at health and wellbeing boards and their potential to be a major catalyst for integration and involving people in their area.

Chris Brophy, partner, Capsticks
Last month the NHS published its Five Year Forward View, which sets out three fundamental ways in which the health service needs to change.

Those three changes are:
- A radical upgrade in prevention and public health
- Patients to gain far greater control over their care
- Barriers in how care is provided to be broken down

Integration is self-evidently at the heart of the third of these priorities. The report speaks of managing systems, not just organisations, making out-of-hospital care a much larger part of what the NHS does, integrating services around the patient, learning faster from the best examples in the UK and internationally, and evaluating new care models following their introduction.

The models to which the Forward View referred included multi-specialty community providers including GPs, nurses, therapists and other community-based professionals; viable smaller hospitals; and enhanced health in care homes. The NHS has committed to working with local communities and leaders, and it is clear that new models of care such as these need the support of health and wellbeing boards and clinical commissioning groups.

The second priority that the report identified, that patients must gain far greater control, recognises that patients’ own life goals are what count and that patients, their families and carers are often ‘experts by experience’. With 70% of the health service budget taken by long-term health conditions, clearly patients, their families and carers can and do have a major impact on costs.

One of the Forward View’s commitments is the introduction of integrated personal commissioning (IPC), a voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an ‘integrated year of care’ budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation. Carers and volunteers involved will also be helped more and the LGA has proposed that volunteers should get a 10% reduction in their council tax bill. All this thinking in the Forward View is continuing and embedding the drive to shift power to citizens.

Giving patients far greater control is all about breaking down barriers between those giving and those receiving care. It enables the patient, their family and carers to be at the centre of integrating services from the perspective of those for whom care services exist.

But it is the first priority that is really eye-catching: the need for a radical upgrade in prevention and public health. Twelve years ago Sir Derek Wanless’s health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. However, one in five adults smoke; a third drink too much; and just under two thirds are overweight or obese. The NHS is spending about £10bn on diabetes caring for three million people, with a further seven million at risk of becoming diabetic. The Wanless warning has not been heeded; is anybody listening now?

Some local authorities clearly are. They have a responsibility for improving health, and the Forward View highlights the recent actions of various councils, including those in relation to limiting junk food outlets, action on alcohol and establishing health commissions. The report also supports the LGA’s idea of enhanced powers for councils to allow local democratic decisions on public health policy to go further than national law.

The NHS is listening as well as local government but the Wanless warning was a warning to the country. If the health service is to survive, it is we who need to change; in our lifestyles, how we look after our health, how we access and use services when we need them. If we are to become engaged in the whole subject of our own health, and the health of our families and community, then we must not be passive recipients of services but active partners in the whole project, including participants in shaping reform. As citizens, we need to be integrated. Are local government and the NHS committed to that?

In next month’s column we will look more closely at health and wellbeing boards and their potential to be a major catalyst for integration.

This is the fifth in a 12-part series – for the other articles visit LGClplus.com/capsticks-integration

Chris Brophy is a partner and Cliff Mills is a consultant at Capsticks
Previously in this series we have suggested that:
- the decision to integrate services is a no-brainer;
- the reforming public sector landscape provides the perfect opportunity to deliver that integration;
- the more embedded the commitment to integration, the better;
- taxpayers would assume integration was happening anyway; and
- the requirement to use public funding of care much more effectively in the future requires a step-change in the behaviour/role of individual citizens and society at large.

Let’s assume for now we are right on all counts. How, then, is that step-change to happen? What vehicle will carry us to the promised land of hope and ever-greater harmony and collaboration?

One possible agent of change is health and wellbeing boards. They were created to bring together the movers and shakers of health and social care and secure better and more equal outcomes for their local populace, the citizens who should benefit from integration.

But is all well with HWBs? It depends on who you ask. Some complain that the new beast in the jungle is in fact a toothless pussycat, devoid of all the powers necessary to meet the fiscal and demographic challenges which threaten to subsume us.

Others point, acknowledging the irony, to the mistrust (actual or perceived) they see permeating the very boards designed to bring people from different walks of life closer together. Social care and healthcare, they say, have never been happy bedfellows, so why should it be different now?

Some, while they accept the principle of HWBs, find fault in the implementation. They say the boards are creatures of local government with all the old baggage of county and town hall politics: not the right starting point.

In terms of opportunities for HWBs, a careful reading of NHS England’s Five Year Forward View suggests a more radical approach emerging from within the health service itself. The NHS will play its part in these initiatives through HWBs, it says. It expresses agreement with the LGA that English mayors and local authorities should be granted enhanced powers that allow local democratic decisions on public health policy to go further and faster than prevailing national law.

The Forward View also sees the possibility of joint commissioning between the NHS and local government. It commits to supporting ambitious local areas which want to define and champion some models, including integrated personal commissioning and better care fund-style pooled budgets for specific purposes. It even countenances the idea of full joint management of social and health care commissioning, perhaps under the leadership of HWBs.

These are very interesting possibilities in terms of development of current arrangements and are far from toothless but what about the other criticisms referred to above?

In relation to public health, the Forward View commends local authorities in Greater Manchester which are increasingly acting together to drive health and wellbeing. The NHS will play its part in these initiatives through HWBs, it says. It expresses agreement with the LGA that English mayors and local authorities should be granted enhanced powers that allow local democratic decisions on public health policy to go further and faster than prevailing national law.

Individual participants on the HWBs do have genuine power to make a difference in their respective fields and they are acting more than ever before to ensure that their collective efforts chime, not just in Greater Manchester. Elected council chairs break bread with clinical commissioning group-appointed vice chairs and increasingly, the wider board membership stretches well beyond the statutorily prescribed core, reflecting local priorities and dynamics.

HWBs undoubtedly present intriguing opportunities and the Forward View suggests a willingness from the NHS to see how far they might go with the some good ideas and a genuine willingness to collaborate. Who wouldn’t want to pick up that challenge?

This is the sixth in a 12-part series. For the other articles visit LGCplus.com/capsticks-integration

Matthew Smith, partner with Capsticks
In many localities we have already seen local authorities and the NHS seeking to adopt ‘integration’ through the ‘simple’ use of combining services into one new commissioning process for one contract award: the prime contractor model (see diagrams below). The reasons behind this demand closer scrutiny.

There is no single approach to achieving integration but more public bodies have now started high-profile procurements to seek to impose a radical system reconfiguration and to do this by appointing a prime contractor.

There is strong support nationally to adopt new approaches to contracting like this. It may feel right from a central point of view, but there are drawbacks as well.

We are seeing large value prime contracts with long terms. This increases the pressure on the commissioning processes, as the risk to providers who lose out is much greater. A five- or 10-year contract on a prime contractor basis results in a ‘winner takes all’ scenario; any providers who fail to win a role will be significantly affected. So the processes are complex and more sensitive to challenge than short-term and low-value procurements.

The current number of prime contractor approaches has come under criticism due to the problems in implementing them; take, for instance, LGC sister title Health Service Journal’s recent editorial, ‘Prime contractor model looks old before its time’ (www.hsj.co.uk/5076645.article). Also, providers who have been competing for years are bound to be critical. There is a real threat to successful small providers such as pioneering social enterprises where they are smaller subcontractors in the new model.

The prime contractor model should not be seen as a quick fix. The majority of the benefits tend to show up on the commissioner’s side of the ledger but the commissioners must consider the impact on providers, including the expectation that providers revise the system and take on management of wider services from day one at a reduced margin.

Crucially, what will be the impact on citizens? Central to the NHS Five Year Forward View is a more engaged relationship with patients, carers and citizens. How is this ever likely to happen with engineered solutions focussing on what works best for commissioners and providers?

If the commissioners see the prime approach as a way to shoehorn a wider package of services together for a reduced budget, then we are unlikely to see much positive change in the service and can expect a reversion to a traditional command and control approach.

If the desire is to change the way services are provided and better integrate for the public benefit, then the starting point needs to be with providers working collaboratively together to respond to citizens in new and imaginative ways. New contracting arrangements can support this.

Local authorities and clinical commissioning groups must encourage collaboration. They must also build in time to plan and design their procurement processes to emphasise and reward integration and collaborative working. But remember: contracting arrangements are a means to an end, not an end in themselves.

Robert McGough, partner, Capsticks

This is the seventh in a 12-part series. To read more visit LGCplus.com/capsticks-integration
It's the holiday of a lifetime, saved for, planned for and eagerly anticipated: a guided Himalayan trek into the mountainous wilds.

But when a connecting flight is cancelled, a series of missed connections is set in train, leaving you 36 hours behind the rest of the party, negotiating in a Kathmandu taxi rank to catch up the lost time.

How would your view of this experience change if you arrived at the airport to find a driver holding a card with your name at arrivals, ready to transfer you to the first stopover hotel and reunite you with your planned tour? TripAdvisor five stars all round!

Every package company sells you a seamless experience and presumably does its best to live up to the promise but what happens when the unexpected happens and some problem threatens to derail the carefully planned process?

Of course, risks are anticipated and planned for, but parts of the system need to quickly interact to re-establish service. This requires effective relationships between the departments and companies involved. Where they are merely bound together by a contract, everyone can shrug their corporate shoulders; after all, it's not their problem. The apparently seamless package unravels.

An integrated care system needs to appear seamless but behind the scenes, it needs a whole series of connections to make it effective, with relationships up and down the strata of organisations, across the silos and between partner providers. Where these connections are established and strong, issues can be quickly identified and collaborative problem solving is part of the culture. Organisations work to a shared user-focused purpose. Responsiveness and initiative thrive. Service users benefit. Where connections are weak, you get the shrug and a culture of blame.

Hard-wiring of relationships between organisations within a system takes time and energy. The King's Fund recently concluded: "There are no shortcuts to building trust or nurturing the relationships needed to deliver high-quality, cost-effective care."

There are often organisational cultural gaps to bridge, past histories to address and differing goals to align but it is worthwhile work if your staff begin to invest energy in relationship-building initiatives, regardless of their specific job description, or whether the system feels primed for, rather than resistant to, the inevitable change that such integration demands.

One way to encourage the growth of effective relationships is to introduce a common language that describes and assesses it. This helps define what 'positive' looks like and helps teams grow in their accountability to each other. We tend to think of our relationships as good or bad but if pushed on why, we might describe a variety of aspects, such as how well we communicate or whether we have the same values, or how much time we spend together. Shared language becomes particularly important if you are addressing one organisation's rapport with another.

Research identifies five main drivers of corporate relationships: power, information, story, communication and purpose. These are all elements of Relational Proximity, a framework that two parties can use to measure how effective their relationship is and to identify specific actions they can take together to improve it. It works because nothing is imposed. It encourages both sides to offer improvement, equipped with a common language and a common insight.

Translating 'seamless in theory' into 'seamless in practice' benefits staff on the ground, the citizens who access services and also senior teams experiencing a time dividend, as relational friction lessens in the system. Of course, seamless really means, in most cases, that the seams aren't obvious. Under duress, it is effective relationships that hold the stitching together to achieve this. This is fundamental to integration.

Will Sopwith, associate with Capsticks’ Consultancy Service

This article is the seventh in a 12-part series. To read the rest, visit www.LGCplus.com/capsticks-integration
Pioneer programmes are never easy to get on to. The Pony Express, a groundbreaking horseback mail service operating across the Great Plains and the Rocky Mountains between Missouri and California from 1860-61, wanted “young, skinny, wiry fellows not over 18.”

“Must be expert riders, willing to risk death daily. Orphans preferred,” the advertisement added. In November 2013, people were probably pleased that they did not have to meet such specifications when they applied to become integrated care pioneers.

The first annual report for the integrated care pioneers programme was published in January and confirmed the belief that integrated care improves health and the experience of care.

It cites a proactive care service in Kent where there has been a 55% reduction in non-elective admissions; Greenwich with a 35% reduction in admissions to care homes and south Devon and Torbay, which has reduced the number of people living in residential and nursing care homes and secured a fall of nearly 10% over the past year in the number of emergency admissions from care homes. In Islington, an integrated liaison and assessment team has halved the length of stay for its patients and has cut by three quarters their readmission rate.

The work of the these pioneers has also helped shape the new models of care mentioned in the NHS’ s Five Year Forward View and the better care fund framework and they are increasingly looking at the economic case for integrated care. The second year of the programme will focus on how best to disseminate learning from replicable local solutions across the country.

Pioneers always need to be alert because they are involved in rapidly changing environments, possibilities and challenges. Some commentators have warned that although there are some new health and care systems in place, pioneers must still “change or die”. The Pony Express only lasted a year or so before a new model of provision came in and stagecoaches took over core contracts. Soon after that the introduction of the transcontinental telegraph changed everything again.

Arguably, however, the integrated care pioneers are working smartly. In January, 11 new sites were added to the pioneers – including Greater Manchester.

Last month, Greater Manchester’s 10 councils, 12 clinical commissioning groups and NHS England released a memorandum of understanding with the overriding purpose of ensuring the greatest and fastest possible improvement to citizens’ health and wellbeing.

There is a recognition that achieving this requires a more integrated approach to the use of the existing health and care resources as well as service delivery transformation. The memorandum is a roadmap, with initial undertakings and further anticipated steps, which will require ratification in the light of experience and developments in the future.

The memorandum sets out the context and the ‘why’; the detail and the ‘what’; and the principles, processes and the ‘how’.

In a recent publication, The New Era of Thinking and Practice in Change and Transformation, NHS Improving Quality highlighted how organisations that embraced building shared purpose, connectivity, imagination, relationships and empathy tend to get better outcomes in large scale transformation.

NHS Improving Quality also said building bridges between previously disparate groups and individuals can be good. In other words, if you can improve your weak ties there is a greater chance of mobilising all the resources in the community to contribute to the cause. This can give you the best chance to deliver the scale of improvements that care leaders need in a challenging timescale.

There is however a risk in looking to weak ties. The Pony Express’ oath required riders to say that they would not quarrel or fight with employees, and maybe we do still need that reminder when different sectors come together.

As the New Era publication said: “In situations of uncertainty we have a tendency to revert to our strong relationships, to stick to what and who we know and who we can trust. Research shows that information flows of policy makers are often based on strong ties. Yet the evidence tells us that weak ties are much more important than strong ties when it comes to searching out resources and innovative thinking in times of scarcity.”

Chris Brophy is a partner at Capsticks. This article is the eighth in a 12-part series. To read the rest, visit www.LGCplus.com/capsticks-integration
The power of partnerships

Stephen Burns on how housing associations and local authorities can collaborate

Last month saw the launch of a report from the New Local Government Network, A Design for Life, which was published in partnership with Peabody, Moat and Capsticks.

The report looks at how councils and housing associations can achieve better health outcomes and employment opportunities for residents by working together.

Too often partnerships can be short-term arrangements, because of perceived and real barriers that get in the way of embedding a culture of collaboration. These barriers must be overcome to help partnerships flourish.

As well as recommendations to help adjust the culture of both sectors towards greater integration, the report contains useful, practical tools such as data sharing and joint funding to ensure successful collaborative working. These are simple steps that partners can use to develop joint strategies to deliver for their residents.

Also included within the report are examples of effective partnership working. These include Peabody’s ambitious 10-year programme, delivered in partnership with Hackney LBC, to develop the Pembury Children’s Community.

Pembury Pass is the first pilot initiative of the wider children’s community programme, which is transforming the lives of young people on the Pembury estate. The programme aims to significantly improve the life chances of children and young people (aged 0-24) on the estate. Taking inspiration from the Harlem Children’s Zone in New York, it is part of a wider national pilot for children’s zone approaches, championed by Save the Children and evaluated by the University of Manchester.

Pembury Pass focuses on young people aged 16-24 who are not in education, employment, or training (Neets), or otherwise vulnerable. It provides an intense level of personal support to help them access education, training and employment opportunities.

Support takes the form of linking each young person to a customised programme of opportunities and experiences, providing guidance around personal and social development and offering financial support in the form of a personal budget.

We’ve engaged 240 young people in positive development activities, with 48 classed as ‘hard to reach’, receiving intensive support on the estate.

Testimony from the young people participating is positive, with many describing how they have gained confidence through Pembury Pass and now have a trusting relationship with Peabody. Furthermore, the young people have commented on how case workers have increased their awareness of a range of opportunities and potential careers, rather than narrowly focusing on immediate employment.

Of the numerous practical tools contained within the report, there are three in particular which we can see demonstrated in the development and delivery of the Pembury Pass.

We have put a solid governance structure in place, setting up a Pembury Pass project group with senior representatives from Peabody, Hackney LBC and the voluntary sector; this group has been instrumental in ensuring awareness and buy-in across the borough. In addition, the chief executives of both Peabody and Hackney LBC meet regularly to review progress and discuss any strategic issues arising.

Another key reason for the project’s success has been the strong relationship between frontline staff in Hackney’s Ways into Work team and Peabody staff; this has enabled a joined-up approach towards supporting young people on the Pembury estate, who are fully prepared for and able to access work experience, apprenticeships and job opportunities.

Initially Hackney commissioned Peabody to deliver the project but staff costs have subsequently been absorbed by Peabody and the project is now jointly funded.

The report confirms our belief in the power of partnership working. As one of London’s oldest and largest housing associations, providing homes to more than 80,000 residents, by working together we have seen the progress that can be made in our shared aims to alleviate poverty and create opportunities for the people we serve.

To read the report A Design for Life, visit www.nlgn.org.uk/public/wp-content/uploads/A-DESIGN-FOR-LIFE.pdf

Stephen Burns is executive director of community investment at Peabody

● This article is the ninth in a 12-part series. See LGCplus.com/capsticks-integration. In next month’s article Moat will focus on the public policy implications of partnership working
Collaboration between local authorities and housing associations has been around as a topic since time began. We are, after all, natural partners. There is a significant overlap in the people we work with and the challenges they face. Yet despite the numerous excellent examples of collaboration that works brilliantly, deep partnerships still remain relatively uncommon. We’ve been determined to find out why that is.

March saw the launch of the New Local Government Network publication A Design For Life, supported by Peabody, Capsticks and Moat. The report looked at the practicalities of collaboration, suggested why successful integration infrequently occurred and asked whether or not the barriers – both real and perceived – could be overcome.

Somewhat perversely, it seems that the drivers themselves can form a barrier of sorts. Though they vary greatly, one of the main drivers often cited for collaboration is the mitigation of costs. We’re sympathetic to the budgetary pressures councils face so it makes sense to co-operate where we can save some money. But proving the value of collaboration in monetary terms is not always straightforward – especially where social value is concerned. Without an effective and convincing method of measuring savings, the perceived effort can easily outweigh the perceived gains.

In my view, it is time to expand the range of factors that lead us into joined-up partnerships, guided by two overarching drivers: greater efficiency for providers, and superior support for end users.

First, efficiency is not the same as saving money. Collaboration based around cost mitigation tends to be time or programme-limited, after which we can too easily go back to the way it was before. Efficiency, on the other hand, is enduring. An example might be sharing information on households affected by under-occupation rules versus a longer-term agreement on data-sharing with the aim of identifying residents at risk of arrears. I would argue that the former may be useful for a limited period, but it would not vastly change the way we work. The latter, however, would force us to look for more effective ways of measuring, collecting, supplying and evaluating data on an ongoing basis.

Second, our administrative structures must not only be approachable, they must be responsive to what our communities need. Many housing associations are moving towards a more holistic approach with the aim of influencing outcomes beyond bricks and mortar. In people’s daily lives, problems are not tightly contained within departments or agencies; they are interdependent and often mutually reinforcing. So as important as the physical home is, the creation of thriving communities depends on a range of joined-up services that bridge policy areas such as employment, healthcare and education.

If we agree with the notion that people and communities face problems that are not tightly sealed within departments, we also need to sign up to the notion that greater collaboration will help us span these issues.

The past ‘go-to’ driver of cost mitigation is no longer enough; we have to be driven in providing a better level of support to our residents and customers. In order to achieve this, we have to become more efficient in the way we distribute our resources.

Clearly, there is a great deal more we can do both for current and future residents. But only by working in deeper partnerships will we deliver the coherent, personalised, multi-agency approach needed for people and communities to prosper.

Elizabeth Austerberry, chief executive, Moat

To read the report, A Design for Life, visit www.nlgn.org.uk/public/wp-content/uploads/A-DESIGN-FOR-LIFE.pdf

This is the tenth in a 12-part series. For the other articles visit LGCplus.com/capsticks-integration
A tool for integration

Ann Radmore and Susie Rogers say staff are key to integrated services

The right support and care delivered by skilled people sits at the heart of successful plans to transform services for citizens and to increase their independence and self-reliance.

When we look at the better care fund plans across the country, most are staff-dependent schemes developing integrated care solutions; supporting reablement; increasing care at home and providing intermediate care. A significantly smaller proportion of projects (8-10%) are created using assistive technologies.

This raises issues for the future planning of integrated work. If there is to be a continuing high level of dependence on people for successful delivery, we need a shared understanding of the local workforce plan and how integrating that workforce might be accelerated.

The health and wellbeing board is a good place to start, perhaps with an assessment of the local workforce and the challenges being faced. Near full employment is being reached in some parts of the country, coupled with a fall-out rate of almost 50% from some nursing courses and significant demands in hospitals, making recruitment and retention harder than ever.

A collaborative approach can lever off both NHS and local authority brands, and offer something new to help attract and retain staff. Local authorities and the NHS can pool their knowledge about the changing demographics of an area, the employment potential of the workforce and the key dynamics shaping the local community, and use this information to shape a combined workforce. They can consult the experts for help, such as local education and training boards, which could facilitate and support these conversations. Local authorities and the NHS will always be significant local employers, and an integrated workforce plan should feature in any business development strategy for the area.

The real benefits to the citizen of integrated and joined up care must be supported by clarity on recruitment arrangements; a clear set of employment rules; and clarity on managing integrated staff. Anecdotally, areas find it easier to recruit to these integrated teams. There are a variety of choices to be made on how to bring staff together, from informal joint working and secondments to partnerships, joint ventures and formal s75 agreements. The key point is to use the model that best suits the partnership's business needs and your approach to risk. The first step will be making sure you and your partners agree on a number of factors:
- How you want this workforce to operate
- What the culture will be
- What an appropriate sharing of risk will look like
- How employee information will be shared
- Who will be responsible for operational HR matters (for example recruitment, management and dispute resolution)
- What your aligned post-integration goals are

Discussions need to be open and honest, and set the tone for the future partnership. The early and sustained buy-in of the workforce, and the HR team, is essential to success.

There are challenges involved, and some areas have been cautious about tackling them, but the long-term benefits are there for the taking. If we don't change the way we work, we face poor morale and commitment, low staff retention, increased tension between partners over employment issues and, most importantly, failure to deliver the potential benefits from integrated teams.

There are opportunities to use standard legal frameworks to shape integrated teams that work strategically and create a positive and effective environment in which to work.

The successful creation of strong arrangements that enable individuals to remain active in their home and community will depend upon significant numbers of care staff in a variety of roles. The benefits to citizens and staff are clear—what are you waiting for?

Ann Radmore is programme director for the better care fund, NHS England, and Susie Rogers is a partner at Capsticks

The benefits to citizens and staff are clear
A lot has been said in the past 12 months in this column about what integration is, what it could achieve, why/where it is or isn’t happening, and where duties and obligations rest or arise.

But there is a time for soul-searching and asking questions, and there is a time for getting on and doing. What is important right now is that every council, health organisation, housing body – any publicly-funded organisation working to achieve better lives for citizens – accepts responsibility for doing this in an integrated way.

All of us working in or for the public sector have a collective responsibility for delivering public benefit. That means getting the most out of every pound of public money. When there is a problem it is all too easy to see it as someone else’s fault. We do not have responsibility for that awful decision or terrible action because it rests with somebody else.

Well is that really the case? What have you contributed to the situation and what has been the consequence of the decisions that you have taken? Do we not all share responsibility when things go wrong, and for making sure that in future they go right?

How often do we hide behind our own organisation, its targets and achievements, and the area in which we are perceived as having primary responsibility? How often do we look at risks, and managing risks, in terms of how they affect our council, our trust, our agency, rather than how they impact on citizens?

Nothing is achieved if it is generally accepted that collaboration and integration are needed, but are too difficult or impossible to deliver “because of the way things are”. Much silo-thinking is based on and justified by the need to make responsible decisions for my organisation, even when that manifestly runs against the public interest and the best use of money.

At the recent Health and Care 2015 Conference at the Excel, Jeremy Hunt made the point completely and utterly clearly in saying that he was looking for “full integration”, whatever that means, and that he is looking to the health and care system to achieve this. He absolutely underlined the need to think of prevention and to approach the whole subject from a patient centred perspective.

“Full integration” means, for every person working in the public sector, being aware of and working collaboratively with every other person having responsibility in relation to the same citizen, or community, or neighbourhood. It means, for every person, looking right through the boundaries, between health and social care, between councils and NHS trusts, between one set of objectives and another, and working collaboratively for what is best in the public interest.

Of course, this is easy to say, but much more difficult in practice. Legal duties and responsibilities, to deliver services, to stay solvent, to take account of some things and not others make this very hard. How often do we hear that concerns about conflict of interest get in the way, when in reality all working for the public good have a fundamental harmony of interest, which goes much deeper than their institution?

Although directors of course need to work in the best interests of their organisations, where those organisations have objectives which are geared towards the public or community benefit they have not just an ability but a duty to work in a way that does not simply consider what is in that organisation’s best interests; they must act in the best interests of the community and in such circumstances they can work across organisational boundaries.

A director might say that it is fine for Jeremy Hunt to make great speeches at important conferences but “we need to stay focussed on what is right for our organisation”. No problem with directors doing that, but perhaps those boards should read again their constitution or rules or other governance requirements and challenge themselves about what exactly their underlying purpose and objects are. One of the things we can do as lawyers is to find a way of making it easier for organisations committed to the public or community benefit to work collaboratively together.

A sea-change is needed in public services; but whether it occurs will depend on individuals within organisations, and whether by acting differently and taking some collective responsibility, they refuse to be constrained by organisational boundaries. We all have a responsibility, and it is only by accepting that responsibility in the first place and then working better together that we can change things.

Cliff Mills is a consultant with Capsticks and principle associate with Mutuo; Chris Brophy is a partner with Capsticks

This article is the 12th and final part in a series. To read the rest, visit www.LGCplus.com/capsticks-integration