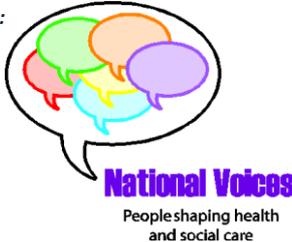# *Integrated Care and Support: Our Shared Commitment*

May 2013

National Collaboration for Integrated Care and Support

National Collaboration for Integrated Care and Support:

Logo	Description
adass directors of adult social services	The Association of Directors of Adult Social Services (ADASS) is working for social justice and acting as the voice of adult social care.
ADCS Leading Children's Services	The Association of Directors of Children's Services (ADCS) provides a collective voice of professionals in children's services leadership roles on policy, practice and resourcing.
Q Care Quality Commission	The Care Quality Commission (CQC) regulates all health and social care services in England and assures essential levels of safety and quality of health and adult social care.
Department of Health	The Department of Health (DH) is the system steward and lead on legislation and parliamentary accountability for health and care in England.
Local Government Association	The Local Government Association (LGA) provides the national voice of local government and working to support, promote and improve local government.
Monitor	Monitor regulates the provision of health care services to ensure it is effective, efficient and economic and maintains or improves the quality of those services.
NHS England	NHS England creates the culture and conditions for health and care services and staff to deliver the best outcomes for individuals, communities and society for now and for future generations.
NHS Improving Quality	NHS Improving Quality (NHS IQ) is hosted by NHS England and has a system wide remit for quality improvement across the NHS in England.
NHS Health Education England	Health Education England (HEE) is responsible for the education, training and professional development of every member of NHS staff.
NICE National Institute for Health and Care Excellence	The National Institute for Health and Care Excellence (NICE) produces guidance and quality standards to support the best possible quality care and the best value for money.
Public Health England	Public Health England (PHE) works with national and local government, industry and the NHS to protect and improve the nation's health and support healthier choice.
scie social care institute for excellence	The Social Care Institute for Excellence (SCIE) is an independent charity working with adults, families and children's social care and social work services across the UK to support improvement.
think local act personal	Think Local Act Personal (TLAP) is a national, cross sector Partnership leading the implementation of personalisation and community based care and support.
in association with: **National Voices** People shaping health and social care	National Voices is a national coalition of health and social care charities, working together to strengthen the voice of patients, people who use services, carers, their families and the voluntary organisations that work for them. The charity has worked closely with our National Collaboration to develop a definition and narrative on integrated care and support based around the individual.

Foreword

People today are living longer, healthier lives than ever before. Once fatal diseases can now be cured or managed, adding years or even decades to a person's life. This is an extraordinary achievement and testament to the many who have dedicated their lives to improving people's health and wellbeing.

But progress brings challenges. Our system of health and care is under more pressure than ever before. People may be living for longer, but often they are living with several complex conditions that need constant care and attention, conditions like diabetes, asthma or heart disease. And this is not only about older people – children born with complex conditions are now living to adulthood, while those with learning disabilities and other groups have lifelong needs. All these people need continuous care and support, and the right systems and resource to enable that.

With the shocking events at Stafford Hospital and the Winterbourne View care home fresh in our minds, it is also vital that every single person is treated with compassion and with the respect they deserve.

We need major change and we are determined to act. That means building a system of integrated care for every person in England. It means care and support built around the needs of the individual, their carers and family and that gets the most out of every penny we spend.   If the illness is prevented, the condition properly managed, the fall avoided, not only is that better care for the individual but it also means less pressure on the system.

We are grateful to National Voices for explaining in easy to understand terms exactly what this means for patients. This will help us to understand what people want and need from integrated care and support.

Integrated care and support isn't the end. It is the means to the end of achieving high quality, compassionate care resulting in better health and wellbeing and a better experience for patients and service users, their carers and families.

There are significant challenges ahead. We need to create a culture of cooperation and coordination between health, social care, public health, other local services and the third sector. Working in silos is no longer acceptable. We have to end the institutional divide between physical and mental health, primary and secondary care, and health and social

care. We must provide a seamless service focussed on the individual within their own home. A big part of this will be working to ensure that we avoid crises in people's care which too often result in hospital admissions. This should always be regarded as a failure. If we can do better at preventing deterioration of health then we know that fewer people will end up in hospital. Instead they will receive the right care, when and where they need it.

We will also need to fully embrace the extraordinary potential presented by new technology and shared information. This can help local services to plan more effectively and will help doctors, care professionals and others to give people far better and far more tailored services. It will also give those who are able the ability to manage their own conditions, gaining a degree of independence thought impossible until only recently.

All of this needs to happen at scale and at pace. A number of local integration pioneers will help to get the ball rolling, learning fast and actively sharing every lesson learned. These pioneers will be the first to test new models of commissioning, new payment arrangements which encourage organisations to work collaboratively to improve the patient's health and the delivery of integrated care and support.

But it is not enough for there to be isolated pockets of excellence. We are determined that, over the next five years, this will become the standard model for everyone with health and care needs. Better integration can help drive positive change. But in the end this is not about systems, it's about people. It's about inspiring local leaders, dedicated and energetic staff and individuals who deserve the most integrated, personalised and empowering care and support we can offer.

We commit to doing all that we can to support you in making integrated care and support the norm in your local area. Other organisations, such as NHS Confederation, SOLACE and the Care Provide Alliance, are already coming forward to support this initiative. We encourage others to do the same.
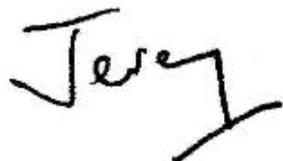
Rt. Hon Jeremy Hunt MP,
Secretary of State for Health

Norman Lamb MP,
Minister of State for Care and Support

Box 1a. Two different stories of caring

George and Florence

Florence is 85 years old and has lived with her 82-year-old husband, George, in their two storey house for the past 40 years. Their son, Andy, emigrated to Australia 12 years ago.

Florence was diagnosed with dementia in 2010. Both George and Florence were devastated by Florence's initial diagnosis. They could barely talk about it with anyone for the first few months. Since then, George has increasingly adopted the role of sole carer to his wife, as they wanted to stay together in their own home.

Two years ago, the couple found out Florence also had diabetes. In addition to visits to the dementia clinic, George now has to take Florence for appointments for her diabetes including regular chiropody visits. And just recently, George has found out he has high blood pressure. George has had to attend regular clinic appointments for check-ups on his hypertension, which means bringing Florence along too.

Although the treatment they both receive at these appointments is good, no one has asked how they were coping. Even if he was asked, George would not want to admit that he was finding it increasingly difficult to carry out his role as carer. And Florence became increasingly preoccupied with Andy's absence.

Until recently, George still managed to get to his club a few times a week to meet his friends, while a neighbour stayed with his wife. However, Florence's condition seemed to be worsening, so he feels he could no longer leave her with a neighbour anymore and go to his club. Florence was no longer able to climb the stairs, so George put a bed in the dining room for her. He slept on the couch next door, so he could hear her if she tried to get up in the night. Unfortunately, with all of his focus on caring for his wife, George was not paying so much attention to controlling his own hypertension.

Eventually, Florence became irritable and aggressive as part of the progression of her dementia and stopped letting George help her to wash, dress or even give her the diabetic medication. George had to call an ambulance when he couldn't rouse Florence one morning and she ended up in hospital for six weeks. The hospital staff decided that George had reached the point where he was no longer able to look after Florence and manage his own condition, so she was discharged to a residential care home.

George visits Florence every day.

Box 1b. Two different stories of caring

Florence and George

Florence is 85 years old and has lived with her 82-year-old husband, George, in their two storey house for the past 40 years. Their son, Andy, emigrated to Australia 12 years ago.

When Florence was first diagnosed with dementia in 2010, both she and George were put in touch with a dementia care nurse and were given information on the disease and the available support that could be on offer if it was required. Together, a plan of care was agreed which could be reviewed and amended whenever Florence's or George's needs changed and included the decision that both Florence and George wanted to live at home for as long as possible in the home that they had shared for so long together.

The dementia care nurse kept in close contact with the family and was copied in, at the request of Florence and George, to all correspondence to and from their GP, hospital consultants, community psychiatric nurse, diabetic team and practice nurse to save having to keep telling his story and enabling continuity in the care he and Florence receive. Recently, George found out he has high blood pressure. He has had to attend regular clinic appointments for check-ups on his hypertension. The dementia care nurse was able to arrange a carer to stay with Florence while he attended his appointments.

George also noticed that Florence was becoming increasingly preoccupied with Andy's absence. So he got in touch with one of the charities that he had been given information about from the dementia care nurse. The charity helped him buy a laptop with a webcam and taught him how to set up video calling, so both Florence and George could see and speak to Andy every week and sometimes more often.

As Florence's dementia progressed, both she and George felt they were able to talk openly about what additional support was available for both of them. They spoke with their GP about how they both were coping and what they should do if they developed any concerns at home. The GP arranged for a home assessment and additional equipment was fitted to help Florence get in and out of the bath and use the stairs. George was shown some techniques to help calm Florence down if she became aggressive or irritable, part of the progression of her dementia. And to make sure his hypertension remained under control, George was also shown how to manage his own stress and anxiety and get repeat prescriptions for his medication, and Florence's, delivered directly to the house.

Although the couple often get support and help from neighbours, the dementia care nurse also arranged for a carer to visit in the evening to help Florence with her evening meal and prepare for bed, so George could spend some time enjoying the company of his friends.

Contents

Executive Summary

National and local organisations need to take urgent and sustained action to make integrated care and support happen. Person-centred coordinated care and support is key to improving outcomes for individuals who use health and social care services. Too often, we don't communicate properly with each other, don't work together as a team or don't treat people as whole individuals. As a result, care and support is often fragmented, delayed or duplicated, which can result in missed opportunities to prevent needs from escalating and intervening early. This leads to poorer outcomes and experiences for the people who use our services. Our growing older population, and children and young people with long term and complex conditions, are particularly vulnerable; outside these groups, many more people have physical and mental health needs which mean they need support from their community, be it for housing, help with personal care such as washing and dressing, or companionship. Every time someone has an unplanned trip to hospital, it can reduce his or her capacity to cope independently. People deserve better than this and we all need to play our part in delivering services that are better coordinated around preventing and meeting their needs. Alongside the toughening financial climate, we have no option but to work together, think creatively, and identify new ways of doing more for patients and people who use services, so that every pound spent on care and support counts while we strive to improve outcomes for individuals and local communities.

Recent reforms to the health and care system have enabled local communities to increase focus on commissioning and ensure the kind of care and support that best meets their needs, with local practitioners in the driving seat. Local leaders have the opportunity to develop a shared vision across health, public health, social care and local authorities working closely with providers in the public, voluntary and private sectors to improve local services. Focusing on the specific needs of their local populations, they have a key role in finding local solutions to improve local services.

By establishing our national collaboration, we are sending a clear signal to the entire health and social care system that integrated care and support is a critical issue to us all and that we are committed to sustaining our support for it over the years ahead. This document sets out this ambition, relevant to all health and care services and people who use services. Work is already underway targeting particular services, such as the local authority Pathfinders testing out approaches for education, health and care planning for children and young people with special educational needs, and the Long Term Conditions Year of Care programme. We need to go further, however, and adopt and support approaches for joining up across whole systems at the local level.

Many local areas already recognise the need to provide better-coordinated person-centred care, and have a track record of success in some areas. But we encourage all areas, without exception, to do more and act with a continued sense of urgency. We commit to providing help and support to local areas. In return, we expect you, as local leaders, to:

→ *Engage with local people, patients and people who use services to hear their experiences and work with them to find co-produced solutions*

→ *Adopt, and measure progress against, the definition of integrated care and support co-developed for us by National* Voices, aligned with *Making it Real;*

→ *Coordinate care and support so that people and their carers are at the centre and directly involved in planning for the whole person, not just for a disease or dependency score*

→ *Share individuals' data where this improves the quality and safety of care and support through shared decision making*

→ *Identify opportunities for your frontline staff to build relationships with colleagues who provide parallel forms of care and support to theirs*

→ *Avoid retreating into old, familiar silos as the financial climate toughens*

→ *Be ambitious in planning person centred care and support, and jointly allocating resources*

Here, we describe how we have adopted a definition of integrated care and support to provide a shared language and common goal for the whole system to work towards. The definition, co-developed for us by National Voices, and aligned with *Making it Real*, through engagement with patients, people who use services and carers, puts the individual at the centre and around whom services should be coordinated: *"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."* We expect localities to adopt this definition of what "good" looks like to inform their local initiatives but with the freedom to apply it in ways that suit their local needs. We also expect individuals to be helped to use the narrative both to help shape the services they receive and challenge the system if it falls short of what good looks like.

We want all localities to innovate and share their lessons to strengthen the evidence base. To support and promote widespread innovation, we describe in this document the current freedoms and flexibilities in the rules concerning commissioning, competition, reimbursement and information governance. We will also work to remove barriers where they exist. In addition, CCGs set aside two per cent of their annual funding for non-recurrent expenditure; we encourage them to consider using this to support innovative approaches to integrated care and support.

National partner organisations have committed to helping local organisations work towards providing more person-centred, coordinated care for their communities. In this document, we describe the support you can expect from us and what we expect from you in return. We want to work with you to develop the culture, leadership and workforce capable of undertaking the changes required to commission and deliver integrated care and

support in your locality. This document sets out a series of shared commitments, explaining what we have done or are committed to doing to aid local innovation as well as what we expect from every locality in response.

For the most ambitious and visionary areas, the ones that have particularly challenging issues or ideas about experimenting with new models of integrated care and support, we will launch a pioneer programme. We commit to providing additional bespoke expertise and constructive challenge to help pioneers realise their aspirations on integrated care and accelerate the learning across the system. We aim to stimulate successive cohorts of pioneers, from which we expect to draw out, disseminate and promote lessons for adoption across the rest of the system.

Our shared vision is for integrated care and support to become the norm in the next five years. We want you all to take action to help achieve this ambitious vision. We don't yet have all the answers, but we commit to a sustained national collaborative programme to help organisations find local solutions. Where we do have solutions right now, we highlight them in this document. We will judge ourselves successful if, in two years, all localities in England have adopted models of commissioning and delivering integrated care and support and if, five years from now, integrated care and support has become the norm with improving outcomes and more positive experiences of care and support reported by patients and people who use services. Ultimately, integrated care and support is a means to these ends, not an end in itself. However, we have no other option if we are to have the positive impact on the outcomes and experiences of individuals, their carers, their families and their communities.

Sandie Keene,
President, Association of
Directors of Adult Social
Services (ADASS)

Andrew Webb,
President, Association of
Directors of Children's
Services (ADCS)

David Behan,
Chief Executive,
Care Quality
Commission (CQC)

Norman Lamb MP,
Minister of State for
Care Services,
Department of Health

Carolyn Downs,
Chief Executive,
Local Government
Association (LGA)

Dr David Bennett,
Chief Executive,
Monitor

Sir David Nicholson,
Chief Executive,
NHS England

Julian Hartley,
Managing Director,
NHS Improving Quality
(NHS IQ)
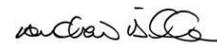
Sir Andrew Dillon,
Chief Executive, National
Institute for Health and
Care Excellence (NICE)

Prof. Ian Cumming OBE,
Chief Executive,
Health Education
England (HEE)

Duncan Selbie,
Chief Executive,
Public Health England
(PHE)

Andrea Sutcliffe,
Chief Executive,
Social Care Institute for
Excellence (SCIE)

Sam Bennett,
Programme Director,
Think Local Act Personal
(TLAP)

Shared Commitments

Pursuing a common purpose

1. NATIONAL: *To enable a shared understanding of integrated care and support, we have adopted the definition and narrative that National Voices have developed for us and aligned these with 'Making it Real' from Think Local Act Personal (TLAP).*
   LOCAL: *We expect all localities to adopt this definition and narrative too.*

2. NATIONAL: *Given the importance of leadership in any programme of transformational change, national leaders commit to back local leaders in their efforts to integrate care and support.*
   LOCAL: *In return, we expect local leaders to come together in all localities to support the development of innovative models of integrated care and support that are better at meeting local needs.*

National resources for local ambitions

3. NATIONAL: *We have established the Integrated Care and Support Exchange (ICASE), a national resource bringing together practical expertise from national partners.*
   LOCAL: *We expect localities to engage fully with ICASE as they develop their own models of integrated care and support and to share any lessons as widely as possible across the system.*

4. NATIONAL: *To stimulate working cultures that actively encourage integrated care and support, we commit to supporting localities in workforce training and organisational development, working with relevant Local Education and Training Boards (LETBs).*
   LOCAL: *We expect localities to engage fully with their LETBs and share lessons across the system.*

Providing practical tools to localities

5. NATIONAL: *National partners commit to working with localities to clarify freedoms and flexibilities, such as on reimbursement.*
   LOCAL: *We expect all localities to take advantage of these to develop, at scale and pace, their models of integrated care and support.*

6. NATIONAL: *We commit to providing new support to help localities develop their models of integrated care and support.*
   LOCAL: *We expect localities to use this support, and contribute extensively to, this growing resource base.*

7. NATIONAL: *Drawing on the Narrative developed by National Voices, we commit to developing by the end of 2013 new ways of measuring people's experience of integrated care and support.*
   LOCAL: *We expect localities to help us test, further develop and refine these measurements for adoption system-wide.*

Integrating information

8. NATIONAL: *Recognising that information systems and governance are critically important in efforts to integrate care and support, we will enable the use of information systems to support better coordinated care and support by aligning national information systems development projects and providing timely advice and support on information governance.*
   LOCAL: *We expect localities to adhere to the principles of the Caldicott Report and the NHS Constitution on data sharing, in their efforts to integrate care and support for the benefit of patients and people who use services.*

Accelerating learning across the system

9. NATIONAL: *For the most ambitious and visionary localities, we commit to providing additional bespoke support to help such 'pioneers' realise their local ambitions and accelerate learning across the system.*
   LOCAL: *We expect pioneers to work in partnership with us to help disseminate and promote lessons for wider, rapid adoption.*

10. NATIONAL: *Recognising the importance of growing the evidence base about the benefits of integrated care and support, we commit to conducting a systematic evaluation of progress and impact over time.*
    LOCAL: *We expect pioneers and localities to collaborate with us in the co-production of this evaluation.*

> ## 1. *Improving the outcomes and experiences of individuals*
>
> *In this section, we explain why all of the partner organisations in our national collaboration believe that it is essential for care and support to be personalised and coordinated around the needs and preferences of individuals, their carers and families. We also describe what "good" integrated care and support looks like from the individuals' point of view.*

1.1 *Changing demographics and the fragmentation of care*

Delivering the high quality outcomes and experience that individuals expect is already a challenge for many areas. Demand is projected to grow due to the increasing number of people with multiple co-morbidities who have numerous and complex interactions with health and social care services and where early intervention and prevention are key. Current estimates show there are 15 million people living in the UK with a long term condition (LTC) and of these, 25% of over 60's have two or more long LTCs. We also know the prevalence of LTCs is increasing; the number of individuals with multiple LTCs is set to rise from 1.9 million in 2008 to 2.9 million in 2018[1]. Moreover, LTCs are not restricted to older people. A recent study found that 15% of all school pupils aged 11-15 report having been diagnosed with a long-term illness, disability or medical condition[2].

Alongside existing conditions, there is a growing need to reduce obesity, promote smoking cessation and reduce alcohol consumption. These examples are typical of the challenges facing the health and care sector, and other local authority sectors such as education, where there is a real need to focus both on primary prevention and wellbeing and on smooth transitions between different services for all age groups.

Many people with mental and physical disabilities, complex needs, long-term conditions and terminal illness also need to access different health care, social care, housing and other services, such as education, and often simultaneously. The evidence is clear, however, that these services can be fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them. For example, the complexity of children's needs, the diverse range of services that are often involved, and the rapidly changing nature of needs as the child develops, can make integrated approaches particularly valuable to ensure families do not find themselves caught between different parts of the system, waiting for a particular service. Whilst fragmentation of care can lead to a poor experience for the individual and their family, it also has the potential for substantial inefficiency within the health and social care system and for whole populations.

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[1] https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition
[2] http://www.ayph.org.uk/publications/242_Final%20Summary%20RU9%20Long-term%20Conditions%20Feb%202012.pdf

> ## Box 2. Individual's viewpoint on fragmented care
>
> *"We are sick of falling through gaps. We are tired of organisational barriers and boundaries that delay or prevent our access to care. We do not accept being discharged from a service into a void. We want services to be seamless and care to be continuous".*
>
> *National Voices*

With health, public health, primary, community and social care and local authority all working towards an outcomes based approach, they can design care and support to prevent, delay and meet the increasing needs of populations. For example, they can together provide older people with support to remain in their own home or support people with a terminal illness who wish to die at home.

> ## Box 3. The consequences of fragmented care and support
>
> The impact of fragmentation can be just as much of a problem *between different NHS services* as it is *between NHS and social care services*. Such fragmentation has the potential to lead to:
>
> - Failure to take steps to prevent or delay onset of needs through prevention or early intervention
> - Multiple and uncoordinated assessments from health and social care, leading to delay of provision
> - Packages of health and social care provision that do not fit in with the person's lifestyle or are not age-appropriate
> - Multiple, uncoordinated visits from health and social care professionals
> - Multiple trips to hospitals for tests, diagnostics and treatment
> - Unsafe transfers from hospital to residential care
> - Unreliable transitions through care pathways, including from childhood to adult care
> - Emergency admission to hospital e.g. after avoidable worsening condition or avoidable fall
> - Emergency readmission following unsafe discharge from hospital or lack of information for people managing their conditions
> - Failure to meet a person's wish to die at home or receive end of life care in their own home

1.2 Improved outcomes

We believe that integrated care and support can help to remove gaps and duplications in existing service provision and improve effectiveness, safety, and the experience of patients and people who use services. We also expect it to promote equality and improve access for all. Although the evidence base is developing, for example via evaluation of Integrated Care Pilots,[3,4] we know it needs to be strengthened considerably. Despite this, we also know that there are numerous examples of progress (see Boxes 4, 9, 10, 11, 14 and 15 for some examples).

Integrated care and support needs to extend beyond traditional perceptions of "healthcare" and "social care" and into areas involving early intervention, prevention, self-care and promoting and supporting independent living (see Box 5). For instance, we know that well designed housing is a key factor in facilitating timely discharge from hospital and avoiding admissions to hospital or a residential home in the first place and maintaining independence. Asset-based community development, for example, has found evidence that the increases seen in social capital can improve resilience and health protection alongside helping to tackle health inequalities.[5]

> ## Box 4. Early indications of positive impacts of approaches to integrated care from the Quality, Innovation, Productivity and Prevention (QIPP) LTC workstream
>
> The QIPP LTC workstream has resulted in many positive improvements such as the development of a single integrated personalised care plan for people with LTCs, and identified opportunities to integrate commissioning plans across the system. The workstream has reported numerous qualitative benefits from integrated care approaches, including:
> - People feeling more confident to manage their condition
> - Fewer GP consultations
> - Improved sharing decisions with patients about their care
> - Improved team working across the system
> - Improved partnerships
> - Improved relationships
> - Better sharing of information, with the patient and among different servcies
> - Faster referral process between organisations
> - Better identification of patients using the risk stratification tool and admissions data along with the 'soft' knowledge of the team
> - Embedding tele-health within the care model
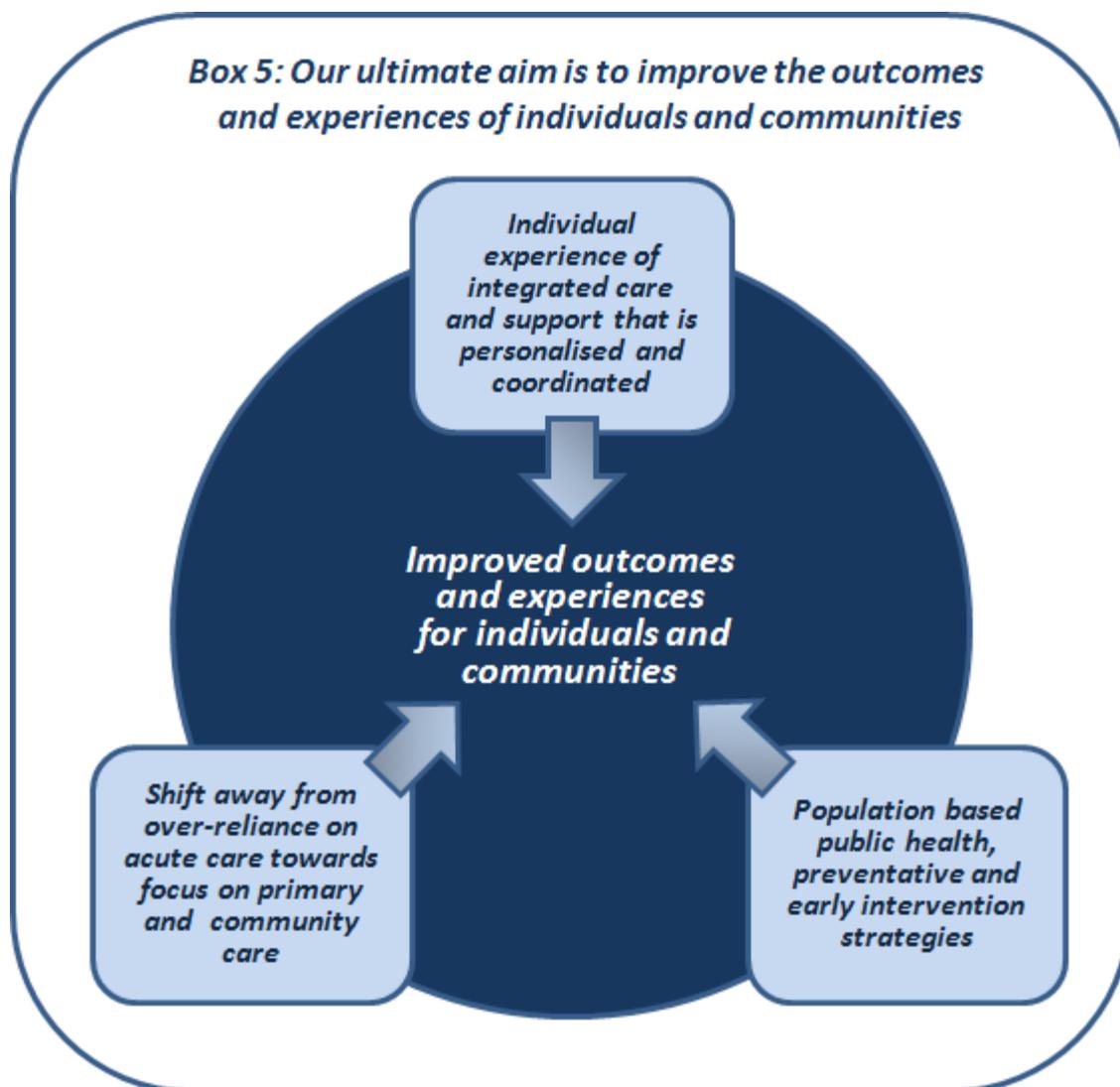
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[3] http://www.rand.org/randeurope/research/projects/integrated-care-pilots.html
[4] http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation
[5] http://www.healthempowerment.co.uk/

These wider social determinants of health and wellbeing are one of the main drivers of health inequalities and directly affect health outcomes[6]. Health and Wellbeing Boards (HWBs) and local authorities are well placed to link the NHS, public health and social care with partners such as the police and the criminal justice system, schools, employers, and the business and voluntary sectors, refining services in response to local needs.

All of this means we need to bear in mind that integrated care and support is simply a means to an end. We must always remember that our efforts in this area and ultimate aspirations should be targeted at improving the experiences and outcomes of individuals and their communities, whilst allowing people to be true partners in their own care and support. (see Box 5)

Box 5: Our ultimate aim is to improve the outcomes and experiences of individuals and communities

Individual experience of integrated care and support that is personalised and coordinated

Improved outcomes and experiences for individuals and communities

Shift away from over-reliance on acute care towards focus on primary and community care

Population based public health, preventative and early intervention strategies

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[6] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthinequalities/DH_094770

This also means we need to think and work differently and more effectively between and across sectors. The success of pilot Community Development sites[7] demonstrate the positive impact that working collaboratively between health, education, housing and policing and involving individuals and the community can have on health and wellbeing outcomes alongside generating cost efficiencies in the delivery of local services.[8]

There is a toughening financial climate in which to pay for care and support. Between 2010 and 2014 the NHS expects to deliver £20 billion of efficiency savings through its Quality, Innovation, Productivity and Prevention (QIPP) programme. Increased efficiency savings are expected to continue past 2014. At the same time, local authorities, responsible for the commissioning of social care services, community services and public health budget, are experiencing significant pressures on their budgets. If we provide truly integrated care and support, in a sustainable way, there is real potential to achieve improved outcomes for less money in response to these challenges.

> ## *Box 6. Health Select Committee on Integrated Care and Support*
>
> *"These targets can only be met if resources move out of hospitals and into primary, community and social care. Care needs to be integrated, more focussed on prevention and less on picking up the pieces in acute hospitals".*
>
> Rt. Hon. Steven Dorrell, Chair

1.3 Defining integrated care and support

In order to deliver care and support that truly meets the needs and preferences of individuals, organisations will need to work across traditional boundaries. To achieve this, we need a common language and a shared understanding of the term "integrated care and support".[9] The NHS Future Forum highlighted that the term "integration" is used by different people in different settings to mean different things. Within the published literature, for example, there are over 175 different definitions.[10]

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[7] http://www.healthempowermentgroup.org.uk/
[8] http://www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/CfC/Working With Communities Developing Communities.ashx
[9] http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/narrative-coordinated-care.pdf
[10] http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf

Importantly, integrated care is not about structures, organisations or pathways *per se,* nor about the way services are commissioned or funded. Rather, it is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes. That is why we have embraced the concept of the individual lying at the heart of integrated care and support and being the organising principle for services, as expounded by the NHS Future Forum.[11]

To this end, NHS England asked National Voices to co-develop with the health and care system, a narrative of integrated care and support: something that an individual person would recognise as integrated care and support.

Box 7. The Narrative

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

National Voices

The Narrative offers a detailed understanding of what the *headline definition* (See Box 7) means, describing an individual's experience of person-centred, coordinated care and support using a series of generic "I" statements. For example, "I tell my story once" (See Box 8). National Voices developed these statements through consultations with patient and user organisations, and from patient experience indicators. They tested and refined them in two workshops involving system leaders, patients, people who use services, carers and patient organisations.

The Narrative is aligned with the statements that feature in Think Local Act Personal's (TLAP) *Making it Real* initiative around the personalisation of care and support. The organisations in our national collaboration, together with TLAP, have all endorsed, and signed up to, the Narrative. For the first time, therefore, we have an agreed understanding of what good integrated care and support looks and feels like for individuals. All parts of the health and care system can now embrace and adopt it in planning, commissioning and delivering better coordinated care and support for the benefit of patients, people who use services and their families and carers. As well as being a tool for all parts of the health and care system, we also see the Narrative, particularly through the "I" statements, as a powerful tool for individual empowerment. It will help them know what they should expect of their care and support services and use it to challenge the system if it falls short of what good looks like.

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[11] http://healthandcare.dh.gov.uk/forum-report/

Box 8 . What integrated care and support looks like from an individual's perspective.

My goals/outcomes
- All my needs as a person are assessed and taken into account.
- My carer/family have their needs recognised and are given support to care for me.
- I am supported to understand my choices and to set and achieve my goals.
- Taken together, my care and support help me live the life I want to the best of my ability.

Communication
- I tell my story once.
- I am listened to about what works for me, in my life.
- I am always kept informed about what the next steps will be.
- The professionals involved with my care talk to each other. We all work as a team.
- I always know who is coordinating my care.
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.

Information
- I have the information, and support to use it, that I need to make decisions and choices about my care and support.
- I have information, and support to use it, that helps me manage my condition(s).
- I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.
- Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.
- I am told about the other services that are available to someone in my circumstances, including support organisations.
- I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.

(...continued)

Box 8 (...continued). What integrated care and support looks like from an individual's perspective.

Decision making including budgets
- I am as involved in discussions and decisions about my care, support and treatment as I want to be.
- My family or carer is also involved in these decisions as much as I want them to be.
- I have help to make informed choices if I need and want it.
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS).
- I am able to get skilled advice to understand costs and make the best use of my budget.
- I can get access to the money quickly without over-complicated procedures.

Care planning
- I work with my team to agree a care and support plan.
- I know what is in my care and support plan. I know what to do if things change or go wrong.
- I have as much control of planning my care and support as I want.
- I can decide the kind of support I need and how to receive it.
- My care plan is clearly entered on my record.
- I have regular reviews of my care and treatment, and of my care and support plan.
- I have regular, comprehensive reviews of my medicines.
- When something is planned, it happens.
- I can plan ahead and stay in control in emergencies.
- I have systems in place to get help at an early stage to avoid a crisis.

Transitions
- When I use a new service, my care plan is known in advance and respected.
- When I move between services or settings, there is a plan in place for what happens next.
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact.
- I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
- If I still need contact with previous services/professionals, this is made possible.
- If I move across geographical boundaries I do not lose my entitlements to care and support.

"I statements"
The Person Narrative by National Voices

We have already started to use the Narrative to inform our national work to support local initiatives. For example, we are developing the "I" statements as indicators for measuring people's experience of integrated care and support and are looking for them to be used at the local level to ensure integrated care and support is developed around the needs of the individual. We are looking for HWBs with commissioners and providers to come forward to test how the "I" statements can be used in practice to deliver better-coordinated care and support across local health and social care systems.

We expect local and regional organisations to adopt the Narrative and use it to support the planning, commissioning, and delivery of better-coordinated care and support tailored around the individual. The Narrative is intended to be used flexibly at a local level. We therefore encourage localities to develop and adopt "we" statements setting out what you will do in order to make the "I" statements a reality for your patients and service-users.
In implementing the Narrative, we encourage localities to adopt a three-step process, in line with *Making it Real,* ensuring:

1. Co-production with patients and people who use services
2. Board level commitment
3. Production of an action plan, and sharing this publicly.

In order to ensure coherence, the organisations in our national collaborative and TLAP will work closely together to align the implementation of the Narrative and *Making it Real*.

Shared commitment

NATIONAL: *To enable a shared understanding of integrated care and support, we have adopted the definition and narrative that National Voices have developed for us and aligned these with 'Making it Real' from Think Local Act Personal (TLAP).*

LOCAL: *We expect all localities to adopt this definition and narrative too*

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2. The opportunity for all localities

In the previous section, we explained why we believe that integrated care and support is essential and that all localities must act to bring this about. In this section, we explain why the ideal opportunity to make this happen is now*. Further, we outline many of the freedoms and flexibilities that already exist within the rules of the system for local areas to consider in taking forward their models of integrated care and support.*

2.1 The opportunity is now

The new reforms for the health and social care system are now in operation. In the new system architecture, the emphasis is on:

- outcomes, quality of care, reducing inequalities and efficiency
- empowerment of patients, people who use services, carers and parents
- local ownership (including close working between health and local government)
- working in a proactive way with communities
- professional leadership to drive change and enable innovation.

NHS England and Monitor have statutory duties, respectively, to promote and enable integrated care. Local authorities have a statutory duty to improve the public's health. CCGs and HWBs also have statutory duties, respectively, to promote and encourage the delivery and advancement of integration within their local areas at scale and pace.[12] NHS England's planning guidance to CCGs, *Everyone counts: planning for patients 2013/14*[13] requires integration, including the pooling of budgets to reflect local need, to be given "explicit consideration" in local area planning. It also requires CCGs to work with local authorities to agree the allocation of funds to benefit health outcomes in their local population, and emphasises that CCGs will be accountable to their HWB and NHS England on how health and care have benefited from this allocation.

As acknowledged by the recent Health Select Committee report[14], HWBs provide the ideal platform for ensuring commissioned services meet the needs and ambitions of their local populations, including through integrated care and support. HWBs are comprised of representatives from the local community, including the NHS, public health and local authorities including social care, housing, education and the police. Through their Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS), they are able to facilitate local initiatives on integrating care and support to suit their local circumstances using active engagement with the public. The JSNA and JHWS are where a

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[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf.pdf
[13] http://www.commissioningboard.nhs.uk/everyonecounts/
[14] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/651/65102.htm

locality can articulate a clear description of the local ambitions and vision for integrated care and support, allowing everyone in the locality to share, and strive towards, these goals. Public Health England will support local government colleagues' work on their JSNA and JHWS. They will also offer training and evidence of good practice to support local government colleagues' work on prevention of ill health and promotion of health and wellbeing to underpin action to tackle health inequalities.

Work relating to individual groups is already underway to support improved integration of care for those groups. For example, local authority Pathfinders across the country are testing out approaches to integrated assessment and planning to meet the education, health and care needs of children and young people with special educational needs. New statutory duties on CCGs to promote integration for this group will be introduced in the Children and Families Bill[15].

Box 9. Pathfinders for children with special needs.

'Pathfinder' groups of local authorities are exploring with CCGs approaches to integrated commissioning for children with special educational needs (SEN), using a proposed statutory framework to be introduced in 2014. The joint arrangements are focused on an Education, Health and Care plan to be developed with each child (and their parents), which assesses their needs in terms of the outcomes which will make a difference to them, and sets out the services to be commissioned across the different sectors to deliver them. The learning from the Pathfinders will be valuable for informing approaches to integration for other patient groups. For more information, see http://www.sendpathfinder.co.uk/

Any significant change to services also needs developing with the support of local people. For example, we know that some acute health care services need to move towards primary and community care. Engaging patient groups and the public in an open dialogue at an early stage is essential if people are to understand that services will improve as a result. Commissioners, local authorities and local politicians as well as clinicians and other care professionals all have a role to play in clearly demonstrating robust evidence to the public that better coordinated care and support is in everyone's best interests.

The Care Quality Commission (CQC) will appoint a chief inspector of hospitals and a chief inspector of adult social care and support and consider the appointment of a chief inspector for primary and integrated care. CQC will be working more closely with our partners in thehealth and care system to improve the quality and safety of care including across the

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[15] http://www.publications.parliament.uk/pa/bills/cbill/2012-2013/0131/2013131.pdf

health and care system. CQC will also publish better information for the public including ratings of services. We are all committed to working with a sense of determination and urgency to ensure patient's and people who use services experience improved outcomes. To make this happen, whether operating nationally or locally, our *only* option is to change the *status quo*.

> ### *Shared Commitment*
>
> NATIONAL: *Given the importance of leadership in any programme of transformational change, national leaders commit to back local leaders in their efforts to integrate care and support.*
>
> LOCAL: *In return, we expect local leaders to come together in all localities to support the development of innovative models of integrated care and support that are better at meeting local needs.*

As well as opportunities provided by system reforms, national partner organisations are working to clarify the scope and extent of the freedoms and flexibilities in the system. These will allow localities to innovate and develop their chosen models for integrated care and support. Some of these are described below in more detail. Further, we will seek to address at local level any additional barriers that emerge as pioneers and other local areas push forward on integrated care and support. We will assess whether any rules should be changed at the national level, as a result.

> ### *Shared Commitment*
>
> NATIONAL: *National partners commit to working with localities to clarify freedoms and flexibilities, such as on reimbursement.*
>
> LOCAL: *We expect all localities to take advantage of these to develop, at scale and pace, their models of integrated care and support.*

2.2 The Commissioning Environment

Monitor's recent Fair Playing Field Review[16] reported that an uncertain financial outlook could make it difficult for commissioners to plan and make strategic decisions. Reducing uncertainty is needed for commissioners, providers and patients. That is something we learnt from the Community Budget pilots (see Box 10).

> ## Box 10. Community Budgets
>
> Since 2010, the Department of Communities and Local Government has run its Community Budgets initiative. Community budgets are the means by which a new model of public service delivery is being achieved. There is now widespread recognition that public services must break away from inefficient and fragmented delivery based on bureaucracies and silos. Community budgets aim to stop the waste caused by multiple producer interests and bureaucracies dealing separately with clients, and allow a much more straightforward focus on the clients as people who have the potential to take responsibility for their own lives. Community budgets can make it easier for health to be seen in joined up ways alongside, for example, education and police.
>
> Key inputs in the development of the community budget pilots have come from HM Treasury, the Department of Health, Monitor, NHS England and the Local Government Association. The community budget pilots will form a key part of encouraging, enabling and supporting more areas to experiment and set up integrated care and support initiatives.

Whereas the public health ring-fenced funding and local authority settlements cover a two-year period, NHS Commissioners' funding settlements are currently decided on an annual basis, which we know can lead to insecurity about future revenue streams. Volatility in national prices is a contributor to this uncertainty and has been highlighted in previous research undertaken for Monitor.[17] Monitor will start to address this in their role of regulating the payment system for NHS-funded services from 2014-15. In the meantime, NHS England will review funding flexibilities and support sites that are able to test the practicalities of these flexibilities.

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[16] http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/monitors-new-role/-fair-playing-field-the-benefit

[17] http://www.monitor-nhsft.gov.uk/sites/default/files/Evaluation%20Report%20-%20Full%20Report%20FINAL.pdf

There is a requirement within CCG and direct commissioning plans for 2% of the total funding allocation to be ring-fenced for non-recurrent purposes.[18] This remains within the commissioners budget and it is for them to decide how best to spend it and what schemes they wish to support financially and are locally controlled. This ensures that funds are available to support investment in new services, double running costs and other costs of transformation, and costs of time defined pilots which all support the development and implementation of new services. As part of this, we encourage CCGs to consider using these funds to support their local efforts to integrate care and support over the coming years.

A key emphasis within the reforms is clinically led commissioning, whose principles are:
- empowering local professionals to deliver better outcomes for the communities they serve
- greater accountability to the communities they serve.

The approaches for delivery will vary and local commissioners will have freedom to develop these. This includes working across health, social care, public health and other local authority services to best meet the needs of their local populations. For example, commissioning for Community Development, pooling the skills, knowledge and abilities of individuals', communities and public service to create opportunities and solve local problems has been demonstrated to have beneficial effects on, amongst others, childhood asthma, teenage pregnancy and employability. It could also contribute to alleviating depression, preventing falls in older people and reducing emergency hospital admissions and readmissions.[19] All of these can have a profound impact on the health and social wellbeing of individuals and the community as a whole, whilst providing cost efficiencies.

The NHS Standard Contract has been revised for 2013/14 to help strengthen commissioners' ability to hold providers of NHS funded care to account and enable innovative commissioning. The Standard Contract is designed to be an enabler of safe, innovative and transformational commissioning and a driver for change. It can provide flexibility whilst promoting innovation and still focussing on outcomes.

NHS England has responsibility for commissioning primary care, and will support primary care providers in working more innovatively and collaboratively with other local community services to ensure that patients receive and experience more integrated care and support. Primary care has a key role to play in supporting the local delivery of integrated care, by providing continuity across primary, community and secondary settings, focusing on preventative care and facilitating access to social care, including for carers, through effective coordination of care planning and management and risk stratification. NHS England is

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[18] http://www.england.nhs.uk/everyonecounts/
[19] http://www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/CfC/Working With Communities Developing Communities.ashx

working with a range of partner organisations, both nationally and locally, to develop its strategic approach to promoting and enabling on-going improvements in the quality of primary care services. NHS England commits to ensuring that, in its commissioning of primary care services, it supports person-centred services that are coordinated around the needs of individuals.

Further work is required on how primary care contracts can better support integrated care and align current incentives. The changes introduced to the GP contract for 2013/14 include new enhanced services that are designed to support a more integrated approach to managing care for people with complex health and care needs (who are more at risk of avoidable emergency admissions) and for people with dementia. GPs, as "gatekeepers" need to play a pivotal role in ensuring the delivery of care is person centred and coordinated.

Local authority contracts are more flexible than those in the NHS, as there is no specific supporting guidance other than the requirement to operate within national and European legal rules. There is currently nothing in local authority contracts to inhibit contracting for integrated care and support by local authorities. Personal Budgets for social care are direct payments to individuals to cover the costs of their care and support. First introduced in 1996, they have become a common way for local authorities to pay for social care. Because of the success of Personal Budgets, Lord Darzi's Review[20] proposed extending them to cover healthcare costs. This led to the development of Personal Health Budgets (see Box 11), a policy which has been developed wherever possible building on Personal Budgets for social care, to allow the possibility for integration of the two. In social care, personal budgets have deeper roots having been piloted in 2005 and mainstreamed under the last Government. More recently, the Coalition Government confirmed in the Care and Support White Paper that everyone eligible for social care should have this delivered through a personal budget by 2015. The White Paper also announced that following the conclusion of the personal health budgets pilots, it would be made "straightforward for people to combine them with personal social care budgets so that they can make the most of the support to which they are entitled," with the, "freedom to co-design joined-up services that best meet their needs and goals."[21] To build on the evidence base, In Control have been commissioned to support local authorities to assess the impact of personal budgets for children and young people.

Think Local Act Personal is leading a programme of activity to promote and support the use of personal budgets as a lever for integration at the level of the individual, the learning from which will be shared across the system.

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[20]http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Highqualitycareforall/index.htm

[21] https://www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

Box 11. Personal Health Budgets

A personal health budget is an amount of money that is spent on meeting the health care and wellbeing needs of children and adults, generally those with a long term illness or disability. At the heart of a personal health budget is a care plan, developed in partnership between the patient and their health care professionals. The plan sets out the person's health care and wellbeing needs, the health outcomes they want, the amount of money in the budget and how the person will spend it.

The final independent evaluation report on the personal health budgets pilot programme was published in November 2012 by the Department of Health. It found that personal health budgets improved people's quality of life and that people had a significant improvement in their care-related quality of life and psychological wellbeing. The evaluation also found personal health budgets to be cost-effective, particularly for people who receive NHS Continuing Healthcare and those who use mental health services. Overall, the report suggests that personal health budgets are beneficial, to both the individual and the NHS, especially when they give people genuine choice and control.

The Personal Health Budgets team at the Department of Health have built upon this work to produce a "mythbuster" document around integration of personal health budgets for healthcare with personal budgets for social care (http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/MakingPHBshappen/Integrating/).

2.3   Joint commissioning and funding flexibilities

Previous legislative flexibilities that enable joint working between NHS bodies and local authorities in respect of their health and social care functions still apply under the Health and Social Care Act 2012.[22] These include provisions in the NHS Act 2006 which itself consolidated those in the NHS Act 1977 and the Health Act 1999. Studies by the Audit Commission[23] in 2008 and 2009 found that formal pooled funds were most commonly in use in services for people whose needs crossed the health and social care divide, most notably for learning disabilities, mental health and community equipment services.

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[22] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[23] http://archive.audit-commission.gov.uk/auditcommission/nationalstudies/health/financialmanagement/Pages/clarifyingjointfinancingarrangements_copy.aspx.html
http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/91029meanstoanendsummaryrep.pdf

Box 12. Provisions for partnership arrangements under the NHS Act 2006

The NHS Act 2006 makes provision for the delegation of a local authority's health-related functions (statutory powers or duties) to their NHS partner, and vice versa, to help meet partnership objectives and create joint funding arrangements.[1] There are several statutory options for joint financing, including:

- *Pooled funds (section 75), which allow partners to contribute to a common fund to be spent on agreed projects or services.*
- *Transfer payments (sections 76 and 256), which (respectively) allow local authorities to make service revenue or capital contributions to health bodies to support specific additional health services, and vice versa.*

Alongside pooled funds, section 75 of the NHS Act 2006 also offers other flexibilities such as lead commissioning arrangements and the integrated management and provision of services, although these flexibilities can be combined:

- *Lead commissioning, where one partner leads service commissioning on behalf of another. This may be a sensible option depending on the size and make-up of the service to be commissioned.*
- *Integrated management and provision, where functions are delegated to a partner to jointly manage service provision, or resources, staff and management are combined from senior levels to the frontline. Examples include joint directors of finance or health and social care co-ordinators as single points of contact for service users.*

Joint funding, as one enabler of integrated care, can help to facilitate:
- a coordinated network of health, public health, social care and local authority services, eliminating gaps in provision
- best use of resources by reducing duplication and achieving greater economies of scale
- service providers being more responsive to the needs and views of people who use services, without the distortion that can be caused by separate funding streams for different service inputs.

Local partners using such flexibilities must ensure that a signed agreement is in place along with arrangements to manage the operation of any joint funds. The agreement should include, for example, identification of the host partner, functions, agreed aims and outcomes, levels of contributions, and relevant financial accountability and audit procedures, alongside joint governance arrangements for quality.

Joint financing arrangements, such as pooled funds, can make things easier by providing legitimacy and transparency. However, these are not essential for delivering integrated care and support. Aligned budgets are an alternative example of where funding streams are brought together but remain separately managed. Such options are often considered useful, given the perceived complexity and technical requirements of entering into formal pooled funding arrangements (see Box 12).

2.4 Procurement, choice and competition

Providers need to be able to cooperate in order to coordinate care for people. Monitor's new provider licence[24] includes an Integrated Care Condition, which states that licence holders "shall not do anything that could reasonably be regarded as detrimental to enabling integrated care". It also includes a patient interest test, which means that the obligations apply when the integration of care is in the interests of patients.

At the same time, NHS patients have certain national rights to choice, as set out in the NHS Constitution,[25] including, for example, the right to choose the organisation that provides their NHS care when they are referred for their first outpatient appointment.

Commissioners and providers of clinical services to the NHS are subject to rules designed to ensure that they protect the rights of patients to make choices and do not engage in anti-competitive behaviour that is against the interests of patients. They are also expected to follow procurement best practice.

A perceived risk of breaching rules on choice and competition is sometimes cited as one of the barriers to commissioning and delivering better integrated care. However, the Procurement, Patient Choice and Competition Regulations[26] require that the foremost objective of commissioners in procuring health care services must be to act with a view to meeting the needs of their patients and improving the quality and efficiency of NHS services, including through services being provided in an integrated way.

In March 2013, NHS England and Monitor released a joint statement[27] on choice and competition in commissioning clinical services in the NHS in England. That statement re-iterated that competition should be employed where it serves the interests of the public, whilst ensuring integration and safeguarding choice, quality and patient safety. It:
  • emphasises that patients and their interests always come first; nothing will require any decision to be made that conflicts with this; and

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[24] http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/monitors-new-role/the-new-nhs-provider-licence
[25] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[26] http://www.legislation.gov.uk/uksi/2013/257/contents/made
[27] http://www.england.nhs.uk/wp-content/uploads/2013/03/choice-comp-note.pdf

- reinforces the principle that it is for commissioners to decide if and when to introduce choice and competition where it is in the interests of patients, beyond the rights set out in the NHS Constitution.

The joint statement highlighted the work of NHS England and Monitor to develop a Choice and Competition Framework as a 'one stop' web-based resource[28] to help commissioners improve patient outcomes by helping them to understand the role of choice and competition. Due by the end of 2013, this will bring together for the first time in one place all of the key material that has a bearing on choice and competition in the NHS in England, including:

- the rules on choice and competition to which commissioners and providers must adhere
- guidance, produced by Monitor for commissioners and providers on how to comply with these rules and how it will enforce the regulations, as well as NHS England guidance on procurement best practice.

Guidance from Monitor on how to comply with many of these rules can already be found alongside other existing resources on the cooperation and competition section of the Monitor website.[29]

Monitor's guidance on the choice and competition licence conditions and answers to frequently asked questions around integrated care will explain that integrated care, choice and competition are not mutually exclusive and that choice and competition can actually facilitate the delivery of integrated care.

2.5 Reimbursement

The Department of Health is responsible for the national price and payment rules for 2013-14. Guidance was published by the Department of Health in February 2013[30], highlighting that the national 'rules' on the operation of Payment by Results (PbR) are mandatory. The PbR payment approach is often seen to favour inpatient, episodic care. However, there are considerable flexibilities (see Boxes 13 and 14).

NHS England and Monitor have taken on joint responsibility from the Department of Health for pricing NHS care for 2014-15, as required by the Health and Social Care Act 2012. Their respective duties include putting the patient at the heart of decision-making, ensuring services are delivered to a high quality, as efficiently as possible, and delivered sustainably over time.

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[28] http://www.monitor-nhsft.gov.uk/choiceandcompetition
[29] http://www.monitor.gov.uk/regulating-health-care-providers-commissioners/cooperation-and-competition
[30] https://www.gov.uk/government/publications/confirmation-of-payment-by-results-pbr-arrangements-for-2012-13

Box 13. Existing flexibility around payments in the NHS

Providers and commissioners are able to agree to vary the prices payable under the PbR tariff, for example, to support innovation in service delivery, integration of services or unbundling of services to enable components of care to be delivered and paid for separately, where this would be in patients' best interests. In implementing any of the permitted flexibilities, all of the following rules must be adhered to:

(a) the flexibility must be the product of local agreement
(b) the flexibility must be clearly established and documented
(c) the flexibility should be time limited and reviewed as appropriate

For services outside the tariff, commissioners generally have wide discretion on pricing, but they should always follow the PbR Code of Conduct: *Department of Health (2013) Code of Conduct for Payment by Results in 2013-14. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/141389/Code-of-Conduct-for-Payment-by-Results-in-2013-14.pdf.pdf*

There is some international evidence concerning payment approaches that support integrated care and support. This indicates that the design of a *currency*, or a descriptor of what is being purchased for a given price, should closely reflect what the people who use care and support deem to be *value*, that is, high quality services which are well coordinated, with minimum duplication, lags, or gaps. This suggests that we need a different concept of what is being paid for: an outcome or series of outcomes. We therefore need a new payment approach that genuinely puts people at the centre.

Monitor and NHS England are working together to design the long-term payment system, with each partner contributing particular expertise. To improve the payment system we will develop standardised currencies, identify the appropriate payment approach for different types of care and collect better data on provider costs.

Monitor will lead on pricing methodology for regulated national prices, local modifications and the rules for price setting and payment. NHS England will lead on the scope of national prices, the design of national currencies and variation rules for national currencies. We are encouraging local areas to test and refine financial incentives to ensure that they fully align with achieving the best outcomes for people.

Over the coming months, NHS England and Monitor will engage with stakeholders on their first National Tariff document for the NHS. This document will explain the rules for when

national prices and currencies can be varied to support, for example, innovation in service delivery and integrated care.

In addition, Monitor and NHS England have started work on a long-term strategy for the pricing system, taking into account sector feedback and evaluations of the current reimbursement models. The design of the payment system must find the right balance of delivering greater value for patients, managing the financial risk of individual local health economies and accounting for affordability.

Monitor and NHS England are publishing a document[31] in May 2013 that presents initial thinking on the design of the payment system in the long-term. This identifies what the payment system could aspire to:

- reimburse providers for delivering specified outcomes for patients rather than particular treatments or inputs
- promote the long-term, sustainable well-being of the whole person
- allow different payment approaches in different care contexts, with room for local flexibility, bounded by a clear structure and rules
- signal clearly to providers and commissioners the choices available to them that will promote sustained better outcomes for patients.

This approach should ensure that the payment system is no longer perceived as a barrier to delivering coordinated, person-centred care. Monitor and NHS England will be working with localities to develop new approaches to payment that support integrated care, such as the LTC year of care pilots.

NHS England has already started to explore further freedoms and flexibilities at a local level for potential wider adoption. The Recovery, Rehabilitation and Reablement (RRR) model (see Box 15) is one example of this, testing a reimbursement flexibility that could be a useful tool to enable certain models of integrated care and support.

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[31] Monitor and NHS England (in press) *How can the payment system better promote value for patients?*

Box 14. Year of Care payment approach

The aim of this programme is to have a national LTC "Year of Care" payment model, which facilitates the delivery of integrated health and social care for people with LTC based on need rather than disease and for those people who need support from more than just their GP practice. These people will be identified through risk profiling GP practice populations and by using a national assessment and classification system to group people according to their needs.

The payment model being tested is an annual risk adjusted capitation budget which is based on levels of need. The approach aims to improve outcomes and deliver a more effective use of resources by focusing providers on moving away from episodic activity-driven funding flows towards person- centred care irrespective of organisational boundaries.

Since July 2012, seven "Early Implementer" sites have been leading this work. They are due toreport on whether the payment approach is fit for purpose or whether any refinements are necessary, before large scale data collection commences.

Box 15. Recovery, Rehabilitation and Reablement (RRR)

The RRR programme can facilitate the set-up and/or access to early supported discharge, rehabilitation in the community, and options to pool budgets with reablement and social care. The aim of RRR is to improve the quality of an individual's care and outcomes, by delivering a service that restores and promotes independence, a key feature of integrated care and support. The service for acute patients admitted into hospital is based on their clinical, emotional and social needs, rather than just their diagnosis or where the care is delivered.

RRR aims to transfer funds within secondary care to local partners or distributed via pooled budgets to be utilised in new ways to commission rehabilitation and care designed to meet local needs as determined by CCGs. The programme is aimed at reducing the average length of stay in acute beds, changing the responsibility for care towards greater emphasis on meeting peoples' needs in an appropriate recovery or rehabilitation setting. Better rehabilitation could create more sustainable discharges and reduce readmissions. It has potential to promote service improvement for many disabling conditions, particularly long term conditions such as stroke and following injury in both the young and older people, although the current evidence base is limited.

In the longer term, there is also the opportunity for pooled budget options with Social Care. This concept is being tested as part of the LTC Year of Care funding model (see Box 14).

3. The offer of support

This section describes the national support that is on offer for local areas to develop their models of integrated care and support. In particular, our offer recognises the importance of effective cultures, workforce and information governance. We also introduce the concept of 'pioneers', highlighting the importance of rapid and widespread exchange of learning across the system.

3.1 Developing national resources

Building a sustainable delivery model in the new landscape of health and social care to support all localities innovating in the commissioning and delivery of integrated care and support requires vision, leadership and practical support to local health and social care communities. Here, we make this offer of support and expertise from the national partner organisations.

To share the learning from local innovation across the system, in addition to the website that the national partners will develop and support, there are already a range of valuable online resources, including those of the national partners and notably from the King's Fund[32], Nuffield Trust[33], QIPP LTC workstream[34], NHS Confederation[35] and the NHS Alliance.[36] We will expect local leaders to seek out and adopt the available evidence and learning about how to deliver integrated models, to learn from each other and share practice to enable progress at scale and pace.

3.2 Supporting local commitment

We are establishing the *Integrated Care and Support Exchange* (ICASE), a national resource bringing together practical expertise from national partners, and delivered by NHS Improving Quality (NHS IQ) working with the Social Care Institute for Excellence (SCIE) and Health Education England (HEE). ICASE will act as a central information and support exchange, assembling a resource of people, including national partners and local areas that have direct experience of delivering integrated care and support. They will provide expertise and, advice, as well as sharing lessons learned as widely as possible across the system. NHS IQ brings extensive expertise in how to achieve systemic change.

ICASE will support local authorities, HWBs, CCGs, GPs, Commissioning Support Units and Strategic Clinical Networks on their service improvement requirements as well as drawing on expertise in the wider NHS system, such as NHS Trust Development Authority (NTDA)

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[32] http://www.kingsfund.org.uk/topics/integrated-care
[33] http://www.nuffieldtrust.org.uk/our-work/integrated-care
[34] http://www.networks.nhs.uk/nhs-networks/qipp-network/ltc
[35] http://www.nhsconfed.org/Pages/home.aspx
[36] http://www.nhsalliance.org/

and Academic Health Science Networks (AHSNs). Appropriate support for providers will also be available. Established and successful networks and partnerships with the voluntary sector, social care and user organisations will continue to be developed. Dissemination of learning from ICASE and across the system will be delivered online via a website that the national partners will develop and support.

> ### *Shared Commitment*
>
> NATIONAL: *We have established the Integrated Care and Support Exchange (ICASE), a national resource bringing together practical expertise from national partners.*
>
> LOCAL: *We expect localities to engage fully with ICASE as they develop their own models of integrated care and support and to share any lessons as widely as possible across the system.*

Depending on the model of integrated care and support developed by the local area, ICASE support will include some, or all, of the following:

A) New Tools, including:
- 'How to' and 'top tips' guides produced in partnership with stakeholders focusing on the key evidenced enablers of integrated care and support
- Organisational metrics covering inputs, process, outcomes and balancing measures
- Local area-led innovation in the use of indicators developed from the "I" statements co-developed for us by National Voices
- Web based resources, e.g. Think Local Act Personal's resources on personal budgets and personalisation. www.thinklocalactpersonal.org.uk
- Further products and support that localities have specifically requested. We shall shortly be sending out a survey asking what particular support is needed around the system.

B) Technology
- One example of data management to enable self-management is through the use of technology such as telehealth. The recent findings from the Whole System Demonstrator[37] programme showed that the use of telehealth and telecare, if implemented as part of a wider integration between health and social care services,

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[37] http://www.bmj.com/content/344/bmj.e3874?tab=responses

could have a positive impact on a person's outcomes. For example, mortality rates were found to be significantly reduced, and a reduction in emergency hospital admissions was seen although this was greater for people with pulmonary and cardiac disorders than it was for people with diabetes and hypertension.

Box 16. Examples of support available from SCIE

Here are links and references to resources developed, or in development, by SCIE, including e-learning and workforce development resources on integrated working:

Co-production
- SCIE has a *Co-production Charter* for its own working methods, hosts a *Co-production Network* of people who use services and has wide range of co-production resources, which are available at:
  http://www.scie.org.uk/topic/keyissues/coproductionparticipation

Dementia
- The Dementia Gateway is available at:
  http://www.scie.org.uk/publications/dementia/index.asp

End of Life
- SCIE's *Dying well at home – the case for integrated working* will be digitally published in May 2013

Integration - web tools and resources available early summer 2013
- *Research Briefing 41.* http://www.scie.org.uk/publications/briefings/briefing41/

Personalisation and personal budgets
- SCIE's digital resource *Personalisation- a rough guide* allows viewers to select content by their own needs and interest.
  http://www.scie.org.uk/publications/guides/guide47/
- SCIE's TV film on integrating health and social care budgets is available here:
  http://www.scie.org.uk/socialcaretv/video-player.asp?v=healthandscintegration&subtitled=yes
- SCIE will launch *Delivering Personalisation* by the end of 2013 .This is a new e-learning resource offering a blueprint for person-centred practise, and developed with health and social care services across a large Trust.

Reablement
- SCTV reablement films are available at
  http://www.scie.org.uk/socialcaretv/index.asp
- SCIE's *Reablement Guide* and e-learning resources will be available in May 2013

Telecare
- SCTV Telecare films are available at http://search02.scie.org.uk/?q=telecare

ICASE support in this area will include:

➔ aligning delivery objectives with the most productive use of assistive technology and telehealth which support people with long term conditions such as:

- assistive technology to use in their own homes
- integrated assistive technology care packages in people's homes to extend independence and enable positive risk taking with extended support to families
- targeted use of assistive technology to support service users with specific needs such as dementia

➔ looking at the wider potential for usage of electronic palliative care coordination systems (EPaCCS) which are currently used within palliative and end of life care to improve the coordination and delivery of care and are underpinned by the ISB standard for quality assurance

The increase in use of technology within people's homes brings with it the ideal opportunity to strive for electronic records access for people. Recent research has found that if 30% of patients accessed their GP records at least twice a year, approximately 10% of GP appointments may be saved.[38]

Shared Commitment

NATIONAL: *We commit to providing new support to help localities develop their models of integrated care and support.*

LOCAL: *We expect localities to use this support, and contribute extensively to, this growing resource base.*

3.3 Developing a culture of cooperation

We recognise that no wide scale change in the way services are provided or staff are required to work will happen without effective leadership and a culture open to change, embracing joint working and the need to work across traditional clinical and sector boundaries. At a local level, support might be required to foster a culture of cooperation between organisations that have not routinely worked closely together before.

ICASE will ensure that innovation is supported. Current pockets of good practice relating to integrated care and supporting literature will be drawn upon, such as the work of the Kings Fund and 'Lessons from Experience'.[39] National Intelligence data will be aligned alongside

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[38] Royal College of General Practitioners (in preparation).
[39] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

local and regional intelligence and comparative information to track evidence and to build a shared profile of improvements in local areas.

3.4 Workforce Training and Development

The provision of integrated care and support can require a specific skill set for professionals, enabling them to work in multi-professional teams and across traditional boundaries. Changes to workforce and education are often necessary to ensure a move towards integrating care within community settings. A more flexible approach is often required to enable staff to assume new approaches and responsibilities with confidence. For example, the increased use of new technologies such as telehealth and telemedicine will require new ways of working and new skills for GPs, nurses and carers.

HEE, the Royal Colleges, Skills for Care and the Leadership Academy are all working to ensure that training for all professionals supports widespread adoption of integrated care and support. HEE and the Local Education Training Boards (LETBs) are to bring together different parts of the system to plan and develop the whole workforce in a more coherent way. In the longer-term, LETBs will take a multi-professional approach to the planning and development of the health workforce and in the commissioning of education and training in line with local needs.

> ### Shared Commitment
>
> *NATIONAL: To stimulate working cultures that actively encourage integrated care and support, we commit to supporting localities in workforce training and organisational development, working with relevant Local Education and Training Boards (LETBs).*
>
> *LOCAL: We expect localities to engage fully with their LETBs and share lessons across the system.*

3.5 Information governance

In order to deliver person-centred coordinated care, data relating to individual's risk factors, identified needs, care plans and status should be shared at the following levels within appropriate time frames:

- between patients, people who use services and care providers such as clinicians, to enable self-management and build independence

- between front line workers, to enable coordination and continuity of care at transitions between services throughout the care pathway

Strong Information governance is also critically important, especially in data sharing across organisations. Organisations must agree what data should be shared within clearly defined information sharing protocols. Keeping individuals' personal data safe and secure is essential and there are already strong legal controls in place to protect this kind of data. There needs to be a clear legal basis for sharing an individuals' information even when it benefits the care of that individual but this should not be a barrier in the majority of cases.

The Information Strategy published by the Department of Health in 2012[40] describes how information can be used to drive integrated care across the health and social care sector, both within and between organisations. The ambition is for the NHS Number to become universally used across health and social care to aid sharing and, therefore, integration. For example, the Children's Health Outcomes Forum's report,[41] recognised the importance of having a single unique identifying number. It recommends "using the NHS number as the unique identifier, to enable good information sharing, at the same time clarifying information sharing across system, and harness the enormous potential for electronic records to provide an accessible comprehensive record to inform professionals and children and families".

Electronic care records will progressively become the source for core information used to improve our care, improve services, inform research, reduce bureaucratic data collections and enable quality to be measured. There is already evidence that people who have access to their records share the data with different parts of the care services, for example, sharing the record with consultants, saving time and avoiding repeat tests; with A&E here and abroad, making care safer; and with carers and with family. People who have access to their records have found they have a better understanding of what they need to do and why and feel more in control of their care.

The Royal College of General Practitioners has recently published guidance about Patient Online, an electronic records system, which, among other benefits, enables online secure communication between patients and their GP practice.[42] Many GP practices have already signed up to record access resources, such as Patient Online or www.myrecord.org.uk, giving their patients greater control over their health and care.

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[40] https://www.gov.uk/government/publications/giving-people-control-of-the-health-and-care-information-they-need
[41] https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results
[42] http://www.rcgp.org.uk/patientonline

The Caldicott[43] Report into Information Governance, published on 26th April 2013. It has recommended a duty for NHS and social care providers to share data when it is in the person's best interests. This recommendation aims to reduce the anxiety staff have over sharing individual's data with others. The Health & Social Care Information Centre (HSCIC) will shortly publish a statutory Code of Practice on the sharing of confidential information. On-going work will ensure that leaders of provider organisations and the General Medical Council and Nursing and Midwifery Council are clear about the rules that apply so that support for staff can be given to help them in decisions about sharing data for care.

The situation is more complex for uses of data beyond the direct care and support of the individuals. Where the data is anonymised or strongly pseudonymised, as would be the case, for example, for the development of collection and analysis of patient resource allocation data, the data can be shared freely across organisational boundaries.

However, where data are to be used in this way but individuals are still identifiable, organisations will have to ensure that there is a legal basis for the activity in line with the HSCIC Code. This may be achieved by gaining consent from each individual whose data they are wishing to share, or make an application under Section 251 of the NHS Act 2006 if it is in the public interest or to improve patient care.

Shared Commitment

NATIONAL: *Recognising that information systems and governance are critically important in efforts to integrate care and support, we will enable the use of information systems to support better coordinated care and support by aligning national information systems development projects and providing timely advice and support on information governance.*

LOCAL: *We expect localities to adhere to the principles of the Caldicott Report and the NHS Constitution on data sharing, in their efforts to integrate care and support for the benefit of patients and people who use services.*

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[43]   www.gov.uk/government/publications/the-information-governance-review

3.6 Pioneers

For the most ambitious and visionary localities, we commit to providing additional bespoke support and constructive challenge. This will be from a range of national and international experts to help pioneers realise their aspirations on integrated care and support and accelerate learning across the system. We aim to stimulate and support successive cohorts of pioneers and, in return, expect them to help rapidly share their accelerated learning across the system for the benefit of all localities (see Box 17).
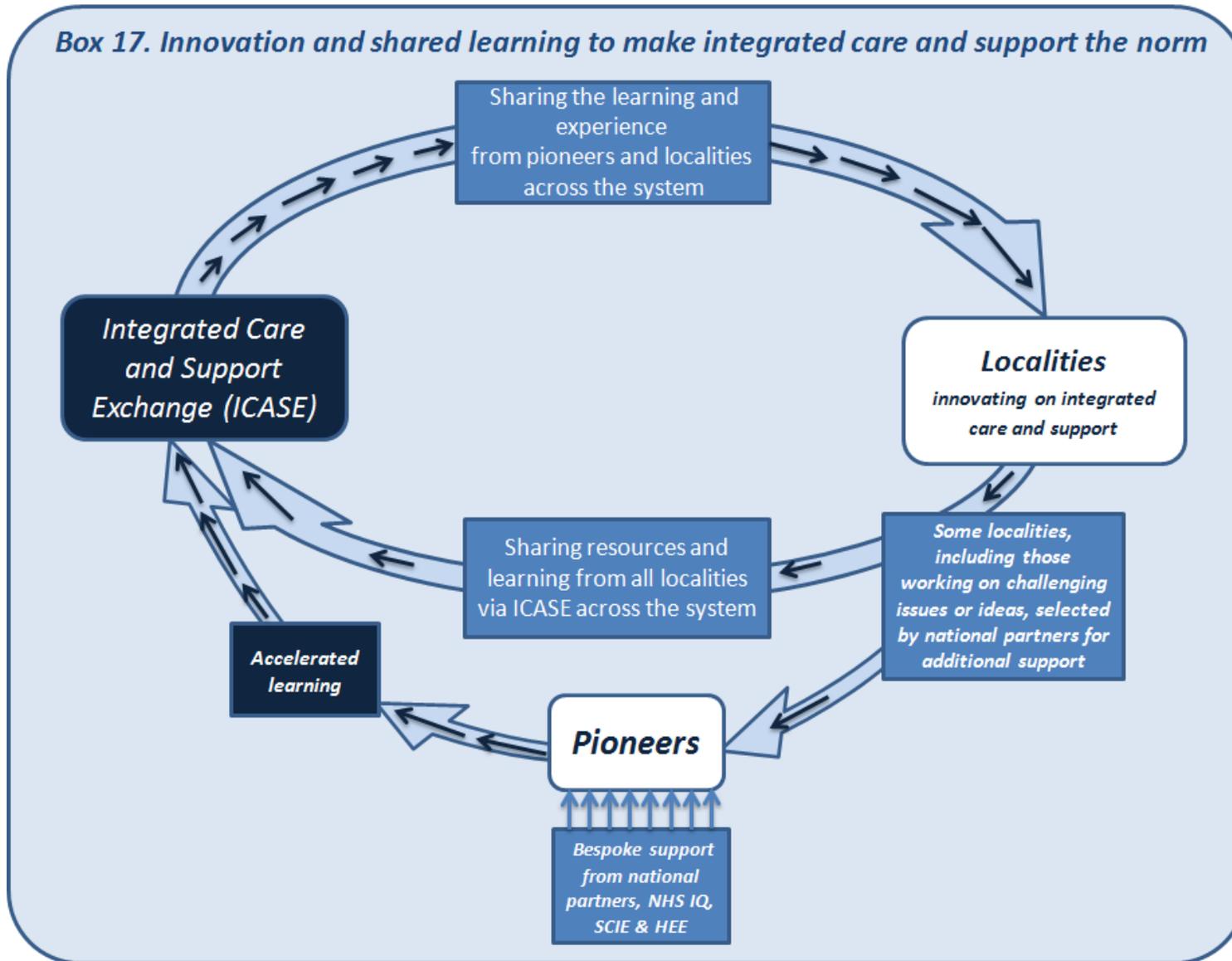
3.7 Resources and support for pioneers

Depending on pioneers' proposed models for integrated care and support, national partners will offer some or all of the following:

- a dedicated 'account manager' as the main on-going point of contact with each pioneer
- drawing together the current learning from literature and sites where integrated care has already been successfully adopted and other related initiatives
- skills matching and deployment of ICASE partners to support local delivery teams to build a strong community of practice by linking the pioneer sites and connecting them together to ensure rapid and real time sharing of best and emerging practice across the pioneers and the rest of the country
- priority setting, site visits, workshops including peer and champion support
- data and service audits covering the component parts of an integrated care and support delivery system
- economic evaluations and analytical support
- traffic light status reports referencing progress on the delivery of projects
- workforce development initiatives
- implementing a structure to cascade and transfer learning from the outcomes and achievements of the first phase early adopter sites

Facilitation of rapid learning and information sharing between pioneers and across all other localities in the system by:

- Web Ex ,virtual learning networks and regular bulletins, the website that the national partners will develop and support, giving access to existing information and guidance
- access to support networks across voluntary, community, charitable provider sector, users and research organisations
- supporting the development of social capital by securing partnership contributions from community networks and voluntary community and faith sector organisations
- ensuring pioneer areas have access to the full range of resources which allow people to make well informed decisions about their care and support wishes
- supporting integration events and road shows through resources from regional structures across the health and social care system

Box 17. Innovation and shared learning to make integrated care and support the norm

Sharing the learning and experience from pioneers and localities across the system

Integrated Care and Support Exchange (ICASE)

Localities
innovating on integrated care and support

Sharing resources and learning from all localities via ICASE across the system

Some localities, including those working on challenging issues or ideas, selected by national partners for additional support

Accelerated learning

Pioneers

Bespoke support from national partners, NHS IQ, SCIE & HEE

3.8 Selection criteria for pioneers

We have no intention to be prescriptive about the specific models that local areas will adopt; this will be for localities to determine based on their own judgements and circumstances.

However, each pioneer area will be expected to**:**

- **articulate a clear vision of its own innovative approaches to integrated care and support**, including how it will (i) utilise the Narrative developed by National Voices and Think Local Act Personal's *Making it Real*, (ii) deliver better outcomes and experiences for individuals in its locality, and (iii) realise any anticipated financial efficiencies
- **present fully developed plans for *whole system* integration**, encompassing health, social care and public health, other public services and the community and voluntary sector, as appropriate
- **make a clear commitment to contribute energetically in sharing any lessons on integrated care and support across the system**. This will involve close working with the *Integrated Care and Support Exchange (ICASE)* and other national partners, including via peer-to-peer dissemination, workshops and learning networks
- **demonstrate that their vision and approach is, and will continue to be, based on robust analysis**. This will include (i) evidence that plans have taken account of the latest available evidence base, (ii) a demonstrated willingness to co-produce, with national partners, new measurements of people's experience of integrated care and support and (iii) a commitment to participate actively in an evaluation of the overall impact of the approach and our work collectively with other pioneers.

Shared Commitment

NATIONAL: *For the most ambitious and visionary localities, we commit to providing additional bespoke support to help such 'pioneers' realise their local ambitions and accelerate learning across the system.*

LOCAL: *We expect pioneers to work in partnership with us to help disseminate and promote lessons for wider, rapid adoption.*

4. Measuring progress

We expect integrated care and support to result in improvements to the experiences and outcomes of individuals and their communities. But we can only know that this is true by measuring and evaluating the impact of all of our efforts. In this section, we describe our plans for evaluation of this work and measurement tools that are either currently-available or in the process of being developed. We also make clear how we will judge ourselves to be successful using such measurement and evaluation.

4.1 Monitoring activity and impact

We are making a commitment of sustained focus on, and support for, integrated care and support because we know it requires a culture of continuous improvement, at both local and national levels, to succeed. Here, we commit to an on-going programme to enable and promote integrated care and support, working in collaboration with local commissioners and providers of care. To ensure progress, we commit to delivering on the actions outlined in this document.

There has been a recent survey conducted by ADASS and the NHS Confederation on integrated care and support, targeted at local authority areas. This helps to establish the extent of activity nationally and direction of travel and explore common barriers and opportunities to expand integrated care and support.

We also recognise the importance of conducting a long term evaluation of the impact of the pioneers. This will provide additional evidence to underpin efforts at integrated care and support and, crucially, add significantly to the evidence base on integrated care and support, including measurement of social capital that all areas can draw from.

Shared Commitment

NATIONAL: *Recognising the importance of growing the evidence base about the benefits of integrated care and support, we commit to conducting a systematic evaluation of progress and impact over time.*

LOCAL: *We expect pioneers and localities to collaborate with us in the co-production of this evaluation.*

4.2 Measurement of peoples' experience of integrated care and support

To tell whether or not we succeed, we need to know that people's experience of care has improved. We have heard from the Kings's Fund, Nuffield Trust[44] and NHS Future Forum[45] about the pressing need to develop ways of measuring integrated care and support.

Currently, we rely on only proxy measurements, such as levels of unplanned hospitalisation, emergency readmission to or delayed transfers of care from hospital. Whilst these are clearly important, they are almost certainly influenced by a variety of factors, only one of which is integrated care and support. Ultimately, we know that the most reliable measure of integrated care is to ask people directly whether the care and support that they experienced was integrated and if this had a positive impact on their experience of the care received.

As an interim solution to the development of such a measurement, in August 2012 the Department of Health published existing survey questions that capture aspects of people's experience of integrated care so that localities could use them as an immediate way to measure, guide and support local innovation on integrated care.[46] These survey questions provide organisations and areas with a baseline set of data to review when planning a change to the delivery model, and serve as a starting point for localities to measure aspects of integrated care and support in their area. The Department of Health also published baseline data, broken down to local level, for all of these seven interim measures. We encourage localities to begin working with these measures as first attempts to develop measurements of people's experience of integrated care and support.

We recognise that these current measures provide data that are incomplete and that reflect only a subset of patients and service users in the system. To develop a more robust approach to measuring people's experience of integration, we are using the Making it Real and Narrative "I" statements, as the foundations for new measures of integrated care and support. In December 2012, the Department of Health commissioned independent research to examine options for developing a measurement tool for local and national purposes across the health and social care sectors. Based on the results of this research, we are now commissioning the development of new measurement tools for people's experience of integrated care and support and reviewing existing surveys that the questions could be added in to. These will be developed by the end of 2013 and will be provided to localities as tools for local service improvement.

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[44]http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf

[45]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152169/dh_132085.pdf.pdf

[46]https://www.gov.uk/government/publications/measuring-patient-experience-of-integration-in-the-nhs

> ### *Shared Commitment*
>
> NATIONAL: *Drawing on the Narrative developed by National Voices, we commit to developing by the end of 2013 new ways of measuring people's experience of integrated care and support.*
>
> LOCAL: *We expect localities to help us test, further develop and refine these measurements for adoption system-wide.*

Furthermore, the National Institute for Health and Care Excellence (NICE) has a number of Quality Standards that contain elements of integrated care and support such as "supporting people to live well with dementia". These standards, alongside the other existing measures, can provide organisations and localities with a clearer picture of the impact of integrated care and support. NICE, working in partnership with, for example, Ofsted, the department for Education and Care Providers Alliance, has a planned programme of work to build further the evidence base and guidance on health and social care standards. These will include the transition between child and adult services and health and social care, which includes discharge planning, admission avoidance, reducing readmissions, and reducing unnecessary bed occupancy by older people with long term conditions.

These Quality Standards are central to supporting the vision for an integrated health and social care system focussed on delivering the best outcomes for people who receive care services. NICE will be closely involved in the on-going measurement work, to align the measures and Quality Standards and involved in the evaluation of pioneers, to utilise their learning to inform future best practice guidelines.

Regardless of specific measures, localities should be able to demonstrate the engagement of people who use services in planning and delivering their coordinated services. Part of this planning, as with any change, would be to identify how to obtain timely feedback and use it to improve services.

5. Next Steps

We conclude with a brief description of our next steps and how we will ultimately judge our efforts to be successful in the future.

Our collaboration has been informed by the work of the NHS Future Forum, the King's Fund and Nuffield Trust, the Year of Care early implementer sites, the Whole Place Community Budget pilots, Integrated Care Pilots,[47,48] and Personal Health Budget pilot programme. We have also heard from many other local areas and teams innovating and experimenting in integrated care and support, inspiring us with their determination and energy to succeed. NHS England will be hosting a number of workshops in the coming months to engage with local areas on our collaborative programme, hear about their experiences of seeking to deliver better integrated care and support, and explore the scope for further national support.

The national partners will be part of an on-going and sustained collaboration to remove national barriers, develop new tools and facilitate local efforts.

We know that integrated care and support is only successful if individuals feel their care and support has been designed and co-ordinated around their needs and preferences. Therefore, in the short term, we will judge ourselves successful if all localities in England have adopted models for integrated care and support within the next two years. The long term measure of our success will be for integrated care and support to become the norm within five years, resulting in improved outcomes and positive experiences of care and support for individuals and their communities

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[47]http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation
[48]http://www.rand.org/randeurope/research/projects/integrated-care-pilots.html

Box 18. About our Collaboration

Integrated Care and Support: Our Shared Commitment is the first output from our *National Collaboration on Integrated Care and Support* involving the following partner organisations:

- Association of Directors of Adult Social Services
- Association of Directors of Children's Services
- Care Quality Commission
- Department of Health
- Local Government Association
- Monitor
- NHS England
- Health Education England
- NHS Improving Quality
- National Institute for Health and Care Excellence
- Public Health England
- Social Care Institute for Excellence
- Think Personal Act Local

in association with:

- National Voices

There are, and will be, no national blueprints for localities to follow, but we recognise that we can take action to make it easier for localities to be successful in their efforts. Instead, this will be an on-going and sustained national collaboration to support localities to develop knowledge, share it across the system and promote integrated care and support.

Box 19. About the audience

This document has been written to inform local practitioners of integrated care and support, or those wishing to become so. Local practitioners include those involved in the planning, commissioning and provision of health and social care and support at local level, namely clinical commissioning groups, Health and Wellbeing Boards, local authorities, the voluntary sector, GPs, NHS trusts, NHS foundation trusts, healthcare providers and the diverse range of care and support providers. It will also be of interest to policy officials in national government and its arms-length bodies, national professional bodies and the Royal Colleges.