



Public Health
England

Health and Care Integration

Making the case from a public health perspective

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Ellen Graham, policy manager – integration

© Crown copyright 2013

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v2.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned. Any enquiries regarding this publication should be sent to ellen.graham@phe.gov.uk.

Published December 2013

PHE publications gateway number: 2013359

This document is available in other formats on request. Please email ellen.graham@phe.gov.uk



Contents

About Public Health England	2
1. Introduction	4
A local approach	4
2. Integration and public health	5
What do we mean when we say integration?	5
3. Learning from others and building the evidence base	7
4. Where next?	8
5. Examples	9
Totally Hooked on Fishing – helping to reduce loneliness	9
Falls Liaison service – Hertfordshire	10
Healthy Homes – improving people’s housing to improve their health	11
Find and Treat – improving tuberculosis care for marginalised groups	13

1. Introduction

Patients and users of care have long been saying that the lack of integration is a major frustration for them. A challenging financial environment and demographic change resulting in rising demand and increasing numbers of people with complex needs means health and social care must be on the front foot. The focus must be on people's wants and needs rather than the organisations and structures that deliver care. We need to prevent ill health and support people to stay well rather than only intervening in a crisis. Never has there been a more pressing need to change the status quo.

Integration must be as much about keeping people well and independent as it is about ensuring they receive the services they need if they become unwell. The aim of this document is to help local areas, in particular health and wellbeing boards, make the case for integration focused on individuals' health and wellbeing as well as their quality of life if they become ill.

A local approach

Through our **centres**, Public Health England will help facilitate new ways of working and the sharing of best practice. This document marks the beginning of our work on integration and brings together a number of inspiring examples of integration projects that are underway. Learning from one another is essential to making progress quickly, building the evidence base, and helping achieve the ambitious goals of integration.



The £3.8bn **Better Care Fund** is an excellent opportunity to take forward transformational change to improve integration of health and care services. Clinical commissioning groups and councils are free to extend the scope of their pooled budget, to include housing or transport, to support better integration in line with their Joint Health and Wellbeing Strategy. Health and wellbeing boards have a pivotal role in driving integration and a formal role in signing off local integration plans. Integrating health and wellbeing is both a challenge and an opportunity for us all. Public Health England's centres, as part of the local health and wellbeing system, will support local areas to be ambitious with their integration plans, helping them to incorporate prevention and a focus on the public's health and wellbeing.

Access to part of the £3.8bn fund will be determined by performance against metrics such as emergency admissions, patient experience, reablement and admissions to care homes. We anticipate that many local areas will include a local measure that has a stronger prevention focus, such as social isolation, or falls in the over 65s. Public Health England can help support local areas to develop and deliver on local measures for the Better Care Fund.

2. Integration and public health

No single part of the system can successfully tackle these challenges alone. To ensure people receive the right support at the right time, we must align incentives and ensure our finite resources are targeted in the most effective way. Preventing illness and empowering people to stay well is not something health and care professionals can do alone; broader action from across society is required.

Michael Marmot's *Fair Society Healthy Lives* highlighted the significance of wider determinants on our health, demonstrating that housing, employment and education are the “causes of the causes” of ill health. We must consider people’s health within the broader context of their lives, rather than working within disease, professional or organisational silos.

What do we mean when we say integration?

“I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me.”

Integrated Care and Support: Our Shared Commitment

Integration within health and care is not new – people using services, carers, politicians and policy makers have been calling for better integration for many decades. For years, the NHS and local government have been trying out different approaches seeking to demonstrate the benefits of integration. Even where there have been positive results, adoption across the country has not followed.

We use the word “integration” to mean many different things, and it is often misunderstood. This has understandably led to confusion about what we mean when we say integration, let alone how we can actually implement it to deliver lasting change that transforms people’s health.



Integrated Care and Support: Our Shared Commitment provides a nationally agreed definition developed by National Voices in partnership with Think Local Act Personal, with patients, users and carers, that encapsulates what integration means to individuals.

In practice, from a public health perspective, that might mean a focus on supporting people to stay out of hospital, by reducing falls or linking people to activities that help them feel part of their local community and reduce loneliness. Equally, it could mean helping people to stay well by reducing fuel poverty.



"We have had a bit of an epiphany locally that 'it all starts with a conversation' to understand the person's story. In Cornwall, we have found that trained volunteers are ideally placed to initiate that conversation, when working at the 'front door' of a multi-agency practice-based team.

As a commissioner of over 13 years, this has been a huge wake-up call. I'll give you an example: for the person who had repeated falls, lived alone, aged 72, I might have commissioned a falls prevention service that included assessment, therapy, bone scanning, medication review, or a home based occupational therapy check. Tick, tick, tick. All bases covered. But without the conversation, without knowing his story, I would have commissioned a service that missed the crucial point: he was falling over because he was grief-stricken following the death of his wife – not eating properly, drinking heavily, generally lost his *raison d'être*. He may have needed medical interventions, but what he really wanted was a bit of help to find some company and friendship - and that's what would have stopped him falling over again."

Rachel Murray, Programme Manager, Kernow CCG

3. Learning from others and building the evidence base

Integration is easy to talk about but difficult to do. Evidence tells us that integrating care can improve people's experience of the services they receive. As a starting point, national partners have developed a **toolkit** to support health and wellbeing boards and local partners to understand the evidence and impact of different integrated care models on service users, as well as the associated impact on activity and cost to different parts of the health and care system.

Many places have already started to design and implement integrated approaches. Included here are some inspiring examples from across the country; they exemplify putting communities at the heart of services, transcending traditional boundaries, and a focus on keeping people well.

As we develop the evidence base, we must use the information we currently have, and we must maximise the opportunities available to us to ensure we all gather, learn and share the experiences that are happening now. This information will form the evidence base of the future, and will help us to learn at pace about what effective interventions look like and about those that do not work so well.



4. Where next?

The launch of the **14 integration pioneer sites** on 1 November 2013, combined with the introduction of the Better Care Fund, creates a real prospect for local areas to work together and do things differently.

The pioneers will implement innovative approaches and share their experiences throughout, so we can all learn in real-time, not only about what works, but also the processes required and the difficulties that need to be addressed to enable rapid adoption across the country.

There will be enormous amounts of activity as local areas share, refine and agree their integration plans. Local leaders, clinicians, providers and local partners will need to be bold and ambitious as they look beyond traditional models of delivery and practice to ensure that people are receiving the care they want and need in the most effective way.

Public Health England is committed to working with local partners to deliver integrated care. We will:

- **work with national partners to support the pioneers** as they implement their ambitious plans and, through our centres, support the gathering and sharing of the learning across the country to help tackle barriers to integration such as contracts, payment mechanisms and data sharing;
- offer **advice and evidence on public health interventions** that can have a significant impact on people's health and wellbeing by being integrated with other local services, for example in relation to social isolation, housing and fuel poverty;
- work with national partners to offer **systems leadership** support to the pioneers by providing a knowledgeable and skilled organisational development and leadership expert to work with each site to unlock the leadership potential across all local organisations involved in their particular integration challenge;
- seek to **build the evidence base** on what works by taking advantage of the local Knowledge and Intelligence teams and working closely with the Early Intervention Foundation to ensure that evidence-based approaches can be shared, applied and integrated locally;
- **share learning** from integration that is already taking place across the country, for example on the Troubled Families Programme; and
- work with national partners, to **support the evaluation** of local integration projects to enable comparisons, demonstrate returns on investment, including social return, and support the development of strong business cases to implement future integrated approaches.

5. Examples

Totally Hooked on Fishing – helping to reduce loneliness

In 2007, Get Hooked on Fishing, a charity based in the Midlands, launched Totally Hooked on Fishing. A scheme designed to enable the elderly and adults at risk of social exclusion to go fishing, helping them to regain self-confidence, aid their physical and mental recovery from long term illness, bereavement, depression, Alzheimer's and other disabilities. Attending fishing trips has enabled participants to stay active and gain a sense of wellbeing.

Benefits identified

People who have taken part have improved their physical and mental health by reducing their experience of isolation and loneliness.

How does it work?

Individuals can refer themselves directly to the programme, alongside referrals from health and care providers including Moseley Hospital, Brain injuries Unit, Stroke Association, MIND, care homes, community groups, GPs and clinical commissioning groups.



Participants are taken out on angling sessions to the countryside either as part of a group or one-to-one sessions. Staff are trained in first aid, bereavement counselling and dementia awareness. Training for staff has been supported by the Birmingham Care Development Agency.

Sessions cost between £40 and £85, participants are asked to contribute £15 per session with the remainder of the costs covered by the charity. In two local authority wards, grants have been made available to cover costs of participation.

The programme also offers an inside “angling experience” which is carried out in a large church, community or sports hall. Local people can attend the session during the day for as much or as little time as they like.

Falls Liaison service – Hertfordshire

In Hertfordshire, over the course of one year falls were causing 45-50 deaths and 22,000 emergency ambulance calls. In 2009/10 Watford had the highest number of hip fractures in England.

In October 2011, the Falls Liaison service was launched as a pilot programme to prevent falls, and resulting hospital admissions, among older people. It was set up by the public health team and is now funded by the CCG. The East of England Ambulance service and GPs can refer to people to the Falls Liaison service.

Benefits identified

- 4,000 people have been referred annually to the Falls Liaison Service
- hospital admissions have been reduced by 7%
- the service has saved an estimated £1.5 million – including the cost of the service; this is an overall saving of around £800,000

How does this work?

The Falls Liaison service offers a 16 week programme of strength and balancing classes designed to improve flexibility and reduce the likelihood of falls.



The strength and balancing classes are provided by a local voluntary organisation, the Hertfordshire Sports Partnership, which works with ten local leisure centres to train fitness instructors who lead the classes.

The Hertfordshire Falls Car also works to prevent hospital admissions after falls – the car responds to 999 calls after a fall where there have been no broken bones or

serious injuries. A paramedic and social worker assess the injured person and where a hospital admission is not needed, they provide equipment to aid mobility and prevent the likelihood of future falls. This team can also refer to the Falls Liaison Service.

The Community Safety Team provides telecare services and assesses the home safety of those who using the Falls Liaison service.

Community pharmacies are also working with the service; patients taking osteoporosis medicines can discuss side-effects and dosage with the pharmacist instead of having to make an appointment with the GP. This means any issues with medication can be quickly dealt with, enabling people to manage side-effects effectively.

Healthy Homes – improving people’s housing to improve their health

Liverpool has among the highest mortality rates and lowest levels of life expectancy in England. It also has 44,100 households in fuel poverty. In April 2009, Liverpool City Council launched the Healthy Homes campaign.

Healthy Homes Advocates visit houses in targeted areas and carry out assessments of residents’ health needs and the condition of their homes. For rented properties, they have enforcement powers to ensure that necessary improvements are made by the landlord. For owner occupied properties, an outline of improvement works to make the property healthier is provided and assistance explored where necessary.



Benefits identified

- a 57% reduction in excess winter deaths city-wide since 2007
- 30,000 homes have been visited and 22,200 referrals made to partner organisations
- 4,500 home risk assessments have identified 3,300 serious housing hazards that have been remedied or are in the process of being remedied
- this work is estimated to support at least 30 construction jobs in the City
- housing improvements made in year 1 of the programme are estimated to save the NHS in the region of £439,405 per year, from this point onwards
- over a 10-year period these could be extrapolated to an approximate saving of £4.4m
- the wider benefits to society including NHS savings are estimated at £11million over 10 years
- as the current phase of the programme will deliver five times the number of inspections undertaken in year one, it is estimated that the Healthy Homes Programme could make savings of up to £55 million over a 10 year period

How does this Healthy Homes work?

An advocate from the Healthy Homes Team visited a 69 year old man after a referral from a district nurse. He was housebound with no telephone line and living alone with no hot water or heating. He was unsure whether his pre-payment gas meter had been cut off and hadn’t used it for six months.

The Healthy Homes advocate looked at the meter and found he was £211.85 in debt; whenever he topped up, the meter would automatically take 70% leaving him with less than a day's usage per top up.

The advocate:

- contacted the fire service to request two oil-filled radiators
- called Scottish Power, which sent an engineer to reset the meter. The debt was wiped off and set to be repaid at £3.55 per top up, leaving the client with more than 70% gas. The client was also put on the Priority Service Register in case of any disconnections in the future
- submitted an application for the Warm Home Discount, this means a one-off payment of up to £130 will be issued to his electricity meter each year
- left a winter survival pack containing a blanket, torch, thermometer and draught excluder



Healthy Homes on Prescription is an extension to the Healthy Homes programme. GPs are prompted to ask patients about their housing conditions. As a consequence, Healthy Homes now receives approximately 25 referrals per month from the 55 practices where the system has been fully introduced.

"Healthy housing surgeries" are also routinely held in approximately 25 GP practices where advocates discuss with patients in the practice waiting room the services that are offered.

Find and Treat – improving tuberculosis care for marginalised groups

The incidence of tuberculosis (TB) in the UK is increasing, with more than 9,000 cases are reported every year, of which 38% occur in London. Most cases occur amongst the homeless, problematic drug users, and those in prison.

A mobile screening unit was launched in 2005 to strengthen TB control in London, to provide targeted mobile screening for two years. Over half of the cases that were referred to TB services were lost to follow-up care.

Consequently Find and Treat was launched in 2007, adding also onward health and social care to the existing screening service. Every year, the service screens between 8000-10000 socially excluded people for TB and supports the management of around 250 of the most socially complex and challenging cases in London.



Benefits

Beating the national average, Find and Treat has reduced the number of patients lost to follow-up care to less than 6% and is able to get 84% of cases found through treatment.

How it works

A mobile X-ray unit visits drug treatment services and hostels and day centres for homeless people. People are screened on a voluntary basis regardless of their symptoms. Those found to have TB are fast tracked into local hospitals and chest services; without having to wait for an appointment, they are less likely to be lost in the system.

To find cases and maintain contact with patients, links with drug and alcohol support services, hostels, and street outreach and criminal justice services are used.

Since 2008, peer educators who have personal experience of homelessness and have been through treatment for TB, have been an integral part of the Find and Treat team. They raise awareness of TB and encourage uptake of screening. This aids their personal recovery and has led to an increased take up of the service in 60% of venues.