

Care Services Improvement Partnership **CSIP**

**Integrated Care**  
Network

BRINGING THE NHS AND LOCAL GOVERNMENT TOGETHER

# A practical guide to integrated working



## What is the Integrated Care Network?

The Integrated Care Network (ICN) provides information and support to frontline NHS and local government organisations seeking to improve the quality of provision to service users, patients and carers by integrating the planning and delivery of services. Key to the role of the ICN is facilitating communication between frontline organisations and government, so that policy and practice inform each other effectively. The ICN is part of the Care Services Improvement Partnership (CSIP).

## Care Services Improvement Partnership

CSIP was launched on 1 April 2005 after a formal public consultation. Our main goal is to support positive changes in services and the well-being of:

- people with mental health problems
- people with learning disabilities
- older people with health and social care needs
- children and families
- people with health and social care needs in the criminal justice system.

ICN offers advice on partnerships and integration that cut across all services in health and social care. It works closely with other networks and programmes across CSIP to ensure synergy in improvements.

## History of the guide

This is an updated version of *Integrated Working: A Guide* (2004). The contents of both versions have been devised and written by Peter Thistlethwaite, who is a specialist R&D consultant in integrated care ([www.integratedcare.org.uk](http://www.integratedcare.org.uk)). Like its predecessor, the new version has been designed and edited at Dartington Social Research Unit by Kevin Mount.

We are grateful to Julia Thompson, Jeremy Porteus, Chris Mahony, Ed Harding and Robin Lorimer of ICN for their support and ingenuity in helping us develop the update.

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## A practical guide to integrated working



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## Foreword

There comes a point when the value of an idea is so well-established that practical advice on implementation is more important than another slice of theory. That is the thinking behind this document which seeks to help organisations in the NHS and local government deliver integrated services – for the benefit of local users of services.

For the Department of Health, cohesion and co-ordination in adult social care are among the key priorities for 2008. That, of course, reflects the continuing Ministerial emphasis on integration – as outlined in *Putting People First*, the concordat between central and local government published in December which set out a shared vision and commitment to the transformation of adult social care. It said: “Ultimately, every locality should seek to have a single community-based support system focussed on the health and well-being of the local population. Binding together local government, primary care, community-based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.”

This guide – a timely update to the 2004 Integrated Care Network (ICN) publication – is a response to these challenges. The benefits of integrated care systems in improving outcomes for services users are clear – the question is how best to achieve them. This guide brings together the latest changes in policy and best practice, and aims to support organisations in the NHS and local government along the road to integration.

Integration is not easy. The circumstances and preferences of each service or locality will differ considerably, and policy and best practice will continue to evolve. For example, those planning and delivering services will have to consider how new initiatives such as Individual Budgets can best be implemented. Correspondingly, this guide cannot remain wholly static. The Integrated Care Network will be providing updated content and features through its website [www.integratedcarenetwork.gov.uk](http://www.integratedcarenetwork.gov.uk) with commentary, user input and networking opportunities.

I warmly invite you to join the Integrated Care Network and take part.

**Peter Horn**

National Director of  
Care Services Improvement Partnership

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## How to use the guide

If you have the power to change policy or local practice, then this guide has been written for people like you. Integration needs leaders at all levels who can rise above their usual roles and responsibilities, and, with support from their employers, work with a range of professionals and organisations to improve outcomes and experiences for users. The guide aims to provide you with the necessary practical back-up.

Try to read the guide from start to finish, although you can pick and choose from the sections. The broad aim is to help you to gather a picture of where you stand locally with the integration agenda, so that you can map out and sustain your own development process. So this is purposely more of a traveller's guide than a textbook; the intention is to provide a carefully sequenced and organised combination of ideas and practical guidance, supplemented by:

**focal points from national policy**

**messages from research**

**pen pictures of early adopters of integration**

You can get an early feel of what a more integrated approach might mean by **assessing your locality or service against the integration benchmarks** given on pages 10 and 11. This may also help you to decide where the guide can help you most.

There is no single route to follow. The guide provides stimulus and ideas to support well thought-out local choices about integration. There is no prescription: a variety of approaches to suit local conditions and histories will continue to be appropriate. In some services frontline practice may actually be ahead of official local policy and strategy: part of the message is to encourage all leaders to promote communication across and between organisations, to make plans in response to local needs and, in the best sense of the word, to improvise.

The different information strands use these three colours throughout.

CSIP organises four networks in addition to the Integrated Care Network. One is devoted to Leadership and Teamwork Development and provides an avenue to a wide range of opportunities for learning and practice exchange and access to online resources.

The guide has been designed to be used in association with the ICN website

<http://www.icn.csip.org.uk>

and with a special section devoted to the guide

<http://www.icn.csip.org.uk/practicalguidetointegratedworking>

where you'll find electronic versions of the book in Word (.doc) and Acrobat (.pdf) formats and also numerous links to other online resources and references.

In the main, it will be easier to read the guide using the published paper version. But the ICN website pages provide a more versatile avenue to other material, and during 2008 development of those online resources will be accelerating.

So, to get the latest information relevant to the guide, we recommend a regular visit to:

<http://www.icn.csip.org.uk/practicalguidetointegratedworking>



To indicate the more important online connections we have used the icon shown in the margin. In the .pdf version of the guide these prompts are given in the same page position but as live hyperlinks: just click the hyperlinks to go to the referenced materials. And all the references can also be found in one place by clicking the reference tab on the website guide home page.

We also give direct links to the *Every Child Matters* website:

<http://www.everychildmatters.gov.uk>

Every Child Matters  
Change for Children

## What is integrated care?

Integrated care refers to advanced arrangements for joint working. In the context of this book the focus is on health and local authority care provision for children and adults, which at times will include Housing and Leisure services. The broad context of Local Area Agreements and joint strategic needs assessment which must underpin such collaboration is set in Section 5 of this guide.

## What integration should mean for your locality or service

The purpose of integration is to improve service user experience and outcomes. This is done by minimising organisational barriers between different services, and between services and commissioners.

Promoting better public services through integration has been the clear intent of recent government legislation and policy and is now regarded as the norm rather than something exceptional or unusual. Key recent documents such as *Every Child Matters* and the Children's Act 2004 which followed it, the DH White Paper *Our Health, Our Care, Our Say*, (2006) and the Local Government White Paper *Strong & Prosperous Communities* (2006) signal the clear intent for higher standards and more integrated provision for service users. This has been reinforced by *Putting People First* (2008), a ministerial concordat on adult social care services, which places integration centre stage in the policy drive towards greater personalisation of services.

**But how integrated is care planning and provision in your locality and service?** ? Is it in place at every level from strategic vision to day-to-day practice? How much progress has been made to ensure that users get the benefits of integration, for example:

- the easiest access to advice and help
- the simplest processes for assessment and decision-making
- the swiftest delivery of whatever help is needed
- the least risk of errors and unnecessary stages in the process (and no passing the buck)
- the maximum opportunity for controlling events themselves?

All of these are features of an effective system of care, and all are difficult to optimise without a local commitment to partnership and integration from politicians, directors, policy makers, managers and practitioners. They also require the engagement of users and carers. The key benefits have been demonstrated in research and in case study evaluations of the provision of care, some of which are highlighted in this guide.

The Integrated Care Network was brought into being to support the realisation of these aspirations. The five target areas for development it established form core elements of the rest of this guide: access, reshaping services, community engagement, reshaping resource flows and workforce development.

These messages have featured strongly in policy and research papers for years, but many readers will acknowledge that local progress has been uneven, and that the obvious barriers may seem insuperable despite the best efforts of professionals and planners. Whilst certain specially-funded schemes may have broken the mould (e.g. the Partnerships for Older People pilots and Sure Start), the mainstream way of doing things is much more resistant to integration. Delivering the benefits of integration can be made to sound very easy, but it requires a huge commitment to a programme of change and there will be daily distractions and pressures in the way.

However, this guide cannot be neutral. It makes the case for integration, and its purpose is to help it into practice everywhere. Beneficial progress has been made all over the country in *co-ordinating* services over many years, but the limitations and frailty of such arrangements are clear, and the more robust and sustainable benefits of the *integrated* approach have now been demonstrated. Furthermore, failure to make progress locally is inexcusable: why should, say, organisational inertia, lack of leadership or professional protectionism be allowed to stand in the way of efficiency and quality gains that can be experienced directly by users? The public expects and needs the key public sector organisations and their strategic partners to lead the way to a better response.

**So let's start with a clear picture of the ends in view.**

In contemplating the benchmarks described on the next two pages, you might like to consider how far they are in place in the mainstream in your locality. Taking your circumstances into account, the rest of the guide will suggest how you might select and focus on what you specially need to do.

## Self assessment: some integration benchmarks

These are some of the standards for fully integrated working as found in policy and research evidence often attained by early adopters. **How do you compare?**

**objectives and plans;** all set in the context of the Sustainable Community Strategy, Local Delivery Plan, Local Area Agreement and Joint Strategic Needs Assessment • public engagement organised together • a shared mission, binding on all partners, widely understood by stakeholders • clarity about outcomes for users

**vision and values;** jointly created, defined in user-oriented terms and understood by all members of the partnership • everyone accountable for delivering them

**use of resources;** all rooted in the local mission, vision and values • financial, capital and human resources pooled, with collaborative commissioning, business planning and a single delivery process • improvement and innovation expected and encouraged

**use of management information;** data shared and pooled, orienting partners' work to ensure effective performance

**access by the public;** a single well advertised gateway to all forms of advice and help • knowledgeable staff signpost and organise the best responses • clear pathways simply explained to the public • stakeholders 'case find' on everyone's behalf.

**organisation of practice;** co-location of staff to facilitate face-to-face encounters between professionals • formal team working the norm, eliminating the need to 'refer on' and avoiding risk of duplication • no need for users to 'navigate' the gaps between services • planned joint training and team development • new hybrid roles encouraged.

**assessment of needs;** a common process across all professions and agencies • information freely and easily shared • all roles and contributions understood by others • everyone accountable for making the system work for users • clear arrangements for joint action with the most complex situations or most vulnerable people.

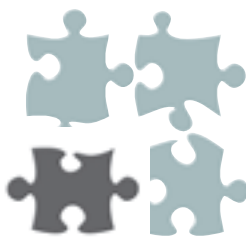
**case management;** designated key workers, able to act on behalf of others • easy communication and transitions • shared caseload of the most vulnerable people with planned multi-disciplinary review.

**decision making with individual users;** a single process with authority delegated to front line staff and/or to users via individual budgets or other devices • choice, innovation and personalisation of support.

**individual case records;** one IT-based record system used by all staff • access for users/patients

In Part Two we will suggest some ideas for local action on these and similar topics. They will be grouped under four 'levels' of integration:

- **community wide governance**
- **commissioning**
- **service provision**
- **practice.**



We have twin girls aged five. Both have a moderate learning disability. One also has autism. We're totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we see on a regular basis: GP, counselling nurse, speech and language therapist, occupational therapist, psychiatrist, psychologist, teacher, classroom assistant, ophthalmologist, audiologist and administrators. We're so confused sometimes. We don't understand the different roles and have so many appointments that clash. Can nobody or no system sort it out?

Although this quotation emanates from work in Ireland, it represents service user concerns all over the developed world.

Parents 'Olive and Peter' quoted in *Developing a Model for Integrated Primary, Community and Continuing Care in the Midland Health Board*, Executive Summary, June 2003.

Part One

# Knowing more about integration

can we have a **common language**?

are we sure of **the benefits**?

what is **the evidence**?



In Part One we help you to develop the critical capacity to make good decisions about local integration, based on an understanding of which users will benefit and how services will improve.

We also challenge preconceptions about integration and clarify the basic concepts and vocabulary. You are asked to consider where your current policies, practices and services might fit on a continuum of collaboration – a process that will identify potential next steps.

Finally, having introduced some important and enduring messages from research, we urge clarity about the benefits sought for and by service users.

All this is designed to highlight where progress might be needed, to identify likely obstacles and to focus efforts on benefits for the public.

# 1 Agreeing what integration means

Put simply, the Government regards integration as a remedy for the fragmentation of services, which has been identified as a barrier to more effective care. A simpler, more user-friendly system is required, with a greater continuity of services and a single point of access wherever possible. Integration is seen as the means to this end. In this vein, the 2000 NHS Plan called for 'a radical redesign of the whole care system'; later, the Green Paper *Every Child Matters* (2004) stated that 'the Government's long term vision is to integrate key services within a single organisational focus'.

Every Child Matters  
Change for Children

Government requirements in relation to integration are now much more specific:

By 2008 we expect all PCTs and local authorities to have established joint health and social care managed networks and/or teams to support those people with long-term conditions who have the most complex needs.

*Our Health, Our Care, Our Say* (2006).

The key feature of an integrated service is that it acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children and families.

[www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk).

The integration of services and the work of professionals to deliver better outcomes for the public is therefore a long-established goal. Expectations of improvement are clear, with an emphasis on early intervention, prevention and support at home. These are now being reinforced by new initiatives and reviews which will sustain this NHS *Next Steps Review* led by Lord Darzi; *Putting People First*, the concordat between key partners over the future of adult social care; and the DCFS Children's Plan, *Building brighter futures*.

ICN  
WEB policy

## Building a common language

This section tries to bring some clarity to the use of language around integration to help all partners to understand the key concepts. Without it, there is an obvious danger that misunderstandings will undermine effective communication and collaboration, no matter how good policies and systems are. To arrive at a ‘common language’ would be a significant achievement. Even the word ‘integration’ needs to be handled with caution, because different professionals may habitually use it in different ways and individuals may come to use it differently over time. So don’t be afraid to challenge colleagues about what they mean by integration: openness will help.

Inconsistency in the use of terms can also belie some of the cultural obstacles likely to be encountered as organisations and services try to become more integrated. For example, to keep things simple, the guide uses the generic term **service user** but we know that it will not find favour everywhere. It also relies on the word **care**, acknowledging that while it works well across health and social services, it is less appropriate in the sphere of integrated children’s services.

Are there any words you or your colleagues opt to use or avoid for any reason? For example, is there a difference between ‘partnership’ and ‘integration’ that affects how you or your colleagues use the terms? Are you more comfortable with a neutral word like ‘collaboration’? Does government advocacy of the benefits of integration inspire mixed emotions: at one moment enthusiasm for putting the service user at the heart of things – at another, anxiety about a threatened loss of independence?

This guide advocates bringing these issues to the fore, and urges you to try to use the vocabulary of collaboration more carefully to help shared meanings to emerge. Confused definitions will complicate things and hold you back. You should also help create the climate for integration in your locality by encouraging staff involved in joint working to think these questions through together.

## Defining integration

**In its most complete form, integration refers a single system of needs assessment, service commissioning and /or service provision.** These arrangements are managed together by partners from health and social care, who nonetheless remain legally independent. They will also need to work alongside service users, carers and the Third Sector to ensure viable and appropriate models of service provision. A partnership is needed to create an integrated system, but a partnership is not the same as integration. This concept will be useful in the project planning process commended in Part Two.

A single system for a particular service, for example, would unite mission, culture, management, budgets, office accommodation, administration and records, and would apply at any level of integration (team, service or organisation). This is absolutely differentiated from an approach which aims to co-ordinate separate systems.

Remember that no-one is tied to a partnership for ever; it can be varied or ended by agreement. This applies even to a Care Trust – which is a local choice and not a statutory requirement like a Primary Care Trust or a Children’s Services Department.

### ‘LAWS’ OF INTEGRATION?

The guide includes frequent references to the work of Walter Leutz, an American academic who studied integrated care in the USA and Britain, comparing underpinning concepts and developments. In presenting his findings he has proposed five ‘laws’ of integration. They are not truly scientific laws, but, like a Japanese haiku, they provide a lot of meaning in a few words – rather entertainingly, too.

*Leutz, W (1999) Five laws for integrating medical and social services: lessons from the US and UK. Milbank Quarterly. 77(1): 77-110.*

In 2005 Leutz proposed a sixth Law (Journal of Integrated Care, Vol. 13 No. 5)

For a useful discussion of these issues, see “Partnering Through Networks: Can Scotland Crack It?”, Bob Hudson, *Journal of Integrated Care*, 15.1, February 2007.

## Choosing integration over better co-ordination

It is acknowledged that better co-ordination, while not the same as integration, can also result in gains for service users. In fact, it has obvious merits:

- it can deliver many, if not most, of the benefits to users of an integrated system
- it can be a positive, facilitating step towards an integrated system.

Indeed, a co-ordinated approach, in which service delivery staff form an informal co-operative network to meet user needs, or use integrated care pathways to structure their work, has undeniable potential as a means of overcoming fragmentation. It can also work in the alignment of policy making, commissioning, training and similar management activities. The question is whether co-ordination is possible to sustain and optimise over time. So, one of the key strategic decisions which you will later be encouraged to face is whether any single integrated system is likely to be more suitable than the co-ordination of existing separate activities.

In this context, the necessary transition might be described as a progression from **fragmentation** to **integration**. An integrated system might be said to demonstrate minimal fragmentation between partners and minimised autonomous action by their staff; but there are many other possibilities, incorporating sustainable degrees of autonomy and a tolerable level of fragmentation. The guide acknowledges the necessary breadth of this spectrum and tries to set it in the context of varying local needs, conditions and outcomes.

### fragmentation

There is no holistic view of user needs; actions and decisions are arrived at independently and without co-ordination.



### co-ordination

There is a shared view of user needs: actions and decision making are co-ordinated.



### integration

Fragmentation between providers and autonomous action are minimised. Working practices come together. Integration is of greatest benefit to those with complex needs.

## The transition to integration

To create the capacity and capability for achieving the necessary change, the Government is depending on being able to harness the energy inside partnerships between what may be traditionally autonomous sectors, for example teaching and social work. Establishing partnerships will inevitably have the side-effect of curtailing to varying extents the freedom of action of the individual partners and will require carefully thought through workforce and team development strategies. Another necessary shift therefore can be represented in a transition from **autonomy** towards **integration**.

Although the Government aims to eliminate the problems associated with the fragmentation of services among professions and organisations by encouraging the creation of single organisational or service entities, the decision to proceed as far as integration may have as many symbolic benefits as practical ones.

### autonomy

The fragmentation of services between and within organisations, and between different professions, is seen by Government as a key obstacle to effective care.



### partnership

Partnerships have been the main means of dealing with fragmentation so far.



### integration

The integration of organisations or services into single entities is a further development which allows potential for greater transparency between partners and enhanced benefits for service users.

**LEUTZ'S FIRST LAW**

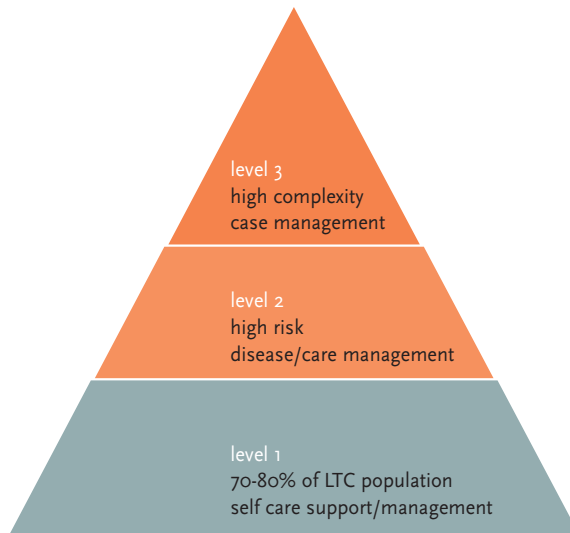
You can integrate some of the services all of the time, all of the services some of the time, but you can't integrate all of the services all of the time.

This is a strong research message about the need to target (expensive) integrated approaches to users with the most complex needs – he argues that it would be highly inefficient not to discriminate in this way.

## Addressing complex, multiple or special needs

Messages from international research suggest that integration works best and is most needed when it focuses on a specifiable group of people with complex needs. The system must also be clear and readily understood by service users (and preferably designed with them as full partners). The converse of this is also important: the vast majority of people with non-complex needs will continue to be well served by their GP or school, acting more or less independently of other services. The degree of complexity of individual needs should determine the requirement and context for integration.

This type of thinking has now been firmly built into policy in services for both children (e.g. CAMHS tiers) and adults. The example given below is the NHS *and Social Care Model for Long Term Conditions*, which suggests three levels of intervention, with the most integrated approach concentrated on the limited numbers of people at the top of the triangle.



## 2 The journey to integration

Policy documents have consistently given a clear vision of how integration might improve provision. The original *National Service Framework for Older People* set a clear direction of travel:

Person-centred care needs to be supported by services that are organised to meet needs. The NHS and councils should deploy the 1999 Health Act Flexibilities to ensure an integrated approach to service provision, such that they are person-centred, regardless of professional or organisational boundaries.



*A New Ambition for Old Age* gives guidance on implementation and the user benefits to be achieved:

A key principle in the care of frail older people is that of timely intervention through joined-up care. This involves the early identification of problems and treatment to prevent a crisis and rapid response to a crisis when it occurs to quickly restore health, independence and well-being. Timely intervention not only improves outcomes for older people but also reduces longer term costs of care, by reducing the need for support by families, hospital bed use and the need for intensive long-term care services.

Good long-term conditions management is underpinned by a holistic assessment of needs, when older people come into contact with the care system. In crisis, older people often develop falls or confusion. Emergency care is being re-designed to respond to these needs.

These developments are making an important contribution to system reform in the National Health Service and in Social Care. If system reforms are not fit to meet the needs of frail older people, they will not succeed.

Weak accountability and poor integration are cited in *Every Child Matters* as aspects of the underlying problem:

Our systems for supporting children and young people who are beginning to experience difficulties are often poorly coordinated and accountability is unclear. This means that information is not shared between agencies so that warning signs are not acted upon. Some children are assessed many times by different agencies and despite this may get no services. Children may experience a range of professionals involved in their lives but little continuity and consistency of support.



## The continuum of collaboration

It may be helpful to think of a continuum of organisational and professional relationships passing from **autonomy**, through **co-ordination** towards **integration**. Given that it is now firmly part of UK policy and culture that professions and organisations should not act autonomously, communication and mutual understanding are minimum requirements (Leutz calls this minimal pattern ‘linkage’, one step before co-ordination or integration). But even in the high profile collaborative world of child protection, communication failure has still been occurring, highlighting the fragility of the co-ordinated approach and the inherent dangers of fragmentation. Government has not surprisingly concluded that a more integrated set of local arrangements might, for example, reduce the risk of a repetition of the events underlying the Victoria Climbié tragedy – hence the Children Act 2004. Nothing should be taken for granted: a review of current practice is an important preliminary to seeking better partnerships.

The guide maps out steps to more integrated care systems, knowing that, wherever integration is being contemplated, services will almost certainly have evolved towards it at different rates, perhaps because of the existence of a National Service Framework or the tenacity of a local champion. No preconceived outcome is advocated here because the solution must always be arrived at in the local context of what people consider best for those they serve. Clarity of vision and transparency of purpose are the key objectives.

### a continuum of partnership/co-ordination

A degree of co-operation between **autonomous** bodies – they have a relationship but there is no transparency or sense of coherence, nor shared point of contact with service users.



A **co-ordinated**, user-centred network, embodying some alignment of policy making, service commissioning and management and practice.



A coherent relationship between **integrated** bodies – the point of connection is a clear focus on the needs of users.

## The World Health Organisation framework

A World Health Organisation (WHO) Regional Office for Europe report states: 'Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency'. It teases out four main elements:



- **horizontal integration** relates to strategies linking similar levels of care (e.g. overcoming professional and departmental boundaries)
- **vertical integration** relates to strategies linking different levels of care (e.g. primary, secondary, tertiary)
- **continuity of care** is understood to imply a user perspective, highlighting the patient's experience
- **integrated care** is a broader term encompassing, for example, technological, managerial and economic aspects of services.

The WHO framework identifies the key features likely to be associated with integration and distinguishes them from autonomous working or a co-ordinated approach.

	autonomy	co-ordination	integration
vision of system	individual perception	shared commitment to improve system	common values, all accountable
nature of partnership	own rules, occasional partnership	time limited or similar co-operative projects	formal mission statements, legislation
use of resources	to meet self determined objectives	to meet complementary objectives, mutual reinforcement	used according to common framework
decision making	independent	consultative	authority delegated, single process
information	used independently	circulates among partners	orients partners work towards agreed needs

Use the WHO framework to consider how far your service or locality has progressed. Don't worry about generalising; you tackle the detail later.

### 3 How evidence of what works can help

You can make your journey towards integration by applying lessons from evaluations of efforts made elsewhere – there's no need to reinvent the wheel in its entirety.

The Government has been actively promoting evidence-based policy and practice for over a decade. The issues for local implementers are implicit in the following quotation from the original Aims and Objectives for health and social care research in the Department of Health:

The Department needs research and development to ensure that:

- policy for health, health care and social care is based on reliable evidence of needs and of what works best to meet those needs
- improved interventions are developed to promote health, treat ill-health and provide social care
- information is available to those responsible for health and social care services on what works and what does not, and on known ways of improving quality, access and efficiency.

In support of this approach the National Institute for Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have been established. A Joint Improvement Partnership has also been established by nine leading national bodies spanning all sectors of health and social care [www.jointimprovementpartnership.org.uk](http://www.jointimprovementpartnership.org.uk). Other bodies to support evidence-informed practice have also been brought into being through the support of local authorities and others, for example, *Research in Practice* [www.rip.org.uk](http://www.rip.org.uk) and *Research in Practice for Adults* [www.ripfa.org.uk](http://www.ripfa.org.uk)

## Research and integration

Messages from research have a place in this guide for the light they can shed on the underlying complexities of local circumstances. They are not put forward because they are thought to have universal applicability. The methodology of most current studies is too limited to produce solid findings for general commendation: what might be useful in one place may be inappropriate in another.

There are also many things other than research evidence to consider when deciding how to improve services: user views, resources, legislation, timescales, public opinion and professional experience must all be taken into account. Decision-making about integration can nevertheless be usefully informed by research; it would be negligent not to look for and apply relevant knowledge alongside the other factors.

**Most researchers in the field would agree that certain messages about joint working are reliable and, if heeded, can help people to understand local issues better and to avoid some pitfalls. The lessons in the studies selected here have proved enduring and have not been bettered in more recent years. They provide a simple introduction to the established evidence, but remember – we give the headlines only; they are not meant to be comprehensive summaries.**

Findings have been included to increase general awareness among partners about some important factors that will need constant attention; many, especially the cultural ones, will not go away in the short or medium term. The subjective conclusions reached in reflecting on the research should serve you well in planning and action.

The case studies in Part Two provide more evidence of the benefits of integration.

The work of the CARMEN network, funded by the EU, involved a review of experiences across Europe. The result is a comprehensive picture of good practice in integration and is relevant to all types of provision. *Integrated Services for Older People: A resource book for managers* EHMA, 2004

## The Bristol University review of joint working

The findings on the next page are derived from a systematic review of the literature on joint working published between 1983 and 2000 by the School for Policy Studies at Bristol University. A careful methodology was used to ensure that conclusions were drawn only from well-constructed studies.

The review revealed four main patterns of joint working:

- strategic, i.e. joint planning, joint commissioning
- multi-agency teams (notably in mental health)
- care management
- placement schemes (mainly linking workers in primary care).

It then analysed the issues into three categories: organisational, cultural and professional, and contextual. In their conclusion, the authors remarked that over the years the same problems kept coming up, indicating that there had been a failure to learn from research. To assess progress made since 2000, the Integrated Care Network will be following up this research in 2008.

On the page opposite, the findings of the review are translated into a series of statements associated with successful joint working. Take time to consider how each of the research messages might bear on your locality's or your service's approach to integration. The idea is to pinpoint strengths to build upon and risks to attend to.

Cameron, A, Lart, R, Harrison, L, Macdonald, G, and Smith, R (2000) *Factors promoting and obstacles hindering joint working: a systematic review*. Bristol: Policy Press

## What helps: a checklist

**The political climate is favourable.** Is there a shared vision at Board/Cabinet level and a history of collaboration? Problems here can easily undermine progress elsewhere.

**Friction between councils, NHS bodies, general practice and independent sector is being minimised.** Differences in cultures, processes and basic goals should be accepted but not ignored. Anticipate difficulties and plan organisational development programmes accordingly.

**Senior managers and professional leaders are supportive.** It is harder to overcome barriers in the absence of good leadership or links between planning processes.

**Overall objectives are clear and realistic.**

The risk of failure is greater where objectives are unclear or over-ambitious.

**Resources, including staff skills and time, are adequate to the task.** Uncertainties concerning funding will jeopardise progress and make staff feel insecure.

**The negative impact of continuous change is being minimised.** It cannot always be avoided, but organisational instability can undermine relationships, teamwork, concentration and planning. Attention to organisational development will minimise the problem.

**The clash of professional philosophies and language and the risk of professional tribalism are being minimised.** Divided loyalties and stereotyping are harmful. Try to establish a basis of shared values and collective trust from the start.

**The right people with the right skills are involved.** Risks of failure will increase unless all stakeholders have a say, and leaders can emerge. Personality clashes need attention.

**Communication in and between teams and units is good at all levels.** Communication failure has been shown to be at the heart of many problems.

**Staff have 'ownership' of the development.** An obviously important consideration which managers and staff must actively sustain.

**The roles and responsibilities of staff are clear and understood.** Uncertainty here is a common cause of failure in joint work: clear policies and procedures and regular contact help.

**Management accountability is clearly delineated and professional support routines are in place.** Multi-disciplinary teams are prone to problems in this area.

**Accommodation and IT are shared.** Co-location of staff is strongly associated with successful joint working, but the absence of shared IT is a common limitation.

**Joint training has been provided and team building is supported.** Both can help overcome engrained misunderstandings, prejudices and other differences. They can be applied to all levels of management, to non-executive directors, members, specialists and practitioners.

**Monitoring and evaluation strategies are built in.** It is good practice to learn about the impact of your changes.

## Using ‘partnership flexibilities’

In 1999, the Government introduced the Health Act which sought to promote collaborative working by removing legal and other barriers and by explicitly encouraging lead commissioning, integrated service provision and pooled budgets. Early use of these new ‘flexibilities’ was evaluated by researchers at Manchester and Leeds Universities, who identified issues that help or hinder partnership development. The findings have much in common with those in the University of Bristol review.

The table opposite lists the more tangible benefits identified in the study, but the researchers pointed to other ‘intangibles’, for example, the removal of ‘hiding places’ and the replacement of ‘silos’ by ‘whole system’ thinking. These messages are relevant to any form of partnership working, not merely those formalised under the Health Act.

The researchers acknowledged that implementation had not always been easy and that barriers to partnership persisted, not least the historically different financial planning and performance management systems for the NHS and local government. They also counselled against barriers ‘rooted in cautious local relationships’.

[Section 75 of the *National Health Service Act 2006* is now the legislative force behind the flexibilities, replacing the original s31 as above. Across the country there has been a big investment in a wide range of partnerships, particularly initially in mental health and learning disability services. The Pen Pictures in the guide give examples of the accountability systems emerging to govern more ambitious use of the flexibilities; other examples of local good practice can be found on the ICN website].

National Primary Care  
Research and Development  
Centre (NPCRDC) (2002)  
*National Evaluation of  
Notifications for Use of the  
Section 31 Partnership  
Flexibilities in the Health Act  
1999.*

**ICN** local case studies  
**WEB**

## Using flexibilities: the findings

### what partners were trying to achieve

- improved efficiency
- seamless, more flexible patterns of service
- equitable redistribution of services across a locality
- enhanced experience on the part of service users.

### the methods used

- integrating existing services (e.g. co-location of staff, joint community equipment services)
- developing new services
- re-prioritising/refocusing existing services (for example, by diverting resources from hospital or residential care to community services).

### what helped

- high and broadly equal levels of commitment
- local organisational stability (e.g. coterminous boundaries)
- 'dense' networks of people
- perceived financial equity among partners
- senior managers with vision, skills and time to develop the partnership.

### what took the time

- legal frameworks spelling out respective responsibilities, especially in order to safeguard financial commitments and manage risks (being careful to deepen trust, not displace it)
- finance – disaggregating mainstream budgets and deciding a fair basis for contributing to a pooled budget

- human resources – joint training and secondments (more rarely, the transfer of staff)
- IT – resolving widespread system incompatibilities to deal with matters of confidentiality and professional access
- sectoral differences – harmonising financial planning cycles, audit systems and performance management between NHS and local authorities.

### the benefits

- thinking governed less by blame and more by shared vision
- better commissioning processes, greater readiness to engage users and carers
- transparency necessary for setting up a pooled budget also contributed to the pattern of strategic development and was visible in:
  - simplified lead commissioning
  - improved community equipment services
  - increased opportunities for investment and external grant funding
  - sharing buildings
  - innovative service packages
- synergy and added value, e.g. improving 'Cinderella' services, staff morale, communications
- new legal and financial arrangements geared towards partnerships, signifying a shift from margin to mainstream.

## Research findings in children's services

As the *Children Act* 2004 has propelled service provision towards the more integrated model envisioned in *Every Child Matters*, research evidence has been reviewed in order to clarify the anticipated benefits. In some cases they parallel findings in adult services.

### improving outcomes for children and families

- access to services not previously available and a wider range of services
- easier or quicker access to services or expertise
- improved educational attainment and better engagement in education
- early identification and intervention
- better support for parents
- children's needs addressed more appropriately
- better quality services
- reduced need for more specialist services.

### benefits for staff and services

- less replication between different service providers
- better links between service providers, including a greater understanding of their practices
- professional development and career progression opportunities
- more involvement in community development
- improved awareness of different services and changed public perceptions of service providers.

Practitioners with backgrounds in single, traditional agencies report high levels of satisfaction with multi-agency working. In particular, they feel liberated from the narrow bureaucratic and cultural constraints of their parent organisation. This is attributed to new ways of working, particularly within multi-agency teams.

### providing what children and families say they want

Families say they want a single point of contact with services and a trusted, named person to coordinate assessments, information-sharing and care pathways to help ensure quicker access to the right kind of support.

In his research review of front-line working with children and families, Nick Frost says most commentators regard increased and enhanced joined-up working as a desirable goal and suggests that collaboration can offer:

- effectiveness gains – through improving outcomes
- efficiency gains – through improving the use of resources
- resource gains – through increasing the availability of resources
- capacity gains – through increased ability to achieve
- legitimacy gains – through increased acceptance
- social development gains – through permitting social change.

He concludes that:

- working together is complex and difficult
- professionals have different modes of understanding and intervening in the world, which can act as barriers to joined-up working
- where there is enthusiasm and motivation, people can work effectively together
- working together does not mean doing away with difference – it can mean living with diversity.

### work in progress

LARC, the Local Authority Research Consortium, was formed at the start of 2007 in the belief that there would be considerable value in launching a cross-authority project that could assess local evidence for the early impact of integrated children's services. It is focusing on three key groups of children and young people whom it might be expected that the integrated service would benefit.

*Professionalism, partnership and joined-up thinking* by Nick Frost, 2005. Research in Practice, Dartington, [www.rip.org.uk](http://www.rip.org.uk)

To keep in touch with progress go to [www.nfer.ac.uk](http://www.nfer.ac.uk)

## 4 Understanding the potential benefits

The Government has given clear messages about the high-level outcomes it is seeking for individual people.

The *Every Child Matters* green paper (2004) identified five:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

It went on to say that they were to be regarded as universal ambitions for every child and young person, whatever their background or circumstances.

Outcomes set out in *Our Health, Our Care, Our Say* (2006) were:

- improved health and emotional well-being
- improved quality of life
- making a positive contribution
- choice and control
- freedom from discrimination
- economic well-being
- personal dignity.

It described them as the standard towards which social care services should be working with their partners. 'We will build on them to develop outcomes that apply both to the NHS and social care. We will also use this set of outcome measures to structure our goal-setting for health, social care and related activity in the LAAs.'

The White Paper *Valuing People: A New Strategy for Learning Disability for the 21st Century* published in March 2001 sets out an ambitious programme of action based on four key principles. These are civil rights, independence, choice and inclusion. It takes a lifelong perspective, beginning with an integrated approach to services for disabled children and their families and then providing new opportunities for a full and purposeful adult life. Consultation on the next steps of implementation is being undertaken from December 2007 under the *Valuing People Now* programme.

## User benefits

The World Health Organisation has stated that integration should be seen as a means to an end, and not an end in itself. Government policies defined after extensive consultations (some of which are shown opposite) reveal a broad high-level view of what the ends might be. To motivate people to change their established working routines, an even more specific message is needed about the intended benefits for individual service users.

Findings from a range of evaluations in recent years provide some help with this, and the benefits for service users can be summarised as follows:

- making access easier
- improving the speed of response to identified needs
- simplifying the decision-making processes by involving fewer people
- eliminating buck passing
- ensuring a more creative use of resources
- reducing communication failure.

These should make service users feel more in control of their own care. We suggest later that partners should build their plans for more integrated services around these specific benefits.

### LEUTZ'S FOURTH LAW

**You can't integrate a square peg and a round hole.**

A timely reminder that certain things may remain permanent challenges, e.g. charging for social care when health care is free at the point of delivery. Such matters have to be carefully managed in practice.

## PEN PICTURE 1 Establishing a user focus

## Letting service user benefits drive the process of change



When Torbay Council and Torbay Primary Care Trust began their journey towards a fully integrated health and social care organisation, the benefits for users identified in research were adopted as a prime target. These were then made more real by the creation of an imaginary service user with complex needs, 'Mrs Smith'. Sharp focus on an individual demonstrated that integration was the means to eliminate the palpable fragmentation in the system of service provision around her – by simplifying access and decision-making, and reducing the considerable delays and errors that were known to feature in local provision.

When an integrated locality team was piloted, its progress was also evaluated against these outcomes for users. The result on the ground has been a demonstrable simplification of processes, easier communication between professionals and a massive improvement in response times. [See also Pen Picture 8 on page 65.]

Perceiving what he saw at the beginning of the process as provision made up of a scattering of separate pieces, the Chief Executive of the then PCT represented his vision of integration as a completed jigsaw.



## Added value from integration

As well as greater benefits for users, there are indications that in comparison with coordinated services, integration may be able to add value in the following ways:

- by changing the identity or branding of a service to create more positive user responses and staff allegiances, suggesting a clearer break with the past
- by securing organisational efficiencies, for example in the shape of shared support services, integrated management, innovative administrative processes, emerging hybrid roles
- by defining a focus for action that includes clearer processes of accountability, less prone to distraction by individual organisational concerns
- by introducing more robust arrangements for teamworking and leadership – pulling together if the going gets tough
- by creating new opportunities for investment, for example in IT systems and opening access to new sources of funds
- by having a greater capacity to advocate and negotiate powerfully on behalf of users, for example with regulators or policy makers.

Are any of these benefits needed in your local area or service as it now stands? Can you think of more? This is an important task for managers to consider, but it will also be a relevant exercise for front-line stakeholders including users and carers. Clarity about the benefits for users and organisations is a powerful influence on planning, teamwork and professional practice.

## Part One in summary

The journey towards integration will be smoother if each locality or service can state clearly at the outset exactly what improvements will be sought and how they will be put in place.

No text book on integration can provide a perfect solution for every locality or service. A positive process of co-learning and co-evolution is needed. Integration should be seen as a means to an end and not an end in itself: being clear about the ends in view is an essential early stage in the journey.

Before contemplating integration in relation to any aspect of current provision or when reviewing what has already been implemented, it would be wise to check:

- the extent to which understanding of key concepts and words, especially the word ‘integration’ itself, is shared
- your position on a continuum of collaboration and in relation to the benchmarks on pages 10 and 11
- the implications for your circumstances of messages from research
- your capacity to identify particular groups of service users with complex needs as the focus for integration, and the specific benefits you intend for them.

The NIHR Service Delivery and Organisation programme will be commissioning research on integrated health and social care in 2008. Other research themes will include commissioning, workforce issues and patient and carer-centred services. For more information, as well as to download reports, please visit [www.sdo.lshtm.ac.uk](http://www.sdo.lshtm.ac.uk).

## Part Two

# Making it happen

community-wide governance  
commissioning together  
providing and managing integrated services  
putting integrated care into practice



Integration can be initiated and developed at any organisational level and on any scale. Here we recommend a simultaneous and balanced engagement at all levels.

We begin by introducing ideas about raising awareness of the ‘whole system’ and go on to examine what might be needed at the strategic, operational and practice levels to achieve sustainable results. Illustrations of what has been achieved elsewhere are included as ‘pen pictures’, but the nature, scale and processes of integration are left to your local decision-making.

It should be possible to use the sections flexibly, in any order, to meet specific local needs. At every point, the engagement of all stakeholders in the search for the best solutions to meet user need is central.

The levels are therefore interdependent. Effective integration will ultimately require paying some attention to them all.

## 5 Community-wide governance

Integrated health and social care will be best achieved in the context of new cross-sectoral community strategies that will deliver the established vision and policy imperatives.

Local authorities are already under a duty to prepare a Sustainable Community Strategy which sets the strategic vision for an area. We will now require county and unitary authorities, in consultation with local partners, to prepare a delivery plan for the strategy – known as a Local Area Agreement.

The Local Area Agreement will set out a single set of priorities for local partners. We will therefore introduce a duty for local authorities and other local partners to work together to agree their priorities. Delivery of local priorities will be the responsibility of partners in key local partnerships like the Crime and Disorder Reduction Partnership, the children's trust and the new health and well-being partnerships. And, once agreed with the Government, local partners will be required to have regard to these priorities for improvement.

The Local Government White Paper, 2006  
*Strong and Prosperous Communities*

PCTs need to work with local authorities to improve health and well-being, reduce inequalities and achieve a shift towards prevention. We have brought the NHS planning timetable forward to facilitate effective joint working with local government. PCTs are expected to play their full part in the local area agreement process and to agree with local authorities those aspects of Local Delivery Plans that require joint work.

NHS Operating Framework 2007-8

The 2007 *Commissioning Framework for Health and Well-being* adds a new dimension, the proposal to place a duty on PCTs and local authorities to produce a joint strategic needs assessment:

Joint needs assessment is the only firm foundation for commissioning decisions and investment: it provides a solid justification, and ensures that decisions about resource use are fair.



## Four levels of integration

This section concentrates on giving the broadest possible consideration to the context for partnerships across the whole system in order to create the right backdrop for improving the provision for personal care. It offers an approach to evaluating current arrangements against the characteristics of four possible levels of co-operation inside any locality. The first level is dealt with in this section; the others are considered in turn in the remaining sections. The Telford and Wrekin case study in Section 7 gives an excellent example of interconnections between all four.

## Leadership and strategic support

The *Local Government and Public Involvement in Health Act 2007* strengthens local authority leadership. It also envisages empowered citizens and greater engagement of local people in shaping public policies and services. A new duty requires local authorities to inform, consult and involve local people in running local services. Councillors are also empowered to resolve issues of concern to the communities they represent, if necessary by requiring consideration by Overview and Scrutiny Committees, for whom guidance has been issued.

With more? joint appointments of Directors of Public Health, the scope for strategic leadership is increasing. A recent ICN publication has explored the role of public health in supporting the development of integrated services:

There is a natural synergy between the drive for reducing health inequalities and improving public health on the one hand and integrated services on the other. Both require concerted action across a range of sectors and input of a variety of players working in partnership. Both have a focus on improving health outcomes for service users. But whereas public health tools and resources have been central to health service planning, they have been less fully applied in the planning and delivery of integrated services.



policy

See: *The Role of Public Health in Supporting the Delivery of Integrated Services* ICN Discussion Paper

However, fragmentation is patently visible at the institutional and strategic level. Tackling issues such as social exclusion and anti-social behaviour requires community-wide partnerships. In every case, success will depend on local politicians, non-executive directors of NHS bodies, senior managers, lead professionals and other partners sharing a clear vision, being willing to bring their resources to bear collectively and being able to demonstrate consistent leadership of the process. They will need to reach across existing divisions and to manage joint needs assessment and commissioning processes. The new roles of Director of Adult Services and Director of Children's Services are designed with this in mind.

Wherever boundaries are untidy, for example in some urban areas and in large counties with multiple District Councils, Primary Care Trusts and NHS Trusts, imaginative collaborative processes are needed.

Without strategic vision and support, collaboration at the front line of service delivery will be impossible to optimise, however well intentioned the professional practitioners. The impact of policy can be improved by planned support to the efforts of front-line staff. This is a key output for strategic collaboration. But without whole-hearted collaboration at the front line, strategic vision may count for nothing.

There is now likely to be plenty of experience of community-wide governance in all localities, but expectations are being raised by recent government policy and legislation. For example, councils are expected to be, in effect, commissioners of children's services, including the full range and type of schools. They are already commissioners of housing and housing-related support services. Two locality illustrations are given next. Barnsley has a mature and comprehensive approach established over many years; Herefordshire is contemplating a radical reconfiguration.



DH Guidance: Joint Strategic Needs Assessments

#### LEUTZ'S SECOND LAW

*Integration costs before it pays.*

This is a good reminder that success is likely to depend on wise, pump-priming investment of time for planning and on resources for training and systems development. Always plan for the long haul.

## PEN PICTURE 2 Barnsley

## One for all and all for one

A 'One Barnsley' Board has been the decision-making body for the Local Strategic Partnership for some years and now is supported by a number of Delivery Partnerships, two of which concentrate on delivering joined up services to adults and children. The Barnsley family of partnerships consists of:

- Adults and Communities Well-being Partnership
- Children, Young People and Families Well-being Partnership
- Barnsley Development Agency/Economic Forum
- Cultural Consortium
- Environment Partnership
- Equalities, Diversity and Inclusion Partnership
- Fit for the Future (The Partnership for Health)
- Partnership for Transport
- Safer Communities Partnership



A Local Area Agreement (LAA) was established in March 2005 and has been updated twice as it has developed. It takes account of central government requirements, and is implemented through the Delivery Partnerships. It is split into four specific areas covering Children and Young People, Safer and Stronger Communities, Healthier Communities and Older People and Economic Development and Enterprise.

With such a platform of cooperation, it is not surprising that Barnsley has also developed a highly integrated approach to the organisation of services for children and for adults, with merged management and joint appointments, an 'Every Adult Matters' programme, and a positive approach to piloting 'personalisation' initiatives.

## PEN PICTURE 3 Herefordshire

# Maximising partnership and taking trust to a higher level

The County Council and the Primary Care Trust were jointly engaged in formal consultations in 2007 about an entirely new way of working together. Their aim was to improve the way local public services are planned, purchased, designed and integrated around the needs and expectations of individual customers and patients. They wrote:

This proposal is for a new partnership we are calling a Public Service Trust. This is not a legal entity – but it is an innovative partnership that makes new and maximum use of existing legal powers for NHS bodies and Councils to work together in purchasing (or commissioning) improved services for local people. It helps to overcome organisational boundaries between health and the council, and achieve the fundamental shift in thinking from an NHS that traditionally addresses ill health first and then promotes well-being, to one that promotes health and well-being, and addresses ill health to the highest standard possible.

An enhanced partnership will enable the Primary Care Trust and the council to pool resources, create a single management structure and bring together staff, in the expectation that this will achieve economies of scale, better value for money, and more integrated planning and purchasing of joined up and responsive services focused on the specific needs of people in Herefordshire.

A joint chief executive was appointed at the end of 2007 and a timetable has been decided to bring the Trust into being during 2008.



## Evaluating current patterns of collaboration

As a prelude to integration, or as a way of checking progress, it makes sense to consider how far your locality matches up to the goals of partnership working. Since a complete 'whole system' view will inevitably be complex to assemble and understand, four 'levels' and their associated outcomes are proposed here. They may not fit every circumstance perfectly, but they should make it possible to get a sense of what an integrated whole system might feel like in practice. Only the first of the levels is dealt with in any detail in this section of the guide. Keep in mind the conclusions reached in Part One about the centrality of the users who are likely to benefit from integration and of the need for clarity about the actual improvements being sought for them.



**Community-wide governance** should ensure the overall infrastructure of support, e.g. in housing provision, public health, lifelong learning and economic security.



**Formal strategic commissioning partnerships** should make it possible to co-ordinate health, social care, education and related responsibilities, develop a shared vision and commission specific services.



**Joint management arrangements** should underpin the redesign of service provision and how it is supported.



**Multi-disciplinary teams** should be the main means of collaboration between practitioners, and of ensuring the collection and distribution of information on needs and outcomes.

Different arrangements for democratic accountability in the NHS and local government are a likely source of uncertainty as new governance arrangements come to the fore. For example, if an elected council member is to sit on the Board of a new partnership body, should his or her principal allegiance be to that body or to the council? Some tensions are inevitable.

### Key questions to ask

- What arrangements are in place locally at each level?
- Are they working satisfactorily or could their impact be improved?
- Are goals clear at each level and to what extent have they already been achieved?
- How well are goals supported in practice by local bodies and key individuals?
- What changes could be made?

While these issues are most relevant for politicians and managers at the top level, frontline managers and staff are often unaware how their organisations or agencies operate, make plans and take decisions. This can lead to inefficiencies and confusion and sap morale. Integrated services are also likely to make the organisational context even more complex. Look to create opportunities to explain and consult widely.

## Research messages

An important and very relevant Audit Commission study in 2005, *Governing partnerships: bridging the accountability gap*, identified a range of problems being encountered in partnership working. It clarified good practice principles, including the necessity for carefully considered Partnership Agreements, and it deserves close attention. It concluded:

There is no one size fits all model of governing partnerships: governance arrangements should be proportionate to the risks involved. Partners must strike the right balance between the need to protect the public pound and ensure value for money, and the innovation and flexibility that can exist when organisations collaborate. The governance of partnerships should promote good internal accountability between partners and better external accountability to service users. Shared responsibility should not mean diminished accountability.

The background issues are succinctly put by Skelcher and Sullivan:

Partnerships present a challenge to the principles of public sector corporate governance. They are located at arm's length from the processes of representative democracy yet have a key role to play in delivering improved public services... They can have extensive public involvement mechanisms but also be governed by boards whose operations demonstrate a considerable democratic deficit. Their legal forms can vary considerably, as can their statutory base and financial relationships. Overall, the governance of partnerships is an area of considerable complexity and potential confusion.

Skelcher C and Sullivan H (2002) *Working Across Boundaries: Collaboration in Public Services*, Palgrave: Basingstoke

For another closer look at governance issues, and an appraisal of published research, see the ICN publication "We have to stop meeting like this: the governance of inter-agency partnerships", produced by the Health Services Management Centre at Birmingham University.

## If things aren't working out well...

This guide is unlikely to be of much practical use if you are finding it impossible to get strategic dialogue going – or if partnerships are stagnant, unproductive or patchy. In these conditions, change will depend on finding individuals who are willing and confident enough to try to break the spell. Here are some suggestions about what to do if you are stuck or are lacking direction or effective organisation.

First, be honest with yourself and ask if a better contribution from your own organisation might have led to a better outcome. Facing up to this reality might be enough to spur you on. Problems of this sort are not unique and may have been solved elsewhere, so consider the following possibilities:

- make individual contacts in relevant government departments and take specific advice
- get in touch with someone with the power to intervene and go over the perspectives obtained from the WHO framework, or the research messages in Section 3
- get together informally with like-minded people in partner agencies and try to create momentum for a joint 'away day' with an independent facilitator and clear goals
- propose turning a scheduled business meeting or joint planning forum into a special review with an independent facilitator
- learn from others, by making contacts through the Integrated Care Network or the *Every Child Matters* website
- create opportunities for the voice of users and carers to be heard strategically
- watch out for the cultural factors that can create resistance to partnership and block communication: this may warrant outside attention
- think about what might add up to a win-win outcome – how a partnership might be the only way of ensuring individual objectives are met.



A variety of self assessment tools are available for partnerships. See Partnership Assessment Tool and Integrated Team Monitoring and Assessment tool on the [ICN?website](http://ICN?website). Also see [www.lgpartnerships.com](http://www.lgpartnerships.com)

## Section 5 in summary

Taking the widest possible view of integration, this section has looked broadly at high-level governance of partnerships, given examples of good practice and provided encouragement to face up to obstacles to progress.

Crucially, it also offers a process for considering aspects of planning for the integration of health, education, housing and social care at four main levels. It has concentrated on the first level, community-wide governance; in the next three sections the remaining levels will be considered in turn.

# 6 Commissioning together

The Department of Health's *Commissioning Framework for health and well-being* (2007) is the key policy document to consider. It defines its objectives this way:

Commissioning is the means to secure the best value for local citizens.

It is the process of translating aspirations and needs into services by specifying and procuring services for the local population. Services should:

- deliver the best possible health and well-being outcomes, including promoting equality
- provide the best possible health and social care provision
- achieve this within the best use of available resources.

It also suggests eight steps to drive more effective commissioning:

- putting people at the centre of commissioning
- understanding the needs of populations and individuals
- sharing and using information more effectively
- assuring high-quality providers for all services
- recognising the interdependence between work, health and well-being
- developing incentives for commissioning for health and well-being
- making it happen – accountability
- making it happen – capability and leadership.

These principles are as relevant to practice-based commissioning as to strategic commissioning, and to children's services as well as those for adults. The performance of PCTs and their partners in securing better outcomes for public and patients through commissioning is expected from 2008 to be 'world class': see *NHS World Class Commissioning*. Working with community partners is a key competence.



CSIP Commissioning e-book

*Better Outcomes for Children's Services: A practice guide* is an excellent all-round resource for developing processes for joint planning and commissioning (DH and DCSF, August 2007).

See also ICN Advisory Notes 1-6 which cover: agreements; governance; pooled budgets; VAT; workforce; LSPs (on the ICN website). Various toolkits for Children's Services at the ECM website.

## Using the partnership flexibilities

The three original 'flexibilities' (see P28) remain central to many aspects of partnership development. The Commissioning Framework is intended to ensure local authorities and primary care trusts are better able to identify need and commission services to meet it. They have to do this together but there may be some lack of organisational symmetry to contend with: local authorities are more experienced than PCTs in dealing with independent providers. PCTs are being required to manage their own provision of community health care separately from other responsibilities. Commissioning should be linked to a determination to align or pool existing budgets and to re-design service provision. It is not always helpful to see the flexibilities as separate entities: if the purpose is to achieve specified benefits and outcomes for users, the whole process of needs assessment, planning, resource use and service design will have to be brought together. That is the ultimate goal but it will not fall into place overnight.

The Integrated Care Network has acknowledged that the reshaping of financial and other resource flows is a desirable objective. Partners will be understandably cautious about losing autonomy as a result of integration, and this can sometimes unnecessarily inhibit the pooling of budgets. The NPCRDC research quoted in Section 3 indicates that some immediate financial benefits are possible, but an over-cautious, controlling regime will never unlock the undoubted potential. Similarly, integration and partnership can improve efficiency by encouraging the creative use of available property and land.

There are also specific technical areas to cope with, for example concerning VAT. However, the guidance and regulations now in place and the fruits of local experience mean that progress can be made with confidence.

## PEN PICTURE 4 Peterborough

### Putting public benefit before self-interest

Several years ago, the city council and the then Greater Peterborough PCT agreed that it made good sense from the public's point of view to integrate their services. Under a formal s31 Agreement, a joint management team was brought together under the leadership of the PCT chief executive and it set about gradually bringing together strategic and operational functions. PCT senior staff then moved into the Town Hall - a very unusual example of co-location! The benefits showed when the NHS reconfiguration of PCTs took place: the council itself made strong, and ultimately successful, representations for a coterminous PCT. This is a good demonstration that successful partnerships can have great strength and authority.

As the arrangement has matured, all the resources of the council's adult social services have been transferred (with only minor exceptions) to the PCT under a revised agreement (s75). The council's (statutory) director of adult social services now simultaneously holds the post of PCT director of performance, enabling joint monitoring of national targets for local authorities and the NHS. Commissioning is undertaken jointly via another PCT director. A joint director of service provision manages all health and social care services, which are integrated in localities under a single management structure. All former SSD staff are now PCT employees under Agenda for Change.

This is a very comprehensive model of integration – the only real difference with a Care Trust is in the governance model (see Torbay Care Trust case study). It has met the challenge of bringing commissioning processes together, and it has an integrated service provider arm.



Audit Commission (2002)  
*Integrated services for older people: Building a whole system approach in England.* London: Audit Commission.  
 See also from the Audit Commission, (2002)  
*A Fruitful Partnership.*

See also ICN Discussion Papers *Whole Systems Working*, October 2006 and *Strengthening service user and carer involvement: A guide for partnerships*, November 2006.

## The implications of a whole systems approach

The Audit Commission contends:

whole system working takes place when:

- services are organised around the user
- all the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere
- the following are all shared: vision, objectives, action (including re-designing services) and risk
- users experience services as seamless and the boundaries between organisations are not apparent to them.

This method requires everyone to agree direction and approach. They must then act flexibly to deliver it. The strategy does not lend itself to rigid central planning. Senior staff and politicians must endorse the broad vision, which should have been developed in partnership with users, but service providers and practitioners from all organisations will be the ones to adjust and adapt how they work in order to translate this vision into actions that in turn support the needs and wishes of the individual user.

This quotation summarises the most important elements of strategic responsibility for integration. Note, nonetheless, that:

- shared knowledge of community and user need is the starting point
- partnership with users is a key process
- communication of strategic vision can empower action in services and teams.

There is no single way to put this into practice: examples of local approaches are given in the pen pictures.

## A more local NHS?

The interim report (Oct 2007) of the NHS *Next Stage Review* envisages ‘a more personalised NHS’ requiring services that are locally designed and can adapt quickly to patients’ needs. It argues for ‘world class commissioning’ of services based on models of care that local clinical pathway groups devise. This will provide new opportunities for initiatives in children’s and adult services, from tackling the wider social determinants of health to innovative provision. Given the general intention of shifting 5% of expenditure from secondary to primary care over the next few years, practice-based commissioners will have powerful incentives to use NHS funds more flexibly to meet individual need. This is highly relevant to integrated care: public sector collaboration, new service models and partnerships with independent providers should all be reconsidered locally.



## Clarifying local aspirations

Some form of strategic partnership of all relevant agencies, including joint appointments and joint teams, is likely to be required to deal with the issues raised in this section. The partnership will need to settle standing arrangements for working together and to establish the over-arching policies that will ultimately determine the shape of integrated services.

It also means returning to the big issue raised at the beginning – the nature and likely pattern of local partnerships – and asking a number of more specific questions about the vision for particular services. There is a clear advantage in establishing and communicating the values and objectives of any new arrangement in advance in a form that clearly describes the benefits for service users and the community as a whole.

*Putting People First* is a new ministerial concordat over the future of social care, which seeks to be a catalyst for national and local leadership of ‘authentic’ partnership working, leading to system-wide transformation to ensure personalised care.

An Office of the Third Sector has been established within the Cabinet Office to highlight the contribution of the varied range of non-governmental bodies to society and to the economy. See [www.cabinetoffice.gov.uk/third\\_sector](http://www.cabinetoffice.gov.uk/third_sector)



*Explaining Connected Care* gives an account of community-led and fully integrated health, social care and housing services which are aimed at excluded people with the most complex needs. It highlights the strong potential of 'third sector' bodies (Turning Point, 2007)



Housing LIN *Strategic Moves* DVD – this deals broadly with strategic commissioning

## Key questions for commissioning partnerships

Here are some key questions you can use when exploring the options for strategic commissioning partnerships.

- How will partnerships with users be established and maintained?
- How will the planning and commissioning processes be used to promote improved services and user outcomes?
- What role could a social enterprise or the third independent sector play?
- How will individual purchasers of personalised services influence strategy?
- What new resources, and what existing ones, will be made available for each of the services to be integrated? Who will be accountable for ensuring that the resources are used to improve the experience of service users?
- Will opportunities exist for new joint appointments at the most senior level?
- Will options for large-scale integration into a single organisation be considered, for example a Care Trust, an NHS Partnership Trust, or a particular type of Children's Trust. If so, when?; if not, what other arrangements will be put in place, e.g. other uses of Health Act flexibilities?
- Will there be joint boards or management teams for particular services, geographical areas or functions? If so, what will be their delegated roles and responsibilities?
- What will be the overarching policy on transfer/employment of staff, ownership of buildings, financial management regimes, etc.?
- How will partnership with NHS Foundation Trusts be established and a market of care services developed?
- How will the process of change be resourced and managed?
- Have the partners identified a local currency for measuring achievement against local milestones and expectations?

Avoid any lingering uncertainty on any such questions. Giving a clear lead will help operational and practice staff and other stakeholders to respond more readily.

Solutions are bound to differ from place to place and the pattern inside a locality may vary if it encompasses several NHS Trusts and District Councils. For the early adopters of integrated approaches, the prompts above may present an opportunity for review. In places where progress has been patchy, they may help to ensure more even development. For those who have been stuck, one step forward here may constitute the 'giant leap'.

It may lead to difficulties in the partnership if the big decisions are not taken, so make good use of the opportunities available, e.g. the Children's and Young People's Plans that are now required. Major decisions will need to be taken at Cabinet and Board level but smaller-scale initiatives may emerge by local management agreement. Proposals should specify which individuals (or groups) are responsible and to which bodies or management teams they will report. Any initial agreement will also need to be kept under review as it evolves.

## Seizing opportunities for change

The two pen pictures in this section demonstrate the importance of quick or creative responses when new opportunities arise. In the case of Knowsley, it resulted in innovative arrangements to fill a senior post and so to signal local intent about integration. In South Tyneside, an invitation to bid for a project resulted in a new joint approach to commissioning children's services.

The final pen picture looks at prevention, where the recent announcement of a Social Care Reform grant will create new development opportunities.

### LEUTZ'S SIXTH LAW

#### All integration is local.

National government may lay out the policy and provide resources but local leadership is the key to implementation and innovative outcomes.



policy

## PEN PICTURE 5 Knowsley

## Two bodies, one head, organic change

The Director of Social Services was some years ago appointed simultaneously to the vacant post of Chief Executive of the Primary Care Trust to initiate the organic integration of health and social care. A leadership team of senior managers from across the Social Services Department and the Primary Care Trust was formed, with a joint headquarters for both organisations (as part of a joint estate improvement strategy). There is now a single senior management team.

A 'Go Integral' project was launched to integrate social care services and community health services for adults and older people. Occupational therapy services were integrated to assist with performance and the recruitment and retention of staff and a pooled budget was used for Learning Disability. Even before the *Children Act* 2004, a significant number of health staff began to work with social work teams to develop services for children and plans to introduce an integrated service for children with disability were initiated. In Adult Services, integrated locality teams are now being formed: the project is gradually being used to re-shape and embed change in mainstream service delivery.

This local partnership has proved it has the capacity to stand the test of time. But another such arrangement in a London Borough was wound up after two years. This model of integration nevertheless seems to have found some favour among other urban councils, e.g. Swindon and Southwark.



PEN PICTURE 6 South Tyneside

# Finding the path by commissioning together

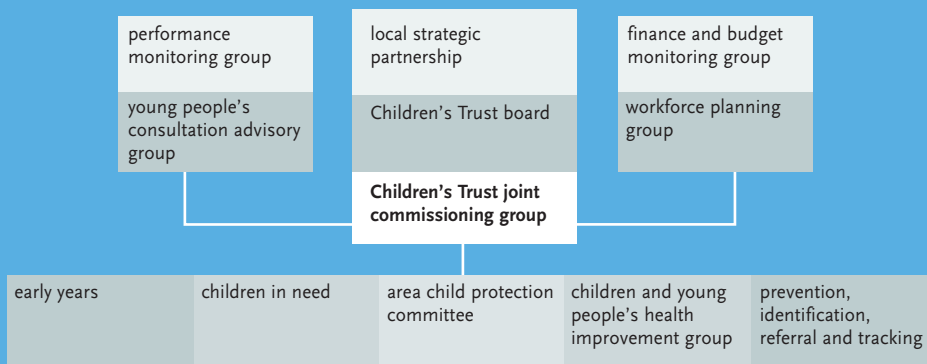
South Tyneside was one of the original Children’s Trust ‘pathfinders’, and has therefore had an early opportunity to reshape its commissioning and provision organically over time. The Trust now calls itself The South Tyneside Children and Young People’s Alliance. It brings together the Primary Care Trust, the Council (lifelong learning and leisure and social care and health), the local NHS Foundation Trust, South of Tyne & Wearside Mental Health NHS Trust, the Youth Offending Team and Connexions.

The Alliance has established a Board and Stakeholder Group to manage, commission and monitor work in order to ensure that our long term aim of developing services that are community based and easy to access, often in one-stop shops, delivers a brighter future for all children and young people in South Tyneside. (see [www.stct.org.uk](http://www.stct.org.uk))

The original emphasis in the Pathfinder phase was to ensure a comprehensive approach to joint commissioning – which is represented in the following model. It illustrates how a variety of workstreams associated with children and young people can be co-ordinated through a single process.



The South Tyneside pathfinder model of joint commissioning



## PEN PICTURE 7

## Commissioning for prevention and early intervention

The eligibility criteria local authorities use to determine which individuals benefit from services can be an obstacle to integration. Although local decisions are underpinned by a national formula, *Fair Access to Care Services*, the process is not uniformly understood by GPs and other NHS personnel, and it has been a source of misunderstanding. Tightening criteria to be able cope with the increasing demand for expensive care packages has also created a perception that valuable 'low-level' help has been lost – an unwanted side-effect which in turn has prompted the Government to make special grant funding available to counter the problem. We mention two examples here: the DH Partnerships for Older People Projects (POPP) and telecare.

The **POPP programme** has generated activity ranging from community development, healthy living and access to information to more specialist help with avoiding hospital admission and coping with discharge home. A project in Poole, was based on case-finding and early intervention, directly linked to GP surgeries, but with widespread involvement of older people in the community. An integrated model for mainstream change has been worked out as a result and is now being implemented.

A combination of new technology and government grants has brought about an expansion in **telecare** provision in recent years, which has the potential to make a big contribution to prevention services. Now Cornwall, Kent and Newham are taking part in a major national study of the use of telecare and telehealth in the management of long-term conditions.

The point here is that commissioners are in a perfect position to promote a shared view of the whole system and to adjust the balance of spending. Evidence from the pilots of Individual Budgets suggests that users prioritise informal neighbourhood support when given choice.



**ICN  
WEB**

An evaluation of the POPP programme has provided evidence of improved partnership working and strategic links in the pilot areas.

**ICN  
WEB**

You can keep up-to-date through the CSIP Networks' Telecare Learning and Improvement Network, and through the DH website.

## Research messages

This section has been about strategic vision, but try to avoid any tendency for thoughts to concentrate only on organisational structures. Researchers at the Nuffield Institute at Leeds University remind us that the vision must always be wider than that.

The research team drew on empirical and theoretical literature from the US and UK to construct a framework for analysing theories of joint working. Supplemented and supported by local case studies, their report highlights the vital importance of integrated systems of local needs assessment, goal setting, funding, training, devolved financial management and multidisciplinary service delivery as opposed to any narrower focus on structural integration.

Johnson P et al 'Interagency and interprofessional collaboration in community care: the interdependence of structures and values', *Journal of Interprofessional Care*, Volume 17, Number 1 February 2003

## Section 6 in summary

This section has highlighted the importance of robust arrangements for working in strategic partnerships and for clear thinking about needs and demands, resource availability and arrangements for commissioning services.

Partnerships should:

- settle standing arrangements for working together
- consult and involve other stakeholders, such as other governmental bodies, independent sector, users
- decide the nature of partnerships needed
- set up a collaborative commissioning process
- secure resources and establish priorities
- frame expectations
- review agreements/partnerships over time.

## 7 Providing integrated services

Service providers in all sectors will increasingly face the challenge of responding to the requirements of strategic, joint and practice-based commissioners and to the personal preferences of individuals seeking help.

Providing service users with choice and relying on 'contestability' (ie competition) to guarantee best value are the cornerstones of the DH White paper *Our Health, Our Care, Our Say* (2006):

We need innovative providers – whether state-owned, not-for-profit or independent businesses, like primary care practices, pharmacies and many social care providers - that work together as part of a joined-up system. We also need to support different approaches from non-traditional providers. We will encourage the independent and voluntary sectors to bring their capabilities much more into play in developing services that respond to need.

We need strategies for workforce development that support radical shifts in service delivery and equip staff with the skills and confidence to deliver excellent services, often in new settings. Staff will increasingly need to bridge hospital and community settings in their work. And we will work with staff organisations to make sure the changes are implemented in a way that is consistent with good employment practice.

Staff employment policy is a key issue to be faced everywhere. The Guidance on Children's Trusts, which is broadly applicable to other situations, explains:

...a decision will have to be taken as to the best means of drawing staff together to work in truly integrated teams. This could be through co-location, secondment, or transfer... Wherever any movements of staff are proposed, whether in terms of location only or to a different organisation, it is essential to involve staff, unions and other staff-side organisations as early as possible and throughout. The best possible starting point is where staff themselves recognise that bringing staff from different organisations together will improve process and outcomes for children and families.

The best way into the issues relating to social enterprise, both for the third sector and current publicly managed services is via the ICN publication *Integration for Social Enterprise* (November, 2007).

### **ICN WEB** locality case study

In Milton Keynes, the council and PCT are exploring options for establishing a Joint Provider Body, preferably as an independently functioning Social Enterprise.

## The future of public sector provision?

Although the development of commissioning capacity is a priority for local authorities and PCTs, most of their staff, estate and spending are devoted to the traditional service provider role. Without doubt, the key issues for integration will play out here: how to put functions together, what sort of teams to build, how to innovate, and how to ensure public accountability? This will often lead to new models of delivery, sometimes perhaps as not-for-profit 'social enterprises' or also via Care Trusts and other formal partnership models. This section of the guide therefore describes how the shift to a more integrated public sector provider can best be managed.

## Towards integrated leadership

Responsibility for leadership is often vested in the specific partnership board, joint management team or any similar body set up to plan and oversee a particular service, whatever its scope or size. Everything that follows assumes that such an arrangement is in place and, ideally, that its manager or chair will report to the strategic commissioners. Accountability for any joint service must always be made explicit.

Since service users will only feel the benefits of integrated leadership when those who are in regular direct contact with them – doctors, social workers, teachers and therapists – work well together, the key strategic intention must be to support operational staff. Professionals are frequently enthusiastic about integration and some have done conspicuously well in making the promised advantages a reality, but elsewhere they have been made to struggle by a lack of practical support. This has been visible, for example, in negative management attitudes or a lack of training, IT or resources. Leadership matters.

## Research messages

A review of integration initiatives in community care in a number of countries has been undertaken by a US academic, Denis Kodner. He argues in favour of 'vertically integrated systems of care', and has identified seven factors associated with successful outcomes:

- care management across time, place and discipline, spanning both medical and social care
- multi-disciplinary or inter-disciplinary teamwork
- GP involvement, with application of geriatric philosophy and methods
- formal organised networks of providers
- use of clinical support tools (e.g. guidelines, protocols) to facilitate co-ordination and continuity
- appropriate targeting
- financial mechanisms to encourage flexibility and efficiency.

Kodner has also developed his thinking about integration to make the link with 'consumer-directed care' which the guide deals with in Section 8. Passionate about the benefits of user-control, he asks if integration is its antithesis. His conclusion is that integrated care needs to incorporate as many of the successful features of consumer-directed care as possible into its philosophy and practice.

Kodner D *Consumer-directed services: lessons and implications or integrated systems of care* [www.ijic.org](http://www.ijic.org)  
Vol 3 April/June 2003

## Project plans

Whatever the scale or nature of the integrated service to be put in place, remember that dedicated management time is a key predictor of success in joint working.

The first step should be to commission and resource a project management process including milestones and realistic timescales. The more ambitious the plan, the more likely it will be to warrant a project manager and project team. The preliminaries should deal with how the project is to be funded by the partners, how staff are to be seconded or appointed and how specialist advice about finance, IT and human resources is to be obtained. Lines of accountability and performance expectations will also need to be defined.

This is an important stage, which it should be possible to reach as a result of strategic decision-making (top-down), or as a considered response to ‘user needs’ (bottom-up) – or as a combination of both. Weaving together political and managerial will, practitioner enthusiasm and user support for change will help to establish a climate for integration.

Consider:

- who needs to be involved?
- where are good practice models to be found?
- are there local champions of integration?
- how could stakeholder involvement be resourced?
- what specific learning opportunities can be created to enable people to come together to consider their roles and future contributions?

This is not just a task for the project team but for all managers. Practical support for staff should be explicit and careful attention given to methods of communication with and between staff throughout. Local managers and practitioners may already have established patterns of good practice and have good ideas to contribute.

### LEUTZ’S THIRD LAW

#### Your integration is my fragmentation

This may well explain why many people resist new approaches. It suggests that as much attention needs to be given to what may be lost through integration as to what is likely to be gained.

## PEN PICTURE 8 Torbay Care Trust

### A single organisation with integrated governance

Torbay Council and Torbay Primary Care Trust decided together late in 2003 to explore the potential benefits of integration, and set up a 'commission' of selected councillors and non-executive Trust directors. Their report favoured an ambitious approach, culminating in a decision later in 2004 to apply to be a Care Trust. The Trust formally came into being at the end of the following year, when all council staff transferred to its employment under TUPE, and became subject to *Agenda for Change*.

In the interim, an integrated system of operational management was put in place, and an integrated team was piloted with a 'single point of contact', comprising occupational therapists, physiotherapists, social services staff and district nurses, all linked to three GP surgeries. Progress was continuously and independently evaluated.

Feedback enriched the planning process and stimulated co-learning. The best example was how a post of 'health and social care co-ordinator' was conceived and developed to make the single point of contact effective.

Crucially for such an ambitious plan, a project manager was appointed to co-ordinate all aspects of the development, including the massive HR, IT and finance implications, the organisational development programme, communications strategy and s31 Agreement.

In its annual performance assessments, Torbay Care Trust has maintained its position as a top performing PCT, and has significantly improved local social care.

Although Care Trusts are NHS bodies, serving councillors can be nominated to be non-executive Board members, the only form of NHS organisation where this is allowed.

[Care Trusts formed subsequently: Solihull in 2006/7, and North East Lincolnshire, which recently became Care Trust *Plus*, with public health functions transferred from NHS to council.]



The story of the project management has been written up and published in the *Journal of Integrated Care*, Issue 14.5, October 2006, "Creation of a Care Trust: Managing the project" by Andrew Lavender.

**ICN** locality case study  
**WEB**

## Project planning: the DH checklist

The DH some time ago developed a form of notification for S31 Agreements (now S75 of the NHS Act 2006). It also provides the following valuable checklist of issues to be considered in any partnership:

- what are the aims and intended outcomes?
- how will the partnership lead to improvements in services as defined by local delivery plans?
- who has been consulted and how?
- if there is to be a movement of staff, have they and their unions been consulted?
- how will local authority functions contribute to a healthy outcome through this partnership?
- how will existing local joint working be promoted?
- who will be the services users, e.g. defined in terms of client group, age range, NHS and local authority areas?
- in financial terms, how much resource is to be committed by each partner?
- Following consultation, are the signatories satisfied that arrangements for the following are robust?
  - governance, including decision-making processes, monitoring, accounting and auditing, operational and management arrangements
  - when the partnership will be reviewed
  - human resources, including staffing, terms and conditions, policies
  - information sharing
  - identification of functions
  - eligibility criteria and assessment processes
  - complaints
  - financial issues such as charging, accountancy and VAT implications
  - how disputes will be resolved, and how partners will resolve changes or dissolve the partnership altogether.

For a detailed and critical examination of the options for provider bodies, see the ICN publication 'Adult care joint-ventures: Aspirations, challenges and options' (Freeman and Peck, HSMC, Birmingham University, 2007)

## Organisational development and culture

Successful delivery of the project plan will to some extent depend on how well the organisational implications are examined and re-modelled, and how far staff are helped to understand and adopt them. Cultural barriers to integrated working resulting from separate methods of professional training, varying management styles and differing political environments should also be anticipated. The creative interaction between different schools of thought may bring benefits, but in the short run the tension between them is more likely to stand in the way of any more unified culture. There is no substitute therefore for recognising the risks, planning how to reduce them and staying alert to specific problems likely to arise from ignorance, prejudice and self-protection. Leutz's third law: *Your integration is my fragmentation* provides a good cautionary backdrop.

Attention should also be given to employment issues and staff learning needs. It is likely that formal negotiations and specialist human resources advice will be required. The process will need planning and resourcing: a major initiative like a Care Trust application will call for continuous dialogue with staff and unions

## Monitoring and evaluation

Evaluation and feedback are associated with effective joint working. As the Torbay case study illustrates, this is the right time to establish the framework for monitoring user outcomes and for establishing baseline measures from which progress and impact will be judged. The purpose of an integrated service is to improve outcomes and services for users: what they are and how they will be measured should be agreed from the start. This has implications for performance management measures, too: think how the monitoring you are having to undertake anyway can be fed into the development process.

For a more detailed and creative look at this topic, see Hudson, B

'Interprofessionality in health and social care: the Achilles heel of partnership', *Journal of Interprofessional Care*, Vol 16, Number 1, 2002.

See also the ICN Discussion Paper *Culture in Partnerships: What do we mean by it and what can we do about it?* 2004



See: *Integrating the Workforce*,  
ICN Guide, 2005.

## Workforce issues

The Government has acted to ensure that employment practice in children's and adult services is consistent with future integration. A Children's Workforce strategy was one of the first outcomes from *Every Child Matters*. A common core of skills and knowledge has been defined, and the Children's Workforce Development Council formed from key stakeholders in the training and development process.

Skills for Care has a similar role. One of its key projects has been a 'New Types of Worker/Working programme', which has made connections with other professional agencies, and has focused on 'hybrid roles' relevant to personalised care, prevention and community support with a range of client groups. The message for localities is that there should be no limit to innovation that directly benefits users.

## Variations on a theme

Four case studies are included in this section to shed light on different aspects of integration. The stories underline the importance of a cumulative local dynamic, seizing chances for increasing degrees of collaboration as they arise. The outcomes vary, even down to solutions relating to staff employment and financial responsibility.

The studies include examples of formal, single management arrangements – but it should not be inferred that they are a recommended option. Any partnership arrangement that has been given governance responsibility for a specified service, having established a business plan covering objectives, roles, processes and training, could operate effectively through a system of managed networks and joint accountability.

Elements of such a model are common and they could also be a legitimate forerunner of more integrated management arrangements. Whether a 'network' is likely to be as robust and sustainable as a 'merger' as the vehicle for delivering the benefits of integration should be settled by the project plan.

## PEN PICTURE 9 Telford & Wrekin Children's Services

### Sustained development at every level

The Borough of Telford & Wrekin has a history of working in partnership. It was one of the pilots for Sure Start for children in 2000, became an ISA (information sharing and assessment) trailblazer in 2003 and opened one of the first children's centres. This progress is consistent with the research messages given in Part One: today's achievements often have long roots.

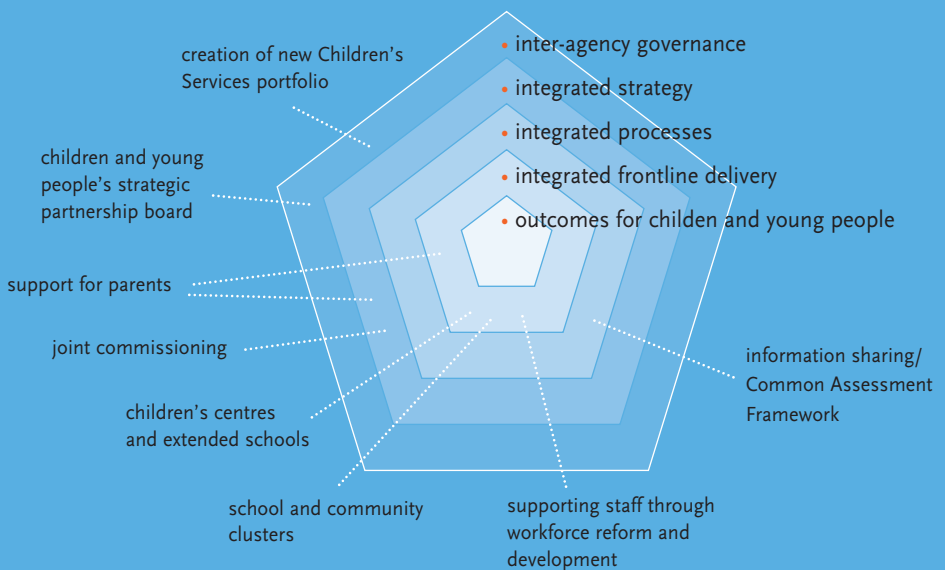
We have achieved Beacon Status for our groundbreaking and innovative work in delivering integrated services and early intervention through whole system change. We believe our vision, joint planning and commissioning arrangements, imaginative use of ICT and the involvement of children, young people and their families in shaping the delivery of services are transferable to any part of the country.

([www.telford.gov.uk](http://www.telford.gov.uk))



The council has set up several integrated teams to serve clusters of schools and communities, each with an Integrated Services Manager and lead professionals appointed from the Team Around the Child (TAC). There is a structure for planning and stakeholder engagement, and a new edition of the council's *Children and Young People's Plan* demonstrates a comprehensive interconnection of the levels of integration described in section 5.

#### How Telford connects the four levels



## PEN PICTURE 10 Sandwell Mental Health

## Negotiating harmony to integrate the workforce

From the start of consultations, the intention in Sandwell was to transfer staff employment from the Borough Council to the new Mental Health NHS and Social Care Trust. The change called for a massive programme of collaboration, which exposed cultural divides – not only between the NHS and local government but also within the two sides of Unison. Ultimately the employment of all council staff except Approved Social Workers was transferred. (Approved Social Workers are required to retain accountability to the Council for that function.)

The Trust worked from the principle that there would be ‘no detriment’ in pay and conditions for any individual. The process unearthed a lengthy agenda of human resources issues for ‘harmonisation’, the most vital of which, for example those relating to pensions and continuity of service, were settled early on. A programme to tackle other issues, linked to initiatives such as Agenda for Change, was initiated.

Established in April 2003, the Care Trust has made good progress through a more coherent, fully integrated organisation and by a well motivated and cohesive staff group. It is in the process of becoming an NHS Foundation Trust.



## Improving access to services

Access strategies are an important focus for integration and can include everything from general information giving through to redesigning the point of entry to specialist services. It is a topic worthy of attention at this point, because significant innovation may be achievable if it is well planned and can be properly resourced. IT systems and investment are obviously central, and opportunities for partnership may be fruitful. This is why access features in the ICN list of development areas.

A project in Liverpool some years ago led by the city council is a good example. Involving partners including NHS bodies, it was triggered by the acknowledgement of poor access arrangements in the past. It is now 'Liverpool Direct', a 24/7 contact centre. The opportunity was nevertheless taken for a collaborative – rather than departmental – approach to developing the IT system and, like the Telford and Wrekin example quoted later, this will help overcome what research has shown to be one of the key barriers to collaboration.

 locality case study

## Information sharing

Integrated services must enable all their staff to share information quickly and easily, particularly about individual service users and their families. This is a major efficiency and quality gain. Generally, local solutions are needed. Many integrated services have appointed 'co-ordinators' who have access to everyone's information systems (GP, social services, PCT) to ensure that a full picture of each individual can be put together quickly and easily before new action is taken. This is enhanced when IT systems themselves can be integrated, providing data on individuals and on performance across the board: in Torbay this is a stage that will only begin to be reached during 2008 after several years' work and investment.

Every Child Matters  
Change for Children

## Contact Point

In children's services, a national IT-based system enabling professionals to find out who else might be involved with a particular child is being established in 2008. Called Contact Point, it is described by the *Every Child Matters* website as 'the quick way to find out who else is working with the same child or young person – making it easier to deliver more coordinated support'.

Several local authority 'trailblazers' have been piloting local directories (known as 'indexes'). They indicated that this type of tool produces some key benefits:

- less time trying to find other practitioners
- quicker assessment of whether a child is receiving universal services (education, primary health care)
- more effective multi-agency working which leads to better service experience for children and young people.

Contact Point has to be a national system to ensure it works for children who receive services across, or who move across, local authority boundaries. The information content is quite basic:

- name, address, gender, date of birth and an identifying number of all children in England (up to age 18)
- name and contact details for:
  - parents or carers
  - educational setting (e.g. school)
  - primary medical practitioner (e.g. GP practice)
  - other services working with the child.

It will also be possible to indicate who is the lead professional for a child and if an assessment under the Common Assessment Framework has been completed.

## CASE STUDY 11 Sedgefield

### Locating housing in the integrated team

Most current examples of progress with integration come from unitary authorities and London boroughs, where boundary issues and problems of scale are less taxing than they are than in counties. But here is an example of how a successful scheme emerged in a county. A local partnership board for the District Council area was the chosen method for governance.

From 2003, Sedgefield Primary Care Trust, Sedgefield Borough Council and Durham County Council worked together to establish five locality based, co-located front-line teams across the Borough, each consisting of social workers, district nurses and housing officers, under single management. The inclusion of the last group was a distinctive feature. The Sedgefield Integrated Team was evaluated from the planning stage by Bob Hudson, whose findings have been published as “Integrated Team Working: You can get it if you really want it” (*Journal of Integrated Care*, February and April 2006).

Progress in Sedgefield was evaluated against Hudson’s own ‘optimistic’ model of collaboration, based on three hypotheses:

- promoting professional values of service to users can form the basis of inter-professional partnership
- socialisation among the members of one’s immediate work group can override professional or hierarchical differences
- effective interprofessional working can lead to more effective service delivery and user outcomes.

He concluded that the evidence from Sedgefield supported the optimistic model and therefore that co-located integrated teams can succeed where there is a willingness and capacity to establish them.



Joining up housing with health and social care is a key development area, with the Supporting People programme and initiatives to create ‘extra care’ housing as obvious areas for coming together. See *Independence and Opportunity: Our Strategy for Supporting People* (DCLG, 2007)

## It won't always be plain sailing

Over a period of ten years, Wiltshire County Council and its local NHS organisations organically developed a model of integration, starting with SSD link workers in surgeries and then three s31 Agreements (with the then three PCTs) to integrate the management of community services. These resulted in joint management appointments and joint integrated teams. It was the original intention to establish three Care Trusts. However, certain long-running financial pressures ultimately proved impossible to handle when coupled with the reconfiguration of the NHS which disrupted established working relationships. Although professional links remain positive, the agreements were unexpectedly ended in 2007, and separate management of PCT and county council staff re-introduced.

Northumberland was the first Care Trust to be established and it is still operating, albeit within a complex regional primary care structure, having survived a threat to its survival during NHS reconfiguration. It was also once criticised by regulators for allegedly neglecting social care at the expense of the NHS. This scenario for an NHS 'takeover' has long been a fear in local government circles and highlights the need for an equal partnership and an effective voice for social care at all times. A Director of Adult Services is now in post, responsible for both community health and social care services.

One of the early Care Trusts, in Witham, Braintree and Halstead, was in fact disestablished after several years when the structure of PCTs was reconfigured across the county of Essex.

Barking and Dagenham was the first locality to appoint one person to be PCT Chief Executive and Director of Social Services at the same time. Despite the efforts of local leaders, the arrangement lasted only two years and ended, as in the case of Wiltshire, under the weight of external expectations over finance and performance. This disappointing outcome was analysed in an article in the *Journal of Integrated Care* in June 2006:

Local government and the NHS in Barking and Dagenham embarked on a bold initiative in 2001 to integrate health and social care management structures. Although it was not sustained, this local experience is an important source of learning as the search for improved partnership working enters yet another new phase. In particular, it demonstrates that the route to better outcomes depends on managing not only the tension between structure and culture but also that between national targets and local discretion in services based on fundamentally different principles of governance: central management and local accountability.

The authors also speculated that, had a Care Trust been established at the start, it might have been given longer to establish and prove itself, even though this may not ultimately have been enough to withstand the two different performance regimes impinging on the arrangement. The experience of Torbay Care Trust provides some confirmation of this point: it did prove more resilient in dealing with financial pressures that unexpectedly emerged, and has acknowledged that these might not have been as satisfactorily or creatively resolved before it was formed.

It is interesting to note that the integration of health and social care performance management regimes was promised in *Our Health, Our Care, Our Say*, along with the synchronisation of financial planning cycles. These are being put in place now.

“Learning from Doing: Implications of the Barking and Dagenham experience for Integrating Health and Social Care” Gerald Wistow and Eileen Waddington, *Journal of Integrated Care*, June 2006

## Section 7 in summary

This section has concentrated on the creation and implementation of business plans for more co-ordinated or integrated working, giving illustrations of the processes followed in four localities and highlighting the possible content of a project plan. It underlines the benefit of establishing secure governance arrangements and clear management accountability within integrated services.

Joint management arrangements should be put in place to plan and redesign specific services to meet user needs. In doing so you will need jointly to:

- maintain dialogue with stakeholders, including users
- set out the mission and goals to be delivered
- set out service structure and management accountabilities
- allocate resources, support implementation, manage performance, monitor progress (including user satisfaction), ensure compliance and manage risks.

This potential emergence of social enterprises as major service providers was also highlighted.

## 8 Putting integrated care into practice

The policies of extending user choice and integrating the work of professionals will have continuing repercussions for individual staff. It is a challenge for managers and practitioners alike. For example, *Every Child Matters* states:

Current training, as well as pay and conditions, are very different for each role. Within the more integrated structures and working practices... it will remain the case that some children and families need support from a range of professionals. We need to establish new cultures in the workplace so that individual professionals work horizontally across professional boundaries rather than vertically in professional hierarchies.

Everyone working with children needs to be trained to do their own job well. They also need to know how their role fits with that of others. They need the skills to work positively with, and draw on the expertise of, other professionals and support staff. Among other things this will avoid unnecessary and unproductive referrals. This is true not only for those working with children, but also for teachers and GPs who can be the first to spot emerging problems.

Every Child Matters  
Change for Children  
multi-agency toolkit

The White Paper *Our Health, Our Care, Our Say* emphasises that people should be able to exercise more control over the support they need to live at home. It says:

At the moment, half the people with long-term conditions are not aware of support or treatment options and do not have a clear plan that lays out what they can do for themselves to manage their condition better. If people have a clear understanding of their condition and what they can do, they are more likely to take control themselves.

This is a challenge to the prevailing nature of professional practice, especially in community nursing. Similarly in social care, the role of 'care manager' will need to evolve alongside: some local councils are already encouraging 'self assessments', often online. There are also demands to extend the operation of Direct Payments, and pilots of a broader policy of Individual Budgets are supporting the drive towards greater personalisation of services.

## Creating the climate for integrated practice

This is the fourth level of planning integrated care, but it can be carried out in tandem with, or in advance of, the others. It considers how practitioners can form multi-disciplinary teams or specialist services to deal with people with complex needs and how such teams and services should dovetail with universal services such as primary health care and schools. This key aspect of any project plan should address the Integrated Care Network's target of reshaping care services and redesigning workforce patterns, both in terms of how care management systems are conceived and designed and how care provision can be re-configured to improve the user's care experience.

It is possible to start using the guide here by adopting a 'bottom up' approach. Strategic and operational support are vital in resourcing and sustaining practitioner initiatives, but the practices and ideas that will have the biggest impact on service users are likely to be rooted in service delivery. Piloting is an approach often used in this context.

The need to engage people other than managers in the development process is one of the guide's themes. The essence is open dialogue about national policy requirements and local professional practice – and a willingness to generate and debate ideas about integration at the front line, creating the sense of a common pursuit between management and practice and those people who need help. Without it, even a major step, such as the creation of a Care Trust, may have little impact on established routines and communication methods.

Increasingly, however, formerly passive service users will become the commissioners of their own care. It remains to be seen whether the service user in fact becomes the service integrator.

### LEUTZ'S FIFTH LAW

#### *S/he who integrates calls the tune.*

This looks like a comment on relative organisational and professional power. However, Leutz principally argues that ways should be found for users and carers to determine the shape of services and their integration: Direct Payments are an important policy option in this context.

## The integrated practice environment

As more integrated forms of service delivery are conceived for particular groups of people with complex needs (e.g. children with disabilities, or older people with mental health needs), networks or teams from the range of existing agencies will need to be formally assembled for the purpose. This is easy enough when starting a new service from scratch with new funding but changing established mainstream ways of working can be more difficult. *Our Health, Our Care, Our Say* requires the creation of integrated teams or managed networks, where someone is accountable for making inter-agency relationships effective. This is a step change from ad hoc liaison and communication.

In a highly co-ordinated, networked or integrated system all practitioners and clinicians will consider user needs simultaneously and act on them as members of a team, rather than sequentially along a chain of cross-agency referral. Doing so is more efficient and also makes life easier for users, but the implication is that the daily routine of everyone at the frontline will have to change, if only in a small way. Research has suggested that investment in facilitating change at this level will increase the chance of success.

Many factors come into play in developing the integrated practice environment. Two are singled out next for particular attention: **tools and protocols** that facilitate communication and decision-making processes and **teamwork**.

Decision making about individual entitlement to NHS-funded Continuing Health Care has been difficult in many places, with ill feeling about 'cost shunting'. Extra funding and new guidance have been provided by government. Making this work is a test for local integrated practice.



## Tools and protocols

A number of national initiatives have sought to make integration practical and visible in frontline practice, including at a general level the National Service Frameworks, as well as more specific approaches to assessment practice, such as the Common Assessment Framework for children, and the Single Assessment Process for adults. Certain other initiatives such as user-held records and the design of integrated care pathways represent aspects of the practical response by professionals to national goals and user needs. All serve to create common ground and more effective communication between historically divided practice. Any initiative which seeks to distil the work of different agencies or professionals into a 'protocol' governing individual contributions has a place in the bigger scheme of things. The NHS Next Stage Review sets great store by the engagement of practitioners in devising local pathways.

However, it is one thing to create a new approach – realising the desired effects can be tantalisingly difficult. Successful implementation requires anticipating the likely obstacles (see Part 1). For example, a well-conceived assessment system supported by introductory training is an important component of an integrated approach, but it may well not be sufficient without longer-term support to teamwork development. IT is another example: research has demonstrated that the lack of supportive IT is regarded by practitioners as a common obstacle to integrated practice.

The inter-dependence of the strategic, operational and practice elements of the integration process is highlighted by such situations: change needs investment as well as vision.

## Teamwork

Teamwork is an antidote to fragmentation and co-locating staff from different services is sometimes used as an informal preliminary step towards integration. Identifying possible teams and setting about building them can nevertheless amount to an important strategic route to ‘a radical redesign of the whole care system’ (NHS plan, 2000). This is often easier said than done: researchers have found that teamwork is underdeveloped in the NHS and that multi-disciplinary teams can often struggle to be cohesive. Resources from an organisational development programme would be well invested in team-building: there is good research evidence about what can work.

Most attention in this area has been given to the case management process, e.g. managing hospital discharges and decision-making in child protection, but there is an equivalent scope for more integrated teamwork in care provision: good examples are intermediate care services and Sure Start schemes which have flourished as a result of dedicated funding, or Extra Care Housing which is an expanding integrated service. Integrated ‘hands on’ services should directly improve the user’s experiences. Can this be achieved in mainstream services by merging or systematically linking established working groups, such as District Nursing Teams and Home Care services? Or by exploiting ‘extended schools’ which, like community hospitals, can be a positive focus for collaboration and earlier intervention when services have been fragmented? This is an important challenge.

To co-ordinate or to integrate is the question that must be resolved to give practitioners the confidence to progress together. Much can be done for users by creating and sustaining effective networks but formal team development with budget devolution and easy access can be more focused

In Croydon, multi-disciplinary networks have formed to monitor vulnerable people in the community, who are treated as if they were patients in a ‘virtual ward’. This is an award-winning innovation.



locality case studies



## PEN PICTURE 12 Castlefields Surgery, Runcorn

### Extending the primary care team

Some years ago, the Castlefields Surgery in Runcorn made a major contribution to the evidence base for integration care with an approach later developed as the *Unique Care* model.

The surgery secured a year's funding for a pilot project in the north of England in which a social worker was based in a surgery and worked proactively with a District Nurse to introduce an integrated case management approach for patients in the practice. The impact of the new arrangement was carefully monitored and compared with the performance of the practice before and after the pilot – and with other local practices.

At the end of the project, the evaluation concluded that there had been a significant reduction in admissions to hospital, with no increase in the use of residential or nursing home beds. Hospital length of stay was also significantly reduced. The authors recommended that PCTs should consider the benefits of social care input to case management, especially when planning new services and new roles such as the community matron.

The *Unique Care* model was later adapted for a 22-week trial in Enfield, where it was also thoroughly evaluated. The Castlefield results were replicated with a 50% fall in hospital admissions and 98% reduction in 'excess' bed days. Given the potential for savings, the pilot has been seen as an endorsement of the capacity of Practice Based Commissioning to generate innovative integrated solutions which sustain care at home. A further trial with six practices will follow.



Lyon et al, "The Castlefields Integrated Care Model", *Journal of Integrated Care*, 14.1, 2006.

Keating et al "Reducing unplanned hospital admissions and hospital bed days in the over-65 age group: results from a pilot study", *Journal of Integrated Care*, 16.1, February 2008

The PARR tool has been developed at the Kings Fund to assist in identifying people from hospital and GP information systems who are specifically at risk of hospital readmission. It might complement this work.

**ICN  
WEB**

## Supporting practitioners in integration

There could be significant scope for self-organisation among practitioners and other key stakeholders (especially users) if they can be made to feel they are partners in determining how a collaborative approach might work – and how it will benefit service users and carers. What follows is one possible route to achieving this. Potential members of each multi-disciplinary team or integrated service should be involved.

### looking together at caseloads and workflow

Let groups of staff come together to map out how they currently communicate with each other and how they deal with the needs of individual service users.

Start with the safe assumption that staff do not know much about their colleagues' jobs, caseloads and routines and that there will be variation in what might be described as a 'complex needs' or 'a priority'. A good focus would be to try to categorise current workloads on the basis of the complexity of the needs they are designed to meet. The process will expose differences and overlap and might well lead to the identification of people who would benefit from a more coordinated approach. They could include those at the top of the Long Term Conditions triangle or on the right side of the 'windscreen' diagram on page 82.

### brainstorming the options

Gradually brainstorm ideas for doing things in a more integrated way. Application of Leutz's first law suggests the creation of frontline multidisciplinary teams and specialist services focussing on people with complex needs but such a team will need to link easily with more universal services (e.g. schools and GP practices).

Always keeping in mind the benefits being sought for users, the process should pay particular attention to:

- the basis for distinguishing between needs, ie what do the different levels of complexity encompass and who is involved in addressing them
- ideas for a better model for dealing with the most complex needs, setting out the extent of integration required and estimating the caseload
- the support needed from employing bodies to implement the models and to translate strategic objectives into routine practice.

### **giving responsibility**

Ultimately, all new arrangements for working together in service delivery require a leader. Responsibility for the quality and effectiveness of the new arrangements should therefore be delegated to someone who can act on behalf of all involved: it may be a single manager in an integrated system or a network manager. It has also long been advocated by the Audit Commission that the delegation of budget management to local service managers is likely to increase the potential for service responsiveness to individual needs.

Depending on the scale of change introduced, continuous support for frontline staff involved will need to be made available, e.g. in budget and human resource management, training, IT, etc.

### **finalising project plans**

A recommended model and a picture of organisational development requirements should eventually emerge from these processes. Conclusions should be written into reports (for example those of the integration project team) – and should be reflected in service re-design.

Practitioners might also begin gradually to introduce aspects of the new approach into their routines and establish a process for monitoring and evaluating the benefits.

## Self-directed support and integrated care

There can be little doubt that a working balance will have to be found in all localities in the implementation of these key national policies. For this reason, ICN has started a workstream to consider it.

Self-Directed Support (SDS) seems to be a new paradigm with a consequent risk of an uncomfortable fit with existing ways of doing things. Integrated care, in this context, might be seen as part of the old order. This raises the question of what can be done to enhance the joint impact on the lives of people needing help to live independently at home?

One further complicating factor is whether health care can be treated in the same way as social care. The former is 'free at the point of delivery', a situation broadly reflected in children's social care; charging for services is more of the norm in adult social care, and this is why Individual Budgets and Direct Payments are likely to be effective in creating choice and innovation. However, the push for a 'personalised NHS' has the potential to introduce a complementary dynamic. It has been speculated that adults with long-term conditions are the most suitable patients for a parallel healthcare approach – where they can determine their pattern of support directly. In fact, in the NHS *Next Stage Review Interim Report* (Oct 2007) it was stated that 'integrating care is also a key driver of personalisation because, for example, there are likely to be fewer appointments on a typical pathway, greater familiarity between patients and staff, better information for the patient, and a more "seamless experience"'

This rises to Kodner's challenge in Section 7. The quest will be for a citizen-based model of integration.

[The ICN and 'In Control' are embarking on a series of joint pilots in 2008 to consider the opportunities for integration around personalisation.]

## Research messages

The guide can end on a positive note with robust findings from a scientifically-designed study. It found that a partnership between NHS clinicians and care managers helped to reduce deterioration in the physical health of older people and also their need for services.

The objective was to ascertain through a randomised controlled trial the value of Social Services obtaining a specialist NHS clinical assessment before placing an older person in a residential home and redesigning the decision-making process accordingly.

A sample of 256 older people at risk of care home entry was randomly allocated to either a control group, who received the usual care management assessment, or to an experimental group who, in addition, received a clinical assessment by a geriatrician or old age psychiatrist.

The clinical assessments uncovered covert morbidity previously unknown to care managers, particularly in respect of cognitive impairment, opening up alternative treatment and management options. Those receiving the clinical assessment went on to experience less deterioration in their physical functioning, had less contact with nursing homes and emergency services and their carers experienced reduced levels of distress. Overall, the costs of care for those receiving the assessment were no greater, with NHS costs actually lower. Both partners benefited from pooling expertise, establishing a new protocol, and opening direct communication. There were also improved outcomes for users and carers.

More of this sort of research should be commissioned.

Challis D et al. "The value of specialist clinical assessment of older people prior to entry to care homes." *Age and Ageing* Volume 33, Number 1 2004, pp 25-34

## Section 8 in summary

There is an increasing expectation that individual children and adult service users should experience more personally tailored services which respond to their needs and wishes. A key part of this is that access to advice and help is made easier, and that having to navigate unaided between elements of a service is eliminated. Frontline practice can facilitate this, promote self care and put the user more directly in control.

A basis for redesigning the care system can be established by identifying practice and services whose quality and effectiveness can be improved by integration – and by clarifying the numbers of potential users with complex needs who should most benefit. Engaging frontline staff in these processes and giving purposeful support for team and organizational development will assist the process of change.

Multi-disciplinary teams or managed networks are the main means of collaboration between practitioners to commission and deliver services for individuals. They can help ensure the collection and distribution of information on needs and outcomes.

Ideally, they should:

- have a single manager (or co-ordinator)
- include a mix of staff appropriate to role of team
- have a single point of access, single assessment process, record system, administration
- have access to a pooled, delegated budget
- support users in commissioning individual care programmes.

They must link easily and coherently with universal services, such as GPs and schools, and with more specialist secondary care services, e.g. hospitals and residential schools.

## The guide in summary

In Part One the guide introduced the idea of a continuum of co-ordination, from fragmentation and autonomy to integration. In considering action to achieve integration, Part Two has emphasized the interdependence of various levels within a whole system of governance and care provision. The complex system that they represent together, and some of the main issues involved, are brought together in the guide to:

- give insight into effective integration
- provide practical guidance for planning and implementation.





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