



Research report March 2018

Managing the hospital and social care interface

Interventions targeting older adults

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About the report

The health and social care sectors are dependent on one another to succeed. But the boundary between the two is challenged daily: the quality and appropriateness of the care received in one sector has consequences for the services required in the other. This report focuses on this interface, outlining some of the different initiatives being implemented by providers in order to reduce delayed transfers of care, length of stay and admissions and qualitatively exploring some of the enablers and barriers to these initiatives in order to try to understand whether interventions have had the intended impact. The report finds that although the impact of limited resources is visible, there is evidence of good practice where local areas have come together to deliver or commission care collaboratively in order to improve patient outcomes and, in some cases, make efficiency savings. Drawing on the experience of these cases, as well as evidence of what has worked to date, we make a set of recommendations for national policy-makers and local hospital leaders on how best to manage this interface.

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Key messages

The health and social care sectors are dependent on one another to succeed. But the boundary – or interface – between the two is challenged daily: care received in one of the sectors has a direct impact on the other. This report focuses on that interface.

Now more than ever before, hospitals are struggling to meet performance targets. Delayed transfers of care increased by 185,000 in 2015/16 compared with 2014/15 – costing a total of £146 million more than planned (National Audit Office, 2017). By the third quarter of 2016/17, just 82% of patients attending Accident & Emergency (A&E) departments were seen, treated and admitted or discharged within four hours (National Audit Office, 2017) – the worst performance since the target was introduced in 2004.

Hospitals are increasingly blaming their local social care sector for playing a part in their deteriorating performance and tensions are rising at a time when collaboration between the two sectors is needed more than ever before.

This report explores the actions and strategies that providers and commissioners have put in place to improve the interface between secondary and social care, with a focus on what hospitals can do.

In particular, we look at:

- collaboration to prevent avoidable hospital admissions
- the interface between hospitals and social care providers when patients are discharged from hospital
- the relationship between commissioners and social care providers
- wholesale organisational integration.

Drawing on the experience of seven case study sites, as well as evidence of what has worked to date, we make five recommendations for national policy-makers:

- 1 Move beyond a focus on delayed transfers of care.** A focus on delayed transfers of care is not sufficient to address the wider issues facing health and social care. And requiring local areas to concentrate on this single issue may actually have a negative impact on local relationships.
- 2 Consider small-scale as well as large-scale organisational change.** The national drive towards certain models of care and accountable care organisations will deliver successful outcomes in some areas, but do not underestimate the potential of small-scale change in bringing about significant results in a faster and less resource-intensive way. One size does not fit all.
- 3 Focus on increasing the health and social care workforce.** The workforce is the health and social care sectors' greatest asset. Innovation and growth in the sectors are meaningless without a workforce to deliver the changes. Enable providers to create a positive learning environment for staff where they feel respected and rewarded.
- 4 Understand the capacity of community-based services.** The strategies highlighted in this report are interconnected with the performance of local community-based services. A mapping of the capacity in these services is vital for an understanding of the pressures facing secondary and social care.
- 5 Make use of other sectors where possible.** A vibrant and diverse voluntary and community sector will support effective interfaces between hospitals and social care, and should be nurtured. Similarly, making the best use of Extra Care Housing and other such schemes will help people to live independently at home.

We also make seven recommendations for local hospital leaders:

- 1 Think imaginatively about the workforce.** We heard many novel ideas to help address recruitment and retention challenges in the workforce, such as paying for travel, helping employees to hire cars, providing priority parking and subsidising accommodation (with advice from HM Revenue & Customs – HMRC – to avoid staff getting tax bills for accommodation).
- 2 Do not make decisions about social care, without social care.** Hospitals that make decisions about providing or commissioning social care without consulting their local authority or social care providers may risk destabilising the social care market.
- 3 Think carefully about different types of integration.** Organisational, service-level and patient-level integration all have their own strengths and weaknesses. Organisational integration requires a lot of time and dedicated resources to create the necessary infrastructure. Progress towards integrated working on the ground can be made more quickly via service-level integration, but organisational integration can bring other benefits such as helping all members of staff to understand the entire health and social care pathway. It is important to be very clear about exactly what it is hoped will be gained from integration.
- 4 Consider pooling budgets to facilitate progress.** Most of our case studies benefited from a shared budget to initiate and sustain integration efforts. Some of this came from ‘vanguard’ funding, but most of the case study sites also drew on the Better Care Fund.
- 5 Make sure that integrated teams have appropriate processes to support them.** Where integrated teams work effectively, they have appropriate processual and managerial support. Shared governance and accountability processes mean that everyone is working to the same set of standards.
- 6 Make sure that commissioners are on board.** Collaboration and buy-in from all local commissioners and providers, including primary and community care, was a key factor in successful implementation for most of the case study sites.

- 7 Collaborate with housing partners. There are good examples of collaboration with housing partners at the local level. A project set up in the North East of England between a clinical commissioning group and a housing association allowed people with respiratory diseases who were living in cold, damp homes to be 'prescribed' double glazing, a boiler and insulation. This 'Boilers on Prescription' project reported a 30% reduction in A&E attendances and a 60% reduction in the number of general practitioner (GP) appointments needed by people taking part in the project (Burns and Coxon, 2016).

None of this is easy. But as both the health and social care sectors face the biggest challenges that they have ever faced, improving collaboration is more important than ever.

1 Introduction

The health and social care sectors are dependent on one another to succeed. But the boundary – or interface – between the two is challenged daily: care received in one of the sectors has a direct impact on the other. This report focuses on that interface. We set out to explore the actions and strategies that providers and commissioners have put in place to improve the interface.

In particular, we look at:

- collaboration to prevent avoidable hospital admissions
- the interface between hospitals and social care providers when patients are discharged from hospital
- the relationship between commissioners and social care providers
- wholesale organisational integration.

The case studies and further evidence presented in this report aim to help health care providers, and in particular hospital boards, to think about how to address some of the barriers at the interface in these areas in order to work more collaboratively – and ultimately more successfully.

Context

Now more than ever before, hospitals are struggling to meet performance targets. Delayed transfers of care increased by 185,000 in 2015/16 compared with 2014/15 – costing a total of £146 million more than planned. By the third quarter of 2016/17, just 82% of patients attending A&E departments were seen, treated and admitted or discharged within four hours – the worst performance since the target was introduced in 2004. The number of emergency admissions also increased by 87,000 in 2015/16 compared with the previous year, and only 31% of local areas achieved their target to keep older people at home

91 days after discharge from hospital (National Audit Office, 2017). Hospitals are increasingly blaming their local social care sector for playing a part in their deteriorating performance and tensions are rising at a time when collaboration between the two sectors is needed more than ever before.

All of this is happening against the backdrop of a population that is becoming increasingly dependent on health and social care services. There are currently 11.8 million people aged 65 and over in the UK (Office for National Statistics, 2017) – 40% of whom have a limiting longstanding illness (Age UK, 2017). Also, 21% of men and 30% of women in this age group report needing help with at least one activity of daily living (ADL) (NHS Digital, 2016). The increase in the over-65 cohort has led to a rise in the numbers of people suffering from ‘diseases of old age’, including dementia and Parkinson’s disease – conditions for which social care is at least as important as health care (Barker, 2014). The over-65 cohort also make up 42% of elective admissions and 43% of emergency admissions to hospital (NHS Benchmarking Network, 2017). Prolonged hospital stays for patients in this age group can have profound consequences for their overall condition, including a loss of capacity for independent living.

At the same time, both the health and social sectors are facing significant financial challenges. NHS funding has increased in line with inflation since 2010/11, but not with demand for its services, which is growing by an estimated 3.1% a year (Gainsbury, 2016). The social care funding situation is even more challenging. Decreased allocations from central government have resulted in the vast majority of local authorities cutting their adult social care spending. The average fee paid by councils to social care providers has fallen nationally by 6.2% since 2011 (Humphries and others, 2016).

Both sectors are also experiencing workforce pressures. The social care sector has a turnover rate of approximately 27% a year and a vacancy rate of 4.8% a year (Humphries and others, 2016; Skills For Care, 2016). Meanwhile, the health workforce is suffering from a lack of appropriate staff to provide older people’s care. Geriatricians make up only 3.6% (mean value) of the consultant workforce (NHS Benchmarking Network, 2017) and the number of district nurses working in the community (who are ideally placed to enable people to remain at home) reduced by a half between 2003 and 2013 (Ball and others, 2014).

To respond to the challenges, health and social care leaders are thinking about how they can work more collaboratively. National policy in England under both the previous and current governments has been to support the expansion of integrated care at ‘scale and pace’ in order to improve patient outcomes, while also contributing to the financial sustainability of the NHS. The most recent national integrated care initiatives are the ‘integrated care and support pioneers’ in 25 areas (Erens and others, 2016) and a national Better Care Fund for the NHS and councils to create pooled budgets using health service funds.

But there are systemic barriers that pose a challenge to the integration of the two sectors. Health care is generally considered to be a public responsibility, essentially free at the point of use. By contrast, social care is means-tested, subject to co-payments based on levels of assets or income. In addition, the NHS is governed centrally and commissioned for whole populations, while social care is the responsibility of local authorities and is provided for individuals by thousands of private providers.

The health and social care workforces are also structured differently. Most health care professionals have traditionally undertaken specialist roles based on training and formal qualifications; meanwhile in social care services, most care is provided by unpaid carers, and where paid (formal) carers are involved they undertake more generic caring tasks learned during basic qualification or training in the role (Comas-Herrera, 2012). This means that embedding new ways of working and developing trust and shared understandings of goals, values and patient risk (and the appropriate strategies of risk management) between health and social care organisations and their leaders can take time (Bate, 2017; National Audit Office, 2017).

Differences in the workforces are part of a bigger cultural issue. Health service provision has tended to be dominated by biomedical models of health, and their focus on diagnosing and responding to primarily physical symptoms of disease and disability among individuals. Social care services, on the other hand, are intended to focus on the whole person in the context of the physical, economic and social contexts in which they live and their relationships with others. In the traditional medical model, social care is viewed predominantly as an adjunct to health services, enabling them to fulfil their goals of, for example, increasing the number of safe and timely discharges from hospital or reducing avoidable admissions, rather than as separate services with a

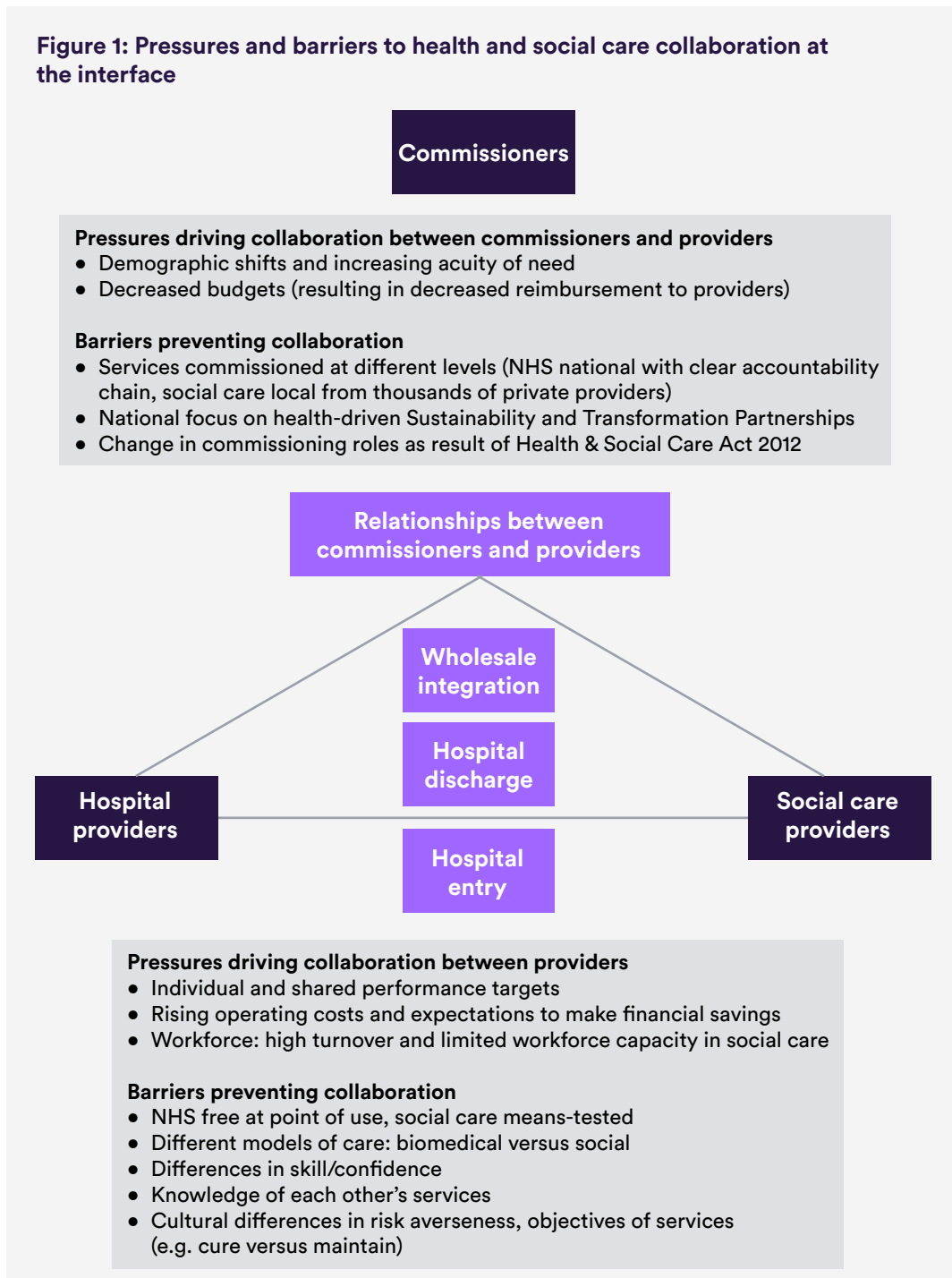
wider range of distinct purposes (Kumpunen and Wistow, 2016). Social care services have been described as ‘a poor relation; everybody’s distant relative but nobody’s baby’ (Griffiths, 1988).

Finally, national policy has inhibited integration:

- To date, regulatory inspection and performance measurement have focused on the quality of care that individual organisations provide, rather than the patient’s experience of the system as a whole.
- Competing policy priorities – such as the focus on choice and competition brought about through the Health and Social Care Act 2012 and the primarily health-focused sustainability and transformation partnerships (STPs) – have distracted from the aim to improve collaboration between the sectors.
- The Integration Partnership Board only receives updates on the Better Care Fund, rather than integration efforts more broadly (National Audit Office, 2017).

In Figure 1 we summarise the pressures and barriers to collaboration described above, separating out the pressures driving collaboration between commissioners and providers, and those between hospital and social care providers themselves. We also highlight the four strategic areas that the local areas we spoke to are focusing on to improve older people’s care.

Figure 1: Pressures and barriers to health and social care collaboration at the interface



About this report

This report explores opportunities to overcome the barriers described above, drawing on the evidence to date and the lived experience of health and social care organisations. Chapter 2 looks at four different aspects of the interface between health and social care and summarises the experience of six case study areas that have chosen to pursue a particular route to integration. Chapter 3 focuses on the role that technology and information sharing can play in supporting integration, as this emerged as a key theme in all case study areas. Chapter 4 describes national-level barriers that the research participants identified, and these are placed within the literature. Chapter 5 sets out our recommendations for how national policy-makers can help to make better progress on integration policies as well as our recommendations for hospitals that want to improve the ways in which they work with social care partners. The Appendix gives further details on the methodology for this research.

2 Improving collaboration at the health and social care interface

To better understand how hospitals can work with local partners to overcome barriers to integration, the Nuffield Trust undertook a survey of health system leaders, two workshops with providers and policy-makers, and a rapid review of the literature. We identified four common themes in relation to the interface between health and social care where several local areas were strategically focusing their integration efforts:

- avoidable hospital admissions
- hospital discharge pathways
- building relationships between commissioners and social care providers
- wholesale organisational integration.

These have been areas of tension for decades and have taken centre stage in current policy debate.

In this chapter we look at the four areas and present one to two case studies for each (see Table 1). We also provide a brief review of the available evidence linked to the strategies that the case study areas employed, and enablers and barriers for health and social care providers and commissioners interested in implementing the strategies.

Table 1: Roles that acute hospitals are undertaking to improve integration and the case studies featured in this chapter

Role	Case study
Managing hospital admission pathways from the social care sector	East and North Hertfordshire care home vanguard Airedale NHS Foundation Trust vanguard
Managing discharge pathways from hospitals to community and social care services	Sheffield Teaching Hospital and local partners
Managing social care provision	Northern Devon Healthcare NHS Trust Leicestershire County Council and local clinical commissioning group partners
Participating in full integration	Stockport Together

Avoiding hospital admissions in the care home sector

The increasing complexity of the needs of older people seeking social care support, coupled with insufficient community-based services in many areas, now often mean that social care staff are being asked to undertake clinical tasks that previously would have been carried out by community nurses (Humphries and others, 2016). The capacity and confidence of social care staff to support the health needs of the people they care for have a significant impact on an individual’s health and wellbeing outcomes, and similarly, on the demand for GP and hospital services (Imison and others, 2017; Martin, no date). Yet it is widely understood that care homes’ access to NHS services is erratic and inequitable (Goodman and others, 2014), and evidence about which interventions will redress these inequalities is not well established (Gordon and others, 2013).

The 'care home vanguards'¹ in England have trialled four mechanisms to improve health care in care homes, including:

- telecare and telemedicine (including video consultation and remote monitoring)
- integrated working between care home staff and visiting health care professionals
- the use of integrated records/data
- comprehensive assessment and care planning (face to face or remotely) by a GP or consultant hospital doctor.

A recently published study on the care home vanguards revealed that the best results were achieved when health care professionals working with care homes on a regular, ongoing basis were linked in with other NHS services as part of a wider network of expertise. This:

- created naturally occurring opportunities to meet and discuss care
- nurtured a mutual appreciation of the challenges that both NHS and care home staff face
- reduced demand on stretched urgent and emergency care services
- increased staff confidence around decisions not to admit a resident to hospital and around decisions to discharge patients from hospitals (Goodman and others, 2017).

1 There are six enhanced health in care home vanguards whose aims are to improve the quality of life, healthcare and health planning for people living in care homes. See <https://www.england.nhs.uk/new-care-models/vanguards/care-models/care-homes-sites> for more information

However, broader evaluations of telecare – where patients are able to access health care expertise from their care home via a video link – have shown mixed results. The Whole Systems Demonstrator project – a randomised controlled trial of telehealth and telecare involving over 6,000 patients – showed that it does not significantly reduce health service use, nor is it cost-effective (Henderson and others, 2013; Steventon and others, 2013).

But setting standards for how care homes should be interacting with hospitals (and vice versa) is difficult to develop and implement across the country because of the variation in social care providers. The care home market, for both residential and nursing care, is dominated by private sector, for-profit, providers. And there can be significant variation in the size of care home, the type of care provided and the skill levels of staff, making each relationship unique.

Below are two examples that are currently being showcased and invested in as part of NHS England’s care home vanguard scheme. The initiatives target the point at which a carer or clinical professional (such as a paramedic) decides whether a social care user needs to go to hospital. Similar initiatives are being trialled elsewhere. For example, Wirral Community NHS Foundation Trust has given iPads to care homes to connect carers with clinical expertise. Northern Devon Healthcare NHS Trust has partnered with a local further education college to develop joint health and social care courses and apprenticeships, funded by their contribution to the new Apprenticeship Levy.² There are also several well-known services that target issues faced by older people, such as palliative care services provided by Marie Curie. The schemes presented in this section indicate the gains that can be made from improving interactions between health and social care without necessarily needing to undertake complex or lengthy contractual processes.

2 The Apprenticeship Levy is a levy on UK employers to fund apprenticeships. The levy is charged at a rate of 0.5 per cent of an employer’s paybill. Each employer receives an allowance of £15,000 to offset against their levy payment.

Case study: East and North Hertfordshire care home vanguard

Organisational context

The East and North Hertfordshire care home vanguard scheme is a collaboration between Hertfordshire County Council, East and North Hertfordshire Clinical Commissioning Group and Hertfordshire Care Providers Association (an umbrella group that represents social care providers in the area). The area has 92 care homes, delivering services to around 3,000 people.

What was done?

To manage care home residents' high rates of attendance at A&E and admissions to hospitals, commissioners began working with providers to improve the quality of care delivered in care homes, with the aims of improving patient outcomes and reducing costs. These were to be measured in terms of the numbers of 999 calls made, A&E attendances, emergency admissions, calls to out-of-hours GPs, and delayed transfers of care.

The programme of work aims to enhance the quality of care that people receive in the community, primarily through upskilling staff in care homes to make them feel more confident about supporting residents' health and wellbeing through greater integration with multidisciplinary teams – including pharmacists, dieticians, geriatricians, mental health professionals, doctors, nurses and therapists. It also aims to improve the quality of care by establishing a series of proactive and rapid-response initiatives, two of which are described below.

The first initiative is the Early Intervention Vehicle, which is a dedicated ambulance service that responds to 999 calls deemed appropriate for the targeted cohort by the call handler – aged 65 and over and coded as either 'falls' or 'sick'. It is staffed by a paramedic or emergency care practitioner and a council-employed social care professional (either an occupational therapist or a social worker). The team operates seven days a week, from 7:30am to 6:30pm. The aim of the programme is to reduce the number of conveyances to hospital for those who could be dealt with at home and to refer them to the relevant service if required. The typical conditions the team treats are dehydration, dementia, urinary tract

infections, falls, head injuries without loss of consciousness and acute decline in function and mobility. Between May 2016 and December 2017, the team reduced the conveyance rate for the targeted cohort from 52% to 28%.

The second initiative is a training programme for staff in care homes to increase their knowledge of dealing with complex patients. The programme is arranged by Hertfordshire Care Providers Association (HCPA), a local membership body for independent providers. It is a six- to nine-month programme for which staff gain a qualification through the ‘Complex Care Premium’ programme. ‘Complex care champions’ have been trained in areas such as dementia, wound care, health management, user engagement, nutrition and falls. Homes receive funding for backfilling staff. Training was targeted initially at those homes that received poor inspection results from the Care Quality Commission. As of May 2017, 213 champions had been trained, covering 44% of the 92 care homes in the area. Estimates suggest that between December 2015 and December 2017 there was a 45% reduction in hospital admissions because of the training. In addition to improving patient care, this programme is also aiming to improve staff retention rates, but no information is yet available on this.

Enablers

- Care homes in the area being represented by a single trade association (the Hertfordshire Care Providers Association), which provides training for all the care homes and home care providers and gives them a common voice to the NHS and Hertfordshire County Council – the association has been in existence for over 10 years.
- Pre-existing collaboration between the local authority and clinical commissioning group around social care provision.

Challenges

- Information governance – the amount of time and resources it takes to establish.
- Recruitment for newly created roles.
- Monitoring of outcomes without a clear baseline to measure against.

Case study: Airedale NHS Foundation Trust

Organisational context

Airedale NHS Foundation Trust has created a digital care hub that provides a range of telehealth services to nursing and residential care homes and patients' own homes. The care home service, Immedicare, is run as a joint venture between the hospital and the technology company, Involve.

What was done?

The original driver for this work was a recognition that improving the quality of remote community-based care could deliver significant improvements to the number of hospital attendances and admissions and be beneficial for users/patients.

The hub provides a telemedicine service to almost 600 care homes, which cover a caseload of around 20,000 service users, and provides 24/7 access to a clinical team staffed by nurses, paramedics and therapists with expertise in a range of specialities. Hospital consultants, advanced practitioners and specialist teams are available when relevant, via video consultation. Care homes are provided with a laptop, a detachable camera and wireless internet access points throughout their buildings so that the consultation can take place in the individual's bedroom if necessary. Depending on the condition of the individual, the hospital-based team will continue to monitor the individual remotely, arrange for an onward referral using their local Directory of Services or decide that no further action is needed. Care home staff are given training on the software and technology, and are also supported clinically 24/7 by the registered practitioners in the hub. The hub staff also deliver training virtually, using the technology, in subjects such as nutrition and hydration, pressure ulcer prevention, infection prevention, vital signs and the National Early Warning Score (NEWS)³ as well as end-of-life care.

Impact

An evaluation of this telemedicine service has demonstrated a series of positive impacts. Comparing 27 care homes with telemedicine (with 21 care homes without telemedicine) before and after the introduction of the

3 NEWS is a scoring system launched in 2012 to improve the detection of and response to clinical deterioration in adult patients.

service, using data from 2012 to 2014, the service was shown to reduce non-elective admissions by 37% and A&E visits by 45%, compared with the care homes without telemedicine, which were able to reduce both non-elective admissions and A&E visits by 31% (Hex and others, 2015). The evaluation also found that the incremental difference in costs between the telemedicine intervention group and the control group was almost £1.2 million, with a return on investment of £6.74 per £1 spent by the clinical commissioning group (Hex and others, 2015). There have also been informal reports that care home staff have appreciated the training and feel supported to deliver care, knowing that a registered practitioner is available 24/7. A formal evaluation has been carried out looking at a larger cohort of over 200 care homes, which is in publication.

Enablers

- Support for new ways of working from all local staff (including those not directly involved): GPs, hospital clinicians and clinical commissioning groups.
- Agreement from all staff to use the hub as their single point of access.
- Using highly trained staff as the first point of access, rather than relying on pathways or algorithms, as other triage services do.

Challenges

- Some care home managers and staff being reluctant to embrace the technology and use a new and remote service.
- The high turnover of staff in care homes, meaning that numerous staff need to be trained on the processes and technologies involved.
- Some care homes being familiar with contacting their GPs and community teams directly and some GP practices insisting that the care home staff should still contact them rather than use the new service.

In summary, there are gains to be made by improving the ways in which hospitals and social care providers communicate and share skills. Successful initiatives can improve patient experience, improve staff experience and reduce demand for hospital (and other NHS) services. The encouragement of general practice and hospital staff and their embedding of the new processes into their everyday practices can have a significant impact on the success of the initiatives. The right incentives need to be put in place to ensure that partnership working can extend beyond vanguard funding.

Further reading

- For detailed information about what is being trialled as part of NHS England’s vanguard programme, please visit <https://www.england.nhs.uk/new-care-models/vanguards/care-models/care-homes-sites>
- Numerous initiatives designed to improve integration between care homes and health services were systematically reviewed by Davies and others (2011). As well as reviewing effectiveness, this report also includes tips for successful implementation. Davies SL, Goodman C, Bunn F, Victor C, Dickinson A, Iliffe S, Gage H, Martin W and Froggatt K (2011) ‘A systematic review of integrated working between care homes and health care services’, *BMC Health Serv. Res.* 11, 320.
- On reducing medication errors, Allred and others (2016) undertook a systematic review of evidence and NICE have published a guide for managing medicines in care homes at www.nice.org.uk/Guidance/SC1. On the impact of improving GP engagement with care homes, see Goldman R (2013), Evidence review on partnership working between GPs, care home residents and care homes. Social Care Institute for Excellence.
- An evidence review of various NHS-focused hospital avoidance schemes including intermediate care services, hospital to home initiatives and improved end of life care services can be found in Imison C and others (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.
- This chapter has focused on care homes. For information about providing high quality, personalised home care, there are resources on the NICE website (guideline 21) at www.nice.org.uk/guidance/ng21/chapter/Recommendations

Similarly, this report does not cover the debate on demand for social care. See Bolton (2016) and the below:

- On tackling demand: Government Association (2014) LGA Adult Social Care Efficiency Programme; <https://www.local.gov.uk/sites/default/files/documents/lga-adult-social-care-eff-549.pdf>

- On evidence for self-care: Health Foundation (2011) Evidence: Helping people help themselves. www.health.org.uk/publication/evidence-helping-people-help-themselves

Managing discharge pathways from hospitals to community and social care services

The interface between hospitals and social care providers at the point of discharge has significant implications for patient flow and capacity within both sectors, and has been an issue for debate for many years. But worryingly, one of the main measures of patient flow - 'delayed transfers of care' - spiked in 2016/17: the number of delayed days in a single month peaked in October 2016 at 200,095 delayed days (NHS England, 2017a).

Data suggest that in the fourth quarter of 2016/17, on average around 56% of delays were attributable to the NHS, 36% to social care and 8% to both. The three main reported reasons for the increase in delays between 2015/16 and 2016/17 were patients waiting for the completion of an assessment, patients waiting for a care package in their own home and patients waiting for further non-acute NHS care (NHS England, 2017a).

Although it is difficult to know exactly what is happening on the ground, the literature suggests that complications in being discharged from hospital are caused by a complex range of factors, including:

- inadequate patient assessment
- poor organisation between both hospital and community teams and ongoing out-of-hospital health and social care teams
- a complete lack of community and social services altogether (Gonçalves-Bradley and others, 2016; Humphries and others, 2016).

Extra days in hospital are problematic because:

- they lead to muscle deconditioning in older people (Kortebein and others, 2008)
- they are costlier than out-of-hospital care (£820 million versus £180 million per year) (Carter, 2016; National Audit Office, 2017)
- they increase patients' risks of catching a hospital-acquired infection and/or having an injurious fall (NHS Providers, 2015)
- they can prevent severely ill people from accessing hospitals if they are occupied by patients whose care can be delivered in another setting.

On the flipside, there are also challenges associated with premature and poorly coordinated discharges, which can be as problematic as delayed transfers of care.

Initiatives to tackle these problems often focus on the workforce and ways to improve communication between the health and social care sectors. Good practice on improving discharge processes has been widely shared, and is described below alongside some of the best available evidence. However, little is still known about the cost-effectiveness of best practice or the best mix of interventions to put in place where it isn't possible to implement all facets of good practice. Good practice includes (Gonçalves-Bradley and others, 2016; House of Commons Committee of Public Accounts, 2016; Local Government Association, 2016; NICE, 2015):

- avoiding older people being admitted to hospital unnecessarily, through care planning, or health care at home or in care home schemes
- starting comprehensive assessments and discharge planning early, setting an estimated discharge date within 48 hours of admission and involving the patient and their family in discussions about current and proposed care – this can reduce hospital length of stay and hospital readmissions as well as increase patient satisfaction

- developing multidisciplinary discharge teams and joint/shared patient assessments between health and social care providers or trusted assessors, supported by electronic patient flow systems – this can reduce hospital admissions, reduce length of stay and lower costs
- appointing a single designated health or social care practitioner to coordinate the patient’s discharge from hospital
- undertaking the assessment of the patient’s long-term care needs in the most appropriate setting, whenever possible in their own home (often referred to as ‘discharge to assess’) –in one case study area this reduced length of stay, supported the acute provider to meet its four-hour A&E target, saved 62 bed days and reduced bed costs by £153,000 (NHS England, 2016)
- offering short-term intermediate, step-down and reablement care as discharge pathways (for example, Extra Care Housing or wards of acute or community hospitals for those who are medically fit) – this can decrease the need for ongoing support for around 40% of patients to whom it is offered (Glendinning and others, 2010; Kent and others, 2000; Lewin and Vandermeulen, 2010).

Progress in implementing good practice appears to be patchy. For example, a 2016 NHS benchmarking project found that only about a half of NHS trusts document discharge information in a single document (NHS Benchmarking Network, 2017). As a result of variation in practice and performance metrics, the Government recently introduced a new performance management scheme comparing regional variation across the following measures (Department of Health, 2017), which it hopes will encourage the use of good practice:

- delayed transfers of care
- emergency admissions
- length of stay in hospital
- the number of people still at home 90 days after being discharged from hospital.

Below we examine Sheffield Teaching Hospital's pioneering main discharge pathways, which were explicitly developed using best practice guidance.

Case study: Sheffield Teaching Hospital and local partners

Organisational context

The health and social care structure in Sheffield is coterminous with one acute NHS foundation trust, one clinical commissioning group and one local authority. In 2011, the local care economy underwent vertical integration, removing organisational divides between hospital and community-based teams (Offord and others, 2017), allowing the hospital to provide all community services and manage individual pathways.

What was done?

After several years of high numbers of delayed transfers of care, a suite of schemes at both the front and back doors of the hospital was developed in partnership with the local authority, community-based teams and local GPs. Most of these schemes were adaptations to existing services. The discharge-focused services include the following:

Early discharge planning. A team of nurses and therapists work with the A&E department, the frailty unit and the medical and surgical assessment units. The team remain involved in coordinating discharge plans for up to 48 hours of the inpatient stay. The team work as 'generic assessors', crossing traditional professional boundaries, starting assessments that are then continued outside of the acute setting with the philosophy of 'home first', helping to reduce duplication.

Discharge to Assess (D2A). This service is delivered by a vertically and horizontally integrated team composed of health and social care professionals. The team predominantly support frail older people to return home by undertaking a full assessment of their health and social care needs and providing the necessary health care, therapy and equipment for them to continue their recovery safely at home. After one to ten days, the person is either discharged as independent or passed to other community teams for ongoing management. Funding for this service is provided by the local Better Care Fund.

- **Reablement.** This home-based service is delivered by the local authority-employed Short Term Intervention Team (STIT), supported by Community Therapy Services and funded by the Better Care Fund. It is provided free to people discharged from hospital for up to six weeks. People who need further packages of care are then passed to independent sector providers.
- **Transfer of Care.** This service is provided by a team of 25 nurses who work in hubs in various wards (orthopaedics, surgical, diabetics/ endocrine, palliative care and elderly care) and provide input to every base ward across four Sheffield Teaching Hospital sites. Their purpose is to assist the multidisciplinary team in facilitating patient discharge from an acute bed and to take a lead in discharging patients with complex health needs.

In addition to continuing professional development, all assessors have undertaken a three-day course at Sheffield Hallam University. The course was designed by managers and Sheffield Hallam University tutors to promote interdisciplinary working by sharing clinical assessment skills and understanding across nurses, occupational therapists and physiotherapists. The model reduces footfall in people's homes by providing an integrated assessment and is a more cost-effective and efficient way of working. Staff have given positive feedback on the model as it extends their skills, promotes collaborative working and patients benefit from greater continuity and less duplication.

Impact

Sheffield Teaching Hospital reports that the number of medically fit patients in trust beds decreased from approximately 300 to 175 between February and April 2017, and the number of bed days decreased from 4,600 to under 3,000 in the same time period.

Enablers

- Vertical integration bringing acute and community services together, setting a precedent for other types of integration.
- Joint management of teams to share learning between staff, and discharge teams and clinicians being located in the same place.
- Managers having the autonomy to innovate and improve services where problems arise (especially where changes are within current budgets).

Challenges

- Availability of council-commissioned, private sector-provided home care was a massive challenge in 2016/17, particularly over winter of that year, reinforcing the need for a whole-system approach.
- Cross-organisation working still being problematic, although this improved significantly over the summer of 2017.
- It being difficult to restrict access to D2A and reablement services to the planned number of days – pathways may need to be reshaped.
- Evolving services, which can make it difficult to measure impact and assign attribution between cause and effect.

In summary, discharge pathways involving hospital and community teams undertaking assessment and delivering reablement care in people's homes can bridge the communication and coordination barriers common to this interface, and are translatable to different acute trusts and their local partners. Managers of discharge schemes should undertake ongoing evaluation and adapt service delivery as needed, but be aware that it can take time to see impacts.

Further reading

Draw on well-known best practice to design discharge pathways.

For example:

- Local Government Association (no date) ‘High impact change model’.
<https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model>.
Accessed 18 December 2017.
- NICE (National Institute for Health and Care Excellence) (2015) Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs. NICE. <https://www.nice.org.uk/guidance/ng27/resources/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs-1837336935877>. Accessed 18 December 2017.

Quick guides for transforming urgent and emergency care services can be found at:

- <https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx>. Accessed 18 December 2017.
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Managing social care provision

The social care market consists of multiple submarkets covering different types of clients and services and different geographies. The sustainability and capacity of these submarkets vary significantly, but across England, providers are leaving the market or accepting only self-funded service users (ADASS, 2017). Providers are facing challenges such as decreasing fee rates from local commissioners, lack of access to affordable housing for the local workforce, low local unemployment rates and high vacancy rates for qualified nurses in some areas (CordisBright, 2015; Skills For Care, 2016).

To overcome local sustainability and capacity issues, commissioners are using a range of approaches. For example, they are focusing on collaborating with a smaller number of providers willing to transparently discuss operating costs (Institute of Public Care, 2016a). They are also decreasing the size of current care packages, especially those developed by health colleagues, as evidence suggests that one in every five packages of care from hospital prescribes higher levels of care than is needed (Bolton, 2016, using Short- and Long-Term Support (SALT) returns data; Local Government Association, 2016). This is allowing many commissioners to move towards outcomes-based approaches, which are shaped around the expressed wishes of service users and pay providers on the basis of outcomes achieved rather than the volume of what they provide. Some of the benefits of outcomes-based commissioning include:

- more person-centred services
- a more mature approach to the market involving shared risk
- greater collaboration between local authorities, providers and other partners
- a greater focus on impact rather than just activity (Institute of Public Care, 2012a)

However, these approaches also face challenges, such as providers perceiving themselves to be taking on too much risk, services being inhibited by bureaucratic approaches or overlooked by resource constraints, and users

not being given the choice about how outcomes are achieved (Bolton, 2015); Glendinning, 2006; Local Government Association, 2015).

Growing evidence also suggests that, to tackle the mutual challenges that they face and increasing demand, health and social care partners should coordinate their commissioning approaches and develop place-based perspectives on how the health and social care markets operate, so that services can meet the needs of the populations they serve (Ham and Alderwick, 2015; Humphries and Wenzel, 2015) Institute of Public Care, 2016b). But this can be complicated as social care providers often have more complex contract arrangements, monitoring requirements and fee structures with their local authority compared with their NHS counterparts. Frequently, providers have contracts with multiple councils and/or clinical commissioning groups in a region, but at different rates depending on their geographical reach (Institute of Public Care, 2016a). Collaboration at the interface between health and social care is therefore very important, but translating this into practice is not always straightforward.

In some places that have adopted an outcomes-based approach to domiciliary care, such as Leicestershire County Council (see the case study described later in this section), commissioners may decide to enter contracts with a smaller number of providers. This can facilitate the development of more strategic relationships between commissioners and providers and a smoother transition to a new approach to the service. In practice, commissioners need to work closely with providers and allow them an appropriate amount of time to build the necessary workforce to implement the new approach (Institute of Public Care, 2016c).

The following case studies provide examples of health and social care commissioners working together to implement the strategies discussed above. The examples require joint contractual arrangements and/or new arrangements to organise and manage service provision. They demonstrate benefits in that if scarce resources are used more efficiently, access to appropriate levels of care can be improved and capacity in the market can be maximised, thereby improving the sustainability of the care market as a whole.

Case study: Northern Devon Healthcare NHS Trust

Organisational context

Northern Devon Healthcare NHS Trust (NDHT) has been an integrated acute and community trust since 2006. In addition, in 2008, social care staff (social workers and therapists) transferred to the management of the trust. The trust therefore employs 400 people who work in the community. In response to variable quality and capacity in the local social care market, the trust set ambitions to build market capacity, raise the quality of care and support for complex patients and improve the use of hospital services.

What was done?

In July 2016, NDHT signed a five contract (which was extended by two years) with Devon County Council, the Northern, Eastern and Western Devon Clinical Commissioning Group and Devon Partnership Trust for the provision of domiciliary care in North and Mid Devon. Devon County Council is the lead commissioner and NDHT acts as the lead contractor for this patch under the name Devon Cares. It does not deliver the care itself – it acts as an independent broker/commissioner for care providers and improves their collaboration, quality and delivery coordination. In 2015, NDHT piloted a scheme to directly provide domiciliary care, but found that it was not sustainable due to the NHS' Agenda for Change pay rates and to the small scale of operation, meaning inefficient delivery.

NDHT/Devon Cares is currently working with over 40 domiciliary and personal care providers. These are accepted onto the Devon Cares framework on the basis of quality, not price, and they also need to undergo a procurement process managed in-house. Providers are classified into one of four groups depending on the level of input and risk they want to undertake. For example, Tier 1 providers – the group with the highest level of input and risk – can influence Devon Cares' strategy, they are given the first opportunity to accept packages of care and they share potential liquidated damages costs (fines for unfilled packages).

The hourly fee paid to providers is £18.56, a high rate for the area, in an effort to adequately cover the national living wage, travel times, paid breaks, corporate activity including training and supervision and

an acceptable profit margin. Rates are top-sliced to create a risk pool that funds an emergency cover team responsible for providing care to service users in the event that a Tier 1, Tier 2, Tier 3 or specialist provider is unable to accept a package of care. Any unspent risk pool left at the end of the financial year is put towards quality improvement initiatives to benefit all providers.

Impact

From April 2016 to March 2017, the average length of hospital stay fell from 4.5 to 3.5 days and, since Devon Cares has been in operation, there have been very few delayed transfers of care as a result of unfilled domiciliary care packages. Overall, the number of delayed transfers of care fell by 25% from the last quarter of 2015/16 to the last quarter of 2016/17. The programme will continue to monitor its impact on delayed transfers of care, quality and the recruitment and retention rates of the care workforce, and continue to participate in regional research. Baseline data will be published in 2018.

Next steps

Future plans for NDHT include creating a shared information system and moving towards an outcomes-based commissioning model. The trust is also exploring the potential of acting as a prime provider for other commissioned social care services, in both North Devon and elsewhere.

Enablers

- Pre-existing integration between acute and community teams, meaning that there was already a culture of collaboration.
- Creation of a spirit of partnership and trust between partners, supported by the lead commissioner role being undertaken by a neutral organisation (that is, not a social care provider) – trust was more easily built because providers knew that the NHS would not deliver care and was therefore not a competitor.
- Support from local political leadership and social care commissioners willing to take a risk on a new approach.
- Effective leadership managing the transition to the new model.

Challenges

- Delays in establishing information technology (IT) infrastructure – providers were required to set up an NHS email account for information governance and data protection purposes.
- Underestimation of the time and resources required to mobilise new ways of working.
- A culture change required by the middle tier of health and social care managers, not helped by a lack of knowledge by some NHS colleagues about social care services.

Case study: Leicestershire County Council and local clinical commissioning group partners

Organisational context

In 2015, Leicestershire County Council (LCC) found itself with a growing waiting list for care as a result of an ongoing lack of capacity and capability in the home care market and a rising demand in acute care (Leicestershire County Council and others, 2015). Historically, despite LCC commissioning the majority of domiciliary care packages, the two local clinical commissioning groups (East Leicestershire and Rutland Clinical Commissioning Group and West Leicestershire Clinical Commissioning Group) purchased more care hours and high-intensity care packages than the council (for recipients of Continuing Health Care). There was also variation in the frequency of the care packages' review process, with LCC undertaking reviews more frequently than the clinical commissioning groups.

What was done?

To achieve a more coherent and sustainable commissioning strategy across the two sectors, a business case was put together for NHS and local authority partners in Leicestershire to jointly commission domiciliary care with effect from November 2016. Under these arrangements, LCC acts as the lead commissioner of domiciliary care on behalf of two local clinical commissioning groups. Budgets have not been formally pooled, except for the new reablement offer, which is funded through the Better Care Fund.

A revised tender was published for a five-year contract (three years plus a two-year extension), which condensed the provider landscape with which the local authority would contract, from 70 to eight preferred providers, each covering their natural geographic alignment. All preferred providers engaged in honest conversations about sustainability, and mutually revised hourly rates to include the national living wage and travel times. They also began the process of moving towards outcomes-based contracts. Therefore, the payment mechanism moved from volume-based payments to a new outcomes-based payment system where providers were transparent about their operating costs, and agreed with commissioners how they could reduce their current workload (driven by unnecessarily large care packages) to free up capacity for newly referred service users. The aim was to empower providers to release care where appropriate and to maximise the opportunities to make service users independent as early as possible. The process offered stability to these providers and also expanded their networks, as they were encouraged to attend primary care locality meetings, which were facilitated by the clinical commissioning groups.

To initiate the process, all service users' care packages were reviewed and in most cases reduced. Service users who wished to maintain continuity with their current providers were offered direct payments, otherwise they were switched to one of the eight independent sector providers. Alongside the initial review process, the team developed protocols for ongoing reviews, which included monitoring the number of people who asked for increases to their care packages. A new reablement service offer was also introduced in line with the local sustainability and transformation partnership vision.

Together, the local authority and clinical commissioning groups have created:

- a single point of access for the public
- a single point of contact for contract managers
- a single payment process for all providers
- a single set of reports for governance bodies.

Hourly rates have remained stable and now include the national living wage and travel times.

Impact

As a result of changes in commissioning and review practices, as well as efficiencies made through joint delivery and accountability structures, LCC reports that the overall savings for 2016/17 were about £1 million (from an approximate £23 million contract). Its newer post-discharge reablement offer has also seen less than half of all referred patients needing an ongoing care package following the service, but this will require further evaluation.

Enablers

- Being open among commissioning partners about objectives.
- Sharing learning about good and bad practice – and being willing to change.
- Sharing back-office functions where possible to deliver efficiency savings.

Challenges

- The length of time it can take to build trust between the multiple governance, procurement and legal teams.
- Reaching agreement between the local authority's and clinical commissioning groups' legal teams and other professional groups being difficult when not facilitated well.

In summary, novel commissioning approaches are starting to result in more efficient care. In Devon, new approaches to delivering domiciliary care improved transfers of care. Pre-existing integration between health and social care teams, and support from local political leaders and social care commissioners who were willing to take a risk on a new approach, both facilitated the arrangement. In Leicestershire, a joint commissioning approach enabled honest conversations about costs and sustainability, and empowered providers to release care where needed.

We couldn't find any examples of health organisations providing social care services. Interestingly, Devon Cares felt direct provision was too expensive. However, South West England pays higher rates for domiciliary care than other parts of the country, which means that direct provision may be possible elsewhere.

Further reading

Where possible, use available guidance, for example on:

- the costs of provision – see Chartered Institute of Public Finance & Accounting, Department of Health, Local Government Association, Care Provider Alliance and Association of Directors of Adult Social Services (2017) Working with Care Providers to Understand Costs. Chartered Institute of Public Finance & Accounting. www.cipfa.org/policy-and-guidance/reports/working-with-care-providers-to-understand-costs. Accessed 14 December 2018.
 - home care sustainability – see Association of Directors of Adult Social Services (2017) ‘Top tips for directors of adult social services: home care sustainability’. <https://www.adass.org.uk/top-tips-for-directors-of-adult-social-services-home-care-sustainability>; CordisBright (2015) Assessing Social Care Market and Provider Sustainability. CordisBright. www.cordisbright.co.uk/admin/resources/market-sustainability.zip. Accessed 14 December 2018.
 - moving towards outcomes-based commissioning – see Local Government Association (2015) Commissioning for Better Outcomes: A route map. Local Government Association. <https://www.local.gov.uk/sites/default/files/documents/commissioning-better-outc-bb6.pdf>
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Participating in full integration

Health and social care integration initiatives attempt to reduce the fragmentation and duplication of health and social care provision that can lead to costly and inefficient services, poor patient outcomes and wasted resources (see MacAdam, 2008). All of the initiatives described so far in this report are collaborative schemes that would recognise these aims to some degree. However, accountable care systems – the ultimate aim for all sustainability and transformation partnerships– or accountable care organisations take this one step further by redefining the interfaces between commissioners and providers and providing care for an entire registered patient list.

This section particularly focuses on organisational integration, where different providers, including acute hospitals, have been brought together under one contract to deliver care to a patient population via a delegated capitated budget. The benefits of this approach are seen as an ability to:

- improve relationships at all levels of the system (macro to micro)
- ensure that all employees (no matter where they work) are striving for the same goals and are judged on the same set of performance metrics
- ensure that all providers are held to account for outcomes and care across the system
- spend money in a way that makes sense for the organisation as a whole (rather than individual sectors).

The vast majority of organisational integration efforts in the UK and elsewhere have focused on integrating health services, as opposed to integrating health and social care. Where there is evidence on the impact of health and social care integration, it tends to be fairly mixed.

The more positive evidence has shown improvements in the process for discharging patients from hospital. For example, evaluation of the integrated discharge teams in the Southwark and Lambeth Integrated Care (SLIC)

initiative showed that completion of the London Health Needs Assessment fell from 22 days at baseline to six days as a result of the intervention (Southwark and Lambeth Integrated Care, 2016).

There is also some positive evidence around care planning as a result of integration efforts. Of the 16 integrated care pilots, only two brought secondary and social care together. The Nene pilot was one of these, which brought together primary, secondary, community and social care as well as commissioners and the voluntary sector. An evaluation of the pilot found that the proportion of patients receiving care plans and the organisation of care following hospital discharge both improved considerably; meanwhile medication reviews completed within a week of discharge increased from 8% to 80% (Nolte, 2012).

But organisational integration takes significant time and resources and is not always wholly effective. Work on the experience of care trusts, which were established under *The NHS Plan* (Department of Health, 2000) and brought together health and social care services, found that while benefits included improved joint working and a multidisciplinary approach to care, half of care trust chief executives would recommend other options for achieving better integrated working (Miller and others, 2011). A 2002 report by the Commission for Health Improvement on allegations about the abuse of patients in the Manchester care trust concluded that ‘establishing the care trust diverted scarce management time away from service issues and quality of care’ (quoted in Wistow and Waddington, 2006, p. 5).

Similarly, the integrated care and support pioneers have experienced a number of barriers to realising integrated working. An early evaluation found that ‘facilitators of integrated working tended to be related to factors such as leadership, vision, trust and shared values that are largely developed locally, while the barriers were more likely to be features of formal organisational structures and systems only amenable to resolution by national agencies’ (Erens and others, 2016, p. 10). The evaluation also found that the environment for whole-systems transformation is not becoming any easier – and if anything barriers are becoming more pronounced as funding pressures increase (Erens and others, 2016).

We spoke to several integrated care organisations in Northumbria, Stockport and Torbay about their approach to organisational integration. Below we set out learning from Stockport.

Case study: Stockport Together

Organisational context

Stockport Together is a multispecialty community provider, formed in January 2015 and serving 300,000 people. It was established due to a growing feeling across local partners that care could be improved by working together, particularly in the context of mounting financial pressures. The organisation brings together local acute hospital, community, mental health and primary care services, voluntary sector providers and health and social care commissioners.

What was done?

As part of the multispecialty community provider programme, financial and contractual arrangements have changed. Under an agreement under Section 75 of the National Health Service Act 2006, Stockport Together pooled £200 million of health care, adult social care and public health resources (for 2016/17). It has an ultimate ambition to pool all permissible resources within an overall budget of approximately £500 million. In 2016, Stockport Together also established a joint commissioning arrangement to manage the pool, which brought together the clinical commissioning group and the local authority. The organisation has reported noticeable differences, for example around commissioning in the care home sector.

At an operational level, decisions about how these funds are deployed are taken by a newly formed provider board, which includes executive-level directors from each of the four partner provider organisations. This board is now operating as a formal, legally constituted alliance. There are plans to take a single contract approach across the four key providers. The alliance also has an increasingly integrated IT infrastructure. All GP practices and the out-of-hours service use a single electronic patient record system (EMIS) and implementation of the same system has begun for community-based services. There is also a shared record in place.

Impact

These structural and contractual changes have enabled several modifications on the ground. The organisation has set up a ‘transfer to assess’ scheme (preferring not to label it ‘discharge to assess’ in acknowledgement of it being a single organisation). It created a fully integrated discharge team, bringing together community, hospital and social care staff to work under a single manager, and has reduced the number of people going on to use social care services once discharged. One of the biggest impacts on patients is more timely discharge to their own home, rather than an intermediate care bed, with support to live independently. Length of stay has reduced, although occupied bed days have increased, and the overall resource implications are not clear.

Home care packages are now commissioned, planned and undertaken jointly between health and social care, providing additional home care capacity across the system.

Integration has also allowed specialists to reach out to community settings. A semi-retired psychiatrist works with community and social care teams one day a week, helping them to understand how to help service users with mental health issues.

One of the biggest impacts on staff is improved understanding of the whole patient pathway. There is no longer a sense of ‘passing on problems’ from one sector to another. A good example is the discharge team: initially each sector saw others as part of the problem, but as a result of integration, teams became involved in shaping the solution together and developed a sense of ownership. “That’s one of the big changes we’re trying to get across the system... ownership of solutions because teams are now able to work across a total pathway” (Tim Ryley, Director of Strategic Planning & Governance, NHS Stockport Clinical Commissioning Group).

Ultimately, building collaborative relationships across the system is considered more important than any process changes – and developing integrated teams is a key part of that.

Next steps

Following a consultation process about the best kind of integrated organisation to create, the local providers have decided to develop a care trust. This will involve the Stockport NHS Foundation Trust transforming itself into a care trust, encompassing adult social care. It will have two wings, one of which will be inpatients and elective care, and the other will be the multispecialty community provider, including A&E, outpatients, some admission wards, community and social care services and additional general practice work over and above core contract activities. Discharge arrangements will sit with the multispecialty community provider – giving it overall responsibility for pulling patients through the system. It is likely to be at least two years before this comes to fruition.

Enablers

- Investment from the NHS England new care models vanguard programme and the Greater Manchester Transformation Fund.
- The development of joint provider and commissioning boards with responsibility for the pooled budget.
- Tracked finances at a health economy level – all finance directors fully understand the financial situation of all of the providers, which enables investment decisions to be taken based on benefits to the system as a whole.
- The creation of new joint roles, for example a Director of Integrated Commissioning.
- Integrated teams that are co-located, under one manager and one set of objectives.
- Restructured senior management across multiprofessional teams, supported by particular training on how to manage employees from a different professional background.
- Ensuring professional competence and development via appointed leadership teams for each profession (separate from the multidisciplinary team manager).
- Shared governance and accountability arrangements – that is, all parts of the workforce work towards the same set of organisational objectives and are held accountable by the same organisational processes.
- An interoperable IT system and shared records (also see Chapter 3).

Challenges

- The significant amounts of time and resources needed to make the infrastructural and processual changes required.
- Initial resistance to change across the organisation – it required senior leadership to push change through.
- Staff resistance to working in new teams with a manager from a different professional background, particularly from an allied health profession.
- Particular uncertainty about how effectively professional competence and development would be supported.
- Initial scepticism, but this tended to dissipate once changes took place and benefits were seen.

In summary, organisational integration is an attempt to break down the barriers that separate health and social care commissioners and providers. It can be particularly effective at bringing staff together to work under a shared aim. Organisational integration requires significant time and energy from all stakeholders. Given the scale of change required, funding to allow clinicians to be involved in co-design and testing will likely be needed. For many of the integrated care organisations in the NHS, vanguard funding has been an important enabler.

Further reading

The evaluation of the Integrated Care and Support Pioneers Programme provides a detailed account of the enablers and barriers to undertaking organisational integration – see:

- Erens B, Wistow G, Mounier-Jack S, Douglas N, Jones L, Manacorda T and Mays N (2016) Early Evaluation of the Integrated Care and Support Pioneers Programme: Final report. Policy Innovation Research Unit.

For guidance for leaders on organisational development and navigating the new commissioning landscape, see:

- Hulks S, Walsh N, Powell M, Ham C and Alderwick H (2017) Leading Across the Health and Care System. The King’s Fund. <https://www.kingsfund.org.uk/publications/leading-across-health-and-care-system>. Accessed 18 December 2017.

For further details on the contractual arrangements, see:

- Addicott R (2014) Commissioning and Contracting for Integrated Care. The King’s Fund. <https://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf>
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3 Supporting integration with technology

Technology facilitates integration across teams, services and organisations. Sharing clinical and administrative data is a big part of that. Clinically, it means that everyone involved in a patient's care, regardless of the service or sector they work in, has access to all of the information they need at the point of care. That could be the patient's medical history, their interactions with other health and care providers and the treatments they are receiving. It improves clinicians' ability to make the right decision, first time.

This is important for any integrated system, but it is particularly important where teams are working in community settings and need to make quick decisions about a patient's care. 'Discharge to assess' teams working in care homes or people's own homes are a good example. In these kinds of settings, mobile devices such as tablets are needed, so that clinicians can access the data in real time when they need it. In one example, midwives' use of mobile devices in the community released significant time savings – the equivalent of £9,000 per midwife per year (Isosec and Imperial College Healthcare NHS Trust, 2015).

Shared data are also important for service improvements and monitoring quality. It means that integrated teams can be measured against their shared performance metrics, and that improvements can be made where there are variations in care. In this way, it also supports shared governance arrangements. Transparent data mean that it is clear how clinicians have acted across the board.

How to share data

Data can be shared by creating a single record (this is sometimes the approach taken by integrated care organisations), by linking different datasets or by using an integration engine that pulls relevant information from many different databases, and displays it uniformly. The last of these approaches is used in the Connecting Care Partnership initiative in the South West of England (see the case study below).

There is no consensus about the best way to share data. It is important to customise records so that they are most useful to particular specialties. But over-customisation can limit data sharing – even when an organisation has a shared record provided by one technology supplier. Where data are linked, it can be difficult to line up relevant data across organisations, although advancements in aggregation technology are making this easier.

Kaiser Permanente, one of the largest integrated health care systems, initially used different records for different specialties, but struggled to link them together effectively. Eventually, it decided that a single record, with room for some level of specialist customisation, was more effective.

There are numerous data-sharing initiatives across the NHS. All of the integrated care organisations mentioned in the previous chapter share data in some form. There are also large data-sharing initiatives across geographies such as DataWell in Greater Manchester, the Leeds Care Record and the Connecting Care Partnership. At the heart of all of them is an ambition to reduce duplication and fragmentation across the system, thereby increasing efficiencies and improving care.

Case study: Connecting Care Partnership

Organisational context

The Connecting Care Partnership is an initiative to share health and social care data across 17 organisations serving one million patients in Bristol, North Somerset and South Gloucestershire. The initiative arose out of a realisation by health and social care providers that duplication of both consultation and patient information was having an impact on patient waiting times and outcomes.

What was done?

In March 2013, Orion Health was selected out of over 40 suppliers to implement its Clinical Portal technology. This technology enables clinicians to access patient records across systems, locations and organisations. It includes:

- a summary from the patient's GP record (including appointments, diagnoses, medications and allergies)
- information about contacts with out-of-hours services, hospital care, community and social care and mental health services
- information about the End of Life Care Plan
- discharge summaries from University Hospitals Bristol
- children's social care safeguarding flags
- a 'my patients in hospital' view for GP practices.

New things are being developed every month as part of the initiative. Local teams and services using Connecting Care include:

- a wide range of hospital services (from A&E to pre-operative assessment)
- out-of-hours services
- care coordinators in GP practices
- social workers
- occupational therapists
- 'Independent Living' and 'Promoting Independence' teams
- safeguarding teams
- community discharge and nursing teams.

Impact

Work on the programme suggests that it has been very beneficial to date, particularly in saving clinicians' time during and in between consultations and in producing efficiencies across the system. Anecdotally, the system has also improved the quality and safety of care.

Enablers

- Annual co-funding by all of the partners – the amount paid varies by the size of organisation but all pay less than £100,000; the initiative has also received additional grant funding for certain projects.
- Good relationships and strong partnership working across the region – these have been strengthened through monthly meetings, not taking an organisational focus (and speaking in terms of patients, the city or the region) and perseverance.
- Strong core teams and numerous working groups.

Challenges

- Encouraging IT suppliers to engage in interoperable solutions (see the 'Issues to consider' section below).
- Managing competing priorities across partner organisations
- Mounting financial pressures on partner organisations.

Issues to consider

Sharing data can present logistical challenges. An initiative like the Connecting Care Partnership requires good cooperation from all the technology suppliers involved. It uses an integration engine that can process most forms of data. But securing those data from system suppliers proved challenging in some cases. Enabling functions like ‘context launching’ – where the Connecting Care platform can be opened from the main organisational electronic health record to avoid professionals having to separately open different systems – also requires agreement from the technology suppliers to make adjustments to their systems.

There are also information governance issues to consider, which require substantial resources to navigate. The Connecting Care Partnership has an information governance group consisting of representatives across the health and social care organisations involved. The priorities of the group were established following a privacy impact assessment that was carried out at the time of the pilot. These include ensuring that data-sharing agreements are in place and informing the public about information governance arrangements. The group continues to meet monthly. At the start of any new project using the Connecting Care dataset, a new privacy impact assessment is carried out. The group is also tasked with keeping up to date with changes to legislation and is currently working on how its processes may be affected by the General Data Protection Regulation (GDPR), which comes into effect in May 2018. When setting up a large-scale data-sharing initiative, it is essential to have people with specific responsibility for project management and logistics.

It is also important to tell patients who their data will be shared with, how the data will be used and how they can opt out of the scheme. Evidence suggests that people are generally happy for their data to be used for their own care and that there is a sense of frustration in having to repeat their information to the different professionals involved in their care (King and others, 2012; National Data Guardian, 2016). Research has consistently shown that there are three things that feed into a person’s willingness to share their data, as follows (adapted from Riordan and others, 2015):

- what the data are and how sensitive the individual perceives them to be
- who will be using their data and the extent to which the individual trusts that user
- what the data will be used for and how informed the individual feels about that.

This underscores the need for a good communication campaign to ensure that people understand how their data will be used.

In summary, shared data are fundamental to effective integration, and can be approached as part of organisational integration or as part of regional data-sharing efforts. The technicalities of data sharing can be difficult, and weighing up the pros and cons of a shared record versus an interoperable system will depend on the infrastructure already in place, how the data will be used and the level of customisation required. Gaining public buy-in will require strong communication efforts as well as sound information governance policies. Using tools like the Department of Health's Information Governance Toolkit may be helpful (see <https://www.igt.hscic.gov.uk>). This will likely require a dedicated logistics team.

4 Addressing national barriers

There remain a number of prominent challenges to collaboration and integration, many of which are the product of national policy decisions. Local areas are testing the limits of what they can achieve but ultimately remain constrained by several well-known barriers (Evans and others, 2015). Given that the UK now has a Secretary of State with responsibility for both health and social care, the government may be in the best place to remove some of these barriers. With regard to the interface between hospitals and social care, the main barriers identified in this research were:

- the workforce
- differences in organisational incentives and motivations (driven by national NHS leaders' focus on delayed transfers of care)
- a lack of national-level leadership to drive innovation
- information governance and data sharing
- cultural attitudes that the public and staff have towards service use.

This chapter looks at each of these challenges in turn and provides some examples of the lessons learnt from our case study sites.

Our participants mentioned a lack of funding as an issue that either underpinned or exacerbated all of the challenges set out here. As it has been widely discussed in detail elsewhere, we have chosen not to discuss it here. However, whether deepening financial pressures on local authorities and the NHS create a shared burning platform for collaboration or fuel cost-shunting and conflict (such as the Local Government Association's withdrawal of support for Better Care Fund arrangements) is an important question, and one that should be monitored as funding constraints worsen.

The workforce

The case studies in this report highlight the crucial role of frontline staff in embedding new ways of working and delivering change to patients. However, the lack of capacity in the workforce is also one of the clearest barriers to innovation. As it presently stands, the social care sector is struggling to recruit and retain staff due to a lack of a clear career path, high levels of job insecurity and stress, low pay and perceptions of low status. Of the social care workforce, 24% are on zero-hour contracts and the turnover rate is approximately 27% a year (Skills for Care, 2016). Over the past few years, there have been attempts to improve the skills of and career path for care workers; however, beyond induction schemes and other training programmes, only 52% of the workforce have a relevant social care qualification (Skills for Care, 2016). Vacancy rates for qualified nurses are also high and the uncertainties of Brexit negotiations raise further concerns about the long-term sustainability of the care workforce (7% of whom are European Union nationals; United Kingdom Homecare Association, 2017).

There are also deep-set challenges to creating a joint health and social care workforce. First, there is no mechanism for joint workforce planning, which means that long-term plans for integrated teams are lacking. Second, staff across health and social care are trained (and approach their work) differently – most health care professionals have specialist roles underpinned by formal qualifications, while in social care services, formal carers undertake more generic caring tasks learned through basic qualifications or training in the role (Comas-Herrera, 2012). Finally, the two workforces are often valued differently by society, which is reflected most visibly in pay structures.

There is a significant disparity between how much is spent on training for social care staff and the amount put aside for the NHS' training budget, and this is set to worsen, as financial pressures have led to some social care providers reducing their investment in staff training and development (Humphries and others, 2016). Some providers argue that the reductions to profit margins for public sector contracts (from 10% to between 4 and 7% gross) have limited their ability to continue to invest sufficiently in training management systems and quality improvements (Institute of Public Care, 2012b)(Institute of Public Care, 2012b), but it is still unclear whether this could be a reasonable return in a difficult financial context.

A few of the most promising schemes we encountered were those that focused on giving care workers the confidence and skills to make better decisions about the people they cared for (for example, see the East and North Hertfordshire care home vanguard case study on page 16). Training and access to clinical advice were demonstrated as successful ways of achieving this goal (for example, see the Airedale NHS Foundation Trust case study on page 18), without requiring significant investment in organisational development. Another area had taken advantage of the more clearly defined career pathway for health care workers to attract new staff by developing joint training schemes that allowed people to experience different parts of the system and feel more connected to the whole health and social care community (for example, see the Northern Devon Healthcare NHS Trust case study on page 30). These schemes are collaborations between multiple commissioners and providers across the NHS and social care. However, the final message we heard was that, ultimately, care staff need to feel adequately respected and rewarded for their work and this requires sufficiently funding social care providers so that they can offer competitive wages.

A national focus on delayed transfers of care

One of the messages repeatedly given to us during this research was about the intricacies of the local relationships between health and social care. In a local area today, the types of services offered, their capacity, the coordination of teams across sectoral boundaries and so on, may be a reflection of decisions that were taken decades ago.

It was with this in mind that there was significant criticism of the current national focus on delayed transfers of care as a panacea to solving efficiency issues and the funding and capacity crisis. The most recent demonstration of the Government's narrow focus to 'managing the social care crisis' was the announcement that the additional money for social care announced in the Spring Budget will be distributed based on delayed transfers of care data through the Better Care Fund (NHS England, 2017b). This in turn caused the Local Government Association to pull their support for the programme. The Government's approach may reflect the small number of levers on social

care held by the centre, which leaves the Department of Health with few options to intervene other than via the NHS (which is subject to much greater national control than local government and social care providers). However, delayed transfers of care are one of many symptoms of a distressed interface between health and social care, and a focus on them will not solve the root cause. In fact, this narrow lens through which to see the challenges facing the health and social care sectors could distort organisational behaviours, hinder collaborative working and distract from efforts focusing on the prevention of avoidable admissions to hospital.

As demonstrated in this report, Sheffield Teaching Hospital managed to tackle high levels of delayed transfers of care because it extended its work to consider the individual's journey from first entering the hospital, right through to being medically fit, at home and in receipt of social care, and it did so in collaboration with the local authority and independent sector providers (see the case study on page 24). Equal partnership and a focus on what was within each partner's gift to change were important to developing new services and teams and for seeing results in performance. In the past, hospitals may have seen care homes as 'warehouses' for older people needing additional support, rather than a legitimate place for rehabilitation and care for those who need it (Glasby and Henwood, 2005).

Innovation: leadership and investment

The NHS has multiple, nationally led bodies that support and, importantly, invest in the improvement and development of the health sector and its staff (for example, NHS England, NHS Improvement, the NHS Leadership Academy, the National Institute for Health and Care Excellence (NICE) and Public Health England). Despite the Local Government Association's peer review programme, there is no comparable level of investment in improvement and support in the social care sector. The NHS Leadership Academy's baseline budget for 2016/17 was £44.7 million; despite leadership programmes delivered through the Social Care Institute for Excellence (SCIE), an organisation with similar financial backing is lacking in social care.

SCIE is one of the few national social care bodies to survive, and has moved from being largely funded via core funding to relying on self-financing. While

it provides guidance and training programmes to the social care sector, it does not invest in piloting new models of care as NHS England and NHS Improvement have done. Other support comes from national representative provider bodies.

In the course of this research, the innovation we saw was being driven by all local partners, not just acute care providers. This is positive in some ways: local leaders will try to meet the specific needs of the populations they serve rather than trying to implement a top-down ‘solution’. A number of different approaches were being taken. We came across the Graham Care Group – a social care provider that was working with a local, clinically led design and learning centre – which had built a care home with specifications that would allow it to be used for more acutely unwell individuals, “making out-of-hospital care safer for both citizens and the professionals”. The care home owner funded this themselves, and they were waiting for confirmation from the clinical commissioning group about whether services would be commissioned. We also heard about interesting collaborations with housing providers who were using Extra Care Housing design principles to support people to live independently in their own homes. However, the lack of national leadership also left some local commissioners and social care providers unsure about where to invest, what groups of people to prioritise and what types of care to focus on – particularly when this sort of planning needs to take place alongside strategic thinking around the capacity of local NHS community services. NHS and social care colleagues alike also mentioned that some consistency around, for example, transitions from care homes to hospital and back would be welcomed and that this could be a role for national leaders to undertake (the Red Bag initiative in Sutton was mentioned as a best practice example).

Similarly, collaboration around the planning of services at a local level is patchy, and depends on the resources and capacity of health and wellbeing boards, and at a larger-scale sustainability and transformation partnerships. The Care Act 2014 requires that each council shapes the market to match local needs and to publish market position statements that enable the local provider markets to adapt to changes in commissioning strategies. However, some providers in this research said that they were not sufficiently involved and therefore had difficulties planning for the future. This challenge was partially overcome in some of our case studies. For example, in Leicestershire,

where local health and social care commissioners came together to share information on their contracting approaches and move forward acting as one, they report having made significant improvements in commissioning processes, resulting in cost savings from simply being able to understand how each was operating (see the case study on page 32). Similarly, schemes such as the Connecting Care Partnership, while not necessarily designed to support this aim, could help local areas to understand how patients are moving between services and where the gaps in provision are (see the case study on page 45).

A significant challenge to implementing new ways of working and sharing best practice seemed to arise from the number and diversity of social care providers, resulting in the absence of a natural local leader or organisation to drive innovation. Like general practice, social care providers are usually small, independent, privately owned organisations. Communication is hindered by the fact that commissioners, representative organisations and national bodies often only have a single point of contact in small care homes – a general manager – who is often undertaking more than management functions to ensure that good care is provided day to day (rather than focusing on building external relationships). In the example of the East and North Hertfordshire care home vanguard project (see the case study on page 16), a key enabler was that commissioners were able to work with a single local provider representative organisation – a model that national NHS leaders have been steadily imposing on general practice as a prerequisite to the implementation of new models of care.

Information governance and data sharing

A perpetual challenge for schemes that attempt to improve the interface between health and social care is information governance and data sharing. A lack of understanding of how individuals move between services, decision making by professionals without access to a full set of notes and the duplication of tests, are but a few of the consequences to this barrier. The difficulty in understanding information governance requirements, the time taken to get data-sharing agreements approved and signed by all partners, and the resources needed to achieve each of these steps, were common challenges mentioned by our case studies, and reflect many other integrated care

initiatives (Erens and others, 2016; Wistow and others, 2015). Facilitators for breaking down these barriers were found in schemes like the Connecting Care Partnership, which brings together data from across the sectors (see the case study on page 45). In areas that are redefining the boundaries between the sectors by creating a single provider organisation with joint commissioning arrangements – as in Stockport Together (see the case study on page 38) – data are able to be shared and used across a wider group of professionals.

Cultural attitudes towards service use (and a lack of incentives to encourage behaviour change)

Another challenge, which resonates with findings from primary care-led hospital avoidance schemes, is perceptions around the use of hospitals among the public and some health and social care staff. It is incredibly difficult to change the widely held belief that hospitals are the safest places to be when crises happen. NHS 111 (the free NHS helpline for urgent medical concerns) and other similar services established to prevent avoidable hospital use have had mixed results (Appleby and Dayan, 2017; Imison and others, 2017).

From a social care staff perspective, an investment in preventative care and schemes that train social care staff to give them the skills, competence and confidence to make assessments about a patient's/user's deterioration, are some of most rewarding in terms of improving patient experience and reducing demand (Imison and others, 2017; Glasby and others, 2016). Investment in staff training by social care providers, particularly smaller ones, is difficult in the current environment. However, our case studies suggest that collaboration and increased communication between care providers, hospitals and primary care are a step in the right direction. From an NHS perspective, it is vital that hospital and other NHS staff do not over-prescribe social care services to the extent that it hinders an individual's recovery and rehabilitation, or that risk averseness or a lack of knowledge of local reablement services prevents people from being discharged when they should be (see, for example, Bolton, 2016). There remains a question about whether the system sufficiently empowers professionals to hold risk outside of hospital.

5 Conclusion and recommendations

The health and social care sectors are dependent on one another for the success and effectiveness of their services. The boundary between the two sectors is challenged daily by the flow of patients between services, meaning that the quality and appropriateness of the care received in one area will have consequences for the services required in the other. Since it is a vastly complicated local picture involving a whole range of health and social care providers and commissioners, this report has focused on actions and strategies that have been attempted to improve the interface between hospitals and social care providers. This was further divided into four areas within which various strategies have been implemented:

- the interface between NHS and social care providers when people are admitted to hospital
- the interface between NHS and social care providers when patients are discharged from hospital
- the interface between commissioners and providers
- wholesale organisational integration – tackling all of these interfaces at the same time.

The case studies and further evidence presented in this report aim to give food for thought about strategies that may address some of the barriers at these interfaces and improve outcomes for patients.

These examples were united by a common catalyst: a consensus among local leaders that something had to change, that things had to improve, because if not, patient care would start or continue to deteriorate. Their common enablers were: collaboration between frontline staff, leaders willing to invest resources and/or staff time in new ways of working and facilitation from local

commissioners. But was it enough to overcome their greatest underlying challenge: a lack of funding?

The impact of limited resources is visible in the form of rising levels of unmet need, longer waiting times for services, concerns around the quality of care and increasing pressure on carers and families. In this research, we saw pockets of good practice where local areas had come together to deliver or commission care collaboratively in order to improve patient outcomes and, in some cases, make efficiency savings. Some of the initiatives required additional investment and resources in order to get started but others simply focused on improving the processes already in place. Certainly, it seemed evident that there was a gap in national leadership in terms of investing and experimenting in new models of care that could both address the resources versus demand issue, and improve care. The growing inequities in social care around paying for care and the cost of it, the level of choice and control available to users and the quality of services they receive, need to be dealt with urgently. Postcode lotteries and variations in waiting times and access to community-based care mean that very similar concerns can increasingly be levelled at the NHS too.

What next?

The Government has committed to a Green Paper in the summer of 2018 that aims to spark further debate around the long-term funding of social care. Many of the arguments on this issue have been well rehearsed (see, for example, Barker, 2014) but any attempt to raise public awareness is to be commended. As the 2017 General Election showed, there is still a great deal of confusion in the public's mind around accessing and paying for social care, and its relationship to the NHS.

The other important policy development that has an impact on these issues are sustainability and transformation partnerships (STPs). These 44 organisations/forums should encourage more strategic and inclusive planning between sectors. However, we know that to date there has not been a great deal, if any, engagement with the social care provider sector (this may be a consequence of the size of sustainability and transformation partnerships compared with the scale of most care providers and symptomatic of a lack of

relationships at the local level). Similarly, some local authority commissioners have reportedly felt sidelined in the processes involved (Alderwick and others, 2016) and much of the national guidance being produced at present focuses on integration and planning between NHS organisations as well as their performance management (NHS England, 2017c).

That is not to say that all is lost. Local authorities in North Central London Sustainability and Transformation Partnership, for example, are coming together to design a single discharge process for the area and to undertake recruitment planning across the patch. There are similar examples in other parts of the country. Both the Nottingham and Nottinghamshire Sustainability and Transformation Partnership and the Norfolk and Waveney Sustainability and Transformation Partnership are being led by local authorities.

Key recommendations for national policy-makers

Some of the key messages that local leaders directed towards national policy-makers during the course of this research are as follows.

- 1 **Move beyond a focus on delayed transfers of care.**
A focus on delayed transfers of care is not sufficient to address the wider issues facing health and social care. And requiring local areas to focus on this single issue may actually have a negative impact on local relationships.
- 2 **Consider small-scale as well as large-scale organisational change.**
Large-scale organisational change is not always necessary to bring about change. The national drive towards certain models of care and accountable care organisations will deliver successful outcomes in some areas but do not underestimate the potential of small-scale change in bringing about significant results in a faster and less resource-intensive way. No one size fits all and local areas will need to create their own solutions.
- 3 **Focus on increasing the health and social care workforce.**
The workforce is the health and social care sectors' greatest asset. Innovation and growth in these sectors is meaningless without a workforce

to deliver the changes. Enable providers to create a positive, learning environment for staff, where they feel respected and rewarded.

4 Understand the capacity of community-based services.

The strategies that the case study sites in this research are implementing are interconnected with the performance of local community-based services. A mapping of the capacity in these services is vital for an understanding of the pressures faced across the sectors. This is not to say that moving care into the community will always provide improved delivery and performance; there are multiple contextual factors that affect where and who is able to provide the most effective and efficient service for patients (Imison and others, 2017). However, if one part of the complex web of health and social care provision is under strain, a ripple effect will be felt throughout.

- 5 Make use of other sectors where possible.** A vibrant and diverse voluntary and community sector will support effective interfaces between hospitals and social care, and should be supported. Similarly, making the best use of Extra Care Housing and other such schemes will help enable people to live independently at home.

Key recommendations for local hospital leaders

While changes to national policy are particularly important to improving the relationship between health and social care, there are also things that organisations can do locally to facilitate greater collaboration.

These recommendations are drawn from the experience of the hospitals, integrated care organisations and local authorities we spoke to throughout the course of this research.

1 Think imaginatively about the workforce.

We have already set out the recruitment and retention challenges facing the social care sector, and the way national policy needs to change to help address them. But there are also things that local providers can do. We

heard many novel ideas, such as paying for travel, helping employees with hire cars, providing priority parking and subsidising accommodation (with advice from HMRC to avoid staff getting tax bills for accommodation). We also heard about providers rethinking recruitment boundaries: one area used French workers on a three-week rotation and another recruited British expats living in Spain to work as carers.

2 Do not make decisions about social care, without social care.

Hospitals that make decisions about providing or commissioning social care without consulting their local authority or social care providers may risk destabilising the social care market. For example, we heard about a hospital that increased the number of intermediate care beds it bought from local social care providers. The hospital paid social care providers a higher rate than normal in an effort to secure beds over those being placed by the local authority. It was a high-cost, short-term solution that ultimately failed – the ‘step-down’ beds purchased by the hospital became full of users waiting for ongoing local authority services, whose reduced capacity meant they were unable to meet demand. Delayed transfers of care in the hospital began to rise once again.

3 Think carefully about different types of integration.

This report has set out integration efforts at the organisational level, at the service level and at the patient level. Each has its own strengths and weaknesses. Organisational integration requires a lot of time and dedicated resources to create the necessary infrastructure – such as shared governance and accountability processes, new boards and budgetary arrangements, and a shared IT infrastructure across diverse providers. Evidence suggests that the effort this requires can offset measurable gains (see Curry and Ham, 2010). Progress towards integrated working on the ground can be made more quickly via service-level integration, where integrated teams are established for a particular purpose such as expediting discharge. But organisational integration can bring other benefits such as improving relationships across the organisation and helping all members of staff to understand the entire pathway. It also means that decisions can be made based on data from across the system. It is important to set out what it is hoped will be achieved from integration, and to consider whether targeted integration efforts could be used more effectively than wholesale organisational integration.

4 Consider pooling budgets to facilitate progress.

Most of our case studies benefited from a shared budget to initiate and sustain integration efforts. Some of this came from vanguard funding, but most of the sites also drew on the Better Care Fund. The first year of the Better Care Fund produced some notable successes. Around 90% of areas agreed or strongly agreed that the fund had a positive impact on the integration of health and social care and improved joint working in their area (National Audit Office, 2017). Around 76% felt that it had improved joined-up health and social care provision (National Audit Office, 2017). Stockport Together has pooled budgets across the system and has found that it has enabled it to take decisions based on what is best for the system as a whole rather than the component parts (see the case study on page 38). However, the Local Government Association's withdrawal of support for Better Care Fund guidance following announcements that the fund must be used to reduce delayed transfers of care, may mean that it is less effective in the future. Organisations may need to focus on pooling existing budgets to support their integration efforts.

5 Make sure that integrated teams have appropriate processes to support them.

Where integrated teams work effectively, they have appropriate processual and managerial support. Shared governance and accountability processes mean that everyone is working to the same set of standards. This is enhanced when integrated teams have one manager, responsible for managing the team as a whole, regardless of professional background. Where this is the case, it is important to ensure that employees also have a lead or mentor from their own professional background, who can offer support with professional development and answer professional queries particular to their role.

6 Make sure that commissioners are on board.

The collaboration and buy-in from all local commissioners and providers, including primary and community care, was a key factor in successful implementation for most of our case study sites. This has also been seen in other evaluations of large-scale transformation (Rosen and others, 2016; Wistow and others, 2015).

7 Collaborate with housing partners.

Estimates suggest that investing £1.6 billion annually in housing-related support services could generate net savings of £3.41 billion of public sector money – including £315.2 million in health service funding (Capp Gemini, 2008). Work is already happening at the national level to bring health, social care and housing together. The Healthy New Towns initiative has enabled 10 demonstrator sites to rethink the health of communities, and how health and social care can be delivered differently (NHS England, no date).

But there are also good examples of things happening locally. For example, a project set up in the North East of England between a housing association and a clinical commissioning group allowed people with respiratory diseases living in cold, damp homes to be ‘prescribed’ double glazing, a boiler and insulation. The ‘Boilers on Prescription’ project reported a 30% reduction in A&E attendances and a 60% reduction in the number of GP appointments needed by people taking part in the project (Burns and Coxon, 2016). This kind of initiative needs good joint working across primary, secondary and social care as well as clinical commissioning groups.

Appendix: Methods

To investigate the novel ways in which local areas are innovating to overcome prominent barriers to health and social care collaboration, the Nuffield Trust first undertook a survey of health system leaders to better understand their strategies for working with social care – strategies that they or their colleagues had used. We also held a workshop with health and social care commissioners and providers from across England to discuss local innovation, enablers and barriers. Using survey and workshop intelligence, as well as literature gathered on the health and social care divide (for example, Glendinning, 2003; Lewis, 2001), we mapped out the interfaces at which commissioners, hospitals and social care providers meet. We also mapped out the barriers preventing collaboration at each of these interfaces and the strategies being used to overcome them (see Figure 1 in Chapter 1). We focused specifically on how acute hospitals interact with social care providers, as well as clinical commissioning groups and local authority commissioners, to plan and deliver services for older people. We focused on this because the circumstances surrounding the admission of older people to hospital and their discharge from hospital are often an indication of pressures on the broader system, they have been areas of tension for decades and they have taken centre stage in current policy debate.

Our focus on hospitals and interventions targeted at older people meant excluding, for example, innovations in prevention or self-care schemes in general practice, services for people with learning disabilities or mental health problems, and an examination of the interdependencies between health and social care and housing or welfare and benefits. Also, we did not look at international examples. However, our focus on well-recognised health and social care interfaces allowed us to build on significant amounts of pre-existing knowledge, policy debate and practice experience.

We decided to focus on the following four interfaces:

- 1 the interface between social care providers and hospitals in relation to hospital entry pathways

- 2 the interface between hospitals and social care providers in relation to hospital discharge pathways
- 3 the interface between commissioners and social care providers
- 4 redefined interfaces: wholesale organisational integration.

We approached 18 local areas to act as case studies or contribute to this report. The local areas had either attended the workshop or were mentioned in the survey or workshop as having implemented a strategy to improve the hospital and social care interface. We asked them to describe their strategy, its progress on the ground, its intended and unintended consequences, and its impact. Ten areas agreed to take part. Others declined because they were too busy (four) or because their interventions had not yet sufficiently progressed (two) and two did not respond to the invitation. We used a sampling framework to guide our invitations to case studies from acute, community and social care. We also aimed to speak to representatives from both the health and social care sectors in each case study. This enabled us to present a more balanced view of the issues at stake, as the causes of barriers and challenges can be contested and perceived differently by stakeholders across sectors. To understand case studies' approaches, we undertook document reviews and telephone interviews, and in one case a day-long visit that included observation and face-to-face interviews. After the data had been collected and analysed, we held a second workshop with national representatives of care providers and policy-makers to understand their perspectives on national-level obstacles to overcoming barriers. We are grateful to all those who participated in these processes.

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