Integrated services for older people

Building a whole system approach in England
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Preface

This study looks at the way in which authorities, trusts and other organisations are working together, alongside older people, to promote integrated services in England.

It forms part of a programme of work on older people, which has focused so far on care services. Previous studies include *The Coming of Age*, which addressed the range of services for older people, *Forget Me Not*, which looked at services for older people with mental health problems and *The Way to Go Home*, which examined rehabilitation services (Refs. 1, 2 and 3). Two themes that ran through all of these studies were that:

- services for older people are not well co-ordinated; and
- preventative services, which aim to promote independence, are underdeveloped.

This study examines the first theme in more depth, while the Audit Commission’s next initiative will look in detail at services and interventions that help older people to live independent lives.

The study team would like to thank the many people from our study sites who generously gave their time and shared their experience with us. Thanks are also due to the participants in the advisory workshop and, in particular, to Jan Stevenson, Linda Spencer, Penny Banks, Helen Bowers, Dave Martin and Val Jones for their detailed comments on the text.

The study was carried out by Jane Carrier, with the invaluable assistance of Carole Garnett (on secondment from the National Audit Office). Other contributors were Ludmila Iyavoo (National Audit Office), Peter Scurfield and Tom Dixon. The study took place under the direction of David Browning.
Introduction

*Help us to stay in our own homes ... we live to be independent.*

*Older person, quoted in Ref. 4*

*There doesn’t seem to be any connection between government services... you are saying the same thing to them over and over again.*

*Older person, as above*

1. Services for older people must work together if they are to meet people’s needs and aspirations effectively. Many different agencies work with older people, including many non-specialist services, such as transport, education and housing, as well as services that provide care. All too often older people receive a disjointed, confused response when they need help or advice. Frequently the responses that they receive meet their needs only in part.

2. Consultation with older people highlights the fact that they would like public services to be more flexible, better co-ordinated and more focused on helping them to remain independent for as long as possible (Ref. 5). These aspirations will only be achieved if the full range of services that have a contribution to make work together in order to deliver better outcomes for older people. A whole system approach, which places the older person at the centre, will benefit older people by providing the right support, at the right time and by addressing the entire range of their needs. A whole system approach will also involve older people as partners – both as individuals who express their needs and help to define the outcomes they would like to see and as a group of citizens and users of public services who have a voice in the way that services are shaped and delivered. For those who provide services to older people, a whole system approach encourages better management of the system and clarifies the roles and responsibilities of each agency.

3. The following examples illustrate why older people need services to work together within a whole system approach. They show:
   - the complex needs that older people may have;
   - the help that they might need;
   - the range of organisations that may contribute towards providing help.
Scenario one

A couple in their 80s are struggling to continue living at home. The husband has chest problems and occasional incontinence. His wife is struggling to wash her husband’s sheets, as the boiler is not working properly. They have very little social contact with other people and are managing on a very low income [Exhibit 1A].

Exhibit 1A

The range of support that older people need

Older people may need to be in contact with a wide range of statutory and voluntary organisations in order to improve their health and quality of life.

Source: Audit Commission
Scenario two

An older woman in her 70s has a fall at home. Her husband has died recently, but she has had a great deal of support from her daughter, living nearby – albeit with small children and a full-time job. Although she has been fit and active until now, the fall has affected her confidence and she feels anxious about being at home alone in case she falls again [Exhibit 1B].

Exhibit 1B

The range of support that older people need

As well as dealing with crises it is important to provide services that smooth transitions and help to maintain independence.

Source: Audit Commission
These exhibits demonstrate that, for older people, it is important that a comprehensive range of services is in place. These services must be delivered across organisational boundaries, with clear assessment processes, access routes, pathways through services and mechanisms to guide older people through. In short, services must work together as a single integrated whole system.

The National Service Framework (NSF) for older people (Ref. 6) promotes this approach:

*Staff working in services for older people will be supported in their aim to deliver person-centred care across organisational boundaries by joined-up processes for commissioning and delivering older people’s services.*

**About this study**

Although the terminology of whole systems is now widely used, there is still confusion about how a whole system approach to older people’s services might operate, what benefits it might offer and how it might be developed locally. While there are no easy answers, this report offers advice on how to work towards a local whole system view of services for older people, drawing on the experiences of a number of areas across the country where progress is being made in some aspects of whole system working. We hope that it will be useful to all those who are seeking to improve the services that older people use. It is aimed, in particular, at those who are developing the range of services for older people at a local level.

This study builds on and develops a key theme from the Audit Commission’s previous work on older people: the importance of providing joined up, accessible services for older people.

- Chapter One sets the policy context and background to whole system working.
- Chapter Two describes the process adopted by our study sites to build a whole system perspective and to take action to implement it.
- Chapter Three highlights the elements needed to work as a whole system: a comprehensive range of services and a mechanism to guide older people through.
- Chapter Four outlines the underpinning factors and infrastructure, which enable a whole system approach to develop.
- Chapter Five suggests a number of steps to help to get the work started.

Our focus is on the spectrum of services that older people need. Within our study sites, we have explored the important contributions made by housing, the independent sector and the voluntary sector. We have also investigated the local government corporate agenda on older people as citizens. A small number of examples that relate to these issues are included in the text. However, the overwhelming majority of examples are drawn from the NHS/social care interface,
reflecting the current stage of development of older people’s services and also the effects of central government imperatives. Care services play a key role in the whole system of services that older people need, but they are only one part. Services that are flexible, well co-ordinated, rooted in the views of older people and with a strong focus on promoting independence remain, in most areas, an aspiration. However, our fieldwork highlighted how important it is to build on the useful work already started within care services. A more integrated response needs to draw in the wider local authority, as well as other players – most importantly, older people themselves. The Audit Commission is planning to continue this work. Publications planned for 2003 will look more broadly at services that promote independence.

The study has looked at the needs of all groups of older people, including older people from black and minority ethnic communities. Where we found examples of innovative whole system approaches to service delivery for black and minority ethnic elders, we have highlighted these in the text, although some of our study sites acknowledged that this was a priority area for further development.

The sites included in the study are listed in Appendix 1. All were able to show significant changes to the way that they deliver services for older people and all highlighted areas where much remained to be done. At this stage, it was too early for most to demonstrate that their initiatives were making an impact on the lives of older people, although some were beginning to make progress in this area. The focus of the study is therefore primarily on process, but where data on impact/outcome is available, it has been included. Our findings support the conclusions of other recent commentaries and studies on partnership, which also found that methods for assessing the impact of partnership working are underdeveloped (Refs. 7 and 8). However, we have engaged with older people at a number of our sites to explore their views of local services. Their comments provide additional support for better service integration.
Background and context

The need to work across organisational boundaries in order to deliver joined up services is a key theme of public policy. However, it is not always clear what this means in practice. A whole system approach benefits everyone, from older people to partner agencies and the staff who work within them.
This chapter describes the broader policy context within which developments in services for older people are taking place. It offers definitions of whole system thinking and demonstrates the benefits of this approach, both for older people and for the organisations and staff who work with them.

The policy perspective

Since 1997, the Government has stressed the need for organisations and government departments to co-operate more closely in the delivery of public services, placing the service user, or citizen, at the centre. This emphasis is reflected in the many multi-agency, cross-cutting structures which have emerged in the past few years, such as the various action zones, youth offending teams, drug action teams and the range of bodies addressing regeneration and urban renewal.

Authorities must also develop local strategic partnerships (LSPs), that provide a framework for policies that cut across their various responsibilities. These partnerships have an overarching responsibility for developing community strategies to promote economic, social and environmental well-being. LSPs also play a role in promoting an integrated approach to health, by overseeing the implementation of the NSFs.

The move towards joined-up working is particularly relevant to older people. The need to integrate services for older people became a Labour party manifesto commitment in 2001:

Pensioners... need simple, accessible services that treat them with dignity and promote independence. We will build on Care Direct to provide a better integration of health, housing, benefits and social care for older people. This will be an integrated ‘third age service’ to help older people and those who care for them.

The Department for Work and Pensions (DWP), the Department of Health (DoH) and the Office of the Deputy Prime Minister (ODPM) have been working together to explore how a single gateway can be developed into the range of local services that older people need, in order to streamline access.

The Better Government for Older People (BGOP) initiative is also taking forward the cross-government agenda for older people. BGOP aims to ‘improve public services for older people by better meeting their needs, listening to their views, and encouraging and recognizing their contribution’ (Ref. 5).

The NSF for older people also places a strong emphasis on the need to integrate care for older people through closer co-operation across boundaries and through the development of agreed pathways (Ref. 6). The NSF is underpinned by four guiding principles:

• respecting the individual;
• joining up care;
providing timely access to best specialist care; and
promoting healthy and active living.

Similarly, guidance on intermediate care and the DH’s review of progress, *Intermediate Care: Moving Forward*, emphasise the importance of integrating services to form a coherent whole system of care *(Refs. 9 and 10)*.

**What is whole system working?**

A number of concepts and terms, such as partnership, whole systems and working across boundaries are often used interchangeably to describe joined-up services. In fact, they all mean very different things to different people. In this document, we see partnership as an important part of a whole system approach. However, while whole system working always rests on a foundation of partnership, not all partnerships operate within the context of a whole system.

We brought together a group of key people from our study sites and other external advisors to the project *(Appendix 2)* and asked them to identify the most important characteristics of whole system working *[Box A]*.

This method of working requires everyone to agree on the direction and approach. They must then act flexibly to deliver it. This approach does not lend itself to rigid central planning. Senior staff and politicians must endorse the broad vision, which must have been developed in partnership with older people. Service providers and practitioners from all organisations must then adjust and adapt the way that they work in order to translate this vision into actions that support the needs and wishes of individual older people.

This approach to thinking about services builds on work by commentators, such as Peter Senge, who have applied systems thinking to organisations:

*Systems thinking is a discipline for seeing the whole. It is a framework for seeing inter-relationships rather than things, for seeing patterns of change rather than snapshots* *(Ref. 11)*.

This new emphasis on the connections between things is particularly relevant for older people’s services, in which difficulties frequently occur at the interfaces between services. Foote and Pisek, who are commentators on systems thinking and care services, note that delivering seamless services demands a management focus on the spaces between services, not just on the services themselves *(Ref. 12)*.

Thinking on complex adaptive systems also provides a useful framework for considering services for older people:

*A complex adaptive system is a collection of individuals (or organisations) with freedom to act in ways that are not always totally predictable and whose actions are*
interconnected, so that the actions of one will change the context within which others operate – examples are the immune system, a colony of termites, the financial markets and just about any collection of human beings (Ref. 13).

This suggests that complex systems are inherently unpredictable, so detailed planning and performance management may not be the best route to take when trying to improve services. Minimum specifications, or simple rules that determine the broad direction of travel, are more likely to engage creativity and encourage change. An example of a minimum specification for older people’s services is given below [Box B].

**Box B**

**Minimum specification for system for older people**

- **User focus** – base the system on a knowledge of older peoples’, carers’ and the community's needs, values and definition of quality of life
- **Networks of care** – Build networks that allow people from different agencies and backgrounds to learn together, that place more emphasis on what people need than on organisational boundaries
- **Easy access** – Make access to care easy, through one point, always available, rapid and responsive
- **Effective assessment** – focus on rapid, effective, shared, detailed assessment systems that mobilise needed services
- **Avoiding personal crisis** – Practice prevention and education to intervene and help early and avoid crisis
- **Easy information flow** – Make information flow so that when someone knows about the older person, everyone in the system knows (within constraints of confidentiality)
- **Blurred boundaries** – Find ways to share budgets and resources to blur organisational boundaries
- **Continued feedback** – Build in evaluation and feedback loops, be flexible, and continually review the whole system

**Source:** The Great Missenden Group (work group on the elderly people’s integrated care system (EPICS)) November 1998 (Quoted in Ref. 12)

**What does this mean in practice?**

The chapters that follow give many practical examples of whole system working in relation to services for older people. They show that adopting a whole system approach brings benefits, but that it also requires different ways of thinking and behaving, at both strategic and operational levels.

At a strategic level, for senior managers, it means:

- engaging with older people as citizens and users of public services to enable them to help shape local services;
having a strategic vision that is shared with others; and
having a broader view of all the services and interventions that older people need to access, where these are available and how they fit together.

For frontline staff it means:
• working with individual older people to identify the whole range of their needs;
• knowing what else is available in the system and who else can help;
• working alongside other professional groups; and
• taking responsibility for bringing in the right care or service, when it is needed.

Whole system working does not mean that, on a strategic level, everyone needs to be involved in making each decision. Neither does it mean that frontline staff should take on tasks that they are not confident or trained to do. It should, however, mean that everyone is clear about the strategic vision, about their own contribution towards achieving this and about who else can help.

Why is it important?

Older people’s needs are complex. An older person may need support and information from a range of different agencies at any one time and their needs may change and fluctuate from day to day. They are likely to need services that help them to play an active role in community life, such as transport or leisure opportunities. But there will also be times when older people will need care from the NHS or from social services. With so many players involved, it is all too easy for services to suffer from fragmentation, duplication and a lack of direction and co-ordination.

In addition, older people are likely to struggle to get the services that they need when information is poor – particularly when it is unclear how they access services, what the different organisations do and how they relate to each other. A whole system approach must therefore remove barriers to access and tackle the discriminatory effects of cumbersome, complicated patterns of service provision. This will contribute towards achieving the first of the NSF’s eight standards, which aims to root out age discrimination. It will also benefit groups facing additional problems, such as black and minority ethnic elders.

Although whole system working lies at the heart of policy on older people and offers considerable benefits for older people, not all of the players in the system are convinced of the need for change. Some may believe that they are already working in this way, but in fact, they may only have considered one small part of the system rather than the wide range of agencies and services that need to be included. Those who are responsible for the development of older people’s services must make the case for whole system working at all levels of partner organisations, as well as across the whole system. Different organisations and professional groups are likely to see different benefits. Local factors also play their part. The list below describes some of these benefits [Exhibit 2]. While it is not comprehensive, it acts as a starting point for local discussion.
Exhibit 2

The benefits of whole system working

Working as a whole system brings benefits for all groups and organisations.

<table>
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<th>Older people benefit by:</th>
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<td>• having all of their needs considered, not just health and social care needs in isolation;</td>
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<td>• having their aspirations, priorities and hopes taken into account;</td>
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<td>• having choice and control;</td>
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<td>• having information about what is available;</td>
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<td>• remaining integrated in the community;</td>
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<td>• avoiding repetition and frustration;</td>
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<tr>
<td>• being offered simpler and faster access to services; and</td>
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<tr>
<td>• being a partner in the whole system.</td>
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All organisations providing services to older people benefit by:

• gaining a greater sense of control through a more managed system, with fewer crises and greater control over resources;
• allowing each organisation to play to its strengths;
• rebalancing and redesigning the system to place more emphasis on preventative services;
• sharing risk with others;
• improving information sharing; and |
• using resources better.

<table>
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<th>All staff benefit by:</th>
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<td>• having a clearer sense of their role and how it fits into the bigger picture;</td>
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<tr>
<td>• supporting people to be safe and well at home, rather than in hospital, nursing or residential care;</td>
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<tr>
<td>• knowing who else can help;</td>
</tr>
<tr>
<td>• delivering better care; and</td>
</tr>
<tr>
<td>• achieving greater job satisfaction.</td>
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Social services departments benefit because they can:

• achieve a better balance between care at home and residential placements;
• avoid a culture of blame and financial penalties for delayed transfers;
• get better recognition and appreciation of the department; and |
• make better use of resources and so achieve better outcomes.

Social services practitioners benefit because they can:

• shift towards helping people to live independently rather than responding to crisis; and |
• are able to work in a person centred way.

Primary care trusts benefit because they can:

• establish a greater role for primary care in keeping people at home;
• develop the commissioning role in a proactive way by commissioning for change; and |
• establish the new organisation as a key player, respected by partners.

Primary care practitioners, including GPs and other staff groups benefit because they can:

• work proactively and constructively with older people; |
• share responsibility with others; |
• manage workload; |
• make appropriate referrals; |
• spend more time preventing older people from becoming ill, rather than responding to crisis; and |
• enhance the role of general practice.

Hospitals benefit because they can:

• achieve sustainable solutions to pressures on the hospital, particularly on A&E; |
• contribute towards meeting targets on waiting lists, trolley waits and delayed transfers; |
• reduce avoidable admissions; |
• move towards a more managed acute service by shifting the balance between emergency and planned work; |
• focus on what hospitals do best; and |
• dilute the media focus on the hospital through a joint approach.

Hospital staff, including geriatricians, nurses and other staff benefit because they can:

• reduce pressure from emergencies; |
• strengthen links with community based services; and |
• move older people out of hospital more quickly and more appropriately.

Source: Audit Commission
Developing a whole system perspective

There are a number of steps that need to be taken to build a whole system approach, including developing a shared vision, mapping services and the experiences of older people as they move through them and redesigning services to streamline access or reduce duplication.
We asked all of our study sites to describe how they had worked together to develop a whole system approach over time. The paths that they described all had a distinctive local flavour, but the process had a number of common steps. These are outlined below.

**Preparing the ground**

*Putting in the time to develop relationships and communicate with people [was important] – without that, you don’t have the canvas on which to weave your tapestry.*

Joint NHS/SSD development officer

*We came to an understanding that you couldn’t solve this without looking at the whole piece.*

SSD senior officer

Most of our study sites reported that their whole system perspective rested on several years of close joint working. Often this was the result of a crisis, typically an increase in delayed transfers at the local hospital over the winter period. While such crises had initially, in some cases, provoked recriminations and blame, key people in the partner agencies recognised that resolving the problems required a broad-based approach that involved them all. Working together on these difficulties provided a solid foundation for the development of a shared, longer-term view of how best to improve services for older people. In all cases, the approach was evolutionary and ideas about working as a whole system had emerged over time.

In other sites, where no crisis had triggered action, they still emphasised the importance of investing time to build good relationships and open communication between key staff in order to improve understanding of each others’ roles and drivers. This is the first step towards developing a whole system approach.

It is significant that a number of our sites were Health Action Zones. This meant that they had a history of working in a joined up way, with well established structures for developing strategy across boundaries and that they also had, in some cases, increased access to resources.

**Building a strategic vision**

*Keep focusing tenaciously on the vision of improved outcomes for older people – the complexity of the whole system is not an issue as long as the direction is clear and well understood by everyone. The shared vision is an anchor.*

LA project officer

The NSF sets a clear direction for older people’s care services, with specific milestones and targets, but care communities still need to shape their response in order to suit their local needs and priorities.
All of our study sites emphasised the importance of rooting local strategy in the views expressed by older people and frontline staff. This gives wider credibility to the vision and makes sustainable change more likely. Most of the sites engaged with older people at an early stage, typically in the mid-1990s, and the views expressed have set the direction for local developments. The sites have all carried out large scale events, drawing together a wide range of older people, as well as staff. Many have engaged with local organisations and networks to reach out to older people who have been frequently excluded from consultation processes, such as very frail older people and black and minority ethnic elders. The central role of older people as key partners was a defining characteristic of the study sites that had achieved most in developing an integrated approach.

The experience of the study sites also showed that simplicity of message is essential when building a shared whole system vision. There were a number of sites in which the strength of the shared vision was clear. This clarity was demonstrated by the fact that all our interviewees described the local direction and aspirations for older people’s services in the same brief, clear terms. These may not have been recorded in formal planning documents, but had emerged over time and had been communicated up, down and across the system until they became the foundation of local activity. Complex systems are driven by a shared purpose (Ref. 15) so clarity and brevity of the statement of purpose is essential [Case studies 1 and 2].

Case study 1
Developing strategy in Camden
Camden’s Vulnerable Older People’s project emerged from the public response to a lonely death in 1994. An older woman, who had refused offers of services, had died at home and remained undiscovered for some time. The shocked reaction of councillors, staff and the public acted as a catalyst for action. When the Chair of Social Services called a public meeting to explore how to minimise the risk of such a death in the future, over 100 older people attended. The Vulnerable Older People’s Project was a direct response to the views expressed by older people at the public meeting. Among other things, the project established a network of new schemes to contact and support older people at home. Existing services placed more emphasis on identifying older people who might be vulnerable but who were not receiving support. A communications programme emphasised to staff in all departments the need to be alert for signs that an older person might need help. The programme drew together the Social Services and Housing Departments, the NHS and voluntary organisations. Older people played a key role on the steering group. The involvement of older people from such an early stage has had a significant impact on local strategy and priorities in Camden. The care community has adopted a strong, whole system approach to promoting independence, and has produced a Quality of Life Strategy for Older People. The local authority has been awarded Beacon status in recognition of its leadership of this work. It is estimated that 4,000 additional older people are in touch with services as a result of the Vulnerable Older People’s Project.

Source: Audit Commission
Case study 2
Developing strategy in Leeds
In Leeds, once the care community had agreed to tackle the imbalances in local services using a whole system approach, a stakeholder event was held to explore the priorities for change. Over 100 people attended, including older people, carers and the voluntary sector. A number of key priorities emerged. These became the foundation of a shared commissioning framework across the former Health Authority and the Social Services Department. The strategic direction set by the framework was widely accepted because it reflected the views of older people. Priorities identified by the stakeholder event included increasing interventions that promote independence and reduce hospital admission, delivering services locally and offering greater choice to older people. These principles continue to underpin the local approach and direction.

Source: Audit Commission

Mapping services across the system
An important early step in understanding the local system and in improving the way that it operates is to map existing services, referral patterns and routes, the pathways that older people take between them and the experiences of older people themselves. This highlights any bottlenecks in the system, as well as any duplication or gaps in services. It can take place on two levels:

- system level (creating a map of the services available and the flow between them) [Case study 3]; and
- individual level (following the experiences of individual older people as a way of highlighting local issues) [Case study 4, overleaf].

Case study 3
Service mapping in Leeds
Whole system working in Leeds started with a service and resource mapping exercise, commissioned jointly by the Social Services Department and the Health Authority in 1996. The mapping took place against a background of rising pressures on the hospital. It showed that there was a mismatch between older people’s needs and the services that were available. Although there was a great deal of capacity, resources were of the wrong kind and they were not located where they were needed, with a bias towards acute services and gaps in community provision. This clear picture of the problems acted as a starting point for the development of a long-term modernisation strategy that aimed to rebalance services in the city. Shortly afterwards, when funding was made available for older people’s services, Leeds was able to make a rapid start on developing community services because the mapping process had already highlighted what needed to be done.

Source: Audit Commission
Case study 4

Older peoples’ collaborative programmes

The care communities that are participating in the two collaborative programmes in London and Trent have all mapped local services as a first step towards identifying opportunities for streamlining provision. In Brent, for example, the project manager worked closely with an older person to analyse in detail the route that she had taken through services. This highlighted duplication, delays and the older person’s feelings of loss of control and lack of choice. These experiences were developed into a storyboard which has been used locally as a tool to enable professionals to rethink the way that they deliver care. Resulting service improvements have included a reduction in the time that it takes for discharge information to reach GPs from the hospital from an average of nine days in October 2001 to under two days in December 2001. The care community is aiming for same day receipt, which would ensure that support from GPs is available to all older people as soon as they return home.

Source: Audit Commission

Case study 5

Redesigning services in Leeds

In 1997, both the NHS and the social services department agreed to organise services in Leeds through the same coterminous localities, which are now the boundaries for the city’s five PCTs. The City Council is also planning to set up a neighbourhood committee structure in line with these boundaries. Joint care management teams and intermediate care teams were later established to provide an integrated, local range of services for older people in each PCT area.

Source: Audit Commission

Case study 6

Locality networks in Camden

Staff in Camden are exploring integrated models for delivering services for older people through locality networks, based in and operating from primary care premises. Each locality team will include community nurses, social workers, and specialist advice workers, and will be managed by a locality manager.

Source: Audit Commission

Redesigning services

Service mapping can highlight issues that demand a radical response at either a strategic or operational level, by creating integrated services to reduce duplication, for example.

The development of primary care trusts (PCTs), particularly where these are coterminous with social services departments, offers enormous scope to redesign services across agency boundaries to deliver integrated care locally. In a number of our study sites, PCTs and social services departments saw themselves as natural allies with similar values, in particular promoting independence and delivering person centred care. They were developing an increasingly integrated approach to both the commissioning and the provision of services.

To date, efforts have concentrated on redesigning health services, but many examples now exist of initiatives that cross organisational boundaries. Some of the study sites were carrying out large scale redesign processes, which aim to rebalance local services in order to deliver what older people say they want, to reduce duplication or to simplify access arrangements [Case studies 5 and 6]. Similarly, the collaboratives on older people’s services are redesigning services at an operational level in order to streamline services to improve the experience of older people.
Pathways and journeys – putting the older person at the centre

A whole system contains a comprehensive range of services, including services which enable older people to live independent lives. It also requires a way of co-ordinating the services older people need and guiding them through the system.
A successful whole system of care, in which services are organised around the older
person, requires three key elements:

• a shared vision, which is rooted in the views of older people, as described in the
previous chapter;
• a comprehensive range of services, including prevention services, which are
delivered by flexible, multi-professional teams; and
• a way of guiding/accompanying older people through the system to make sure
that they receive what they need, when they need it.

This chapter focuses on the second and third elements.

The whole system will only operate smoothly if it contains both an appropriate local
balance of services and clear processes for getting into and moving around these
services. Symptoms such as high levels of emergency admissions, delayed transfers
of care and high use of residential and nursing home care all indicate that this balance
and these processes are absent.

Evidence from our study sites and elsewhere suggests that the strong national
emphasis on reducing delayed transfers of care has meant that enormous attention
and resources have been focused on getting people out of hospital, often at the
expense of more preventative activities that help older people to live independent
lives. We saw a number of examples of teams that had been established with a dual
goal of preventing avoidable hospital admissions and tackling delayed transfers, but
who were working almost exclusively on moving older people out of hospital. As
noted earlier, older people value services that help them to live independently
(Ref. 4).

This requires a comprehensive range of services.

A comprehensive range of services

*We’re investing money in a continuum of services, not in projects.*

*Director of Social Services*

Rebalancing or redesigning the system is likely to involve a wide range of services and
require action at every stage. As these actions are taken, they not only provide
immediate improvements, but also other benefits, sometimes unforeseen, at other
points in the system as they build a ‘virtuous circle’ of improvement. The
co-ordinated range of services that older people are likely to need is presented below
[Exhibit 3]. The inter-relationship between the different elements is key, as action in
one part of the circle can have an impact at a different point.

The elements of the virtuous circle are endorsed by government policy. Standard 8 of
the NSF (Ref. 6) relates to the promotion of health and active life in older age and aims
to keep older people well and able to live independent lives. Some areas are using this
standard as a vehicle for a wider strategic approach to promoting independence.
Exhibit 3
A ‘virtuous circle of services’
A balanced whole system needs to deliver a full range of services.

The next stages of the virtuous circle, fall within the definition of intermediate care, as contained within DH guidance. While this study does not aim to address intermediate care in detail, as it forms only one part of the whole system of services for older people, we highlight below examples of integration across and within intermediate care services. For a comprehensive overview of how to plan, deliver and evaluate intermediate care services see Planning and Developing Intermediate Care for Older People (Ref. 16). The DH’s review of intermediate care services (Ref. 10) contains a number of examples of innovative practice. The illustrations that follow are drawn from these, as well as from our study sites.
Staying well at home

We need to be obsessed with the health of the 86.6 per cent of older people who don’t use care services, but we’re obsessed with the 13.4 per cent who do.

Lead officer – LA corporate programme

Interviewer: What’s the most important thing the [chronic obstructive pulmonary disease] team have done for you?
Older man: Being with you, being there...

An enormous range of activities, interventions and services help to promote independence and prevent or delay ill health and frailty among older people. When asked about what most affects their quality of life, older people frequently mention their immediate environment or their ability to travel easily, rather than the availability or quality of care services. A recent exercise to gather older people’s views on neighbourhood renewal, carried out for the Audit Commission by Age Concern, highlighted that issues such as transport, community safety and housing repairs were of most concern. Many also identified the importance of neighbourliness and community spirit and saw themselves as having a key role in fostering and maintaining this.

The range of activities that aim to reduce or delay older people’s loss of independence includes:

- provision of support and activities in the community that keep older people fit, healthy and able to participate [Case studies 7 and 8];
- identification of older people who are at risk of becoming more dependent (case finding) [Case study 9]; and
- provision of proactive, ongoing support that enables older people to remain at home (case management/chronic disease management) [Case study 10].

Case study 7
Well and Wise – Camden

Camden’s Well and Wise programme is a healthy living network involving 14 partners from across the Local Authority, NHS and voluntary sector, including the umbrella body for the voluntary sector, a minority ethnic elders’ organisation, the acute trust, the former PCGs and the Citizen’s Advice Bureau. Funding is provided by the local authority and the New Opportunities Fund. The network is led by Age Concern Camden and focuses on widening access to opportunities that promote healthy living. The programme recruits older people as volunteers to raise awareness of the activities that are available in the borough and to expand the range of activities available. Their role will include taking classes out into older people’s homes.

Source: Audit Commission
Case study 8
Neighbourhood community care organisations in Leeds

In Leeds, the local authority invested £1 million in 1993/94 in supporting 35 neighbourhood community care organisations across the city. They are geographically based, locally owned and cover most of the city. Their roles vary, but all are involved in identifying and supporting vulnerable older people in the community, with a strong focus on social inclusion. They offer activities that older people themselves identify as having the greatest impact on their quality of life. Some activities are jointly provided with black elders’ groups. All the groups are able to present examples that demonstrate how their work has transformed the lives of vulnerable, isolated older people. The organisations depend on volunteers, many of whom are themselves older people. In total, the schemes have 900 volunteers and are in contact with 18,500 older people.

Source: Audit Commission

Case Study 9
Case Finding: Keep Well at Home – Hammersmith & Fulham

It’s nice to know I’m not forgotten
(Older person in contact with Keep Well at Home)

Keep Well at Home (KWAH) aims to identify potentially vulnerable older people in the community and to monitor their health and risk status. The initiative is based within the social services department and is staffed by a co-ordinator, two assessment nurses, an occupational therapist, a handyman and administrative support. The steering group includes all partner agencies, including older people representing BGOP.

All over-75s who are on GP lists receive initial screening, using a validated postal questionnaire. Those who are assessed as being ‘at risk’, including all non-responders, are then offered an assessment, which is carried out using the EasyCare assessment tool.

KWAH makes sure that older people have the services that they need to continue living independently at home. This can include helping with benefits claims, arranging repairs or adaptations in the home, promoting healthy, active lifestyles and encouraging people to be more proactive in accessing the services that are available, as they are needed. Many older people have been identified through the project who were not previously in contact with services and many previously unrecognised problems have been addressed.

KWAH was initially set up as a pilot project, but it has now been extended to cover 20 practices, which represent half of the borough’s population of over-75 year olds.

Source: Audit Commission
Case Study 10
Case Management: Halton PCT

A GP practice in Runcorn, Cheshire has piloted a joint case management approach with the Social Services Department to reduce admissions and length of stay among older people. Targeted case management, proactive discharge planning and close working between a practice-based social worker and a nominated district nurse were the key elements. The project targeted older people who were at high risk of hospital admission, or who were already making heavy use of services. The project therefore focused on people over 65, who met at least three of the following criteria:

- four or more active chronic diagnoses;
- four or more medications, prescribed for six months or more;
- two or more hospitalisations, not necessarily as an emergency, in the past twelve months;
- two or more accident and emergency attendances in the past twelve months;
- significant impairment in one or more major activity of daily living;
- significant impairment in one or more of the instrumental activities of living, particularly where there are no support systems in place;
- older people in the top 3 per cent of frequent visitors to the practice;
- older people who have had two or more outpatient appointments;
- older people whose total stay in hospital exceeded four weeks in a year;
- older people whose social work contact exceeded four assessment visits in each three-month period; or
- older people whose pharmacy bill exceeded £100 per month.

Older people meeting the criteria were contacted by the care management nurse for assessment and follow-up, which could include health education, practical advice or referral to other services, many of which were low level community-based support services provided by voluntary organisations. The assessment focused on the older person’s views about the way in which they would like to see their life improve and on setting goals for change.

The results of the pilot were impressive:

- the number of admissions among older people at the practice fell by 15 per cent;
- average length of stay fell by 31 per cent (from 6.2 days to 4.3 days); and
- total hospital bed days used by this group fell by 41 per cent.

In addition, links between practice staff and other agencies in the community were improved, leading to a range of benefits for older people. These included more appropriate referrals to other services and much faster response times for social services assessments.
On the basis of the results of the pilot, case management is being rolled out across the PCT and part-time care managers for older people are to be located in every practice in the PCT.

Source: Audit Commission

Responding to crises

Following the publication of the intermediate care guidance, all care communities are required to provide a service that responds to crises. This can be located in the community, or in some cases, in A&E. Many intermediate care teams offer both crisis response and discharge support to older people [Case study 11].

Case study 11

Intermediate care in Portsmouth

Portsmouth’s Rapid Response Team (RRT) operates seven days per week and offers up to fourteen days of care to older people who are referred from GPs, district nursing or social services. The team is made up of four nurses and five generic home care support workers. The team works very closely with Portsmouth’s Community Rehab Team (CRT), which is based in social services. If the older person needs continued support after fourteen days, the CRT will take over, providing six to eight weeks of care per discipline (different disciplines may work sequentially with the older person, so their total time in the service may be more than six to eight weeks). The CRT is made up of seventeen NHS and social care staff, including four support workers who rotate through the team from the home care service. This has offered a useful way of influencing the culture and approach in the mainstream home care service. Case management of RRT patients is carried out by CRT social workers. The two teams also liaise to identify people who have been referred to both and decide between them which service is more appropriate.

Source: Audit Commission

Assessing the range of needs

Assessment forms a central plank of the NSF for older people. It needs to take place at key points in older people’s journey through services. For example, if older people arrive at accident and emergency departments following a crisis, it is important that the opportunity is taken to look at the range of their needs and not exclusively their medical condition. Some hospitals have developed assessment units that are developing specialist expertise in rapidly assessing need and in returning older people home quickly with the support that they need to remain in the community. Geriatricians have a key role to play in this process.
Planning to go home

A proactive, integrated approach to hospital discharge can reduce delayed transfers of care and ensure that older people are able to move as quickly as possible to an environment that is appropriate to their needs [Case studies 12 and 13].

Case study 12
Discharge planning at St Mary's Hospital, Paddington

Discharge planning at St Mary's Hospital, Paddington has made a demonstrable impact on delayed transfers, reducing levels of delay from about 50-60 per week to about 10-15. Very few delays now relate to older people. They have adopted an integrated team approach, empowering ward staff and changing culture, particularly among clinicians.

Source: Audit Commission

Case study 13
Trent older people’s collaborative

The former Trent NHS Regional Office Older People’s Collaborative focused on discharge planning. Participating care communities piloted a range of innovative multi-agency approaches to streamlining the process.

Source: Audit Commission

Preparing to go home

A range of services now exist in all care communities that act as a bridge between hospital and home. Initially the funding streams for intermediate care, which were often non-recurrent, short term and attached to winter pressures, encouraged a piecemeal approach, with a proliferation of projects and teams. However, with the appointment of intermediate care co-ordinators, many care communities are now developing a more strategic approach by integrating existing services into a coherent whole and ensuring that intermediate care services are well linked into the wider care system [Case studies 14 and 15].

Case study 14
Hartlepool Multi Link Team

Hartlepool Multi Link Team is a multi-disciplinary, multi-agency initiative to bring together a range of intermediate care services, including separate NHS and social services rapid response teams, a rehabilitation team, rehabilitation unit, discharge liaison service and Red Cross Home from Hospital service. Evaluation by professionals and users highlighted fragmentation and duplication, so the services were integrated into a whole system approach, which offers seamless and user-centred care.

Source: Department of Health
Case study 15
Intermediate care in Camden
Camden has established an integrated, PCT-based team, which brings together rehab services and the hospital social work team. The team includes 15 hospital-based therapists, who have transferred into the team. The team will work in a range of settings, including day centres and resource centres, as well as in older people’s own homes.

Source: Audit Commission

Going home

Many areas offer some form of support in the community to ease the transition between hospital or intermediate care service and home. Some are also establishing services to return older people in residential care to independent living [Case studies 16 and 17].

Case study 16
Rehabilitation flat – Portsmouth
Portsmouth offers a service to return older people who are in residential care back to the community. They offer a rehabilitation flat in a sheltered housing development, which can be used as a transition between residential care and a home of their own. There are plans to provide a ‘show flat’ which will be available for older people in residential and nursing homes to visit, to give them a sense of what they might expect if they moved out of institutional care.

Source: Audit Commission

Case study 17
Anchor Staying Put – Sefton
In Sefton, Anchor Staying Put is involved in a hospital discharge project, in partnership with Care and Repair, the social services department and the acute trust. This speeds up transfers by installing minor adaptations in the home, as well as carrying out a benefits check and exploring other possible needs. Over 1000 older people have benefited from the scheme to date. A parallel project, the Healthy Homes Initiative, provides a similar service to people moving out of intermediate care services.

Source: Anchor Trust
Guiding older people through the system

A comprehensive range of services is clearly essential to the provision of integrated care for older people, but on its own it is not enough. Although individual services may provide excellent care, older people still experience difficulties getting access to services or moving between them. Exhibit 3 shows that it is important that a key person has lead responsibility for accompanying the older person on their journey through services [Exhibit 4].

Exhibit 4
Guiding people through the system
A comprehensive range of services is not enough.

Source: Audit Commission
Many of the care communities we visited had recognised this problem and introduced various ways of tackling it. Although the models differ, all are based on a lead person who is responsible for co-ordinating the older person’s care, for accompanying them through the system and who:

- is based in the community, but retains contact with the older person if they need to go into hospital;
- can operate across organisational boundaries, bringing in services from the NHS, local authorities and the voluntary sector, according to the older person’s needs;
- has a proactive focus on keeping older people well and at home;
- manages pathways of care;
- has access to resources, often pooled budgets; and
- works in a defined locality and has excellent networks and knowledge of what is available in that area [Case studies 18 and 19].

We found a number of examples of proactive management of older people’s pathways of care. Older people need varying levels of support at different times, so it is important to develop a local strategy for identifying and prioritising those people who may benefit most from a more intensive approach. Both examples in case studies 9 and 10 use evidence-based methods for identifying vulnerable, or potentially vulnerable, older people in the community which may offer a framework for prioritisation. A robust approach to case finding, that includes triggers at critical points so that any problems are picked up and dealt with quickly, combined with intensive case management for the relatively small numbers of older people who require this, may be the most effective strategy.

For some older people, direct payments, which have not been widely taken up by older people, offer a route for them to act as co-ordinators of their own care. However, it is not yet clear what support older people require in order to use direct payments successfully.

The overview and co-ordination function is also close to the operational intermediate care co-ordinator role, which is responsible for, among other areas:

- making sure that clients enter services at the most appropriate point on agreed care pathway, with a named case manager and individual care plan and review date, building on local care management arrangements (Ref. 17).
Building the infrastructure

A number of factors will help communities to make good progress when trying to develop a whole system approach. Good leadership, a flexible organisational culture and shared information, for example, will all have a positive impact.
The previous two chapters have demonstrated that it is important to build a shared understanding of how the whole system operates and also to ensure that all of the key elements are in place. However, it was clear that for our study sites, whole system working was the product of local circumstances and external factors, combined with a number of internal factors specific to the way that those care communities work. We explored with the study sites their views about the factors that had allowed them to make progress in whole system working. From these discussions, we have built up a picture of the common factors required.

**Leadership**

_I say to the staff, ‘Forget who you are employed by, we’re putting the patient at the centre.’_

Joint NHS/SSD development officer

All of our study sites to date have emphasised the importance of leadership, at a senior level, in developing a whole system approach to older people’s services. From this, a series of whole system leadership competencies, or behaviours, are beginning to emerge. While some of these are generic, applying to leaders of any organisation, some are specific to the whole system context. Leadership behaviours identified by our study sites include:

- modelling and acting as a champion for partnership behaviour, so that working across boundaries is seen as normal behaviour;
- developing healthy relationships with peers across the system to build a leadership team;
- taking joint responsibility, with other members of the leadership team across the whole system, for delivering improved services and holding each other to account for inaction or failure;
- supporting actions that benefit older people and the system as a whole, even if these are not the most favourable for their own organisation;
- creating an organisational culture in which whole system working can flourish (see below);
- identifying ‘win/win’ solutions to shared difficulties, where possible;
- managing the political context (for example, by addressing the concerns of elected members);
- agreeing and communicating consistent messages about the system’s values, vision and priorities, in particular by placing older people at the centre;
- valuing staff who work in a whole system way;
- supporting innovation, celebrating success and learning from failure; and
- sharing financial risk.
However, it is not just at the most senior level that leadership is important. Middle managers and team leaders also have a key role to play in mirroring the leadership behaviours listed above, to ensure that consistent values, messages and approaches are cascaded throughout the system [Case study 20].

Organisational Culture

People constantly have the attitude, ‘Why not…?’

HA senior officer

We don’t allow who should pay to get in the way of delivering care – there’s no value in not being flexible.

Joint PCT/SSD finance officer

Closely linked to the issue of leadership is organisational culture. Staff at all levels in the study sites have identified a number of factors that have allowed them to develop a whole system approach to older people’s services. These include:

- a genuine commitment to place the older person at the centre of all that they do;
- what many people have described as a ‘can do’ approach;
- willingness to take risks (within sensible boundaries);
- a flexible, pragmatic working style;
- openness to new ideas and ability to customise to meet local needs; and
- entrepreneurialism – the ability to take advantage of any new source of funding to support local priorities [Case studies 21 and 22].

Case study 20

New Partnerships, New Leaders programme – London

As part of its Older People’s Development Programme, the London Directorate of Health and Social Care (formerly London NHS Region) is working with the King’s Fund to deliver a leadership development programme for future whole system leaders, New Partnerships, New Leaders. Most participants are currently in middle management roles. The programme includes a strong focus on developing the skills required to operate effectively in a whole system, such as influencing across organisational boundaries. It includes a number of taught modules and learning sets. The programme has been accredited by Middlesex University as part of its work-based learning programmes.

Source: Audit Commission

Case study 21

Organisational culture in Camden

Camden has become successful at winning awards, such as the Beacon award, at raising money and at maintaining a high profile. This has in turn created a ‘virtuous circle’ of momentum and raised expectations among staff, elected members and service users that services will continue to develop and improve.

Source: Audit Commission

Case study 22

Organisational culture in Portsmouth

In Portsmouth, the SSD and PCT described their approach, which had developed over time between four or five key players who had worked in the area, in different roles, for some time. All shared a practical, problem solving focus. If funds were available, they would test out new ways of working, often based on experience from elsewhere. All the partner agencies tended to consider each others’ needs and would take a flexible approach to considering what might be achieved now to improve services for older people with the resources they jointly had available.

Source: Audit Commission
Case study 23

IT demonstrator project – Leeds

Leeds is running a demonstrator project on behalf of the Department of Health, which aims to link the intermediate care team, joint care management team, independent sector nursing home and a GP practice in the west of the city via an internet connection, so that all staff can access and contribute to a single record. The project uses different levels of access for different groups of staff. GPs, for example, can only access records on their own patients, while staff at the independent sector home can view, but not add to records.

Source: Audit Commission

Information

Who has the problem sharing information? We don’t!

Older person, Cambridgeshire

There has been a sea change in the past couple of years, with people welcoming IT solutions. It’s important to reassure people that data won’t be used to punish them.

LA IT manager

Whole system working requires information to flow easily between organisations and professionals. Information sharing is required at the level of the individual older person, when different agencies and teams who are involved in their care need to have mechanisms in place to access information on progress. At a management level, it is also important to share information on trends and service use by the local population in order to inform whole system planning and service development.

Developing integrated care is hampered by IT systems that fail to connect. While it is clearly a long-term aspiration to integrate systems across organisational boundaries, some of the study sites are piloting changes in this area [Case study 23].

Single assessment

Single assessment forms the central plank of the implementation of NSF standard 2, on person-centred care. It is seen as being the key mechanism for ensuring that services are organised around the older person. There has been a great deal of debate about the most appropriate tools to deliver single assessment. However, our study sites reported that local discussions on the single assessment process were acting as a vehicle for working through wider issues relating to professional roles and relationships and for modernising services for older people [Case study 24].

Case study 24

Single Assessment – Cambridgeshire

The questions asked within the assessment are appropriate and not offensive – you need to ask us personal questions so that you can provide care.

Older person, Cambridgeshire

Cambridgeshire has made early progress on single assessment, as this had already been identified as a local priority. The assessment process was seen as a way of tackling a number of local issues, such as duplication of assessment, fragmented data collection, limited opportunities for prevention, high levels of delayed discharges and poor cross-agency IT communication.

The aspiration was to establish a streamlined assessment that was owned by and used across the whole system and that had a role in triggering pathways to prevention and in increasing understanding of the roles of different professionals. The first step for the group which was tasked with taking the work forward was to assess existing...
models. They decided to use a customised version of EasyCare and to adopt an action learning approach to its implementation. The process was piloted in four sites across Cambridgeshire, as well as in Peterborough. The pilots had a strong focus on user involvement. Learning points included:

• both professionals and users found the process logical and easy to follow
• assessments took between 30 and 60 minutes
• there were difficulties with commissioning pathways
• the process worked well in a community setting, but less well in the hospital
• most professionals identified needs for further multi-agency training, particularly in areas such as benefits advice, mental health and recognising abuse.

The pilot is now to be extended across all PCT sites in Cambridgeshire, using an electronic version of the assessment. All staff will have access to hand-held computers into which they will input the assessment data in real time. The package includes triggers which signpost staff to further information on, for example, local services and local or national policy documents. Not only will this streamline the assessment process and make available a vast range of supporting information to staff, but it will also provide up to date electoral ward level management information which can be used for planning services or targeting prevention interventions.

The development of the Cambridgeshire assessment process has been extremely inclusive, with staff and older people involved from the outset in shaping the content and how it operates. The assessment process has therefore become a focus for improving services across the whole system to deliver better outcomes for older people. Staff who have been involved report that one of the main benefits to date for them has been making connections with other professionals and they are now working in a much more integrated way. The central role that older people have played has also been extremely important and has strongly influenced the local approach.

Source: Audit Commission

Workforce

One of the greatest challenges to improving care for older people is making sure that the right number of staff with the right skills and experience are in place. Recruitment and retention constitute a wider problem in many care communities, particularly where housing and travel costs are high and where many other employment opportunities exist beyond the public sector. A range of national and local initiatives are in place to attempt to tackle this, from developing low-cost homes for key workers to increasing training places and recruiting staff overseas (Ref. 18).

For older people, the number of staff who may be involved in delivering a complex package of care in the home can also be an issue, so improving the quality and integration of care requires a fresh look at the way in which roles are defined across the NHS and social care.
Delivery of integrated care and a whole system approach to older people’s services will require a joined up approach to workforce, which brings together local authorities, the voluntary and independent sectors and the NHS. This should include:

- a joint strategy for recruiting and retaining staff, across the system; and
- flexible use of scarce staff resources, through the development of new roles.

However, it is important to involve older people in discussions about changing roles and what this will mean for them, as, for example, the expansion of the roles of home carers may raise concerns about skills and training [Case studies 25, 26 and 27, overleaf].

I don’t agree with carers doing nurses’ jobs… I don’t like the idea of the same person cleaning the toilet and bathing you. You can’t expect one person to do everything.

Older person, Leeds

Older people would like one or two faces [delivering their care]. They don’t want to have different people traipsing in and out of their homes, but they want people to be qualified.

Volunteer, Leeds

**Case study 25**

NHS Changing Workforce Programme

The NHS Plan highlights the need to introduce new ways of working in order to improve patient care and to make the best use of scarce skills. The NHS Changing Workforce Programme was set up to help the NHS and its partner agencies to do this. The programme focuses on changing or expanding existing roles and on developing new ones. Thirteen pilot sites across the country are testing out a range of approaches. One of the programme’s pilot sites, North Derbyshire, is looking at new ways of working in relation to the care of older people across the NHS and social care. The pilot aims to develop, test and implement changing roles for health and social care staff that best support the delivery of patient care and the NSF. Objectives include improving continuity of care across the patient journey and reducing the number of unnecessary handovers and re-assessments. The North Derbyshire pilot brings together several strands, two of which aim to provide home care staff with new skills in rehabilitation and in supervising medication. Although it is in its early stages, the pilots are already demonstrating promising results. In one case, for example, training a home help to administer eye drops has reduced the number of daily visits to one older person by half.

*Source: Audit Commission*

**Case study 26**

Flexible roles – Leeds

Most of the sites visited as part of this study have integrated community teams in place that use therapy or rehabilitation assistants to deliver care. In Leeds, for example, each of the five intermediate care teams which cover the city includes about...
20 clinical support workers, who are trained in core competencies in nursing, physiotherapy and occupational therapy. Specialist staff agree goals with the older person, while the programme is delivered by team members working together.

Source: Audit Commission

**Case study 27**

**Integrated teams – Northumberland**

In Northumberland, four rehabilitation teams operate within the Care Trust. These are integrated health and social care teams, which are made up of a co-ordinator from either an NHS or social services background, occupational therapy and generic rehabilitation workers and dedicated physiotherapy and speech and language therapy input. The generic staff have an intensive induction programme and a foundation course on stroke and are also expected to pass NVQ Level 3 (Promoting Independence)

Source: Audit Commission

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### Teamworking

You don’t have to make a big effort to involve people any more – we sit next to each other and talk every day.

Social services senior manager

We’ve got here through battles and working through the issues together.

Joint PCT/social services development officer

The experience of all of our sites suggests that multi-professional, multi-agency teams are one of the most important routes for delivering integrated care within a whole system setting. This reduces the number of handovers between services and, therefore, the number of points at which the pathway might fracture. Research carried out in primary care settings suggests that teams that include many different professional groups deliver better care and implement more innovations (Ref. 19).

Teamworking highlights differences in approach or culture. For example, a number of the study sites identified different perceptions of risk as an area of tension between staff from NHS and social care backgrounds, with NHS staff having a lower tolerance of risk. This required a great deal of managed discussion, negotiation and working together to resolve, requiring sophisticated management skills of managers of joint teams.

Many of the sites emphasised the importance of investing in team development at an early stage to clarify roles, responsibilities and ways of working. Some had joint leadership in place, others saw co-location and joint training as important factors. Older people and their carers can play a key role in fostering a user-centred approach by contributing to training and team development [Case studies 28 and 29].
Moving forward

Building a whole system approach is a long term change programme. Tools such as pooled budgets and care trusts can play a useful role, while sustained support for staff and organisational development initiatives are also needed. It will be important to develop mechanisms for monitoring whole system performance.
Drawing on the experience of our study sites, we have described the route towards whole systems working, the components of a whole system of services for older people and the factors that support a whole system approach. In this final chapter, we consider how to achieve change, including:

- the tools that may help to support whole system working;
- how to support organisational change;
- monitoring progress;
- a summary of steps towards delivery; and
- a case study on Hammersmith & Fulham, which illustrates and brings together many of the conclusions of this study [Case study 32, page 43].

Tools for delivery

*We use existing funds flexibly – pooled budgets don’t add anything.*

Social Services Department senior officer

*The Care Trust is a mere mechanism for what we wanted to do anyway.*

Local authority chief executive

*The fixation with structure has led to a preoccupation with the means of integrated working, and a neglect of the ends (Ref. 20).*

In the past two to three years, the Government has introduced a number of structural and organisational changes that remove some of the previous barriers to greater integration between the NHS and local authorities. Implementation of these may boost whole system working. Key developments are:

- partnership flexibilities, introduced by section 31 of the Health Act 1999, which allow the NHS and local authorities to pool budgets, agree on a lead commissioner and integrate services across organisational boundaries; and
- care trusts.

Section 31

The DH requests all authorities to notify them before using the partnership flexibilities locally. However, very few of the study sites had formally notified their use of the flexibilities, even though most had developed a local approach to using resources flexibly, to aligning commissioning and to integrating services. Many of these initiatives predated the legislation. Most sites intended to make greater use of the flexibilities in future.

The Nuffield Institute for Health and the National Primary Care Research and Development Centre have highlighted the following interim findings in their national evaluation of the early notifications (Ref. 8).
For many sites, use of the flexibilities was built upon a history of close partnership working, with some already adopting a whole system approach to service provision.

- Factors that facilitated implementation included:
  - shared values and a commitment to service users;
  - a willingness to think outside conventional organisational boundaries;
  - strong and complex local networks and good relationships between key players; and
  - a cohesive partnership board which brought together all the stakeholder groups.

- Although it was too early to point to many improvements for service users as a result of use of the flexibilities, some early changes could be seen:
  - reduced duplication and better use of resources;
  - being able to take advantage of either local authority or NHS systems or processes, depending on which offered the best ‘deal’; and
  - leveraging in additional funding.

- In addition, there was a significant impact on the behaviour and attitudes of partners towards collaborative working, with the emphasis on organisational and professional boundaries replaced by a stronger whole system approach and a focus on the needs of the service user.

- Implementation was hindered by a number of factors, such as:
  - boundary differences;
  - differences in approach to financial management, processes and accountability;
  - human resource issues getting in the way of the integration of NHS and local government staff into a single organisation;
  - legal and accountability concerns; and
  - information systems.

- Stakeholder consultation had been limited, although some sites were exploring new ways of involving service users and other groups.

Care trusts

There has been a mixed response to the introduction of care trusts. Uptake has been lower than initially anticipated and some commentators have been sceptical about the likely effectiveness of structural solutions to complex problems that have their roots in cultural or professional difference (Ref. 20). The King’s Fund’s review of partnership working also sounds a note of caution about creating new boundaries by setting up care trusts, for example, between social services and other local authority functions (Ref. 7).

Our study sites included two care trust pilots, both of which had a strong focus on older people. In both cases, becoming a care trust was seen as the next logical step in a close collaborative relationship that had developed over a number of years. Both
referring to the waste and duplication in operating two systems for HR and finance, for example:

*Parallel systems burn up management time. Organisational change burns up management time, too, but only once.*

**Social services department senior officer**

79 For some care communities, it appears that moving towards care trust status represents an important milestone in a long history of joint working. Our study sites emphasised that this should not be considered unless a solid foundation of partnership is in place. Others, however, have achieved a high level of integration with a minimum of structural change and without formal use of Section 31. The level of organisational change necessary to deliver integrated care as part of a whole system approach is likely to be different for each care community and will be influenced by such factors as history and preferred working style. Care trusts provide one option.

80 Our study sites have chosen various routes towards integration. However, all of them have invested considerable time in building a shared vision, values and approach across the whole system. It seems likely that this process plays at least as important a role in supporting integrated, whole system care for older people as the organisational arrangements that are in place.

**Supporting innovation and change**

*Whatever system you have, nothing will change if you don’t think and behave differently.*

**Health authority senior officer**

81 Much of the study has focused on the importance of managing major organisational change on a whole system, multi-agency basis. This is a huge, complex task and our study sites have emphasised that it can take a number of years to make significant progress. The evaluation of the integrated mental health trust in Somerset highlights the importance of introducing personal and organisational development initiatives alongside structural change (Ref. 21). There is an enormous amount of literature on organisational change. A selection of the most relevant documents and tools for whole system change is available in the web based version of this document.

82 All of the sites we visited also emphasised the importance of investing in development capacity to take the change effort forward, as the day-to-day pressures of managing and delivering services make it difficult to focus on service improvement. Ideally, this requires a full-time development manager or project officer. In some cases, such as Hammersmith & Fulham (see case study at the end of this chapter), partner agencies jointly funded a post, which strengthened the sense of whole system ownership and gave them all an equal stake in the work.
The study identified a number of initiatives which aim to support whole system change in older people’s services. Most of these formed part of wider activity on modernisation. In most cases they were located within the NHS, although they drew in other partners and used methods that had been developed in healthcare settings [Case study 30].

Monitoring progress

It’s a real challenge letting a thousand flowers bloom and keeping performance tight.

Director of social services

As outlined in the whole system benefits section in Chapter 1, a whole system approach should result in fewer crises, in more older people living independently and in fewer admissions to residential and nursing home care. Existing indicators, as outlined below, offer some data on local progress:

- the number of older people supported to live at home;
- the number of intensive home care packages;
- the number of people admitted to residential and nursing care; and
- the number of emergency admissions/readmissions.

Foote and Stanners propose the balanced scorecard as one model for monitoring progress in complex systems at a local level (Ref. 22). The balanced scorecard offers a framework for evaluation in several dimensions simultaneously:

- care outcomes;
- customer satisfaction;
- process complexity; and
- cost effectiveness.

Monitoring progress across the whole system is a complex task, with national indicators focusing primarily on the performance of individual organisations, rather than on the performance of the care system. As Plsek and Wilson note:

In the UK... having separate budgets and performance targets for primary care, secondary care and social services promotes an internal focus on the operation of each of these parts, but not necessarily on the good functioning of the system as a whole (Ref. 14).

The evaluation of the use of the health act flexibilities also highlighted the tension between the strong policy emphasis on partnership and whole systems working and the perceived lack of joined-up operation at a national level, particularly in relation to audit and performance management processes (Ref. 8).

In the absence of integrated, whole system performance information, we encountered many local attempts to analyse existing performance data in order to increase
understanding of the care system. However, the publicly available information sheds little light on the underlying reasons for performance problems, the actions that might be taken to address these or indeed, the impact of services on older people’s quality of life.

The Audit Commission acknowledges this and is therefore undertaking a piece of scoping work to explore how best to interpret available information to give a picture of whole system performance. We hope it may be possible to produce a diagnostic tool that highlights possible problem areas by grouping related indicators.

It will be important, over time, to move towards an integrated system of monitoring and performance measurement that captures both performance across the system and the impact on older people’s quality of life. Meanwhile, how can care communities assess whether their whole system working is making a difference? Evidence of the benefits is patchy, but it is possible to gain some insights on the health and effectiveness of whole system working by examining existing indicators. Some of our study sites, such as Halton PCT (Case study 10) have demonstrated the impact of their work (and strengthened their case for wider implementation and increased funding) by tracking trends in areas such as length of hospital stay or the number of hospital bed days used by identified groups of people. Just as importantly, they have also asked older people themselves about the difference that the project has made to their lives. They have received very positive feedback [Case study 31].

Steps towards delivery

From the experience of our study sites, there appear to be a number of common steps towards whole system working. These steps are briefly summarised below. Every care community is unique in its history, preferred working style and service configuration, so the steps are not intended to be prescriptive, nor to be sequential. However, they do offer a route map towards a whole system approach.

- **start with the views and aspirations of older people**;
- **understand your local whole system** – mapping services, flows and bottlenecks, using existing data to paint a picture;
- **invest in development capacity** – all study sites emphasised the importance of funding dedicated staff to carry out the co-ordination/service development role across the whole system;
- **encourage small scale innovation**, assess the impact and if it works, roll it out;
- **ensure there are well placed enthusiasts at key points in the whole system** – a number of sites identified key enthusiasts not only in the local authority and the PCT, but also in acute trusts;
- **exploit the opportunities for new organisational relationships and for rebalancing the system offered by PCTs** – several sites were about to integrate community services and commissioning for older people and saw this as offering potential to counteract the traditional power of the acute sector;

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**Case study 31**

**Integrated performance framework – Barking & Dagenham**

Barking & Dagenham has a joint Director of Social Services and PCT Chief Executive. The PCT and social services have developed an integrated framework that links the whole system vision and values with its performance plans, indicators and targets. The framework is based on the balanced scorecard approach and is organised around four themes:

- **community first** – setting standards, involving users;
- **people matter** – focusing on human resources practice and organisational development, supporting staff to deliver high standards;
- **funding the future** – embedding commissioning, evaluating services and leveraging in resources; and
- **performance counts** – ensuring that all staff report on performance.

Source: Audit Commission
create mechanisms to ensure that new approaches and ways of working penetrate mainstream services – for example, by rotating staff through intermediate care or rehabilitation teams; and

monitor progress, involving older people.

**Case Study 32**
**Hammersmith & Fulham**

**What did they do?**

*Preparing the ground*

Joint working in Hammersmith and Fulham initially involved the acute trust and the social services department. The focus of the early discussions, which took place in the mid-1990s, was the hospital’s difficulties with rising numbers of delayed transfers of care. These were first blamed on social services’ perceived failure to clear beds sufficiently quickly. Although the discussions were difficult, the trust and the social services department agreed to carry out an audit together, to increase understanding of the underlying reasons for the delays. The audit showed that most delays were caused not by social services, but by processes within the hospital.

From these early beginnings grew a joint approach to bed management and later, capacity planning. The acute trust has remained unusually engaged with whole system working in the borough, possibly because senior staff came to view the social services department as an ally in tackling pressures on the hospital at an early stage.

Around the same time, a Whole System Group on older people was established. This brought together all of the local key players and was chaired by a geriatrician who was medical director of the community trust. The chair’s role was key in that he was visionary, charismatic and had a very early understanding of the ways in which a whole system approach would benefit older people.

*Building a strategic vision*

Hammersmith & Fulham was a pilot site for the BGOP initiative, which was mentioned by all our interviewees as being an extremely important influence on the way that services developed in the borough. In particular, the strong preventative ethos of local services was in line with BGOP’s broad aims. At an early stage, close connections were made with the political process and minority ethnic representation was also built into the structure.

In addition to the strong influence of BGOP, Hammersmith & Fulham have regularly held large events for older people. An event for 80 people was held shortly after the publication of the NSF to consider the implications for the care community. Older people were keen to add a small number of additional local priorities, including transport, housing and support for carers. This is now reflected in Hammersmith & Fulham’s vision for the future. The event also reviewed the composition of the Whole Systems Group and, as a result, the contribution of the voluntary sector was strengthened.

From these processes, an approach has emerged that champions preventative, integrated, community-based services. A local ‘flower’ strategy was often referred to as...
an important graphic summary of local aspirations. This placed Keep Well at Home (case study 9) at the centre of local provision, with other local priorities presented as the petals.

Mapping services
As one of its first tasks, the Whole System Group carried out an early service mapping exercise, which focused in detail on mapping pathways and processes as a way of better understanding the local system. The exercise showed that there was a need to pull together the disparate services in order to create a coherent system of care. All the partner agencies then agreed to contribute towards appointing a joint development manager to act as a focus for joined up service development across the borough.

Redesigning services
In 1999 the local authority and health authority agreed to work together to reconfigure services for older people, as both were struggling with financial pressures and they shared concerns about the quality and cost of existing provision. The care community developed and implemented a whole system strategy between the NHS, social services and housing to replace all local directly managed residential homes with extra sheltered housing and to build new nursing homes. The new nursing homes would expand the number of local placements and accommodate both social services and NHS placements. In addition, day care provision was to be reprovided alongside these developments. The development was part funded through the private finance initiative (PFI). BGOP members were closely involved throughout and over time, they became strong advocates for the replacement of existing provision. Their role included contributing towards specifications and sitting on interview panels.

What made this possible?
Leadership
There was a striking consensus among our interviewees that the key factor that had allowed them to develop a whole system approach was the commitment and approach of key leaders in all of the partner organisations. Staff from across the system reported that they felt supported and valued as professionals and encouraged to innovate to improve the experience of older people. They valued senior staff’s ability to work together across boundaries in finding pragmatic solutions to shared difficulties and to ‘do deals’ which placed older people and the healthy functioning of the whole system above corporate considerations, sometimes at personal cost. Middle managers, too, played an important role in working with frontline staff to emphasise the importance of placing older people at the centre, rather than prioritising organisational or professional loyalties. The roles of the well respected lead acute geriatrician and GP on the Whole System Group were also highlighted as crucial in increasing support and buy in from clinicians.

Organisational culture
Hammersmith & Fulham’s organisational culture was highlighted as another important factor in making progress towards whole system working. It was described as ‘can do’, flexible and entrepreneurial. For example, the newly appointed development worker was told that one of her first tasks would be to prepare a number of outline proposals, related to the agreed local development priorities in case any funding should become available at short notice (which it subsequently did). This allowed the care community
to take advantage of any available sources of funding quickly. They were successful in flexing the outline proposals to meet funding criteria, but without sacrificing their strong local vision, which was summarised clearly in the “flower” strategy.

Other factors
The former PCG and the social services department developed a close, flexible working relationship over time. This was characterised by co-location of staff (with the PCG head of commissioning for older people’s services located in the social services offices, for example) and by developing a shared approach which made best use of available capacity. There was an integrated approach to commissioning older people’s services, for example, with the social services department taking a lead because their infrastructure was better developed at that stage.

What difference has this made for older people?
Discussions with older people who were involved in BGOP showed that experiences of local services were mixed. Some provided examples of excellent care, in particular on discharge from hospital, but others expressed frustration at the perceived inflexibility of some community-based services. However, the strongest theme that emerged from the discussion was the important role that BGOP had played in influencing local services. The group had worked closely with senior staff across the system in order to develop an atmosphere of mutual trust. They had moved far beyond consultation to become key partners in the decision-making process and did not hesitate to call the local authority or the NHS to account for actions that adversely affected older people.

Source: Audit Commission

Concluding words of advice...
We asked all those we spoke to at the study sites for the advice they would offer to care communities who were at an earlier stage of whole system working. Some of their comments are reproduced below.

With a whole system, it doesn’t matter where you start. If you do something, you’ll understand better how the system works.

It’s not about pots of money, it’s about changing ways of working.

Don’t underestimate the degree of cultural change that is required.

It’s important to be practical, but not to let that fetter creativity.

Have a clear strategy which staff know and support and a consistent set of messages.

Teach people they have nothing to fear from loss of territory – partnerships are always stronger than individuals.

Give yourself room to innovate by having good mainstream services – it’s difficult to achieve change when you’re battling with failing services.

Build ownership and mutual respect to reduce competitiveness and create synergy.

Look forward, beyond the immediate, to find solutions which are fit for the future.
Appendix 1: Case study sites

Barking & Dagenham
Braintree
Cambridgeshire
Camden*
Hammersmith & Fulham*
Halton
Kensington & Chelsea/Westminster
Leeds*
Portsmouth
Reading
Tameside & Glossop
Trent Health & Social Care Collaborative for Older People
London Older People’s Development Programme

Site visits varied in length from half a day to several days. The sites marked with an asterisk received the most intensive visits.

The study sites ranged from a large, sparsely populated county through a large city, made up of a single local authority and five PCTs, to a coterminous borough/PCT. We have also kept in close contact with the two multi-agency service improvement programmes for older people’s services, which are based in the former London and Trent NHS Regions. The study sites are not intended to be representative, indeed rural areas are under-represented. They were selected through a combination of routes, including scanning lists of Beacon sites and use of the section 31 flexibilities, reviewing the literature and local and national advice and intelligence. The key criteria for inclusion were that they had achieved, or were attempting to achieve, something ambitious, distinctive and potentially useful for others in some aspect of their work as a whole system.

Throughout the course of this study we liaised closely with a team at the National Audit Office (NAO), who were undertaking a national examination of the discharge of older people from acute NHS hospitals in England for a report to Parliament. As our studies complement one another some of the fieldwork for both studies, such as visits to NHS trusts and local authority social services departments, was carried out together, thus minimising the disruption to those visited. A member of staff from the NAO also joined the Audit Commission team for a four month secondment. The NAO report will be published early in 2003.
Appendix 2: Participants in advisory workshop

Penny Banks King’s Fund
Helen Bowers Institute for Applied Health & Social Policy, King’s College
Jeni Bremner Local Government Association
Beverly Castleton North Surrey and Woking PCTs/Ashford & St Peter’s NHS Trust
John England Leeds City Council
Caroline Glendinning National Primary Care Research & Development Centre, University of Manchester
Jeremy Gostick National Audit Office
Mark Howe Cambridgeshire County Council
Gareth Jones Department of Health
Jackie Lelkes Portsmouth Community Rehab Team
Elizabeth Lowe London Directorate of Health and Social Care
Dave Martin Better Government for Older People Network
Nicki McNaney NHS Modernisation Agency
Denis O’Rourke London Borough of Hillingdon
Linda Spencer King’s Fund
Jan Stevenson King’s Fund
Alan Tyrer London Borough of Hammersmith & Fulham
David Browning Audit Commission
Emma Brown Audit Commission
Jane Carrier Audit Commission
Tom Dixon Audit Commission
Peter Scurfield Audit Commission
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16 Stevenson J, Spencer L, Planning and Developing Intermediate Care for Older People, King’s Fund, forthcoming.
20 Hudson B, Ten Reasons not to Trust Care Trusts, MCC, Volume 10, April 2002.
**Forget-Me-Not: Mental health services for older people.** This update summarises the wide variation in practice and provision of mental health services for older people across England, and makes good practice recommendations to help trusts tackle these variations.

Price: £12, Update 2002
ISBN 1862403414, Stock code HUP2681
www.audit-commission.gov.uk

**Fully Equipped 2002: Assisting Independence.** This latest update from the Audit Commission looks at the progress that has been made by the NHS trusts and social service authorities in the provision of equipment services to older or disabled people since Fully Equipped was published in 2000.

Price: £12, Update 2002
ISBN 1862403678, Stock code HUP2771
www.audit-commission.gov.uk

**The Way to Go Home: Rehabilitation and remedial services for older people.** Rehabilitation services for older people are often patchy and disjointed. This report argues that a more strategic approach is needed; a whole-systems approach that looks at rehabilitation in the round and makes full use of new financial flexibilities.

Price: £20, National Report 2000
ISBN 1862402213, Stock code HNR1401
www.audit-commission.gov.uk

**The Coming of Age: Improving care services for older people.** This report reviews care services for older people, focusing on the roles of the different agencies involved, including social services, the NHS and independent care providers. Drawing on case studies, the report makes a number of detailed recommendations.

Price: £20, National Report
ISBN 1862400598, Stock code LNR1230
www.audit-commission.gov.uk
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