ATTACHMENT B

London Health and Care Integration Collaborative

Planning for the Integration Transformation Fund and update on the national integrated care programme

11 September 2013

1. Purpose of the paper:

- To provide an update on the planning process for the Integration Transformation Fund and seek the Collaborative's input
- To provide an update on the national programme of work on integrated care and agree how London can best influence and benefit from the programme
- To provide an update on the integration pioneer process

2. The Integration Transformation Fund

Following the announcement of the Integration Transformation Fund (ITF) on 26 June, further guidance about the ITF was issued by the LGA and NHS England in August (http://www.england.nhs.uk/wp-content/uploads/2013/08/itf-aug13.pdf).

Following the discussion at the previous Collaborative meeting, Peter Kohn canvassed London CCGs for their views about what would prove useful in further guidance. The following comments were made:-

- Further details of the financial allocations/impact at a local level would be beneficial as soon as possible
- Will all the resource be allocated to CCG/Local authority or will other commissioners e.g. NHSE have a share?
- There should be as much local discretion as possible
- Should plans be borough level or cross system?
- Need to make the links with the planning being done by Urgent Care Boards
- The system of payments should incentivise acute trusts to make the systemic changes necessary
- From experience of measuring QIPP initiatives it is difficult to isolate the outcome benefits between schemes

To enable London to contribute to this discussion, Martin Smith suggested that Ealing formed a quick view of what a plan to deliver the objectives of the Integration Transformation Fund might look like. This was circulated in mid-August and is at **Appendix A** (not for onward circulation please).

The format for ITF plans is now expected to be finalised in the next month or so. Geoff will provide a further update at the meeting but at present, it is envisaged that there will be a requirement for plans to indicate how localities are meeting the six pre-conditions for funding:

- Protection for social care services (rather than spending) with the definition determined locally
- Seven day working in social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Plans and targets for reducing A&E attendances and emergency admissions
- Risk sharing principles and contingency plans for if/when targets are not being met

- Agreement on consequential impacts of changes in the acute sector

Discussion is currently focussed on the measures that will be used to monitor delivery as a precursor to the release of funds.

The views of the Collaborative would be useful on the following:
- How to keep ITF plans simple and brief, recognising that they are an element/excerpt of locality strategies that will have ministerial scrutiny?
- How to encourage plans to be ambitious and transformational, while recognising that to access funds, localities will need to deliver concrete results within a short timeframe?
- Which measures will allow localities to demonstrate concrete results, recognising that the evidence for which interventions deliver system impact is patchy and that attribution of impact to individual interventions is difficult?
- The need to use only those measures for which high quality data is available to allow robust monitoring.
- How to establish appropriate baselines and trajectories recognising that each locality will have a different starting point?

Regional road shows are planned for November/December following publication of the planning framework and guidance on the ITF. The aim of the road shows is to provide localities with an overview of the ITF and the technical arrangements underpinning them and to support them in the ITF planning process. It has also been suggested that designated integration pioneers might present at the road shows. This is a good opportunity for a London-wide event on integrated care and **the Collaborative is invited to provide a steer on what good would look like for a London event**.

3. The national integrated care programme

The National Collaboration for Health and Care issued Integrated Care and Support: Our Shared Commitment in May.
(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf)

Following this, a programme of work has been established to develop a national Community of Practice for Integrated Care and a toolkit to support localities in integrating care. The work was commissioned by the LGA in collaboration with key national partners. Rachel Bartlett sits on the steering group and London has been able to inform and influence the approach being taken.

The programme began with three workshops in Bristol, Leeds and London to define stakeholder needs and expectations. As a result, six tools are being developed:

- An overarching ‘Value Case' for integrated care
- ‘Value case' (including financial business case) summaries from 8-12 local areas demonstrating whole system integrated care (**Appendix B**)
- An evidence review of existing knowledge on outcomes of integrated care (**Appendix C**)
- A model showing the impact of different interventions or whole system models of integrated care on outcomes, cost, activity and individual journey through the system at a local level
- A searchable database of integrated care initiatives throughout the country

- A signposting tool which will point to existing useful sources around the planning and implementation of integrated care

Input and comments on the emerging tools is now being sought and localities are being invited to suggest case studies, evidence and resources that should be included. Only the most relevant documents have been attached here. Lizzie Comley (elizabeth.comley@nhs.net) can forward the full email on request. The deadline for comments is 11 September and can be provided directly via info@integratingcare.org. Rachel will also provide a summary of the Collaborative's feedback following the meeting.

The programme provides important opportunities to enable the London Collaborative to deliver its agreed objectives in alignment with the national approach:

- **Capturing a fuller account of integrated care across London:** Collaborative members are asked to use their networks to encourage all localities within London to provide information about their integrated care initiatives for inclusion on the database. Several London localities are likely to be included in the 8-12 value cases. It is suggested that we invite all London localities to consider completing Value cases to describe their work.
- **Summarising and signposting the evidence base:** the national evidence review will be a helpful starting point for discussions with AHSNs about where the evidence needs strengthening.

4. Integration Pioneers

A long-list of pioneers has been agreed and a panel of announced. An announcement of the final list of designated pioneers is expected in October/November. This is a critical time to reach out to all London localities to maintain confidence and momentum and the Collaborative is invited to advise how best to do this. The regional road show is a key opportunity for this.

Rachel Bartlett
September 2013

Appendix A

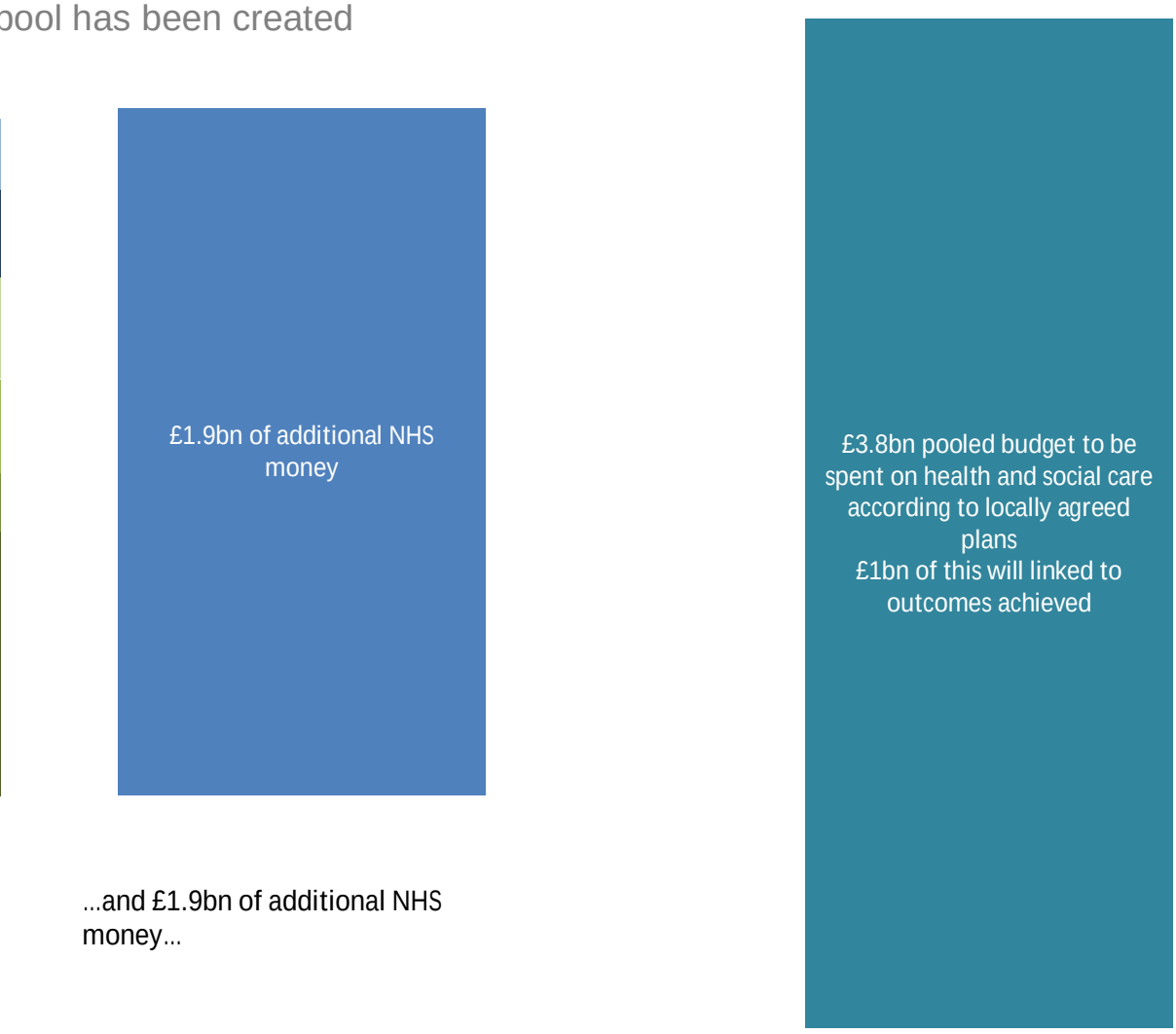
Transformation Fund Proposal August 2013

NHS
Ealing
ning Group

Ealing
www.ealing.gov.uk

£3.8 billion pool of new funding to help enable older people and people living with long term health endent at home as part of the spending round for 2015/16. This funding is intended to strengthen incentives work together to deliver integrated services, ensure the right outcomes and provide better services for local nditional on local authorities and CCG's agreeing plans with local Health and Well-being Boards to improve ces, to improve quality and prevent people staying in hospital unnecessarily. The DH is considering the ing of funding locally through the Care Bill.

pool has been created



...and £1.9bn of additional NHS money...

authorities but will be subject to plans being agreed by local Health and Wellbeing Boards and signed off would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is oped this year, signed-off and assured over the winter and would be implemented from 2014/15.

ation of locally and nationally set outcome measures. Half of the funding will be paid at the beginning of mance) and the remainder paid in arrears against performance in 2015/16

satisfy nationally prescribed conditions,

vices (rather than spending) with the definition

care to support patients being discharged and
ions at weekends,
health and social care, based on the NHS

g A&E attendances and emergency

ontingency plans for if/when targets are not

impacts of changes in the acute sector.

ed with the CCG and in line with the conditions above and set out in Appendix 1. The plans will build on nd initiatives such as:
rategy
y

are Pilot
egration
diate Care Ealing (ICE)

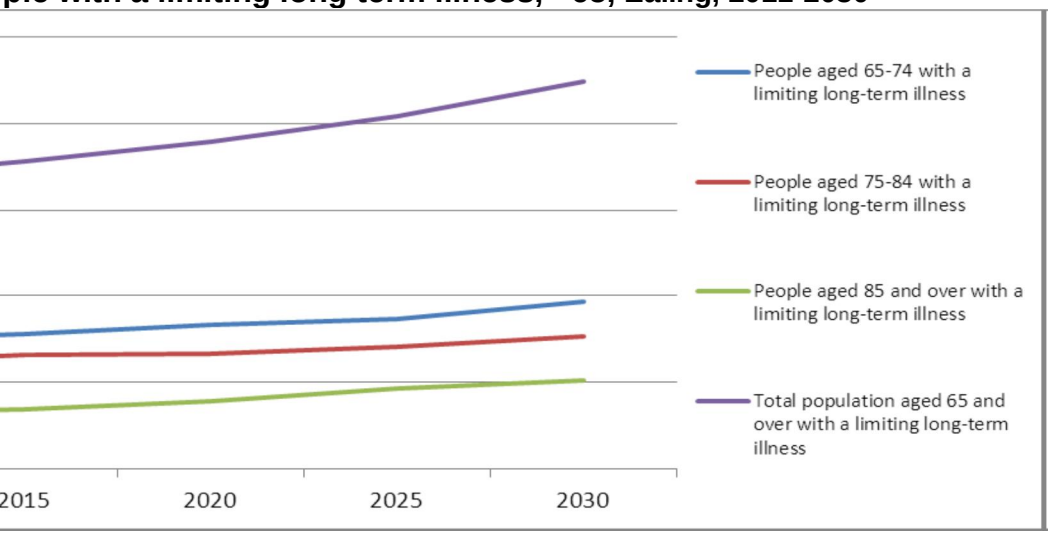
Ealing has agreed a shared commitment to implement integrated care at scale and pace, building on commitment the Board has agreed to:

ous, borough-wide integrated care programme and to review current project management and resourcing he right capacity is in place to drive this work.
e benefits of integrated care for different population groups as well as older people; and that opportunities ch to commissioning involving public health are considered;
ntegrated care is important for the people of Ealing and the benefits of this approach for clinicians and other

ture the benefits and impact of existing integrated services and how data can be shared across NHS and to support this.

hat the total number of people over 65 years in Ealing will grow by 14,900 between 2012 and 2030. he 85 and over age group with a predicted increase of 58.6% or 3,400 people. The number of people over 65 in Ealing is projected to increase by 33% by 2030 (from 16,838 to 22,409) (see table below)

ple with a limiting long term illness, <65, Ealing, 2011-2030



n rate for all hospital admissions and emergency hospital admissions for people aged over 65 in Ealing are and London rates and over twice as high as the lowest rates in England. From hospital admission data for g mental health), 75% of admissions are due to the three commonest causes: circulatory diseases (41%), ses (18%). In relation to dementia in 2012/13 there were 1781 admissions for residents recorded as having of these were admitted through accident and emergency. The associated cost of these dementia 1 million.

en the Council and CCG for redeployment of the funding held back in event of the outcomes not being

mes and investment are set out in Appendix 1

	Investment (14/15) £	Outcomes (Activity) – 14/15	Outcomes (Financial) –14/15 £	Investment (15/16) £	Outcomes (Activity) – 15/16	Outcomes (Financial) – 15/16 £
	50,000 Set up costs **Total Investment** **<u>50,000</u>**	Policies/Procedures updated Recruitment underway	NA	2 x Social worker; £33.35 per hour x 35 hours per week **120,000** Homecare hours commissioned with external providers calculated at Band 3 rate. £18.00 per hour x 5,000 hours **90,000** Additional investment in telecare/telehealth (200 pieces of equipment) **75,000** **Total Investment** **<u>285,000</u>**	**Reduction in number of escalation beds open in EHT** ?% reduction for service duration (against 14/15 baseline) **Reduction in the number of long stay patients** ?% for service duration (against 14/15 baseline) **Improved patient outcomes** Patient reported outcome measure Minimum ?% reported satisfaction with the service **Increased accessibility to intermediate care** ?% increase in service take-up (against 14/15 baseline)	Cost of unplanned acute episode between 2,000 to 8,000 per patient

					Reduction in numbers of reported delayed transfers of care against both the NHS and SS ?% reduction for service duration(against 14/15 baseline)	
nd er **ers** n ies, de ust and s **ical** ent	The equivalent resource of 2 full time Grade 14 posts will be required co-ordinate and drive this project. **45.000** **50,000**	50% of social care records with NHS numbers	NA	**45,000** **150,000**	100% of social care records with NHS numbers	NA

	Total Investment **<u>95,000</u>**			**Total Investment** **<u>195,000</u>**		
of and l out will the	Social Care Capacity pump priming **100,000** **Total Investment** **<u>100,000</u>**	To deliver the Ealing Integration Plan (data capture/systems planning/risk stratification of patients/staff recruitment)	NA	6 x health and social care co-ordinators (1 for each network) **360,000** Infrastructure costs (finance support/IT development) **150,000** **Total Investment** **<u>510,000</u>**	**Improved patient outcomes** Patient reported outcome measure Minimum ?% reported satisfaction with the service **A reduction in non-elective activity** of 4% on the 14/15 baseline **Reduction in the number of long stay patients** ?% for service duration (against 14/15 baseline) **Reduction in admissions to residential care** ?% for service duration (against 14/15 baseline	Cost of unplanned acute episode between 2,000 to 8,000 per patient Cost of residential care for older people (WLA rate) £466pw standard/£530pw dementia)

re	None	NA	NA	Additional Reviewing officers - (Grade 7) **270,000** Trusted Assessor Training **4,500** Additional OT Support **90,000** Additional reablement workers/hours **500,000** **Total Investment** **<u>864,500</u>**	**Reduction in numbers of reported delayed transfers of care against both the NHS and SS** ?% reduction for service duration(against 14/15 baseline) **Improved patient outcomes** Patient reported outcome measure Minimum ?% reported satisfaction with the service **A reduction in non-elective activity** of 4% on the 14/15 baseline **Reduction in the number of long stay patients** ?% for service duration (against 14/15 baseline **Reduction in admissions to residential care** ?% for service duration (against 14/15 baseline	Cost of unplanned acute episode between 2,000 to 8,000 per patient Cost of residential care for older people (WLA rate) £466pw standard/£530pw dementia)

ar	Placement Officer x 1 **45,000** **Total** **Investment** **45,000**	Identification of patients and procurement of suitable service providers (supported living)	. NA	Placement Officer x 1 **45,000** 11 step down units at a cost of £606 per week x 52 weeks **346,000** **Total Investment** **391,000**	**Reduction in numbers of reported delayed transfers of care against both the NHS and SS** ?% reduction for service duration(against 14/15 baseline) **Reduction in the number of long stay patients** ?% for service duration (against 14/15 baseline **Improved patient outcomes** Patient reported outcome measure Minimum ?% reported satisfaction with the service	Cost of in-patient mental health admission TBC Mental Health Residential care costs average £850 per week.

e	None	NA	NA	**<u>Telehealth</u>** Staff –Technical Support/Project Lead **40,000** Non-Staff Costs **200,000** **<u>Telecare</u>** Staff Costs – Expert Telecare Assessor/Telecare Co-ordinator **70,000** Non-Staff Costs (based on approx. 400) – equipment, installation, maintenance, call response service **150,000** **Total Investment** **<u>460,,000</u>**	**Reduction in numbers of reported delayed transfers of care against both the NHS and SS** ?% reduction for service duration(against 14/15 baseline) **Improved patient outcomes** Patient reported outcome measure Minimum ?% reported satisfaction with the service **A reduction in non-elective activity** of 4% on the 14/15 baseline **Reduction in the number of long stay patients** ?% for service duration (against 14/15 baseline **Reduction in admissions to residential care** ?% for service duration (against 14/15 baseline	Cost of unplanned acute episode between 2,000 to 8,000 per patient Cost of residential care for older people (WLA rate) £466pw standard/£530pw dementia)

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Care
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integrating care

r the value case

f this work is to develop value cases which are:

h & Wellbeing Boards

ate:

ories, capturing changes to the service user's journey

e model, including enablers

odel

nefit, including to activity, spend and outcomes

nt

integrating care

Torbay

Value Case

Devon Care Trust serves a population of 250,000 on the
von.

n health and Social Care began in earnest in 2002, and led
shment of the Care Trust in December 2005.

ficantly higher than average number of residents over
d it was clear a decade ago that the major service question
neet the needs of the rapidly growing number of people with
ealth and social care needs.

an NHS body, from which Torbay Council commissions its
ervices.

is based on integrated multi-disciplinary teams, which work
y care, and specialist health services to manage the care of
ey serve.

emphasis on speed of response, the promotion of
d providing services in people's own homes.

d by Torbay

- Use of Direct Payments is one of the best in the region

- Annual staff survey showed an increase in staff satisfaction, with 28 of 36 indicators above the national average satisfaction
- Reduction in staff sickness and absenteeism
- Reduction in staff reporting abuse

Berg balance score
Needs assessment scores

- Average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10
- Emergency bed day use in in the 65+ population was 1,920 per 1,000 population in 2009/10 (compared with an average of 2,698 nationally)
- Torbay Care Trust has been responsible for 144 fewer people since 2007/8

- In its first year, Torbay Care Trust saved approximately £250,000.

Delayed transfers of care have been reduced to a negligible number

"Torbay stands out as the site that is able to demonstrate most progress ... Torbay can claim with some justification to be showing a measureable return on its investment in integrated care"

nablers

d between Torbay Council and Torbay PCT to establish ated NHS organisation responsible for commissioning and social care services.

atutory accountability for adult social care. An annual outline the resources available for social care and the ements.

l worker posts, assuaging some concerns from council staff vestment inn social care.

rogrammes and ongoing collaboration with Kaiser Permanente

ng focus groups, journey mapping & cameras/ interviews gets & direct payments

vices, and an annual agreement with Torbay Council for Social e integrated budgets.

owards section 75

tegrated, co-located health and social care., teams, with a strong leadership and development.

"I am able to ensure access, support & care for my patients"

"I am able to have time to care for my patients." am

ted care design

Local Government Association

integrating care

s Mrs Smith, an 80-year old user of fragmented service,
around integration , and to explain the approach from a

Reablement for the Elderly

are Trust, CARRIE was a key multi-disciplinary service
or stronger social care support was a driver for integration

clusters of GP practices based on GP registration rather
zones' because facilitators of integration.

anagement

ed to focus services on patients with the most complex

d with these patients to maximise impact.

ach zone, co-ordinating health and social care.
oss zones.
ith hospitals, primary care and community services
ships with the zones.

"Central to the vision was the concept of improving access to services for Mrs Smith"

Local Government Association integrating care

unt to successful delivery
the needs of the most complex, vulnerable older people

nts staying in hospital unnecessarily. Low rates of
ter lengths of stay, and no delayed discharges.

lt social care in Torbay Council. Increased provision of
ficant reduction in the use of residential and nursing home

ood for the population
mple of the service user and economic benefits of the full
ial care.
at a time when there is fear of privatisation

sely with a single provider of community services, with the
ssions, and significant improvements to discharge
issions

"The current system was unsustainable Integrated care will allow us to provide a sustainable person-centred future"

Local Government Association integrating care

ion for and benefits being sought for service users/patients
advance, communicate them constantly, invest in
improvement

om the bottom up around GP registration to simplify access
er.

gement, cultural, political, organisational and financial risks
kers – they can be overcome. The evidence base is useful.

dle management from the start, and avoid separate
for different professions (including social care).

t home, with immediate care provision and hospital
e to support it.

across health and social care providers, with
ser role.

"Using a section 75 proved too bureaucratic, through discussion and compromise we agreed to pool our budgets"

Local Government Association

integrating care

Evidence review update
August 2013

A rapid search of the evidence and literature for integrated care (primarily in the UK) has been undertaken. The approach has included grey literature review, collation of information using a respondent-driven process, consultation with senior stakeholders, and on and offline search.

The nature of the evidence base for the interventions is primarily case studies or qualitative data. There is a paucity of robust systematic reviews or peer-reviewed articles providing quantitative evidence, particularly of cost outcomes. One explanation has been the historic difficulty of accessing linked health and social care system data at scale. Another is the relatively recent development of integrated care initiatives across the UK.

As result, the search used a "snowball" approach combined with respondent-driven sampling as opposed to a systematic review. The findings so far have been broken down into the following categories:

Current Document Contents (page number)

Local Government Association

Overarching/systematic reviews of integrated care

Author/s	Date	Title	Publisher	Study	Key Findings
Bardsley, M. Car, J. Smith, J.	2013	Evaluation of the first year of the Inner North West London Integrated Care Pilot: summary	Nuffield Trust	This summary is based on an evaluation undertaken by a team of researchers from Imperial College London and the Nuffield Trust of the Inner North West London (INWL) Integrated Care Pilot (ICP), which aimed to develop new forms of care for older people and those with diabetes.	• Better care pla real potential t patients' exper in particular in duplication and access. Patien care plan repo access to NHS (64%), that the spend less tim appointments t GP and other h professionals (that health car them fewer qu their medical h
RAND Europe, Ernst & Young LLP	2012	National Evaluation of the Department of Health's Integrated Care Pilots Final Report: Summary Version	Department of Health	This review provides a summary of a longer final output of an evaluation of the 16 Department of Health (DH) integrated care pilots (ICPs), the activities conducted, the data collected and the analyses completed. Identified are the key findings and conclusions about the processes and outcomes seen within the pilots during the evaluation	• Patients report care plans mor (26%) and felt better coordina discharged fro (71%) • However, patie reported findin difficult to see t their choice an reported being less frequently reduction) • Reduction in el admissions an attendances by 20% respective

	Publisher	Study	Key Findings	Applicability
			• For case management sites, there was a 9% reduction in overall secondary care costs in the 6 months following intervention • Staff felt there was improved team working and improved communication (60%) • 54% of staff thought that care of their patients had improved	
n the Ground Up: port on rated care gn and delivery	Institute of Public Care, Oxford Brookes University	This report was jointly commissioned by Community Health Partnerships and the Integrated Care Network. It is based on a combination of literature review, stakeholder interviews and four in-depth case studies of integrated services - 1) Mill Rise Village, Knutton and Cross Heath, Staffordshire, 2) The Walkden Centre, Salford, 3) Community Homes Resettlement Project, NHS Norfolk and Norfolk County Council, 4) Oxfordshire Older Peoples' Services. It analyses the elements	• The report concludes that for integrated services to flourish managers must: 1. Clearly map the strategic fit of each of the partner organisations to identify opportunities as they arise. 2. Make the time and effort to understand each other's agendas. 3. Have the right people with the right level of decision making power together around the table. 4. Integrate services that offer a logical fit. 5. Agree with partners the core principles of the services to be developed and work out which areas can	This report aims to support service commissioners; including those involved in planning, service delivery, finance and infrastructure as well as local partnerships, who are looking to develop integrated care services. A guide is available which provides a practical interpretation of the full report:

	Publisher	Study	Key Findings	Applicability
		of success in integrating care, and presents a model of design and delivery for managers to consider in relation to their own services and planning new facilities. .	be compromised on further down the line. 6. Look at integrating processes as well as services. 7. Seek management solutions which are both flexible and innovative. 8. Have trust and confidence in each of the partners and recognise that all are working to the same outcomes. 9. Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes. 10. Recognise that efficiency does not lead to integration, but integration can lead to more efficient working practices. 11. Pay attention to issues in procurement early on, whether they are about how to integrate different legal and planning processes or address issues around building design and IT infrastructure. There	

	Publisher	Study	Key Findings	Applicability
			are numerous examples where good planning at the start of projects saves considerable expenditure further down the line. 12. Finally, underpinning all of the above remain the reasons for integration. For a successfully integrated care service, the outcomes must shape the form that enables them to happen	
th and Social Integration: ections from hern Ireland sentation to King's l Summit - day 1 May 2012)	The Kings Fund	This presentation looks at the lessons that can be learned for integration elsewhere in the UK by looking at the Integrated Health and Social Services Boards that were introduced in Northern Ireland in the 1970s.	• Integrated Working: • Has the potential to provide a seamless system • Improves access, referral and assessment processes • Provides a single point of entry and only one assessment process • Reduces waiting times and duplication of services • Facilitates preventative work and intermediate care, reablement and discharge. • Can provide evidence of professional	The lessons from Northern Ireland demonstrate the positive impact of integrated working and highlight some of the issues that need to be addressed.

	Publisher	Study	Key Findings	Applicability

			boundaries disappearing – user centred
			• There are still issues with the system notably:
			  • The need for constant vigilance to ensure health does not completely dominate the agenda
			  • There are some issues with levels of GP engagement	

e	Publisher	Study	Key Findings	Applicability
t Commissioning ealth and Social e: An Exploration efinitions, cesses, Services Outcomes	National Institute for Health Research, Service Delivery and Organisation Programme	This study seeks to provide a theoretically and empirically robust understanding of the dynamic relationship between joint commissioning, services and outcomes. The authors sought to map out the range of ways in which joint commissioning is understood across five case study sites which all have different types of joint commissioning arrangements in place.	• There may not be anything that is specific about joint commissioning that is different to other ways of working and it is far from a coherent model with a set of clear organisational processes and practices. • The very value of joint commissioning may then be in its ambiguity and symbolism as a concept that is seen as inherently good and able to deliver against a range of the very sorts of pernicious issues that contemporary health and social care organisations struggle with (e.g. health inequalities, constrained budgets, involving the public and service users in the design and delivery of care services). • The study confirms the findings of numerous previous studies of patient and public involvement; that it is difficult, time consuming and fragile in the face of radical organisational or policy change.	This study seeks to address three key questions: 1. How can the relationships between joint commissioning arrangements, services and outcomes be conceptualised? 2. What does primary and secondary empirical data tell us about the veracity of the hypothesised relationships between joint commissioning, services and outcomes? 3. What are the implications of this analysis for policy and practice in terms of health and social care partnerships?

	Publisher	Study	Key Findings	Applicability
missioning in h, education social care: els, research ography and in- h review of joint missioning een health and al care agencies	EPPI-Centre, Social Science Research Unit, Institute of Education, University of London	This report was funded by the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) programme in order to examine the available evidence on joint commissioning. The study sought to identify good practice and/or help with the production of better quality research on commissioning in the future.	• This project identified a far larger evidence base for service commissioning in health, education and social care than was previously known. A searchable database of research is available at: http://eppi.ioe.ac.uk/webdatabases/Intro.aspx?ID=22. • Synthesis of the results of these studies highlight the importance to successful joint commissioning of: trusting relationships between commissioners, and how these are built up over time by continuity of staff; clarity over responsibilities and legal frameworks, particularly in the context of any shared or pooled financial arrangements; the importance of co-terminosity between organisational geographical boundaries; the development of clear structures, information systems and communications between stakeholders.	The evidence in the report may be helpful in improving the practice of commissioning and/or undertaking better quality research on commissioning in the future.
ncial Integration ss Health And al Care: ence Review	Scottish Government Social Research	This study reviewed the recent evidence and practice outside Scotland relating to better use of	• The goals driving integration need to be made explicit to all those involved in providing the service.	This is an extensive review of literature from across the world that describes and examines

	Publisher	Study	Key Findings	Applicability
		joint resources with a specific focus on financial and resource integration within and across health and adult social care services. The review was undertaken by a team from the Centre for Health Economics and the Centre for Reviews and Dissemination, University of York.	• Full structural integration is rare. • Recognition of different perspectives on key issues such as client risk, financial constraints and accountability is vital if the partnership is to flourish. • Financial and non-financial incentives and organisational processes may be used to help align aims of the Integrated Resource Mechanism (IRM) with the appropriate behaviours and actions of those involved. • The use of common objectives would help to support integrated care on the front line. • All programme staff need to see how integration benefits them and their work. • Use of a central co-ordinator or team may be useful for driving change and supporting staff within the integrated system. • It is important that there is agreement from providers on a key set of data to be recorded routinely and uniformly. • A one-size-fits-all approach to integration should be	the different tools, techniques, systems and processes that have been used to enable financial integration between health and social care

	Publisher	Study	Key Findings	Applicability
			avoided: • The type and degree of integration should reflect programme goals and local circumstances. • Approaches to integration require some flexibility, adapting to stakeholder views including those of front-line staff, users and managers. • The evaluation process can be useful for identifying successes and challenges and in supporting change. • Allowance for a local approach within the framework of central/national guidance may be appropriate. Some of the case studies mentioned in the report that are not included elsewhere in this literature review are: • Hertfordshire Integrated specialist mental health service found that the team approach was helpful and supportive. Service-users viewed the integration of care positively, as did carers. • The Audit Commission's 2009 report 'Working Better Together?' found no	

	Publisher	Study	Key Findings	Applicability
			evidence that pooled budgets impact on emergency bed days, no significant effect on delayed transfers of care and little impact on per capita spend. • Somerset mental health services found an improvement in self-reported mental health status by service users following the introduction of Joint commissioning through a Joint Commissioning Board • Qualitative evidence with Care Coordination Trials in Australia suggested an increased sense of wellbeing in participants due to care coordination • SIPA in Canada which showed the positive impact of case management provided by a multidisciplinary team. There was a 20% reduction in emergency room use, a reduction in bed blockers and a reduction in the number of nursing home admissions. There was also increased carer and care recipient satisfaction. • PRISMA in Canada demonstrated that an integrated service delivery	

	Publisher	Study	Key Findings	Applicability
			system could decrease the incidence of functional decline amongst service users, decrease the burden for caregivers and lead to a smaller proportion of older people wishing to be institutionalised • Rovereto in Italy resulted in a requirement for fewer hours of home support, fewer GP home visits, a lower number of days spent per year in acute hospitals and lower rates of admission to nursing homes, indicating a 23% saving in per capita health care costs • Vittorio Veneto in Italy found that integrated home care services were cost effective and resulted in a reduction in hospitalisations that meant a 29% cost reduction in the intervention group compared to control group. • Jönköping County Council, Sweden introduced 3 major initiatives which resulted in reductions in hospital admissions, length of stay and waiting times.	

	Publisher	Study	Key Findings	Applicability
Management Health Care of People: The ngton munity Care ct (Abstract)	University of Kent, Kent Academic Repository	Evaluation of Darlington project designed to enable frail elderly people, who would otherwise need long-stay hospital care, to remain in their own homes.	• The study found that elderly people receiving the Darlington model of care had a higher quality of life and their care was provided at a lower cost than would have been the case if they had been in hospital.	The study describes the development of a service designed to enable frail elderly people, who would otherwise need long-stay hospital care, to remain in their own homes.

	Publisher	Study	Key Findings	Applicability

ty in and ity of Access to ncare Services gland Research 40)	Centre for Health Economics, University of York	This "country report" for England is part of a larger, collaborative effort between eight European countries to document and analyse access to health care services. The report uses available research to identify and analyze barriers to access to health care services which are faced by vulnerable groups in society, especially those most exposed to social exclusion.	• Increasing supply is probably less important than devising ways of supporting people in accessing existing services
			• The author suggests that the following are likely to be key features of promising policy initiatives in England:
			  • A national context: Initiatives are likely to have a greater impact across the board if they are part of a larger scale initiative that is clearly thought out and provides a framework within which local schemes can be developed and assessed.
			  • A pilot phase: piloting or experimentation of initiatives seems useful and policies that have worked in one sector can be adapted for other sectors or locations.
			  • Financial incentives: many initiatives have focused on providing extra funding for providers to develop
				The report identifies the barriers to access that are faced by vulnerable groups and discusses the characteristics of those initiatives which appear to be helpful.