NHS Confederation

What can integrated care systems in England learn from the devolved nations?

Exploring examples of integrated health and care in Wales, Scotland and Northern Ireland

NOVARTIS

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About us

NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit www.nhsconfed.org

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About this resource

This resource has been developed for relevant UK healthcare decision makers and stakeholders. The NHS Confederation is responsible for the editorial content of this resource. This resource forms part of a Collaborative Working Agreement between Novartis Pharmaceuticals UK Ltd and the NHS Confederation. Funding for the Collaborative Working Agreement is provided by Novartis Pharmaceuticals UK Ltd.

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Contents

Key points

- Approaches to integrating health and care services to improve efficiency and meet population needs have varied across the United Kingdom's four devolved nations.

- Despite policy divergence between these four health systems, similar challenges and pressures exist. In many cases, NHS leaders are exploring similar solutions, whether through service integration, new models of care or increasing use of digital and data.

- Given the differences in approach to integration across the four nations, the NHS Confederation, supported by Novartis, has developed this resource to showcase both examples of good practice and lessons learned in Wales, Scotland and Northern Ireland.

- The case studies included in this resource leverage digital, data and care personalisation approaches. General learnings and further resources can also be found at the end of this document.

- By highlighting specific work taking place from across the UK, it is hoped that integrated care systems (ICSs) in England can take learnings from their devolved counterparts, some of which are further along on their integration journey.

Background

In the UK, the National Health Service (NHS) is the umbrella term for the four health systems of England, Scotland, Wales and Northern Ireland. Across the United Kingdom's four nations, health is a devolved matter and all four nations are overseen by separate UK government departments. As such, approaches to integrating health and care services to improve efficiency and meet population needs have varied across the devolved authorities.

In England, for example, healthcare is under the jurisdiction of national government while social care is the responsibility of local authorities. Meanwhile, in Scotland health and social care exist under one integrated system. However, despite policy divergence between the health systems, similar challenges and pressures exist. In many cases, NHS leaders are exploring similar solutions, whether through service integration, new models of care or increasing use of digital and data.

Integrating health and social care can support people to live healthy and independent lives for longer, and improve outcomes for whole populations, while making better use of available resources and services. Integration remains a priority across the four nations, but administrations have pursued different policies, within different legislative frameworks and structures, to achieve this objective.

Given the varying approaches to integration across the four nations, the NHS Confederation, supported by Novartis, has developed this resource to showcase both examples of good practice and lessons learned in Wales, Scotland and Northern Ireland. By highlighting specific work taking place from across the UK, it is hoped that ICSs in England can take learnings from their devolved counterparts, some of which are further along on their integration journey.

Integration in the devolved nations

Wales

The seven local health boards (LHBs) in Wales are responsible for planning and securing the delivery of primary, community and secondary care services alongside specialist services for their areas including dentistry, optometry, pharmacy and mental health services. There are currently three NHS trusts with an all-Wales focus: the Welsh Ambulance Services Trust for emergency services, Velindre NHS Trust for specialist cancer and blood services, and Public Health Wales for protecting and improving health and wellbeing and reducing inequalities. Additionally, two special health authorities provide services to and on behalf of NHS Wales: Digital Health and Care Wales, and Health Education and Improvement Wales.

The legislative agenda in Wales focuses on partnership working and collaborations across health, social care and the wider public sector. This agenda is underpinned by the Social Services and Well-being (Wales) Act 2014 and Well-being and Future Generations Act (2015), as well as A Healthier Wales, the Welsh Government's long-term plan for health and social care in Wales that provides the strategic direction to move the health service away from hospital-based services to prevention and wellbeing.

The LHBs are also responsible for delivering services in partnership, improving physical and mental health outcomes, promoting wellbeing, and reducing health inequalities across their respective populations. In addition, there are seven regional partnership boards (RPBs) covering the LHB footprint. The RPBs were established to improve the wellbeing of the population and improve how health and care services are delivered.

Scotland

There are 14 territorial NHS boards across Scotland, with each board holding overall responsibility for the health of their populations. This involves planning and commissioning services, as well as delivering frontline NHS services to their populations. Special NHS boards support the territorial NHS boards by providing specialist and national services.

Nationally agreed outcomes are supported by the legislature, including the Public Bodies (Joint Working) (Scotland) Act 2014. This legislation provided a framework to improve the quality and consistency of health and social care services in Scotland, notably by requiring NHS boards and local authorities to enter an integration scheme. This legislation was developed in the context of the Christie Commission report on the future of public services in Scotland (2011), which sets out a vision for collaborative public services based on four principles of empowerment, integration, prevention and efficiency.

The 2014 Act also allowed NHS boards and local authorities to create separate legal entities known as integration joint boards (IJBs). IJBs each have a chief officer who is accountable for the delivery of integrated services. In total, there are 31 IJBs across Scotland.

Northern Ireland

Health and social care services in Northern Ireland have been integrated since 1973. There are six health and social care (HSC) trusts – five HSC trusts providing integrated services, plus the NI Ambulance Service.

Over the past number of years, the Department of Health has been developing their policy for the Integrated Care System for Northern Ireland (ICS NI). Under the new integrated care system arrangements, five integrated partnership boards (AIPBs) will be established, co-terminus with the current HSC trust areas. These AIPBs will have responsibility for planning local services, ensuring services meet key priority areas based on population needs, with an overarching aim to improve health and social care outcomes

and reduce health inequalities based on a population health approach. When adopting this approach, AIPBs will be placing an emphasis on prevention, early intervention and community health and wellbeing.

AIPBs will consist of key stakeholders from across the health and social care system, including representation from local government, the voluntary and community sectors, as well as service users and carers. The AIPBs are now in a pilot phase and learning will be incorporated when boards become statutory in 2025.

Examples of integrated working in the devolved nations

Legislation and policy now mean that integrated care is a requirement – as opposed to an aspiration – across the four nations. We hope that the examples below from the devolved nations are food for thought for those working in ICSs in England.

Digital and data

Cardiff and Vale Regional Partnership Board: Regional Information Sharing Site

The **Cardiff and Vale Regional Information Sharing Site (RISS)** is an online resource that brings together and links key, pseudonymised data from the Welsh Ambulance Service Trust, Cardiff and Vale University Health Board, Cardiff Council, Vale of Glamorgan Council and third sector partners.

Context

- The Regional Partnership Board (RPB) wanted to understand the collective impact of its partnership efforts and aimed to gain a holistic view of the system to optimise service delivery.

- A regional outcomes framework with eight regionally agreed outcomes was developed to guide our endeavours and provide a tangible way to assess the impact of the region's health and social care system on the health and wellbeing of the population. The RISS was developed to bring together the data to evidence whether the RPB was having an impact on these eight outcomes.

- The RISS was designed to be an online resource that brings together key linked and pseudonymised data, creating a unique view of demand and utilisation across the health and care system in Cardiff and Vale.

- The RPB commissioned Lightfoot Solutions to develop and build the RISS utilising their Signals from Noise (sfn) predictive analytics platform.

Aims

- To improve partners' understanding of how people use the health and care system as a whole and how to use linked data to identify opportunities for improvement, monitor key performance metrics and create a single place bringing together demographic data.

- To inform planning and decision-making by providing data-driven insights into the local health and social care system.

- To enable partners to improve care delivery, anticipate demand fluctuations, and measure the impact of service changes and new ways of working.

Impact

- **Improved access to data**: Partners can now access data in one place for the first time, as well as linked data allowing a more holistic view of the health and social care system. This informs planning and decision-making for individual partners, as well as identifying opportunities for collaboration. Different elements of the RISS can help support different data intelligence needs, for example:

  – **Population profiles** provide key data and insights into the characteristics and needs of the local population.

  – **Journeys through health and social care** provide pseudonymised data on those who enter the local health and social care system, the nature of this demand and usage, and the impact of local change initiatives.

- **Supporting improvement and more informed decision-making**: Timeseries charts enable easy visualisation of trends and identification of areas for improvement.

- **Monitoring and evaluation of system performance**: The Regional Outcomes Framework (ROF) on the RISS tracks progress towards eight regionally agreed outcomes, helping to measure the impact of the system on population wellbeing. Whole system dashboards are also being developed to monitor the impact of new initiatives and track progress against the status quo.

Learning for ICSs

- **Holding early discussions on shared strategic priorities across the organisations involved**. When a partnership operates with a common goal, an idea can be developed to its greatest potential and benefit everyone.

- **Understanding the complexity of data and interpreting these correctly** is crucial to sharing information in a way that maximises impact, avoids misunderstandings, and is appropriate for the intended audience.

The following examples from Northern Ireland demonstrate integrated working at a national level during the COVID-19 pandemic. The pandemic highlighted the need for stronger and more resilient systems, as well as exposing some fragmentation in existing health and care systems. Despite the unique context in which these collaborative projects took place, the learnings from the below examples have significant relevance for integration in the longer-term, particularly as digital healthcare approaches become more commonplace.

Northern Ireland COVID-19 proximity app and symptom checker

The **'COVIDCare NI' solution** was a self-diagnosis tool, providing COVID-19 advice on self-care or when to seek a clinical consultation. There was a website with an online symptom checker and an app with a 'chatbot' solution answering general queries about COVID-19.

The **StopCOVID NI app** was Northern Ireland's (NI) 'proximity app' solution, providing anonymous alerts to close contacts of people with proven COVID-19 infection, allowing self-isolation at the earliest opportunity, breaking chains of transmission and lowering the rate of infection.

Context

- The COVIDCare NI app was designed and delivered in just 14 days. It was the first symptom checker launched in the UK and was launched second in the world on the 30 March 2020 (three days behind the US CDC app – developed by Apple).

- The StopCOVID NI proximity app was designed and delivered in just four weeks. It was launched first in the UK (31 July 2020). It was first in the world to deliver a cross border interoperable solution with the ROI COVIDTracker app – enabling interoperability, across two jurisdictions. It was the first approved for use in post-primary-aged school children.

Aims

- Infection control polices to control COVID-19 infection necessitated a re-think of healthcare delivery. Digital adoption was driven by necessity, with the need to minimise face-to-face contact where possible, reducing viral transmission.

- A core aim was also to promote 'digital self-service' and 'digital shift', enabling delivery of more cost-effective services, helping reduce the gap between workforce shortages and increasing demand.

Impact

- Prior to the symptom checker app's development, the diagnosis algorithm was developed and deployed on-call scripts for the NI 111 Pandemic Helpline. The app was designed around the same call script algorithm, and its introduction changed the situation from one where all calls were being referred to clinical services, to only a fraction of calls being referred onward.

- The fall in demand for GP and GP out-of-hours services (that were previously overwhelmed) was dramatic. Prior to the app's introduction, the NI Pandemic Helpline was managing over 6,000 calls daily. After the app was introduced, this dropped to below 1,000 calls per day. The app managed 6,000 daily citizen journeys during the peak of the pandemic, demonstrating a clear digital shift. Only 13 per cent of those checking COVID-19 symptoms were recommended to seek clinical assessment (87 per cent being advised to self-manage). This significantly contributed to alleviating pressure on front-line services.

- The proximity app was downloaded 679,456 times (NI population is 1.93 million). It delivered 97,248 notifications to self-isolate, helping reduce transmission. It achieved an average 'index case:notification' ratio of 1:2.46; superior to manual contact tracing processes.

- 'COVIDCare NI' (the NI COVID-19 symptom checker solution) cost about £1.2 million to develop and deliver. 'StopCOVID NI' (the NI proximity app) cost about £1.2 million. The combined cost of about £2.4 million compared very favourably with the NHS England COVID-19 app, (providing the same combined functionality), which reportedly cost £35 million in total.

Learning for ICSs

- This success was possible through **decisive and accountable clinical leadership, an enabling administrative environment and citizen-centred interactive design**.

- **Trust** was a key factor in success. The **real value of stakeholder engagement** should not be underestimated.
- Through stakeholder engagement and through following Information Commissioner's Office (ICO) design guidance, the NI app was welcomed, particularly for **setting a benchmark on data privacy**.
- Success also depended upon **agile delivery**, in an **unprecedented public-private partnership**, with separation of function (multiple companies delivering different aspects of the development process) in a constructive and cooperative team environment, with **'hands-on' daily clinically-led 'product management'**.
- Companies were prepared to **initiate work 'at risk'**, with accelerated financial approvals.
- **Working constructively with ICO guidance, NCSC advice, and engaged citizens** helped to drive getting it mostly right first time, by design, reducing expenditure.
- **User feedback and agile development approaches** delivered optimisation rapidly, reducing costs.

Northern Ireland digital identity solution

The NI COVID Certification Service (CCS) was an interim service including an app and online application process (with fully validated identity checks), and a non-digital helpline application process to ensure equity of citizens unable to use digital products.

Context

After Malta and Portugal made certification of COVID-19 vaccination an entry requirement, the NI CCS was set up and delivered as an interim service in just four days (from 2 July 2021). A fully automated digital solution was delivered in three weeks (on 23 July 2021).

Aims

To align with ICO 'best practice' advice and meet GDPR requirements on giving access to medical data, it was decided to drive the adoption of the existing NIDA (Northern Ireland Identity Assurance) solution, through use of AI, to provide an automated identity check.

Impact

- The solution achieved automation of well over 80 per cent, well ahead of industry standards, with the ability to verify the identity documents of over 130 countries.

- During the period of operation, the amount of digitally engaged citizens with verified accounts was increased by 5,100 per cent. This led to 85 per cent of the over 16s population of Northern Ireland having a digital account and 66 per cent of over 16s having a fully-checked and verified digital identity (to LOA2 standard).

- The legacy of a digitally registered population enables further digital services for NI citizens, helping ease pressure on health services. The digital identities are already enabling citizens to access the patient portal 'MyChart' in the new digital health record being rolled out across hospitals in NI.

- Ninety-four per cent of COVID-19 certificates issued digitally, indicating an appetite for digital services.

- There were over 1.5 million downloads of the mobile app and over 2.1 million COVID-19 QR codes were scanned domestically to access hospitality and events. Had the service not been available, patients would have been inundating GPs with requests for certification.

Learning

- **Effective, low-cost, successful delivery of technology can unlock optimisation, 'digital self-service' and 'digital shift'**, enabling delivery

of more cost-effective services, helping reduce the gap between workforce shortages and increasing demand for services.

- One of the key benefits of embedding technology in healthcare delivery is production of **reliable standardised data**, as a **by-product of business as usual**.
- **Purposive design allows data to be collected to deliver business intelligence**, helping drive service optimisation and performance management.
- **Creating an alternative non-digital pathway and helpline**, for product support and non-digital applications, ensured **equality in terms of access**, and promoted **quicker product optimisation**, through fewer steps of iteration, (from the initial launch of a 'minimum viable product') by **harnessing direct public feedback on the digital user experience** (helping further reduce expenditure).

Urgent and emergency care examples

Cardiff and Vale Safe@Home: phase 1 – winter response

Safe@home is a new, multi-agency and multi-professional integrated urgent response service which addresses a current gap in Cardiff and Vale's range of intermediate care services. Its aim is to provide an immediate and safe 'now' response, within the hour, as a genuine alternative to ambulance conveyance, emergency unit (EU) attendance and admission to hospital. Referrals are professional-to-professional: mainly via GPs dealing with patients in crisis and direct advanced paramedic practitioner interception of the Welsh Ambulance Service stack to identify people for whom Safe@home could provide a safe alternative to conveyance for.

Context

- Shaping Our Future Wellbeing, a Cardiff and Vale University Health Board strategy, aims to shift the balance to prevention, community and primary care over time.
- Cardiff and Vale Regional Partnership Board's Safe@home programme brings together partners to achieve this and also deliver elements of the six goals for urgent and emergency care.
- Analysis using the linked data capability of the Regional Information Sharing Site (RISS) indicated that some cases are unnecessary admissions, and these often translate into long lengths of stay and associated harm.
- A 'high risk adult cohort' was identified: 2 per cent of the population using 40-60 per cent of bed capacity. Getting it right for a small number of people would therefore have a disproportionately positive impact.

Aims

- To respond rapidly in a crisis, keep people safely at home and prevent the need to go to hospital unnecessarily.
- To support patients to remain at home with the right treatment and care, enabling them to recover from a medical crisis and avoid harm associated with an inappropriate admission and long length of stay.
- To shift focus to prevention, de-escalation of medical crisis, prevention of avoidable admissions, faster recovery and avoidance of harm.
- To reduce demand on secondary care, ambulance conveyances and social care.

Impact

- An effective community-based response for people in crisis.
- Better quality and more accessible health and social care services.
- Higher value health and social care.
- Opportunity to build a more motivated and sustainable health and social care workforce.
- Improved quality of care and experience.

Learning for ICSs

- Partnerships that **align objectives and leverage the respective expertise and resources of organisations** can create successful, fully-integrated services.
- **Supporting change management** ensuring detailed understanding of the nature of demand, with the right skills to meet that demand.
- **Holding 'big room' conversations** with all partners, clinicians and practitioners to develop new integrated, multi-agency care models.
- **Being open to adopting or adapting from elsewhere**. In this case, helpful examples came from Hywel Dda University Health Board and Carmarthenshire County Council's Home First approach, Airedale NHS Foundation Trust's collaborative care team and Bradford Teaching Hospitals NHS Foundation Trust's virtual ward.
- **Being driven by the evidence**. This care model has been data-driven: fully understanding demand and the nature of that demand, across partners has been critical to developing the care model, skill mix and anticipated impact. Linked ambulance, secondary care and social care data is key to that, validated with case note reviews.

Responding to mental health emergencies through integrated approaches in Scotland

The use of a **dedicated vehicle to respond to mental health emergencies** is being expanded in Inverness following a successful pilot of the initiative... Under the new plans, five new specialist staff members are being introduced to staff the mental health response car which will operate out of Inverness and provide services 24 hours a day, seven days a week.

The dedicated mental health response unit, based at Inverness ambulance station, provides specialist mental health assessment, care, and support for people who are experiencing mental health challenges and who contact the Scottish Ambulance Service for help.

Michael Dickson, chief executive of the Scottish Ambulance Service said: 'Our clinicians are often the first responders to have contact with a person experiencing mental health distress. These are patients with very specific needs and often require specialist help and support to make sure they get the right care.

"These units are staffed by paramedics who have undertaken advanced mental health training. The aim is to treat these patients at home, within the community, or through specialist mental health support and our staff work in partnership with mental health practitioners at New Craigs Hospital to provide the best possible support to any individual going through mental health distress.

"It's been a really successful initiative so far and our ambition across all three pilot areas is to connect people to the most appropriate care to meet their needs and for them to get the right care, in the right place.

For more information: SAS boosts mental health services after successful pilot, Scottish Ambulance Service

Care personalisation

Denbighshire's Complex Case meetings

Complex Case meetings have been established as a weekly collaborative forum for multi-disciplinary discussions. They demonstrate a truly united, integrated, single service as well as offering a coordinated, multi-agency approach and response.

Project partners: Community and Voluntary Support Conwy, Conwy Borough Council, Betsi Cadwaladr University Health Board, Denbighshire County Council and Denbighshire Voluntary Services Council.

Context

- A community resource team (CRT) is a combined team of health, social care, voluntary organisations and independent providers, who are working together to provide a seamless service to meet the individual needs of citizens/patients.

- The CRT consists of a wide range of professionals including social care, community therapies, district nurses and the voluntary sector as well as the wider CRT members, for example primary care, palliative care, pharmacy, mental health, including memory clinic and older people's mental health.

- Further to the Healthier Wales plan (2018) published by the Welsh Government, other localities' good practice in this area was researched in 2019, for example observing the multi-disciplinary team board round meeting in Nefyn in Gwynedd.

- Denbighshire's Complex Case meetings were set up in partnership between local authority, health, primary care and third sector. They were introduced at the beginning of COVID-19 and they continue to date.

Aims

- To provide an opportunity for improved and open communications across the health, third sector and social care spectrum.
- To enable better health and wellbeing outcomes for patients.
- To identify high-risk patients who may need additional support to prevent hospital admission, especially when winter approaches.

Impact

- Between April 2022 and March 2023 there were a total of 1,976 discussions.
- On average there are approximately between 30-50 complex case discussions held per week.
- Immediate responses to crisis situations that occur in the community are possible, often resulting in avoiding hospital (re-)admission.
- The meetings offer streamlined communications and networking opportunities, promote learning and have improved relationships between organisations.

Learning for ICSs

- Providing **structured opportunities for communication across sectors**.
- Engaging with other localities to adopt or **adapt proven practice**.
- Mantra is **'we work together and respond as one team'**.

"Integration with the CRT through these meetings has reignited a cohesive team approach to our patient's community-based problems

and needs. With the pressures of general practice workload this has been lost over the last ten years to some extent in my practice and it's clear that through investing a small amount of my time in these meetings it has reconnected our practice with teams that have been under similar pressures... I have seen a real positive change and a lifting of barriers and I hope this simple and small time investment will enable this to continue."
GP involved in project

IMPACTAgewell® Demonstrator Project with IMPACT UK Centre for Improving Adult Social Care

IMPACTAgewell® is an asset-based community development model of care based within older person's charity Mid and East Antrim Agewell Partnership (MEAAP).

Context

- IMPACTAgewell® officers meet older people in their own homes to learn what matters to them and discuss options to improve their social situation and health conditions.

- Where appropriate and with their agreement, the older person will be connected with community groups and statutory bodies that provide relevant services and support. These include lunch clubs; walking groups; home maintenance services; meal services; decluttering advice; energy advice; internet safety advice; benefit reviews; security and safety checks; befriending options; telephone call blockers; and keep warm packs.

- When a community group engages with an older person, they are provided with financial resources to help cover their costs.

- Referrals can come from self-referrals, GPs, social workers, community

pharmacies and others. Bi-monthly Locality Hub meetings bring together the older person's GP, community pharmacist, Northern Health and Social Care Trust worker and IMPACTAgewell® officer to share information and learn lessons relating to individual older people and the population needs of their area.

Aims

- The project was led by two steering groups – a community group involving older people and voluntary sector organisations, and a practice group involving professionals, health and social care organisations, funders, and networks.

- The steering groups set out key questions to be explored initially through research, practice and lived experience evidence. Insights from evidence were discussed at a World Café event involving professionals, older people, and community groups.

- A theory of change was developed following the event which identified key areas for development: engagement from professionals, including GPs, social workers and pharmacists; accessibility to older people from minority communities; strengthening collaboration across the community sector; and widening learning and impact.

- To determine how we can embed these learnings in policy and practice across the UK and Northern Ireland.

Impact

- Increase the number of GP practices they can receive referrals from across the locality.

- Development of deepening working practices with health trust social worker teams, including the creation of an innovative pilot with intermediate rehabilitation wards where IMPACTAgewell® officers visit the older person on the rehab ward before they return home to ensure they have everything they need in place to return home safely, such

as having a keysafe installed to allow carers entry; emergency food packs; OT referrals for alterations; and meals on wheels. Enabling more efficient discharge and decreasing the risk of older people being readmitted to hospital with falls, infections, etc.

- Development of increased working practices with ethnic minority community workers. These workers provided a link to isolated communities of older people with translation services, for example.

- Intercultural training for IMPACTAgewell® officersto ensure they are better placed to support the growing demographic of older ethnic minorities.

- Direct approaches to smaller community groups to build relationships, develop assets and create partnerships to allow funding to follow the person.

- Increased cross-sector sharing of our approach and learning, and recognition of the lack of statutory funding or requirement for social prescribing models despite the clear benefits they bring to the heath service and older people.

Learning for ICSs

- This work has highlighted the importance of the elements of the IMPACTAgewell® approach, ie **locality hubs, skilled and empathetic project officers, a community development approach, and funding for smaller community organisations to build capacity to support individuals**.

- Instability in strategic decision-making can damage the capacity and morale of the community and statutory sectors, but **integration at a strategic level** can enable a community development approach. This involves a **shared approach to investing resources** and how to balance issues of equity and individual need, and **inter-agency co-ordination of funded community services**. The community sector must be provided opportunities to be partners within strategic policy

decisions. Social prescribing can be used to build and strengthen service relationships. Securing funding for core services such as community pharmacy and community transport is essential to provide continuity of support and collaboration.

- **Professional engagement with health professionals** requires continual focus due to changes in personnel, structures and operational environments.

- **Comparing referral data to population-level data** can pinpoint communities that are not accessing support.

- **Backing social prescribing with fees per individual prescription** helps to build capacity and meets the costs of the community sector.

Developing primary care through integrated approaches in Scotland

"GPs in Scotland coordinate across local 'clusters' of practices to share learning and spread good practice. In Fife, the IJB extended this approach to support some clusters not only for quality improvement initiatives between GP practices, but also with other health and care partners. This has included developing GP and nurse practitioner input to care homes to ensure access to treatment outside hospital, continuity of care, regular assessment and development of care home staff roles. Work with social care colleagues to develop social prescribing and other non-medicalised support for wellbeing, such as mindfulness classes, is a notable feature.

GPs in Scotland are under significant pressure but empowering and supporting them to define and develop good practice for their specific community of patients has improved morale. By rooting this work in GPs' own existing networks, and involving local medical committees, the 'early adopter' GPs are promoting new roles in joined-up care to their peers. This is work in progress and expected to develop over time. It reflects an approach of enabling and supporting, rather than top-down direction, and allowing for potentially significant local variation within a broad strategic direction." Leading across health and social care in Scotland, The King's Fund

General learnings

Throughout the process of collecting these case studies, common themes and learnings emerged that could enable successful integration practices.

Embedding integrated care is an incremental process and approaches need time to be tested and, if necessary, adapted. **Integration is not in itself the goal, but rather a means** to improve health, wellbeing, quality of care and service efficiency. By using integration as the vehicle for achieving these improvements, it is vital that any transformational change starts from the best interests of communities and service users.

Working with external partners

- **Local leadership** is critical to building a common vision across participating organisations, driving engagement and advancing the integration agenda.

- Integration authorities cannot make integration happen alone – **collaboration and partnerships** are key.

- Consideration of **partnerships beyond healthcare**. A focus on population wellbeing should mean working with wider external partners that specialise in housing or other social determinants of health.

- Partners should be engaged with **early in the process**. Their **unique expertise, resources and networks** should be explored thoroughly and viewed with equal respect.

- To manage partner expectations from the outset, early conversations around **organisational risk appetite**, **programme management** and **reporting** can be useful.

- Clear and specific objectives and visions allow organisations to **evaluate and evidence their success**, and make it easier to **clearly communicate** the value of work to stakeholders and the local population.
  - As part of this, data can not only inform a strategy but also be vital for measuring impact and iterating approaches as needed.
  - Data should ideally be used to learn for improvement, inform decision-making, and to build an open culture across organisations.
- Discussion around **variance in governance** cycles between partners can also help to mitigate issues later down the line.

Workforce

- Aside from ensuring buy-in from executive teams, **effective clinical leadership** also plays an important role.
- The ability to adapt and use **multiple leadership styles**, especially when peers from different organisations with system-wide roles work together, can enable success.
- **Learning together from wherever knowledge exists** should be valued.
- **Understanding staff perspectives** is a key early step in developing any strategy. Taking time to understand the **workforce implications** of new ways of working in partnership is valuable.
- Given the shift from traditional workforce structures, **empowering teams** can be crucial for success.

Further information

Contact details

Cardiff and Vale Regional Partnership Board Regional Information Sharing Site and Cardiff and Vale Safe@Home: **cath.doman@wales.nhs.uk**

Northern Ireland COVID-19 proximity app and symptom checker and Northern Ireland digital identity solution: **edward.o'neill@hscni.net**

Denbighshire's Complex Case meetings: **david.soley@denbighshire.gov.uk**

IMPACTAgewell® Demonstrator Project with IMPACT UK Centre for Improving Adult Social Care: **sarah.mclaughlin@meaap.co.uk**

Additional resources

This document is intended to prompt reflection and discussion. We encourage you to further explore these perspectives with your colleagues.

The NHS Confederation is available to support peer learning and sharing of good practice.

The NHS Confederation and Novartis jointly coordinate a Community of Practice that brings together healthcare system stakeholders from across the NHS ecosystem, covering a variety of backgrounds, roles and localities.

For more information and to sign up, please visit **www.nhsconfed.org/commercial/community-of-practice**

The Health Foundation, NHS Confederation and the Q community are working in partnership to support health and care systems to learn and improve. This partnership brings the improvement expertise of the Health Foundation and the networks and relationships of the NHS Confederation together with Q's membership community of over 5,000 people collaborating to improve the safety and quality of care.

For more information, please visit **www.nhsconfed.org/improvement-support/learning-improving-systems**

18 Smith Square
Westminster
London SW1P 3HZ

020 7799 6666
www.nhsconfed.org
@NHSConfed

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