The King's Fund>

Ideas that change
health care

Author
Peter Thistlethwaite

March 2011

Integrating health and social care in Torbay
Improving care for Mrs Smith

Key messages

- This paper tells the story of health and social care integration for older people in Torbay, and how the known barriers to this were overcome. It shows how integration evolved from small-scale beginnings to system-wide change. Central to the work done in Torbay was how care could be improved for 'Mrs Smith', a fictitious user of health and social care services.

- The establishment of integrated health and social care teams and the pooling of budgets helped to facilitate the development of a wider range of intermediate care services. Teams worked closely with general practices to provide care to older people in need and to help them live independently in the community. The appointment of health and social care co-ordinators was an important innovation in harnessing the contribution of all team members in improving care.

- The results of integration include reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Use of residential and nursing homes has fallen and at the same time there has been an increase in the use of home care services. There has been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.

- Torbay's story underlines the time needed to make changes in the NHS and the role of local leaders in this process, including those in local government who will have an important role in the future of health care. It also demonstrates the importance of organisational stability and continuity of leadership. The power of keeping patients and service users like Mrs Smith at the centre of the vision for improvement is another key message, and one whose importance is difficult to overestimate.

Foreword

Torbay has attracted increasing interest in recent years because of its work to integrate health and adult social care services to better meet the needs of older people. Peter Thistlethwaite's paper draws on his work as a researcher and adviser to the health and social care community and provides a fascinating account of the different elements that contributed to Torbay's success.

The King's Fund commissioned this paper because of a belief that achieving closer integration of health and social care is central to the challenge of improving outcomes for patients and service users (Curry and Ham 2010). Integration is especially important for people with long-term conditions and older people whose needs are rarely either just 'medical' or 'social'. The main aim of the paper is to set out how NHS and local government leaders in Torbay together with frontline staff overcame the obstacles to integration that have hindered progress in this direction in other areas, and to distil lessons of wider relevance from their experience.

Although the paper includes quantitative data demonstrating the achievements of Torbay, it was commissioned mainly as a case study designed to tell the story of what lies behind these achievements. The value of case studies is their ability to get underneath the surface of innovations in public services and to describe in some detail the complexities of bringing about change and the factors that were most important in this process. The focus of what follows is therefore primarily on the interplay of people, relationships and processes in the Torbay health and social care community and how these came together to deliver measurable improvements in performance.

Central to the Torbay story was the receptive context for change based on a long-term commitment to joint working. Also important were the presence of NHS leaders who had developed a good working relationship over time and the burning platform of adult social care services that were performing poorly. It was in this context that a compelling shared vision was developed, centred on improving the care of 'Mrs Smith', a fictitious user of health and social care services in her 80s.

The journey to integrating health and adult social care services started from the bottom up. A fundamental building block was the creation of an integrated health and social care team in Brixham in 2004, which worked with a number of general practices to help older people most at risk, with a particular focus on enabling them to remain independent for as long as possible. Later on, increased investment in intermediate care became a key priority and this improved access to services, thereby helping to reduce avoidable hospital admissions.

Discussion of bringing together the functions of the primary care trust and adult social care services provided by Torbay Council emerged out of the establishment of the integrated team in Brixham and the extension of this approach to other localities. The managers overseeing the work of these teams highlighted the complexities of different contractual and other arrangements in place for staff and this led to the suggestion that a care trust should be established. The idea won support from the council and after debate and consultation, the Secretary of State for Health gave approval to the creation of the Torbay Care Trust in 2005.

As the work of integrated teams evolved, it became clear that the appointment of health and social care co-ordinators was a critical innovation. Co-ordinators became the main point of contact for referrals and liaised with other team members to decide who should handle these referrals and how. They also worked closely with nurses, allied health professionals and social care staff to put in place appropriate care packages and support. Co-ordinators do not have formal professional training but know how to harness the contribution of team members to improve the care of Mrs Smith and people like her.

The work of co-ordinators was underpinned by a commitment to sharing data, enabling co-ordinators to access information about users from the hospital, general practices and the care trust. At first, co-ordinators had to switch between different systems, but eventually a single system was introduced for social care and community health services. As trust has developed, named co-ordinators have been given access to the patient information system at the hospital, and certain practices have offered similar access to link workers at the care trust.

Integration in Torbay has been facilitated by a large measure of continuity among senior leaders and, until recently, by much greater organisational stability than in the rest of England. For example, the reorganisation of primary care trusts in 2006 did not affect Torbay because the establishment of the care trust in the previous year meant that further organisational change was deemed unnecessary. The reforms under way following the May 2010 election, including the changes that have followed from the transforming community services initiative, have had a bigger impact, and at the time of writing it is not clear what the consequences will be in the longer term.

Three wider lessons can be distilled from Torbay's story. First, making change happen in public services takes time and requires persistence by local leaders in overcoming obstacles and challenges. Second, delivering real results depends on working on several fronts simultaneously while remaining faithful to the vision of improving outcomes for 'Mrs Smith'. Third, improvement in this case resulted mainly from the leadership of providers of health and adult social care services, with commissioners having a lesser role.

It might be added that the achievements of Torbay derived more from the commitment of managers and clinicians to make a difference than from the impact of policies on choice and competition. This reflects the geography of the area, with local people naturally gravitating towards local services rather than travelling to neighbouring providers for their care. It also illustrates the way in which internal drivers can be just as important as external factors in improving performance.

The question that many readers will ask at the end of this paper is: to what extent can the experience of Torbay be replicated, or more accurately adapted, in other areas? My reading is that while Torbay has some distinctive characteristics that will be difficult to reproduce elsewhere, some clear messages are applicable everywhere, even if, as Peter Thistlethwaite notes, there is no textbook to follow. The ones that stand out for me are:

- have a clear vision based on making a positive difference for service users, and be sure to keep this in sight at all times

- start from the bottom up by bringing together frontline teams and align these teams with general practices and their registered populations

- consider how simple and inexpensive innovations like the appointment of health and social care co-ordinators can make a major impact

- keep the faith in what you are doing even when all those around you may be losing their heads as a consequence of organisational and other changes that may hinder rather than help the cause of integration and service improvement.

These messages take on added importance at a time when national leaders of the NHS have emphasised the importance of integrated approaches in enabling health and social care organisations to meet the financial and service challenges that lie ahead.

Chris Ham
Chief Executive, The King's Fund

Introduction

Since publication of *A Joint Framework for Social Policies* (Central Policy Review Staff) in 1975, governments have consistently encouraged inter-disciplinary and inter-agency collaboration to meet the needs of individuals and communities more effectively and efficiently. Much attention has been given to the divide between the NHS responsibility for health care and local authority responsibility for social care. Despite this, resistance to major change in practice and re-organisation appears to exist at a local level. In 1997, New Labour's first Secretary of State for Health, Frank Dobson, railed against the 'Berlin Wall' he then observed. Although there have been some success stories and some failures and a variety of different models, generally there has been a lack of ambition to attempt wholesale and sustainable adjustments to the existing fragmented services. As recently as 2006, *Our Health, Our Care, Our Say: A new direction for community services* (Department of Health) stated: 'The current interface between health and social care appears confusing, lacking in co-ordination, and can feel fragmented to the individual'.

Innovation such as integrated care is necessary, particularly in this time of economic austerity, as nations and localities search for effective responses to the needs and demands of an ageing population. This paper explores beyond the integration of health care provision to examine the benefits of integrated health and social care, which is now a core policy aim of the new coalition government in England. This case study outlines the ambitious and comprehensive approach to the integration of health and social care that took place in Torbay and resulted in better responsiveness to the needs of individuals and enhanced performance of the whole system of care. Although improved care is important, the most significant aspect of this case study is how the local authority worked together with the local NHS organisations to change the whole system of care in Torbay.

This paper documents:

■ the importance of health and social care integration

■ the experience of how an organisation that delivers integrated health and social care can be created

■ the lessons learned by overcoming the established barriers to integration and capitalising on a common vision for local change.

The Torbay context

Torbay is a small unitary council area that includes the three towns of Torquay, Paignton and Brixham (*see* Figure 1 opposite).

Torbay's economy was built on tourism and fishing, but both industries have declined over recent decades. Employment has historically been seasonal and low-paid, making Torbay a generally impoverished area despite its 'English Riviera' reputation. Torbay is predominantly urban, and has a higher than average population of older people – 23 per cent of the population are over 65, while the national average is 16 per cent. Many of these older residents retired to the area and so have weak local family support.

Figure 1 Map of Torbay and neighbouring South Devon

The foundation for collaborative health care

For quite some time Torbay has benefited from strong primary health care services that were innovative and influenced early developments in whole-system thinking. Prior to the establishment of primary care trusts (PCTs) a decade ago, South Devon Healthcare Trust, the local hospital, which has a catchment area that extends into the southern part of Devon, was a whole district NHS trust. The trust eventually appointed a director specifically for the community health service (eg, district nursing, community hospitals and therapy). It also nurtured GP fundholding.

One innovation at that time involved the practice manager of a GP surgery in Dawlish, a nearby town in Devon for which the trust was responsible, acting as the locality manager for the trust. This person managed the community teams and the local community hospital and also provided accommodation in the hospital for social services staff. This integration of primary, community and secondary health care demonstrates a history of collaborative thinking in the area. Interestingly, this kind of collaborative thinking may be destined to return in many parts of the country in response to the Transforming Community Services agenda.

There are two small community hospitals in Torbay, at Paignton and Brixham. In common with many seaside towns, Torbay has numerous care homes that were established prior to the NHS and Community Care Act 1990. For many years this meant that services were focused away from home care.

For the past 10 years, mental health services and the health care elements of learning disability services in Torbay have been provided by Devon Partnership NHS Trust.

Shaping the system of collaboration – impact of the creation of Torbay Primary Care Trust

The drive to develop a more collaborative approach between primary and secondary care clinicians had been actively supported by NHS managers and reinforced by the formation of the Torbay Primary Care Trust (Torbay PCT). The Torbay PCT took over the management of community services from the hospital in 2002/3 and began leading and shaping the whole system of health care. Its chief executive was an experienced health authority chief executive from Devon (which had included Torbay), and the hospital chief executive was long-serving, so relationships were well established and links with primary health care were sound. GPs were encouraged to work together in five small local clusters that facilitated communication with the Torbay PCT. This enabled GP leaders to emerge.

Karakusevic (2010) documented this period, which included the following important initiatives.

- The Getting Patients Treated Group co-ordinated the work of local stakeholders, including collecting and sharing data across the whole system. Chief executives, medical leaders, finance directors and performance directors were all involved in the system-wide strategy, which was previously outside the scope of fundholding.

- Clinician to Clinician Commissioning aimed to continue the benefits of primary and secondary care collaboration when the whole-district trust was fragmented, but with the addition of consistent managerial and organisational development support. This brought a strong focus to pathway redesign and ensured a collaborative response to new government targets (for example, for accident and emergency departments (A&E) and consultant referrals).

- An Integrated Care Network was gradually established in response to the *NHS Plan: A plan for investment, a plan for reform* (Department of Health 2000) to target change in clinical practice, business processes, workforce and community services.

The Torbay PCT was a strong, lean organisation, with stakeholder support, and control of its finances (many other PCTs across the country were struggling with historical debt) – this was a significantly positive platform for further developments. Furthermore, the success of the South Devon Healthcare Foundation Trust meant that there were no distractions from work to improve community services. The health community was offered the opportunity to join the Kaiser NHS Beacon Sites Programme (Ham 2010), which resulted from the unfavourable comparisons made between the performance of the NHS and the highly integrated Kaiser Permanente organisation in America. This international evidence prompted self-appraisal and underpinned subsequent changes.

The chief executive of the Torbay PCT was looking for every possible opportunity to get involved in special projects and pilots to stimulate and take forward thinking. The Kaiser NHS Beacon Sites Programme provided numerous managers and senior clinicians from primary and secondary care with the opportunity to visit California to broaden their understanding of the nature and benefits of integrated health care, and, therefore, to be more able to undertake peer review of local practice.

It became apparent that effective health care was increasingly partly dependent on responsive social care provision, which seemed to be lacking in Torbay. Earlier collaboration between the NHS and Torbay Council had resulted in small-scale projects to develop 'rapid response' intermediate care and services for carers. However, the interface of health care and social care was in need of a much larger transformation.

Local leaders became aware of the evidence base for joint working between local government and the NHS, which included:

■ a systematic review of the literature, which was published by the School for Policy Studies at Bristol University (Cameron *et al* 2000). This was a key influence, highlighting the organisational, cultural and professional, and contextual issues that created barriers to joint working, and this awareness enabled effective action to avoid them.

■ lessons from a series of studies of health and social care by the Audit Commission (1997, 2000, 2002) recommending more joint working

■ work from pioneers of whole-system working (Pratt *et al* 1999).

From this evidence base grew a fully integrated approach initiated by managers, professional leaders and clinicians at local level and later delivered by a single NHS organisation. This system provided uncomplicated access to social care for service users.

Table 1 demonstrates how synergising the work undertaken at four different organisational levels achieves and sustains integrated health and social care.

Bringing together local government and the NHS

How Torbay Care Trust came into being

Early experiences of collaboration

When integration was first considered in the light of whole-system thinking developed by the Integrated Care Network, the former trust, the PCT and the council had already made some joint appointments, and some joint projects were in place. This included a multi-disciplinary Crisis Assessment and Rapid Reablement for the Elderly service (CARRIE) that could be accessed by GPs to avoid a hospital admission. CARRIE had been independently evaluated and was popular with GPs.

The chief executive of the PCT thought that health care was being damaged by a social service provision that was poor or, at best, not well focused. This triggered a more joined-up approach to health and social care in Torbay. At the height of national concerns about delayed discharges from hospitals, Torbay Council engaged positively in preventing unnecessary hospital admissions and arranging prompt and safe discharges.

Changes at Torbay Council

By 2003, new government performance regimes began to indicate that Torbay Council was unsuccessful and its future was uncertain. It had become a unitary council in 1998 as part of local government re-organisation. Its social services department had not progressed beyond 'one star' in the national ratings. It was one of a handful of departments publicly 'named and shamed' by the Secretary of State, Alan Milburn, at a national conference in 2002. All of this acted as a driver of change, and the council appointed a new chief executive on a short-term performance contract to lead its overall improvement.

A 'commission' of leading council members was formed, which initially focused on the education department. The commission aimed to create a multi-agency children's trust – an idea floated by the government in *Every Child Matters* (Department for Education 2003). While planning to merge the child care responsibilities of the social services department into a new children's services function, questions were raised about

Table 1 Timeline of integration of community health and social care in Torbay (2000–2008)

Year	Frontline practice level	Management of provider services level	Commissioning level	Whole-system governance level
2000–2002	Work begins to build co-operation between the whole district trust and primary care at clinical level. Rapid response intermediate care services, and, later, carers support, are created with the Torbay Council.			
2003		Torbay PCT and South Devon Healthcare Foundation Trust managers maintain close working links and start to develop a shared information system. Meetings begin between strategic management teams at Torbay PCT and adult social services, which increase collaborative effort across the board. Some new joint appointments are made.		A 'commission', led by the council and involving elected members and non-executive directors of the Torbay PCT, is set up to explore options for the future of children's and adults' services. It recommended an integrated service for the latter.
2004	An integrated team of local community health and social care staff and services is piloted. It is linked to three local GP practices in Brixham, with a population of approximately 23,000. The core staff – nurses, community matrons, therapists and social workers – are able to be co-located during the pilot phase.	Allocation of work in social services is linked to GP registration of the individual rather than by address. A locality manager (Torbay PCT and Torbay Council) is later appointed to lead the pilot integrated service in Brixham. A joint director of operations (PCT and council) is appointed and a single management team is formed.		A Torbay PCT chief executive/ director of adult social services is appointed. A decision is made to apply to become a care trust.
2005	The first health and social care co-ordinator is appointed in Brixham. This proves to be a crucial future component of the Torbay system.	An integrated management structure for the Torbay PCT and adult social services is conceived and implementation commences.	A single commissioning team is formed from existing staff in the council and the Torbay PCT. This is led by a care trust executive director who becomes responsible for supporting practice-based commissioning and then for leading world-class commissioning developments as they are introduced.	Torbay Care Trust is established and contracted to provide all social care functions for the council (with annual review of budget and performance). The board includes two nominated council members. Senior appointments are made to the new integrated management structure of the care trust, including a professional lead for social work. A single budget is formed. Savings in management costs are made.
2006	In accordance with findings from an independent evaluation of the pilot, the system was developed and then extended across the whole area and linked to four more clusters (or 'zones') of GP surgeries, each with its own manager and professional leads.		A joint performance team is established.	
2007	Major investment in integrated intermediate care services begins in each of the zones. More co-ordinators appointed			
2008	Health and social care co-ordinators introduced to certain hospital wards.	Successful bid by Torbay Care Trust and South Devon Healthcare Foundation Trust to be a national pilot of (vertically) integrated care.		

the future of social services for adults. These were subsequently considered by the commission and the chair of the Torbay PCT was invited to join.

The commission recommended an integrated approach to the care of adults that was to be achieved by a partnership between Torbay Council and Torbay PCT. The council saw the PCT as a confident and well-managed organisation, led by people it could trust. The partnership was seen on all sides as mutually beneficial, although social services performance represented a real risk for the PCT. The management teams from both organisations began to have regularly scheduled joint meetings. In 2004, the council and the PCT resolved to merge the posts of chief executive of the trust and director of adult social services for the council. After interview by a joint panel, the PCT chief executive was offered the post. His leadership accelerated the planning of an integrated service, including early piloting in Brixham, and all management and support functions (for example, finance and human resources) were aligned from 2004/5.

Preparing for change

In 2004, a decision was made to allocate work to staff teams in adult social services in Torbay on the basis of GP registration rather than home address. This aligned social work with community health and linked it to clusters of GP practices operating in Torquay (two clusters), Paignton (two clusters) and Brixham (one cluster). It is difficult to see how integration could have progressed so readily without this decision. These clusters later came to be called 'zones', which ultimately proved to be the facilitators of bottom-up change.

The joint management teams met more regularly from 2004 and initiated a series of staff seminars that focused on the benefits of integrated care. Quarterly seminars were delivered to approximately 200 staff from both organisations (approximately 100 staff attended the morning session and 100 the afternoon session). The sessions were usually independently chaired and facilitated, and feedback was formally sought from delegates on the day. Management responded to the comments within one week. These sessions ensured the process was transparent and that staff had access to those leading the changes. This model is still used by Torbay Care Trust to engage staff on important new issues.

The experiences of Mrs Smith, a fictitious 80-year-old user of a fragmented range of services (*see* Figure 2), were used by the chief executive to convey the need for and purpose of an integrated service.

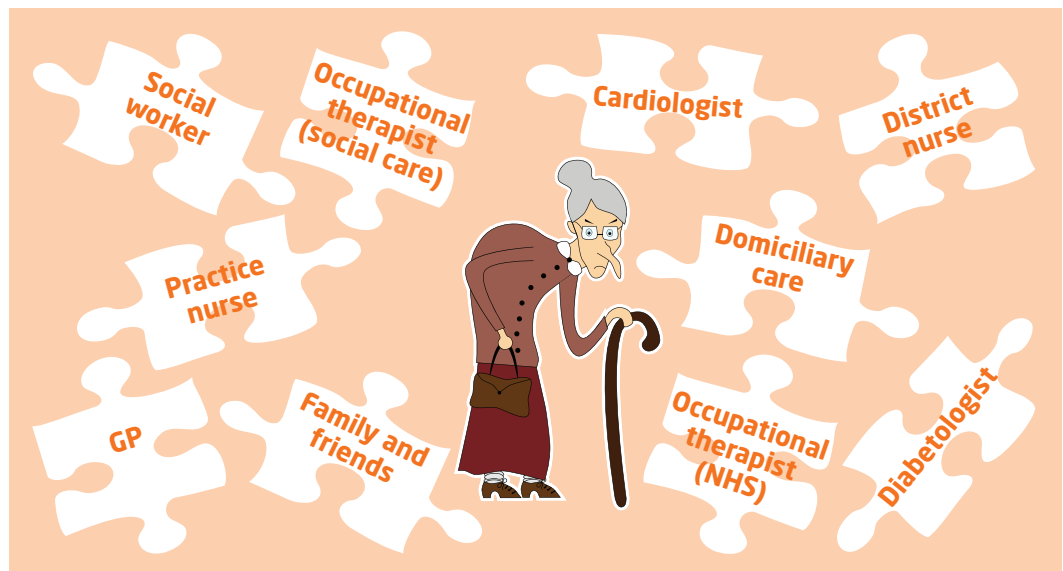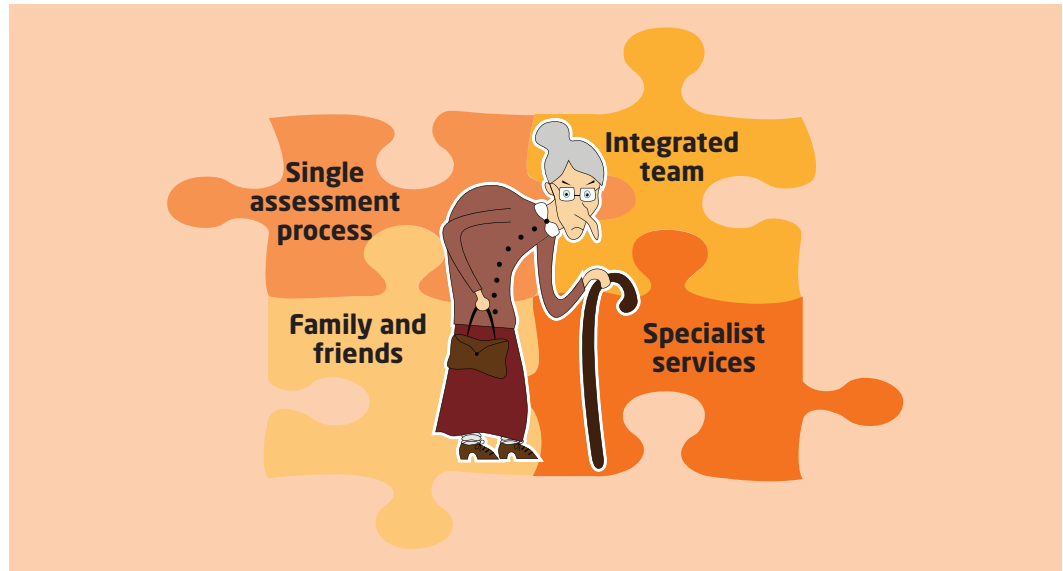**Figure 2** Mrs Smith

Figure 3 Future model

The ambition was to overcome fragmentation so as to provide a co-ordinated and integrated experience for Mrs Smith and people like her (*see* Figure 3).

Lavender (2006) describes the importance of Mrs Smith as follows.

> *A story was constructed around Mrs Smith, about the services she required, and the difficulties and frustrations she faced in trying to navigate the local health and social care system. Simple problems were highlighted, such as many separate assessments, having to repeat her story to many people, inherent delays in the system due to the transmission of information, and the complexity of the system. This story was then contrasted with the vision of how health and social care services would operate within a care trust.*

> *Central to the vision was the concept of improving access to services for Mrs Smith, and making the delivery of those services as simple and as quick as possible. It was recognised that this required a rethinking of how services were currently offered and development of new ways of working. The intention was to be as innovative as possible in the way in which the organisation operated, and to try and make the best use of all the skills staff had, rather than be constrained by the way the existing system worked…*

> *The power of Mrs Smith's story was obvious, in the connection that everyone had with her. Many service users, carers and staff knew a Mrs Smith, and they all recognised the problems she faced.*

> *Soon there was no presentation on the care trust which did not contain Mrs Smith, and she has become the symbol of the new organisation.*

Initial ideas for change

The chief executive identified the following local advantages:

- co-terminosity
- quality of staff
- political support
- the foundation of joint work.

However, he also identified several challenges:

- cultural differences between professionals
- differing terms and conditions in the workforce
- no basis for information sharing
- central/local balance (social services were centralised)
- governance/accountability would have to be thought through
- increasing financial pressures.

He felt that the introduction of 'general management' was necessary, but that it had to be balanced by effective leadership of the professions. The model was tested in one locality before it was adopted more widely. In the end, this philosophy had a key test: should the new organisation have a Director of Social Care, as seen in some mental health trusts? It was concluded that the introduction of this post would reinforce the 'silos' and hold back full integration, so the post was never introduced.

The chief executive also introduced staff to the Kaiser Triangle, which emphasises how a focus on chronic care differentiates the needs of the local older population, and how introducing case management to support people with the most complex needs is essential to integrated care.

This approach chimes with the first 'law' of integration formulated by Walter Leutz (1999): '*You can integrate some of the services for all of the people, all of the services for some of the people, but you can't integrate all of the services for all of the people*'. The chief executive's challenge to each of the new zones was to get to know their population and apply this sort of model.

The broad vision was eventually distilled into a number of practical benefits (*see* Table 2 below), justified by research evidence from elsewhere, to be delivered to Mrs Smith.

One senior occupational therapist employed by Torbay Council remarked in a questionnaire about the change process:

> *My knowledge and experience of change in health and social services over the last 25 years or more is that it has always been difficult for fieldworkers, clinicians or practitioners to accept change because of their fear of a reduction in their ability to assist a client or patient. Generally, it feels that this is not how people see it now.*

Table 2 Achieving benefits for service users

Benefit for patient/user	How it was to be achieved
Improved overall access to services	Single point of contact in each zone (health and social care co-ordinators)
Shortened time from identification of need to delivery of community service	Informal and formal multidisciplinary teamwork in zones
Simplified decision-making processes	Unified single management system, including financial delegation to local managers
Increased efficiency of processes of assessment (for example, cutting out duplication)	Informal and formal multidisciplinary teamwork in zones
Eliminate 'buck-passing'	Staff in zones work as a team to achieve a shared vision
	Whole-system approach, with hospitals, primary health care and other community services (for example, mental health) encouraged to be in partnership with zones
Communication failures reduced	Named links between services; face-to-face working

Project management

An existing member of the Torbay Care Trust staff was seconded to be the project manager for integration. He formed a number of work streams to tackle the numerous issues (*see* Lavender 2006). Staff engagement was central to the process: existing staff played key roles in all work streams and work stream leaders undertook additional consultations. An example of the success of the integration work is the forging of a single occupational therapy service from the existing PCT and council services. During the pilot stage in Brixham, a vacancy for a part-time hospital occupational therapist arose and was filled by extending the hours of a social services occupational therapist working locally. A senior occupational therapist commented: '*That could never have happened before we formed the integrated team. No one would have even thought of asking*'. This is a simple example of how leaders were ready to be responsive to the creative ideas generated by frontline staff.

Some staff were released from their normal duties to support work streams on a full-time or part-time basis. An experienced human resources director was recruited and played a major role in securing staff and trade union support for the changes. Weekly email bulletins and a glossy monthly newsletter kept staff and other stakeholders up to date with developments.

During the pilot of the integrated team in Brixham late in the winter of 2004/5, it became apparent that it might be advantageous to create a fully integrated model delivered through a single organisation, rather than continuing to work in formal partnerships. The person appointed as locality general manager (or zone manager) identified that she was doing 'two of everything' in order to meet the requirements of both the council and the PCT (for example, processes for budget monitoring, staff recruitment and approval of travel claims). This triggered new thinking about governance in order to improve efficiency and accountability.

The Health and Social Care Act (2001) introduced the concept of 'care trusts' – NHS bodies providing social care under contract from a local authority. Although these were not favoured by local government bodies, a small number were created. Half of the care trusts, not unexpectedly, specialised in mental health and learning disability. Three care trusts were PCT-based (Northumbria; Bexley; and Witham, Braintree and Halstead [Essex]), so their experiences were closely examined.

The idea of becoming a care trust won political support and the project manager began a process of public consultations and a formal application to the secretary of state. The idea was not opposed locally by any professional or public body in Torbay. The strongest resistance came from the regional level of the NHS, which had concerns about the good performance of the PCT being undermined, and the Commission for Social Care Inspection, which was concerned about the council failing to improve social services. A prolonged debate took place during the early summer of 2005 (delayed by the uncertainty of a general election) before the new secretary of state was finally able to give approval to the creation of Torbay Care Trust. The chief executive of the care trust continues to act in the statutory role of director of adult social services for the council and contributes more generally in its affairs as a chief officer.

In late 2004, integration of operational management commenced. The joint post of director of operations was created and filled by one of the two existing senior managers. From that point, middle management began to be integrated further. To ensure a strong voice for social work and social care, the new post of professional lead for social work was created and was later given a place as a non-voting member of the Torbay Care Trust board when it came into being. Two social workers joined the local professional executive committee (PEC). This was reassuring for council staff; however, a small minority of professional social workers remained convinced that a 'medical model' had been imposed on them and that there was a real threat to their professional status.

Piloting an integrated locality team

The Brixham context

One of the existing GP cluster areas, Brixham, was selected to trial integrated health and social care. This was an established and self-contained community that comprised 23,000 residents, three GP practices, a community hospital and a local authority residential home/day centre. Late in the summer of 2004, social care staff and services of the council and the PCT were placed under the management of a new zone general manager. The person appointed had a background in finance in social services and management of home care services. Many council staff found it reassuring that one of their colleagues had secured this important new post, particularly because there was a feeling that social care was being 'taken over by the NHS'.

Middle managers from the council initially proved reluctant to allow a small group of their centrally based staff to work exclusively from the Brixham locality for the pilot, citing potential loss of control of the referral process and flexibility of their staff management. It took several months before a volunteer group of social workers and a leader were able to work with community health staff in Brixham. The whole team was eventually based together in spare accommodation that unexpectedly became available at the community hospital. The box below outlines the Brixham zone team.

The Brixham zone

Zone manager.

Professional leads: social work, physiotherapy, occupational therapy, district nursing and community hospital manager (all part of the zone management team).

Teams: social workers and community care workers; physiotherapists and assistants; occupational therapists and assistants; community nurses and nursing assistants.

Health and social care co-ordinators.

In 2007, an intermediate care team was introduced that involved all disciplines and was therapy-led. The team included multi-skilled support workers.

Note: individual zones also have additional responsibility for managing some trust-wide services (for example, hospital social workers and rehabilitation services) and for liaison with community psychiatric nurses and similar specialist services.

The evaluation

The chief executive/director of adult social services engaged an independent person (the author) to evaluate the pilot, and an action research methodology was proposed. The evaluator was actively to engage with the team in a joint enquiry to establish the best way to integrate people and services to achieve the vision outlined for Mrs Smith. The evaluation was designed to be a cyclical collective learning process; that is, it involved clarification of initial objectives, monitoring, feedback and then any consequent adjustment of objectives. This cycle happened twice during the pilot period. Progress was shared widely by the evaluator and Brixham staff at the regular staff seminars and in the newsletters.

Access – managing referrals

The referral pathway from NHS staff and GPs to adult social care was reviewed to establish a baseline. The results confirmed Torbay Council's poor performance. GPs who were interviewed at the start of the pilot specifically expressed concern about lack of feedback from social services. The evaluation identified an essentially linear and bureaucratic process of referral management, with extensive use of waiting lists to even out demands.

In the knowledge that integrated working could speed up decision-making and eliminate inefficiencies, the zone manager asked staff to improve the service for Mrs Smith. Table 3 demonstrates a considerable improvement over a six-month period.

Table 3 Time taken to process referrals for social care services

	Referral to first contact	Referral to assessment	Assessment to services
Baseline (Torbay) summer 2004	15 days average (range 1–81 days)	27 days average (range 1–146)	5 days average (range 1–45)
Brixham Pilot March 2005	4 days average (range 1–14)	10 days average (range 1–32)	3 days average (range 1–22)
Torquay/Paignton March 2005	5.5 days average (range 1–20)	10 days average (range 1–27)	4.5 days average (range 1–57)

Although the improvement achieved in Brixham is interesting, it is also important to note the almost simultaneous performance improvement elsewhere. This is attributable to the new approach to leadership and communication across the borough. Improvement continued to be maintained. The Brixham team leader stated: '*We are getting to know GPs much more now, and named social workers link to surgeries so we can discuss referrals and give feedback*'.

Health and social care co-ordinators

Once based in shared premises, the integrated team members were able to examine more closely the scope for innovation and efficiency gains. Referral pathways were judged to be the priority for improvement because separate routes existed for each profession, some were unnecessarily complex and some were unsupported by information technology. The council employed administrative referral co-ordinators and one of these came to Brixham as part of the social services team. There was also a CARRIE co-ordinator in Brixham.

In early 2005, the zone manager proposed the creation of a health and social care co-ordinator post to streamline and control referral processes. Although an apparently obvious solution, which originated from the experience of frontline professionals trying to work better together, it encountered many obstacles before approval. This was primarily because the post straddled both organisations and challenged established arrangements for pay grades in similar posts.

The existing CARRIE co-ordinator was appointed to the post and formed a team with the referral co-ordinator. All referrals were directed through the co-ordinators who, by consulting computerised and paper records, using their own knowledge and recall, and setting up their own spreadsheets, were able to ensure an enhanced level of information sharing. For example, a nurse could discover quickly and informally whether another professional had had contact with a patient – this led to case discussions and better planning of contacts. One NHS occupational therapist said of one case: '*I got all the background I needed directly from the social care occupational therapist for my visit to the patient. We think this saved five hours of our time*'.

Single management was providing the drive forward, and being in the same location was helping the team to form, but new co-ordination process challenged thinking. To illustrate, one remit given to co-ordinators (which had previously been used by CARRIE co-ordinators) was to arrange care packages and modify them in accordance with changed circumstances. In the pilot this proved a major efficiency gain. If a patient's needs changed, a nurse would previously have made a referral to the council's office in Torquay for a social work assessment; under the new system, the co-ordinator could introduce changes based on the assessment of the nurse. This kind of change required sensitive management, but the benefits to Mrs Smith were clear to all. The linear process of referral management was replaced with integrated teamwork. The culture of inter-professional working began to change. One social worker also commented: '*A nurse can just have a discussion with me and find a solution. This prevents a referral*'.

The job profile for the co-ordinator was refined in the light of experience from the pilot and was incorporated into the care trust proposal. Each of the zones now has several health and social care co-ordinators, and, as a consequence, there are fewer assistant practitioners. Co-ordinators now have access to Torbay Care Trust's integrated information system, the hospital patient information system and, in some cases, primary care systems. Co-ordinators do not have formal professional training but are expected to work closely with professional staff and managers in the zones. Some professional staff remain sceptical about the responsibilities and comparative pay levels of co-ordinators (both are perceived as being excessive), and, of course, there is variation in competence. Despite this, most observers would agree that it is the co-ordinators who 'lubricate' integrated care.

A short case study of Torbay was recently presented to professional staff at a conference in Norfolk. In response, a member of the audience commented:

> *My father lives alone in Paignton, 300 miles from here. He has been very unwell recently, and in and out of hospital. But all I need to do is phone the co-ordinator. She knows exactly what the current situation is, and can deal with any worries that I may have by speaking directly to the relevant medical or care staff. It is such a reassurance for me. This is a wonderful system that I wish we could have here.*

Team members' perceptions of progress

A grid was devised to chart the views of Brixham staff members, based on a World Health Organization (WHO) model that classifies the key approaches to care provision on a continuum from autonomous (that is, historically fragmented services) to co-ordinated and then integrated (Gröne and Garcia-Barbero 2000). The original model's five domains were extended to 10 for the pilot, and staff were asked to indicate on the grid where they judged the service in Brixham to be – the closer the proximity to the right, the higher the degree of integration (*see* Table 4). Through analysing regular questionnaires and focus group discussions, it became clear where progress was being made and where local management needed to focus its attention.

During the 18-month pilot there was a gradual but sustained shift from left to right in all domains. 'Records' was always the least successful domain, and staff called for integrated information technology (IT) support. Domains that were specifically and successfully targeted by management in the early days after feedback were 'Access', 'Assessment' and 'Organisation' (achieving a shared team base). The staff seemed to unite around the emerging vision, values and plans, and celebrated key events. One referral co-ordinator reported at a staff seminar: '*For the first ever time, last week we put in a package of care for a lady without a social worker visiting. It was all done on the assessment of the nurse who knew her and who reported that she had deteriorated*'. A nurse also stated: '*There are no arguments about budget responsibility … managers are now in the same building and can sort things out face to face*'.

Table 4 Framework to measure progress towards integration

	Autonomous ➔	Co-ordinated ➔	Integrated
Vision and values	Individually determined	Shared commitment to improve the system	Common values All accountable User-oriented
Objectives and plans	Individually determined	Complementary approaches Informal or time-limited agreements	Agreed mission statement United planning process
Access by public	Each agency has a gateway	Formal links and liaison between gateways	Single gateway – triage
Assessment of needs	Individual agency process	Clear shared understanding of each other's process Ability to share information	Principles and roles agreed by all agencies, with single system used by one professional on behalf of others Shared process for selected patients
Case management	Individual agency process and system Cross-referral	Key workers and liaison Policy for information sharing	Shared caseload, with designated key workers able to act for others Transitions easy
Decision-making	Independent	Prior consultation Case conferences	Common process, shared delegated authority Agreed conflict-resolution process
Organisation and practice	Independent operation and development	Enhanced opportunity for communication and collaboration	Co-location Face-to-face encounters Formal teamworking Planned development
Resources	Used to meet self-determined objectives	Used complementarily Mutually reinforcing	Pooling Used according to agreed common framework, with management united Innovation
Records	Own system	User-held records, or similar agreed arrangements for access to each other's records	Collective input to shared record system IT-based
Information	Used independently	Circulates among partners	Orients partners' work towards agreed needs

GPs' views

Fourteen GPs across Torbay were interviewed during the middle stages of the project and the following picture emerged.

- There was a wide variation in knowledge of social services among GPs and their confidence to make contact. Some GPs knew about referral co-ordinators, but most asked receptionists and nurses to make contact on their behalf. One GP said: '*I wouldn't want to make a fool of myself by asking for the wrong thing*'.

- Some GPs had no confidence in the management of the district nursing service and would have preferred to take it over to ensure the employment of nurses sympathetic to the practice philosophy.

- Patterns of teamwork in surgeries were extremely variable, sometimes making it difficult for community staff to engage with practice staff.

The overwhelming request from GPs was for a single point of contact within zones for advice, information and referral, which they felt would improve access and speed up responses – the emerging co-ordinator role became the perfect solution for this. GPs also wanted named link workers.

At the end of the pilot in Brixham, lead GPs were asked for their views on progress. All were very positive: links were seen to be better and most GPs knew the first name of the co-ordinator they used; complex/urgent situations were judged to be much easier to handle; some GPs were self-critical about failing to improve their responses to the integrated team. Not all agreed that feedback was better. One GP stated: '*One phone call is all that is needed, so it's a definite improvement*'. Another said: '*Overall, I'm very impressed with the outcomes of integration*'.

Outside Brixham, GP leaders who later became involved in the management of the new service were supportive, but it was apparent that their colleagues did not take much interest. Interestingly, some GPs perceived community nurses as being different from the other members of the integrated team. A small number of practices feared that the care trust might further distance community nurses from their practices, particularly as zone integrated teams took on a life of their own, with their own priorities.

Six months after the second zone was established in Torquay, negative feedback from the two GP practices prompted one GP leader and the new zone manager to come up with a plan to improve working links: one of the practices established a rota to send one GP to the zone office every morning. There, the GP could get on with his or her own routine duties, but was also available to members of the integrated team and the co-ordinators for consultation. Although this model was not copied in other zones, it has continued for several years in Torquay and co-operation is optimal.

Knowing your population

All five zones tried to address the chief executive's challenge to identify those vulnerable people with the most complex needs, but with mixed results. Each zone had a community matron to lead the initiative, and was mindful of the 'virtual ward' ideas pioneered in Croydon (Department of Health 2007). The Brixham team created a list of people who were regularly reviewed by a multidisciplinary group on a formal basis, but this proved to be impossible to sustain over time. Because informal working for patients had been optimised, the effort involved in formalising decision-making was no longer considered worthwhile. The Kaiser Triangle was clearly relevant to understanding long-term needs, but a mechanistic approach to case management was not needed given the new culture of co-operation.

Staff attitudes to integration

Although the project demonstrated benefits for Mrs Smith and achieved high levels of staff engagement, a top-down approach to organisational change was ultimately needed. This involved a forced change of employer for Torbay Council staff, changes in management structures and processes, and new teams for PCT professionals. Once the care trust application had been approved during 2005, a survey of attitudes and expectations was undertaken among practitioners and their managers/supervisors. Staff (response rate 53 per cent) were asked to choose the option that most applied to them (*see* Table 5).

The number of staff who changed their views during the process was testimony to the effectiveness of the staff engagement process and the open communication, especially given the initial reservations of social services staff about an 'NHS takeover'.

Table 5 Staff questionnaire

	Social services staff	PCT staff
Always favoured integration	60 per cent	35 per cent
Reservations initially, but now convinced about integration	29 per cent	46 per cent
Improved co-ordination preferred to integration	11 per cent	19 per cent
Against integration in principle	0 per cent	0 per cent

The most enthusiastic group of staff surprisingly proved to be the social services department practitioners, while the least enthusiastic were the social services department managers. The PCT staff seemed reluctant to be associated with social care at first, but gradually came to see the benefits. The majority of practitioners felt there would be no detriment to their:

- professional identity
- capacity to do their jobs
- training opportunities
- employment security.

One-third of respondents expected that easier access to other professionals in difficult situations was likely to improve personal support and advice.

What worked?

The urgent need to improve the council's performance and the PCT's awareness that more effective health care relied on improved social care meant that both the council and the PCT were receptive to change. This minimised any potential resistance to integration. The care trust option was the most difficult for the council, but its chief executive trusted the PCT and was able to work effectively on this with the commission and other elected members.

The leaders of the change in Torbay were mindful of research about potential barriers and attempted to anticipate them in planning and to engage staff in discussing the related issues. Torbay Council staff welcomed this new new style of management and leadership. Mrs Smith was an effective instrument for emphasising patient/service user benefits to staff. One senior care trust manager said: '*There has been a high tolerance of risk while achieving our vision. We were not afraid to press on even if we hadn't worked out every detail. You can't be daunted by fear of the unknown*'.
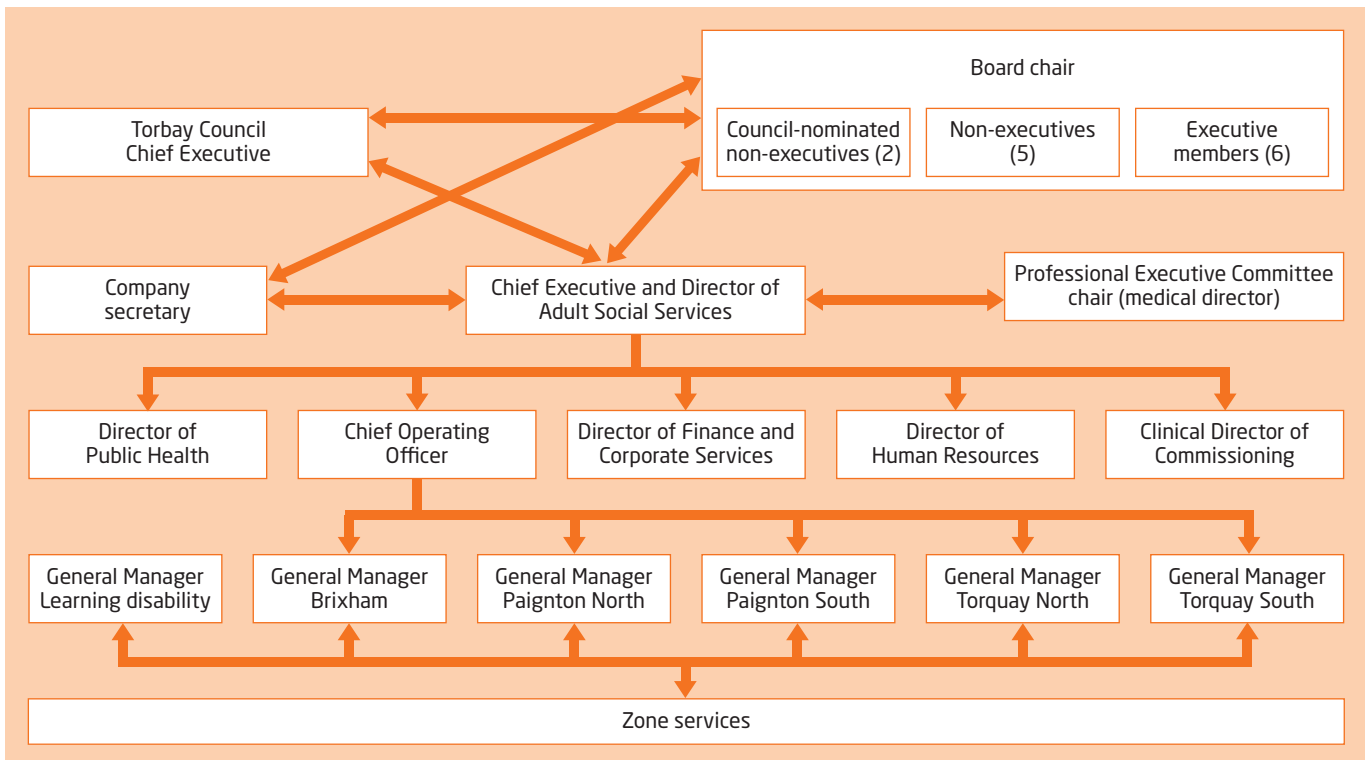
Formal agreements

The roles and responsibilities of the Torbay Council and Torbay PCT were clarified during the legal and contractual negotiations necessary to settle the formal agreement to establish Torbay Care Trust (Torbay Council and Torbay Care Trust 2005), which is a fully integrated NHS organisation responsible for commissioning and providing community health and social care services.

Almost all former council staff in adult social services were formally transferred to the employment of the NHS in this process.

It is important to note that this shift of staff did not mean that the council had transferred its accountability for social care for adults – this is its permanent statutory duty, and the council remains subject to external scrutiny for finance and performance. In order to protect its own interests as the accountable body, the council keeps itself informed. An annual agreement allows the council to outline the resources it will transfer to support

Figure 4 Torbay Care Trust organisational structure

social care and the performance expectations, including a schedule of monitoring. In the context of rising demand and reduced resources for local government, the annual agreement has been an increasing challenge. There is no doubt that the healthier financial situation of the NHS has afforded a measure of continuing protection to, and investment in, social care provision in Torbay.

Opportunities

The partnership generated new and unexpected opportunities.

- The integrated management structure of Torbay Care Trust saved approximately £250,000 in the first year. This money was used to develop services.

- During the pilot, staff identified issues about sharing information. After negotiation, it was agreed to extend the new IT system being introduced at the council (PARIS) to PCT staff. Torbay Care Trust's chief executive commented: '*We didn't realise that the solution to the information-sharing problem would be found by going for PARIS. But it proved the right call*'.

- 'NHS money' was spent on a number of new social worker posts at a point when no funding was available from the council. Although these posts were considered to be the best use of that money at the time, even for the NHS, the decision attracted external criticism. Incidentally, this relieved fears held by some council staff about integration threatening investment in social care.

- Investment in local leadership programmes and ongoing collaboration with Kaiser Permanente in the USA.

Two unforeseen initiatives warrant particular note.

Ward-based health and social care co-ordinators After all the zones were established, health and social care co-ordinators were appointed to certain key wards at the main

hospital in order to improve working links with secondary care. They have access to Torbay Care Trust's IT system and work in conjunction with zone colleagues to co-ordinate or set up care to facilitate safe discharge. A co-ordinator based in a ward is able to exercise more influence than a co-ordinator based in the zone. This gets patients and their families involved early, speeds up the processes, and has reduced the number of professional staff (for example, social workers) involved in discharge planning (Wade 2010b).

Improved access to intermediate care For some years CARRIE was the main local intermediate care service. At the time of the Brixham pilot, the PCT and the council joined the national Accelerated Development Programme (Ottley *et al* 2005) and created the innovative generic health and social care assistant posts to support nurses, therapists and social workers with 'hands-on' interventions in the home. To prevent admissions to hospitals or care homes (long term) and secure prompt discharges, investment was needed to expand the range of responsive services capable of providing re-ablement, nursing and social care in the home. In 2006, the surplus funding available from the improved performance of the health care system was combined with additional Department of Health funding to finance the development of physiotherapy and occupational therapy services, supplemented by additional nursing and social work.

The key question was how the service should be organised: as a centralised specialist service overseeing the pathway between hospital and home (which is the usual model), or linked to GP clusters and the integrated teams within zones.

The latter option was chosen and it improved access to intermediate care in the home, which was an important recommendation in the national study of intermediate care (Intermediate Care National Evaluation Team 2006). In Torbay, it meant that the need for formal referral to a separate intermediate care service was eliminated. Co-ordinators could access intermediate care when they felt it was appropriate and effect easy transfers between short-term interventions and longer-term support. Opening up the availability of intermediate care changed attitudes. One zone manager stated: '*We have effectively opened intermediate care up to people for whom it would never have been thought of before. We can see it works for them, and it is a great resource to have at our disposal*'.

The £2 million investment significantly changed the way zones operated. Intermediate care was provided through local multidisciplinary teams that managed a small, but rapidly changing, joint caseload. Their focus was on short-term interventions to meet acute needs and restore the confidence and capability of individuals. The service operated more flexibly over time – an extended working day was introduced as well as weekends. Response times were very short – within an hour in certain circumstances – and this reassured GPs who had initially been concerned about the abolition of CARRIE.

Intermediate care created a range of flexible new options for support in the home in Torbay for those being discharged from hospital. By contrast, Devon PCT relied primarily on its network of community hospitals in the south area close to Torbay. An audit of bed use conducted on one day in 2010 (Wade 2010a) revealed that Devon patients remained in acute and community hospital beds longer than Torbay patients. Clinicians and managers at South Devon Healthcare Foundation Trust suggest that access to community support on discharge is much simpler to achieve for Torbay patients.

Increased confidence

Torbay Care Trust has developed organically and consolidated its position. During the reconfiguration of PCTs in 2006, which was extensive elsewhere in the south-west, and later the initial separation of commissioning and provision within the NHS, it avoided the change imposed on others because it had already undertaken an extensive process of

innovation involving integrated care. It also survived a period of intense scrutiny when an elected mayor came to power in the borough. The depth and formality of the agreement may have protected it, confirming a point made by Wistow and Waddington (2006) in their study of a failed health and social care partnership in London. A senior manager of the care trust commented later: '*Whenever things got rough, we knew we had to hold our nerve and rely on our convictions about what we were planning to achieve*'.

Torbay Care Trust maintains its international contacts and continues to be involved in national projects. It became one of 16 localities in the government's Integrated Care Organisation pilot programme in 2009 (Wilding 2010). Its project was to resume options for vertical integration with the foundation trust now that the horizontal integration of community services has been secured. This was based on the model in Figure 5.

Figure 5 Balancing horizontal and vertical integration
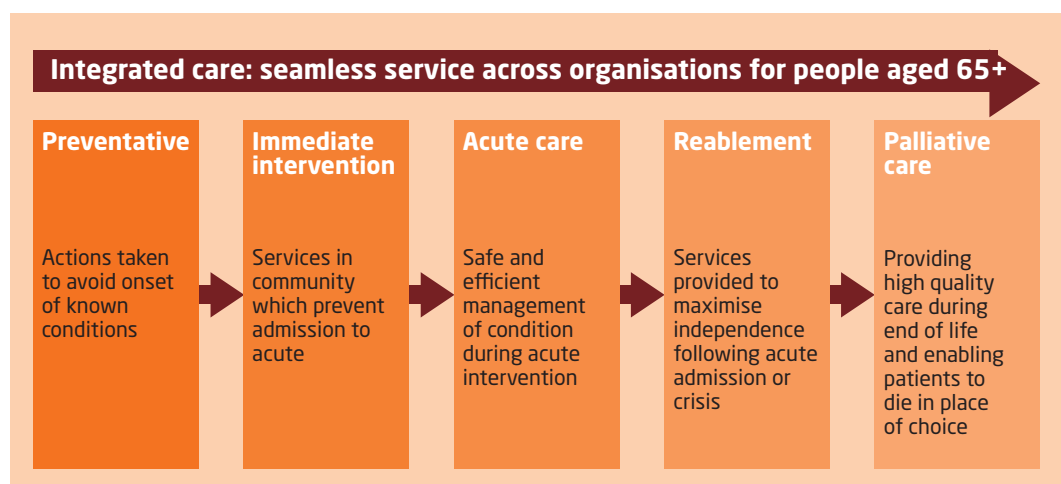
Impact on the performance of the Torbay health and social care economy

Even in a relatively small community like Torbay, health and social care is a complex system involving hundreds of people, so establishing cause and effect is difficult (Curry and Ham 2010). In the absence of any independent scientific study, the strong circumstantial evidence available must be considered. Reflecting on the Kaiser NHS Beacon Sites Programme, Ham (2010) said: '*Torbay stands out as the site that is able to demonstrate most progress … Torbay can claim with some justification to be showing a measurable return on its investment in integrated care*'.

Much has already been written from the point of view of health care about the achievements in Torbay (Currie 2010; Curry and Ham 2010; Ham 2010; Karakusevic 2010). The key messages can be summarised as follows.

- The daily average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10.

- Emergency bed day use in the population aged 65 and over is the lowest in the region at 1920 per 1000 population compared with an average of 2698 per 1000 in 2009/10.

- Emergency bed day use for people aged 75 and over fell by 24 per cent between 2003 and 2008 and by 32 per cent for people aged 85 and over in the same period .

- Delayed transfers of care from hospital have been reduced to a negligible number and this has been sustained over a number of years.
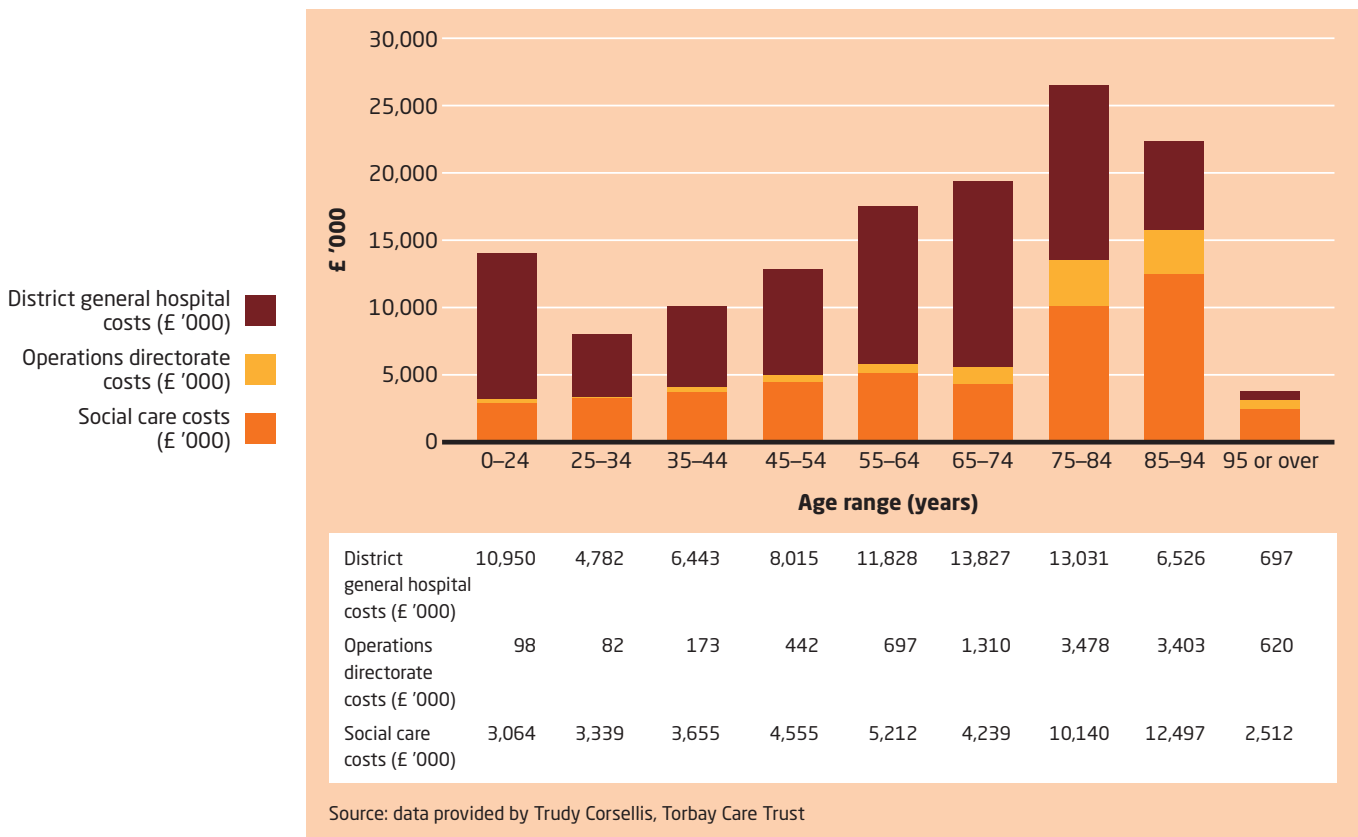
Progress has also been made in the previously poorly performing area of social care.

■ Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes.

■ There has been a corresponding increase in the use of home-care services, some of which are now being targeted on preventive low-level support.

■ The use of Direct Payments is one of the best in the region.

■ In 2010, the Care Quality Commission judged Torbay to be 'performing well'.

Karakusevic has additionally pointed out (personal communication, March 2011) that as non-elective bed use by people over 65 in Torbay has maintained its downward trend in comparison with other parts of the region, home care provision by the care trust has increased in parallel. Double the regional average of people aged over 65 now receive some form of social care package from Torbay Care Trust.

Whole-system working has highlighted how costs impact on different services in Torbay. Figure 6 compares expenditure by age between the hospital, the care trust's health care services (including community hospitals, community nursing and therapy, and intermediate care), and the care trust's social care services. The figure highlights how costs shift to social care away from health care as people become older. This finding was recently confirmed by a national study undertaken by the Nuffield Trust (Bardsley *et al* 2010), demonstrating how important it is for the NHS to plan and co-operate with local authorities. It also supports the new government's plans to shift resources from the NHS to social care over the next few years.

Figure 6 Costs by organisation 2009/10

	0–24	25–34	35–44	45–54	55–64	65–74	75–84	85–94	95 or over
District general hospital costs (£ '000)	10,950	4,782	6,443	8,015	11,828	13,827	13,031	6,526	697
Operations directorate costs (£ '000)	98	82	173	442	697	1,310	3,478	3,403	620
Social care costs (£ '000)	3,064	3,339	3,655	4,555	5,212	4,239	10,140	12,497	2,512

Source: data provided by Trudy Corsellis, Torbay Care Trust

Wider issues

Children's services in Torbay have not progressed as well over the same period, despite the local collaborative culture. Regulators have recently raised concerns about performance, and the council is working to make improvements. Despite joint working with Devon Partnership Trust, learning disability services are still not functioning effectively.

The future of integrated care

Torbay Care Trust has evolved enormously over the past five years. It has also been subject to wider changes in government policy; for example:

- drives for greater personalisation of care services

- deeper separation of NHS commissioning and provider services

- efficiency programmes such as QIPP (Quality, Innovation, Productivity and Prevention)

- cutbacks in public expenditure.

The imminent changes in health care commissioning will herald a new phase of development. Relationships with future GP commissioners are well established and Torbay Care Trust expects to continue as a *provider* organisation, although it will continue to be the commisioner of social care. The current lead GP commissioner is already on the care trust board as clinical director of transition and commissioning (the new Devon-wide PCT cluster will temporarily take over the formal commissioning of health care). The existing roles of medical director and professional executive committee chair are being adjusted accordingly.

In addition, a dialogue has already started with the embryonic GP consortium in South Devon and with Devon PCT community services. The care trust is taking over responsibility for Devon PCT community services and Devon County Council Adult Care Services in South Devon for a three-year period. Work to achieve closer integration between Torbay Care Trust and South Devon Healthcare Foundation Trust continues, although all future forms of integration may be more difficult in a more competitive context (Ham and Smith 2010).

During the course of these changes, the challenge will be to ensure that organisational instability does not have adverse consequences for Mrs Smith. If this can be done, there is a real opportunity to extend the achievements of Torbay to south Devon.

Conclusion

If the vision laid out in *Equity and Excellence: Liberating the NHS* (Department of Health 2010b) is put into practice, the statement that 'all integration is local' (Leutz 2006) is never going to be truer than in England over the next few years. Local people and professionals will be empowered to shape the future. Torbay's experiences, when put alongside evidence from elsewhere, highlight the importance of the following messages.

- Base any strategy on the benefits being sought for service users/patients. Specify the benefits in advance, communicate them constantly, invest in the things that will help achieve them, monitor progress, listen to staff experiences, share results and encourage further improvement.

- Use GP registration, not home addresses, to allocate work to integrated community support services – this is a key building block of sustainable team working that will simplify access to help and make co-ordination of effort easier.

- Establish joint governance early (NHS, local authority and primary care).

- Invest in a professional approach to organisational development/change management over an appropriate period of time. Cultural, political and organisational differences and financial and other risks do not have to be deal breakers – they can be overcome. The evidence base is helpful.

- Make sure senior/middle managers and clinical leaders are engaged from the start and avoid separate management arrangements for individual professions, including social care. Be confident that individual professional practitioners will enjoy opportunities to work more closely with other professionals. Locating teams together will enhance this.

- Prioritise continuity of care at home, with intermediate care provision and hospital discharge processes tied in to support it.

- Make sure everyone understands what is meant by the term 'integration' (*see* Curry and Ham [2010] for a helpful analysis of the concept).

In its entirety, the Torbay approach may not travel well: Torbay is a small and compact community, with its own environment and history. A question still lingers about whether the care trust would ever have been conceived without the crisis over performance at Torbay Council. However, people in Torbay examined evidence from elsewhere, appraised their own performance, built communication and teamwork between stakeholders, made choices, managed risks, and reaped rewards: these things are replicable. There is no textbook to guide the process because local context (especially the interplay of people, relationships and processes) is a key variable. Anyone embarking on this approach needs to conceive of it as a learning process.

References

Audit Commission (2002). *Integrated Services for Older People: Building a whole system approach in England*. London: Audit Commission. Available at: www.audit-commission. gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/ OlderPeopleNationalReport.pdf (accessed on 14 March 2011).

Audit Commission (2000). *The Way to Go Home: Rehabilitation and remedial services for older people*. London: Audit Commission. Available at: www.audit-commission.gov.uk/ SiteCollectionDocuments/AuditCommissionReports/NationalStudies/WayToGoHome. pdf (accessed on 14 March 2011).

Audit Commission (1997). *The Coming of Age: Improving care services for older people*. London: Audit Commission. Available at: www.audit-commission.gov.uk/ SiteCollectionDocuments/AuditCommissionReports/NationalStudies/TheComingofAge. pdf (accessed on 14 March 2011).

Bardsley M, Georghiou T, Dixon J (2010). *Social Care and Hospital Use at the End of Life*. London: Nuffield Trust.

Cameron A, Lart R, Harrison L, Macdonald G, Smith R (2000). *Factors Promoting and Obstacles Hindering Joint Working: A systematic review*. Bristol: School for Policy Studies.

Central Policy Review Staff (1975). *A Joint Framework for Social Policies*. London: HMSO.

Currie C (2010). 'Health and social care of older people: could policy generalise good practice?'. *Journal of Integrated Care*, vol 18, no 6, pp 19–26.

Curry N, Ham C (2010). *Clinical and Service Integration: The route to improved outcomes*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/clinical_and_ service.html (accessed on 14 March 2011).

Department for Education (2003). *Every Child Matters*. Cm 5860. London: HMSO. Available at: www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters. pdf (accessed on 14 March 2011).

Department of Health (2010a). *A Vision for Adult Social Care: Capable communities and active citizens*. London: Department of Health. Available at: www.dh.gov.uk/prod_ consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_121971. pdf (accessed on 14 March 2011).

Department of Health (2010b). *Equity and Excellence: Liberating the NHS*. Cm 7881. London: HMSO. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_ digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf (accessed on 14 March 2011).

Department of Health (2010c). 'Transforming Community Services: Overview'. Department of Health website. Available at: www.dh.gov.uk/en/Healthcare/TCS/ Abouttheprogramme/DH_121964 (accessed on 12 March 2011).

Department of Health (2007). 'Case Study: Virtual wards at Croydon Primary Care Trust'. Department of Health website. Available at: www.dhcarenetworks.org.uk/_library/ croydon_virtual_wards_case_study.pdf (accessed on 14 March 2011).

Department of Health (2006). *Our Health, Our Care, Our Say: A new direction for community services*. London: Department of Health. Available at: http://webarchive. nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/ PublicationsPolicyAndGuidance/Browsable/DH_4127552 (accessed on 14 March 2011).

Department of Health (2000). *NHS Plan: A plan for investment, a plan for reform*. Cm 4818-I. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/ groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf (accessed on 14 March 2011).

Gröne O, Garcia-Barbero M (2000). *Trends in Integrated Care – Reflections on conceptual issues*. Copenhagen: World Health Organization.

Ham C (2010). *Working Together for Health: Achievements and challenges in the Kaiser NHS Beacon Sites Programme*. HSMC policy paper 6. Birmingham: University of Birmingham. Available at: www.hsmc.bham.ac.uk/news/pdfs/Kaiser_policy_paper_Jan_ 2010.pdf (accessed on 14 March 2011).

Ham C (2009). *Only Connect: Policy options for integrating health and social care*. London: Nuffield Trust.

Ham C, Smith J (2010). *Removing the Policy Barriers to Integrated Care in England*. London: Nuffield Trust.

Health and Social Care Act 2001 (c 15). London: The Stationery Office.

Intermediate Care National Evaluation Team (2006). *A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People*. Birmingham: Universities of Leicester and Birmingham. Available at: www.hsmc.bham.ac.uk/research/cost_outcomes.shtml (accessed on 14 March 2011).

Karakusevic S (2010). 'Designing an integrated health care system – What are the key features?'. *Journal of Integrated Care*, vol 18, no 4, pp 36–42.

Lavender A (2006). 'Creation of a care trust: managing the project'. *Journal of Integrated Care*, vol 14, no 5, pp 14–22.

Leutz W (2005). 'Reflections on integrating medical and social care: five laws revisited'. *Journal of Integrated Care*, vol 14, no 5, pp 3–12.

Leutz W (1999). 'Five laws for integrating medical and social services: lessons from the US and UK'. *Milbank Quarterly*, vol 77, no 1, pp 77–110.

Ottley E, Tongue A, McGill M (2005). 'Redefining the role of support workers in intermediate care: key findings from a national project'. *Journal of Integrated Care*, vol 13, no 1, pp 28–34.

Pratt J, Gordon P, Plamping D (1999). *Working Whole Systems: Putting theory into practice in organisations*. London: The King's Fund.

Torbay Council and Torbay Care Trust (2005). 'Partnership agreement relating to the proposed Torbay Care Trust'. Torbay Care Trust website. Available at: www. torbaycaretrust.nhs.uk/publications/Publications/TCT%20Partnership%20Agreement. pdf (accessed on 25 March 2011).

Wade L (2010a). *Community Resource and Bed Audit Undertaken May 10 2010: Summary report*. Torbay: Torbay Care Trust.

Wade L (2010b). 'Integrated hospital discharge in Torbay: results from a pilot project'. *Journal of Integrated Care*, vol 18, no 3, pp 37–44.

Wilding H (2010). 'Integrating care: from horizontal to vertical integration'. *Journal of Integrated Care*, vol 18, no 3, pp 15–20.

Wistow G, Waddington E (2006). 'Learning from doing: implications of the Barking and Dagenham experience for integrating health and social care'. *Journal of Integrated Care*, vol 14, no 3, pp 8–18.

Acknowledgements

About the author

Peter Thistlethwaite has been self-employed since 1998, specialising in research and development in health and social care integration. He has worked mainly with NHS organisations and local authorities in the south west of England, where he lives. He acted as 'critical friend' in Torbay during the years of the formation and establishment of the Torbay Care Trust, and specifically led the action research programme which identified and embedded the early lessons about what worked.

Peter conceived and wrote the Department of Health publication *Integrated Working – A Guide* in 2004, and an updated version *A practical guide to integrated working* in 2008. He is also the founding editor of *Journal of Integrated Care*, which is now in its nineteenth volume. He has been involved in the International Network of Integrated Care since it started a decade ago. All this reflects a very long-standing interest in integrated care, and in evidence-based approaches to organisational development and to multi-disciplinary practice.

In his earlier career, Peter trained as a social worker and worked in the London Borough of Brent, Cheshire, and Devon. He decided to take early retirement from the post of Deputy Director of Social Services in Devon in order to concentrate more on integrated care. He has had honorary appointments at Bristol, Exeter and Birmingham Universities, and is a Fellow of the Centre for Social Policy at Dartington Hall.

Contact details: Peter@integratedcare.org.uk

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