

# Briefing: Improvement capabilities across boundaries

*The Health Foundation, Insight & Analysis Unit*

**June 2019**

## Overview

Delivering joined-up, coordinated care has long been an aspiration of the NHS in each country of the UK. Integrating health and social care in particular has been an explicit policy goal for successive governments for the last two decades due to growing pressure in the NHS and the identified need to reduce fragmentation and duplication and improve patient outcomes and experience.

Each country in the UK varies significantly in its approach and progress towards an integrated system.<sup>1</sup> In England, the health and care system has historically been divided between various organisations, with local government taking on some elements of care such as adult social care and public health and the NHS providing health care. In addition, the NHS has maintained a separation between the commissioning and provision of health care. However, in recent years, the system is increasingly moving towards more joined-up care for patients, e.g. integrated care systems and devolved regions (such as Greater Manchester). Northern Ireland has had a fully integrated health and social care system since 1973, but due to various barriers and political instability it hasn't reached its full potential. Scotland has an integrated NHS with unified health boards and no commissioner-provider separation, however local authorities continue to be responsible for provision of social care. Likewise, Wales has unified health boards and local authorities have responsibility for social care.

---

<sup>1</sup> <https://www.kingsfund.org.uk/publications/integrated-care-northern-ireland-scotland-and-wales>

Given this, whilst there are many examples of good work, there is still a long way to go to truly join up services and increase levels of cross-sector collaboration particularly between health and social care. We believe building improvement capability across boundaries will be vital to realising this. This involves an approach which enables staff to develop and deploy the skills, tools and knowledge necessary to improve the quality and safety of the care they provide.<sup>2</sup> It is especially important across organisational boundaries and between different sectors where there are often many barriers to working collaboratively and leaders must look out of their own organisations to lead across systems.

The NHS Long Term Plan for England stressed the importance of building capability in cross-sector working as we move to an increasingly interconnected system, including through a focus on Integrated care systems (ICSs) as a key delivery mechanism for integrated care.<sup>3</sup> ICSs take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers, commissioners and local authorities to work in partnership in improving health and care in their area.<sup>4</sup> The aim of these is to improve population health, reduce health inequalities, modernise services and meet patients mental, physical and social needs in a coordinated manner.<sup>5</sup> The NHS has said that by April 2021, ICSs will cover all of England and will be central in delivering the aspirations of the NHS Long Term Plan.<sup>6</sup> Delivery will rely on local health systems having the capability to implement change effectively. In partnership with NHS England, The Health Foundation will support an increase in the number of ICSs building improvement capability to implement new ideas and practices.<sup>7</sup>

It will require teams across health care, local authorities and others to come together, develop new approaches and agree to work in different ways – something we know from our award programmes can be harder than it sounds. Some of the projects that The Health Foundation have funded have worked specifically as partnerships between the health service and local governments, exemplifying this way of working and highlighting key learnings. A common theme throughout these projects is the importance of communication and collaboration not only between the various organisations and workers involved but also with patients and families. Building these relationships can take time, but is crucial to the success of cross border working.

This briefing provides information on 11 improvement projects that the Health Foundation has funded that relate specifically to cross border working between the NHS and local government. Nine of the projects have been funded through our small-scale innovation programmes, *Shine* and *Innovating for Improvement*. One project was supported through the *Advancing Applied Analytics* programme and another project was funded through the *Closing the Gap in Patient Safety* programme.

The projects are grouped broadly into three categories:

1. Enhancing health and care in care homes
2. Improving care for vulnerable children
3. Actions to tackle inequalities and social determinants

---

<sup>2</sup> <https://www.health.org.uk/newsletter-feature/five-key-lessons-building-improvement-capability>

<sup>3</sup> <https://www.longtermplan.nhs.uk/online-version/>

<sup>4</sup> <https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems>

<sup>5</sup> <https://www.england.nhs.uk/integratedcare/>

<sup>6</sup> <https://www.hsj.co.uk/policy-and-regulation/all-of-england-to-become-ics-by-2021/7024122.article>

<sup>7</sup> <https://www.longtermplan.nhs.uk/online-version/>

## 1. Enhancing health and care in care homes

### **Eastbourne, Hailsham and Seaford CCG: Remote assessment using head mounted technology in Sussex**

*Innovating for Improvement Round 5 (January 2017 – April 2018)*

*South East, England*

Led by Eastbourne, Hailsham and Seaford CCG, the 'see what I see' project involves care home workers using head-mounted technology (Xpert Eye smart glasses) to have two-way communication in real time with GPs. GPs remain in their practice and assess patients in real time using the view of the care home worker wearing the smart glasses. The potential benefits include shorter waiting times and reduced hospital admissions, as well as reduced travel times for GPs.

Testing of the technology was undertaken in two GP practices and two care homes in Eastbourne. Collaborative working between all partners helped move things forward when obstacles were faced. There was some nervousness about using the new technology, which was overcome by users being encouraged to share any problems with the project team. Whilst it was noted that the remote assessment couldn't always replace a GP visit, it resulted in a more interactive experience than phone advice. Qualitative feedback was generally very positive from care home staff, GPs and patients. Patients felt involved in their consultation and could ask questions or discuss concerns.

Primary contact: Fiona Streeter, Deputy Director of Organisational Development and Corporate Affairs, Eastbourne, Hailsham and Seaford CCG.

Email: [Fiona.streeter@nhs.net](mailto:Fiona.streeter@nhs.net)

### **Altogether Better: Creating collaborative care in South West Yorkshire**

*Innovating for Improvement Round 5 (January 2017 – April 2018)*

*Yorkshire and the Humber, England*

Altogether Better has developed a pioneering way to bring citizens together with health and care services through a more collaborative way of delivering care. Since 2008, over 25,000 citizens have volunteered their time as 'health champions', working in a range of health care settings, including GP surgeries, hospitals and other community services. Through this project in North Tyneside, Altogether Better took the approach into care home settings for the first time. Core to the approach is closer collaboration between the health care professionals involved in caring for the residents and an invitation to local citizens, residents and families to develop new ideas, offers and activities that will improve people's health, wellbeing and the quality of their care and their lives. One area of joint working has focused on improving the process of prescribing medicines for care home residents. GPs have since noticed more streamlined connections between practice and care home staff in relation to the repeat prescription system, which results in fewer unnecessary visits to the care homes, and better outcomes for residents in relation to prescribing. Upskilling of care home staff to undertake basic observations and wound care is helping to reduce the need for visits by GPs or nurses, leading to better clinical outcomes as care staff can make decisions closer to the front line. Feedback from care home staff and residents' family members has described how champions make a tangible difference to life in the homes.

Primary contact: Helena Hughes, Head of Operations, South West Yorkshire Partnership NHS Foundation Trust.

Email: [Helena.hughes@swyt.nhs.uk](mailto:Helena.hughes@swyt.nhs.uk)

**NHS Lanarkshire Health and Social Care Partnerships: Care home continence promotion care bundle: improving quality of care and safety**

*Innovating for Improvement Round 3 (March 2016 – August 2017)*

*Scotland*

NHS Lanarkshire Health Board, in partnership with NHS National Procurement, developed and tested a 'continence care bundle' in two care homes to make a positive difference to patients and reduce the amount spent on incontinence products, such as high-absorbency pads. The care bundle includes the use of screening and assessment tools that focus on optimal fluids and nutrition, reduction of caffeinated products, and toilet assistance. The interventions are supported by national guidelines and evidence.

The project measured the use of incontinence products, with the aim of reducing their use by 25% within 12 months. The project team also audited continence care and the prevalence of associated harm such as pressure damage, urinary tract infections and falls, and evaluated staff and carer experience of the improvement project. Comparing pre-project to post-project data, the project demonstrated the following successes:

- a reduction in episodes of incontinence and in pad use, and less distress in residents and families
- a 30% reduction in skin damage
- a 40% - 65% reduction in falls
- a 50% reduction in urinary tract infections (UTI)
- a 40% reduction in unplanned hospital admission for falls/UTI
- improved record keeping and ability to have more time with residents.

Economic analysis showed the potential for savings of £250,000 over nine months. The team believe the intervention is transferable to other care homes, however further testing and refining of the data capture measures would be beneficial.

Primary contact: Alice Macleod, Senior Nurse, National Procurement, Procurement, Commissioning and Facilities, NHS National Services Scotland.

Email: [Alice.macleod1@nhs.net](mailto:Alice.macleod1@nhs.net)

**Essex County Council: PROSPER: Promoting safer provision of care for the elderly in Essex**

*Closing the Gap in Patient Safety 2014-17*

*South East, England*

PROSPER was a ground-breaking initiative to test whether quality improvement methods could be implemented in the care home context. A core team from Essex County Council worked with staff in 90 care homes to introduce data collection methods, a safety culture assessment tool ([MaPSaF](#)) and adaptation of the [NHS Safety Thermometer](#) measurement tool and principles. The goal was to reduce the number of falls, pressure ulcers and urinary tract infections (UTIs). In addition to working with care home staff, the team has nurtured good working relationships with the provider, commissioning and regulatory bodies in Essex.

The Care Quality Commission (CQC) is also supportive of the project, encouraging homes to take part.

An evaluation by University College London suggested only small and variable changes in the prevalence of safety incidents during the lifetime of the project. It did, however, find that the programme helped to increase knowledge and awareness of resident safety, encouraged new approaches and, in some homes, resulted in tangible reductions in harms. As part of the project, the team developed a new safety culture assessment tool for use in care homes, adapted from the MaPSaF used in health care.

Essex County Council agreed to fund the work for an additional 12 months, resulting in a further two cohorts of homes being recruited, taking the total to over 100. It is hoped that the continuation of the programme will enable longer-term evaluation of results.

Primary contact: Lesley Cruickshank, Quality Innovation Manager, Essex County Council.

Email: [Lesley.cruickshank@essex.gov.uk](mailto:Lesley.cruickshank@essex.gov.uk)

[More information: Pimp my zimmer article](#)

### **Northumbria Healthcare NHS Foundation Trust: Reviewing medication in care homes in Northumbria**

*Shine 2012*

*North East, England*

Northumbria Healthcare NHS Foundation Trust's medication review brings together care home residents, their families and health professionals together to ensure residents are getting the right mix of medicines. This increases the quality of life for residents, reduces unwanted side effects as well as cutting down on the time and money wasted from unnecessary prescribing. The multi-disciplinary teams include pharmacists and GPs, working with the residents, their families and the care home staff to review patients' multiple medications and make shared prescribing decisions and reducing polypharmacy effectively. Care homes taking part in the medication review project have reduced the amount of medicine prescribed to residents by 17%. For every pound invested in the review process, £2.38 has been saved in medication costs. It now takes nurses less time to administer medications, giving them an extra hour a day to focus on caring for residents. The impact extends further into relationship too, and has had a lasting effect – nurses feel more valued by GPs, residents feel heard, family members have a better understanding of their loved one's care. The new approach has also enabled better discussions and involvement from families around end-of-life care and advance care planning. Staff, residents and families have reported that it improves quality of life for the residents. In the summer of 2015 the service was offered to an additional 3,000 care home residents across Northumberland.

Primary contact: Dr Wasim Baqir, Primary and Acute Care System Lead Pharmacist, Northumbria Healthcare NHS Foundation Trust's.

Email: [Wasim.baqir@nhs.net](mailto:Wasim.baqir@nhs.net)

[More information: Video](#)

### **Manchester Community Health: Nursing home improvement programme in Manchester**

*Shine 2010*

*North West, England*

The Care Home Collaborative project, led by Manchester Community Health, brought together multidisciplinary teams from across social care, primary care and secondary care to design and test changes to improve care for nursing home residents. Care home teams attended a series of workshops where they learnt about improvement methods. In between the workshops, the teams met to monitor their results and review their action plans. The team reported a reduction in the number of inpatient admissions and the average length of hospital stay per admission of residents from the care homes that were part of the collaborative. This led to savings of approximately £120,000 over the project (under a year). New protocols established through the project included a patient transfer form and communication standard to inform nursing homes about a resident's hospital stay, and a process for sharing end-of-life care plans with out-of-hours doctors. The team reported that the project was instrumental in reducing the barriers to communication that existed between the community health services and the care homes.

## 2. Improving care for vulnerable children

**Southampton Children and Families Social Care: Improving children's social care staff wellbeing through reflexive peer group supervision and critical incident debrief**  
*Innovating for Improvement Round 7 (March 2019 – January 2020)*  
*South West, England*

There are significant difficulties in staff recruitment and retention in social care services. Research suggests this can be due to staff not feeling adequately supported or valued. When staff wellbeing is not prioritised, there is an increasing possibility of staff burnout, compassion fatigue, and secondary trauma, which impacts negatively on staff wellbeing and the quality of the service delivered to clients.

Understanding and normalising emotional, behavioural, physical and cognitive symptoms and access to social support are significant factors associated with reducing the risk of trauma responses. This project will implement a new pathway of staff support for those dealing with complex cases and high levels of trauma.

Reflexive peer group supervision will be available for all staff in children's social care. There will be around 22 groups, across the teams in the service, with between six to eight people, and a maximum of 12. The groups will meet regularly every six weeks.

The sessions will be facilitated by professionals with therapeutic experience, who are not associated with the management of the teams. The sessions will provide a safe space to reflect on the social and emotional impact of staff members' work with clients who have complex needs.

Critical incident debriefs will also be available, which will ensure all staff have a space to process significant traumatic events in a safe, evidence-based manner. This will help to normalise emotional responses, broaden social support and identify coping strategies.

Primary contact: Dr Emma Selwood, Clinical Psychologist, Southampton Children and Families Social Care

Email: [Emma.selwood@southampton.gov.uk](mailto:Emma.selwood@southampton.gov.uk)

**Sheffield Children's NHS Trust: Intensive behavioural intervention to improve sleep in vulnerable children**

*Innovating for Improvement Round 4 (August 2016 – November 2017)  
Yorkshire and the Humber, England*

Groups of vulnerable children that are frequently identified as having sleep disturbance are fostered and adopted 'looked after' children, and children with eating disorders or neurodevelopment disorders such as ADHD.

Sleep difficulties for many disabled and vulnerable children are due to the way parents address and manage their child's sleep. Evidence from sleep clinics delivered in the voluntary sector has shown that an intensive two-week behavioural intervention can be highly effective.

Sheffield Children's Hospital, Sheffield City Council and the Children's Sleep Charity evaluated a behavioural intervention to provide support to parent/carers and young people to improve sleep patterns. Practitioners received sleep practitioner training from The Children's Sleep Charity, and then gave bespoke support to parents and carers, including information provision, group workshops and one-to-one support in a sleep clinic.

The project has been successful in raising awareness of sleep deprivation in children and their families, and demonstrating how a behavioural intervention can empower parents to help their children to sleep.

Early analysis of results has indicated that the intervention has had a significant impact on families, particularly on the number of hours slept at night and on wellbeing. In addition, the project has been a catalyst to building a model for provision of sleep support within Sheffield city involving a strategic group (with the local authority, health and third sector) and, as a result, there is now a drive to embed this within services outside of hospitals. Funding has been secured to train six health visitors/ school nurses and 19 residential home staff, foster care support workers and MAST staff based on this model and the promising results. These results are generalisable and the model could potentially be adopted nationwide.

Primary contact: Professor Heather Elphick, Consultant in Paediatric Respiratory and Sleep Medicine, Sheffield Children's Hospital  
Email: [Heather.elphick@sch.nhs.uk](mailto:Heather.elphick@sch.nhs.uk)

## **1. Actions to tackle inequalities and the social determinants of health**

### **Cardiff and Vale University Health Board: Changing the conversation: developing an alliancing approach to whole system transformation of health and care**

*Innovating for Improvement Round 7 (March 2019 – January 2020)  
Wales*

The population in Cardiff and the Vale of Glamorgan is growing rapidly, and has shifting health needs including an ageing population and greater ethnic diversity than much of Wales.

This project plans to transform service delivery for this changing population with a 'best for patient, best for system' method. It will develop an innovative 'alliancing' approach to bring together varied staff from across health disciplines and different partner organisations; activating a network of people to identify and solve system-wide health and care problems through new models of care and ways of working.

The project team will receive guidance from Canterbury District Health Board in New Zealand, which successfully developed the alliancing approach to navigate the challenges of rapid population growth and ageing. Crucial leadership support will be provided by Cardiff and Vale Regional Partnership Board, which brings together health care, local authorities, voluntary sector and independent providers, and carer representatives to enable whole-system change. The project model will be developed with community falls prevention as the focus and test area, with the potential to spread to all clinical areas. Community design workshops involving patients and the public will be used to identify what services should be sustained, stopped or started, and inform the design and implementation of a new system for falls prevention. Plans for the measurement of this innovation will be updated as the alliance develops, and if successful it could be used to drive service development across the health and care system.

Primary contact: Ruth Jordan, Head of Continuous Service Improvement, Cardiff and Vale University Health Board

Email: [Ruth.jordan@wales.nhs.uk](mailto:Ruth.jordan@wales.nhs.uk)

### **London Borough of Islington: Linking health and local government data at household level to understand social determinants of health**

*Advancing Applied Analytics (January 2018 – April 2019)*

*London, England*

The social determinants of health are a key driver of demand for health and care, and in the London borough of Islington, they underpin the stark inequalities in the area. To better prioritise services and interventions, there needs to be understanding about the impact of the social determinants of health on health status, outcomes and service use.

In order to gain this understanding, data in local government need to be linked to NHS data. For example, describing how housing conditions might impact on hospital admissions; serious childhood illnesses and school attendance and attainment; anti-social behaviour and hospital admissions; and household-level health status and health service use.

This project will see the development of an innovative linked dataset between the NHS and local government. Council data will be linked with NHS data using an encrypted (pseudonymised) unique property reference number (which every address in Great Britain has, and is collected on both NHS and local government datasets). This will enable analysis of social determinants of health at a household level.

The project will bring together analytical capabilities across the local NHS, local authority and academia. Currently there is limited understanding between the NHS and local government around data. This project will involve training sessions to generate shared understanding and learning.

The linked dataset will allow the impact of social determinants of health on health service usage to be quantified, and will help identify unmet needs and inequalities across the local public sector system.

It will also enable more sophisticated analyses of return on investment, with a particular focus on prevention, early intervention and social prescribing.

The findings of the project will be communicated through a variety of methods across the wider health and care system within Islington, including clinicians, NHS managers, councillors and officers.



Primary contact Sarah Dougan, Chief Analytical Officer, London Borough of Islington.  
Email: [Sarah.dougan@islington.gov.uk](mailto:Sarah.dougan@islington.gov.uk)

**Royal Borough of Greenwich Council and Greenwich CCG: Live Well coaches in primary care**

*Innovating for Improvement Round 5 (January 2017 – April 2018)*

*London, England*

This project involved the creation of a network of Live Well Coaches trained in using motivational approaches and social prescribing across 12 GP practices in Greenwich. The Live Well Coaches are part of a tiered system of support aimed at the frequent visitors to local practices.

Prior to the project, practices could already signpost patients towards the existing online Greenwich Community Directory, which offers general advice and information about local services, or the Live Well Greenwich line, if they need tailored support. This project has allowed patients who need more in-depth support to be referred to a Live Well Coach connected to their practice, who can offer help on issues including welfare, housing, employment and personal finances as well as healthy living. The coaches work intensively with patients to change the way they think about their health and use local services, and give them the skills and confidence to improve their wellbeing. If they need any ongoing support the coaches can then refer them onto a network of volunteer Community Health Champions, who have had training through the Royal Society for Public Health.

Early evaluation of the Live Well Coach pilot is promising, with 75% of those contacted to meet a coach booking an appointment. Available outcomes data show that 97% of patients were at least in the early stages of change, and 62% were at 'action' stage.

Primary contact: Aideen Silke, Head of Live Well Greenwich

Email: [Aideen.silke@royalgreenwich.gov.uk](mailto:Aideen.silke@royalgreenwich.gov.uk)