Integrated commissioning

NHS Norfolk and Norfolk County Council

A blueprint for achieving integrated commissioning which involves comprehensive planning and attention to detail.
Background
Following the introduction of the White Paper, Equity and Excellence: Liberating the NHS, (Department of Health, 2010) NHS Norfolk and Norfolk County Council signed up to joint commissioning in April 2010. This would create two director level posts to provide leadership to develop integrated commissioning. It was important for both organisations to understand any implications before integrating the two commissioning teams.

Aims
The aim was for form to follow function. This meant working to create effective integrated commissioning rather than being driven by existing structures or pooling budgets. The shared vision was that joint commissioning improves the delivery of services by sharing expertise; integrated health and social care provides better outcomes for individuals.

What was done?
A proposal was developed for an integrated team structure. The team recognised that this would be an interim arrangement as the future GP commissioning arrangements would need to develop over future months.

An interim integrated post was set up to support the project: Human Resources and Organisational Development Specialist Project Manager, reporting to both the Head of HR and Organisational Development, Community Services, Norfolk County Council and the Director of Workforce at NHS Norfolk.

A joint integration board was established across both organisations, the membership included HR and organisational development and key senior managers from both organisations.

To support the integration board, a small core group was established to identify challenges and priorities across the areas of communications, accommodation, ICT, employee relations, health and safety and legal issues such as secondment agreements and Section 75 arrangements, (Department of Health, 2006)

Following the creation of an HR and organisational development focused mindmap (see Appendix 1), a detailed change plan was created to cover both organisations’ requirements and challenges.

A comprehensive workforce planning approach was taken, based on the Skills for Health six steps plan, a methodology for integrated workforce planning (Skills for Health, 2011). This was used to ensure that decisions made across both organisations were sustainable and realistic and that plans supported:

- delivery of quality patient and service user care
- productivity and efficiency
- displaced staff to maximize their opportunities for continued employment.
Outcomes

The integrated structure was designed following a number of assumptions:

- all posts would have integrated responsibilities across health and social care
- commissioning would have a local focus unless there was a need for it to remain countywide
- costs would become more generic in order to create flexibility to respond to the changing landscape.

It was proposed that the key focus of the integrated team’s responsibilities would be to deliver person centred care close to people’s own homes or as locally as possible. The key duties of the integrated team would be:

- commissioning health and social care out of hospital community services
- commissioning health and social care pathways for specific conditions and client groups
- delivery of a redesigned package of services for frail and elderly people into the quality, innovation, productivity and prevention (QIPP) programme
- transforming community services by a move from block to tariff for community services
- redesigning of community care services to address QIPP, comprehensive spending review and transformation of social care services
- commissioning for prevention and housing related support under the Supporting People programme
- leadership of personalisation and patient centred care in health and social care commissioning
- engagement with primary care, emerging GP commissioning consortia and other community stakeholders to ensure that community commissioning is locally delivered.

The organisations created a joint formal consultation document (see Appendix 2) that was issued in January 2011 (giving a 30 day consultation period) across Norfolk County Council and NHS Norfolk to look at the creation of a joint interim structure and delivery unit for out of hospital commissioning.

The team led staff briefings and workshops to discuss the proposed model and used a total engagement strategy to work very closely with all staff members, both at team level and individually. In addition, regular weekly communications were sent to staff and unions to update them and to provide feedback during the consultation period.

The consultation placed the commissioning of services for learning difficulties, mental health and drug and alcohol outside the at risk and appointments process. There were no plans to integrate those services at the point of developing the model, but they were included as part of the overall consultation to ensure that those teams had an opportunity to explore and, where possible, influence the future.
Arrangements were made during the consultation to interview each member of staff affected by the proposals and confirm:

- personal preferences and restrictions
- skills and qualifications
- experience
- grade and level of responsibility
- options for suitable redeployment and retraining (if appropriate).

It was recognised that staff were anticipating a substantial amount of change and that jobs were likely to be at risk so individual support and coaching was offered to (and taken up by many) staff going through the recruitment and selection process.

In addition, an integrated health and social care staff development coaching programme was initiated to ensure that all affected staff could explore their personal development needs prior to assessment and interview. It enabled the team to:

- identify and map talent and aspirations
- offer an opportunity to ask questions and raise issues
- provide a forum to discuss personal development needs
- provide employees with support to create a personal development plan for the transition.

The two organisations created a joint system to analyse the content of new job roles and to give appropriate gradings to the posts. Joint pay bandings were agreed across the two organisations to ensure parity of pay. Staff appointed to the new roles in the structure would remain employed by their current organisation, but be seconded to work across both organisations until end of March 2013, with the interim arrangement being supported by a Section 75 agreement.

A robust, shared recruitment and selection assessment centre process was created, which built upon the best practice from both organisations and took into consideration the NHS East of England Employment framework. Managers from both organisations had training in the requirements of the assessment centre and acted as assessors and interviewers.

Following the assessment centre process, successful candidates were required to be co-located which enabled shared access to IT systems. There has been a further relocation of some of the teams to sit with some of the clinical commissioning teams.
Impact
The new integrated team has built strong collaborative working across the health and social care system; commissioners now have health and social care knowledge and experience. The impact of the team includes:

- patients and service users experience integrated care across health and care services
- better interventions for people who need both health and care services
- more responsive use of the resources available for services
- a shared, local approach
- reduced commissioning costs
- now seen as a regional and national leader in integrated commissioning
- new community support service for older people in each locality commissioned and linked to GPs
- new information, advice and advocacy service commissioned and its budget reduced
- new integrated equipment store designed
- improved care for people at end of life
- integrated reablement pathway and pilot, to avoid hospital and care home admissions
- new carers’ services designed and ready to procure, within a reduced budget
- new arrangements for 65 local day services to achieve personalisation and budget reductions
- Living Well in the Community Fund set up and delivering innovative prevention projects
- early delivery of Supporting People savings programme
- co-production strategy in place and embedded in commissioning
- new countywide services for gypsies and travellers commissioned
- new service for chronic fatigue and myalgic encephalitis designed and ready for commissioning
- management of NHS funding to social care.

Learning
The management of large organisational change frequently creates a tension around the leadership of the project since it is still regarded as a discipline which HR and organisational development specialists only can lead on. However, the intensive work done by the HR and organisational development specialists led to the creation of long lasting relationships of trust with managers in the service.

Next steps
The team is continuing to develop relationships across the clinical commissioning groups and Norfolk County Council to establish a commissioning service beyond March 2013 when NHS Norfolk will cease to exist.

References
Department of Health, 2006  
DH; NHS Act, Partnership Arrangements, 2006.  
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Skills for Health, 2011  
Skills for Health, Six steps workforce planning methodology, 2011.  

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