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Anticipating the new Health Act: Messages from the Innovation Forum

Gerald Wistow and Catherine Henderson¹

Abstract

Nine councils in the Innovation Forum for high performing local authorities voluntarily set a target of reducing hospital bed days for people aged 75+ by 20% over the three years to 2006/07. This kind of objective was new for the NHS as much as local government. It was motivated by a concern among the councils that hospital admission exposed residents to risks to their independence and wellbeing which should be avoided wherever possible. They wished to demonstrate the value of the local authority community leadership or, as it has since become known, place making role. Their success in meeting this target supports the new NHS White Paper's proposed transfer of functions and responsibilities from PCTs to councils. It suggests that councils can successfully adopt, in appropriate circumstances, the lead responsibility for ensuring the strategic coordination of place-based commissioning. In health and wellbeing.

Key Words

Preventing emergency admissions, joint commissioning, community leadership, place making, integrating health and social care for older people.

Introduction

During 2003/04, a group of English local authorities voluntarily embarked on an initiative for older people which was to prove important and influential. Their act was a bold one. It might also have been described as 'brave' in the Sir Humphrey sense of being foolhardy and unnecessarily exposing themselves to excessive risk, at least reputationally. They agreed to embark on a project to reduce the exposure of older people to clinically unnecessary stays in hospital. The agreement was part of a programme of activity agreed between central and local government through the Innovation Forum (IF), the 'club' for local authorities (22 in the first instance) who were rated 'excellent' in the Comprehensive Performance Assessment (CPA) process. The Forum had been set up earlier in 2003 by the (then) Office of the Deputy Prime Minister (ODPM) and the Local Government Association (LGA). Its purpose was to provide a framework within which high performing councils could explore ways of working with central government "to identify bold strategies for reducing constraints and opening further opportunities," in areas of shared priority (Audit Commission 2003: para 112). This article reports on the experience of its older person's programme and concludes with some reflections on its implications for implementing the recent NHS White Paper (DH 2010).

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In the world of local government and central/local relations, the IF was a high profile initiative. It was established to demonstrate that 'excellent' councils were capable of even more; that they could make an even bigger contribution to local outcomes than was expected of them by the CPA. The original IF prospectus was explicit about its improvement goals: 'the Forum exists to pioneer ways of delivering a better quality of life and improved public services for local communities'. In addition, however, it was designed to pioneer more mature central/local relationships based on dialogue, shared priorities and the exercise of 'earned autonomy'. Thus, the prospectus also emphasised that 'the government is keen to use the existence of the excellent local councils to develop, explore and test new ways of working including the scope for new relationships with government agencies and other partners at local level'.

In this respect, the IF reflected the developing emphasis on local government's 'community leadership' role with power under the Local Government Act 2000 to prepare comprehensive community strategies to promote the economic, social and environmental wellbeing of their area (DETR 2000 para.1). The preceding White Paper had described this leadership role as lying at the heart of modern local government because 'councils are the organisations best placed to take a comprehensive overview of the needs and priorities of their local areas and communities and lead the work to meet those needs and priorities in the round' (DETR 1998, para.8.1). In so doing they would initiate a common direction or vision in partnership with other local organisations and people and integrate the work of local organisations to support the realisation of that vision. From the LGA perspective, not only were councils best placed to fulfil what would subsequently be termed a 'place shaping' role (LGA 2006, Lyons ?), and not least because of their local democratic mandate, but the need to integrate local planning, resource allocation and delivery was growing in importance and urgency. First, the shift from government to governance was increasing fragmentation and calling for more effective locally managed networks. Second, many of the most pressing local problems - the so called 'wicked issues' - were difficult precisely because they crossed so many organisational boundaries and responsibilities (LGA 2000, p.10).

Against this background, the stakes were high: for local government because it needed to prove it could be relied on to lead the integration of local governance systems. If the so called 'excellent' councils could not fulfil this role, it would be difficult to argue that the generality of councils could be entrusted with it. For central government, and especially the DETR as the Department responsible for local government, it was no less critical to demonstrate the capabilities of its 'flagship' councils and build commitment to the new vision for local government after a long period of low trust and conflictual central/local relationships (see, for example, House of Lords 1996). Such concerns were generic to the IF initiative as a whole. However, they were particularly pronounced in the case of its older people's project.

'Improving the Future for Older People' (IFOP)

The IF developed a number of projects during 2003 including one focussed on reducing hospital stays by older people so that they could retain their

independence in the community and experience a better quality of life. This project became known as IFOP ('improving the future for older people'), It was led by Kent County Council and sponsored by Stephen Ladyman, the then Care Services Minister in the Department of Health. The project attracted the largest degree of interest within the IF programme. Nine² of the original 22 member councils signed up to achieving over the three years from April 2004 the target of a 20% reduction in unscheduled hospital inpatient bed days occupied by older people aged 75 and over compared with the then anticipated level (i.e. what that level could be expected to reach on existing trends without the intervention of the pilots).

The prospectus for the project was drawn up by Kent County Council and the Department of Health with inputs from other participating councils. The project had been conceived from the outset as one with a 'health theme' rather than a purely local government focus. As a result, it adopted a whole systems perspective on needs and outcomes:

Older people thrive, retain their independence, maintain a quality of life, and stay healthy, when they live in good housing with access to a range of facilities (especially for transport, leisure and entertainment) and to families or friends. They may also need the services of a number of public agencies, sometimes only for the short-term (KCC and DH 2003).

In addition, it provided a clear example of the community leadership in arguing that:

Where possible, it is better to avoid using hospital admissions in these circumstances, or if not, to keep these stays to an absolute minimum. Stays can undermine self-confidence; disrupt diet, and increase dependency and the likelihood of infection. The consequences are often more medical treatment and expensive long-term institutional care (ibid).

This approach was a significant new departure on the part of local government. In effect, its argument was that older members of their communities were vulnerable to potential harm from the actions of the NHS. A traditional definition of local government responsibilities might have restricted them to the services provided by councils. Anything else was not strictly their business and might have invited questions about why they were trying to tell the NHS how to do its job by interfering in matters which were its proper concern. In practice, a council might have responded that it had a legitimate role because hospital induced dependency created unnecessary demands on its own community services. IFOP was going further than this service bound approach, however. It was embracing and advancing the local government responsibility for taking the lead in promoting the health and wellbeing of all its

² The nine councils were Kent (the lead council), Cornwall, Cheshire, Dorset, Hampshire, Hertfordshire, Westminster, West Sussex and Wigan

citizens and in securing the coordination of all local resources which might reduce the threats to and extend the opportunities for a better quality of life in local communities.

The commissioning brief (Kent County Council and Department of Health 2003 p.1) was explicit about the nature of what it described as 'this exciting community leadership challenge':

(the project) will require high performing pilot councils to provide strong community leadership, to form effective local partnerships, and to direct investments in health and social care. The pilot councils will play a 'strategic commissioning' role, ensuring that partners take a broad view of how resources are used across the whole system, including both acute and community care, and a broad range of preventative measures, across all local public services.

In concrete terms, this role was seen as requiring them to:

'provide a "single point" at which local public services come together to take a holistic view of the lives of older people in the communities they serve. Within the health and social care system, they would build upon a strong purposeful alliance between councils, Primary Care Trusts and GPs.

As a result, it envisaged that the pilot councils and their partners would be:

'more empowered to develop imaginative new services, and to change how services are used. This broad perspective, councils' commissioning expertise and their local networks, would all be deployed to promote community health and well being, to maintain independent living and to improve care and treatment services'.

From this perspective, a project to reduce hospital admissions and lengths of stay was a core responsibility of modernised councils and the IF provided a framework for piloting it with support from central government. Moreover, the notion that hospitals should be avoided because they might be damaging to health was not one with which local politicians and electorates were usually associated. Indeed, they were more generally perceived by the NHS as blocks to the reconfiguration of health services by insisting on the retention of local hospitals even where such services were considered clinically unsafe. IFOP was, therefore, innovatory in its definition of the problem no less than of the role for local communities.

Reducing the Use of Emergency Bed-days

By the time the IF was established, the balance of care between health and social services had long proved to be a difficult challenge in national planning and priority setting. Since at least the hospital and community care plans of the early 1960's, the role and mix of hospital and other services had been a focus for developing more integrated policy development and service delivery

(Wistow 1997). A prominent driver for this approach was growing evidence that acute hospital services were 'being used inappropriately, either by people admitted to hospital when they could be cared for in alternative settings, or by people who are medically fit to leave but are unable to do so.....' (Glasby 2003, p.12; see also Chapters 4 and 5).

For example, one influential study suggested that the inappropriate use of hospital beds could be as great as 20% (McDonagh et al 2000, para. 29). The National Beds Inquiry (Department of Health 2000) also cited this study as evidence of 'inappropriate or avoidable' bed use 'if alternative facilities were in place'. Other evidence obtained by the inquiry confirmed that the 'availability of community health services and social care are key to differences in acute bed use, while in some cases variations in primary care service delivery are also material' (ibid. para. 39).

The significance of this evidence was reinforced by the growing numbers of emergency admissions, especially during the winter, and the consequences for planned surgery in terms of cancelled operations and lengths of waiting lists (e.g. NHSE1997, 1998, Audit Commission 1997). Since shorter waiting times for A and E and for elective surgery were the highest central government priorities for the NHS, it followed that reductions in the inappropriate use of existing capacity were a major concern. The National Beds Inquiry, itself, identified three options for managing the demand for hospital beds one of which, the 'care closer to home' option, was adopted by the NHS Plan (DH 2000b). This option involved an active policy to expand community health and social care services and recognition that 'over time places in community schemes might replace some acute hospital beds'.

The option also involved an explicit commitment to Intermediate care defined as 'services designed to prevent avoidable admission to acute care settings and to facilitate the transition from hospital to home and from medical dependence to functional independence'. This clinical definition reflected the subsidiary or supplementary role of social services (and the almost complete absence of other local government responsibilities) in policy thinking around the preparation of the NHS Plan (Wistow 2001). Its task appeared to be that of 'handmaiden' to the NHS, helping to maximise capacity in the acute sector by developing community alternatives to hospital admission. The central role of hospitals in health and care systems was apparently revealed by terminology describing intermediate care as fulfilling 'step up' and 'step down' functions in relation to acute beds.

However, this approach began to broaden out quite rapidly. The intermediate care implementation guidance located it 'within a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, support for carers and acute hospital care.' (DH 2000) Social services also began to receive specific grants to prevent dependence and 'promote independence' (much broader concepts than facilitating the transition 'from medical dependence to functional independence' (see above). The Audit Commission (1997) had called for such investments to break out of the 'vicious circle' of insufficient investment in

preventive or rehabilitative services which meant that acute hospital services faced unnecessary and inappropriate pressures of demand leading to unplanned (emergency) admissions of older people to hospital and, in turn, premature admission to long term residential services in the absence of rehabilitation or reablement services.

Implicit in much of the above discussion is the recognition that emergency bed days can be reduced by two routes: avoiding unplanned admissions and shortening lengths of stay (LOS), but without increasing re-admissions disproportionately. The latter route of reducing LOS can, in principle, also be met in two ways: the more universal adoption of new technologies and techniques which permit shorter stays; and the arrangement of more timely discharges. In practice, the number of acute beds had fallen substantially from a peak of 250,000 in 1960 to 147,000 at the turn of the century (DH 2000a para. 18), largely as a result of reductions in the length of stay (LOS) including a substantial growth in day cases. Yet, hospital admissions had also shown a long term trend of 3.5% growth pa and, as we have seen, the increase in emergency admissions during the winter became a particular policy concern (ibid).

Paradoxically, however, by far the greater effort appears to have been directed at reducing lengths of stay rather than the number of admissions, especially by minimising the number and extent of 'delayed' discharges. In other words, priority had continued to be focussed on speeding up the flow of patients through and out of the hospital rather than addressing inappropriate demand at the 'front door'. The shift in social care and the NHS towards prevention and intermediate care supported a stronger emphasis on diverting patients from the hospital front door. This stream of thinking was, moreover, consistent with the largely separate conceptualisation of the community leadership role of local government in promoting citizen wellbeing and creating sustainable communities. It was in the IF older persons' project that these various streams met and reinforced each other.

Setting and Achieving the IFOP Target

This conjunction of community leadership and whole systems thinking for older people still left open the question of how the IF was to measure success. As noted above, the nine councils accepted a single quantitative target to be achieved over the three years from 2004/05: a 20% reduction in unscheduled hospital inpatient bed days used by people aged 75+ compared with the level that would have been reached if the IF project had not existed. However, it was intended that this 'headline target' should 'merely' provide a unifying focus for the project and a high level indicator of whether it was broadly on track in terms of enabling older people to live healthier and more independent lives, 'with greater choice of service, more means of support and increased community participation' (ibid. p.2). While there were, of course, ever present dangers of reduced hospital stays becoming an end in itself, the intention was that they were needed as a means to securing a better quality of life for older citizens.

Three features of this measure should be highlighted. First, it was entirely voluntary and did not release the participating councils from any current or future national targets. Second, progress was to be assessed for the group as a whole and not authority by authority. Third, the headline indicator was defined in terms of bed days rather than admissions in order to avoid perverse consequences. Thus the measure to be applied was the number of "unscheduled acute hospital inpatient bed days occupied by people over 75 years old, living in partner PCT areas". This figure was defined as the product of admissions for 'first finished consultant episodes' (FFCEs) and 'average lengths of stay'.

The primary impact of the proposal was expected to be on reducing the number of such episodes. However, it was recognised that the target might mean reducing lengths of stay, 'where this reflects more modern care and treatment, but not where this leads to inefficient discharges. Occupied bed days will therefore be the measure' (ibid). At first sight, the logic underpinning this reasoning is not entirely clear. It appears to point to monitoring the number of admissions rather than bed days on the grounds that the latter target might encourage hospitals to discharge prematurely. In such circumstances, monitoring admission numbers might seem more appropriate.

But there was also concern at the time that admission figures were being artificially inflated by counting the admission of a patient with more than one condition requiring treatment as more than one episode of care and thus more than one admission. From this perspective, monitoring admissions might simply lead to a re-definition of what constituted a single admission without equivalent changes in the number of days spent in hospital. Whatever the logic, the important issue at this point is that the target was set with regard to the possibilities of gaming and unintended consequences. Subsequent meetings with those responsible for setting the target also suggested that the bed days measure was purposively chosen because it was considered 'the more demanding figure'.

The formula for quantifying the headline target had not been fully developed within the project brief. Consequently, the national evaluation took the lead in carrying out this task taking into account projected demographic changes and the historic trend in the level of emergency bed days used by older people. (Wistow, King and Huntingford 2005). In the event, monitoring against the headline target was restricted to eight of the nine pilot councils. Hampshire was not included in the monitoring (though it remained a full part of IFOP in every other respect) because its interventions operated at the level of two GP practices rather than the defined geographical area of councils or PCTs. For the eight remaining authorities, the 20% headline target to be achieved over the three years from 2004/05 was expressed in two ways:

- *compared with the projection for 2006/07, which produced the 20% headline target of 269,480 emergency bed days fewer than would otherwise have been used by that date³;*
- *compared with the baseline year of 2003/04, which amounted to an absolute reduction of 97,571 emergency bed days over the three years to 2006/07.*

Although each council had signed up to a target of using 20% percent fewer bed days than would otherwise have been the case, local variations in context produced substantial differences in terms of what the target meant for individual localities. For example, in both Hertfordshire and Kent, it implied absolute reductions in bed days totalling almost 19% over the three years to 2006/07. By contrast, it equated to an increase of some 15% in Cornwall and virtually no change in West Sussex. To the extent that these differences reflect differing rates of growth in the 75+ population, they represented variations in the level of response needed to deliver *the same order* of change in emergency bed days in the face of differing levels of potential demand. Similarly, and to the extent that the different targets incorporated each locality's historical trend in bed day reductions, they may be seen as presenting ever more challenging targets for those areas that had already made significant inroads into 'excess' bed utilisation.

Results: Interventions and Investments

Each council and its partners initiated the service developments they judged necessary to achieve the headline target. Participation in the project did not imply commitment to a common service model. Project leads supplied brief descriptions of IF interventions, including their aims, funding, and delivery). Details of 128 projects had been reported by the end of the project's final year (2006/07) and categorised according to whether they were designed to

- prevent attendance at A and E (85%)
- divert A and E attenders from hospital admission (65%)
- reduce lengths of stay for those admitted (70%)
- improve discharge arrangements to reduce the risk of re-admissions (69%)

Individual interventions could serve more than one aim and three sites reported that all their projects addressed all four aims. Nonetheless, the findings do indicate a strong focus on diversion from the hospital front door as well as to reduce LOS improve discharge. They imply a rounded, whole systems approach to reducing hospital stays rather than one focussed more narrowly on faster throughput and early discharge. The emphasis on diversion from A and E is also consistent with the national target for a maximum 4 hour wait.

³ The headline target was initially reported to be 265,450 bed days. However, following the official annual revisions to the HES data set, the target was re-calculated to the 269,480 total shown above.

Five types of project accounted for more than half the total:

- expansion of intermediate care services (22%)
- case management of chronic conditions (13%)
- falls prevention (8%)
- improving (diagnosis-specific) care pathways from hospital to community (7%)
- supporting care homes with health staff (7%).

Many projects shared an element of rehabilitation, with 40 (33%) projects involving therapy staff in delivery. In addition, the project's focus on improving wellbeing led to the project leads developing knowledge and expertise in preventive approaches to sustain people in community settings. This development was reflected in their engagement in the development of both the more modest 5% national target for reducing emergency admissions and the POPP programme. The DH acknowledged the influence of the IF on policy development and four councils became POPP pilots.

Whether the IF projects represented a different balance from previous investments or a better balanced overall system of care cannot be determined from these data. However, they are apparently consistent with the intended direction of travel and the great majority (101) were still being funded at the end of IFOP. Another difficulty in interpreting the projects is that IFOP interventions were not the only services and support expected to help achieve the headline target. Rather, they were contributions to a pre-existing and wider system of care. In other words, the introduction of specific interventions at specific sites may reflect recognition of the need to fill particular gaps in existing services rather than the absolute relevance of that intervention to the headline target. Variations in spending between IF sites may, therefore, simply reflect variations in extant service patterns.

Results: the Headline Target

The headline target was monitored annually using both local data sources, which provided more immediate feedback and HES data, which provided slower feedback but could be regarded as independently validated by central government. The results were broadly comparable, with one exception where they continued to be disputed and, in effect, led to the NHS using the health service HES data and the council using the local data set (and securing its acceptance by the regional government office for calculating local public service agreement performance rewards). Whichever data source was used, however, the eight councils and their partners exceeded the headline target. The HES outturns showed that the eight localities had collectively met their overall target by achieving a 22% reduction compared with the projected figure for 2006/07. If the locality with disputed data is excluded, bed days fell by 24.5% in the remaining seven areas. The 22% reduction was equivalent to some 120,000 fewer bed days compared with the 2003/04 baseline and some 300,000 less than the projected figure for 2006/07.

Though it was not part of the headline target, it should be observed for completeness that the 20% reduction was not fully achieved in every area. It was exceeded in three areas, three areas achieved a 10% reduction and one was just below 10%. All improved on the 2006/07 projection which arguably benefitted those which had not already picked the low hanging fruit. At least one PCT area in each of the councils with multiple PCTs met or exceeded the headline target (including those localities where it was not met in the area as a whole). In addition, the councils dealt with other substantial challenges, including repeated policy change, re-structuring and financial deficits, the impact of which were as a source of regular concern for the project leads (Wistow and Henderson 2006).

Conclusions

IFOP more than achieved its headline target, a target which, at the outset, was unique in the health and social care system. Nine councils and their partners effectively became pathfinders for the strategic shift in the balance between hospital and community services which is now central to national policy. They did so, moreover, voluntarily and because they were committed to better outcomes for older people rather than because national policies and priorities required it of them or because they had been incentivised by financial grants for pilot authorities. Their initiative is to be understood as a commitment to the community leadership and the outcome an indication that its vision can be operationalised in at least some places and time, notwithstanding significant challenges along the way.

Alongside this high level assessment, a number of additional conclusions may be drawn. First, the 20% target was valuable in concentrating minds and, project leads argued, in sustaining the local profile and priority for a challenging objective that might otherwise have slipped off the radar, especially given the demands of other non-negotiable national targets.

Second, a single headline target was adopted rather than a multiplicity or hierarchy of targets and it was not only adopted voluntarily but also defined and negotiated locally. As a result, it generated a strong sense of local ownership and commitment compared with, for example the national 5% target which also applied to the IF councils and PCTs. These features also helped to explain how focus and motivation were maintained and have positive implications for the adoption of a smaller number of national and local targets as has since been introduced through the new Local Area Agreements.

Third, the target was explicitly expressed in bed days rather than admissions and as in England more generally, bed days fell while admissions continued to rise. It is of course impossible to know whether the IF councils and PCTs might have reduced admissions if that had been selected as the headline measure. Fourth, the focus on reducing lengths of stay because hospitals can harm as well as heal was an innovatory step in 2003 when there was considerably less awareness of patient safety issues or priority accorded to

them. Ironically, one of the events which has brought the issue to the fore was the death of older patients in a hospital in Kent, one of the IF councils. If nothing else, this experience validates the adoption of the community leadership perspective as advocate for promoting the wellbeing of all citizens irrespective of the services and resources they do or do not access

Finally, the IFOP can be seen as a critical contributor to a wider development path on which health and social care systems are embarked towards care which is both closer to home and also more oriented towards preventing dependence and promoting wellbeing (Wistow et al 2010). When the history of that journey is written, it seems probable that the IF will have a significant part in demonstrating how local government was able to identify new possibilities and initiate new partnerships to support their realisation. Certainly, the Coalition government's first White Paper on the NHS suggests that the centre has begun to accept the potential of the local authority leadership or 'place making' role in the field of health (DH 2010). Not only does it propose the transfer of public health and health improvement functions from PCTs back to local government, but it also proposes lead responsibility for councils in ensuring the strategic coordination of place-based commissioning.

Thus the White Paper says that 'each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement'. As a result, they will be responsible for:

- 'Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions'.

(DH 2010 p. 35)

What these functions will mean in practice, like much else in the White Paper, remains to be clarified. However, the intention seems to be clear, at least for the moment. If implemented, these proposals would represent a major shift to the kind of local authority role in the governance of health envisaged by the Innovation Forum. As ever, the devil will be in the detail.

Three priorities seem immediately relevant. First local government must seize these proposals as the historic opportunities they are. This may be easier said than done in the current financial environment but their contribution to shaping the detail through the consultation process could be critical. Second, they must ensure through that process that their new responsibilities are backed up by an appropriate structure of levers, incentives and organisational

incentives. This will involve the application of the proper lessons from more than one generation of academic research and frustrated practice in the integration field. In particular, it will require recognition that integration has many different faces but depends fundamentally on ensuring that vertical and horizontal power structures are correctly aligned.

Lastly, local authorities must convince local health interests that they are trustworthy partners, motivated by the desire to improve health and wellbeing and, thereby, help GPs and hospitals alike to achieve the outcomes local residents and the new National Commissioning Board will expect them to deliver. In such circumstances, councils could do worse than point to the experience of the Innovation forum and IFOP.

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