Adult Social Care Committee

Item No:

Report title:	**Moving forward integrated health and care**
Date of meeting:	**6 March 2017**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Integration between health and care is fundamentally about supporting vulnerable people by better organising services to provide the outcomes people need. Integration of health and care by 2020 is a policy requirement signalled since 2010 and set out in the 2015 spending review and the Better Care Fund. Integration and system redesign will mean significant changes in the local health and care system and will be determined at a local level. This is work that the Council needs to progress with partners in the NHS. It will be central to the configuration of our future social care services. This is an opportunity to shape the future health and social care system to support the Council's strategic priorities, particularly in relation to supporting vulnerable people within the available resources. See **Appendix 1** for the National Policy Perspective.

Executive summary

Integration is about organising services so that they can achieve the best outcomes for local people, overcoming the organisational, professional, technical and legal barriers to achieving this.

This report responds to national policy relating to integration of health and care services by 2020 and makes recommendations about how to progress on the basis of our existing integrated commissioning and provider arrangements. This will be key in determining how social care will be provided in the future.

Under the Sustainability and Transformation Plan, development of locally integrated health and care provision is proposed, bringing together community health and care services with primary care to address the needs of a local population.

Alongside this, it is proposed that integrated commissioning arrangements with Clinical Commissioning Groups will be reviewed with a view to proposing future integrated arrangements.

Taking stock of the learning from the national Vanguard schemes, good practice examples and local experience, this paper provides a review of existing integration and sets out a proposed framework for progressing the agenda. It considers the opportunities and the risks as they relate to the citizen and to the County Council's strategic outcomes.

Recommendations:

That Committee asks officers to progress the development of integrated health and care in Norfolk by working with partners to:

a) **Review and revise integrated arrangements to ensure they meet Care Act and Sustainability and Transformation Plan requirements**
b) **Review the social models of care and support that are required for good quality and sustainable services**
c) **Review our arrangements for hospital social work and community based learning disability social work**
d) **Agree a Member workshop on integration**
e) **Agree the principles proposed at section 1.9 of this report**

1. Taking stock of integration in Norfolk:

1.1 From review of our integration to date and learning emerging from around the country, it is proposed that our integration continues to be founded on the two existing elements: integrated commissioning and integrated service provision.

1.2 **Integrated commissioning**

1.2.1 There are a number of potential benefits of commissioning health and care services in an integrated way:

a) Being able to plan pathways for citizens and patients regardless of whether it is a health or care service they require e.g. planning for dementia
b) Being able to make the most effective investment with the available funding rather than separate investment decisions e.g. reducing gaps and duplication
c) Reducing the burden on suppliers, particularly smaller organisations, of being commissioned by multiple agencies
d) Being better able to influence local markets and avoid unintended impact e.g. by paying different rates for services
e) Making best use of our shared commissioning officer resource by reducing duplication

1.2.2 We have had integrated commissioning in Norfolk since the inception of the CCGs in 2013 and all of the Council's social care commissioning takes place within an integrated team led by the Council's Director of Integrated Commissioning. All posts are jointly funded with the CCGs and have a remit to work across health and care. There is a small team people based within each CCG which has a strong local focus and a team at County Hall which tends to handle the larger scale commissioning and support the local teams. The CCGs lead the commissioning of key health providers.

1.2.3 Commissioning may involve planning and procurement of large scale services but in social care it is increasingly about shaping our markets and working creatively with providers and communities to achieve outcomes with the available resources.

1.2.4 The Clinical Commissioning Groups (CCGs) have been developing how they work together as commissioning organisations and 2016 saw the publication for the first time of commissioning intentions across Norfolk for health and care. It is anticipated that as we shape a more integrated health and care system this can be better facilitated through integrated commissioning.

1.2.5 It is proposed that integrated commissioning is reviewed and proposals developed with the CCGs seeking to maximise the benefits in terms of service outcomes and efficiency.

1.2.6 We will also seek to maximise the opportunities for efficiency in the support to commissioning, such as shared data and analysis, procurement and contract management.

1.3 **Integrated provision**

1.3.1 Adult Social Services has a well-established integrated management arrangement with Norfolk Community Health and Care (NCHC) under a section 75 agreement and has integrated management with East Coast Community Healthcare (ECCH) for the Great Yarmouth area. These arrangements have enabled development of more integrated approaches across community health and care, for example aligning the work of occupational therapists, co-locating teams and contact points, creating integrated care co-ordinator roles.

1.3.2 This has allowed for services to be better co-ordinated around individual need. A recent survey of people who had received the integrated services has provided positive feedback in terms of the elements which patients and service users had originally told us most mattered to them:

a) **92%** of patients/service users **either strongly agreed or agreed** that the professionals involved in their care **communicated effectively and directly with themselves and their families**

b) **78%** of patients/service users either strongly agreed or agreed that professionals involved in their care **communicated effectively** with each other

c) 76% of patients/ service users **strongly agreed or agreed** that their **care was well co-ordinated**

d) **90%** of patients/service users either **strongly agreed or agreed** that they were seen by the right **professionals who knew and understood their care needs**

e) **79%** of patients/service users either **strongly agreed or agreed** that professionals involved in their care knew their story and **did not need to repeat themselves**

1.3.3 Implementing the new models of care from the Five Year Forward View will shape the future of the social care teams which are integrated with NCHC and ECCH. At this stage, we envisage developing multi-specialty community provider model with primary care in order that there is a team focused on the health and care of each locality population. This could mean our social work teams being aligned with GP practices and community health care colleagues to work as a team focusing on ensuring that people with health and care needs get co-ordinated specialist care. Alongside this, they would work with District Councils and voluntary and care providers to ensure people are connected effectively to local prevention services. The aim is to be the best we can at helping people to be healthy and well at home wherever possible.

1.3.4 It is proposed that we work with our partners in primary care and the health providers, along with local voluntary services and district councils, to develop the future model for integrated community care.

1.4 Learning disability and mental health services

1.4.1 Our learning disability teams are currently joint teams with the commissioned service from NCHC, bringing together social workers, nurses and other specialists. The current arrangement is secured under contract, so this provides us with an opportunity to work with our partners to shape a future service which does the very best we can to help people with a learning disability to live active and fulfilled lives in their local communities. An integrated approach to this will continue to be an essential underpinning, as will strong engagement with local communities.

1.4.2 Similarly an integrated and community-based approach is core in supporting adults with mental health needs. Whilst our services are not formally integrated we will continue to work with CCGs and mental health partners to ensure a seamless approach as we develop our services. For younger adults, these developments will align closely with the existing Promoting Independence activities.

1.5 Aligned and pooled budgets

1.5.1 Aligned and pooled budgets can act as an enabler to integrated health and care. At present pooling of budgets has been limited to particular areas:

a. the integrated community equipment service where NCC holds a contract on behalf of NCC and all CCGs (total value c. £7m)
b. the pooled fund with each CCG for the Better Care Fund, most of which is mandated, totals £60.087m revenue funding in 2016/17 and £6.368m capital funding, alongside a joint agreement for the additional funding for the maintenance of social care totalling £7.9m

1.5.2 Funding within a pooled arrangement can reduce unnecessary and costly transactions, support integrated service provision and ultimately our ability to make best use of health and care resources. There is potential to progress this on a staged basis. For example, aligning funding for a local population to support a population-based approach or pooling our resources for an area of service to support an integrated service area such as rehabilitation and reablement. As such options are explored the Council will want to ensure it has appropriate governance and management of risk.

1.6 **Principles to take forwards into the design**

1.6.1
a) A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities
b) Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities
c) Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
d) A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens

1.6.2 As we progress with integration it will be important to move forwards into a world where the artificial boundaries between health and care become increasingly less relevant as the focus becomes increasingly about shaping services around individuals and communities. However, it will remain vital that the Council is able to assure itself of the value it delivers on behalf of its citizens.

1.6.3 Arrangements must reflect our new model of social work and Promoting Independence programme and indeed furthers these goals. Integration must not compromise our ability to deliver our key duties under the Care Act 2014 within available resources, including strengths-based assessment, review and care and support planning.

1.6.4 Integration should be focused first on achieving outcomes for individuals or service improvements. Consideration of organisational form will follow rather than lead the thinking.

2. Financial Implications

2.1 There are key financial considerations in furthering integrated care. Due to the inherently integrated nature of health and care services, changes in the NHS are highly likely to have implications for the local authority adult care services. For example, increased admissions to hospital will tend to lead to an increase in people who when discharged will need some form of care service. Working together on such key areas, for example through increasing the opportunities for reablement and home based care, may mitigate the risk of this impact.

2.2 Any funding agreements should consider the need for formalised risk agreement. There is no nationally recommended approach and as yet very few areas have tested full pooling of resources between health and social care. Given the severe pressures in the system of increased complexity and demand, the Council and health partners will want to consider how to secure their respective responsibilities. For example, Torbay Council,

whilst heralded as an exemplar of integration across health and care, has recently acknowledged the council's exposure to financial impact due to a risk agreement under which the council is responsible for a percentage of the amount over the control total agreed with NHS England. We would want to ensure we learn from such experience.

2.3 However, the opportunity in integration is also to remove the artificial distinctions between health and social care and the associated funding, creating more seamless services, removing costly and time-consuming bureaucracy and potentially allowing increased funding for social care. The Better Care Fund for example has coordinated existing health and social care revenue and capital funding totalling £66m with £31m supporting adult social services in 2016-17. More funding will be coming from central government into the Better Care Fund in 2018/19 and 2019/20.

2.4 Officers will make use of national and regional networks to inform detailed proposals for the development of joint funding arrangements.

3. Issues, risks and innovation

3.1 Integration offers opportunities for innovation to improve outcomes and whilst there is considerable best practice evidence there is no conclusive blueprint for success. What is clear is that solutions need to both draw on evidence but also be tailored to local application.

3.2 There will be implications for staff, certainly in terms of ways of working, but potentially as we further our integration there may be changes in terms of job roles. For example, we may seek to develop more roles which work across health and care. We have existing strong engagement with our staff and Trade Unions and will ensure staff are engaged and supported in any change and that our existing human resources procedures are followed.

3.3 There is evidence that co-location can facilitate integration and we have already taken several opportunities to co-locate staff. Better use of public estate is one of the opportunities in integration and we will continue to identify how we can do this within the priorities, and governance, of the Council's estates strategy.

3.4 Financial risks have been highlighted above, but current NHS control totals at an organisational level challenge a whole system approach. The STP is developing the financial system overview to support better medium and long term planning and potential reallocation of resources.

3.5 Our existing integration is underpinned by legal agreement and we will continue to ensure proper appraisal of and governance of future arrangements.

3.6 The risk in not progressing with integration is firstly that we fail to meet explicit policy directions, but primarily that we fail to realise the opportunities to secure improved experience and outcomes for people in Norfolk.

4. Background documents

4.1 Stepping up to the Place: the key to successful health and care integration

Five Year Forward View, NHS England

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

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If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

National Policy Perspective

Our focus in integration is to improve the way services are organised in order to better meet the health and wellbeing outcomes of local people. This is reflected in national policy which requires the development of integration between health and social services. The 2015 spending review and subsequently the Better Care Fund has set out the requirement that by April 2017 areas have a plan for the integration of health and care by 2020. This is reflected in Norfolk's Sustainability and Transformation Plan, "In Good Health" which makes integration a priority in the future configuration of health and care systems. A major focus is the reduction in avoidable hospital admissions, by strengthening the community-based health and care, particularly for older people and people with a range of long term health conditions.

Taking stock of integration at a national level:

'Stepping Up to the Place: the key to successful health and care integration', is a joint publication from the Local Government Association, Association of Directors of Adult Social Services, Clinical Commissioners and the NHS Confederation. It set out a vision for integrated care which sets health and care firmly within communities and focused on outcomes for citizens:

"Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities.

They will be in the right place – which is in our neighbourhoods, making the most of the strengths and resources in the community as well as meeting their needs. Care, information and advice will be available at the right time, provided proactively to avoid escalating ill health, and with the emphasis on wellness. Services will be designed with citizens and centred on the needs of the individual, with easy and equitable access for all and making best use of community and voluntary sector provision. And they will be provided by the right people – those skilled to work as partners and citizens, and who enable them to be able to look after their own health and wellbeing.

Leaders – local and national – will together do what is best for their citizens and communities ahead of institutional needs. It means directing all of the resources in a place – not just health and care – to improving citizen's wellbeing, and increasing investment on community provision. It also means sharing responsibility for difficult decisions, particularly in securing sustainable and transformed services."

The report reviewed the ingredients for successful integration and proposed the following essential characteristics:

1. **Shared commitments:**
    a) A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities
    b) Services and the system are designed around the individual and the outcomes important to them, and developed with people who use or provide services and their communities
    c) Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing
    d) A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens

2. **Shared leadership and accountability:**
    a) Locally accountable governance arrangements encompassing community, political, clinical and professional leadership which transcend organisational boundaries are collaborative, and where decisions are taken at the most appropriate local level

b) Locally appropriate governance arrangements which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning
c) A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens

3. Shared systems:

a) Common information and technology – at individual and population level – shared between all relevant agencies and individuals, and use of digital technologies
b) Long-term payment and commissioning models – including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability
c) Integrated workforce planning and development, based on the needs and assets of the community, and supporting multi-disciplinary approaches

These characteristics are reflected in the areas we will want to address as we progress local integration.

STP and the NHS England Five Year Forward View

A key factor in the design of future services is the national requirement on the NHS to address the new models of care set out in NHS England Five Year Forward View, in particular population-based models of either Multi-Specialty Community Provider (MCP) or Primary and Acute Provider Service (PACS) model.

The planning assumptions are place- and population-based. The underlying premise of both models is that a provider, or group of providers, take responsibility for managing the health of the population in an area and the funding is allocated as associated with the population rather than against specific services. The drive is to focus on the outcomes for the population rather than an organisationally focused approach, and that this encourages new ways of working.

MCP is a model which brings together such components as primary care, community nursing, therapy, and potentially social care and the voluntary sector. Elements of services which happen in the acute hospital could be included, such as some diagnostics.

PACS explicitly includes acute services as part of a vertical integration model so the responsibilities for hospital and community services for a population are held in one place.

In addition to these two models, the Five Year Forward View also sets out how care homes must be supported to be better connected to health services in playing their part to avoid unnecessary admissions to hospital.