Adult Social Care Committee

Item No……

Report title:	**Next steps for integration with the health service**
Date of meeting:	**4 September 2017**
Responsible Chief Officer:	**James Bullion, Executive Director for Adult Social Services**

Strategic impact

The health services are key strategic partners for Norfolk County Council (the Council). Integration of health and care is about placing individuals at the centre of the design and delivery of care with the aim of improving individual outcomes, satisfaction and value for money.

Executive summary

A significant proportion of demand for social care services comes through the NHS. Ensuring we have effective arrangements across health and care services is critical to meet national policy expectations for health and care integration. Over £56m of adult social care funding is now held within the Better Care Fund (BCF) jointly with the Clinical Commissioning Groups (CCGs) and requires us to reduce delayed discharges from hospital. Being good partners for integration is one of the five priorities for Adult Social Care.

This report sets out the impact of integration to date, and proposes to refresh and renew the current integration arrangements in the context of the shared challenges across the health and social care system.

Recommendations:

a) **By March 2018 to renew our arrangements for the integrated management of community services with Norfolk Community Health and Care to March 2019**

b) **By March 2018 to renew our arrangements for the integrated management of community services with East Coast Community Healthcare to March 2019**

c) **To put in place arrangements to address integrated leadership in mental health services**

d) **To enter negotiations with hospital services to promote a community-based 'in-reach' model with a greater focus on admission avoidance and discharge support**

1. The drivers for integrated care

1.1 Integrated care responds to increasing demand, increasing complexity of needs and the need to develop a more financially sustainable model for health and care. Drivers include:

Policy:	o Requirement set out in the Autumn spending review of 2015 for 'integration of health and social care by 2020'
	o Better Care Fund with a focus on integration and hospital discharge
Savings:	o Removing duplication
	o Creating shared digital systems
Managing demand:	o Targeting support to high risk needs

Citizen experience:	o Prevention and admission avoidance o Better crisis management, better discharge o Seamless services, single assessment o People don't recognise the health and care divide

2. The case for integration with the NHS

2.1 The 2015 spending review set out the intention that health and social care will be integrated by 2020 and the Better Care Fund requires us to set out how we will achieve this, including a particular focus on ensuring effective discharge from hospital.

2.2 In June 2016, the Local Government Association published "Efficiency opportunities through health and social care integration" which, working with Newton Europe and five councils identified opportunities for delivering better outcomes at reduced cost. It set out efficiency savings of 7-10% *of the affected budget areas* and highlighted priority areas of focus: variation in front line decision making, avoidance of admissions to acute hospitals, discharge planning to maximise independence, deploying better skill mix in teams and noted the most important factor in realising these opportunities is the approach taken to change, characterised by prioritised, evidence-based, locally developed solutions. The report notes that given the increasing demand, any savings are likely to be needed for reinvestment.

2.3 The National Audit Office (NAO) published a report "Health and social care integration" in February 2017. Of their key findings they noted that whilst the Department of Health and Department for Communities and Local Government are driving integration, they have not yet established a robust evidence base to show that integration leads to better outcomes for patients in England, not having tested integration at scale and not having demonstrated that benefits are a consequence of integration. In addition they note that there is no compelling evidence to show that integration in England leads to sustainable reductions in the cost of care, noting the difficulty in tracking patients and in securing comparable data. They recognize that achievements have been made at local level in terms of reablement and reduction in residential admissions for older people.

2.4 The report concludes that joint working between the NHS and local government to manage demand and support out-of-hospital care through integration could be vital to the financial sustainability of the NHS and local government. It notes that the Better Care Fund has increased joint working and the provision of integrated services, but that it has not yet achieved its potential.

2.5 The NAO concludes that there is national work to do to create the environment within which integration can thrive and to create a clear evidence base of what works. It sets out recommendations for action at national level to strengthen the evidence base and co-ordination and measures to support local integration, including addressing financial incentives, workforce and data sharing.

2.6 We know that the population of Norfolk will change substantially over coming years. The number of people who risk being vulnerable adults is projected to grow substantially over the coming years, particularly those people most likely to need health and care services.

2.7 Figure 1: illustrates the anticipated increase in numbers of people with multiple long term conditions which is likely to reflect a need for care services. The solution is not to provide ever more social care services, but to think very differently about how we allow people to retain their wellbeing and independence from formal care. Working effectively with the NHS will be critical to achieving transformation in the health and care system which meets this increased level of need and is reflected in the plans of the

Sustainability and Transformation Partnership (STP).

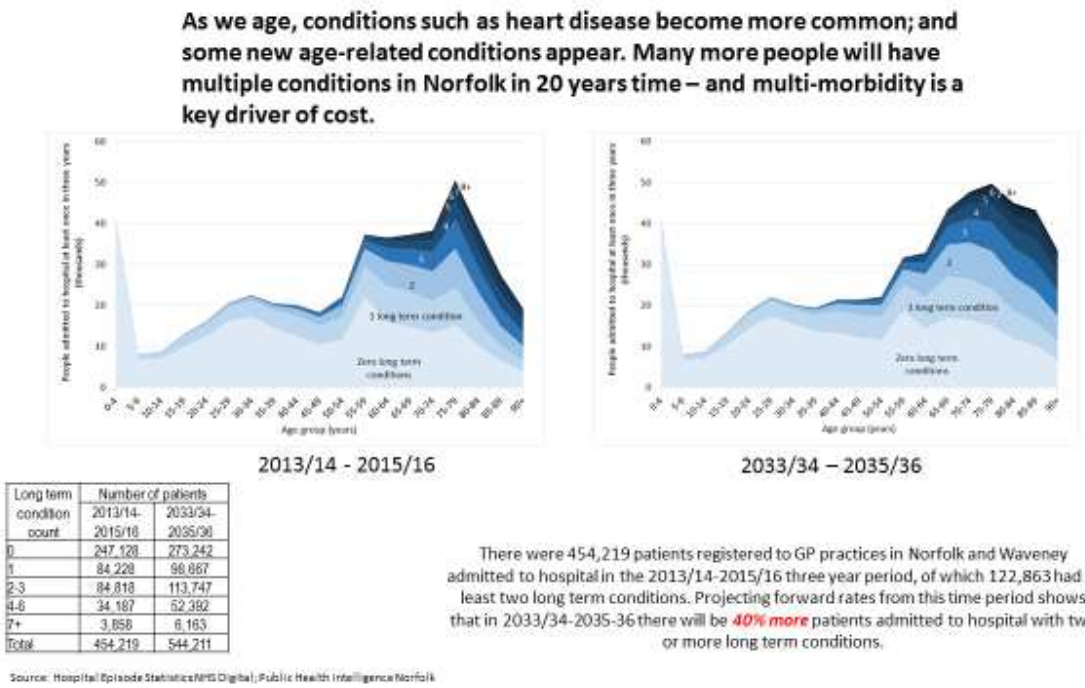

Figure 1: increase in multi-morbidity over the next 20 years

2.8 **Delayed Transfers of Care (DToC) targets**

2.8.1 The increased focus on delayed transfers of care poses challenges for most areas, Norfolk included. The Council has recently received a letter from Jeremy Hunt, Secretary of State for Health, commending Norfolk for the reduction in delayed discharges from hospital. Although our performance has been generally good the targets that the Council is now expected to deliver are very ambitious.

2.8.2 There is an indication that failure to meet delayed transfer targets will mean a reduction in the additional funding available in 2018/19 through the Better Care Fund, currently budgeted for £11m. We will continue to ensure effective discharges and will seek to work with the hospitals to focus our approach on community teams working with patients in hospital to ensure they return home as soon as possible. We know that almost 50% of referrals to adult social care come through our hospitals, so we will also seek to identify people who are most at risk of admission to hospital and work with them to prevent admission and to retain people's independence.

2.8.3

Delayed transfer target	Jul-17	Sep-17	Nov-17	Mar-18
Social care attributed delayed days	860.3	700.5	568.4	587.3
Jointly attributed delayed days	54.4	47.8	42.9	44.3

3. Performance impact to date

3.1 Using standard performance data provided by NHS England, we can summarise Norfolk's rates of admissions/attendances in comparison with other areas:

a) A&E attendances are low – the STP has set a target to reduce these by 20% against expected growth by 2021
b) Rates of non-elective admissions are relatively low apart from West Norfolk – the STP has set a target to reduce these by 20% against expected growth by 2021

c) Emergency length of stay is relatively lower than we would expect – the STP has set a target to reduce this by 35% by 2021
d) Rates for outpatients attendances are relatively low
e) Rates for elective admissions are relatively high
f) Length of stay for elective admissions is relatively high for Norwich and average or relatively low for the other CCGs

3.2 The challenge this relatively strong picture poses for Norfolk is the need to go further in improving our performance.

3.3 **Time to refresh current arrangements**

3.3.1 Norfolk has put in place integrated arrangements with NHS partners over recent years and has made sound progress. There is no clear blueprint for achieving integration in national policy, this is for local determination.

3.3.2 At present, we have 15 joint posts with our community healthcare trusts, Norfolk Community Health & Care (NCH&C) and East Coast Community Healthcare (ECCH). The arrangements have allowed us to develop more seamless and co-ordinated services but they have been based on creating opportunities as they arise and are not even across our geography. We no longer have formal arrangements with Norfolk and Suffolk Foundation Trust (NSFT) for mental health. Our links with primary care are not sufficiently strong for today's requirements and the future of services designed around primary care which will be critical to determining how local services are shaped.

3.3.3 It is proposed that we renew our arrangements with NCH&C and with ECCH to allow us to work together to shape new services with primary care at a local level. Alongside this, it is proposed that we consider how we work with NSFT to ensure we strengthen integrated care for older and working age adults with mental health needs.

3.3.4 Alongside our arrangements for integrated management of services, we have integrated commissioning arrangements, with all commissioners of adult social care and support in joint posts with CCGs. The CCGs and Council are considering how they work together to plan across the Norfolk and Waveney footprint, whilst delivering change at a local level.

3.4 **Integration with other partners**

3.4.1 Whilst integration with the NHS is a practical and policy priority, it will remain critical that we create integrated approaches with other partners, particularly:

a) Aligning our work with the NHS with the development of local services within NCC
b) Working closely with Children's Services to support families
c) Linking with Public Health prevention services and evidence
d) Working closely with District Councils on housing and prevention services
e) Working with other community, voluntary and independent care services

4 What could integration look like?

4.1 **1. Local health and care teams in around 20 localities**

4.1.1 Services will become devolved into local areas. Social workers, nurses, occupational therapists, mental health workers and reablement workers working with GPs:

a) Providing streamlined health and care
b) Acting early to support independence and manage health conditions

c) Using data to identify people whose needs may be increasing and who may need additional support to avoid a crisis ('risk stratification')

d) Sticking with people in crisis, ensuring that no long term decisions are made until their situation has stabilised

e) Connecting people with community prevention resources through information and guidance, including social prescribing

f) Population-based budgets will be developed to run in shadow form during 2018

Under the STP we will be working closely with primary care to develop the model for these services at local level.

4.2 **2. Bespoke integrations for complex care for some people with mental health needs, learning disabilities and autism**

4.2.1 Most services should be provided in ordinary community settings, but for some people needing more complex support, specific integrated working with pooled funds may be developed. For example, under the Transforming Care Programme to better support people with learning disability and/or autism and behaviour which challenges.

4.3 **3. Community prevention model**

4.3.1 Our approach to social care will be based on the three conversations in Living Well:

1. Listen hard and connect
2. Work intensively with people in crisis
3. Build a good life

There will be a core offer of information and guidance to help people put in place the elements which help them stay well and independent of formal care: social contacts, welfare advice, equipment or adaptations at home for example. We will make sure family carers are able to access the support to allow them to continue caring as they wish to. Through social prescribing GPs and others will be able to connect their patients to the wider social and practical support which medical services cannot offer.

4.4 **4. One commissioning approach with the NHS**

4.4.1 We will plan health and care services across the Norfolk and Waveney area for consistency and efficiency. The six clinical commissioning groups will be establishing a single joint commissioning committee of which the Council will be a member.

4.4.2 We will plan locally with commissioners where this is the most effective approach, for example working with local community and care services to design local multi-disciplinary team working within the framework agreed across Norfolk and Waveney.

4.3 **5. The infrastructure for integration**

4.3.1 We will put in place the core components to support integrated care:

a) Shared records across health and care: so all professionals know what is going on and people don't need to keep repeating their story
b) IT systems which are connected and remove the need to duplicate
c) Single point of access to services
d) Co-locating staff in premises to aid better joint working
e) Better use of estates
f) Work force capacity building

5 Principles

5.1 Being a good partner with the NHS means we will take into partnership clarity about our principles which sit under the Department's overarching aim:

'To support people to be independent, resilient and well'

a) A strong social care approach with strong leadership of social work
b) A standard level of service across the county with delivery devolved locally
c) Strong links with primary care – we don't want to first meet people in hospital
d) Simple processes, swift solutions
e) Saving money and avoiding demand
f) Fewer organisations for the public to deal with
g) Providing for the local population within a clear local budget
h) Ensuring that social care does not become dominated by a medical model
i) A focus on person-centred care and personalisation, choice and control

6. Financial implications

6.1 Over £56m of the adult social care budget now comes through the Better Care Fund, which has to be agreed jointly with Clinical Commissioning Groups.

7. Issues, risks and innovation

7.1 Risk and opportunities are set out in Appendices 1 and 2.

8. Recommendations

8.1 **Recommendations:**

a) By March 2018 to renew our arrangements for the integrated management of community services with Norfolk Community Health and Care to March 2019

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9. Background papers

9.1 Local Government Association (June 2016) efficiency opportunities through health and social care integration: delivering more sustainable health and care.

National Audit Office (Feb 2017) Health and Social Care Integration
Appendix 3 provides a glossary of NHS organisations

Officer Contact

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

If you have any questions about matters contained in this paper please get in touch with:

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Appendix 1:

Opportunities	Local evidence
Citizens' experience of services can be improved through integrated management	• Recent survey feedback from the integrated teams provides very positive responses reflecting some of the original ambitions to improve communication and co-ordination.
Posts with responsibility across health and care are better able to create coordinated care around the individual	• There is a level of knowledge which means a wider group of NCC staff are able to identify opportunity for improvement and efficiency, some of which has been realised • e.g. co-location, building networks around primary care to better serve local people • e.g. roll out of multi-disciplinary team meetings with all surgeries to focus on those at risk • e.g. aligning NCC and NHS commissioning of local services to common objectives.
Integrated posts are better able to influence the NHS agenda	• We have a cohort of staff who have established their credibility and standing within the system and are around the tables in shaping services. However, they are frequently having to represent both an NHS and NCC perspective which is challenging • e.g. they are key partners in shaping local pathways with primary care
Efficiency can be created	• There has not been evidence of notable efficiency as a consequence of the integrated arrangements, however opportunities to manage demand are key • Enabling structures are being strengthened e.g. access across data systems, ICT support to co-location • Use of estates will offer opportunities for efficiency.
Leadership role for the Council in establishing new models	• Opportunities to influence how the NHS shapes up – increasing social models and prevention

Appendix 2:

Risk	Likelihood	Severity	Mitigation	Outcome
Loss of democratic accountability	Low	High	• Ensure that governance through democratic structures remains clear • Ensure governance of integration includes elected members • Secure in Section 75	Formal democratic processes can be clearly secured in agreed governance. There will be additional complexity and members may need to engage with governance of partner organisations.
Loss of organisational grip Failure to deliver Care Act and/or financial control	Medium	High	• Clarify NCC priorities • Ensure clear accountability structures equivalent to in-house accountability • Establish clear Key Performance Indicators and ensure robust monitoring.	A risk which will need to be closely monitored and robust mitigations put in place.
Loss of resource for adult social care due to competing priorities	Medium	Medium	• Agree priorities and ensure monitoring • Clear agreements about resourcing changes • Secure in S75.	Formal change can be managed, but the softer elements of competing demands is harder to manage.
Loss of efficiencies of a countywide approach by working on a locality basis	Medium	Medium	• Use of options appraisal to give explicit consideration of the trade-off between local and countywide approaches.	This is not peculiar to integration and is a dynamic the Council will need to manage in many domains.
Changing configuration of NHS providers makes partnerships obsolete i.e. partner loses contract	Medium	Medium	• Assess the likelihood of this as part of the consideration of the business case for integration • Secure what happens in this is eventuality in S75 agreement.	This will be a risk and would cause disruption and distraction to staff and services which would be undesirable but could be managed.
Reputational damage from NHS problems	Low	Low	• Keeping alert to upcoming issues • Agreement of press handling between	This can be handled although there will remain a lower level risk.

			partners.	
Dominance of NHS culture and accountabilities	High	Medium	• Senior leadership brings clear visibility of social care/local authority culture and approaches • Challenge at senior level • Organisational development to support culture.	Joint and separate accountability mechanisms can be made clear.

Glossary of health service arrangements:

Clinical Commissioning Groups (CCGs): Responsible for arranging the health services for their area within a given budget.	**West Norfolk CCG** **North Norfolk CCG** **Norwich CCG** **South Norfolk CCG** **Great Yarmouth and Waveney CCG**
Acute hospitals:	**Queen Elizabeth Hospital, Kings Lynn**
	Norfolk and Norwich University Hospital
	James Paget Hospital, Gorleston
Community health care providers:	**Norfolk Community Health and Care**
	East Coast Community Healthcare (community interest company)
	Norfolk and Suffolk Foundation Trust (mental health)
Sustainability and Transformation Programme (STPs): One of 42 STPs across England required to transform health services to achieve financial sustainability and to address variation in quality.	**Norfolk and Waveney STP**
NHS England: Leading the NHS for England, including setting vision, holding commissioners to account and commissioning specialist services.	**NHS England Midlands and Eastern region**