Health, Housing & Adult Social Care Policy & Scrutiny Committee **12 March 2019**

Report of the Assistant Director – Joint Commissioning

Introduction to Health and Social Care Integration

Summary

1. This paper has been written to support an initial discussion on the approaches to health and social care integration, with examples of what we are doing in York to join up care and support for people who need it.

2. The paper also gives an indication of the challenges to integration we currently experience, and areas where we are making stronger progress.

Background

3. Integration is not a goal in its own right, but the means to achieving the goal of better outcomes for people.

> *'People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined-up services help improve the health and care of local populations and may make more efficient use of available resources.'*
>
> [Department for Communities and Local Government and Department of Health (2017) *Integration and Better Care Fund Policy Framework 2017–19.* London: DCLG & DH. P 5]

4. The illustration below, taken from the same document (p 8), has been included in the Better Care Fund Performance and Delivery Group Terms of Reference as a simple reminder of the main purpose of the fund.

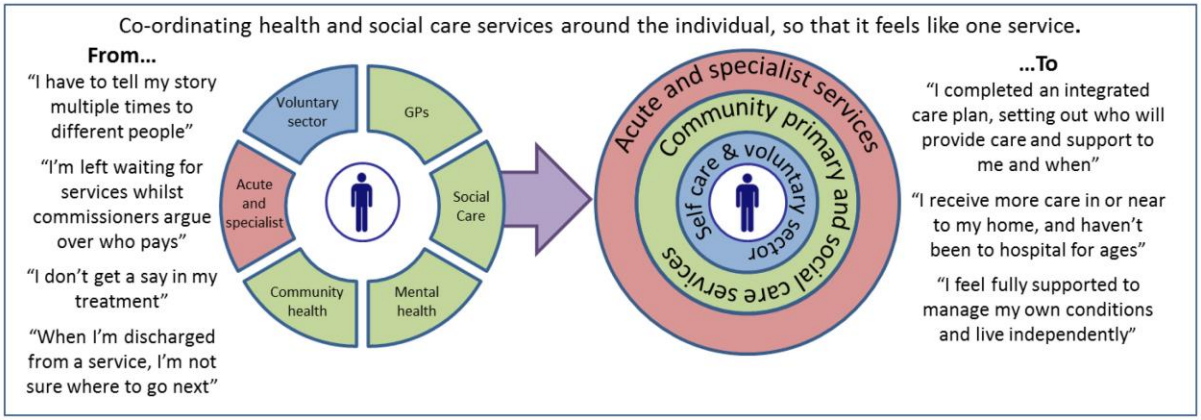


Figure 1: Co-ordinating health and care services around the individual

5. The scrutiny committee received a report in September 2018 about the Care Quality Commission (CQC) Local System Review (LSR) of York which had taken place in 2017, and was then followed by a progress review in November 2018. The CQC methodology was designed to examine how well the various services in an area joined up around an older person needing care and support, to ensure they remained as independent as possible, experiencing a seamless response in times of need.

6. As described succinctly in their 2018 report, 'Beyond Barriers':

   'Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time.'
   [Care Quality Commission, 2018, *Beyond Barriers*, p.4)

Strategic Aspects of Joint Working

7. The paragraphs below offer an overview of the strategic aspects of integration, together with some examples of how it works in York.

   <u>Regulation and Legislation</u>:

8. For health and social care to work in a truly joined up way, organisations (local and national) need to work in partnership from top to bottom. Successive governments have set the policy direction for closer working through Green / White Papers and Acts of Parliament. Notably:

   - The Health Act, 1999, introduced flexibilities to allow the National Health Service (NHS) and local authorities to pool budgets as a means of joint planning and commissioning of services, and

- The Care Act, 2014, which states a council must exercise its functions with a view to ensuring the integration of care and support provision with health provision and health-related provision, and places a general duty of cooperation on local authorities in exercising their functions relating to adults with needs for care and support, and their carers.

- The Care Act, 2014 made Safeguarding Adults Boards a statutory requirement, while The Health and Social Care Act, 2012, placed Health and Wellbeing Boards on a statutory footing.

Vision and Strategy

9. The NHS Long Term Plan 2019 sets out a range of measures to encourage more joined up care. For example, through the evolution of Sustainability and Transformations Partnerships (STP) into new Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP), working across regional, sub-regional and locality footprints, commissioners will make shared decisions with providers on how to use resources, design services and improve population health. As Chapter 7 states:

'. . . the success of our Plan depends mainly on collective endeavour .'
[Department of Health and Social Care (DHSC), 2019, *The NHS Long Term Plan*, p112]

10. Locally, the Joint Health and Wellbeing Strategy 2017-22 sets out our high level, shared vision for people to enjoy the best possible health throughout their lives. It is supported by the continual development of the Joint Strategic Needs Assessment (JSNA), and underpinned by several 'customer group' joint strategies:

- All Age Mental Health Strategy
- All Age Autism Strategy
- All Age Learning Disability Strategy
- Carers' Strategy (current consultation)

Governance and Assurance

'The Acts of Parliament that currently govern the NHS give considerable weight to individual institutions working autonomously . . .'
[DHSC, 2019, *The NHS Long Term Plan*, p112]

11. Individual organisational governance still has primacy over most of the business of health and social care, with partnership decisions ratified through their separate boards where necessary. However, a great deal of work is happening between partners, shaped through multi-agency boards and working groups where members representing their organisation may have delegated responsibility for decision making at the appropriate levels. For example:

    - Through the Complex Discharge Steering Group, partners have agreed the Multi Agency Transfers of Care Protocol, which governs the way frontline services work together to support timely discharge from hospital (and other transfers of care). The protocol has been confirmed through each organisation's arrangements.

    - The Health and Wellbeing Board is supported by a number of 'customer group' partnerships, such as Mental Health Partnership, Learning Disabilities Partnership and Ageing Well Partnership.

    - The Better Care Fund Performance and Delivery Group oversees the Better Care Fund, preparing the plans and evaluating impact, with the CCG and council remaining accountable to government for the formal decisions relating to the use of the fund.

Finance

12. The CCG and council collaborate to align expenditure in certain areas, and to jointly fund services. This is true at a system level, for example through jointly funded posts and schemes, and at an individual level, through joint care packages or placements.

13. The Better Care Fund (BCF) is pooled through a Section 75 Agreement between CCG and council.

14. Government allocations of winter funding come directly to the council or are cascaded through the Health and Care Resilience Board (formerly the A&E Delivery Board). Winter plans are developed jointly to support the

whole system and address pressures. Accountability for the funding remains with either the NHS or the council, depending on the funding route, however it is deployed.

Information Sharing

15. Joining up our information to improve care and support is one of our greatest challenges across the NHS and between partners, both nationally and locally. This is a very wide subject. From the perspective of joined up care, the practical priorities of the NHS Long Term Plan are:

    - Create straightforward digital access to NHS services, and help patients and their carers manage their health.

    - Ensure that clinicians can access and interact with patient records and care plans wherever they are.

    [DHSC, 2019, *The NHS Long Term Plan*, p 92]

16. In 2015, several organisations in the York and North Yorkshire area established an information sharing protocol. Partners include local authorities, NHS trusts, CCG, Housing Associations, Emergency services and other charities and commissioning organisations.

17. It is important to note that the protocol is not an information sharing agreement itself but instead sets standards for partner agencies to follow when sharing information. There are risks involved in sharing too much individual information, on the other hand there are also risks of not sharing, striking the right balance is essential, within the context of the General Data Protection Regulation (GDPR), 2018.

18. In relation to technology strategy, there is a Digital Transformation Board for Humber Coast and Vale (region), and an equivalent board for the Vale of York and Scarborough locality.

Assessing progress towards integration

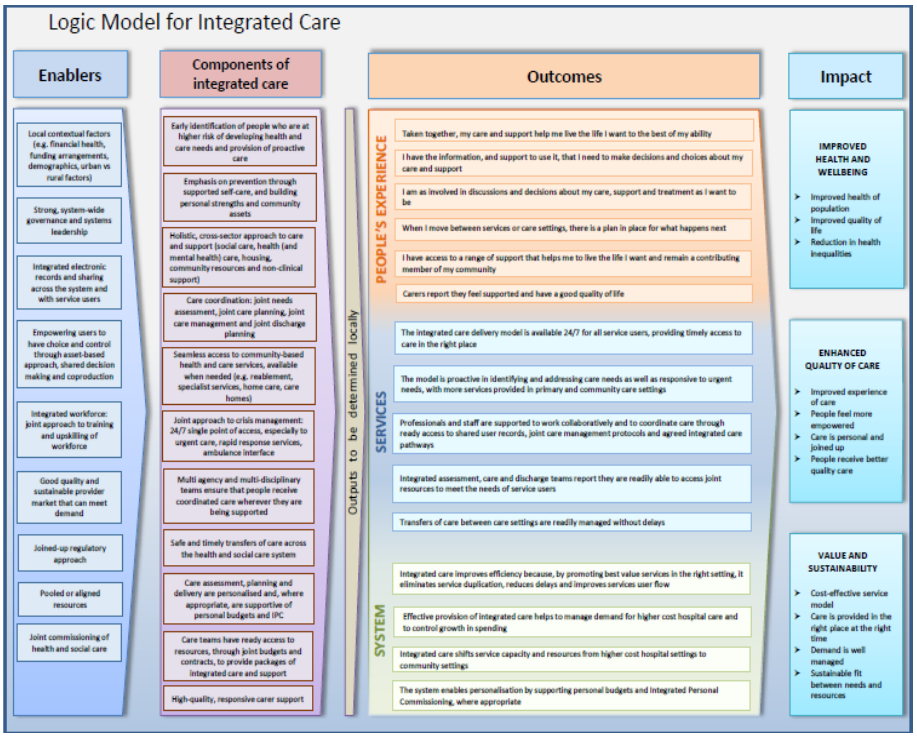
19. The Department of Health and Social Care (DHSC) commissioned the Social Care Institute for Excellence (SCIE) to describe a standard for integration create a way of consistently measuring progress in different areas and care systems. Through their research, SCIE concluded:

‘. . . that an Integration Standard and associated metrics should be driven by people’s experiences and outcomes, and that it should include a focus on leadership and partnership approaches as well as the processes leading to integration of services and care.’

[SCIE: *Developing an integration scorecard: A model for understanding and measuring progress towards health and social care integration*, 2017, *p1*]

20. The SCIE Logic Model creates a means of measuring our progress against consistent standards, or expectations.

21. It is reproduced as an illustration below.



22. In May 2018, at the York BCF partnership event, we started to look at our self assessment against the enablers and components of integrated care in York. Together with the findings of the CQC local system review and progress review, we have a balanced picture of local progress, and of course some of the most significant challenges we share with other areas – for example integrated care records across the NHS and social care.

Analysis – examples of practical progress in York

23. The Better Care Fund Policy Framework refers to the Nuffield Trust's view that there "is no one model of integrated care that is suited to all contexts, settings and circumstances". Each area is required to develop its preferred local approach.

Enablers (SCIE Logic Model)

Strong, system-wide governance and systems leadership

24. In York, the Better Care Fund Performance and Delivery Group has led this 'visioning' process by holding co-production workshops with the partners and service providers funded through BCF. Our approach to integration in York focuses on leadership, collaboration, innovation and prevention, rather than structural, organisational change.

25. By modelling collaboration, the co-production events to inform the use of BCF allocation have also been very effective in bringing together services and organisations to learn from each other, make new connections, and find more efficient ways of working.

26. Integrated electronic records and sharing across the system and with service users

27. Following the recommendations of the CQC review, we have been working on a plan to improve information sharing systems for the One Team. There are multiple care record systems in use across the NHS, council and independent providers. Team members from each service currently rely on face to face discussion at multi-disciplinary team meetings to plan a patient's discharge. In future we hope to automate this so that relevant information from care records can be accessed whenever they are needed to manage the care pathway.
This is a very significant challenge, including the cost implications of modernisation.

28. Members will recall the paper presented to this committee in December relating to York's Evolving Asset Based Approach. It included the successful case studies, and was also presented to the Health and Wellbeing Board as part of a BCF update. The HWBB has adopted the co-production principles as our fundamental way of working.

Integrated workforce; joint approach to training and upskilling of workforce

29. Recent local examples of include the joint training on the revised Continuing Healthcare (CHC) Framework for staff involved in CHC assessment processes and the hospital discharge pathway. This was carried out to ensure a consistent approach to managing, among other things, Discharge to Assess.

Components of Integrated Care (SCIE Logic Model)

Early identification of people who are at higher risk of developing health and care needs and provision of proactive care

30. Primary Care Home is working with the CCG and York Teaching Hospital NHS Foundation Trust (YTHFT) to deliver a 'Frailty' project which will help more people to be supported home from hospital in stead of being admitted after a crisis, to adopt a standardised geriatric assessment, and through a pilot with the consultant geriatrician, provide face-to-face assessment of patients who are unable to access outpatient services at the Trust, and to provide advice and support to GPs managing patients with complex and multiple healthcare and social needs. This is work in progress.

Emphasis on prevention through supported self-care, and building personal strengths and community assets

31. Members will recall the paper presented to this committee in December relating to York's Evolving Asset Based Approach. This is an area of real strength for York, and continues to achieve success with individuals and communities, as well as attracting external recognition through awards and funding.

Care coordination; joint needs assessment, joint care planning, joint care management and joint discharge planning

32. A good local example of this component is the establishment of the Integrated Discharge Hub and the One Team. During their 2018 progress review, CQC found good progress had been made on this aspect of service delivery:

'The One Team, which brought together health intermediate care (community response team and primary care short term care service)

with local authority reablement services and voluntary sector wellbeing support, had developed its approach to integrated care and reablement. The team had developed universal documentation and a single point of referral which meant that people did not have to wait to be seen by as many professionals and reduced duplication in assessments.'

[CQC, Local System Review Progress Report – York, 2019, p18]

Seamless access to community-based health and care services, available when needed (eg. Reablement, specialist services, home care, care homes)

33. This area remains a significant challenge in York due to the availability of services when needed. Market capacity issues and the pressure on recruitment to health and social care in York's high employment environment, is an area for further focus. A multi-agency Reablement and Intermediate Care Steering Group oversees this work, and is exploring how a joint commissioning approach with providers can deliver a sustainable model for the city.

Safe and timely transfers of care across the health and social care system

34. Delayed transfers of care remain a significant challenge in our system, with performance against the national target (3.5% occupied bed days delayed) showing fluctuation during the winter. As indicated earlier in the report, the response to this challenge is co-ordinated through multi-agency partnership groups, working to integrated service models, and implementing the High Impact Changes Model, as required by government.

35. Members should note that revised national guidance for the counting and coding of delayed transfers was introduced in October 2018, and is now being implemented. This may result in an increase in the number of reported delays for York and changes in the attribution of the causes of delays. The purpose of the revised guidance was intended to clarify any areas of ambiguity in the previous guidance, and to improve areas' understanding of the reasons for delay.

36. During the winter 2018-2019 partners have implemented a model of joint working known as MADE (multi-agency discharge events), which bring together all relevant professional disciplines to tackle the specific causes of a patient's delay in hospital. Below are two examples summarising how this has worked in individual cases.

Patient A

- *Patient A details brought to the MADE meeting – complex mental health issues impacting on discharge planning for the patient from the Acute hospital. Patient A has a long history of re-attendance and admission from the community often needing some short term medical treatment. When discharge planning is discussed the patient refuses to leave the hospital and becomes a challenge for the ward teams. As a result of the MADE this patient was identified as a long term mental health patient with specific mental health support already in place in the community, no previous connections had been made between acute and community teams. A professionals meeting was set up and care plan created for Patient A which outlined a clear discharge process to follow should patient A be readmitted. This has since been tested following re-admission and been successful in ensuring the patient is discharged in a timely manner and with the support needed for both the patient and ward teams.*

Patient B

- *Week 1 MADE:- Patient Mr B was brought for discussion at the MADE (Multi-agency Discharge Event) currently an inpatient at one of our community hospitals due for discharge as no longer a need for a rehabilitation bed. Social Worker has allocated 2 care homes to come and assess Mr B. Both homes declined to take him due to his continence needs and behavioural needs. Discussion with Social Care Teams to share the reasons for the homes declining the patient as this information was not available. Agreement to look for alternative accommodation or home with CRT support if possible – for more in-depth assessment.*
- *Week 2 MADE:- Going home is not an option for Mr B as his needs both at night time and behavioural are too great for the services available. Discussion within the meeting of alternative options lead by representatives from CYC, TEWV and the acute trust. Agreement to arrange a separate professionals meeting which would include medical, nursing and therapy input within the following 5 days to find a solution.*
- *Week 3 MADE:- Professionals meeting has taken place, continence issues / behavioural issues now better understood and supported. Two homes within the York area asked to re-assess alongside the Social Worker, Ward Occupational Therapist and Sister. Two additional specialist homes from outside the area requested to assess the patient as an option should he be rejected again from the local homes.*
- *Week 4 MADE:- Patient accepted by a nursing home outside of York area and discharge planning completed, patient discharged.*

The key learning is that, had we not had the opportunity of the weekly MADE meeting, these patients would not have been escalated via an agreed process and with no clear discharge planning would have been in the community/acute hospital for a considerably longer period of time. The benefit of having professionals from all areas, social care, nursing, therapies, medicine and mental health enabled a clear plan of action to be made ensuring the patient was discharged from hospital to the right accommodation and with the right support for their long term future. The importance of having senior decision makers allows for innovative solutions to specific problems.

Options

37. This paper does not attempt to report on each aspect of the SCIE Logic Model, as it is intended as an aid to understanding challenges and opportunities. Members may wish to identify specific areas for future reports, due to the breadth of the topic of integration.

Council Plan

38. *N/A*

Implications

39. *N/A*

- **Financial** – *None*
- **Human Resources (HR)** - *None*
- **Equalities -** None
- **Lega*l* -** *None*
- **Crime and Disorder -** *None*
- **Information Technology (IT) -** None
- **Property -** None

Risk Management

40. *n/a*

Recommendations

41. This report is for information.

Members are asked to consider whether a further report should be developed for a future work programme, and to consider which aspect of integration would benefit from further scrutiny.

Reason: (1) To Update Members on the complex area of integration, with ongoing developments between partner organisations, in the context of government policy, such as the NHS Long Term Plan.

(2) To comply with scrutiny procedures

Contact Details

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✓	**Date** *04/03/2019*

Wards Affected: *List wards or tick box to indicate all* **All** ✓

For further information please contact the author of the report

Background Papers:

All relevant background papers must be listed here*.*
BCF National Policy Framework and Planning Guidance 2017-2019
CQC Local System Review of York
CQC Local System Review Progress Report – York
NHS Long Term Plan
SCIE – Developing an Integration Scorecard

Abbreviations

BCF - Better Care Fund
CHC - Continuing Healthcare
CRT – Community Response Team

CQC - Care Quality Commission
CYC – City of York Council
DCLG - Department for Communities and Local Government
DH - Department of Health
DHSC - Department of Health and Social Care
GDPR - General Data Protection Regulation
HWBB – Health and Wellbeing Board
ICP - Integrated Care Partnership
ICS - Integrated Care System
JSNA - Joint Strategic Needs Assessment
LSR - Local System Review
MADE - Multi-Agency Discharge Events
NHS - National Health Service
SCIE - Social Care Institute for Excellence
STP - Sustainability and Transformations Partnerships
TEWV – Tees , Esk and Wear Valleys NHS Mental Health Foundation Trust
YTHFT - York Teaching Hospital NHS Foundation Trust