Better Care Fund – Integration Executive
Integration Resources – February 2020

A. Social Care Institute for Excellence Bulletin -

This document sets out Warwickshire County Council's (WCC) commitment and strategic approach to working with our partners to deliver an integrated health and social care system. We already have a solid foundation of integrated working arrangements that we are seeking to further build upon and strengthen for the benefit of Warwickshire people

The document 'Warwickshire County Council's Approach to Progressing the Integration of Health and Care' was endorsed at Cabinet – Monday, 16 December 2019 and can be viewed at:

https://democracy.warwickshire.gov.uk/ieListDocuments.aspx?CId=146&MId=178

B. Older People's Health and Social Care: Research findings informing practice and policy.

The 12th Annual Joint Conference (CPD certified) from Age UK London and the Health & Social Care Workforce Research Unit (HSCWRU) & Making Research Count at King's College London will take place on the 10 March.

For more details please see: https://www.eventbrite.co.uk/e/older-peoples-health-social-care-research-findings-informing-practice-policy-tickets-79159198293?aff=ebdssbdestsearch.

C. Social care services: funding cuts are biting hard

This article produced by the King's Fund explores the gap between the number of people requesting social care support from councils and those receiving it.

https://www.kingsfund.org.uk/blog/2020/01/social-care-funding-cuts-are-biting-hard?utm_source=linkedin&utm_medium=social&utm_term=thekingsfund

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D. How will we know if Integrated Care Systems reduce demand for urgent care?

This publication by The Strategy Unit explores the possible implications of a blended payment system between commissioners and providers.

https://www.strategyunitwm.nhs.uk/publications/how-will-we-know-if-integrated-care-systems-reduce-demand-urgent-care

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E. Building on the Success of the Better Care Fund: Integrating Health and Social Care - National Conference

The Better Care Fund programme will be running two national conferences in March one in Manchester and one in London. Register now and join colleagues from across the country to celebrate the achievements of the Better Care Fund and find out more about the future policy direction of health and social care integration.

At this conference, you will hear from leaders in integrated care and alignment with wider integration initiatives. You will have the chance to hear about success in how initiatives through the Better Care Fund have been supporting people to live as healthily and independently as possible at home. Also, we will explore how local areas have worked on integrating health, housing and social care, and what role primary care transformation and prevention plays in the integration landscape.

This event is open to all and is intended for colleagues from the voluntary and statutory health, housing and social care sectors interested in collaboration and partnership.

To book your place, click the date you would like to attend below:

- Monday 20 March 2020 – Manchester

  https://lgaevents.local.gov.uk/lga/frontend/reg/thome.csp?pageID=292390&eventID=857

- Monday 30 March 2020 – London

  https://lgaevents.local.gov.uk/lga/frontend/reg/thome.csp?pageID=292734&eventID=858

F. Digital Toolkit

Material produced for the launch of the 1001 Critical Days have been circulated to partners. A copy of the leaflet has been included at the bottom of this document.

G. Social Care Institute for Excellence

This edition of SCIELine covers a new call for practice on young carers' breaks and gives updated guidance on integration, dementia and much more.

https://mailing.scie.org.uk/4O5-6OXQ2-D3R4OATY6F/cr.aspx

H. Annual information on the health and care of people with learning disabilities is published

Health and Care of People with Learning Disabilities, 2018-191 summarises data relating to 54% of patients in England2 on key health issues for people recorded by their GP as having a learning disability. It also includes comparative data about patients recorded by their GP as not having a learning disability, to show differences in health and care between the two groups.

For the first time, this publication contains a standardised mortality ratio, comparing mortality for those with a learning disability against those without.

Statistics about the prevalence of various health conditions, such as epilepsy and heart disease, are also included.

Trend data is available for 2018-19 and the preceding four years, broken down to Clinical Commissioning Group level.

Read more at: https://digital.nhs.uk/news-and-events/latest-news/annual-information-on-the-health-and-care-of-people-with-learning-disabilities-is-published

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I. Roundtable: Making NHS-Council Collaboration Work – Discussion Summary

The NHS and local authorities frequently work together to improve the lives of the people in their area – but successful initiatives are often limited in scope and do not get scaled up to cover a wider population. However, there now seems to be momentum towards spreading such schemes – partly driven by the wider view of sustainability and transformation partnerships which bring together health and local government bodies in an attempt to provide more integrated care.

An LGC/Health Service Journal roundtable, sponsored by Operose Health, brought together people from the NHS and local government to look at what makes such initiatives successful and how they can be expanded.

In some cases, these initiatives would be badged as “integration” but they do not necessarily have to involve shared budgets or staff – some are just organisations contributing what they can to improve life for local people. Understanding what factors make existing schemes successful is important if they are to be replicated and spread.

Richard Mitchell, chief executive of Sherwood Forest Hospitals Foundation Trust, talked of “a coalition of the willing” and the importance of behaviour change both in organisations and across systems. Techniques using nudge theories were useful in reminding people about what they were trying to do, and symbolic steps – such as a shared lanyard between NHS and local government – could help. But there were times when organisations just had to do the right thing even when there was little evidence to support long-term savings, he said – working with deprived children may not impact on A&E admissions but still should be done.

In Tower Hamlets, the rapidly growing population had meant opportunities for the council and NHS. Council chief executive Will Tuckley said £10m had been invested in primary care facilities through infrastructure levies over the past few years. Social prescribing and community development work had spread across the borough. We are [now] much more data rich. The data may lead you to a different solution this is readily available at a local level

But within this positive picture, relationships and continuity of personnel had been important – for example, Alwen Williams, who now runs Barts Health Trust, had worked in the area for many years, Mr Tuckley said.

In other parts of the capital, relationships between local government and the NHS have sometimes been affected by contentious plans to reconfigure or close local services. But despite councillors’ scepticism about some of the proposed changes, Ealing LBC chief executive Paul Najsarek said his council had continued to work on a portfolio of projects around population health with NHS organisations and had made “fantastic progress” in a couple of areas such as hospital discharge and encouraging healthier lifestyles in Southall. Projects such as this, however, needed to engage both organisations and the community.

“We try to just stay grounded in our place,” he said. “A&E changes, however we view them, were always many years ahead.” Focusing on the needs in the local community helped move beyond some of these differences, he added.

Building up relationships and trust does take time – and what Helen Buckingham, director of strategy and operations at the Nuffield Trust, described as a “certain amount of humility” that no one had all the answers. She said working in Hertfordshire she had seen people “who would put time into building and managing relationships at a local level”. Their ambitions to get mental health and learning disability services right for the population had also coincided with the national direction of travel which had helped. However, systems which put the person at the centre and were almost agnostic about who provided care were crucial.

In North East Lincolnshire the present working arrangements between health and local government have evolved over 12 years. “That is starting to pay off but it takes a long time,” said Rob Walsh, who is chief executive of both the local authority and the clinical commissioning group. Continuity had helped – some councillors and GPs had been around for 15 years – but he cautioned that closer working has risks which included a “single point of failure”.

Practical difficulties in working together go as deep as not sharing the same language – not only the NHS and local authorities using words differently but sometimes two parts of the NHS understanding them differently, pointed out Samantha Jones, chief executive of Operose Health, who is also the independent chair for Oldham Partnership Board.

There was a continual need to check everyone has the same understanding. However, the board had a deep commitment to doing what was best for the people of Oldham. “The focus is on the people, the citizen, and using data to make the changes that need to be made,” she said. Data was what drove change – she gave the example of one system in the NHS which had 38 different integrated discharge teams who were not speaking to each other.

But data needed to be shared so everyone was working with the same information. She talked about information on particular patients who might be using NHS services extensively but would also be in contact with local authorities: a shared list of them was important in discussing the best way to help people get the care that they need.

Data gave new opportunities, said Mr Mitchell. This could include identifying the 50 families that were the heaviest users of all public services and seeing a common thread. This could enable people to get together and discuss what could be done to change these families’ lives which would eventually reduce their use of services.

“One of the things which has changed is that we are much more data rich,” said ¬Trevor Holden, managing director of Broadland DC and South Norfolk Council. “The data may lead you to a different solution that is readily available at a local level.”

But most progress seems to be being made at ‘place’ level rather than across larger footprints such as STPs or ICSs. Chris Hopson, chief executive of NHS Providers, said there could be a frustration on the local government side when STPs seemed to only discuss NHS business: councils needed to feel there was a point to turning up. He cited Frimley as a smaller STP/ICS that had made progress.

But he said work needed to happen at multiple levels within the system and there was fantastic work happening at all levels. “The problem is the NHS is trying to put everything through the STP/ICS level and is sucking up a lot of things that don’t need to be there … that’s what turns STPs and ICSs into really dull places for the local authorities.”

Other panellists felt that without a central push the NHS would not have taken up integration in the same way. Many felt there should be a focus on subsidiarity with work done at the lowest appropriate level. Ms Jones said: “I don’t think it matters what scale we do it at as long as we get the most benefit for the individuals we serve.”

Not every function of local authorities or the NHS will involve partnership working, some will be best done by the organisations alone – the important thing was to focus on the overlap where working together could make a difference, Mr Tuckley said.

Funding is obviously an issue for many initiatives. Mr Najsarek pointed out that many of the priorities identified in the NHS’s Long Term Plan came with a pot of money attached.

The NHS has also had its budget protected – even if it has had to cope with increased demand – while councils have seen severe cuts. Even so some have managed to work constructively together. Ms Jones said in Oldham, where the local authority chief

executive was also the accountable officer for health, the approach had been “this is the budget for Oldham – how can we make use of it?”

A generational change in NHS chief executives may make partnership working come more naturally. Mr Hopson pointed out this new generation saw their role as being much broader – less about their own organisation and more about the systems they worked within – and this was supported by the thrust of the Long Term Plan. But Mr Mitchell said it was important to have stability in your own organisation to allow you to do this.

Ms Buckingham said she saw more and more chief executives like Mr Mitchell who talked meaningfully about what it meant to work in a place. “It gives me some hope that there may be some momentum even if the centre said let’s back off now.”

In Norfolk, different agencies are working together in ‘health hubs’ to offer help to people regardless of whether they have initially contacted the NHS, the police or the council. This has led to a different approach to ‘solving’ their problems and a recognition that often these go beyond the reason for the initial contact. Mr Holden said the aim was “to get upstream of problems before they get acute”.

He cited people who rang up to say they could not pay their council tax. “It used to be that we just made sure they could pay their council tax,” he said. “Someone from the health hubs goes to talk to them about what lies behind their inability to pay. Nine times out of 10 they are living chaotic lives.”

They could then work with people in trouble to find sources of help in the community to address these root causes. Community connectors – working from GP surgeries – could put them in touch with groups and activities which could combat loneliness or isolation, as well as address more practical problems.

The partners in the scheme are now looking at whether this approach could be extended outside normal working hours and at other areas where early intervention could help, such as placing people in police control rooms to help with the one in four calls involving people with mental health problems.

In North East Lincolnshire, joint working has been made real through shared leadership with the two bodies Mr Walsh heads being coterminous. The area had been a care trust since 2007 and had seen responsibility for social care delegated to the NHS by the local authority and health visitors and school nurses working for the council. Two years ago he was appointed to the joint role and the two organisations started to work even closer, recognising the council’s role in many of the wider determinants of health.

Now a single committee has four CCG members and four council cabinet members to make joint decisions about areas such as children’s services and adult social care. The aim is that pooling cash enables it to be spent to greater effect with a single approach to commissioning. The aim is for “right place, right people, right role,” Mr Walsh said. There had been some real progress such as single points of access but also some bumps along the way and much of it was still work in progress. “The past two years have been about getting to understand each other,” he said.

But there was a shared purpose between councillors and clinical leaders about achieving what was best for their areas, he said.

Knife crime uses up NHS resources in caring for those who are injured. Reducing it has been identified as a public health issue – so how can the different sectors work together?

The answer is really around all partners contributing what they can. In Tower Hamlets, many knife crime victims are treated at Barts Health Trust under an internationally renowned team.

But saving these lives does not solve the problem. “The answer is not more heroic surgeons, it’s reinvestment in youth services,” suggested HSJ editor and roundtable chair Alastair McLellan.

Prevention requires a whole raft of interventions – some of which are happening in the area with Barts staff going out into the community both in Tower Hamlets and more widely, talking to people about role models and explaining what happens in the operating theatre. The council also funds some of the team from a voluntary organisation which works with victims of knife crimes in hospital and once they are released. The aim is to stop them facing reprisals and ending up in hospital again.

Apart from staff time, the NHS had not had to put anything in, said Mr Tuckley. “People can contribute to partnership in other ways. The police will never be able to pay for anything, but they can contribute people,” he said. “It is the art of the possible. I would much rather have a hospital that recognises the issue and worked with us on it than just gave us a cheque.”

On the panel

Helen Buckingham, director of strategy and operations, Nuffield Trust

Trevor Holden, managing director, Broadland DC and South Norfolk Council

Chris Hopson, chief executive, NHS Providers

Samantha Jones, chief executive, Operose Health

Alastair McLellan, editor, Health Service Journal (chair)

Richard Mitchell, chief executive, Sherwood Forest Hospitals Foundation Trust

Paul Najsarek, chief executive, Ealing LBC; community wellbeing spokesperson, Solace

Will Tuckley, chief executive, Tower Hamlets LBC

Rob Walsh, chief executive, North East Lincolnshire Council and CCG