Healthier Communities Select Committee		
Title	Health and adult social care integration – second evidence session	
Contributor	Scrutiny Manager	Item 3
Class	Part 1 (open)	18 October 2016

1. Overview

As part of the second evidence session of the in-depth review of health and adult social care integration, the Committee will be hearing from four witnesses:

- Fiona Russell, Senior Adviser, Local Government Association, Care and Health Improvement Programme
- Clive Grimshaw, Strategic Lead for Health & Adult Social Care, London Councils
- Susan Underhill, Deputy CEO, Age UK Lewisham and Southwark (lead provider of Community Connections in Lewisham)
- James Archer, Public World (will be giving an introduction to the Buurtzorg model)

The Committee has also received written evidence (included in this report) from the following organisations:

- Lewisham Local Medical Committee
- Carers Lewisham

These relevant reports are also included as appendices for further reading:

- Parliamentary Office of Science and Technology, *Integrating health and social care*, August 2016
- Kings Fund, *Social care for older people: Home truths*, September 2016

2. Written evidence

2.1 Lewisham Local Medical Committee

Lewisham LMC is grateful to you for your request for an LMC view on the integrated paper. The LMC is sorry for the delay in responding and thanks you for your patience.

In principle, the LMC supports the vision of integrated care across health and social care to provide a more seamless approach to improving lives. The LMC can see that through this, with appropriate resourcing and planning, health outcomes could be improved and unplanned care attendances could be reduced.

The key is in the planning and ensuring a sustainable process and the LMC wishes to highlight some key areas relevant to the primary care role.

1. Development and integration into practices of the neighbourhood care networks and timetabled meetings between the teams - NCNs and GPs

This could be real or virtual using the I Boards. The keys for success here are that the right people are at the table (enablers) and there is protected time for GPs to attend. The process will not work if the meetings are slipped between clinics - the practices will need to be released from patient care services with practice cover provided to ensure continuity of care for the patients

2. Clear simple pathways for communication between partners within the team

One suggestion is that for an integrated form for services users such as Occupational therapy, physio, social care , children's services, third sector etc. to be developed. These would need to simple and easy to complete similar to the integrated referral form used for diabetes. If 3 different forms are required for one patient to meet their needs then it won't happen. Also when patients are referred directly this should be a simple one step process.

Currently if GPs refer to occupational health we often receive a request for more information about the patient such as ability to self care etc - this non clinical information could be captured in the form or reviewed by the receiving service.

A similar process happens with child social care - so a phone call to duty then requires Child Assessment Form (CAF) and this can often be followed by further requests using section 17 enquiries - often the same information is sent 3 times - whilst it is essential that the right information is shared duplication and more of reports is a disabler and could discourage referrals

The LMC appreciates that this works both ways so in essence a more streamlined and efficient method of sharing information would benefit all.

3 Working with our partners

Primary care is an essential spoke in the integration wheel but we face unprecedented demand and limited resources and staffing - as does the Local Authority

So that we can better work together and develop better understandings the LMC would suggest that those leaders charged with developing the integration share work experiences - maybe a ‘walk in my shoes’ scheme between social care and health care.

If we better understand the limitations and barriers of those involved we can better overcome them

4 For integration to be a success there needs to be closer working between the acute services and primary care

This will involve the acute providers seeing primary care as an equal partner where appropriate work is shared and there are clear expectations of each providers rules and responsibilities. If primary care is overwhelmed with inappropriate work demand it will not be able to deliver on the work required for integration. Again once we better understand how each provider works, what they can do and what they can't then outcomes will be improved.

Essentially all providers need to understand the role they have in wrapping care around the patient and take equal responsibility for delivering their part in the care package

5 Sustainability and Transformation Plan (STP)

The LMC noted that STP plans were referenced in relation to integration. However this was presented as a resourced and well-funded programme that might help develop integration. The LMC is not sure that this truly reflects the STP - which in essence is about developing a sustainable health care model through efficiency savings. As indicated there is little new money available and integration is more about reallocating budgets. There does need that be a clear risk assessment about the impact of this 'movement' of resources and the potential impact on currently resources services. In other words where is the money coming from and what is left behind

Finally but probably most importantly if we are to truly integrate and make a success of it there needs to be clear public engagement and ownership. Changes in design need to be patient focused and ensure we are truly meeting our populations needs and thus not exposing patients to risk. The plans need to ensure that it tackles and tries to reduce health inequalities.

The LMC hopes you find the above comments helpful.

2.2 <u>Carers Lewisham</u>

Initial thoughts on integration of health & social care

It is obviously difficult to offer any meaningful comment or critique without seeing concrete proposals so the following represents our initial thoughts based upon discussion we had at board level.

From a practical, carer-perspective:

1. Carers would broadly welcome the integration of health and social care if it resulted in a simplified, streamlined service for them. It would be counterproductive however - for their ability to remain an unpaid carer - if this integration led to the services, which they need to support the medical needs of the cared for person to, becoming subject to means-testing.

2. One key change that would benefit carers would be that they would not have to repeat their story and situation at each consultation and that their situation would be considered as a whole and not in part. For example the situation of the family is not always considered when multiple appointments are made for the cared for person

which can be disruptive and stressful for the carer. It puts pressure on both their time and resources and perhaps could be streamlined in some cases.

3. But this would require an integrated approach to their personal details and their input in the data that is collected and shared, not only between agencies but between the medical professionals and the carer, not just the cared for person. This has a practical implication for an agency such as Carers Lewisham, which uses a distinct CRM database and does not have access to Connect Care or other statutory databases. Any integration would therefore need to allow for the costs of integrating ICT systems, processes and databases particularly amongst voluntary sector partners.

4. There would need to be considerable investment in time and training for staff to consider the whole situation when deciding on interventions (eg, hospital admission or discharge) including the identification of the carer and, once identified, consultation with the carer. A lead organisation responsible for identifying the carer in each situation, particularly young carers, and for sharing that information with all the agencies involved will therefore need to be identified. This is especially important when carrying out risk assessments. Carers need to be at the heart of the solution not an after-thought.

5. Within that consultation and involvement there would need to be an agreed weight given to the input that the carer gives. For example if a risk assessment is taking place around a hospital discharge and the carer says they cannot cope with the person being discharged immediately then there needs to be weight given to that statement, whilst recognising it may also be a nuanced response. The carer might mean “I cannot cope at the moment because I am feeling unwell, but I will be OK in a week or two”. Or it might be their way of saying “I don’t feel I can cope given their level of disability following their hospital admission, but I am not sure / or don’t want them to feel rejected by me”. We would suggest that carers’ needs should be assessed at this point as a matter of course.

6. There would need to be an integration of complaints processes so that the carer, or cared for person, could make one complaint which although it may involve a number of providers would result in one investigation within a set timescale and with a single set of possible outcomes.

7. If integration is going to lead to an increased role and/or reliance upon carers, there must be an increase in funding and opportunities for both general and emergency respite. It is a fundamental fact that carers need respite if their own health and wellbeing is not to suffer. To fail to realise and acknowledge this, is simply storing up problems for the future.

From a professional-perspective:

1. We agree with the premise that greater co-ordination of health and social care would be a good thing. Health outcomes are at least as dependent on LA work as on the NHS. So, aligning objectives and reducing duplication must be good.

2. However we note that all the mechanisms and policy encouragement to integrate was provided in the Government paper, ‘Partnership in Action: new opportunities for

joint working between health and social services; a Department of Health discussion document,’ in 1998. This provided for lead commissioning; better coordinated provision of services; pooled budgets; integrated teams; transfer of funds between sectors; joint finance of services; joint education, training and development; and the development of shared information systems. In other words we have been here before, especially, but not solely, with mental health services. There is therefore perhaps a danger of policy fatigue amongst practitioners and professionals coupled with the danger of policy confusion amongst client groups and the public in general. Indeed, for many of our clients, these policy initiatives do simply conjure up fear and confusion.

3. One of the difficulties with the Scrutiny paper, which admittedly is proposing a review, is that none of the strategies discussed is given any relative weight, so it is unclear what direction the Council is proposing to go in. Terms such as collaboration lack any clear definition and have been used synonymously with concepts such as co-operation, co-ordination, participation and integration.

4. A further difficulty is that integration is not defined. Does this mean: Working more closely? Sharing teams? Different teams working in the same place? Sharing budgets? Merging budgets and commissioning? We note that there is already close working in Lewisham with the Better Care Fund enabling Joint Commissioning by the LBL and CCG. Relationships are - to the outsider - generally good and productive.

5. There is a natural worry that, because these changes are happening under "austerity", quality standards may slip and not be mandated. Furthermore, local authority budgetary pressures may very well make integrated health services more liable to cuts. As we are seeing now, local authorities are so cash-strapped that they are cutting services, including those that used to be in the NHS, such as health visitors and school nurses.

6. We worry that this new push for integration is driven not by client needs but by the Treasury where the focus is on reducing NHS spend and efficiency savings. In SE London, for instance, the STP has to bridge a £1.015bn gap in NHS funding over 5 years to 2020/21. And a £242m gap in social care funding to 2020. Whither the client here?

7. If services are moved into local authorities will this open them up to back-door privatisation through tendering, etc? The service redesigns will be procured by the rules for tendering which remain in place. Indeed, there appears to be a new putsch to privatisation: “NHS Improvement is to explore new partnerships between the health service and the private sector, including the potential for further outsourcing of clinical services and the use of “independent sector management models”.” http://www.hsj.co.uk/topics/service-design/nhs-improvement-to-explore-new-private-sector-partnerships/7009575.article

8. It is not clear if it is intended to have virtual joint teams with common IT systems but separate locations; to co-locate staff but leave them within their own employing organisations, or to have them employed within one integrated Health and Social

Care organisation? Within any joint system it is crucial that the social care element is not lost as has happened to some LA mental health teams which have been located within health systems and lost their social care focus, or lacked support from their social care line managers, or even in some many cases been managed by health staff with little reference to local authority staffing systems. In systems where teams have been integrated, but not been placed under a common employer, all sorts of difficulties have arisen over performance and disciplinary issues where those involved are from different organisations. Similarly the professional needs of staff have sometimes been neglected by managers and training departments unfamiliar with the requirements of other professions. In systems where staff are co-located and integrated, but remained employed by different organisations, it is crucial that staff have effective support from their employing organisation. The overarching legal contracts that have been set up in such situations have always been open to question, which would not occur if all staff were employed within one organisation. Such a situation which pertains in Ireland, would mean that staff within social care who invariably are present in smaller numbers, need an effective voice within a health organisation to represent their professional needs and requirements.

9. The integrated care pioneers mentioned in the document clearly consist of co-located staff, who are only integrated in the sense of their function. It is unclear if they have integrated management or whether the social care staff have their own managers, and vice versa.

10. We would like to make clear at this point that we have significantly reorganised our services along a neighbourhood delivery model to facilitate co-location and integration and wish to discuss this further at a practical level with the Council/CCG

11. We think the concerns about the medicalisation of social care are very real, and it would be essential to have social care representation throughout the management structure of any integrated service, whatever form that service took.

Generally, Carers Lewisham would like to reiterate that we very much want to work in partnership with the Council and CCG to ensure the best possible outcome for our client group and are broadly in favour of integration (but the devil, as always, is in the detail). We are therefore more than happy to participate further and to appear before the committee itself if that would help.

3. Recommendations

The Committee is asked to note this information.

If you have any questions, please contact John Bardens (Scrutiny Manager) on 02083149976.