Agenda Item No: 7

Realising the potential of the Integration of Health and Social Care

To:	Adults and Health Committee
Meeting Date:	24 June 2021
From:	Director of Adult Social Care Deputy Director of Public Health
Electoral division(s):	All
Key decision:	No
Outcome:	Opportunities for further integration of service delivery to provide our residents with more joined up services local to where they live. Increased opportunities for prevention and early intervention and a more seamless approach to meeting the needs of people supported by health and social care.
Recommendation:	It is recommended that the Adults and Health Committee; a) note and support the further integration of services b) note the national and local context and the opportunities presented by the establishment of an Integrated Care System (ICS) c) support the proposed focus on developing a neighbourhood-based approach and to explore the opportunities in more detail going forward as a Committee and with ICS partners

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1. Background

1.1 The purpose of this paper is to provide an overview of opportunities to further integrate service delivery to provide more joined up services to residents close to where they live. To consider how the development of an Integrated Care System will support these opportunities and drive our desire to focus on prevention and early intervention.

2. The national and local policy context

2.1 National Policy - The Integrated Care System (ICS)

2.1.1 The reforms set out in the White Paper 'Integration and Innovation' published in February 2021 and the creation of an Integrated Care System, offer an opportunity to transform health and social care at local and national level. In addition to significant changes to the way the NHS is organised, it signals support for integrated approaches through the creation of a system in which the County Council is a key partner. This includes a duty of cooperation, a move away from the internal market in the NHS and an expectation that the NHS will support social and economic development.

2.1.2 Central to the policy ambition is to achieve the triple aim to:

- Achieve equitable health and wellbeing improvements for the population
- Deliver better quality outcomes from integrated health and social care services
- Demonstrate resource management that is sustainable.
- Create more seamless coordinated services from a service user perspective
- Increase transparency and accountability

2.1.3 This provides an opportunity for increased transparency and local accountability about the way in which health and social care is funded and delivered locally. The development of Integrated Care Systems and Partnerships is being driven nationally and all health and care systems are working on this agenda but are at different stages of development. The ICS provides an opportunity to ensure that the local populations can engage at neighbourhood and small area levels while at the same time look for system reforms that can work at the following levels:

- Neighbourhood (Primary Care Network – GP's)
- Place (North and South Alliance – representing footprint of our two main hospital trusts (North West Anglia Foundation Trust and Cambridgeshire University Hospital)
- System (Cambridgeshire and Peterborough geography)

2.1.4 Health and Wellbeing Boards can play a key role in ICS strategy and governance and there is a growing role for overview and scrutiny committees. The detailed proposals are still being developed about how the health and social care transformation will be led and resourced and the relationship between the ICS and Health and Well Being Boards.

2.1.5 There will be two Boards locally – an NHS Board, which manages NHS resources and a Health and Care Partnership Board, which will oversee joint and integrated working. The NHS Board will oversee allocations of funding to Primary Care (GP's) and Provider Organisation; they will have a duty to collaborate with local partners, including local

authorities. They will also have a duty to promote the triple aim of better health, better care and lower cost.

2.2 Local policy context

2.2.1 Locally the proposals for an Integrated Care System for Cambridgeshire and Peterborough have been approved and work is now underway to define the priorities and next steps over the coming year.

2.2.2 The proposed Cambridgeshire & Peterborough ICS covers a population of nearly one million people with great diversity and many spatial and structural inequalities that have been recognised over time. The ICS provides an opportunity to be a vehicle for achieving greater integration of health and care services; improving population health and reducing inequalities; supporting productivity and sustainability of services; and helping the NHS to support social and economic development.

2.2.3 The ICS in Cambridgeshire and Peterborough will include two Integrated Care Partnerships (ICPs) in the North and South building on the existing North and South Alliances, North covering Peterborough, Fenland and parts of Huntingdonshire and South covering Cambridge City, South Cambs and East Cambs. The North and South Alliance have been in place for over 2 years and the County Council has always been part of the work of the Alliances. A key challenge for the ICS will be to address the underlying inequalities at neighbourhood level as well as structural ones at a spatial system level.

2.2.4 Integrated Neighbourhoods have been established in a number of specific areas. The Primary Care Network (population of 30-50K) is led by a Clinical Director taking a lead in developing local practice. These are still in their early stages and provide a test bed for innovation and integration and are adapting to and reflect local needs and demand. The Alliances and Integrated Neighbourhoods will increasingly be looked to for direction setting and leadership as part of the ICS, as the responsibilities of the current Clinical Commissioning Group are devolved to a local level.

2.2.5 There is also work underway to develop a number of ‘Provider Collaboratives’ and one of these will be focussed on Mental Health and Learning Disabilities. This will provide an opportunity to take the existing integrated model that we have in place for Learning Disability Services further.

2.2.6 Locally we are working with the Chair and Accountable Officer of the ICS to consider how we can streamline strategy and governance; including how the Health and Wellbeing Board and Health and Care Partnership may jointly work together towards the common aim of reducing health inequalities and how we can support people to experience more years of good health during their lives.

3. The current integrated arrangements involving Cambridgeshire County Council

3.1 The needs of our population and its communities

3.1.1 In Cambridgeshire we work continuously to understand the health and social care needs of our population. This is encapsulated by the aims to improve population health **and** reduce health inequalities. These aims are supported by robust evidence found in joint strategic needs assessments (JSNA). The JSNAs provide a holistic analysis into the complex needs of the population and local communities that reflect the social and economic determinants of health along with health and social care services they receive. The JSNAs are complimented by further analysis set out in the Public Health Outcomes Framework (PHOF) produced by Public Health England (PHE). This framework is dividing into outcomes influenced principally by

- Wider determinants of health and wellbeing
- Health improvement outcomes
- Health protection outcomes
- Health care public health and preventing premature mortality

3.1.2 The JSNAs and PHOF have been in existence for some time and influenced local decision makers on the Health and Wellbeing Boards to identify strategic priorities.

3.2 **Current integrated services: Adult Social Care**

3.2.1 Cambridgeshire County Council has a number of integrated services in place with NHS partners. Between 2003 and 2013 CCC did, like many other Councils, adopt a radical approach to integration and transferred all its Older People's Service staff and budgets to the NHS. Around 2012/13 a decision was made to transfer staff and budgets back to CCC due to concerns about loss of professional direction and financial control. This was a very significant decision to make at the time and there is certainly some learning from the experience.

3.2.2 One key learning point was that in the establishment of pooled budgets and transferring staff, the focus was on governance rather than practice, integrated pathways and delivery. The focus on structural change and TUPE transfer of staff was not enough to deliver change in the way that local people experienced services. The creation of pooled budgets to meet care costs was problematic as the level of financial scrutiny was reduced and significant projected overspends developed. Staff who were transferred reported loss of awareness and understanding of best practice in social care and loss of professional direction, whilst seeing the benefits of working alongside NHS colleagues. Significant work followed the transfer back of the staff to address these issues whilst maintaining strong multi-disciplinary arrangements at an operational level supported by continued co location. Co location has over the years been established locally and through national research as a key success factor in developing integrated practice and more important that structural integration.

3.2.3 A number of integrated arrangements were retained as beneficial and working in the interests of the people we support and the delivery of CCC's goals and responsibilities. These include

- Section 75 agreement between CCC and the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for the delivery of **social work mental health support**. This is a legal agreement in which CCC delegates responsibility for the management and provision of Mental Health Social Work to CPFT. The main benefit of this arrangement

is that Social Workers form part of the multi-disciplinary team and work alongside clinicians and joint plans developed which consider someone's social care and health needs.

- Section 75 agreement between CCC and CPFT for **Occupational Therapy (OT) Services**. As for mental health CCC has delegated responsibility for the delivery of Occupational Therapy support which would normally be provides by the Council to CPFT. This means that there is a single OT service and the person being supported receives integrated support.
- **Learning Disability Partnership** which is an integrated delivery model with health and social care staff working in one team, co located with a single management structure managed by CCC. There is a Section 75 between Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and CCC which also includes a pooled budget and a Management Agreement between CPFT and CCC as CCC is managing CPFT employees. The evidence is that this model and the 'wrap around' support that is provided ensured the Learning Disability client group was well supported through the pandemic and the number of people admitted to hospital has been kept down due to the LDPs crisis response.
- **Integrated Community Equipment Service** (ICES) is a jointly commissioned service by CCC and the CCG and ensures a single approach to ensuring that community equipment needs are met in the community or when leaving hospital.
- **Assistive Technology/ Tech Enabled Care Service** is jointly funded by the CCG and CCC and has been a source of excellent practice and innovation and is essential to maintaining independence in the home.

3.2.4 In addition to the formal arrangements and delegated models, there are a number of teams and services delivering an integrated pathway or approach alongside NHS staff, without the need for any formal governance arrangement. Examples include

- Discharge to Assess pathway 1. This pathway includes CCC Reablement and CPFT Intermediate Care staff working in a complementary way. A recent review confirmed that the services have discreet skill sets and work well together to promote and maintain independence and prevent hospital admission or enable it to happen in a timely way.
- Transfer of Care Team- the Council has staff based in our 3 acute hospitals working with clinicians to plan discharge.
- Care Home Support Team and Brokerage Team worked closely throughout the pandemic with the CCGs Quality Team and Public Health as if a single team, supporting independent sector providers with quality, staffing or infection control issues and this approach has s continued.
- Multi-Disciplinary Teams (MDTs) with primary care- named Social Workers had been identified to work with Primary Care Network MDTs and advise and support decision-making, sharing information and planning together how to prevent need escalating.
- Neighbourhood Cares pilots moving into Integrated Neighbourhood working as part of the Integrated Care System (ICS). Neighbourhood Cares pilots were run for 2 years in Soham and St Ives and were a very valuable test bed for integrated working. A separate evaluation report is available and the Integrated Neighbourhoods are building on the best practice developed and are progressing it in the ICS context.

3.2.5 The Think Communities programme has also built on the Neighbourhood Cares principles and throughout the pandemic acted as a unifying force through the establishment of

Community Hubs to also strengthen local support networks across whole communities, rather than just those eligible for Adult Social Care.

3.3 **Current integrated services: Public Health**

3.3.1 Public Health services reflect the need to include consideration of the wider determinants of health and have developed close working relationships with partner organisations that include shared objectives and outcomes along with joint funding arrangement and varying degrees of integration

- In 2013 when Public Health moved to the local authority the funding and commissioning of sexual and reproductive health services was divided between local authorities, clinical commissioning groups and NHS England. This fragmented services with patients having to use different services for related needs. We have undertaken a collaborative commissioning pilot and this year we have a new service model that brings together services commissioned by Cambridgeshire County Council, Peterborough City Council, Clinical Commissioning Group (CCG) and NHS England into an integrated service through a Section 75.
- Public Health commissions a comprehensive lifestyle service that includes weight management services. Central to its role is the integration the prevention and management of obesity through collaborative working across primary care, the NHS, district local authorities and the lifestyle services. There is strong partnering with the CCG and Primary Care Networks and the lifestyle services delivery is are closely aligned their geographies. When Public Health moved to the local authority the funding for the intensive Tier 3 weight management services was transferred from the CCG to Public Health to continue the integrated model of service and the CCG has recently increased its funding allocation to the recently re-commissioned service.
- The CCG also provides funding to the drug and alcohol treatment services commissioned by Public Health for liaison posts that are based in hospital but facilitate integration of the care for drug and alcohol workers with the drug and alcohol treatment services, NHS mental health services and other support services.
- There are examples of joint funding not just with health, but also the Office of the Police and Crime Commissioner for healthy schools' services and Independent Sexual Violence Advisors. Although not health funding but they do embody the principle of an integrated approach is best to address often very complex needs.
- With regard to mental health Public Health has secured NHS funding and is leading the system wide Suicide Prevention Strategy and its delivery. A new mental health post has also been secured to identify mental health data from across the system, which will inform the development of new system wide mental health strategy. A loneliness network has been established with the district authorities, which is collating information to develop a loneliness strategy.
- There are also some good examples of internal integrated commissioning. Public Health commissions supported living accommodation for drug and alcohol treatment service users. We have worked with supported living services to develop an informal integrated approach to service delivery. This enables the complex needs of drug and alcohol users who are often homeless and require input from different services for these needs to be met. The current re-commission of supported living services includes the services commissioned by Public Health and will ensure that the needs of this vulnerable group are more holistically addressed.

3.4 **Commissioning and Governance**

The Commissioning Directorate has formal commissioning arrangements in place with the NHS which provide formal oversight of these services. In addition, the CCG and CCC have a Joint Commissioning Board, which is currently chaired by the Chair of Healthwatch and provides the governance for the Better Care Fund and oversight of other areas of integrated commissioning.

4. Local recent and current innovation - Think Communities and Neighbourhood Cares

4.1 In Adult Social Care a decision was made to see what could be achieved through integrated practice at the most local level, following the principles of the Buurtzorg approach to delivering community health services in Holland. Buurtzorg involves small teams of nursing staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. There is an emphasis on one or two staff working with each individual and their informal carers to access all the resources available in their social networks and neighbourhood to support them to become more independent.

4.2 The Council committed resources over two years to test and learn from the Buurtzorg approach in two Neighbourhood Cares pilot (NCP) areas, Soham and St Ives, each with a population of 10,000. Despite our financial challenges Cambridgeshire invested £900k in NCP to deliver better outcomes and gather the evidence about impact to inform practice and integrated arrangements going forward.

4.3 The teams were given maximum autonomy, a virtual devolved budget and a mandate to develop new solutions focussed on early intervention and strengths-based practice. Their brief was to work with local partners and the local community in a way that would improve outcomes and manage demand on the budget. Cambridgeshire County Council was an early adopter in applying this approach to managing demand and improving outcomes in social care.

4.4 We wanted to:

- Learn from Buurtzorg and test a new approach to adult social care that would also be a catalyst for change in the wider system
- Improve social care workers' job satisfaction by making them part of 'the place', understanding its assets and empowering them to do the right thing at the right time
- Achieve the same or better outcomes in the most cost-effective way
- Develop and increase community assets where there were gaps, particularly in-home care

4.5 Neighbourhood Cares was independently evaluated by York Consulting, who said that

- NCPs achieved high quality outcomes, including some outstanding holistic support and care for people and their families.

  "She (client) had been very negative about things, but now she is much more cheerful and positive about life. If they (NCP) hadn't been involved I'm sure her

mental state would have deteriorated further. They didn't give up – even when she said no." Relative of an NCP client

"Knowing the team are so willing to help and try to make things easier has given me huge comfort. I love the way that they don't sit back and wait for things to happen." Family carer of an NCP client

- The key to achieving better outcomes was recognising that people are experts about themselves and having the time and space to have conversations about what is important to them and how it might best be provided
- Being embedded in the community and immediately accessible was critical
- Changing the conversation from 'needs' and 'eligibility' to 'strengths' and 'wellbeing' built trust and confidence between workers, people, communities and partners
- Job satisfaction and skills development in workers was high and all staff have moved to influential posts across the health and social care system
- As the pilots developed, we recognised 75% of the tasks could be carried out by staff other than social workers given the appropriate training and support
- The evaluation looked at four areas to assess the impact on managing demand and cost effectiveness, with evidence that this was achieved - preventing unplanned admissions to hospital, delaying the need for residential care, and mitigating the cost of loneliness and isolation
- The qualitative evidence indicated significant financial benefits to primary, community and acute healthcare care as well as significantly improved social care outcomes and enablement of self-funders to sustain their financial independence, thereby delaying the need for financial support from the Council

The full report can be found in the 'additional documents' section of the published reports.

5. Next steps and opportunities ahead

5.1 The establishment of the ICS provides the County Council with an opportunity to progress its commitment to integrated working at a neighbourhood level in partnership with the NHS. There are a number of real time challenges that need to be addressed across the health and social care system as we move beyond the worst of the pandemic. These include the need to reduce the number of avoidable hospital admissions and the need to ensure timely discharge takes place with the assessment process taking place in the community. There is also a need to continue to prevent people with Learning Disabilities being admitted to hospital in a crisis and requiring specialist placements outside the County rather than stay in their own home and community with 'wrap around' support from health and social care.

The following quote from Social Care Futures is useful in reminding ourselves what matters to the people we support

'***We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing the things that matter to us'***

5.2 **Taking forward the Neighbourhood Cares approach as part of the Integrated Neighbourhoods work by the ICS**

5.2.1 Cambridgeshire and Peterborough ICS are committed to developing an 'Integrated Neighbourhoods' model based on Primary Care Network footprints. The vision for Integrated Neighbourhoods is to bring together primary, secondary, community, and social care, housing, voluntary sector and other services to provide proactive and integrated care and improve quality, outcomes and value for money for local citizens. The Long-Term Plan includes an integrated delivery framework endorsing the principles learnt through the NCP and the approach advocated by Think Communities.

5.2.2 A new operating model could build on our 'Think Communities' and 'Neighbourhood Cares' programmes and will align to the Integrated Neighbourhoods approach being advocated by the ICS, to change the relationship between public services and local citizens. This would require a full commitment across the ICS and with partners such as District Councils and the Voluntary and Community Sector to deploy all available resources to a neighbourhood level. This would include the creation of a virtual or real place-based budget at neighbourhood level and drive whole system change in the way the public sector does its business responding to local needs and opportunities. This would result in:

- Intervening early to prevent needs increasing and escalating and improve outcomes at an individual and community level
- Strength-based conversations at citizen and community level becoming the norm
- Single cross-partnership conversations becoming business-as usual, based on clear profiles of local need and a shared understanding of the opportunities, risks and challenges
- Listening to individuals and communities to understand what matters to them
- Working with communities in ways that make sense to them, accepting that communities usually know best and that one size doesn't fit all
- Focusing on connecting people with their community to maximise independence and promote wellbeing

5.2.3 Discussions are currently underway about how we could as an ICS develop the role of Integrated Neighbourhood Teams to prevent people being admitted to hospital and enable people to be discharged from hospital in a timely way.

5.3 **Provider Collaboratives**

5.3.1 This is a term that is being used in the NHS to describe the disaggregation of the CCG commissioning functions and work is underway to develop proposals for a Provider Collaborative for Children and Young People, Mental Health and Learning Disabilities. Discussions have started with CPFT and the CCG about how we can use this as an opportunity to build on and strengthen existing integrated arrangements for Learning Disability and Mental Health.

5.3.2 The integrated model proved critical to managing the challenges arising throughout the pandemic and resulted in integrated case management in a crisis situation to avoid admission. The LDP provides a robust basis from which an integrated provider collaborative could be further developed.

5.4 **Integrated Health and Care Record**

A recent joint procurement process led by the STP – now ICS- has successfully identified a provider who will work with all ICS partners to enable the sharing of information across health and social care. This is in its early stages but will create a step change in the way that professionals from different sectors work together in the interests of the individual. In will take time to implement fully but a number of teams and service areas have been identified to start the work. This should mean that people only need to tell their story once and information will be shared in a proportionate way.

5.5 **Improving health and reducing health inequalities**

5.5.1 Generally, the Cambridgeshire population has relatively good health outcomes. However, there are underlying health inequalities that are often masked by the apparent affluence and good health outcomes. These health inequalities reflect the wider determinants of health and along with access to services are played out in the differing health outcomes found across geographies, communities and vulnerable groups.

5.5.2 The Coronavirus pandemic has shone a light on the widely reported pre-existing inequalities in our population and highlighted the need for recovery planning that will 'build back better and fairer'.

5.5.3 There is an opportunity to build integration not just across health and social care but to build integration across the wider system to enable the wider factors that have a critical impact upon health outcomes and health inequalities to be addressed and to shift the focus to primary prevention.

5.5.4 The pandemic has also seen the national public health reorganisation, which abolished Public Health England (PHE) to create a new UK Health Security Agency (UKHSA) and a separate Health Promotion Agency (HPA) linked with the Department of Health and Social Care (DHSC). This is a challenge for public health organisational arrangement at national, regional and local levels but it also provides an opportunity to strengthen the three domains of public health practice – health improvement, health protection and quality in health and social care. All these functions depend on an excellent Population Information Management System as we have seen in the surveillance system reporting, during the pandemic.

5.5.5 Population Health Management is an essential part of the contemporary reform agenda. The approach aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. It includes a focus on the wider determinants of health and acknowledges that less than 20% of a person's health outcomes are attributed to access to good quality health care. It recognises the crucial role of communities and local people and assets. The programme seeks to use widely based data to design new models of proactive care and deliver improvements in health and wellbeing through better use of collective resources.

5.5.6 At a local level the so-called three Ps of - Population Health Management, Primary Care Networks (PCN) and Personalised Care - offer local people services tailored to their needs and delivered as close to home as possible. These 'best solutions' should address health and social care needs as well as the wider determinants that contribute to ill health and inequalities.

5.5.7 Delivering our vision will involve:

- Adopting a Population Health Management approach that will turn public sector information into wellbeing intelligence that will enable proactive primary prevention and early intervention
- Scaling up the prevention and wellbeing activities we know keep people away from specialist health and care services and connected to their communities
- Listening to communities and aligning the prevention and wellbeing offer in a way that works for them
- Working through Primary Care Networks to promote early intervention and prevention with people who are about to step on the path towards care services - the elderly, the isolated, those with long term conditions who are likely to need care and support with daily living at some point
- Having time to build relationships with people who may be in need but currently are not engaging until there is a crisis
- Identifying carers, recognising their contribution and supporting them well
- Transforming the care at home market and mitigating the growing risk of provider failure. We want to deliver a new placed-based, person centred, wellbeing-focused model for long term care

5.6 **Public Health**

Embedding a public health perspective into the ICS which includes ensuring that the following are part of the navigation of the complex policy questions that it poses.

- Define the populations concerned (local, organisational and at ICS level)
- Use Population Health Management intelligence and focus upon health inequalities.
- Apply a life course approach – early years to older people and end of life
- Think of health improvement programmes – addressing health behaviours such as smoking, alcohol, eating and physical activity
- Think of health protection such as water, air, climate change, infectious diseases and wider determinants such as income, housing and work
- Ensure joint working with health and social care, voluntary, community and social enterprise (VCSE) organisations to use best evidence of prevention and use of effective treatments
- Consider settings such as homes, schools and workplaces
- Use information and data to inform policy making and priority setting
- Support the role of a DPH to provide public health advice at a senior policy and executive levels
- Ensure emergency preparedness for Chemical, Biological, Radiological and Nuclear (CBRN) and infectious pandemics

6. Issues for debate and discussion by the Committee

The purpose of this paper is to provide an overview or recent and current developments and opportunities in relation to integration of health and social care and to stimulate debate about the way forward from a County Council perspective. The following are suggested areas for discussion by the Committee

i) Views about the aspirations of the Integrated Care system and the progress so far- how to maximise benefit from County Council involvement and outcomes for local residents
ii) How to maximise local democratic input to the ICS
iii) Support for the County Council's involvement in the 'provider collaborative' approach and the opportunity to build on the Learning Disability Partnership
iv) Support for neighbourhood and place based multi-disciplinary approaches building on the Neighbourhood Cares pilots
v) How to make these developments meaningful for the people we support, their carers and all local residents
vi) Further areas members suggest should be explored for further integration in the next phase

7. Alignment with corporate priorities

7.1 Communities at the heart of everything we do

The report above sets out the implications for this priority in Section 5.

7.2 A good quality of life for everyone
See wording under 7.1 above.

7.3 Helping our children learn, develop and live life to the full
See wording under 7.1 above.

7.4 Cambridgeshire: a well-connected, safe, clean, green environment
See wording under 7.1 above.

7.5 Protecting and caring for those who need us
See wording under 7.1 above.