



Tackling barriers to integration in Health and Social Care

The drivers for greater integration of health and social care are well-known: an increasing elderly population, higher demand for care - for example, because more people are living with long-term conditions like diabetes - the need to develop more responsive, patient-centred services, workforce pressures and reduced funding.

Striving for closer links between the NHS and social care has been part of the policy world in the UK for many years. With the recent publication of the regulations and guidance accompanying the Care Act and its implementation from April next year, this viewpoint considers the issues and challenges facing local authorities tasked with securing greater integration of services and touches on the role housing could play in an emerging landscape of integrated care.

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The push for integrated services

What do we mean by integration? Integration can mean that services are jointly commissioned and/or funded, delivered by multi-disciplinary teams in which team members are employed by more than one organisation, or delivered by multi-disciplinary teams in which members are employed by the same organisation. The essence of integrated care is that individuals receive the care services they need when and where they need them. It is care which appears seamless to the service recipients with multiple needs and without overlaps or gaps between commissioners and providers. Structured correctly, it could transform services and bring significant cost reductions.

The Better Care Fund

Launching the new Better Care Fund in 2013, NHS England asked authorities and CCGs to produce 5 year plans for better integration focused on delayed transfers of care, reduced emergency admissions, more re-ablement services, better management of admissions to residential care, and improved user experience.

The fund will pool £3.8 billion for local authorities and clinical commissioning groups (CCGs) to spend jointly on social services and community services, including £220 million set aside for Disabled Facilities Grants in 2015/2016. Most of the money will come from the NHS budget. Critics have complained that none of it is 'new' and about half is already being spent on these services. The rest, £1.9 billion, will come from money being shifted from acute hospitals to services in the community resulting in fewer people being admitted to hospital, but with possible negative consequences for the finances of acute trusts. 14 Pathfinder areas were identified to develop best practice.

What models of integration already exist?

The 2008 report *NHS Next Stage Review* led to the establishment of 16 care trusts including two 'Care Trusts Plus'. Care Trusts are partnerships between the NHS and councils in which local authorities delegate some social care functions to the care trust. The features of care trusts are usually:

- Pooled budgets (where the partners contribute to a common budget)
- Lead commissioning (where one partner commissions services provided by both partners)
- Integrated provision (where a single organisation provides both health and social care services).

Care Trusts remain within the NHS structure and councils retain ultimate accountability for the delegated services. The two Care Trusts 'Plus' (North East Lincolnshire and Blackburn with Darwen) took the Care Trust principle a stage further and transferred services from the NHS to local authority or vice versa along with the transfer or secondment of staff.

The Care Trust Plus in North East Lincolnshire Council is responsible for commissioning and providing all adult health and social care for the area. At the same time, a children's trust was created to commission health and social care and provide community services, and a joint NHS/local authority public health function was formed, hosted by the Council. A review of the arrangements by the then Audit Commission in 2009 detailed a number of observations.

The benefits attributed to the new arrangements included more integrated teams, an integrated equipment store and closer working relationships between staff. The review also identified:

- Better attendance at multi-agency meetings.
- Improved working between health and education staff.
- Public health became more of corporate priority for the council.
- Multi-agency teams worked together to improve public access. These include a homelessness team and health trainers.
- Health impact assessments became a routine part of the council's regeneration strategy.
- Improved access to information, particularly on children's services.

However, the Commission criticised the new arrangements for not being sufficiently clear about the desired outcomes for service users. The review commented: *"Without having clear, planned service-user outcomes and benefits, and evaluating these, partners cannot be confident that their arrangements are successful or delivering required improvements in value for money."* This illustrates the importance of appropriate consultation with service users and wider stakeholders; the need to comply with the 'best value' duty to consult, the duty to consult on the planning and provision of NHS services and the public sector equality duty in designing new services are also traps for the unwary which could lead to a challenge by judicial review.

Workforce issues must be considered carefully

The terms and conditions of staff transferred under TUPE regulations from the council to the new trust in Lincolnshire were harmonised. However, staff seconded from the NHS to the council were unclear about their position. They were unsure about the basis of their secondment and the impact on pension continuity. In addition, they did not know who to contact to resolve problems and felt transition arrangements were inadequate. This highlights the need to address workforce issues early in any planned integration project and to comply with statutory obligations to staff on informing and consulting, protection of terms and conditions as well as pension benefits.

Taking a step further: Torbay Care Trust

Torbay Care Trust was created in 2005 when the area's existing PCT and adult social services combined. The trust serves a population of around 145,000 with a higher than average proportion of over 75s. The rising prevalence of long-term conditions, including dementia, was a major factor in the decision to form the care trust.

Integrated team members all work from the same location, have a single manager and use a single assessment process. Crucially, each team has a health and social care co-ordinator who deals with referrals and acts as the single point of contact for the team. Co-ordinators provide the link between service users and team members, arranging care and support as necessary. They are not necessarily professionally qualified.

Health and social care budgets are fully pooled and the trust operates with fully integrated, single electronic care records so that teams can commission the care people need regardless of whether it is a health or social service.

Torbay Care Trust also invested in intermediate care facilities in order to reduce inappropriate

admissions. One community hospital changed from a traditional convalescent facility into an intermediate care service by developing the role of nurses, occupational therapists and physiotherapists, and establishing closer links with the local acute hospital's geriatric team. A good example of "up-skilling" and "multi-skilling" in action.

What legal bases are there for collaboration and integration?

There are now numerous legal routes for public bodies to collaborate, whether by joint commissioning, formal transfers of functions, contractual arrangements or setting up new corporate entities. Under the Health and Social Care Act 2012 many of the new collaborative requirements are led by local government. Local authorities now have responsibility for:

- Joint strategic needs assessment (JSNA) – a local analysis of current and future health and wellbeing needs of both adults and children produced by the local authority and clinical commissioning groups.
- The joint health and wellbeing board (JHWP) consisting of representatives from the local authority, the NHS and elsewhere (e.g. Health Watch) which set the local strategic direction for health and wellbeing.

There are also obligations upon the new NHS organisations:

- The central commissioning board 'NHS England' is mandated to 'secure that health services are provided in an integrated way' and that the 'provision of *health services is integrated with the provision of health-related services or social care services*' where they consider this would improve quality or reduce inequalities.
- Section 62 includes a new duty on Monitor (the new regulatory and licensing body) to 'exercise its functions with a view to enabling the provision of healthcare services provided for the purposes of the NHS *to be provided in an integrated way*' where this would improve quality or efficiency and reduce inequalities with respect to either access or outcomes.
- Clinical Commissioning Groups (which hold the budget to arrange most secondary and community health care locally) must exercise their functions 'with a view to securing that health services are *provided in an integrated way*' and further a CCG 'must exercise its functions with a view to securing that the provision of health services is integrated with the provision of health-related or social care services'

The Care Act 2014 requires integration of services and co-operation between service providers:

- Local authorities must exercise their care and support functions with a view to ensuring integration of care and support provision with health and health-related provision, if they believe that this would promote the well-being of adults in their area with needs for care and support and the well-being of carers in their area; or contribute to the prevention or delay of needs for care and support by adults or carers in their area; or improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision). (Section 3 Care Act 2014).
- Local authorities, NHS bodies, Ministers of the Crown, chief officers of police, providers of probation services, and others who may be specified in regulations are subject to a duty to co-operate. They must co-operate in the exercise of their functions for adults in need of care and support and carers and functions relating to these. (Section 6 Care Act 2014).

What does this mean for provision of housing?

The need for integration affects all services received by persons in need of care and support, including the provision of housing. The aforementioned Care Act 2014 also imposes duties on local authorities to carry out their care and support responsibilities with the aim of promoting greater integration. Guidance recently issued under that Act recognises that local organisations need to work in a more joined-up way and has identified that housing and the provision of suitable accommodation is an integral element of care and support. However, the guidance also points out that the Act is clear on the limits of responsibilities and the relationship between care and support and housing legislation, to ensure there is no overlap or confusion. The challenge for local authorities and other housing providers will be to ensure that they work together effectively to integrate the provision of housing with other services provided to meet and prevent care and support needs, whilst at the same time staying within the constraints of the legislation.

A useful case study in the guidance published earlier this year gives the example of the Gloucestershire Affordable Housing Landlords' Forum, which has set out an offer to the Health and Wellbeing Board that demonstrates how each of the housing providers in the forum is working to improve the quality of life of their residents, the neighbourhoods and wider communities, by investing in new homes, supporting independent living, developing the community and supporting older and vulnerable people. The case study, 'Putting Health back into Housing' (and published by the Housing Learning and Improvement Network), reports that over the three years ending March 2013, the forum improved over 14,900 homes, with estimated savings to the NHS of around £1.4 million per year.

What are the barriers to integration?

Factors helping or hindering integrated working usually fall into three categories:

- **Organisational issues**, which can often be related to getting the vision and culture of the organisation right. Sometimes the ability to create unified budgets or management structures can be a powerful driver for change. Equally, simple matters of co-location of staff, communication and IT systems can play a key role.
- **Professional issues** – undoubtedly play an important role. It is sometimes claimed that teams can be dominated by medically qualified staff. Shifting the focus to outcomes for the patient, coupled with a programme of education and training can make all the difference.
- **Policy and legal issues** play an important role. A constantly changing policy and legal environment may not be conducive to long-term planning and collaboration. Similarly, commissioners and providers need to understand the empowering legal bases for collaboration and integration, of which there are many. Finally, inflexible employment contracts, terms and conditions play a role. For some staff, issues of short-term contracts, pension arrangements, pay protection and uncertainty about career structure are a big concern. Some commentators have observed that existing GP contracts may hinder integration.

What does the future hold?

Integration is not a quick or cheap option, so if the main drivers for integration are a need to reduce costs and ease pressure on secondary care, we need to see more innovation emerge. There are now ample opportunities afforded by the legislative and policy environment to deliver services in new ways. For example, in our work with commissioners and providers of public services we have seen the transformative power of establishing new service providers based on the social enterprise model. Combining a mission-driven culture with the disciplines of operating as a commercial enterprise (which reinvests profits for public good) can be a powerful mix. Interesting local models which combine the delivery of health and social care services with appropriate links to procure or commission housing, welfare and reduce re-offending could emerge. The Total Place pilots for neighbourhood budgets demonstrated the scope for massive savings when wider agencies work together. The nettle is there to be grasped by those who show leadership.

Note

The views expressed in this paper are those of the author, and not necessarily those of the Housing Learning and Improvement Network (LIN).

About the author

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About the Housing LIN

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England and Wales involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

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