Nottinghamshire County Council

Discussion paper for Members of the Adult Social Care and Health Committee

1st June 2015

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

Purpose of the Report

1. The report provides the national context on integration between health and social care and explores the benefits and challenges.

2. It identifies lessons learnt on experiences of health and social care integration both at a national and local level.

3. It provides an update on progress in delivering integrated health and social care with the three emerging models in the planning areas of Mid Nottinghamshire, South Nottinghamshire and Bassetlaw.

4. The report asks Members to consider the potential benefits, implications, risks and issues of integration between health and social care.

5. Further, the report asks Members to consider the key components for social care, including the common requirements that must be met in the delivery and configuration of any integrated model for social care in Nottinghamshire, and what elements are subject to differential approaches across the three planning areas.

Information and Advice

National context

6. Better integration between health and social care is almost universally accepted as part of the vision for responsive, caring services and potentially part of the solution to the pressures on health and social care system. Integration is as much about integrating various parts of the health services as it is integrating health with social care. More streamlined services will potentially create a single point of delivery for service users and deliver better outcomes for individuals. The national and international evidence does not support the hope that integration alone will deliver the overall level of savings required. Moreover, any savings tend to be generated through changing the model of care, that is, more investment in community services and less in hospital.

7. The Government has made integration a central platform of its policy for health and social care. The Government's £3.8bn Better Care Fund (BCF) was announced in

June 2013. It is described by NHS England as 'one of the most ambitious ever programmes across the NHS and Local Government'. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. The BCF planned to pool £3.8 billion, but local plans meant that some areas pooled more than the minimum. The total pooled across the country is £5.3 billion. In Nottinghamshire a total of £93 million (2014/5 and 2015/6) of NHS and local authority money has been invested to aid joint working between local authorities and health. Nottinghamshire was fast tracked as an exemplar for the BCF and was the first two-tier authority to be approved.

8. In October 2013 the Government launched 'Integration Pioneers'. The aim of the Pioneers is to make health and social care services work together to provide better support at home and earlier treatment in the community and to prevent people needing emergency care in hospital or care homes. In a second wave, the Mid and South Nottinghamshire Clinical Commissioning Groups have been selected as a new integration pioneer to develop innovative ways to improve the health and well-being of communities.

9. More recently, Mid Nottinghamshire and Rushcliffe Clinical Commissioning Group (CCG) have been awarded Vanguard status to be exemplars of improved care and health across General Practice, community providers, hospitals, social care and mental health.

10. The Care Act guidance says that local authorities must carry out their care and support responsibilities with the aim of joining-up the services provided or other actions taken with those provided by the NHS and other health-related services (for example, housing or leisure services). This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and for carers, including in relation to preventing needs, providing information and advice, shaping and facilitating the market of service providers, safeguarding and transition to adult care and support.

11. This duty applies where the local authority considers that the integration of services will:

    - promote the wellbeing of adults with care and support needs or of carers in its area
    - contribute to the prevention or delay of the development of needs of people
    - improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

Nationally, there is cross party political consensus to progress integration of health and social care. This raft of policy initiatives demonstrates at both a national and local level the commitment to accelerate integration to improve health and wellbeing outcomes for people. Therefore, the question is not whether to integrate with health, but rather, what is the right integration model locally to meet both health and social care needs of the residents of Nottinghamshire?

12. In Nottinghamshire there are three different emerging models for integration with health and social care across the county working to different timescales and with different expectations. These are detailed later in the report. The Council needs to arrive at a position on what are the key requirements of a good social care model for the county that take full account of the wide ranging responsibilities of the Council, and determine to what extent the delivery of social care can be adapted locally to respond to the three emerging models of health and social care integration.

What is integration?

13. Integration can take many different forms in response to meeting local needs and improving outcomes. Integration can range from an alignment of strategic intentions without any change to current arrangements such as commissioning, budgets and service delivery through to full structural integration with joint management arrangements of staff, pooled budgets and integrated commissioning.

14. In Nottinghamshire there are three different models that are emerging, but already there is a closer alignment of strategic intentions in all three planning areas. All areas risk stratify their registered population to identify those who are at risk of a hospital admission, and all have a named GP for registered patients over 75 years old.

15. In Mid Nottinghamshire social care staff have been funded by health to be part of the integrated multi-agency neighbourhood teams. These teams have adopted an approach (PRISM) which targets local people at high risk of hospital admission due to, for example, multiple complex long-term conditions. The team then pro-actively work with individuals in order to prevent this. Work is currently underway to broaden the tool used to identify people, to include factors likely to lead to admission into residential care.

16. Bassetlaw Integrated Neighbourhood Teams were established in early 2015 with social care staff due to join the team in May 2015. This has been achieved through additional investment by health in social care staff and has not required any major structural or contractual changes.

17. In South Nottinghamshire the development of Care Delivery Groups is underway.

What are the benefits of integration?

18. There is general agreement that integration has the potential to transform the way we work.

19. This includes the following potential benefits:

- a seamless service with better outcomes for service users
- a simpler and more joined up service in which health and social care staff work more flexibly together
- removing duplication between health and social care systems
- opportunities for investment in prevention across the whole system
- sharing risks across the health and social care system

- more likely to create a partnership that supports the flow of resources from acute into community based services.

20. One of the frequent claims made for integration is that it can generate savings for both health and social care. The NHS Five Year Forward View outlines a £30 billion funding gap in the NHS by 2020/21 and that efficiency savings and new models of care (including integrated care) will save £22 billion. The assumed gap is £8 billion. For social care, the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) in the document 'Distinctive, Valued, Personal: Why Social Care Matters' calculate that there is a £4.3 billion funding gap in social care by 2020. This assumes 1.5% savings in each of the first two years and 1% thereafter. Whilst integrating services and changing the model of care can contribute savings, there is no evidence that integration will provide the level of savings that are required. In practice there are examples of where integration has increased costs, particularly in relation to social care.

What are the implications of integration for social care?

21. In progressing integrated health and social care model(s) in Nottinghamshire, there are a number of significant implications for the Council that need to be considered and addressed. Lessons also need to be drawn from the challenges of integration from national and local examples. Potential challenges to integration include the variance of health and social care operating models, different funding and governance arrangements and systems of accountability. Inherently cultures, traditions and legislative frameworks vary hugely in practice.

22. Similar challenges to integration were also found locally in the integration of community mental health teams into the NHS Trust in 2003. Workforce issues such as different roles in assessment, personal budgets and commissioning services prevented workers working more flexibly across roles. Without access to the underpinning systems and processes, other professions could not complete these key tasks. Social workers based in multi-disciplinary teams became increasingly distant from the Council and did not maintain a focus on social care priorities nor make the transition to personalisation. The learning from this showed that management and accountability arrangements back to the Council need to be well established and managed. In addition, staff's continuous professional development needs to be maintained alongside links to national, regional and local bodies that develop and champion the role of social workers.

What are the three emerging models in Nottinghamshire?

23. There are six Clinical Commissioning Groups (CCGs) within Nottinghamshire county. A separate CCG covers the unitary authority area of Nottingham City. There are three large acute trusts, one mental health/community trust (Nottinghamshire Healthcare Trust) and two community providers which provide the majority of health services to Nottinghamshire county residents. The acute trusts are Nottingham University Hospitals Trust, Sherwood Forest Hospitals Trust and Doncaster and Bassetlaw Hospitals Trust. The two main community providers are Nottinghamshire Healthcare

Trust (which includes County Health Partnerships and Bassetlaw Health Partnerships), and City Care.

24. In Nottinghamshire there are three different emerging models for integration with health and social care across the three different units of planning. Each area is working to different timescales and each have very different expectations of an integrated health and social care system. Mid Nottinghamshire is the most advanced in progressing plans for an integrated model of health and social care and will set early precedents for the county on the future of integration.

25. Although there are three very different models, the key decisions for social care on integration with health are:

- Service models
- Governance
- Workforce
- Leadership

Mid-Nottinghamshire

26. The Better Together Programme (BTP) aims to deliver a sustainable health and social care system with improved outcomes for local people within the districts of Ashfield, Mansfield and Newark and Sherwood. The BTP forms the basis of the Better Care Fund submission for the Mid Nottinghamshire planning area.

Key themes for Mid-Nottinghamshire	
Long-term conditions (proactive care)	Scale up and expand integrated health and social care community services (known as the PRISM programme) based in the community and attached to practices to create a step change in frail and elderly care, complex and long-term conditions, so the services are introduced at an earlier stage and are more proactive.
Urgent care	Provide an integrated urgent care service to ensure that patients receive the right care in the right place from the right professional. Both in hours and out of hours we will build on existing GP services and integrate GP and A&E/MIU services. A care navigation service will help professionals to ensure people get to the right service in hospital or community settings as quickly as possible.
Elective care	Review each speciality to ensure that quality, safety and viability standards are met – using existing capacity more effectively and providing care closer to home by specialist professionals.
Women and children	Provide rapid medical assessments for children and pregnant women. Ensuring that children with complex needs have joined up packages of care and more support in community settings.

27. Across the three Districts, the health and social care spend amounts to over £300m per annum, of which Nottinghamshire County Council spends in excess of £80m on social care services. A process is underway to map all the expenditure across health and social care within the mid Nottinghamshire area to develop a profile which can then be

used to enable the commissioning of a capitated contract across health and social care.

28. Capitated commissioning aims to deliver better outcomes by removing the incentives for providers to maximise income through episodic care within the current NHS commissioning process. Rather than providers being remunerated for each treatment episode (outputs), they are given a capitated budget to cover the whole population with incentives linked to specific outcomes. This model aims to reward providers for delivery of high quality care rather than by quantity of care.

29. The lead provider model takes this one step further by requiring one co-ordinating provider to lead the delivery system co-ordinating the activity of all other local providers. In this way commissioners can transfer or delegate accountability for delivery to a single accountable provider (SAP) who becomes responsible for establishing an integrated care pathway, procuring services to deliver care and navigating people through the system.

South Nottinghamshire

30. In South Nottinghamshire the unit of planning consists of 12 statutory health and social care organisations, including Nottingham City CCG and Nottingham City Council and is centred around Nottingham University Hospital Trust. The unit of planning has come together to consider and work towards the delivery of integrated services.

31. The partners from the 12 statutory health and social care organisations have established the South Nottinghamshire Transformation Partnership (SNTP) to develop and oversee the implementation of transformation across health and social care services.

32. The SNTP has set out its commitment to partnership working to create a sustainable, high quality health and social care system to promote the health and wellbeing of the citizens of South Nottinghamshire. The main work streams within the partnership include: new models of delivery, Urgent Care, Elective Care and primary care, Engagement and Communication and the Connected Notts IMT programme for health and social care.

33. The partnership also has developed a ‘Case for Change’ which proposes the move to an outcomes-based model of commissioning of health and social care services for all adults.

34. The key components of outcomes based commissioning include providing the means of paying for health and care services based on rewarding the outcomes that are important to the people who use them. It involves the use of a fixed budget for the care of a particular population group, with aligned incentives for care providers to work together to deliver services which meet outcomes. The approach aims to achieve better outcomes through more integrated, person centred services. The South Nottinghamshire partnership is currently considering options for developing a capitated budget, and putting in place a multi-speciality community provider model (MCP) in Rushcliffe (Principia Partners in Health) as part of the Vanguard programme.

North Nottinghamshire (Bassetlaw)

35. Health and social care partners formed a Bassetlaw Integrated Care Board (ICB) in April 2013 to drive forward the vision for better care along with ambitious plans to improve the health and wellbeing of Bassetlaw residents. The unit of planning includes clinical and non-clinical senior representatives from the CCG, local acute, community and mental health care trusts, district council and local authority (social care and public health).

36. The ICB has agreed a joint vision and commitment for health and social care systems to work together to deliver five transformational change programmes in Bassetlaw:

Integrating Care in the community	Improving the pathways of care and integrating local services for frail and vulnerable people
Urgent (Same Day) Care	Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including GP out of hours service and patient self-care
Care Homes and Specialist Accommodation for Oder People	Health and social care working better together to improve the quality of care and standards in Bassetlaw's care homes and develop a range of housing and accommodation options.
Mental Health Services	Emphasis on parity of esteem through improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on acute based mental healthcare
Getting people out of hospital after acute illness	Helping people to become independent after leaving hospital, providing more re-ablement and rehabilitation support at home and in the community.

At a glance summary of the three models

37. What are the similarities and differences between the three emerging models?

	South Nottinghamshire	**North Nottinghamshire**	**Mid Nottinghamshire**
Priority client groups	• The whole population but particularly older	• Frail or vulnerable people with complex needs	• The whole population but particularly older people and people

	people and people with long-term conditions • People who need acute / secondary / elective care • People who have urgent care needs but who don't need hospital admission • People leaving hospital	• People with long term conditions • People with mental health conditions • People who live in care homes • People who need urgent care needs but who don't need hospital admission • People leaving hospital	with long-term conditions • People who need acute / secondary / elective care • People who have urgent care needs but who don't need hospital admission • People leaving hospital
Integrated point of access	Yes	Yes	Yes
Social care staff in health staffing structures	Yes (Care Delivery Groups)	Yes (4 Integrated Neighbourhood Teams)	Yes (8 Integrated Care Teams using PRISM approach)
Integrated intermediate care arrangements	Yes	Yes	Yes
Integrated commissioning model	Yes (Outcomes based commissioning, but still in early stages of development and possibility of multi-speciality community provider model)	(Outcomes based - providers are aligned rather than contractually integrated)	Yes (Outcomes based contract with a population capitated budget and lead Accountable Provider)

What are our key functions and responsibilities?

38. However seamless or joined-up the services may appear to the person needing care and support in the future, accountability for delivery of the local authority's functions and responsibilities remains with the local authority. These functions and responsibilities are described in Part 1 of the Care Act 2014.

39. The social care functions and responsibilities of the local authority can be divided into the following separate categories:

- Provision of information and advice
- Prevention and early intervention

- Personalisation work including assessment, care planning, service brokerage (including personalised approaches and management of personal budgets and direct payments) and review
- Carers' assessments and services
- Social care in prisons
- Safeguarding, Deprivation of Liberty and Approved Mental Health functions
- Strategic commissioning and policy-making functions
- Direct service provision
- Market shaping and managing provider failure

40. The Care Act allows local authorities to delegate the majority, but not all, of their care and support functions to other parties. However, it is still clear from the Act that local authorities retain ultimate responsibility for how their functions are carried out and delegation does not absolve the local authority of its legal responsibilities.

41. In Nottinghamshire, the Care Act implementation is underpinned by the Adult Social Care Strategy. This sets out how social care will be delivered in Nottinghamshire and is guided by the following principles:

    - Promotion of independence and well-being
    - Value for money
    - Personalisation, such as choice and control

What are the key requirements of a good health and social care model?

What are the key components of a good health and social care model that need to be an integral part of any local solution for Nottinghamshire?

42. 'Distinctive, Valued and Personal, why social care matters: the next five years' sets out the key priorities of a newly designed social and health care service. In summary this includes:
    - **Good information and advice:** good information and advice to enable us to look after ourselves and each other and to get the right help at the right time as our needs change
    - **Supportive families and communities:** recognising that we are all interdependent and need to build supportive relationships and resilient communities
    - **Recovery, re-ablement and independence:** developing services that help us get back on track after illness and help disabled people to be independent
    - **Personalised services:** addressing our mental, physical and other forms of wellbeing through services should be much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.

43. Underpinning these key requirements there needs to be:

- **a sustainable, good quality market** for services with a skilled and stable workforce
- **protection** of people's interests and rights when they are in vulnerable situations

What are the key issues emerging for the Council to consider?

Which service user groups should form part of an integrated model?

44. The three health integration programmes tend to focus on older people and people with long term conditions and people with mental health conditions. The driver for change in health is in relation to the pressures in the acute sector and includes the reduction in admissions to hospitals and timely discharge from hospital into community settings. In contrast, social care responds to a wide range of short and long term needs across a diverse population, for example, from an 18 year old with autism who needs support to leave home to an 80 year old with dementia who needs protection as well as personal care. Social care helps people live independently as possible, protects people from harm in vulnerable situations, balances risks with rights and offers essential help in crisis. People with different needs and different groups of people, such as younger adults or those with learning disabilities or mental health issues would therefore largely fall outside of the scope of the integration programmes at this stage, but not out of scope for future phases. However, within younger adult services the Council already have staff co-located working to similar outcomes for service users.

Does the Council support a phased approach to integration across different service user groups?

Integration/alignment with other partners

45. Whilst health is a major player in the need to integrate services, the Care Act requires the Council to work in partnership with a range of organisations to improve outcomes for people in Nottinghamshire. Therefore, the new health and social care system will need to fully engage with the different departments within the Council, including Public Health, and also wider partners such as district councils for housing, leisure and environmental services; welfare services for financial advice and employment opportunities; and the voluntary and community sector to develop stronger communities and local networks.

How do we ensure that other partners are considered as part of the new health and social care system?

Equity

46. The Council will need to ensure that access to and provision of services and outcomes for service users are equitable across the county. This will be potentially more difficult to achieve as services are developed to meet the requirements of the different planning areas and different partner delivery strategies across the county. However, the benefit of local planning is being able to respond to local needs in the community to meet health and wellbeing outcomes. The Council will need to ensure that services are strategically sound and locally sensitive.

47. Access to services is not merely a matter of where and how people access services, but more fundamentally who can access services. Under the Care Act there is a national threshold of eligibility based on the concept of wellbeing.

How do we ensure equity of access and consistency in decisions about who gets social care support funded by the Council?

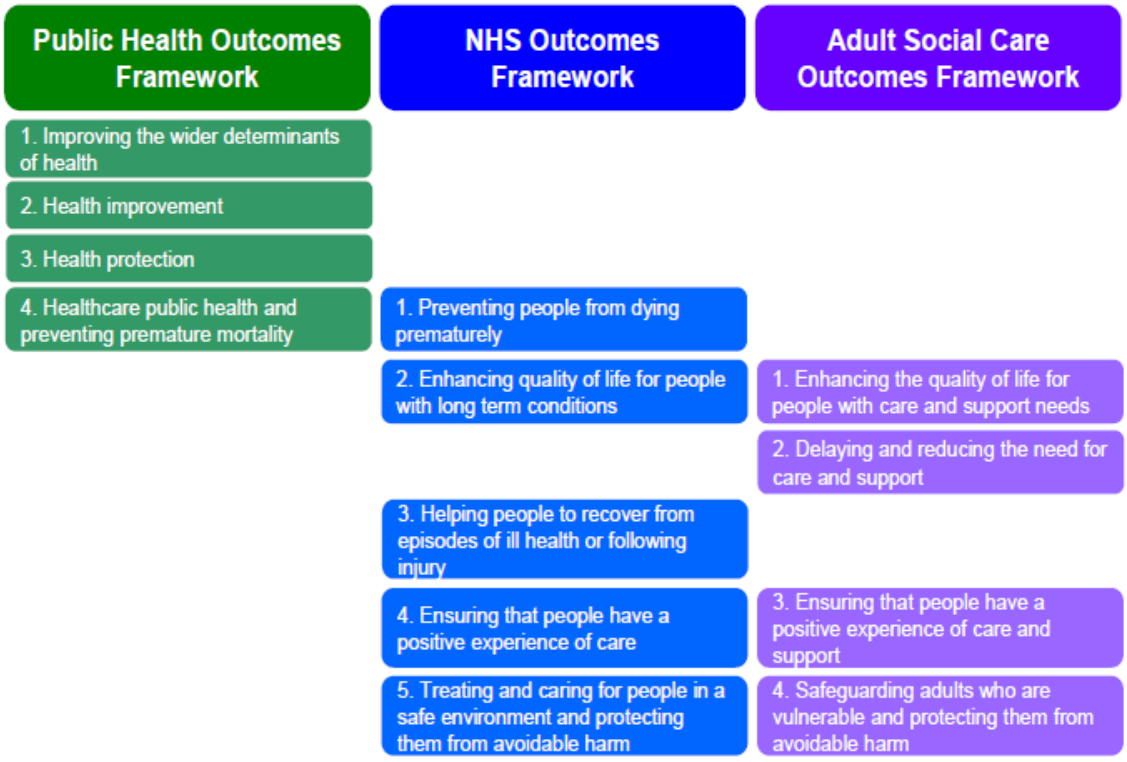
Access

48. Access to social care is through a single point for the county at the Customer Access Centre (CSC) and the Adult Access Service. This arrangement provides one way of managing demand at the front door. It provides economies of scale and is a cost effective way of responding to enquiries. Service advisors provide the first point of contact and the Adult Access Service triages cases. Combined, the services resolve 70% of social care enquiries. However, two units of planning, Mid Nottinghamshire and South Nottinghamshire, would like to have their own routes to access integrated health and social care to be responsive to local needs and services

If members are in agreement to different access points for different service user groups, the Council would need to ensure that these work alongside and do not duplicate existing resources. The new model would need to be able to demonstrate that it would be able to manage demand and provide early intervention to divert people away from costly health and social care services.

Outcomes framework

49. The Council is accountable for the delivery of social care services to the population of Nottinghamshire. The Council may delegate both the commissioning and provision of services to other bodies, but retains accountability for the outcomes of any services which individuals receive. The Council is held to account by Government and the regulator and measures delivery through the Adult Social Care Outcomes Framework, Public Health Outcomes Framework, sector led improvement processes and other performance management frameworks.



Department of Health (2012) Improving health and care: The role of the outcomes frameworks

50. The three Outcome Frameworks cover different parts of the health and care system containing both distinct and overlapping areas of focus. The alignment of domains and indicators provides incentives for different parts of the health and care system to work together to integrate care and coordinate services in the interests of patients, services users, their carers and families.

51. Previous experience of integrated provision across health and social care locally has shown that in some cases NHS providers have struggled to meet social care outcomes and national evidence of integrated provision has largely not demonstrated success in providing value to social care services. Health has a poor track record in valuing and investing in social care. Their incentives and indeed their ethos as an organisation tend to revolve around the provision of acute care and the achievement of clinical outcomes.

52. Nationally, health services are a higher priority than social care and investment in social care has reduced in real terms over the last five years. If this funding reduction continues any plans to integrate with health would need to address this imbalance in resources.

53. It is therefore recommended that any future development of integrated commissioning and provision is based upon a shared outcomes framework which meets the requirements of health care, public health and social care. It would need to reflect the local implementation of the Care Act 2014 together with the principles of the Adult Social Care Strategy including:

    - Promotion of independence and wellbeing
    - Value for money
    - Personalisation, such as, choice and control

54. It would also require better alignment of performance measures that encourage prevention and co-ordinated care in the community and capture how well the local system (rather than individual organisations) is doing in meeting health and wellbeing outcomes.

55. Mid Nottinghamshire has undertaken such an exercise (Mid Notts Outcome Framework) for the Better Together Programme with all partners in the planning unit. North Nottinghamshire developed an Integrated Care Board Programme Work stream Benefits Profile with all partners. South Nottinghamshire is in the early stages of planning an approach.

It is suggested that the Council needs to ensure in any model of integration that the Council is a joint partner in the establishment of an agreed joint outcomes framework(s) which can provide evidence of improvements in social care in line with the local strategy, joint commissioning and national policy.

Cultural differences

56. There is a historical difference in how health and social care services approach risk to individuals. Health services have often tended to be more risk averse than social care services. The Council would need to ensure that health models of intervention do not pull more people into long term social care services. Whilst it is difficult to generalise there are a number of factors which influence appetite for risk such as professional values, ethics, litigation, regulation, choice, individual responsibility, situational responsibility, public expectation, and expediency. These factors all contribute to the manner in which people receive their care, where and how they receive care and the level of care provided. There are no rights and wrongs in this area, it is more a matter of philosophy and ethos; however the degree of difference in approach can be substantial and have consequence on outcomes for individuals. The development of an outcomes framework does not in itself resolve this issue as there may be outcomes which conflict or which may not be mutually supportive, for example keeping people safe versus promoting independence, maximising choice versus being most efficient.

Members may therefore wish to specify which outcomes are more of a priority or consider whether a weighting should be applied to ensure approaches to risk reflect the local authority's priorities.

Personalisation

57. Social care is highly personalised, through the provision of personal budgets within which people exercise choice of service delivery. Nottinghamshire County Council is a high performing council with nearly 100% of community based service users having a personal budget and nearly 50% of those having some form of direct payment.

58. Extending these arrangements so that people can access a combined budget covering health as well as social care needs ('Integrated Personal Commissioning') creates the potential for integrated care to be driven as much by individuals as by organisations.

59. However, despite Nottinghamshire being an In Control pilot site for personal health budgets for people with long term conditions, there has been slow progress since the roll out of personal health budgets from April 2014. There is one personal health budget in Bassetlaw and twenty in the county.

How would the Council ensure that any new ways of delivering services reflect a personalised approach to assessment and care management?

Assessment and care management

60. The Council has duties of assessment, support planning and provision of support for people with eligible needs under the Care Act.

61. For health to deliver social care personal budgets, they would need access to the local authority's underpinning systems, processes and policies such as the assessment and eligibility process, resource allocation system, commissioning processes and direct payments systems.

62. Social care personal budgets must receive an initial review and an annual review. As well as ensuring support that is put in place is meeting outcomes for the individual, reviews ensure that the level of support continues to be appropriate to the current need. Hence, the review process provides a mechanism for the Council to support independence, as well as reduce long term costs.

63. The Council has the same duties of assessment and provision of support for eligible carers. It is difficult to separate out the assessment and provision of support to the carer from the service user. The support that a carer receives is often through the provision of support directly to the person being cared for, such as respite or day care support. It is also the case that the assessment of the carer is often informed by the

needs of the service user. The Care Act promotes assessment and support planning, which considers the individual within the context of family, carers and other networks. The Care Act allows for joint assessments and this is also under consideration.

64. However, it is easier to separate simple assessments for carers where advice and information is required and/or access to an annual direct payment to support them to continue in their caring role. Telephone based carers' assessments are delivered at the Adult Access Service and potentially, this model could be extended, but health would need access to underpinning systems to complete the assessment and allocate a direct payment. This would require either access to care management systems or via online forms and back office functions that could commission the direct payment on their behalf.

65. The Care Act also brings new responsibilities to local authorities for people who fund their own social care. These include new processes to set up individual personal budgets and care accounts following an assessment of need.

Members may wish to consider the options of retaining all or part of the assessment and care management function within the Council or of delegating functions and responsibilities to health

Adult Safeguarding

66. The local authority is the lead organisation tasked with safeguarding adults who may be at risk of harm or abuse under the legislative framework of the Care Act 2014. The Act puts in place a legal framework for adult safeguarding, including the establishment of Safeguarding Adults Boards (SABs), carrying out safeguarding adult reviews and making safeguarding enquiries. Since the local authority must be one of the members of SABs, and it must take the lead role in adult safeguarding, it may not delegate these statutory functions to another party. However, it may commission or arrange for other parties to carry out certain related activities, as long as these do not affect the local authority's lead role and membership of the SAB.

67. Currently the Council requires all experienced social work staff to undertake safeguarding assessment duties which involve the investigation of allegations of harm and abuse wherever these occur within the geographical boundary of Nottinghamshire. The Council together with the Safeguarding Adults Board has held the view that individual providers should not investigate allegations (other than in relation to employment issues) concerning their own provision other than in exceptional circumstances. Health services however have developed internal processes for the investigation and governance of safeguarding arrangements within the NHS. Requiring a provider to carry out safeguarding investigations and decision making of itself and others on behalf of the Council raises potential conflicts of interest and would entail a revision of safeguarding policies and procedures which would require the approval of the Safeguarding Adults Board.

The Council cannot delegate responsibility for statutory safeguarding functions, but there are options about how these are delivered.

Advice, information and advocacy

68. Advice, information and advocacy form the first requirement for local authorities. It is a broad duty that requires the Council to provide a broad range of information including health, social care, housing and financial information to the population of Nottinghamshire. Ensuring people receive the right information at the right time in the right way is intrinsic to the authority's ability to manage demand and therefore manage its resources going forward. Therefore, an integrated health and social care model would need to be able to provide a wide range of information and advice in a timely way to people in Nottinghamshire. The delivery of these functions requires a broad approach and requires the involvement and intervention from many different organisations across the statutory, voluntary and third sector. Good progress has been made with partners in the development of a website called Nottshelpyourself, which provides a range of information.

69. The Council would need to ensure that an integrated health and social care model reflected these wider information requirements to the population at large.

It is recommended the Council builds joined up information, advice and advocacy with partners and ensures it is a priority for the new health and

Prevention and early intervention (including reablement)

70. Prevention and early intervention services are a key requirement of the Care Act and are a way of managing demand for services by deferring, delaying or avoiding the need for long term support. Prevention and early intervention means very different things to different partners and an agreed understanding is required across partners.

71. The Care Act provides a useful definition of prevention with three different approaches of primary prevention which may be based at population level, secondary prevention which may be targeted at individuals who are at risk, and tertiary prevention which relates directly to people who are in receipt of health and social care services. As an authority with both social care responsibilities and public health functions, the Council has a duty to arrange prevention services at all levels, whereas health prioritise those with a health need.

72. However, a joint health and Council commissioning approach to prevention could help with the ambition of investing in preventative services that have been reduced following supporting people funding cuts.

73. There are already some integrated preventative services across Nottinghamshire, such as hospital discharge teams, information prescriptions, Intensive Recovery Intervention Service (IRIS), intermediate care and reablement services. These services are aligned rather than truly integrated and multiple providers continue to be accountable for their own aspect of delivery with separate governance and information management resources. All areas are considering more integrated models of intermediate care/reablement.

74. The integration of reablement services with health would need to be considered within the wider context of alternative delivery models for direct services, which is currently being explored. The alternative delivery models project would need to consider any implications for the other direct services.

Members may wish to support a jointly commissioned approach to preventative services based on an agreement of definitions and a shared approach

Strategic market development and commissioning

75. The social care market is very different from health with the majority of social care providers already in the private sector in a very plural market providing support via managed personal budgets, direct payments and self funders (it is estimated that there are 8,000 self funders in Nottinghamshire with eligible needs). The Council have much more scope than health in determining the price for care and support in the local market with the majority of contracts via a framework agreement.

76. Consequently, the Care Act places wide ranging duties on local authorities for market facilitation, market development and ensuring a high quality of market provision for all citizens of Nottinghamshire. Local authorities are also now required to ensure provider sustainability and financial reliability.

77. Although these are duties placed on a local authority, the Care Act encourages Councils to work in partnership to develop a more joined up approach to these areas. One opportunity would be a joint approach with NHS commissioning partners and providers to the shared problems of recruitment, retention and pay of the workforce in the delivery of care and support.

78. There are many different forms integrated commissioning could take, but any future arrangements would need to give consideration to how to ensure services are available and accessible to service users from across the whole spectrum of need and across the whole of the county. The contracts which are currently procured to deliver these services are commissioned on that basis and any change to this in the near future may present difficulties in respect to access and equity of provision, contract management, and the achievement of best value.

Members may wish to consider how a more joined up approach could be developed with NHS commissioning partners. What would be in scope, what form that might take and how would we ensure access, equity and value for money?

Funding

79. The Council currently spends over £300m gross (over £200m net) on adult social care. The vast majority (over 70%) of this expenditure is on services procured from over 300 different providers.

80. Many of the services commissioned are arranged at an individual level through individual service contracts for residential/nursing care or through individual personal budgets and/or direct payment agreements. Direct payments have grown rapidly over the last five years and account for nearly 50% of services commissioned in the community.

81. Hence, the commissioning of services on an individual basis is complex and requires the support of both specific adult care financial services and the general financial services and systems of the authority.

82. The Council can charge for services and the adult social care financial services ensure the collection of service user contributions and other income to offset the gross cost of services. The assessment for, determination of, and collection of individual contributions is critical to the financial sustainability of the authority. In addition these services provide invoice and payment processing for providers; payments, monitoring and auditing of direct payment accounts; as well as other related client money functions such as deferred payment systems, appointeeships and deputyship services. Under the Care Act, the local authority cannot delegate the decision-making for charging, although there is scope around the administration of this.

83. With any integrated budget arrangements, the Council would need to ensure there were effective control mechanisms, monitoring systems and risk sharing agreements in place to alert the council to and detail arrangements for any over commitment, overspend, under delivery, or underspend. There would also need to be clear processes and monitoring mechanisms for the effective financial management of service users who may transfer from an NHS ‘free at the point of access’ service to a social care service potentially requiring a financial contribution (for example, there could be financial implications for the local authority for transfer to assess type services). The delegated budget would also need to reflect the agreed (current and future) savings and efficiency targets which are required to balance the authority’s budget in the medium term, alongside any demand or cost led budget pressures which the authority may agree to meet.

84. It is anticipated that the Council will be required to make further efficiencies and savings from the Adult Social care and Health budget over the next 4-5 years. The Council would need to ensure that any integrated budget arrangements would build in the proposed additional savings required and this will need to be reflected in the risk sharing agreement.

85. The Council's direct services account for over £30m of expenditure across the county and the Council is currently considering alternative delivery models for these services. A new health and social care model could offer opportunities for some or all of these services to operate as integrated health and social care services. However, it is likely that health would only wish to integrate services which have a direct influence on their existing core business.

86. Although options for exploring alternative delivery models is subject to a separate paper for Members to consider, it is important to note that decisions reached on integration with health will have important implications for the future direction of some of the direct services.

Workforce

87. There is a range of options open to the authority in respect of the workforce. Employees could be transferred to a partner organisation as part of a service transfer, employees could be formally seconded to a partner organisation or employees could be retained by the authority and aligned to a lead partner who may or may not have day to day management responsibility.

88. The consideration of the Council's ongoing employer responsibilities should be determined by the functions under discussion having thought to issues such as future recruitment, retention, staff development, professional support, terms and conditions of employment, and workforce development.

89. A key consideration is learning and development and workforce development in the context of policies, procedures, practice and process. It is also important in considering the future role of Social Work as a profession and the future delivery of social care as an intervention to promote people's independence. Previous integrated approaches to health and social care have proved less successful over time due in part to an underestimation of the importance of supporting and maintaining an ethos and philosophy of social care and the professional development of Social Workers, Occupational Therapists and others. Members should ensure that integrated health and social care arrangements embed a strong focus on the ongoing workforce and the learning and professional development of social care staffing.

Leadership

90. Leadership is a further area of consideration dependent on the future model of service delivery. Experience has shown that staff that have been seconded or aligned to another organisation can become distant from the Council, who continues to be their host employer. This can lead to role ambiguity, loss of organisational and professional accountability and low staff morale. The Council will need to determine how organisational and professional leadership can be delivered to staff who may be working outside the organisation and in different parts of the health and social care system. This could be achieved through ensuring a robust social care based management and leadership function is retained in a structurally integrated care arrangement together with a requirement for the local authority to retain oversight for these areas of practice development. However one of the largest challenges in bringing

together staff across health and social care is to bridge the different organisational and professional cultures which exist.

91. It is envisaged that an integrated health and social care system can bring benefit to the local population through the delivery of a holistic care pathway from information, advice and self-care through to acute medicine and on to long term care. This will require the coming together of various professional disciplines, organisations and agencies each with their own identities, values and ways of working; all of which will need to be understood, embedded and cherished if the benefit to users of services is to be achieved.

92. A new operating culture may emerge as new models of practice are developed and new organisational units formed but this is likely to take time and require considerable leadership and workforce development intervention.

Governance arrangements

93. The Council will need to be assured that there is a robust and transparent process of governance in place which provides the authority with oversight of activity and quality, scrutiny of outcomes, workforce and financial assurance.

94. The particular governance arrangements that need to be put in place will depend on the future level of involvement in decision-making that Members wish to retain over the development of integrated services and the outcomes that this delivers.

95. The Health and Wellbeing Board is well-placed to evolve its role and provide countywide leadership and assurance in relation to integration and its impact on outcomes for residents across the whole of Nottinghamshire. Currently Health and Wellbeing Boards are the only local forum that brings together leaders from health and local government, including public health. A succession of national reviews and reports has argued that they could play a bigger role in overseeing the integration of local services and the development of a more integrated approach to the commissioning of services across health, social care, and local government. This is reflected in the requirement for Boards to sign-off local Better Care Fund plans.

96. The peer challenge led by the Local Government Association (LGA) found that the Nottinghamshire Health and Wellbeing Board is well placed to become a systems leader and the engagement of the Clinical Commissioning Groups (CCGs) and District Councils was noted.

97. The Board offers the opportunity for an evolutionary approach based on partnership between CCGs and local authorities. CCGs would have a strong and continuing role in contributing to the work of the Board in overseeing the commissioning of all local services, market shaping, resource allocation and service delivery.

98. Alternative (or additional options) for governance arrangements could consist of any of the following :

- Member Reference Group focused on integration
- Adult Social Care and Health Committee to receive recommendations for approval as well as reports on progress and the achievement of social care outcomes (relevant to integrated services)
- Clauses within contracts to specify social care requirements, quality standards, reporting requirements and performance outcomes to be achieved by services which deliver, or support the delivery of, social care duties and functions. Monitoring arrangements will need to be in place to ensure compliance and trigger action should performance fall below expected standards.
- Agreement on risk sharing
- Agreement on financial arrangements, including the implications of shifts in budgetary spend for partners as resources move from the acute hospital sector into the community and primary care sector.

What is the preferred model for governance arrangements for the new health and social care system?

Summary

99. This paper has sought to summarise the main implications, benefits and risks involved in integrating health and social care in Nottinghamshire. Given the national legislative and policy context and the increasing numbers of people who have a long term disability or multiple long term conditions, the question is not whether to integrate health and social care, but how and how far.

100. The size of the county means that there are a large number of health and social care organisations commissioning and providing services in Nottinghamshire and the implications of the changes are complicated and far reaching.

101. The paper highlights some of the key questions in terms of the need for a Member steer on the future direction. In practice, this paper represents part of the dialogue and we envisage the need for further discussions over the coming months as plans and dialogue develop locally and any new government policy direction in this area emerges.

Recommendations

1. The report asks Members to consider the potential benefits, implications, risks and issues of integration between health and social care.

2. The report asks Members to consider the key components for social care, including the common requirements that must be met in the delivery and configuration of any integrated model for social care in Nottinghamshire, and what elements are subject to differential approaches across the three planning areas.

David Pearson
Corporate Director, Adult Social Care, Health and Public Protection and Deputy Chief Executive, Nottinghamshire County Council

Immediate Past President, ADASS