The crucial role of social care in the integration agenda

Expert discussion with ADASS East Region

directors of adass
adult social services

Good Governance Institute

Tunstall

On the 27 September 2013, the Good Governance Institute in cooperation with Tunstall Healthcare convened an expert discussion with the ADASS (Association of Directors of Adult Social Services) East Region on the subject of integration with the objective of answering the following 2 questions:

1. **What does social care need to make integration happen at scale?**
2. **What is the role of technology and how will it help to advance integrated care?**

A list of the participants is contained in the appendix. This summary is a stepping stone to a wider report that will be disseminated at the Spring Seminar in April 2014 following further expert discussion groups with ADASS members.

Introduction

In July 2013 the GGI produced a Report "*Rethinking the integration agenda*" that highlighted the need for integration across housing, health and social care to improve outcomes. It aimed to highlight the barriers impeding the integration of care services, and recommended three key steps for creating sustainable, people-centric care models

3 key pathways identified in the report for addressing the barriers to integration:

Whole person care *"good living pathways"* must include housing and community support	•Locally designed but nationally mandated, this new broader approach to integration will lead to the outcomes the public want. *Living well pathways* need to translate into funding, audit, performance management and public debate can release the innovation needed.
New cultures of care	•Evidence points us to co-location, this needs to be incentivised and prepared for. Structural change will not change culture. Alignment of organisations around shared outcomes is essential.
Investing in new enabling technologies	•Our work points to many boards having only trivial understanding of the new possibilities that technology is opening. Leaders now need to benchmark service planning in line with new models of support. Auditors and regulators need to catch up and monitor what is not being made available.

http://uk.tunstall.com/news/359/new-ggi-report-highlights-need-for-integration-across-housing-health-and-social-care-to-improve-outcomes

1. Reaction to the report

The group were in overall agreement with the report and discussion centred around 2 main themes:

Major problems with integration

- Constant structural change "paralysing" the system
- Incentives are not aligned
- Leadership which is 'organisation bound'

The only area which perhaps caused some debate was that change will happen at the coalface, not just at a system level and systems are often slow to respond.

4 areas of challenge arose:

- **Frail elderly** – how do you prevent repeat hospitalisations, how do you provide a safe home environment – technology has a role here
- **Mental health** – so much comorbidity and once someone hits the hospital setting, they're stuck in the health and care system
- **Discharge planning** – it's a big issue and an absolute mess. CCGs think it's an acute problem but it's a community problem. Until you actually stop rewarding failure with money, you won't solve it
- **End of life care** – one member of the group said that they have 40% of people who don't need to be there, dying in the hospital

2. What does social care need to make integration happen at scale?

In answer to the question of what does social care need to make integration happen at scale, two main themes arose:

LEADERSHIP

a) **Sort out national government relationships** – relationships between health and social care within the Department of health are separate and indeed the DCLG / DH interface isn't as joined up as it could be. We need the same messages coming down the NHS and the Local Government line. Also, a lot of councils are looking to DCLG for advice but this isn't necessarily joined up with health.

"If you can't get the messages straight at the national level it creates a lot of confusion and unnecessary hassle."

"We need to tackle the provider arm of the NHS. We've left in place all the perverse incentives in the foundation trust."

b) **Make someone responsible** locally – it's very difficult knowing who is responsible and accountable with the teeth to make a change. We've seen the rise of Health and Wellbeing Boards as the thing to make sense of this but they need the legitimacy, the profile, the commitment of all partners and the time and resources to do so.

"Some of us have spent many years trying to bring services together – it doesn't feel any easier, in fact it feels much more difficult now."

c) **Join up pots but don't necessarily pool budgets** – for now, we need to lay council, acute, CCG and community pots on the table, carry out some projections which will indicate the reductions over the next 4 years, and rather than simply pooling the budget, this lets everyone around the table own the issue. This works best when you have progressive leaders in EACH organisation.

d) **Building from the bottom up** – the vision is clear - develop integrated delivery around people – don't spend time worrying about TUPE etc. Give permission for people to be innovative, free people up.

"Be brave. Ask for forgiveness and not permission."

e) **Work out the joint vision and own it** – we think we know what it means within our own sector but what does it mean to everyone else. We need leaders who look beyond their own

organisation at the wider public interest. Hospital. It's about people and you have to get everyone signed up to the one vision. It's about building partnerships and trust.

"There are usually 2 things you argue about- you either don't get on with your colleagues or it's the money."

"When I worked for the NHS it was always social care to blame. Now I work for social care, it's the other way round. It's amazing how we get comfort from our own organisation structures."

f) **Yes we've got budget cuts, but demonstrate the impact and use this to debate how you might spend money differently,**–Draw up what the health implications will be e.g. the impact on A&E, on GP surgeries etc. Say if you don't want that to happen, we need to work together. An interesting example is where an acute trust is thinking differently about beds i.e. more care is needed so people can be cared for at home in their own beds and less in the hospital so that it can serve fewer people , but more effectively.

"Stroke care needs to be improved in my area. Social care spends money on people who are not going to get any better. We need to focus on the first 6 week intensive recovery period."

g) **Must involve the rest of the Council** – social care is the last biggest budget and is partly funded by council tax. We don't just get pressure from the health system, but also within the council, e.g. competing budgets over libraries, schools, care etc. so trying to get integration up on the council's agenda is quite tricky.

STRUCTURE

h) **Reduce complications in the structure** – there could be 7 CCGs, 2 acute trust, 2 community providers, 7 district councils, 1 county council, numerous housing providers and 1 mental health trust in one area. Alternatively in another council area there could be one just one of each. The CSSR is the common dominator and should step up to lead.

i) **Alternatively be brilliant at understanding and working with the local situation**. It's quite possible you will have several very different integrated commissioning arrangements in each one of your CCG areas, creating distinct health and care systems. Use the structure to your advantage.

j) **Deal with uncertainty as best you can** – you may be going through a procurement exercise which will lead to uncertainty about who the providers will be for several months.

k) **Housing is fundamental** – one challenge for counties is how to integrate housing. Accommodation and care – you have to see them together

"We have an example of a delayed discharge for a chap with complex needs, all of which had been sorted out. The delay was caused by the lack of a ramp at his home. A non-medical need, therefore it's crucial to have housing involvement."

3. What is the role of technology and how will it help to advance integrated care?

Technology such as telecare and telehealth is a tool that can transition people out of very expensive care settings into the home and shift some responsibility to the carers and patients.

Technology is moving at a phenomenal speed and indeed, has moved faster than cultural change.

What role can telehealthcare play?

Telehealthcare has an important role to play in facilitating better integration and more cohesive service delivery across traditional social care, health and housing boundaries

- **Breaking down barriers** between health, housing and social care enabling integration of care around the person
- **Efficiency** - reducing acute hospital and social care episodes
- **Empowering** users to do more for themselves, helping them to make informed decisions about their care
- Delivering improved **clinical effectiveness**
- **Improving the care** experience and outcomes for patients, through reductions in acute care episodes
- **Communications** - informing and engaging all stakeholders in care planning and providing tailored information
- **Family support** - providing extra and much needed support for carers
- **Transitioning** between different care settings easily
- **Productivity** - reducing administrative burden on frontline staff

Hertfordshire – focus on using telecare

Hertfordshire Council has gone into telecare in a big way. We see telecare as describing a service that is 20% technology and 80% people.

In terms of dementia, GPs have nothing to offer people with dementia. But why can't they be prescribed with a telecare gas sensor or a falls sensor, something that can make such a big difference to the person's and their family's life.

It's also more cost effective as it may support a reduction in home care visits and residential care. A third of our visits are 15 minute visits and telecare is playing a big part of changing these.

Another key area is medication prompts where telecare is enabling people to manage their medication in a much better way.

Telehealth is proving more difficult as clinicians can't work out where they will take the money out. It feels like a much longer road and they have not quite been brave enough to invest now to make those savings.

How can technology advance integration?

- **Budget constraints** – we are going to have to rely more and more on it as we can do less and less ourselves
- **Enabling tools** – if you are going to integrate, you need appropriate LA information systems and technology that will align systems and provide you with the information you need

"Innovation usually happens by entrepreneurs in their local area."

- **Link to easy to use smart technology** – changing generations are already equipped with smart phones and ipads. We need to be able to link solutions to explore APPs and services such as “Mindings”.
- **Information has to be easy to find** – invest in a good website with clear signposts and links to social media – the message here is to engage with the public in a different way.

“No one comes to my website looking for a DFG. They may be struggling to have a bath. They may want help because they think they may leave the gas on. We’ve got to think like them. Would the public know about telecare?”

- **Hospital discharge** – there is a huge missed opportunity – the audience is lying in bed waiting for telecare. What are we telling them?
- **Medication** – there is a huge waste of money on missed medication – what do you take, has it worked – you can’t got back to work in parts of Europe until you have feedback. Technology has a big role here

Take aways

- **Not to approach integration as professionals** – when in doubt, focus on the people – whenever there is a blockage or a lack of clarity; get focus through understanding what the user would want. If all the money was with the people who had the service, how would we behave differently and how would we talk to providers?
- **Communities/Peer support** – whether it’s scheduling new mums with experienced mums in the maternity waiting room, or scheduling hip surgery patients together, the evidence shows an improving understanding of what was going on and their outcomes when you link people together. In social care we have lost the notion of communities – need to look beyond the care system at how people in communities interact with and support each other- the whole system .
- **Shared vision** – does everyone across the system know what the vision is, and does everyone know what the implications of not doing something in social care (or housing or planning) will have in health - you have to get everyone signed up to the one vision.

Birmingham Telecare Service – establishing an independent quality assurance process

Tunstall have been supporting Birmingham City Council to roll out a significant telecare service in Birmingham. As part of this work, Tunstall have engaged the Good Governance Institute (GGI) to develop and run an independent quality assurance programme.

This is a ground-breaking opportunity to develop a sound understanding of care quality issues for telecare services, and for the Birmingham Telecare Service to contribute to a national quality template for telecare services.

Appendices

Appendix 1: ADASS East Region Participants

Name	Organisation
John Lewis	ADASS eastern region programme co-ordinator
Julie Ogley	Central Bedfordshire Council
Claire Bruin	Cambridgeshire County Council
David Goldberg (Facilitator)	Good Governance Institute
Iain MacBeath	Hertfordshire County Council
Pam Garraway	Luton Borough Council
Harold Bodmer (Chair)	Norfolk County Council
Jana Burton	Peterborough City Council
Roger Harris	Thurrock Council
Kevin Alderson	Tunstall Healthcare (UK) Ltd
Ali Rogan	Tunstall Healthcare (UK) Ltd

Appendix 2: David Goldberg Biography

David Goldberg is the International Associate for GGI. He has a master's degree in healthcare administration from the University of Colorado Medical Center. David's career includes 20+ years as a consultant to physician group practices, hospitals, health systems and HMOs. Working all over the world, he has held many leadership roles within health.

Further information

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