Integrating Health and Social Care Nottingham Case Study

1 Summary

With a history of innovation and a willingness to take measured risk, leaders in Nottinghamshire worked collectively to develop political support and vision ahead of a raft of projects and programmes designed to deliver the necessary improvements for the area and its population. Having the shared vision clearly set out enabled leaders to develop an understanding of what they were setting out to achieve across the system.

Overcoming silo working and cultural differences including a culture of blame and misunderstanding between teams was essential. Much effort was focused on the development of Multi-Disciplinary Teams (MDTs) which are based around GP surgeries and an investment in building relationships within these locality/community based teams. An evaluation of the effectiveness of the teams undertaken by Nottingham Trent University[1] has enabled evidence-led decision-making and to build on pockets of excellence to deliver better consistency across the system.

Shared IT systems have led to fewer hospital admissions, a reduction in overnight hospital stays and expedited discharges. However, a loss of skills through staff turnover is an ongoing challenge which is being addressed through shared training and the development of new processes to help embed improvements in working methods across the system.

2 Introduction

Like many other areas, the use of data within the Nottinghamshire area highlighted the need for integration and change. Identifying an explosion in the growth of numbers of older people within the area, increasing need and acuity of need, for example the growth in the number of people with learning disabilities living into older age, with dementia. They identified the need for efficiencies through integrated health and social care and an integration with the housing sector and the wider social market. The best way to deliver this was not only through integration, but through delivering the right outcomes in the right place at the right time and through the promotion of self-care. It was also identified that there appeared to be variation in health and social care delivery where service interventions were not always evidence-led.

Nottinghamshire has a history of innovation to draw from having been involved in a number of national initiatives including the Vanguard programme, and a willingness

[1] Nottingham Trent University (2017) *Evaluation of the Social Care Role in Integrated Primary Care Teams for Older Adults who have Complex Needs in Nottinghamshire. Final Report*. Prepared for the LGA Care and Health Improvement Programme by Professor Di Bailey, Dr Dominic Holland and Dr Gabriella Mutale in collaboration with Peopletoo, as commissioned by Nottinghamshire County Council. Available at http://irep.ntu.ac.uk/id/eprint/32630/1/10128_Mutale.pdf

to take measured risks and difficult decisions. In 2015 elected members set out their guiding principles for an integrated health and social care system across Nottinghamshire. This was to ensure that the wider system integration agenda within the area was not swamped in what was recognised as a larger more powerful health agenda and its capacity to potentially drain resources. The principles are given in the table below.

Areas	Principles
Outcomes	Achieves better outcomes for the citizens of Nottinghamshire through improving health and well-being
Co-production	Ensures services are planned and developed in a way that engages with the community (including service users, carers, the local community and the providers of services)
Rights	Service users' and carers' rights are respected and enshrined
Policy making	Ensures that social care statutory duties are met
	Ensures the delivery of the Redefining Your Council (RYC) transformation programme
	Ensures the requirements of the Care Act 2014 are met and fully implemented
	Ensures the underpinning Nottinghamshire Adult Social Care Strategy is delivered
	Ensures the ethos of social care is embedded in new arrangements
Performance	Maintains high performance areas and improves performance overall
Finance	Ensures that social care budgets continue to be effectively managed
	Future savings required from the adult social care budget are taken fully into account
Access to advice, information and advocacy	Enables a joint approach to a wide range of information and advice is offered in a proactive way and access to advocacy is provided
Workforce	Supports a shared and jointly developed workforce strategy which applies across health and social care professions
	Promotes the values, identity and skills of social care as a profession and these are maintained and developed through learning and research
Leadership	Ensures a balanced partnership with a strong contribution from social care, and social care leadership maintained at the highest level.

Areas	Principles
Demand management	Ensures that success with demand management from point of access to social care through to assessment and review is sustained and built on by embedding promoting independence
People are safe	Ensures effective safeguarding and deprivation of liberty arrangements are in place
	Ensures people can take risks to promote independence and well-being
Personalisation	Promotes choice and control to the service user and progresses integrated personal health and care budgets as one way of delivering this
Early intervention, prevention, promotion of independence and well-being	Ensures people have access to the right support at the right time to promote independence
Partnerships	Fosters integration/alignment with the wider Council and other partners, such as district councils, the community and voluntary sector and the independent care sector
Strategic commissioning and market development	Ensures an effective approach to commission and deliver services jointly across the County for older adults, people with learning disabilities, physical and sensory disabilities and mental ill-health.
	Develops and maintains a diverse range of choice and quality of care and support services in the local market, which are viable and sustainable
	Ensures that services commissioned are well monitored for quality and outcomes
Continuity	Ensures the delivery of a large scale, complex social care service can be effectively managed alongside the health elements in the transition to any new model
	Countywide services such as the Customer Service Centre or the reviewing teams are maintained until there is sufficient evidence base that they can be incorporated into integrated delivery models

The development of these guiding principles helped to inform the vision and outcomes that would guide health and care organisations as they designed and developed new integrated care delivery models.

The Nottingham and Nottinghamshire STP Leadership Board established 6 priorities for the integration agenda in the area, these are:

1. **Promote wellbeing, prevention, independence and self-care** - support people to stay healthy and independent, and prevent avoidable illness
2. **Strengthen primary, community, social care, and carer services** - improve access to GPs, help people with long-term conditions stay well and avoid acute care, and support frail elderly to live (and die) in line with their wishes
3. **Simplify urgent and emergency care** - help people to quickly and simply access the most appropriate provider for their urgent care needs
4. **Deliver technology enabled care** - use technology to help citizens stay healthy and manage own care, and to help providers deliver care more productively
5. **Ensure consistent and evidence-based pathways in planned care** - provide planned care with minimum avoidable variations in quality and cost
6. **Cancer and end of life care** - increase prevention, speed up diagnosis, improve the experience of patients and help people living with and beyond disease

Importantly, they also identified key supporting and enabling priorities:

1. **Drive system efficiency and effectiveness** - deliver organisational efficiency savings, by collaborating across organisations
2. **Clinical Services Strategy** - partnership working between Nottingham University Hospitals and Sherwood Forest Hospitals and Community Health and Care Services to ensure the ongoing provision of clinically safe, consistent, high quality acute and specialised care
3. **Improving housing and environment** - address the wider factors in society that impact on health and wellbeing such as the availability of suitable housing and green spaces and air quality
4. **Future proof workforce and organisational development** - introduce new roles, support areas where there are staff shortages and enable system change through organisational development and sharing resources
5. **Maximise estates utilisation** - more care in the community rather than in hospital should reduce the amount of estates. Benefits to be gained through reduced costs, reduced maintenance, making better use of existing buildings, and improved patient experience
6. **Proactive communications and engagement** - openness and transparency in developing plan. Engagement with public, including formal public consultation on any significant service change as required.

Enabling workstreams initially focused on:

- Integrating systems
- Implementing multi-disciplinary teams in primary care
- Integrated discharge arrangements
- Enhanced care in care homes
- Integrated personal commissioning

3 Governance, leadership and commitment

Early on, system integration leaders identified the need for involvement and engagement in the changes, particularly the need for local ownership so that people didn't feel that changes were 'being done to them'.

A significant amount of time and effort was invested in relationship building at all levels, to build trust, confidence and understanding across a complex system where pressures are enormous. It was recognised that without this and the phenomenal amount of effort that went into it, the changes needed couldn't be successfully delivered.

The leadership needed to move from a culture of blame and misunderstanding between teams. Austerity and lack of money proved to be motivators (as well as barriers) and the identification of social care colleagues determined to lead was felt to be very important. Workshops for colleagues involved in workstreams were established to build relationships and understanding. Staff were encouraged to attend meetings, particularly to represent the voice of social care and to challenge health colleagues' thinking, where there was found to be a greater level of risk aversion in care planning. Development of a shared language was also very important.

4 Delivering integrated care

A number of key initiatives and workstreams are focusing on the delivery of integrated care. One of these is the implementation of multi-disciplinary teams (MDTs) across the area which have focused on embedding social care roles into integrated primary care teams, based around GP practices. They focus on prioritising people heading towards a crisis and providing continuity of care rather than episodic care.

An evaluation of the effectiveness of the teams undertaken by Nottingham Trent University in 2017 found that greater embeddedness of the social care role encouraged a more positive, risk-taking approach with service users than might otherwise have been adopted by health colleagues. This led to cost savings and improved outcomes:

- A reduction in hospital admissions
- A reduction in admissions to residential and nursing care
- Greater use of lower level services that helped maintain service users' wellbeing and independence, enabling them to remain at home
- Service users remaining at home with care packages

Where integrated working was at its best, cost savings were made. For example, in Bassetlaw Integrated Team, total social care costs were on average £4,445.72 less per service (over the standardised period of 135 days used in the study) compared to Bassetlaw District. Total social care costs were found to be £2,750.28 less per service user (over the standardised period used in the study) in Newark Integrated Team compared to Newark District Team.

Savings were made because the teams were working more efficiently and making better decisions collectively. Taken together, the cost data and the care quality data suggest that effective integration offers higher quality and more cost-effective care for this cohort of older people with complex health and social care needs. Thematic analysis of the qualitative data from interviews with service users and staff supports this conclusion because it tells us how service users and carers experience the ways of working in an integrated team that generates decreased costs and increased standards of care. The finding that cost savings were only evident in two of the Integrated Teams supports a relationship between better integration and greater cost savings.

The study concluded that; embedding social care workers effectively saves social care costs but requires the right conditions including:

- Leadership
- Training
- A shared sense of purpose
- Sharing social care identity
- Confidence in the social care worker role

Where these conditions are not in place integrated teams increase social care costs.

Another initiative, the Housing to Health Project saw the introduction of four Housing and Health Coordinators across South Nottinghamshire. This project is based on the success of the “Assist” fast-track hospital discharge housing project implemented by Mansfield District Council, which has received national recognition. In the South Nottinghamshire project, one worker is hospital based and the other three are community based. The role is focused on helping to achieve urgent care targets through effective discharge and hospital admission prevention. All of the roles have been filled by staff with housing backgrounds and are funded through Better Care Fund funding through partnership working between housing, CCG, the districts and the relevant NHS Trusts.

These initiatives work well with a ‘Home First’ approach, which focuses on moving health provision out of hospital through the use of district councils’ prevention resources. Also aided by the adoption of a ‘Trusted Assessors’ approach within the Nottingham University Hospitals Integrated Discharge Team, which will see 3 cohorts of integrated health and social care roles trained in relevant competencies for transfer of care screening. This enables a patient to be discharged for home-based care package assessment through a method which is accepted by care providers outside of hospital. This can speed up discharge from hospital as well as reduce inaccurate or overly risk adverse assessments and duplication of assessment. While there is national guidance to help areas establish this process, the challenges of this approach are that it takes a lot of buy-in from relevant staff and a shared culture of trust to be used effectively. Nottinghamshire are currently funding this through their winter pressures funding, the challenge now is to make it sustainable.

5 Integrated personal care

This is a commissioning model which is being introduced using personal health budgets. It is about different conversations with patients (who qualify for continuing healthcare funding), moving the focus away from 'what's the matter with you?' to 'what matters to you?' making the individual more empowered and involved in their own care planning. Initial pilots have shown average cost reductions per budget of around 17%.

Nottinghamshire's advice for others who would like to adopt this approach is to:

- Start small and scale it up
- Do it gradually so as not to have a big impact on contracts
- Use real life examples to explain it to people
- Have a go, it's not for everyone
- Help providers to see it's not a threat to health jobs, for example training personal assistants to do a range of short-term health tasks to avoid lots of professionals visiting separately
- Work with the willing
- Focus on the person and the systems will follow

6 Shared systems

Nottinghamshire is working towards having ICT systems which can do the following:

1. Enable staff from any social care team to have a view through a portal into health records for any particular service user, using the NHS number as a matching field
2. Enable health staff to have a view of social care data through the same portal, for any particular patients, using the NHS number as a matching field
3. Send automatic messages or "workflows" between health and social care to trigger actions or update on existing information when things change eg. to send Assessment Notices from NHS straight into the social care system as a new contact, to send a message to the allocated worker in social care if a patient moves ward or gets discharged

Matching via NHS Number works well because 97% of social care records in Nottinghamshire have an NHS Number and links are being made into the NHS Spine to ensure that these are checked and updated regularly.

The portal view (1 and 2) should be implemented by January 2019 and automated assessment notices were launched in May 2018. This has shaved an average of 4.5 hours off the previous processing time for referrals of hospital patients to social care. Further messaging will be available in the autumn. Another messaging system already in place in one NHS Trust allows clinicians at the front door to retrieve information about whether a patient in ED has a care package already in place or if there is any safeguarding alert. This is available 24/7 and enables better clinical decision-making. It also helps reduce the requests to social care to "look people up"

on their system and has led to an estimated avoidance of circa 15 hospital admissions per week.

6.1 Workforce

Nottingham and Nottinghamshire have established five specific workforce workstreams that will provide the foundation for the development and delivery of a costed, five year workforce plan to deliver Sustainability and Transformation Partnership (STP) ambitions. The plan will build capacity and capability across the system to re-design the workforce of the future, enable them to be deployed more flexibly to where their skills are needed, and equip them with the skills to work in new ways and in the new teams of the future.

A successful integrated workforce model aims to:

- be evidence-based, or, if innovating, evaluate the purpose and impact of the model with regard to social care, as well as health objectives;
- blend health, social care and other professional roles such as housing, maintaining the core professional knowledge and skills that social care offers, whilst enabling some tasks to be completed across roles;
- have a clear joint workforce delivery plan that includes supporting and facilitating the local provider market workforce;
- be supported by clear governance arrangements for monitoring delivery of the workforce model and plan, managing performance, risks and rewards; and
- be supported by a joint workforce learning and development plan that promotes the delivery of core social care strategic objectives, as well as health and other agencies. This will include:
  - an improved integrated information and advice offer as a first option for people;
  - embedding a focus on prevention at all stages of working with people through for example, reablement, promoting independence, technology enabled care and self-care;
  - a shared understanding, framework and tools to proactively manage risks to maintaining independence; and
  - targeted, proactive multi-agency work that includes factors to predict people at risk of requiring social care packages and residential care, as well as using health data to prevent hospital admissions.

7 Next steps

With various stages of development across the system, some work is more advanced than others and there is still much to be done. Future work plans include:

- Review of commissioning to move towards integrated commissioning systems with an overarching architecture for joint commissioning
- Workforce planning – social enterprise led. There is a plan but further iteration and development of it are needed

- Assistive Technology – with seven councils and six CCGs in the area all using different processes and seven different call centres, there is potential for efficiencies through better join-up of these services
- Further development of MDTs