

Opportunities to exploit and challenges to overcome in the implementation of integrated care

An OPM Policy Paper

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-
- 01** Introduction
 - 02** Challenges to overcome
 - 03** Opportunities to exploit
 - 04** Conclusion

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Introduction

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This paper is intended to aid policy makers and local health and social care leaders who are taking the integration agenda forward. Informed by a recent roundtable discussion, as well as OPM's own experience, the paper shares lessons and insights from people actively implementing different integration models.

Last May the Department of Health published Integrated Care and Support: Our Joint Commitment, a document which set out a national commitment to support the integration of health and social care, from a commissioning and service delivery perspective.

Following this, the Better Care Fund (formerly the Integration Transformation Fund) was born, enabling local authorities and CCGs to bid for £3.8 billion of funding set aside for local integration plans. This fund provides real opportunity and incentive for local health and social care integration, but it also comes with strings attached in the form of demanding conditions and targets. While local commissioners wait nervously, NHS England has begun assessing whether their plans are up to the job.

When it comes to health and social care, integration is currently the only game in town. Its success is predicated upon a change in mind-set from all those working in the field. Organisations and individuals will be required to collaborate better, especially around risk sharing, planning, sustainability and contingencies. Similarly, leaders and managers will need to retain a good sense of perspective and remember that as important as

accessing the Better Care Fund (BCF), or indeed achieving health and social care integration are, not in themselves the goal - merely the means by which better outcomes are most likely to be achieved.

Meanwhile a number of outstanding issues remain. These include how to reconcile the different models and approaches to integrated care that vary considerably across localities; how to encourage the move from horizontal to vertical integration; and how to ensure that the BCF fairly shares risks and benefits between all parties.

This paper is an attempt to uncover some answers and offer some insights on these and other issues relating to integrated care. Our thinking for it has in part been informed by a recent roundtable discussion, which included representatives from public health, the integration pioneer sites, local authorities, CCGs; as well as advocates for careers, patient leaders, health and social care providers and the voluntary and community sector.

We are grateful to all of those who participated for their time and contributions.

Key messages

- ◆ The Better Care Fund (BCF) is stimulating different and distinctive approaches to the integration of health and social care, creating a set of local design experiments. The context for change, such as financial pressures and rising service demand, raises risks that are not well understood. While allowing for local responses to the BCF, there remains a national need to track, observe and communicate the benefits and risks of different integration approaches, both in terms of service planning and design, as well as creative approaches to financing and incentivising integrated care.
- ◆ Taking a whole system approach to integration means including the often untapped potential of service users, careers and the voluntary sector in the design and delivery of integrated care. Some of our round table participants felt strongly that innovation is more likely to arise and flourish where there is direct involvement of users and community groups.

- ◆ Designing integrated care requires operating simultaneously at three levels: at the system level (strategy, governance and allocation of resources); at the service level (commissioning, operations and service re-design); and at the interface between service users or carers and their care providers (delivery of care in new and better ways). Each level raises opportunities for how to work differently, challenging existing boundaries and behaviours between system leaders, commissioners, providers, professionals and service users. Transformation of the whole system to integrated care will require all to adapt along a journey of change, to tolerate some risks and to accept ambiguity. Strong, consistent local leadership is therefore essential, and leaders need ongoing support to succeed at their efforts.
- ◆ Sharing learning more widely will help build sustainable integrated care systems and tackle the risks of people working in isolation and getting stuck. Our round table suggests that opportunities for knowledge exchange, collective problem solving and action learning are being sought after - and not just from the Integration Pioneer sites. National and regional support is needed to create the time and space for these types of activities.

Challenges to overcome

Assessing Risk

Perhaps the biggest threat identified to the integration agenda is the need to manage the different types of risk that have arisen as a consequence of closer working between organisations and institutions.

Some of these risks are financial – such as the feeling that the scope and budget of the BCF is unfairly weighted against social care providers who have very little opportunity to influence major decisions.

Others stem from teething problems between increasingly overlapping areas of practice and accountability. For instance the different, sometimes conflicting, approaches to assessing patients' needs conducted by individuals with exclusively health or social care backgrounds has in some cases led to a situation where

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professionals trained in one discipline do not trust their colleagues from another to carry out needs' assessments properly.

On this front it is hoped that the Care Bill currently winding its way through the Commons will offer some much-needed clarity around which professional is the most appropriate to assess different patients' needs.

Nevertheless tensions and suspicions between the medical and social models remain, and the reversion to type which these negative attitudes cause, leads to a stifling of innovation and thus a dearth of creative solutions to complex problems.

Combatting a territorial mind-set

Risk may be the issue on which health and social care are most likely to clash, but the underlying cause of these clashes is the reluctance of organisations to relinquish control and work more collaboratively on areas which have previously been their sole responsibility.

Giving away power is a daunting prospect for anybody but with the current funding situation firmly weighted in favour of the acute sector, securing the buy-in from those who could see themselves as worse-off in a new, zero-sum, budgeting game will be especially difficult.

At the same time despite having less at stake in the restructuring of services and less of a tradition of making cash savings, the acute sector is already diversifying into the community and offering more services traditionally delivered by the voluntary and community sector; a development which the VCF understandably perceives as a threat.

Operational changes will only succeed if they are accompanied by an attitudinal shift. Thinking about certain practice areas, activities or budgets

as either health or social care lures us into the false dichotomy of seeing any changes to the current status quo in terms of ‘winners’ or losers’.

Sharing success more effectively

While there are numerous good examples of health and social care integration working in practice, these examples are often isolated and unequally distributed. Many areas which have piloted new integrated pathways have experienced success, yet it is important to remember that these positive examples of good practice don't reflect the wider picture. In order to be deemed a success, pilots must encourage the spreading of innovations beyond their own boundaries; and to do this they must be used intelligently and designed in a way that is scalable, transferable and repeatable.

There is also evidence to suggest that some areas which have historically had problems or experienced strained relationships between the health and social care sectors are now making the most progress. These areas experienced difficulties early on in their integration journey, and as such were prompted to implement whole systems change – propelling them further and faster along the road than those who are more comfortable with present circumstances.

The realisation that those engaged earlier in integration are more likely to be experiencing improved outcomes applies to people as well as places. For example those areas where personal budgets were introduced earlier have, by and large, responded to and met the needs of users and carers better than the system which preceded them, and for less cost. However in those areas where personal budgets have been introduced late, patients are often resentful of the new system (which they see as imposed upon them rather than designed in collaboration with them), and unable to capitalise on the benefits derived elsewhere, because the supply-side of the market has not had the chance to catch-up with the increased choice the personalised approach offers.

Encouraging better decision making

There is evidence that suggests people who are faced with the prospect of paying for their own social care, under the FACS eligibility criteria, are sometimes choosing not to do so. The impact of such decisions is often costly to both the individual's health and to the departmental

budgets, as the eschewed care package could be the intervention that reduces that person's likelihood of entering acute services or supports them to self-manage their care. As the number of people who fall under the FACS eligibility criteria grows, it will be vital for teams to find a way to encourage them to make the choices which are most likely to lead to improved outcomes.

Opportunities to exploit

Harnessing the potential of the VCS

Generally, the voluntary and community sector (VCS) remains an underused resource. In procurement for example the VCS could be playing a much more substantial role in managing the interface between acute and community sectors, an area where they already have considerable experience.

There are certain areas where this is happening, but not enough. One London borough currently uses the VCS to do all care and support planning. They have realised that the VCS tends to have superior local knowledge to local authority social workers because of their strong community roots. However in order for such initiatives to succeed clear governance structures must be put in place first.

Some VCS organisations also have the edge on innovative ways of engaging with service users and co-production, via community groups and peer mentoring, which are essential in capturing what works in delivering the best care for people.

Better collaboration with providers

In most areas around the country providers remain an underused resource. Their knowledge of the local market and what works in addressing need is frequently second to none, yet they remain under-engaged and excluded from most major decisions.

Commissioners and local authorities would do well to build a more mature and equal relationship with providers in their area. Evidence shows that in areas of the country where this has genuinely happened, providers are helping to encourage more intelligent commissioning by informing commissioners of innovative practices they could be doing and making a business case for introducing these.

This new commissioner/provider relationship should also have at its centre a fairer sharing of risk, whereby providers are not liable for costs outside of their own control.

Commissioning more intelligently

There is a real opportunity for commissioners to make more use of the Public Services Social Value Act. The Act requires commissioners to consider the social value of services they commission, but to do this effectively commissioners must first engage extensively with users and the public to see where the social value to the community of any service truly lies.

Empowering professionals and managers

Professionals and managers need to be involved in conversations about how they manage and reduce their own budgets. Such full and frank discussions are inevitably difficult, but where they have been trialled the suggestions they put forward have been immensely useful.

Most importantly, professionals and managers need to accept (and quickly) that more of the same is no longer a viable option. Integrating health and social care during a time of financial constraint is a considerable task and as such there needs to be a fundamental change in the operational and attitudinal behaviour of staff on a day-to-day basis.

Considerable effort will have to be put into building and maintaining new partnerships, while individuals must have the courage to identify and champion innovation when they see it. Colocation is one simple but effective way of encouraging these fundamental changes to take place.

New Alliances with Public Health

There are increasing opportunities for collaboration with Public Health, especially in working with children and adults on early intervention and prevention initiatives. Using intelligence in an integrated approach supports commissioning processes and an overall enhanced understanding of a locality's needs. Investment in prevention and early intervention is crucial to managing demand for integrated care.

Guidance from Government

There is a need for more guidance from central government which takes into consideration the wide body of evidence-based practice around integration, including best practice from European

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health and social care systems. The stipulations in the BCF that 7 day working and key workers are an obligatory part of integration is welcome, but more could be done, especially around the transition of people from children's to adult services.

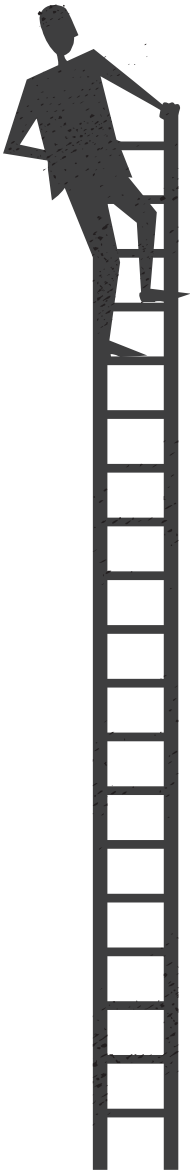
Conclusion

This is a pivotal time for integrated care as localities begin to use the Better Care Fund as a vehicle to drive evidence based good practice forward. While the diversity in the different models of integration practiced from place to place is striking, there is also a clear and common theme that unites all approaches: a desire to achieve attitudinal shift and relationship change.

In the coming weeks and months, as the benefits afforded by the BCF come to bear, it will be vital to ensure that these various communities of integrated practitioners continue to share their skills and experiences beyond the boundaries of their own locality, to facilitate the cross-pollination of accumulated learning.

About OPM

OPM helps local authorities, CCGs, community and acute sector providers and the voluntary sector to implement integrated care. We offer support from strategy to evaluation as well as leadership development, commissioning support and master classes. This includes development and training for senior management teams and practitioners, as well as programme management.



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