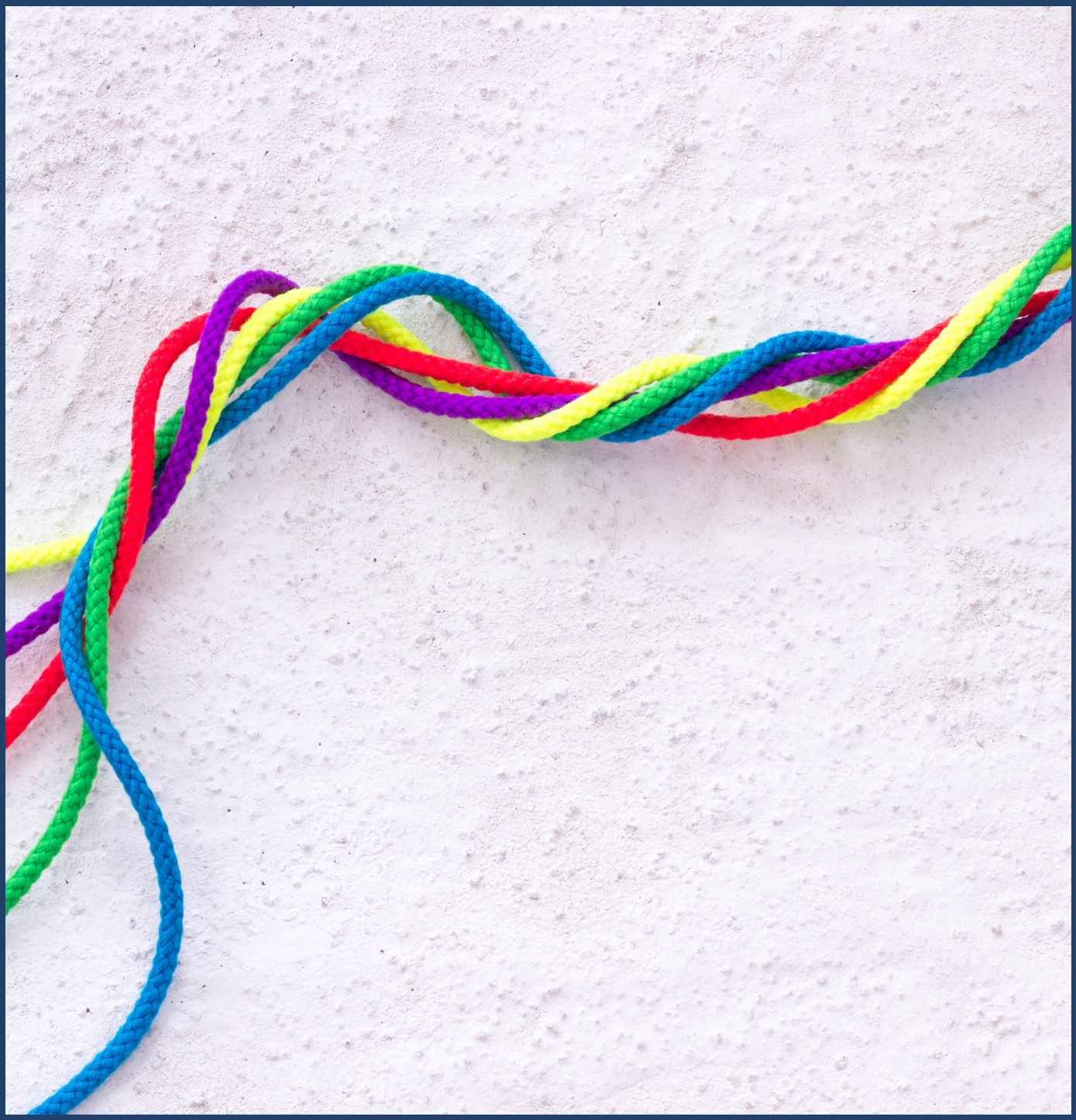
Institute of Healthcare Management

Integrated Care

2021

GREEN PAPER



Welcome

The Institute of Health and Social Care Management convened a group of interested members to explore integrated care across geography and disciplines. The special interest group have shared examples of integrated care, often at grass roots level. This report highlights a number of those examples with the purpose of sharing them wider, inspiring action and identifying recommendations for government, policy makers and leaders. Our big thanks go to the group members for their contribution and insight.

We've identified three common themes:

- Integrated care has many benefits but crucially must be built around the person
- Integrated care is not the norm, in fact, nowhere near
- There is a strong will from people working in health and social care to work in an integrated way but there are many barriers for them to navigate. Many of these barriers began to come down during the first wave of the Coronavirus pandemic but they are creeping back in.

We've included some real stories about people who have struggled when accessing or receiving services, either for themselves or a loved one.

Our call to action:

Our hope is that you are inspired to act after reading this. You will probably know cases where people have experienced similar poor outcomes. You will undoubtedly know practices that can be improved within your workplace or service. You might wish to try some of these ideas or take aspects of them that you think could work where you are. Please do!
And if you do, please get in touch and tell us about your successes or learning so we can continue to share widely.

History

Integrated care has been high on agendas for years.

60s multi-disciplinary working

70s partnership working

80s shared case and disease management

90s integrated care

There are endless strategies, policies and reports focusing on integrated care and yet we still find ourselves in a position with sporadic pockets of good practice rather than integration being the norm.

P's Story

In April this year, at the height of lockdown, Dad had a fall resulting in him requiring several trips to A&E. The first time I was allowed to stay with him due to his dementia, I was able to settle him and he was sent home. However, the second time I wasn't allowed to stay with him, they would x-ray him and give me a call to collect him in a few hours' time. That call never came.

Dad became very confused after I left and he tried to leave, resulting in him having another fall which kept him in hospital for 3 weeks. I pleaded with the hospital to consult me before they took any decisions regarding Dad's discharge. I also strongly recommended that he should not be discharged until a home assessment was undertaken. My concerns were disregarded, and Mum received a call that he was on his way home with a package of care in place. He arrived home minus his glasses and teeth which were lost in the hospital.

The care package was for 3 care visits a day but it just didn't meet his needs. Over 4 months Dad went from being a man who could walk up and down stairs and recognise his family, to someone who refused to move, barely ate, verbally and physically aggressive towards Mum (causing the neighbours to ring me on several occasions), doubly incontinent and who had no knowledge of where he was or who his family were. The only person who rang to check on him was the receptionist from the GP surgery.

Mum, also frail, couldn't cope and the end, I took the difficult decision to go against her wishes and raise Dad's care as a safeguarding issue with his GP. A telephone consultation was arranged for a couple of days later. Before that call happened, Dad tried to get out of bed and fell. He was taken back to A&E with a fractured pelvis, he now weighed less than 6 stone!

Again, I pleaded to be informed regarding any discharge decisions. 2 weeks later I was contacted by the discharge planner and informed that Dad was going to move into a care home under Section 2 of the Mental Health Act, awaiting assessment. I had no say in the choice of care home and was not happy with the one they chose. I was bounced between social workers who were new to Dad. Mum, isolated, wracked with guilt as she equated care homes with death from COVID-19, is not coping.

Recommendations for building around the person

- supporting advanced planning
- identifying outcomes
- shared care records

GOOD PRACTICE EXAMPLE
advanced planning

ReSPECT – Recommended Summary Plan for Emergency Care and Treatment

Resuscitation Council UK has created a range of resources about decision making during COVID-19. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment. Patient preferences and clinical recommendations are recorded on a non-legally binding form which can be reviewed and adapted if circumstances change.

The ReSPECT process can be for anyone but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

The ReSPECT process is increasingly being adopted within health and care communities around the UK.

GOOD PRACTICE EXAMPLE
identifying outcomes

Doris Jones Home Care

Mr A has Parkinson's and called us for help once a day to help with personal care. The couple are independent and were reluctant to have help. We assessed and started an early morning call which was going well until Mr A had a sudden deterioration in his health and was admitted to hospital with a chest infection, he was an inpatient for 2 weeks during which time he did not get out of bed. On discharge we were contacted to resume care but told he would need more support, a hospital bed and hoist. The community rehab team were not visiting during the pandemic.

Our physiotherapist visited with the care workers to reassess mobility during lunch when he was less tired. The team were instructed to use a sit to stand practice from the chair as exercise. Within 3 weeks Mr A was only hoisted to bed at night and was beginning to stand for transfers to the commode and to bed. Within 6 weeks he was able to be assisted safely with one person in all transfers. At no point was he reassessed by the NHS team but we communicated with the OT and updated her on the progress.

Having an in house Physiotherapist in our team enabled, at no extra cost to the client, significant improvements to Mr A's wellbeing and his wife's. When referring back to home with care in place, the input of the therapy teams is so essential to progress and rehabilitation. Often we find the links with the community rehab team are patchy and we need to promote ways to enhance the use of social care as part of rehabilitation by setting clear goals and being more open to making adjustments to care plans.

GOOD PRACTICE EXAMPLE
shared care records

The Yorkshire and Humber Care Record

The Yorkshire and Humber Care Record (YHCR) is an umbrella title for the technology and an associated implementation capability which facilitates record sharing in the Yorkshire and Humber region.

At the heart of the YHCR is the System of Systems (SoS): an interoperability platform that enables data providers to share data with data consumers. The SoS is currently live and is exchanging data between certain organisations within the region. The purpose of the SoS is to ensure that:

1. Relationships between providers and consumers are secure.

2. Data standards are adhered to.

3. Data is shared in compliance with data access policies such as consent.

G's Story

Dad was 79 when he had his first stroke. He lived alone with his adored Doberman, highly active and a varied social life. He lived about an hour away from my wife and I, and would spend most weekends with us, walking the dogs together. He hadn't really needed much input from health or social care in the past, but that all changed.

Initially he went into the general hospital but was moved a couple of weeks later to a specialist rehab hospital where he stayed for a couple of months. He then came to stay with us for a few months and received support from a community stroke rehabilitation team. It was during this time that, after a lot of pushing from my wife who saw the signs, Dad was diagnosed with vascular dementia. He insisted on going home after a few months and did so with a care package. After the second visit he refused the service because the care workers were upsetting his dog (the dog was aggressive, so it was the other way round).

He then spiralled into crisis, unable to care properly for himself, not remembering to take his medication and relying on visits from us which were simply not frequent enough. This broke my heart to see my Dad, my hero, in such a vulnerable state. Eventually we all made the decision, as a family, that Dad would move in with us permanently. This was a huge wrench for him because it meant leaving behind everything he loved about his life, the boxing club, his home, his friends, and worst of all his beloved dog.

At that point, the support for Dad almost completely dried up. His new GP was excellent but overstretched. It was impossible to get any support to cope with the dementia and we struggled through a difficult time. Dad never had a Social Worker and we never had anywhere we could go to for advice or support when things got tough. The once amazing relationship between my Dad and I became fractured as he deteriorated. Whenever we did take Dad for an appointment, we had to explain everything over again. Often, they wouldn't even know that he had dementia.

After 5 years, we weren't coping, and we felt that we were letting Dad down. The difficult decision for Dad to move into a local care home. Dad is forgetting who I am. He's deteriorating and becoming distressed but because of COVID-19 we can barely see him.

S's Story

Although the treatment and care Mum received at the end of her life was good there are a number of areas that caused significant anxiety and suffering. From leaving hospital after recovering from treatment she was still quite poorly. She was coming home to a family who could support her with some form of help at home. She left hospital on the Thursday before Easter. No help or contact was provided, and she deteriorated rapidly.

Eventually we got through to a Macmillan social worker, who was able to get her admitted to our local hospice on Easter Sunday. Only by knowing about continuing healthcare was I in a position to ask for a home care provider that I knew. Social workers only provide names of local authority registered providers. We needed so much more information, laid out in an easy format.

I've since discovered that I could have paid privately for a social worker, which we'd happily have done to get Mum the support she needed. There were so many people involved in her care but no one person who had overall accountability.

The package of care she received was not what she needed, and we ended up sending care workers home because there was nothing for them to do, this was incredibly inefficient and costly. Not person-centred at all.

When Mum passed away, we had so much equipment at home but no one to give it to. Neither the NHS nor the hospice would not accept it back. Again, I felt this was very wasteful. We ended up giving it to a church who sent it to Africa. There must be a way of disinfecting this type of equipment so it can be used by the NHS again.

Recommendations for leadership

- collaborative leadership
- creating culture
- embracing digital
- reducing barriers
- research

Collaborative Leadership has become increasingly vital in today's health and social care landscape. Well networked, team-based, and partnership-focused approaches are key drivers for integration, yet relatively few leaders have been trained or are supported to lead collaboratively. It is also important to recognise that there are leaders at all levels.

GOOD PRACTICE EXAMPLE collaborative leadership

Collaborating Out Loud as a System in Pendle East

A system leadership programme for Pendle East (for staff linked to the regulated care sector).

Group member Paula tells us:
We purposively planned to convene a group of people based on the area they worked within and not (as lots of leadership programmes offer) be restricted to a certain professional role.

Participants come together to talk about their roles within their local systems and how they can best collaborate in a place, choosing to be 'operationally agnostic' where possible.

The aim is to develop a community of leaders who can explore building a new normal together. To build relationships and connections across different boundaries and across the unusual suspects as well as developing tools and resources that can be used by others.

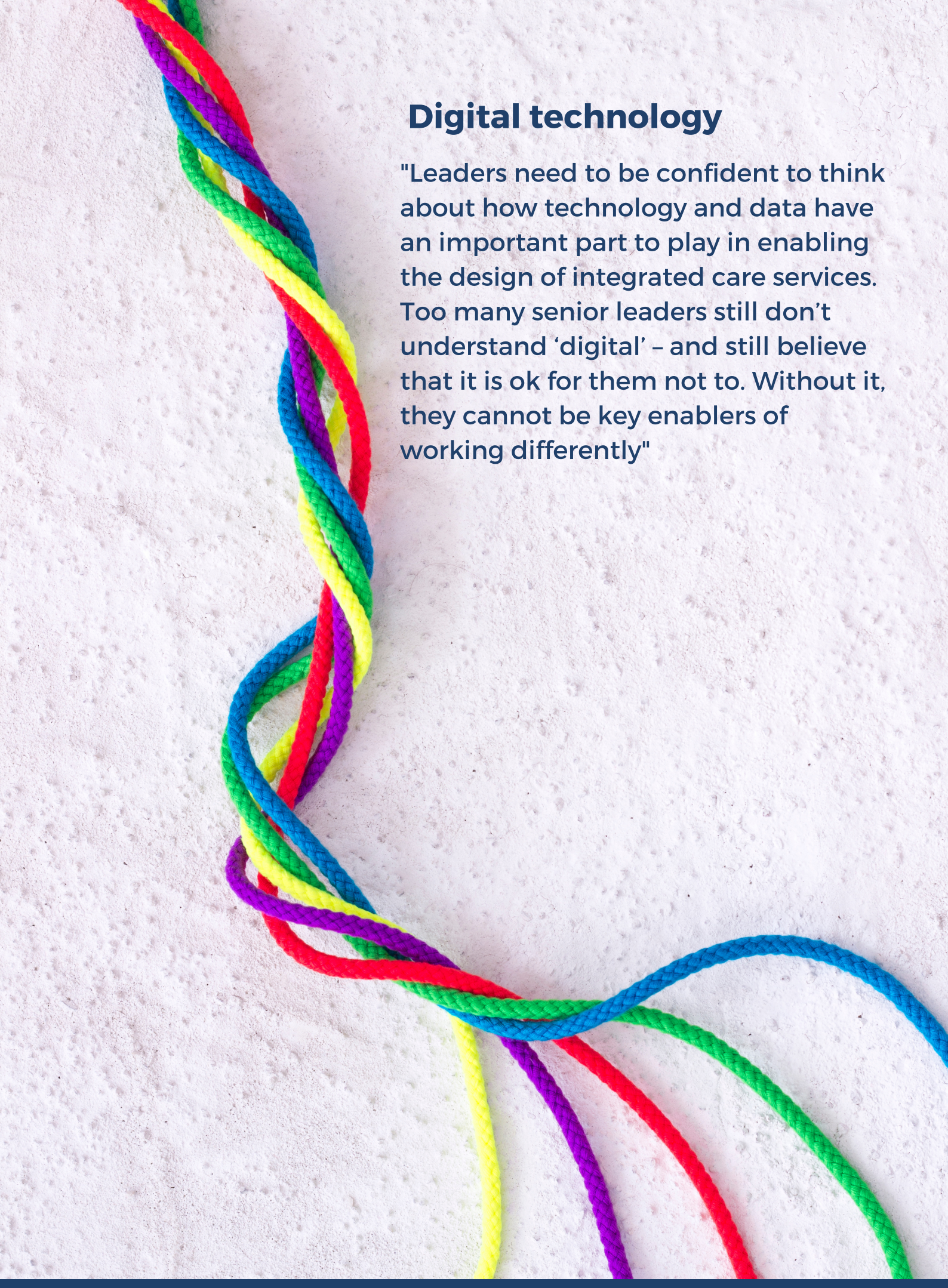
GOOD PRACTICE EXAMPLE
creating culture

Age UK Bradford District - Integrated Care Team

Age UK Bradford District is an independent charity supporting and enabling local older people to love later life. Services are delivered throughout the Bradford community.

The Integrated Care Team was formed to provide a dedicated and trusted point of contact for individuals, carers and families to assist with the navigation of their care and support planning. Aiming to provide advocacy on their behalf and developing strengths based ways of supporting people with complex care needs, to remain independent for longer and experience better health and wellbeing.

The Integrated Care Team work collaboratively as part of a local integrated health, social care and voluntary sector team. The team is led by an Integrated Care Manager and staffed with Personal Support Navigators, Support Workers and staff from designated projects, ensuring services deliver against agreed outcomes and framework agreements and that individuals supported receive person centred, pro-active, co-ordinated care and support.



Digital technology

"Leaders need to be confident to think about how technology and data have an important part to play in enabling the design of integrated care services. Too many senior leaders still don't understand 'digital' – and still believe that it is ok for them not to. Without it, they cannot be key enablers of working differently"

GOOD PRACTICE EXAMPLE
embracing digital

Greater Manchester Combined Authority

Greater Manchester Combined Authority has created a Digital Blueprint which makes a specific commitment to ensure that public services are intuitive, joined-up and available to all.

To date, health and social care services have largely progressed integration through the creation of multi-disciplinary teams to meet regularly, share information about cases and more effectively make decisions about care for their patients or people accessing services.
This has been achieved largely through physical meetings (which will have shifted online through the pandemic), with attendees from each partner organisation bringing the perspective and representing the position of their service within the conversation.

There has been almost no visibility of data across partners –- largely due to the inability of IT systems to enable it and also nervousness around the legal right to share data between services. As a result, the business processes have not been designed to make them easy and joined up for the patient/service user. The work that GMCA are doing is challenging some of the held beliefs that data can't be shared. It's also starting to look practically at the mechanics of making that happen including digital technology which can be outdated or completely lacking in social care.

GOOD PRACTICE EXAMPLE
reducing barriers

Frimley Health & Care Integrated Care System

The Frimley ICS is a partnership of collaborating organisations working together to provide health and social care services for the local population. At the 2020 conference, sessions were held on creating an integrated culture and system collaboration, with involvement from senior finance staff working at Frimley Health NHS Foundation Trust. Examples were shared of how to reduce barriers to the provision of integrated care.

The new approach requires that people adapt working practices including the formation of joint roles, and an evolving "back office" function. There is a need for a shared financial framework and system-wide plan, with closer working between all system partners and a clear governance structure; developing a new financial framework to facilitate distribution of funds equitably. This may be achieved by:

- Focus on value and cost
- System control 'one system, one budget'
- Pooled funding and risk share arrangements
- Moving to outcome based payment systems

A foundation for this integrated working has been the taking of an "open book" approach to financial, quality and operational data between organisations. A good recent examples of this is the Operational system dashboard built in

GOOD PRACTICE EXAMPLE
reducing barriers

Frimley Health & Care Integrated Care System Continued...

response to COVID, with a view to pinpointing issues and developing an early warning system for both COVID and non COVID patients. Data were collated from primary, acute, community, national, regional, OOH, 111 and care homes to provide an operational view to support with the pandemic planning.

This model assists with support and resource allocation, and will also be utilised post COVID.

The ICS has also formed the Frimley Leadership & Improvement Academy to improve faculty support change across the system. The 'Wavelength' leadership programme is driving transformation through effective working between clinical, operational and digital experts, by applying learning from national programmes at a local level. The training course is now in its 3rd cohort of delegates..

Research is an essential tool for supporting people to successfully navigate our complex sectors. Without it, we would need to rely solely on intuition, other people's authority, and pure luck.

GOOD PRACTICE EXAMPLE
research

Research is being undertaken by researchers at Lancaster University who work with the National Institute for Health Research (NIHR).

The Voluntary, Community, Faith and Social Enterprise Sector (VCFSE) has had a significant role within local systems in responding to the immediate and longer-term effects of the COVID-19 pandemic.

In this research we are exploring the response of the VCFSE sector in the context of the Lancashire and South Cumbria Integrated Care System (ICS); an ICS that is interesting because of its recent efforts to develop partnership working with the VCFSE sector.

In addition to providing insight into the COVID-19 response, this research will look more broadly at opportunities for partnership working to support health improvement, drawing upon practices, experiences, and expertise from within the Lancashire and South Cumbria ICS and across its regional footprint. It's anticipated that findings from this work will inform funding bids for a more substantial and comparative piece of research that will consider the approach to VCFSE engagement in different ICSs.

This guide is produced by the Institute of Health & Social Care Management in association with its Special Interest Group membership focused on Integrated Care.

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