

## **CSA response to the Care Act guidance on integration and cooperation**

### **The Care & Support Alliance (CSA)**

The Care & Support Alliance was set up in July 2009. It is a consortium of over 70 organisations that represent and support older and disabled people, including disabled children, those with long-term conditions and their families, and campaigns to keep adult care funding and reform on the political agenda.

### **Overall comments**

The CSA broadly welcomes the draft guidance on integration and cooperation. Clarifying how these duties will work in practice goes some way to addressing an issue which often features as a key concern for people who use services.

We particularly welcome the following points:

- The connection between these duties and those in the Health and Social Care Act 2012.
- The separation of the different levels at which these duties apply
- Recognition that integration is not necessarily about organisational integration but about how to create a seamless service from the point of view of the person (although this could be brought out more strongly at the top of the document)
- Multi-disciplinary working to enable the alignment of processes (but again, this could be developed further as set out below)
- The explicit mention of NHS continuing care and that the boundary between what is health and what is social care has not been changed by the Care Act
- The recognition of the crucial role of housing within the care and support system, how good quality information and advice can allow for people to make early choices about housing options and the role local authorities can play through joint planning and commissioning.

Although we agree that it is useful to not prescribe a single method of integration and cooperation, including further examples of ways that local authorities and partners have overcome common barriers (e.g. sharing information) might be useful in any further planning implementation guidance.

It will be equally important to ensure that guidance for health, social care and potentially voluntary sector providers (through the new Integrated Personal Commissioning Programme) on assessment and care and support planning is as consistent as possible to ensure the best use of limited resources and avoid people going through duplicative or conflicting processes.

### **Detailed feedback on the draft**

#### Definition of person-centred, coordinated care and support

Section 15.1 cites that the vision of this section of the Act is to create “integrated care and support that is person-centred” but this is not defined.

National Voices and TLAP have developed a [Narrative](#) that sets out what person-centred, coordinated care feels like from the perspective of those who use services. This was adopted in May 2013 by the National Collaboration for Integrated Care and Support as the foundations for their [‘Shared Commitment’](#) document. It has also since been used by a number of local partners to shape the development of their integrated care programmes.

Referencing this definition of person-centred coordinated care and support upfront will not only strengthen the connection with existing integration policy but will also ensure a continued focus on the individual and how they experience coordinated care.

Recognition of the value of integration and cooperation in relation to care and support planning

The cross references to other sections of the guidance (15.3), including prevention and information and advice upfront is really positive. We would also like to see recognition of the importance of care and support planning being conducted in a coordinated way too, via a cross-reference to this section of the guidance.

Care and support planning is central to ensuring that professionals understand what matters most to person, and that the services they receive will be most likely to have a positive impact on their wellbeing, and prevent the development of additional needs.

As set out in the care and support planning section of the guidance in more detail, it is important that this process acknowledges any additional points of contact with the system early on in the process, recognises the person's needs and strengths as a whole and ensures that the final package of care fits together in a way that works for them.

An additional case study

Although we very much welcome the inclusion of the case studies on housing, we would suggest that an additional case study also be inserted on p.229, which reflects the barriers in relation to social care more explicitly. We would like to put forward the following case study below for inclusion.

The comments on the housing section of the guidance below set out how the existing two case studies could be redistributed within this document and in other parts of the guidance.

**Promoting the integration of health and social care with regards to carers support in Torbay and Southern Devon Health and Care NHS Trust**

Torbay, a 'Care Trust' or organisation responsible for health and social care, takes a 'whole system' approach to the identification and support of carers. They worked with clinicians in primary care and the acute trust to develop an evidence base to show the positive impact early support and access to services has on carers' health and wellbeing. This led to recognition that carer support is the joint responsibility of primary and acute health services and social care as well as an understanding that carers can be a 'reluctant audience' and may not identify themselves until in crisis.

Torbay has used joint CQUINs (commissioning for quality and innovation payments) to drive change. They developed a model founded on having Carers Support Workers at key points in the carer's journey in all GP practices, in the Acute Hospital Discharge team and in specialist community teams such as Mental Health and Substance Misuse. These workers provide easy access to support, advice to other practitioners, and signpost carers through the system. They also target key staff groups for development; for example the 2013/14 focus has been on training and encouraging district and community nurses to identify and signpost carers to support. This has significantly increased referrals as well as raised awareness.

A pathway exercise was undertaken with staff and carers to map the carer's journey through the whole system and the points at which engagement did, or could, happen. This has led to changes such as Carer Contact Cards, which includes key information on where carers can get support, in all discharge folders and a new Carers Policy for Torbay Hospital.

Providing simple, easy to access services for all carers such as Signpost's information service, a Torbay carers register and carer education programmes, that are not subject to eligibility criteria has brought carers into support much earlier therefore reducing crises

### The role of the voluntary sector

Section 15.8 does not explicitly recognise the value of working in partnership with the voluntary and community sector, in terms of accessing data on certain groups to inform planning, having sector representation present at Health and Wellbeing Board meetings and the delivery of care and support itself.

Section 15.22 similarly does not recognise the voluntary and community sector as a partner with which the local authority should cooperate. It is important to rectify this omission given the central role of VCS providers in co-delivering many adults' care and support packages.

### Combining and aligning processes

Despite references to care plans and the value of joint plans in supporting more integrated care and support delivery, section 15.8c does not recognise the benefits of more integrated care and support planning processes themselves.

If the various professionals in contact with the person do not cooperate throughout the process, there is a risk that the individual will have a series of separate plans, with the services they include being disconnected or retrospectively coordinated. This is not consistent with the wider wellbeing-focussed and person-centred vision of the Act.

Section 15.15 similarly deals with aligning assessments but does not address the value of a joint care and support planning process to ensure that a clear picture of a person's needs is translated into a person-centred and coordinated package of care and support. The current wording of 'should consider' also seems weak and we would like to see this strengthened.

### Joint Strategic Needs Assessment and data collection

Section 15.11 states that 'local authorities should bear in mind that carrying out the JSNA and JWHS on their own *is unlikely to be sufficient* to fulfil the requirement to promote integration'. We would prefer this wording to be replaced with '*will not be sufficient*'.

In the experience of many CSA members, JSNAs vary in quality, usefulness and relevance in practice and often neglect to recognise other important groups of the population, which may have lower prevalence. For example, Sue Ryder conducted a [study](#) of JSNAs and found that only 5% of councils knew how many individuals with neurological conditions there were in their area. We believe that more needs to be done by the Department to ensure that JSNAs can truly become an effective tool to inform local authorities on the needs on their populations and underpin effective commissioning.

We also strongly recommend that carers are specifically referenced within this section to ensure that they are included meaningfully in JSNAs and JWHS. While we recognise that 'the local population' includes carers, we are aware that many local authorities and CCGs are consistently not including them in their strategies or assessments. We would therefore suggest that 'including carers' is added to the end of 15.10 to make requirement explicit.

A number of CSA members have also been working to encourage the collection of data by local authorities by condition. It seems an omission to have such a detailed discussion on the need for integration and not encourage local authorities to improve their collection of social care data, so they can understand who they are providing care for, shape their services accordingly and also identify individuals at high risk of a crisis including unplanned admission to hospital. For example, the recent [CQC State of Care report](#) used hospital episode statistics (HES) to highlight growing numbers of admissions for avoidable conditions and that people with dementia are particularly at risk of unplanned admission.

During the passage of the Care Bill, this issue was raised with the Minister and in correspondence he confirmed that statutory guidance to complement the Care Act 2014 would make it clear that local authorities should consider information and analysis of multiple and complex conditions. It would seem that this chapter is an appropriate place to reiterate the need for better collation of data.

Overall, the guidance seems to support the better operation of existing systems, whereas on the ground, the agenda for producing better joined-up, personalised care is one of ‘system transformation’. It would be useful to encourage Local Authorities to think in this way.

### Sharing information

Section 15.20 states that ‘local authorities *may* share information with other partners’. Appropriate information sharing is vital to more person-centred coordinated care, and it is important to promote a change of culture in this area. We would like to see the “*may*” become a “*should*”.

### Working with the NHS

The inclusion of the statement that the Care Act 2014 has not changed the boundary between care and support and the NHS is crucial and very welcome.

There is, however, not enough emphasis on the need for individuals to be supported and protected through this process, so that they do not end up falling between the two systems. This is particularly crucial where there is a dispute between NHS and LA colleagues about whether the person should be fully funded under NHS continuing care, or funded by the local authority, or indeed self fund their care. In a [recent inquiry](#), CSA member Parkinson’s UK found the system of NHS continuing care to be fraught with dispute and delays. One Parkinson’s nurse said:

“The process is intimidating, humiliating, unfriendly, exhausting, degrading, aggressive, frustrating and also it is adversarial. These are terms that I have written down that patients, relatives and even CHC assessors have used themselves.”

*Karen Guy, Parkinson’s Disease Nurse*

It would be helpful if the guidance could reiterate that the NHS has an obligation to undertake assessments according to timelines in the National Framework, where the expectation is that a decision should take place within 28 days from receiving a completed checklist. It would also be useful to encourage local authorities to use the cooperation clauses to ensure the NHS is acting to resolve NHS continuing care claims rather than leave vulnerable individuals and families in protracted processes.

The guidance could also encourage local authorities to be mindful, that while integration is a key ambition, this should not leave users being unintentionally and unlawfully paying for care that should be free under the NHS. The impact of means testing and charging in social care is keenly felt by many individuals and it is important that integrated packages of support do not leave people exposed to unwarranted charges or contributions.

Finally, where support is arranged following a joint assessment but budgets remain separate, it will be important for the person to be made aware, through inclusion of this information in their plans, which support is provided by health or social care. This will ensure that services are accountable and people are aware which organisation is responsible for delivery.

### Supporting discharge of hospital patients with care and support needs – including links to assessment

The 7 day working week for hospitals set out in regulations is welcome, but the fact that local authorities do not work 7 days creates a potential risk for the safety and wellbeing of discharged individuals. If a hospital discharges a patient over the weekend - outside of local authority working

hours - it may be the case that no arrangements have been made to ensure their safe return to the community.

It will be important to stress that hospitals are required to ensure that patients (and any carers) have a suitable package of care and support in place before they are discharged, and the person's GP, social workers and other relevant professionals in contact with the person are aware that they are back home. Conversations with these partners should take place throughout a person's stay in hospital to enable everyone involved in a person's care to have sufficient time to anticipate and prepare for discharge.

That said, in some circumstances, it might be difficult to establish the person's needs until their health has stabilised sufficiently to enable discharge, until they have had a period of re-ablement or they have experienced living with a new level of support needs. Consequently, guidance should make it clear that assessment should attempt to anticipate risk and changes in need up to the next planned review (further detail on this point is included in the Care and Support Alliance response to the care and support planning sections of the guidance).

More specifically, we know that too often people are discharged from hospital to a care home and the staff at the care home don't have the skills or haven't had the training to be able to support the person's health needs. This can be unsafe for the individual and put huge strain on care staff. We know that hospitals can mistake care homes for nursing homes, and believe that the person will have access to nursing care in the care home. Ensuring the local authority commissioner is involved in the discharge plan will help prevent this happening as they can address concerns, for example make sure staff get training, bring in more staff to the care home, ensure health expertise is brought in, decide the care provider can't meet the person's needs any longer.

To address some of these issues, we would like to see the following wording inserted into 15.39:

*'the local authority commissioner should be involved in agreeing the discharge plan. It should not just be agreed between the hospital and the care provider. The local authority commissioner has a key role to play in assessing the person's needs and ensuring that those needs can be met by the care provider'*

#### Working with housing authorities and providers

We welcome the recognition of the crucial role of housing within the care and support system. There are strong links made across to other sections of the guidance where housing is particularly important, including information & advice, prevention, assessment and its role in promoting well-being. Recognising these cross-linkages is key to enabling the delivery of integrated services which are built around an individual's well-being.

Specifically we welcome the recognition of how good quality information and advice can allow for people to make early choices about housing options (15.61), and the role that local authorities can play through joint planning and commissioning (15.65).

There are, however, two changes that could be made to further strengthen this section.

Firstly in 15.69, the role of housing-related support staff can go beyond signposting and supporting people to access preventive services, and extend to providing these services directly themselves.

The second suggested change to help illustrate how integration with housing can work would be to move the You Trust case study to the information & advice chapter and replace it in the housing section with the Leicester case study, in the event that a new case study is placed into the integration section of the guidance, as suggested above.

Currently there are no case studies in the information and advice chapter, and the You Trust example of the commissioning of a holistic advice service would illustrate how local authorities could effectively arrange for the provision of good quality information and advice services.

Meanwhile, the Leicester case study outlines how local authorities can ensure that housing is integrated in to the health and care system in a way that goes beyond the existing picture in many areas. The links to the County Council's Better Care Fund priorities, the role housing plays in hospital discharge, and the provision of housing related support in the context of prevention, are all particularly helpful and should be retained.

Finally and more specifically, someone with a learning disability and behaviour that challenges may need a house far away from busy roads as traffic triggers their behaviour. This is an example of where housing forms part of the person's need for care and support – and where joint-working is often crucial to ensure an appropriate property can be secured. Consequently, we would like to see the following inserted at the end of 15.58:

*'or from working jointly with housing authorities, for example, providing rent top-ups or capital in order to secure appropriate housing. Joint-working should take place in order to ensure a holistic approach to the individual's needs and aspirations'.*

In relation to 15.59, which talks about the 'suitability of living accommodation', it would be good to see a greater emphasis on finding out the wishes and preferences of individuals and their families and developing real choices for and with them. This should be the basis for determining what is 'suitable'.