Wiltshire Council

Health and Wellbeing Board

12 September 2013

Subject: Community Transformation Update

Executive Summary

This paper provides information on the progress made so far by the Community Transformation programme.

It sets out the phases of the programme and the initial thinking on a service model. It also describes areas of joint working between health and social care which aim to improve outcomes over the next year, and which will also provide evidence for the service model.

The timeline shows the critical path and milestones for the programme.

Proposal(s)

It is recommended that the Health and Wellbeing Board

- Note the progress to date
- Request that the work on the model of care is reported back to the Health and Wellbeing Board at its next meeting
- Request that an update on the vision for integration is signed off by the Health and Wellbeing Board at its next meeting

Reason for Proposal

To provide a regular update to the Health and Wellbeing Board on progress towards developing services to support frail elderly people closer to home, with more joined up provision across health and social care

Debbie Fielding	**Maggie Rae**
Chief Officer	**Corporate Director**
Wiltshire CCG	**Wiltshire Council**

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Purpose of Report

1. This paper provides information on the progress made so far by the Community Transformation programme.

2. It sets out the phases of the programme and the initial thinking on a service model. It also describes areas of joint working between health and social care which aim to improve outcomes for people who use services over the next year, and which will also provide evidence to inform the model of care for the future.

Background

3. In November 2012, Wiltshire Council and Wiltshire CCG, working with Great Western Hospital as the current community healthcare provider, agreed to a shared programme of work entitled Community Transformation - the aim of which was to create an appropriate model for care closer to home, moving people away from hospitals, community hospital and other support beds to a system that is built around individuals and local communities. The scope of the programme is summarised as follows:

    - The focus on elderly, most vulnerable, patients, supporting them appropriately to reduce or avert crises.

    - Multi-disciplinary working across community healthcare, social care, mental health primary care liaison service and other community resources (third sector care/voluntary organisations) to provide integrated, accessible care.

4. The programme of work has two delivery phases. These are set out in the first timeline (Appendix A):

    Phase 1 (November – April 2016) – concentrates on people and services and will include:

    - Extending Primary Care
    - Specialist Care

- Social Care
- Voluntary and Community Sector
- Simple point of access to services
- Rapid response services

Phase 2 (January 2014 – December 2017) – will concentrate on buildings and other resources and take forward the opportunity to link with the Council's Community Campus programme. It will include:

- Community diagnostics, including ambulatory care
- Bed-based care in the community

Main Considerations

<u>Developing a model of care that is evidence-based.</u>

5. The model of care is emerging from an analysis of the evidence of what works, data from current demand and capacity and requirements being gathered from stakeholders. A detailed description of the model is being developed, to include data on needs, demands, capacity and costs. This will be available later in the autumn. As it develops, the model is making use of evidence of best practice and is based upon analyses of demand and capacity across the health and care system.

6. There are different elements of work involved in the creation of a demand and capacity system.

    - Demand and provision data is being collected and defined in order to quantify the activity levels in community services.
    - An "Appropriate Place of Care" audit has been carried out in each acute hospital, community hospital and STARR beds. There have been some delays with GWH, but the audit is due to report in detail shortly.
    - Data about capacity (budgets, workforce, equipment/prescriptions, estates and infrastructure) is being gathered, focussing initially on budgets and workforce. This data will help us understand the number, competencies, place and hours of work of the staff that may be affected by the Community Transformation Programme.
    - Data about demand (people who ask for help) and provision of services is being defined and this combined data will help us answer questions about the use of resource in Wiltshire's health and care system. It will allow us to identify who are the most active and consume most resource and to compare the real movement of patients through different parts of the health and care system with the movements defined by ideal pathways.
    - Two information sharing protocols are being produced, that define the rules and conditions on which the partners will share patient data.

Communications and engagement

7. As the model of care begins to take shape, it is important that the public and all stakeholders are involved and that the programme can demonstrate where feedback has been incorporated.

8. A multi-agency communications group has been established, to include the CCG, the Council, the 3 acute hospitals and the mental health trust. By the end of December 2013, feedback will have been gathered to shape the developing service model and the Community Transformation Plan.

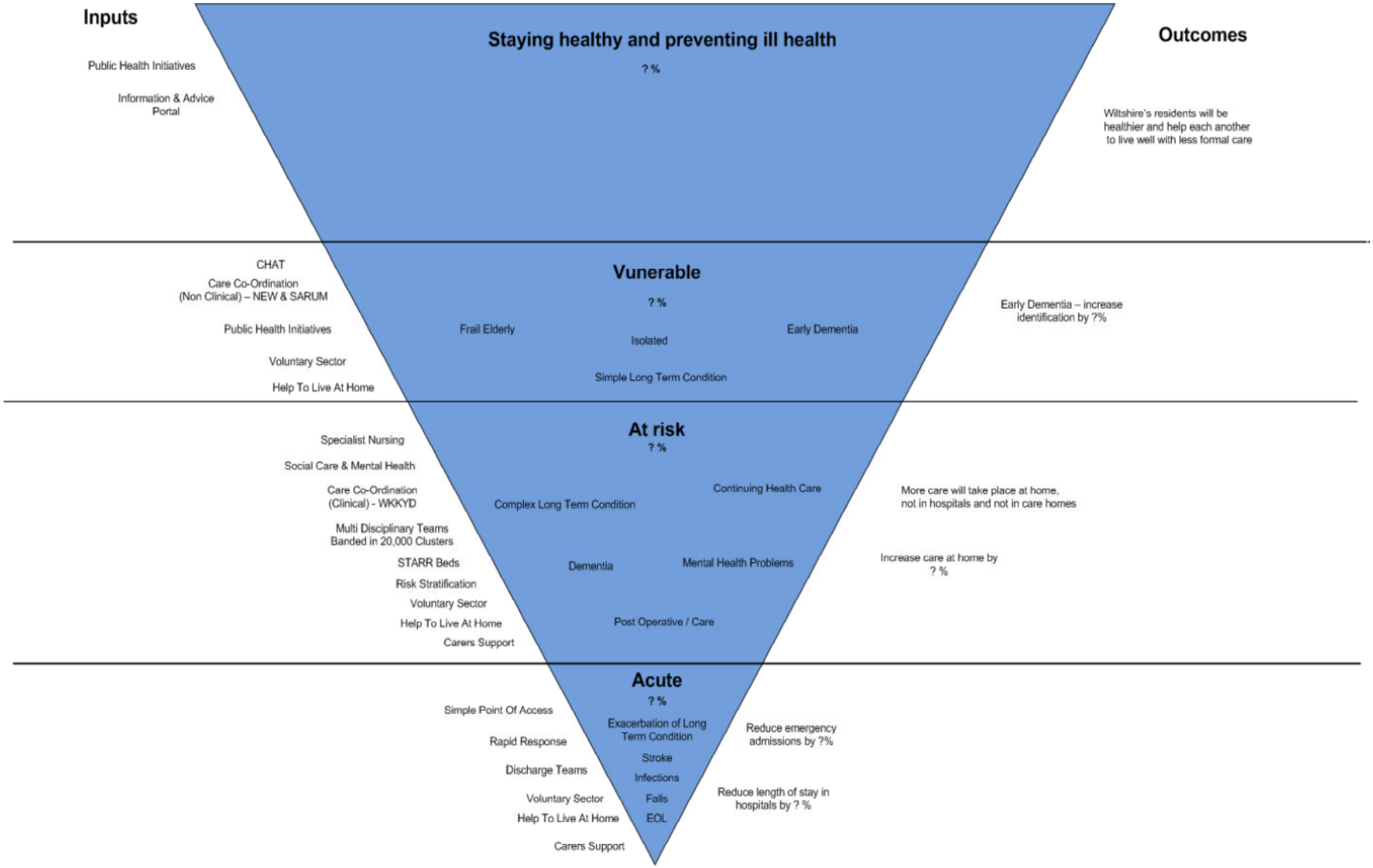
A model of care that supports people at different stages in their lives

9. Services will be designed to meet the needs of people at different stages in their lives, with the aim of maintaining people independently at home for as long as possible.

10. The model of care is based upon populations of 20,000 people, with GP practices as the hub of primary care. Services will be 'wrapped around' GP practices and will be coordinated by multidisciplinary teams that include health, social care, mental health and voluntary agencies as needed. There will be specialist support at a locality level. Primary care services will be designed around 23 clusters of 20,000 population. Each cluster will have a Care Coordinator employed by community health services. Social care services will align services to the 23 clusters. This will include locality team social work and therapy services and also Help to Live at Home services.

11. The inverted triangle in the diagram below describes the stages at which people may need support. The diagram is currently being expanded and developed, with support and guidance from the Public Health Team, to reflect the JSA, include the general older people population need and activity data.

12. This diagram will be accompanied by a series of pathway diagrams, case studies and a geographic representation of resources, will form the first draft of a new model of care, and will be available in October.


Inputs
Outcomes
Staying healthy and preventing ill health
? %
Public Health Initiatives
Information & Advice Portal
Wiltshire's residents will be healthier and help each another to live well with less formal care
Vunerable
? %
CHAT
Care Co-Ordination (Non Clinical) – NEW & SARUM
Public Health Initiatives
Voluntary Sector
Help To Live At Home
Frail Elderly
Isolated
Simple Long Term Condition
Early Dementia
Early Dementia – increase identification by ?%
At risk
? %
Specialist Nursing
Social Care & Mental Health
Care Co-Ordination (Clinical) - WKKYD
Multi Disciplinary Teams Banded in 20,000 Clusters
STARR Beds
Risk Stratification
Voluntary Sector
Help To Live At Home
Carers Support
Complex Long Term Condition
Continuing Health Care
Dementia
Mental Health Problems
Post Operative / Care
More care will take place at home, not in hospitals and not in care homes
Increase care at home by ? %
Acute
? %
Simple Point Of Access
Rapid Response
Discharge Teams
Voluntary Sector
Help To Live At Home
Carers Support
Exacerbation of Long Term Condition
Stroke
Infections
Falls
EOL
Reduce emergency admissions by ?%
Reduce length of stay in hospitals by ? %

13. At the very top of the triangle are the population of older people who are fit and well, who are able to self-care any minor ailments, and who can access a range of community-based services – leisure services, libraries, and voluntary sector groups to maintain their wellbeing. They may participate in public health screening initiatives and use a range of voluntary sector services.

14. People in the next section of the inverted triangle below will be more vulnerable and need additional support from their local community, for example, to prevent them becoming isolated and enjoy a good quality of life. There are a range of services available, should people need them, to stay healthy, including:

    - Help to Live at Home support from one of the 4 providers commissioned by Wiltshire Council, including practical care, equipment and telecare response services;
    - Care coordinators in GP practices – a new role designed to support people who may need to access community services.

15. As we move down towards the tip of the inverted triangle, there will be people who are at risk of hospital admission. They may have several long term conditions, mild to moderate mental health problems, mobility issues or have been recently discharged from hospital. This group may need more professional support from both health and social care, and there will be multi-disciplinary teams to support their needs, coordinated around the GP practice. Clinically trained care coordinators in some GP practices will offer specific support to people in this group.

16. People at the tip of the triangle include those who are in crisis and require urgent care. This may be because of an exacerbation of a long term condition, their carer has been hospitalised or the person has had a fall. A Rapid Response Service will support people in this group to avoid unnecessary admissions to hospital or to reduce the length of stay in hospital. A Simple Point of Access will support professionals to coordinate a rapid response.

<u>Priorities for joint health and social care developments</u>

17. A number of more immediate priorities are being taken forward across health and social care, and these are set out below. Some of these initiatives are already underway, and their evaluation will inform the model of care. Others are at an earlier stage of development. All will be overseen by the Joint Commissioning Board for Adults Services.

    - **STARR**. The STARR scheme for step-up beds (supporting people who would otherwise be admitted to hospital) and step-down beds (supporting people when they need additional help when leaving

hospital) has been running for 18 months, jointly commissioned by the Council and the CCG. STARR beds are commissioned from independent nursing homes, and people within these beds are supported for a maximum of 6 weeks by a multi-disciplinary team comprising of occupational therapists, physiotherapists, nurses and social workers. The scheme has access to specific mental health expertise from AWP. At any one time there are approximately 60 people in Wiltshire within the STARR Scheme. The scheme is being evaluated, including the ability to achieve similar outcomes through non-bed based care.

- **Multi-disciplinary working with primary care**. Care coordinators have been commissioned by the CCG to work with primary care teams and multi-disciplinary team meetings will be held to coordinate work for people who are at risk of hospital admission or who need help accessing other services. New posts are being filled from September 2013 and care coordination will be evaluated in January 2013. Social care staff will align staff to support the 23 primary care localities, including social workers and Help to Live at Home providers who will be integral to multi-disciplinary team working.

- **Transfer of care.** A pilot project has been running since May at the Royal United Hospital, involving adult social care, community health services and the Acute Liaison Service (run by Medvivo – previously known as Wiltshire Medical Services). The intention is to track patients with potential complex discharge plans through the hospital and enable them to be discharged more quickly and effectively. Similar developments are underway within Great Western and Salisbury District Hospitals. Evaluation is planned for December 2013**.**

- **Rapid response.** Evidence suggests that a rapid (1 hour) health and social care response to support people at home at a time of crisis will prevent unnecessary hospital admissions, reduce the need for STARR beds and long-term care placements. Scoping work is underway to identify the demand and costs of a rapid response nursing and Help to Live at Home service.

- **Simple point of access**. A simple point of access would coordinate care delivery, initially for professionals, but potentially to include access by the public. It would include access to:

    - Assessments within one hour for patients needing urgent interventions and care who can remain at home
    - Rapid response services and urgent equipment to avoid hospital admission

- Community bed-based services, where appropriate, including STARR beds
- Intravenous antibiotics
- Community-based therapy services
- Liaison with the patient's GP to manage clinical care at home

Scoping is underway for a simple point of access, and an implementation plan will be put in place once requirements are agreed.

- **Multi-skilled workers.** As more seamless services are being designed, we are scoping new roles for multi-skilled workers who can deliver both health and social care tasks. Such a role will fit well with the ethos of Help to Live at Home services, increasing the continuity and consistency of carers visiting a person at home, also expanding the career path for care workers. The resulting options will be included within the Workforce Strategy and presented to the Joint Commissioning Board in early 2014.

- **Therapists.** Physiotherapists, occupational therapists and other specialist therapy services. Therapists are generally a scarce resource and are currently employed by each acute trust, community health services, adult social care and independent providers. They often work to different rules and each use their own assessment tools. They each have access to different funds for equipment, aids and adaptations. Health and social care therapists work to different terms and conditions, with different pay rates. Options are being considered for improving access to therapists, and will be included within the Workforce Strategy.

- **Voluntary and community sector.** Some joint commissioning of voluntary and community sector services has already proved successful, with a pooled budget for commissioning carers' services, and other examples of joint work such as that with Alzheimer Support. The Community Transformation Programme is exploring other opportunities for maximising the investment in and potential of the VCS in supporting the frail elderly. As projects are identified, they will be presented to the Joint Commissioning Board.

<u>Re-tendering the Community Services contract</u>

18. Wiltshire Clinical Commissioning Group is currently planning to retender its contract for community health services in March 2014. A timeline is set out in Appendix B. The specification for community health services, which is due for completion by January 2014, will take account of the demand and capacity analyses and the emerging model of services. The timescales for the tendering exercise are set out in the timeline below.

Strategy for future integrated working

19. Alongside the work on developing the model of care, work is underway to develop a shared vision for integration into the future. In May 2013, the Government issued *Integrated Care and Support: Our Shared Commitment*, which effectively provides a national mandate for integration of health and social care services by 2018. From 2015, there will be a substantial transfer of resources between the NHS and social care (£3.8bn nationally), aimed at progressing integrated working.

20. The Council and CCG are already well-placed to take this broader integration agenda forward and to transform health and care services together. An initial timeline is set out in Appendix C.

21. Partners began to develop a written vision through the submission of a 'Pioneer' bid to the Department of Health in June this year. Although the bid was not one of the 10 chosen to be supported nationally, it was a valuable exercise in setting out joint thinking in relation to integration.

22. The Council and CCG have, however, been approached to develop one of 20 national "Value Cases" setting out the costs, benefits and next steps towards integrated working. We have also been successful in another similar bid, for systems leadership support in respect of urgent care, and will be working over the next month to select a suitable consultancy organisation to support this work, funded by the national programme, to assist us in developing our 5-year strategy towards integration.

23. The Joint Commissioning Board for Adult Services (JCB), established from July this year, has already made a commitment to explore options for joint commissioning of mental health and learning disability services, and will appraise the options at its October meeting. The JCB also agreed at its meeting in August this year to run a workshop for JCB members, GPs and elected members later this autumn focussed on the opportunities of integrated working.

Safeguarding Considerations

24. There are no safeguarding implications at this stage.

Public Health Implications

25. Public Health is integral to the emerging model of care at all stages in a person's care. The move towards supporting people to maintain their health and wellbeing, and re- focussing away from acute towards more preventative services, including those provided by the voluntary and community sector, will require an ongoing involvement of the Public Health services.

Environmental and Climate Change Considerations

26. There are no immediate environmental or climate change considerations.

Equalities Impact of the Proposal

27. There are no immediate equalities issues. An equalities impact assessment will be required at a later date.

Risk Assessment

28. A detailed risk analysis is incorporated into the programme management of Community Transformation. There are no specific risks to be highlighted at this stage.

Financial Implications

29. There are no financial implications at this stage. Each element of the model of care will be fully costed. Plans for resourcing of any joint health and social care developments will be fully costed and signed off by the Joint Commissioning Board. Written business agreements will be put in place for each joint development.

Legal Implications

30. There are no legal implications at this stage.

Conclusions

31. The Health and Wellbeing Board is asked to

- Note the progress to date
- Request that the work on the model of care is reported back to the Health and Wellbeing Board at its next meeting
- Request that an update on the vision for integration is signed off by the Health and Wellbeing Board at its next meeting

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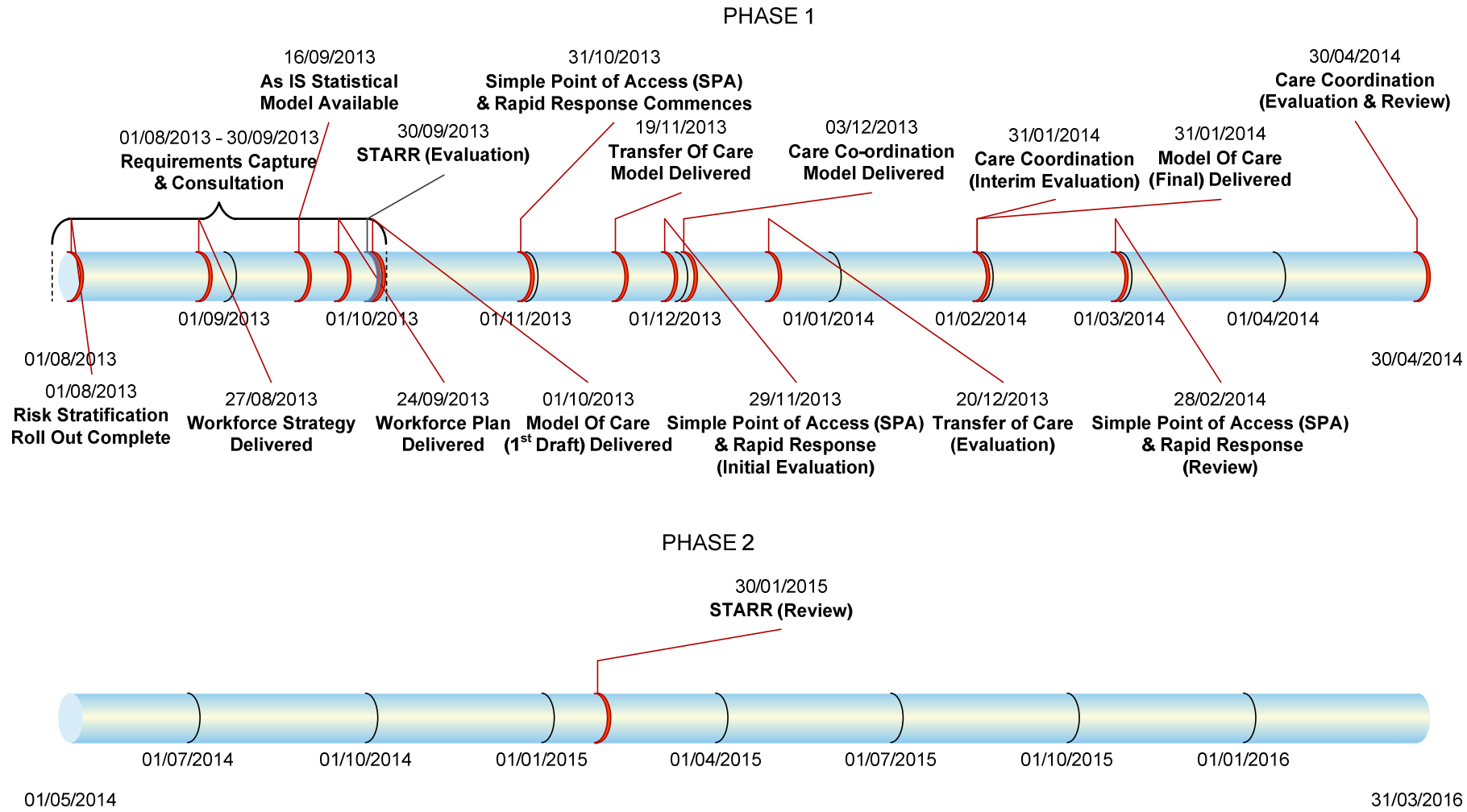
Date: 4th September 2013

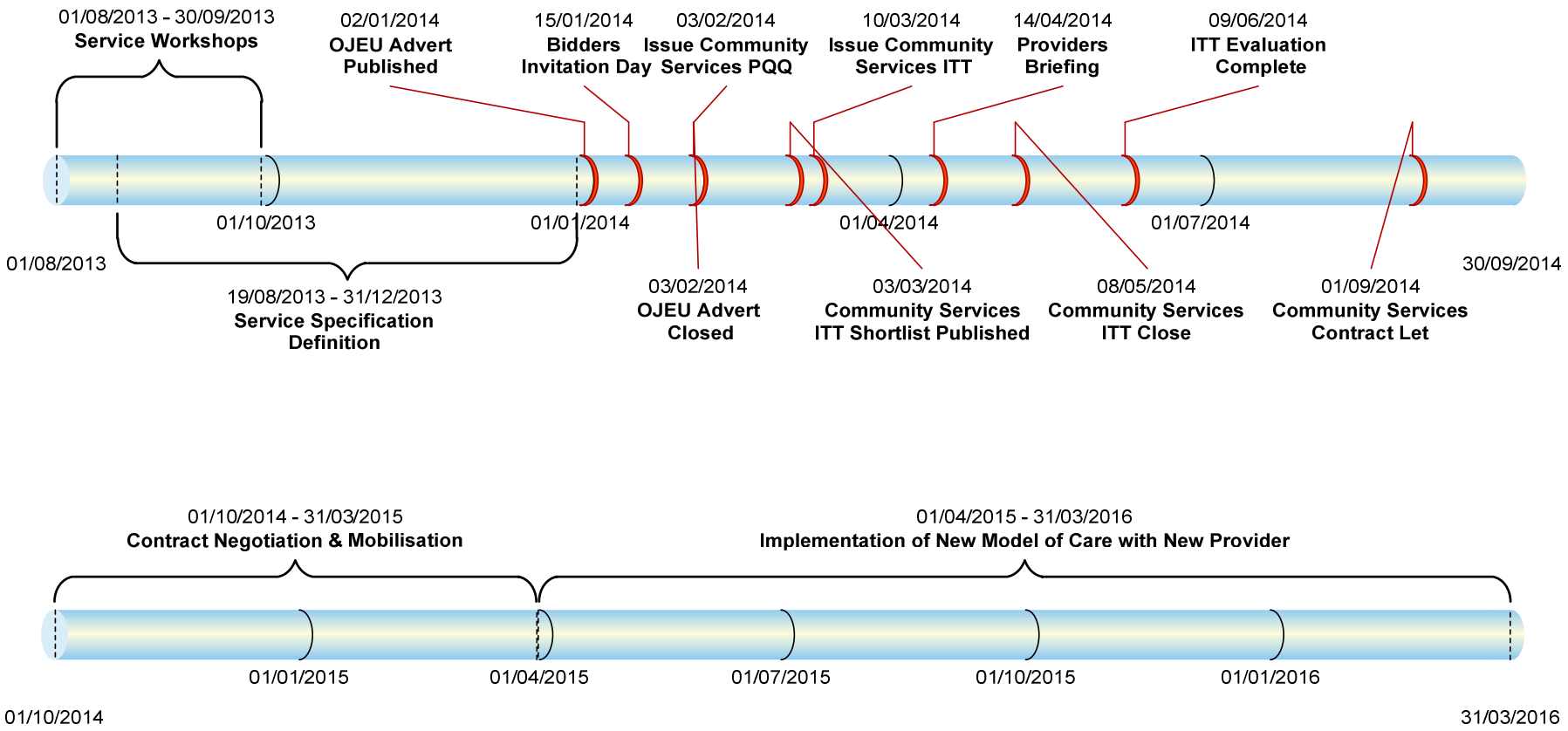
Appendix A

Community Transformation Programme Timeline



Appendix B

Community Services Specification



Appendix C

Developing A Vision For Integrated Working