The Better Care Fund & Integrated Community Services (ICS)

Health & Social Care Scrutiny Committee Briefing

15/12/2014

Agenda

- Strategic Context of the Better Care Fund
- The 'Transformation Schemes' of the Better Care Fund
- Better Care Fund update
- Background to the ICS prototype and model
- Progress to date

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Better Care Fund
Strategic Context

- Better Care Fund announced during 2013 spending round
- CCG & LA Budgets realigned into 'pooled budget' – not new money – budgets tied to existing activity - £12m in 13/14, £21m in 14/15
- BCF Plan should describe how Health & Social Care will work together to improve outcomes:
  - Non-elective admissions
  - Permanent Care Home admissions
  - People still at home 91 days after discharge from hospital into rehab & reablement services
  - 2 Local measures (MH Crisis Care & Hospital admissions for dementia)
- Shropshire's BCF Plan brings existing work streams under BCF umbrella in 1st year – opportunities to influence going forward

The Transformation of Integrated Care & Support v9

Health and Wellbeing Vision

"Everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities"

Outcomes that the Health & Wellbeing Board will strive to achieve

Outcome 1
Health inequalities are reduced

Outcome 2
People are empowered to make better health and lifestyle choices

Outcome 3
Better emotional, mental health and wellbeing for all

Outcome 4
Older people and those with long term conditions remain independent for longer

Outcome 5
Health, Social care and wellbeing services are accessible, good quality and seamless

The Challenge: To improve services and outcomes for the people of Shropshire and make the local health and wellbeing system financially sustainable for the future

Better Care Fund Strategic Themes

Prevention

Governance

Clinical Lead/Sponsor: Rod Thomson
Lead Officer: Kevin Lewis

Theme Objectives

Empowering people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention.

Existing Integrated Activity

- Prevention Services

Transformation Schemes

Scheme	Lead
A1 - Integrated Fall Prevention	Miranda Ashwell

Early Intervention (Case Management)

Governance

Clinical Lead/Sponsor: Colin Stanford
Lead Officer: Kerrie Allward

Theme Objectives

The identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management

Existing Integrated Activity

- 1st phase Care Home Advanced Scheme
- 1st Phase Community & Care Coordinators

Transformation Schemes

Scheme	Lead
B1 - Proactive Care programme	Nina White
B2 - Community & Care Coordinators	Tracey Savage
B3 - Care Home Advanced Scheme	Tracey Savage
B4 - Team Around the Practice	Nina White

Supporting People in Crisis

Governance

Clinical Lead/Sponsor: Colin Stanford
Lead Officer: Kerrie Allward

Theme Objectives

In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible.

Existing Integrated Activity

- Mental Health Support Services
- Specialist rehab

Transformation Schemes

Scheme	Lead
C1 - Integrated Community Services	Emma Pyrah
C2 - Mental Health Crisis Care Services	Paul Cooper

Supporting People to Live Independently for Longer

Governance

Clinical Lead/Sponsor: Sal Riding
Lead Officer: Sam Tilley

Theme Objectives

Reducing dependence on paid support and enabling independence. Maximising the use of community resources and natural support to develop

Existing Integrated Activity

- Housing, Equipment & Adaptations
- Supported Housing Development
- Carers Support
- End of Life Support

Transformation Schemes

Scheme	Lead
D1 – Resilient Communities	Kate Garner
D2 - Dementia Strategy	Louise Jones
D3 – Integrated Carers Support	David Whiting
D4 - End of Life Coordination	David Whiting

Cross Cutting Themes

- Communities
- Workforce
- Information Technology
- Quality & Safety
- Communication & Engagement
- 7 Day Working

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Better Care Fund Update

- Initial plan submitted April 2014 – not assured
- New guidance issued – increased focus on admission avoidance
- Plan refreshed & re-submitted September 2014
- Nationally Consistent Assurance Review (NCAR) process to assure plans
- Shropshire awarded 'Approved with Support' Status
- Final approval of plan, subject to addressing 'improvement areas' on 8th December
- Implementation of plan by April 2015 (with some schemes already started e.g. ICS, CHAS)
- Performance against outcomes will be measured from January 2015

Background of the ICS Prototype

- In November 2013, Shropshire CCG in partnership with Shropshire Council and Shropshire Community Health NHS Trust began the first phase of introducing an integrated health and social care **Integrated Intermediate Care** model.

- Shrewsbury & Atcham was chosen to be the Phase 1 locality in which a first **prototype** version of an integrated service would be introduced to test the operational delivery of the model, with the aim of replicating and learning from it for roll out to the other 2 localities.

- The Shrewsbury prototype is focussed on delivering a model of early supported discharge. Inclusion of admissions avoidance is in Phase 2 plans.

- The phased introduction is using PDSA (Plan, Do, Study, Act) cycles to find the most effective way of delivering this integrated model.

- In 2014 ICS became a Transformation Scheme under the Better Care Fund umberella.

Key components of the ICS early facilitated discharge model

- A locality based health and social care, community and voluntary sector integrated service with responsibility for complex patients who require support to facilitate discharge from an in-patient bed which:-
    - Removes unnecessary complexity through a simple pattern of co-ordinated services
    - Capable of very rapid response
    - Includes mental health
    - Access to high quality expert decision makers as early as possible in the process (especially for older people) Seamless interface with both primary, community and hospital based services
    - Engagement with local communities

- The service will provide **assessment**, **rehabilitation**, **reablement** and **treatment** in the community.

- The service will receive referrals through a **single point of access**.

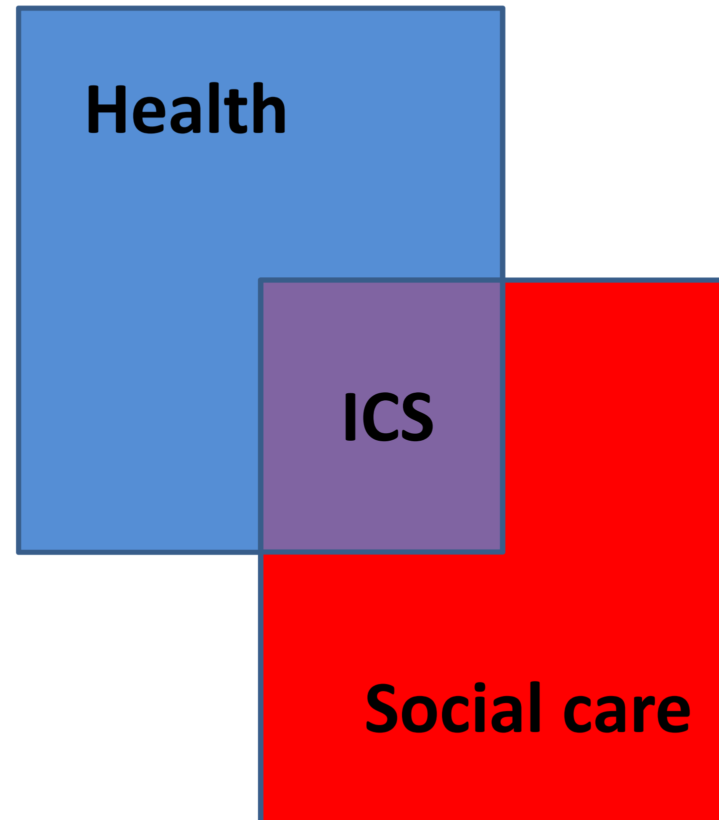
- **Discharge home to assess will be the default position**, home being the patients' usual place of residence.

- The service will undertake **shared generic assessments**, to be completed by any member of the team, so that patients do not have to re-tell their story.

The integration we want is purple!

We want **purple** people, using **purple** processes to deliver purple outcomes…..

…..the type of integration we are trying to achieve requires **more** than blue staff and red staff being based together, aligning their specialist input to meet the needs of the patient – it requires a new shared culture, mind-set, values and objectives to create a new staff group – the **purple people**!



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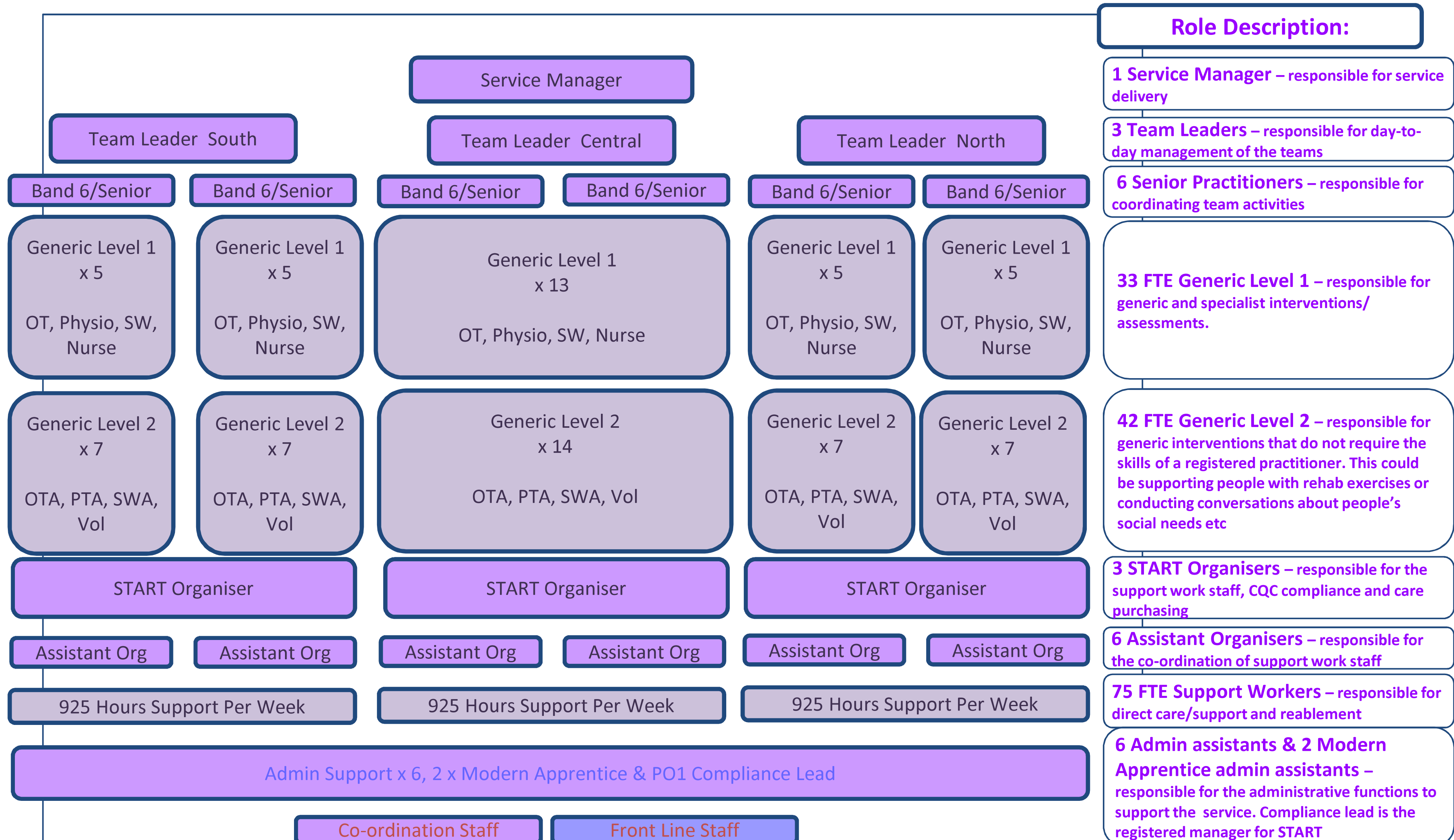
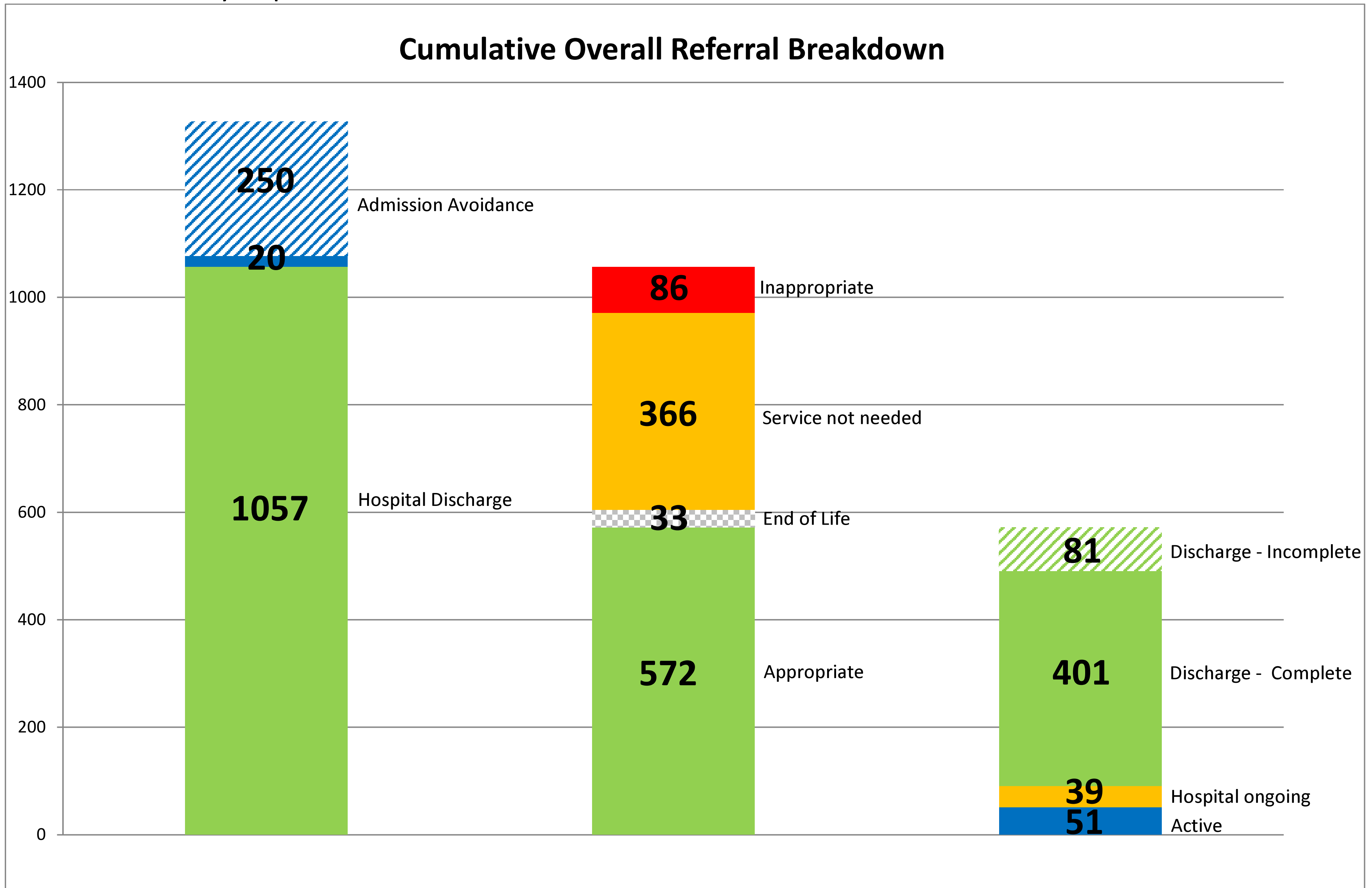
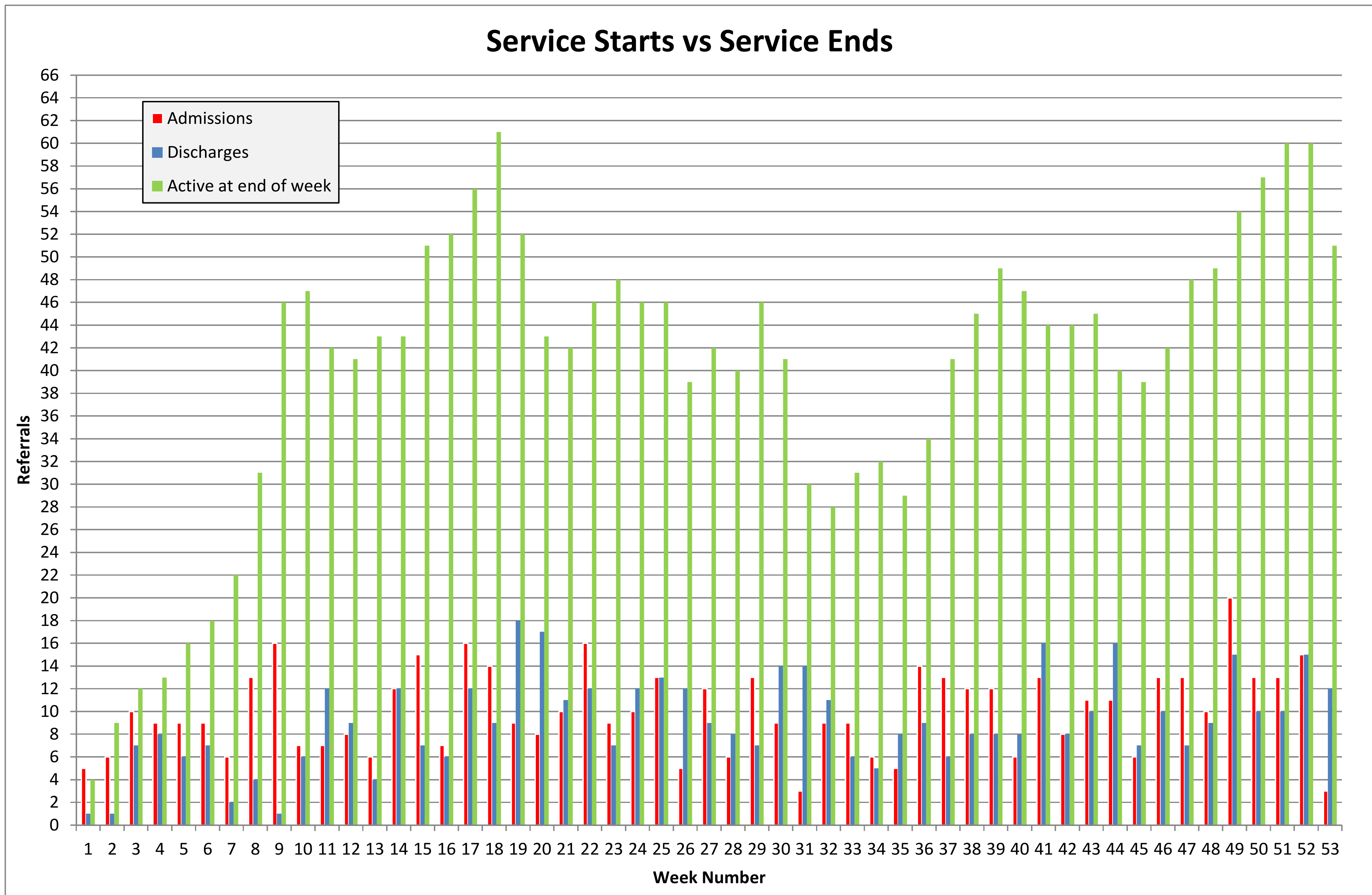
ICS – The Team



Shrewsbury ICS Service
Overall summary of patient referrals



Shrewsbury ICS Service:
Hospital discharges: Patients admitted, discharged and active by week



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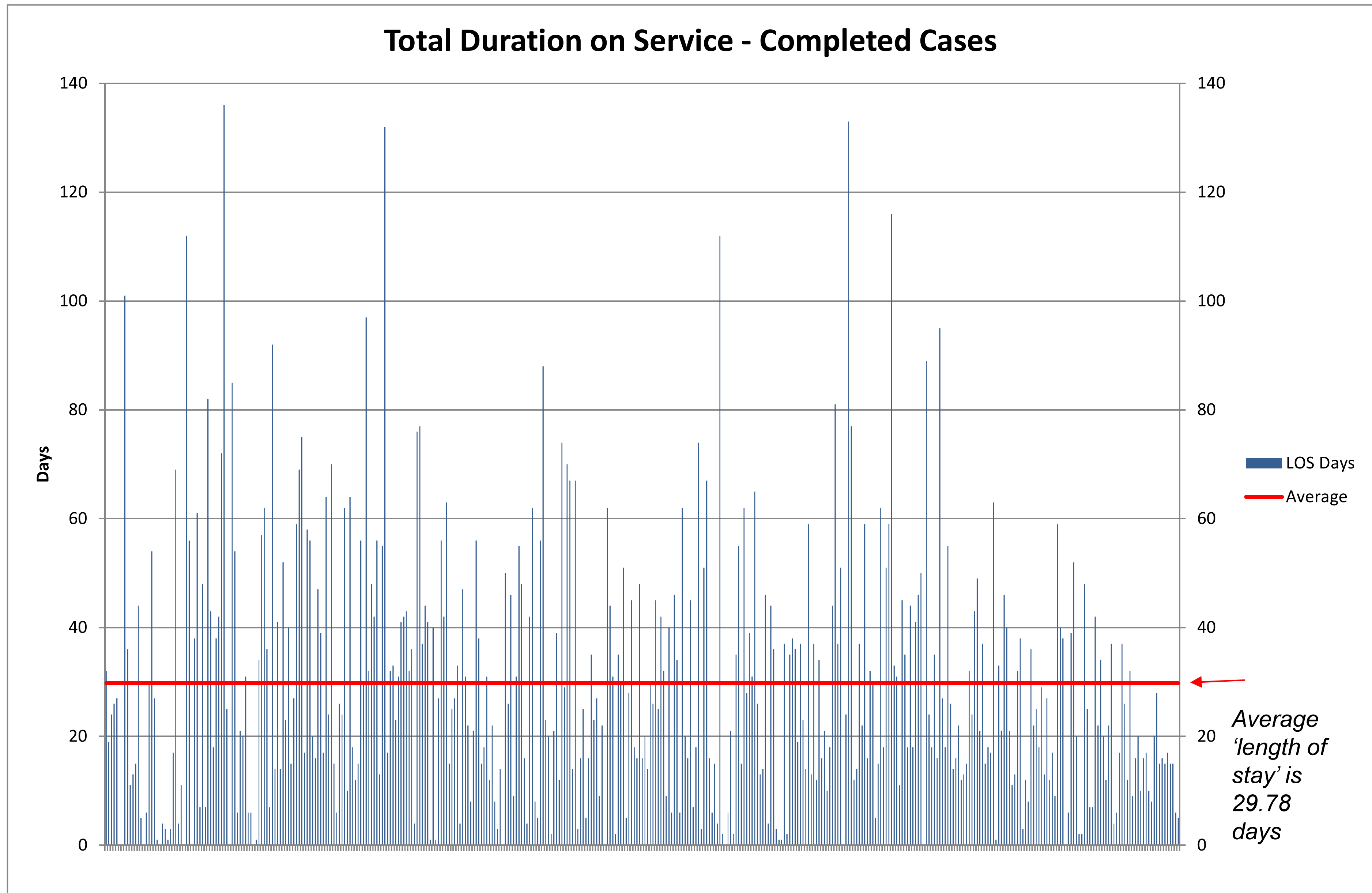
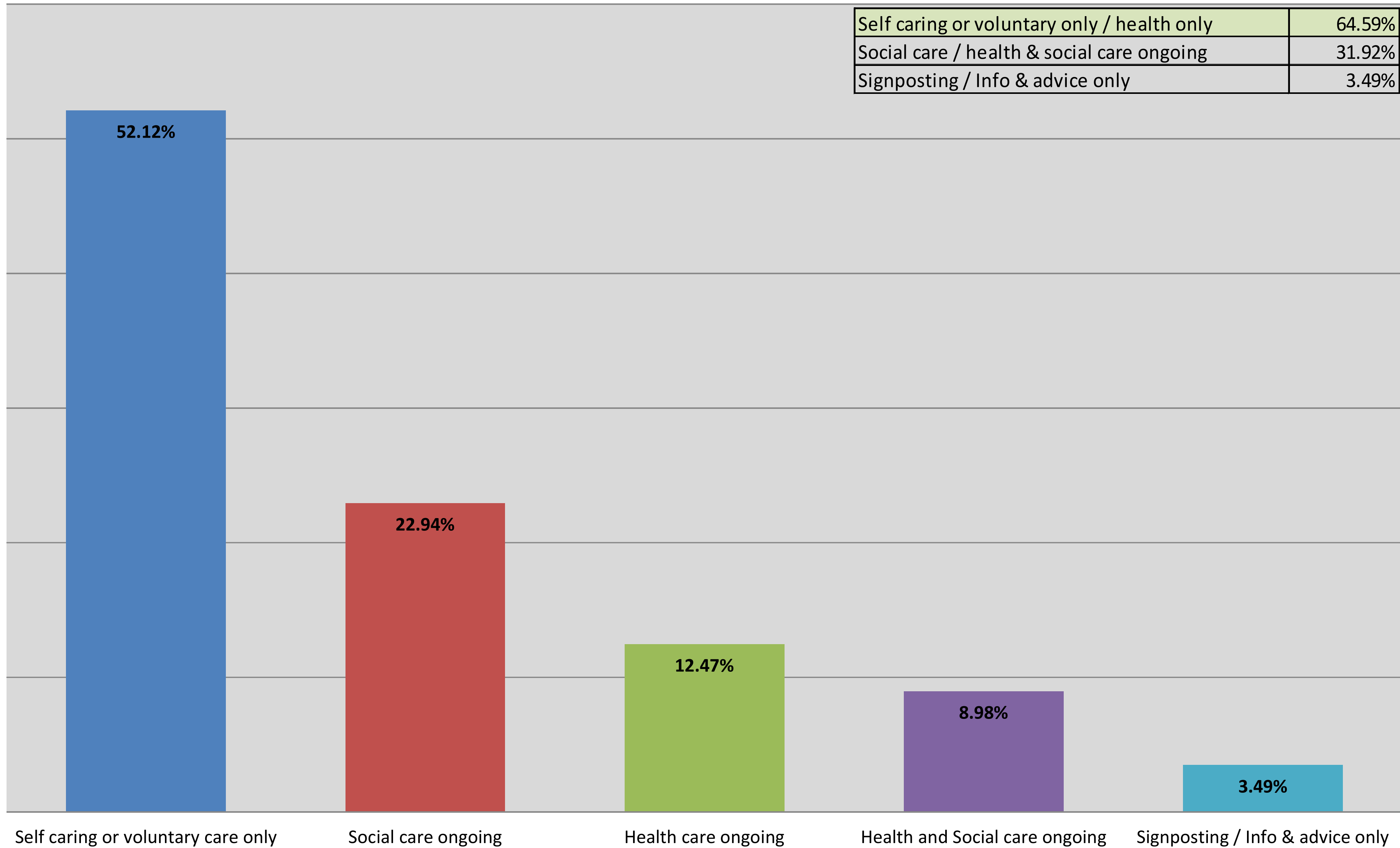
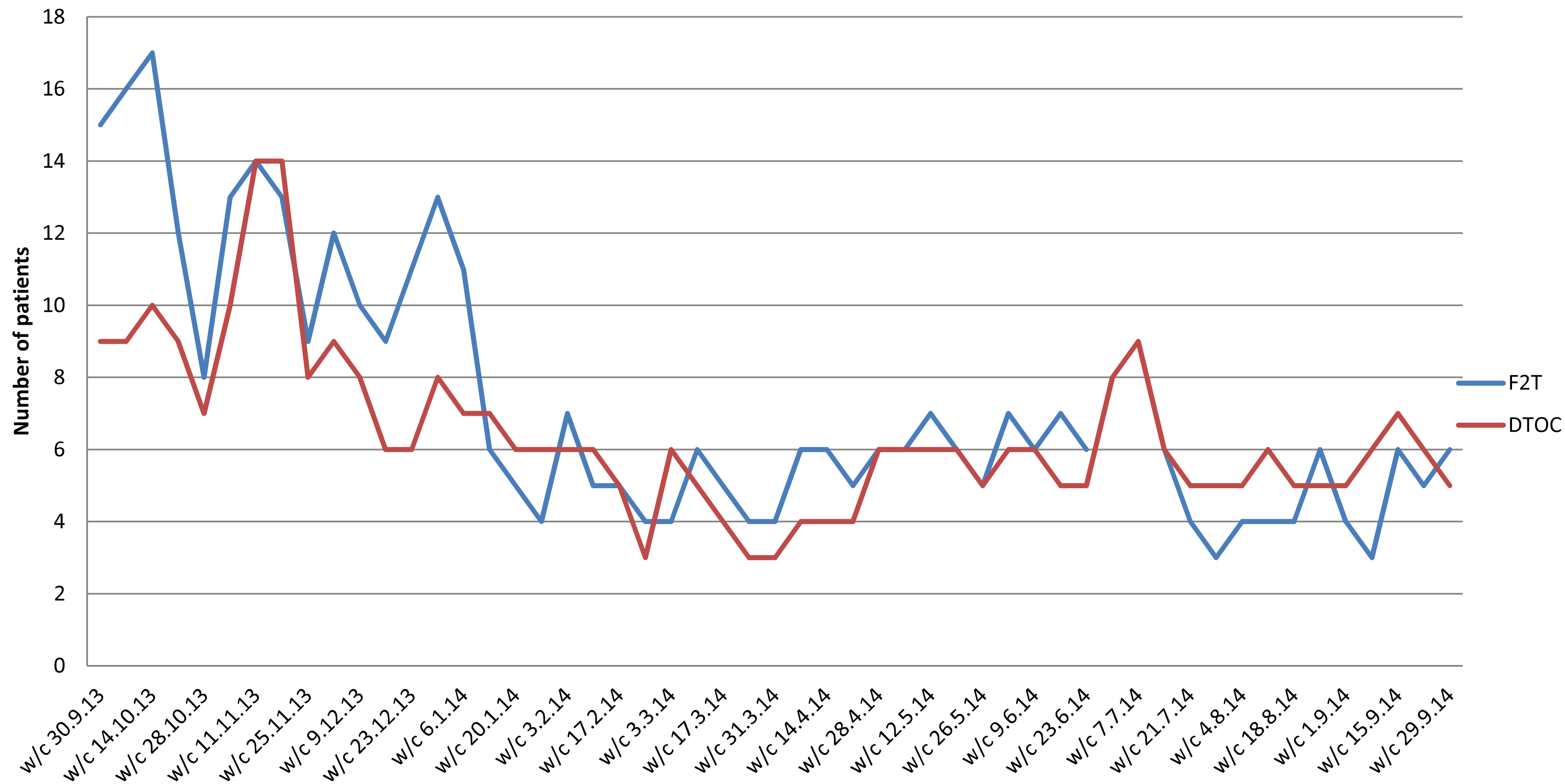
Shrewsbury ICS Service:
Hospital discharges: Total service 'length of stay' for completed ICS cases



Shrewsbury ICS Service:
Hospital discharges: Patient outcome for ICS completed cases




Average number of Shrewsbury & Atcham patients on F2T list and reportable DTOC per week
Number of patients
18
16
14
12
10
8
6
4
2
0
w/c 30.9.13
w/c 14.10.13
w/c 28.10.13
w/c 11.11.13
w/c 25.11.13
w/c 9.12.13
w/c 23.12.13
w/c 6.1.14
w/c 20.1.14
w/c 3.2.14
w/c 17.2.14
w/c 3.3.14
w/c 17.3.14
w/c 31.3.14
w/c 14.4.14
w/c 28.4.14
w/c 12.5.14
w/c 26.5.14
w/c 9.6.14
w/c 23.6.14
w/c 7.7.14
w/c 21.7.14
w/c 4.8.14
w/c 18.8.14
w/c 1.9.14
w/c 15.9.14
w/c 29.9.14
F2T
DTOC

Healthwatch Patient Survey

“The ICS service was excellent, the people were trained to deal with my husband who has MS as well as Alzheimers...Whoever trains the ICS team knows what they are doing - they were all good but some were exceptional.”

77% of respondents said that this was the best way of meeting their needs on returning home from hospital and only 2% of patients felt that support could have been delivered in a better way

78% of people said that they felt supported at home from day one and a further 5% said that they felt supported ‘to some extent’.

When asked if staff treated the patient with respect 83% answered ‘yes’ and similarly when people were asked if staff treated their homes with respect 82% gave positive responses.

healthwatch
Shropshire

Shropshire ICS Service:
Hospital discharges: Patients admitted vs discharged by week