Agenda Item 10

Report to:	**East Sussex Health Overview and Scrutiny Committee (HOSC)**
Date:	**13 September 2012**
By:	**Director of Adult Social Care**
Title of report:	**Community Services: Adult Social Care perspective**
Purpose of report:	**To receive briefing on the potential impact of the ESHT clinical strategy proposals on Adult Social Care and the development of integrated community services.**

RECOMMENDATIONS

HOSC is recommended to:

Note the close and continued involvement of Adult Social Care in the development of the ESHT clinical strategy, the alignment with existing commissioning strategies and the transformational change required to deliver successfully.

1. Background

1.1 Adult Social Care has been involved, alongside other key partners of the East Sussex Healthcare Trust (ESHT), with the development of the clinical strategy.

1.2 The integrated health and social care model for community services promoted in the clinical strategy reflects agreed health and social care commissioning strategies for development of community services; Improving Life Chances Strategy, Older Peoples Commissioning Strategy and the Integrated Plan.

1.3 Adult Social Care is committed through joint commissioning arrangements to holistic whole system working with the NHS and other key partners (third sector and the independent sector) to develop preventative integrated care for residents of East Sussex. Development of a holistic inclusive personalised service model enables efficient support, whilst also retaining the expertise and focus required for particular condition pathways, therefore this commentary is not particular to the current specialities in the consultation.

2. Integrated Community Services: Neighbourhood Support Teams

2.1 The overarching aim of the Neighbourhood Support Team (NST) is to deliver integrated personalised (health and social care) preventative and proactive support that equips service users, carers and their families with the knowledge and skills to facilitate self-care, well-being and promote independence.

2.2 NSTs aim to unify traditionally separate divisions of health and social community care enabling service users to receive an integrated holistic service, personalised to their needs and requirements. NSTs aim to remove artificial or organisational barriers between short term interventions and long term interventions, health or social care interventions.

2.3 For each team the focus is on knowing their population and targeting the most vulnerable and managing their care. This is achieved in partnership with GP's and other partners (voluntary sector and mental health) through regular multi-disciplinary meetings, use of risk stratification tools and implementation of self-care techniques to empower service users and their carers to take a greater role in the management of their long term condition. There are likely to be 13 geographical 'neighbourhoods' to provide local services that are focused around local health and social care

needs. The changes regarding single-site options for some acute services can be successfully supported by local community focused teams (NSTs), ensuring that equitable and appropriate resources are available for every community within East Sussex.

2.4 The focus is to build up capacity within the community (including universal services and third sector partners), ensuring they work in an efficient and focused way, to shift patient reliance to community based provision. Community services will expand their preventative role, providing alternative solutions to hospital or institutionalised care ensuring that interventions are proactive and preventative rather than responsive and intensive.

2.5 The introduction of Neighbourhood Support Team builds on successful integration across health and social care in East Sussex, particularly in domiciliary intermediate care. The Joint Community Rehab Service unites NHS led rehabilitation and Adult Social Care reablement into a single holistic therapy led service. Expanding capacity, sharing best practice and rationalised access will enable greater numbers of East Sussex residents to access reablement and rehab and remain or continue to live independently. Adult Social Care and East Sussex Healthcare NHS Trust are working in partnership to deliver the new service model. The latest highlight report demonstrating the pace and scale of progress can be seen in appendix 2 of this report.

3. Issues for HOSC to consider

3.1 There are a number of implications for Adult Social Care which HOSC may wish to consider:

- **Workforce capacity and capability;** in order for the new service models in the clinical strategy to succeed there needs to be practice transformation across the workforce (embedding self management working culture and practices to empower service users and their carers to be partners in the management of their care). Trust also needs to be built and partnership working developed across previously fragmented disciplines, organisational boundaries and geographical barriers. This could involve changing health and social care roles to reflect a more interdisciplinary ethos which mimics the holistic practice. Additionally accurate workforce mapping to ensure skill mix and capacity is matched to need could reveal areas for investment. This work will take time to achieve the desired results.
- **Rise in demand on social care services;** greater support upfront could result in a rise in activity for lower support services such as information and advice through Social Care Direct, greater traffic to One Space internet pages and higher levels of equipment provision and low level support packages or reablement packages. Greater demand on lower level services has been used as a marker for success of integrated services in other areas, to demonstrate a more preventative focus and reduce demand for more costly acute support.
- **Shift in resources across the system;** in line with activity rises for lower level support services, costs may shift away from high cost areas to lower level areas. Additional expenditure could be expected within community equipment budgets, reablement services and information and advice services. Reductions in costs could be expected across secondary care usage and in placements to nursing and residential homes and in the volume of people with large care packages where people have benefited from short term interventions. It is likely that transitional cash flow pressures could be expected as financial changes lag behind activity changes across the system.

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Integration Programme
East Sussex Adult Community Services

Programme Documentation DRAFT v.2

August 2012

This document contains management information about the programme approach and delivery. It is for the Integrated Care Network other key stakeholders and partners.

For more information about this document and the Integration Programme please contact:

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Integration Programme – Year 1 2012-2013

Introduction

Integration is the Government's vision for the transformation of health and social care, where the role of statutory agencies will be about being more active and enabling and less controlling.

The vision within East Sussex is to work within our organisational boundaries to achieve integration from the service users perspective, integrating pathways to create a seamless experience.

The LTC programme seeks to improve outcomes and experience for patients with long term conditions and maximise the use of resources. It will focus on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their health.

Management Summary

This document outlines East Sussex programme approach to create a platform where integrated care at scale can flourish.

The complexity of health systems is such that there is no firm empirical basis for advocating a particular integrated service delivery model in all circumstances. Therefore programme brings together providers and commissioners to take responsibility for the full spectrum of services to the population they serve.

The programme leaps forward into implementation, adopting a discovery rather than design approach, focusing on removing the barriers to integrated care to enable innovation from health and social care providers.

Aim is to create an integrated pathway across health and social care and delivery of the following benefits to the East Sussex health and social care economy:

- Benefit 1. Users are involved as partners in a high quality personalised service

- Benefit 2. East Sussex has a financially sustainable health and social care system.

- Benefit 3. Greater prevention focused service, enabling more people to stay at home living independently

- Benefit 4. Greater quality and safety for service users

The first benefit is fantastic care experiences, followed by fantastic outcomes that are cost effective.

The benefits are realised through the delivery of seven identified projects, which are focused on the enablers and driving force for integration, respecting the innovation that needs to occur to arrive at the benefit.

East Sussex County Council

Contents

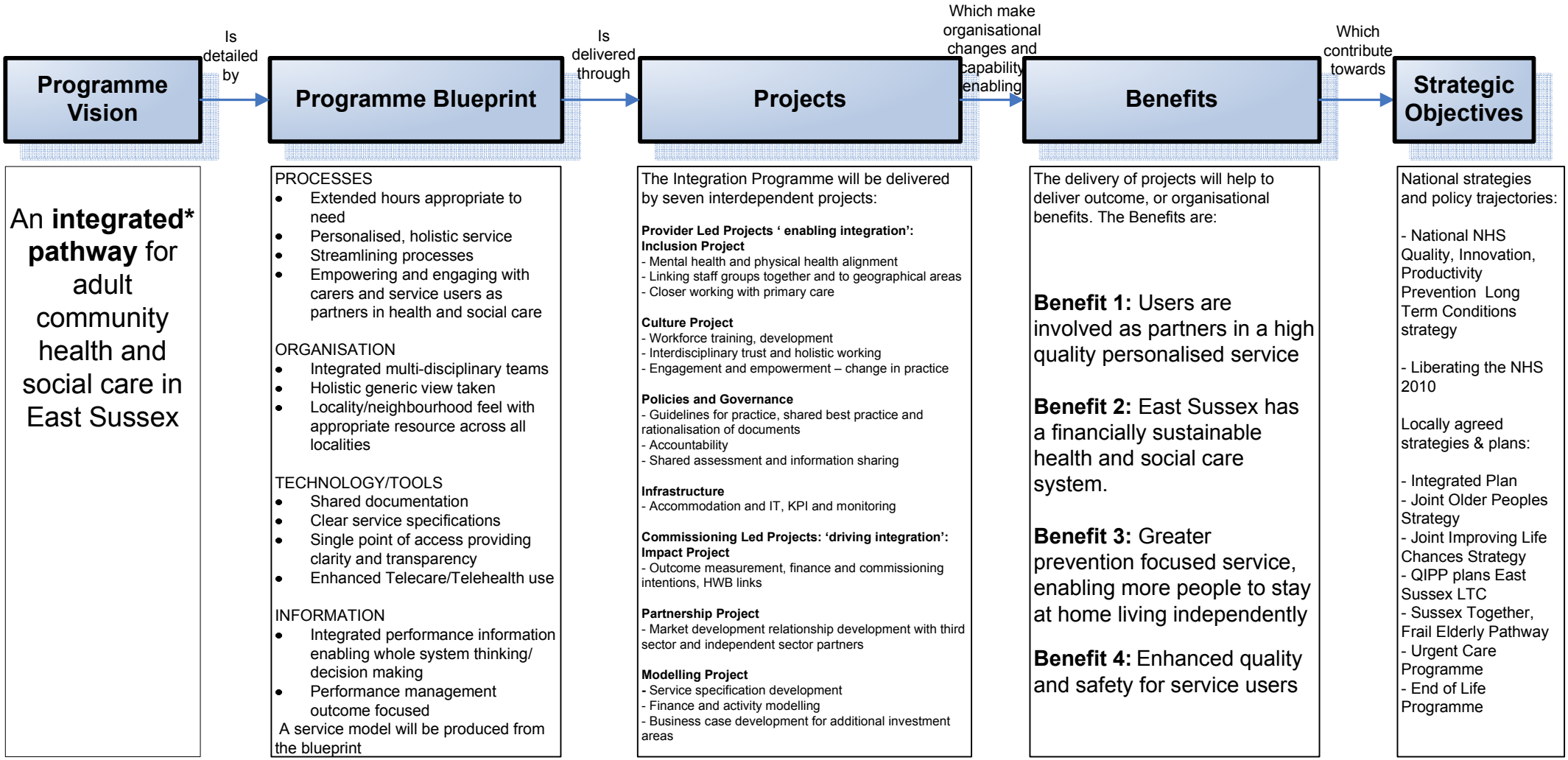
The format is designed to be clear, value adding and informative.

Each of the projects identified within the programme will follow best practice project management guidance and consequently will be underpinned by detailed project plans.

Programme Vision and Overview

The Document outlines the vision for the Integrated Care Programme, the desired future of adult community health and social care services in East Sussex.

The rest of the document serves an overview detailing how everything contributes towards achieving the vision and crucially describing the journey from outputs, outcomes, benefits and strategic objectives. Due to the extensive work from central government outlining the national vision for Integration and the management of people with Long Term Condition, the vision and the benefits identified are rooted heavily in Department of Health policy.



***Integrated definition:** An approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring services are well co-ordinated around their needs. Integrated care is centred around the needs of users.

Integration Benefits

Benefit Profiles describe the expected benefits and lay out methods for their measurement. Existing performance management indicators are being used. All the benefits are using a mixture of quantative and qualitative measures to help give an informed picture of benefit realisation.

Users are involved as partners in a high quality personalised service

"Fantastic Care experiences"

Description

Users and carers are empowered to make informed choices about their care and support through self care and shared decision making by stimulating and supporting a transfer of power and knowledge to service users and carers.
Promoting confidence and control for the person
Positive experience of care, improved patient experience and wellbeing

Measurement

- Greater user confidence and reduced anxiety
- High Service user satisfaction results (Bolton integrated diabetes)
- Favourable ratings from CQC (Torbay)
- High outcomes rates using outcome methodology (e.g. TOMS for therapy interventions or other indicators of independent living)

East Sussex has a financially sustainable health and social care system.

"Cost effective"

Description

Financially viable reduction in high cost secondary care
Ability to respond to population and demographic changes in East Sussex in the coming years
Reduced secondary care provision
More demand absorbed within resources, as more people access lower level interventions

Measurement

- Lower delayed transfers of care from hospital (Hereford Integrated Care org and over 65s Torbay)
- Reduce bed days for emergency admissions for chronic illness by 27% (NHS Wales chronic care demonstrators)
- Low rates of hospital admissions for over 65s (Torbay)
- Reduction in Nursing and Residential Home placements
- Non-elective bed use of over 65 on downward trajectory (Torbay)
- Above CSED modelling for people leaving reablement/ rehab with no ongoing support (56%)

Greater prevention focused service, enabling more people to stay at home living independently

"Fantastic care outcomes"

Description

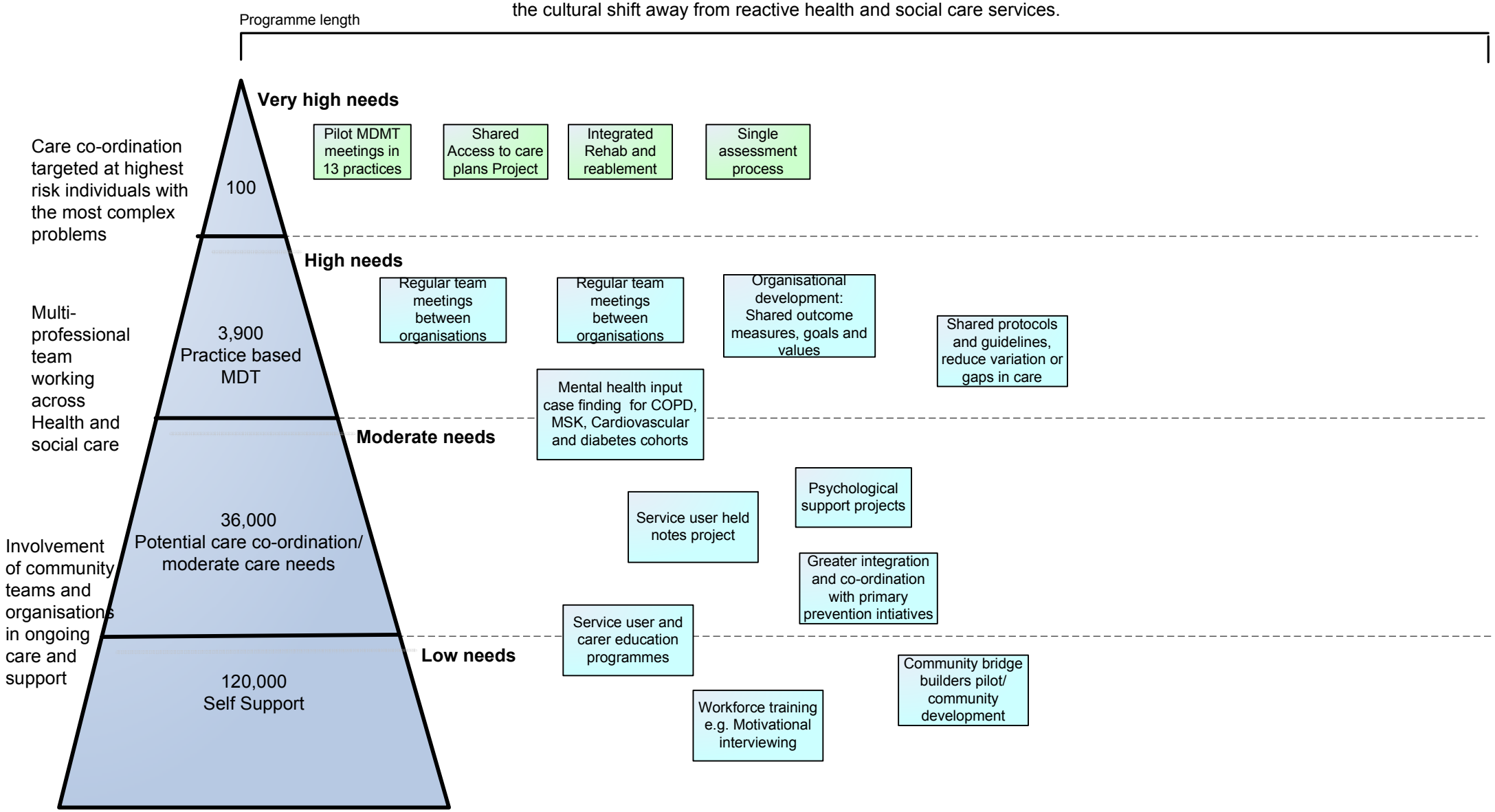
Shift towards step up low level prevention initiatives, with health and social care involved proactively rather than reactively.
Improved health and welling outcomes

Measurement

- Higher than average number of people over 65 receive some form of social care, funded or unfunded (Torbay)
- Increase in uptake of Direct Payments (Torbay)
- Increase in domiciliary service referrals (Torbay)
- Increase in people dying in place of choice

System Shift

The challenge required to develop more proactive health and social care system requires a shift in resources and focus towards preventative interventions and populations. This high level plan, using indicative figures for East Sussex, serves as a sense check to ensure appropriate resource and energy is focused on preventative population, to begin the cultural shift away from reactive health and social care services.



= Current projects/milestones

= Potential projects/ milestones

N.B Boxes in blue are suggestive, they serve as examples only. As the projects in the programme develop, milestones and key projects will be added.

Phased Programme Plan Year 1 = October 2012 – October 2013

Phase 2 October 2012

Ethos: ***" Learning and engaging"***

What's different on the ground:

- Multi-disciplinary discussions through joint team meetings, staff come together and discuss and learn about each other caseloads

- Joint case working occurs where appropriate

What are the outputs:

- Start to develop identity as a 'Neighbourhood Support Team'
- Understanding and progress made on shared goals and values
- Benchmark current services; activity and performance information, including 'shared caseload'
- Learning and understanding around documentation and practice, breeding ideas and informing phase 2 initiatives
- Develop and research shared documentation and rationalisation

Who is involved:

- Adult Social Care Tier 3
- District Nursing Teams
- Advanced Community Nurse Practitioners
- Integrated Night Service
- Mental Health services

Phase 3 April 2013

Ethos: **"establishing and building"**

What's different on the ground:
- Single referral route into the Neighbourhood support teams, enabling greater joint working and the beginning of joint health and social care co-ordinators
- Key worker for each service user established
- Joint case working occurs where appropriate
- Continuation of joint meetings , growth in number, frequency and spread across the county
- Integrated intermediate care joint the group
- Expansion of mental health teams, with the introduction of particular targeted cohorts (using risk stratification) of COPD, MSK, Diabetes and cardiovascular
- Introduce first shared guidelines around practice

What are the outputs:
- Key worker arrangement in place
- Rationalisation of documentation and shared paperwork
- Seamless pathway between LTC and intermediate care
- Seamless pathways becoming a reality
- Smoother and leaner referral pathways and management
- Greater Neighbourhood Support Team identity developed

Who is involved:

Everyone in Phase 1 plus:

- Adult Social Care Tier 2 (reablement)
- Joint community rehab (rehab and reablement)
- Emergency Duty Service (pending OOH changes)

Project Portfolio

The Project Portfolio seeks to analyse the range of projects within the programme, their dependencies and overlaps to help effective delivery within the programme and outside of the programme.

Provider led projects
" delivering integration"

Commissioner led projects
"driving integration"

Inclusion Project
Delivers the operational change to bring component parts of health and social care together. Potential work streams or outputs include:

- Joint team meetings, coordinating, designing and facilitating
- Linking professionals to practices and other teams
- Forging relationships and innovations around closer working with primary care
- Reduce unwarranted variation and/ or identify gaps in provision

Culture Project
Fostering and developing a collaborative, holistic culture across organisations, professions and individuals. Potential work streams or outputs include:

- Workforce support and training around self management
- Holistic working, development of interdisciplinary working
- Communication and engagement events
- Identifying and defining shared core values and purpose

Policies & Governance Project
Delivers the supporting operational guidance to deliver integration. Potential work streams or outputs include:

- Shared best practice and operational guidelines
- Accountability protocols developed
- Shared paperwork and rationalisation of documentation
- Information sharing

Infrastructure Project
Delivers and contributes towards the wider whole system provider blueprint for delivering integrated care. Potential work streams or outputs include:

- Shared IT system
- Accommodation strategy to enable co-location
- Performance reporting and measurement

Impact Project
Seeks to align the programme with annual business and strategic plans as well as monitoring whole system impact. Potential work streams or outputs include:

- Developing performance monitoring/dashboard for integration
- Outcome measurement
- Alignment/monitoring with Health and Wellbeing, JSNA and CCG plans
- Reporting, QIPP, partnership boards, ASC and other governance groups

Partnership Project
Widen the integration plan to ensure other partners across health and social care and other public services and partners are involved to maximise integration. Potential work streams or outputs include:

- Market development initiatives (in direct response to gaps in variation identified)
- Relationship building with voluntary, independent sector and partners to be involved in integration (e.g. Housing, employment, leisure)
- Co-production, ensuring service users, carers and their representatives are involved in shaping the design of integration in East Sussex

Modelling Project
Responsible for defining the service model for integration, contracting and formally commissioning. Potential work streams or outputs include:

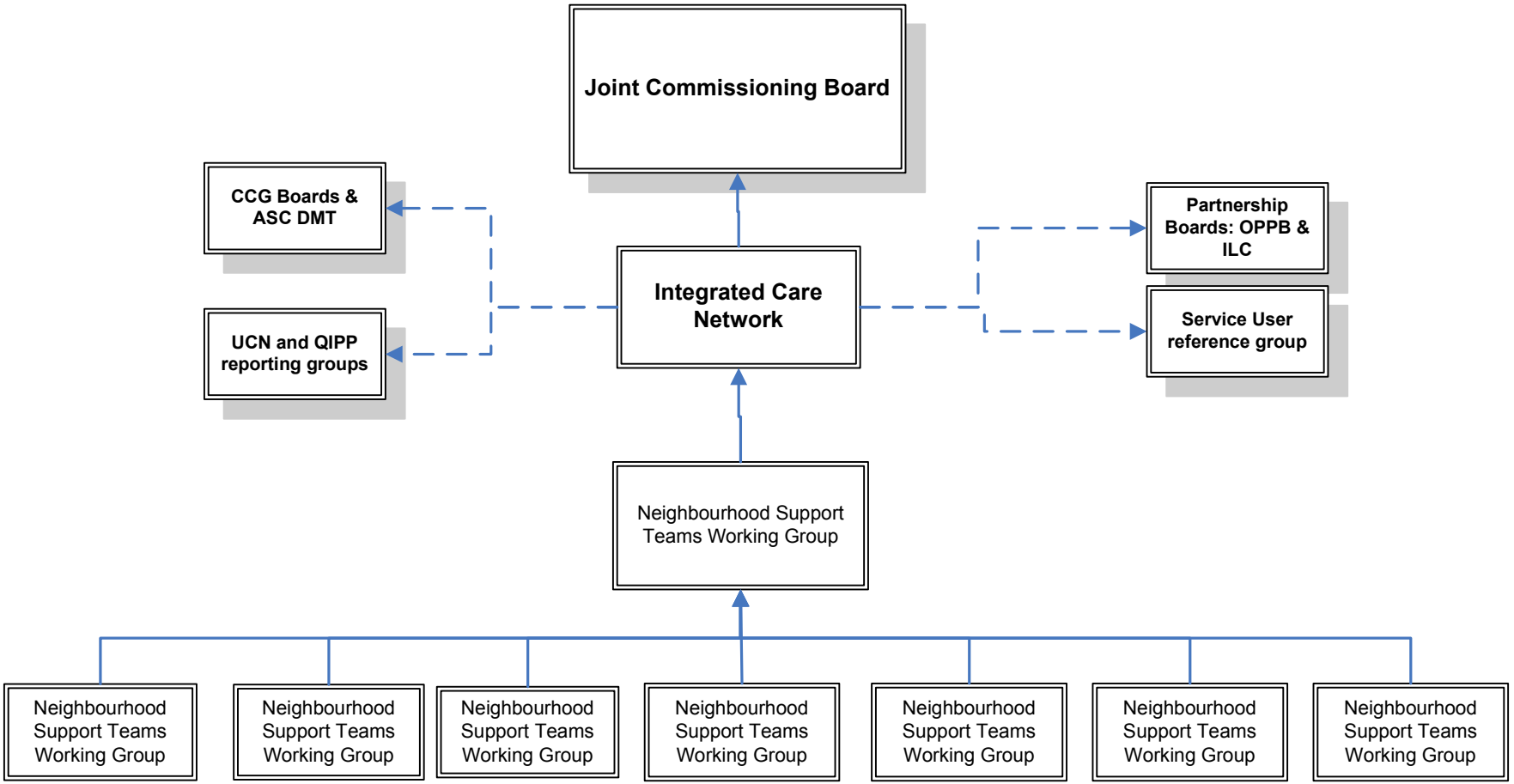
- Service specification development
- Activity and finance modelling around affordability
- Business case development for gaps in service and service change
- Supporting and joint commissioning arrangements
- Year of Care involvement

Phased Programme Plan

This table outlines potential/draft milestones or key tasks that each project could undertake during the two distinct phases. This is to outline the interdependencies and the iterative nature of the programme, gradually building momentum.

	Phase 2	Phase 3	Phase 4
Inclusion Project	- Facilitate joint team meeting between services involved in phase 1, set up terms of reference, frequency - Linked professionals, meet and greet - Planning and preparation for phase 2 services	- Pathway processes in place for single referral for Neighbourhood Support team - Troubleshooting issues and problems with growth in joint team meeting and joint case working	
Infrastructure Project	- Understand and map all the different IT systems and performance metrics collected and gathered - Rationalised and develop synchronise - Link IT governance leads and report back into provider organisation strategies	- Explore co-location and other environmental issues to support integration	
Culture Project	- Workforce mapping and training needs analysis delivered, across the organisations - Communication and staff engagement events to discuss the integration concepts and input into ideas	- Shared agree principles and values agreed for NST and integration - Ongoing shared staff communication routes established - Self management ethos projects e.g. staff training or case studies or champions in place	
Policies & Governance Project	- Workforce mapping and training needs analysis delivered, across the organisations - Communication and staff engagement events to discuss the integration concepts and input into ideas	- Guidelines around best practice developed and introduced - Protocols and guidelines around practice for key worker developed and introduced	
Impact Project	- Baseline current service activity information - Development of Long Term conditions dashboard and performance metrics - Input into the Health and Wellbeing strategy consultation and commissioning intentions work	- Evaluation and case study development, particularly around service user experience and outcomes - Reporting and updates	
Partnership Project	- Service user involvement and engagement events held - establish wider service user reference group to feedback and contribute towards development	- Relationship building with wider universal services and partners, scope pilot to expand involvement, through enhanced Directory of services etc. - Identify market development options and contribute towards	
Modelling Project	- Draft service model developed and publicised to wide stakeholder group for feedback - Activity modelling around volumes and finances, developing rationale for link between activity and cost	- Galvanise learning from phase 1 implementation and provider feedback to revise service model and specification - Facilitation and planning for phase three and four of the programme.	

Programme Organisation and Governance



Communication Strategy

1. The audience

a) Staff involved in delivering, or supporting the delivery of, Neighbourhood Support Teams.

b) Governance groups (Boards, networks, partnership groups) and Implementation Group members.

c) Organisations, partnerships and consortia in the public, private and voluntary and community sectors that are, or want to get involved in, delivering health, social care community services.

d) Local people who use, or are interested in, health, social care community services, their carers and family.

2. Key messages

a) Health and social care committed to working together to support service users.

b) Committed to delivering personalised, holistic service to every east Sussex resident

c) Increased focus on empowering and enabling self management and proactive support is fundamental to the NST

d) Locality 'neighbourhood' feel, providing services around local communities responding to local needs and demands.

3. Tone

a) Visionary; providing clear description of final destination as well as journey to get there

b) Patient focused, description and discussion from patient perspective

c) Gaining buy-in and support for the work of the programme

d) Informative and with purpose; providing detailed information on key changes

f) Plain English, avoiding jargon and lengthy prose

g) Evidence based; providing resources from other areas and rationale behind changes

4. Communication and Engagement Methods

A wide range of communications and engagement methods will be used including:

a) Information, communications and resources for key health and social care staff and stakeholders via e-mail, intranets, bulletins, meetings, events and reports etc.

b) Online information and resources

c) bespoke workshops and forums where necessary for staff and service users

d) Local, social care and health press and media – where necessary

e) Regular updates and reporting through existing governance groups, networks and partnership boards.

5. Outcomes

a) Widespread awareness of Neighbourhood Support Teams amongst partners, commissioners, providers, and other organisations and individuals involved or interested in health, social care.

b) Health and social care professionals, service users and other interest parties understand the public commitment made by all partners to work more closely together on health, social care and wellbeing for the benefit of local people and communities.

c) The Neighbourhood Support Team transformation has the appropriate involvement and engagement of key partners and stakeholders.

d) There is an understanding across health and social care of the demands, expectations and pressures which make these changes both beneficial and essential - 'Not changing is not an option'.

e) The Integrated/Intermediate Care Network and other governance groups are kept informed of progress and have timely information regarding challenges, risks and issues requiring their direct intervention.

6. Measuring success

Success will be measured by:

a) Improved health, social care outcomes for local people

b) Effective delivery of Neighbourhood Support Team's objectives.

c) Levels of participation and engagement in consultations, events and meetings

d) Articles in local newspapers, social care and health magazines and internal newsletters

e) Numbers of enquiries, comments and complaints received

Measurement

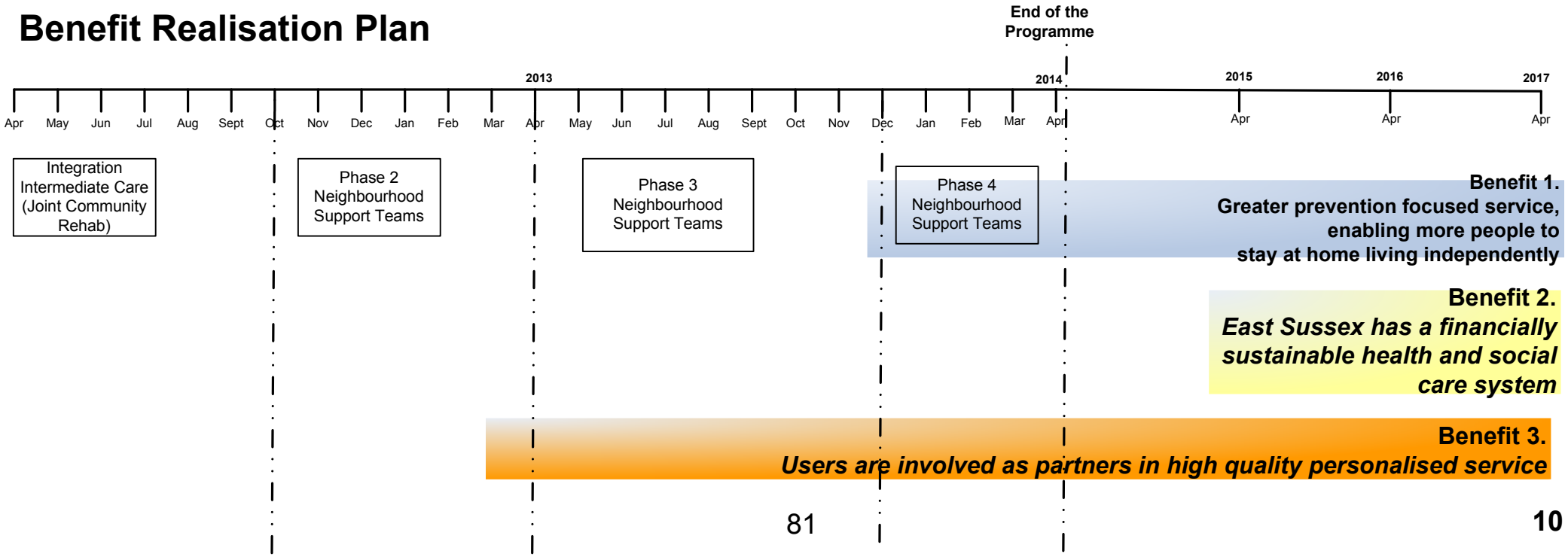
Measurement must occur on the progress made towards integration as well as the final outcome and intended benefits and dis-benefits.

Progress towards integration: Using project management methodology; measuring progress against milestones and agreed plans will help to ensure progress on combination of processes, methods and tools that facilitate integrated care occur as intended.

Benefit realisation: results in the culmination of these processes directly benefiting communities, service users, carers and their families, and particularly progress on the three benefits outlined as the aims of this programme. Therefore integration in this programme is judged successful if it contributes towards better care experiences, improved care outcomes delivered more cost effectively as a financially sustainable health and social care economy.

This programme cuts across commissioner and provider boundaries, therefore imperative for a unified approach to measuring performance, progress and benefits.

Benefit Realisation Plan



Key risks

This table outlines potential/draft milestones or key tasks that each project could undertake during the two distinct phases. This is to outline the interdependencies and the iterative nature of the programme, gradually building momentum.

	Risk	Impact	Probability	Risk rating	Mitigating action	Owner
1	Shift in resource from secondary care towards community and primary care is delayed/doesn't happen appropriately to fund the transformation and progress is stale mate.					
2	Financial framework, pressures undermines the integration agenda, as a pursuit for short term results takes precedence.					
3	Lack of strong reliable baseline information together with history of underinvestment in community services means that benefits from integration are stifled.					
4	Lack of organisational integration causes difficulties and 'work arounds' due to different line management, IT and infrastructure etc.					

Joint Community Rehabilitation Service

Highlight report: 09 Aug 2012

Activities completed in this period

- Further GP forums attended
- Letter sent to all East Sussex GP practices re: new service and referral process
- Internal E-updates re: new service to all ASC and ESHT staff
- Implementation of recording against KPIs in all areas
- First quarter Balanced Scorecard published
- Mapping of existing NHS/ASC training complete
- New admin staff in place in 2 localities
- 2 ASC staff seconded to NHS teams to gain specific experience of rehab and competencies, and shadowing of therapy staff in each
- Demonstration of interim IT system
- JCR staff newsletter produced
- EIA signed off

Activities planned for the next period

- Attendance at further GP forums
- Financial Memorandum of Understanding signed off
- Therapy advert out on NHS jobs
- Remaining community referrers informed of changes to service and referral process
- First JCR newsletter signed off
- Service information working group and referral pathway workshop held
- Drafting of governance agreement
- Training planning meeting held and draft 'to be' programme designed
- First testing of interim IT system
- ICAP service developments in progress
- Visits to other authorities with integrated reablement services booked

Milestones

Eastbourne teams co-located	Apr 12 ✓
Staff consultation completed	May 12 ✓
Staff engagement workshops	Jun 12 ✓
Project Manager in place	Jul 12 ✓
Eastbourne teams jointly allocating	Jul 12 ✓
EIA, spec and KPIs signed off	Jul 12 ✓
GPs advised of key changes to service	Jul 12 ✓
1st Quarter Scorecard	Jul 12 ✓
Client & referrer docs aligned	Sep 12
Start of integrated training	Sep 12
Interim IT system implemented	Oct 12
7 day working begins	Oct 12
Hastings & Rother teams co-located	Dec 12
Lewes, Havens and High Weald Teams co-located	Dec 12
Operational recording docs aligned	Jan 13
Communication of change to other key stakeholders	Jan 13
End of first year report	Apr 13
0perational policies, procedures and guidance aligned	Sep 13
All staff completed new training programme	Sep 13

Issues

- Delay in confirming accommodation impacting timescales for co-location
- Implementation of interim IT system delayed by technical hosting/deployment issues
- Delay with therapy recruitment due to ESHT recruitment process

Key overarching risks/issues identified

#	Description	I	P	S
1	Delay in securing accomm	4	3	12
2	Staff working to different operational policies	5	2	10
3	Staff work to different IG procedures	5	2	10
4	Failure to implement fit for purpose IT system	4	3	12
5	Untimely assessment	2	3	6
6	Failure to effectively communicate changes	4	1	4
7	Staff resist/don't engage with changes	5	1	5
8	Incomplete referrals	3	3	9
9	Recruitment delays	4	3	12
10	Staff working on different terms	1	5	5
11	Partner wishes to pull out	5	1	5
12	Nursing Home referrals	3	2	6
13	EIA requirements	2	2	4
14	Not all referrers informed of changes	1	3	3

Latest Document Versions

Detailed Project Plan	v 12
Key Milestones	v 11.1
High Level Milestone Plan	v 11.1
Risk Log	v 3.3
Working Groups	v 16.1
Comms Plan	v 5

East Sussex Healthcare NHS Trust

East Sussex County Council

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