Appendix 5
Community Oversight Board - Initial Programme of Work

1. Summary of Integrated Community Health and Social Care Programme of Work

1.1 The projects included within the Integrated Community Health and Care Programme (ICHCP) are based upon a revised target operating model attached as Appendix A. At this stage, the model is not intended to bring about 'total integration'; rather it is a pragmatic programme of work that takes account of the current local conditions and progress to date. The model proposes a phased approach to creating the conditions, *systemically*, for improved joint working across community services. The projects are designed to be deliverable within relatively short timescales and to realise benefits quickly.

1.2 The design principles that underpin the target operating model are:

- **Patient/client at centre**
- **Simplify** – remove artificial / organisation barriers where they make no sense. Consolidate services wherever possible i.e. less condition specific services / specialisms. This proposal starts to consolidate services e.g. therapy services but further work may be required in phase 2, for example, to bring about more a more consolidated nursing offer in the community.
- **Standardise –** for example, re-emphasising HSCC as the single route into services.
- **Integrate** - organisationally agnostic, the optimum model for patients/clients is the paramount driver
- **Savings** - cashable and/or by creating capacity through efficiencies

1.3 The 4 main projects within the Phase 1 ICHCP are summarised below:

i) **Locality Working Pilot (Eastbourne Locality)** – Co-location of Community Nursing service and Social Care staff to facilitate better day-to-day working and develop structured pathways to support joint working and to develop Care Coordination. This project will have particular emphasis on engaging with local primary care, mental health and voluntary services to develop an integrated locality working model.

ii) **JCR and OT (Eastbourne, Hailsham and Seaford)** – Develop and implement integrated working between the ASC OT and JCR Team and the ESHT JCR Therapy team– sharing skills and good practice and creating capacity so that the joint service is in a better position to deliver the required services across the System. For example, the initial pilot of HomeFirst Pathway 1 showed very positive results when a patient was discharged to their own home and assessed by an OT; assessed in their home environment the patient exhibited a far higher level of independence and functioning than when assessed in an acute setting. The ability to generate more OT capacity to assess in the community will be essential to the larger scale roll-out of HomeFirst.

iii) **Home First Pathways 1 and 4** – Developing and embedding the 'Home First' ways of working. Pathway 1 is characterised by assessing and supporting people at home (rather than assessing within acute settings);

Pathway 4 is the local 'Interim Beds' model whereby people spend less time in acute settings and can be discharged into a (private sector) nursing bed and provided with extra support e.g. Physiotherapy and/or Occupational Therapy as an interim placement pending the identification of the best longer term option; this may be a permanent nursing home placement but, with the additional recovery time and therapy input, need may be reduced. The patient might then be placed in a residential home or even return to their own home.

iv) Rapid Response - Hospital Avoidance and Discharge – Undertaking an audit of staff and their skillsets across the system and then, where necessary, re-deploying staff to create an integrated Health and Social Care Service that can respond within 2 hours of a referral being made in order to directly avoid a hospital admission or to support a hospital discharge. The team would provide assessment (wherever possible in the person's own home) and short-term nursing and care services as well as arranging equipment and on-going care and support if necessary. This integrated team would play a key role in delivering Home First[1] and the 5 Pathways initiative

2. Further work

2.1 Further work will be undertaken on the current target operating model (which will also feed into the future target operating model, see below) as to the precise scope of the services included. For example, there has been considerable discussion around rationalising the nursing offer in order to simplify and standardise pathways and deploy the available workforce flexibly and efficiently. However, it is also recognised that there are likely to be some areas of specialist nursing that should continue to be delivered as a discreet team(s). Proposals specifying the consolidation of services will be presented in the next financial year.

2.2 An organogram will be produced showing the managerial and professional accountability for health and social care staff within the integrated community services model.

2.3 The current target operating model is badged as 'Phase 1'. Therefore, as requested by the Community Health and Care Services Board, further work will be undertaken to develop the blue print for service delivery in c. 3 years' time. This will include a narrative that clearly articulates the outcomes and benefits for local people.

2.4 Further developing the interface with Primary Care in Locality areas. As well as developing an integrated approach to Care Coordination across the System the work is also likely, for example, to involve looking at the interface between community nursing and practice nursing; with a view, as per the design principles of the target operating model, to developing ways of working that put the patient at the centre through simplifying service pathways.

2.5 Further work on social prescribing with the voluntary and community sector. Obviously this is a System wide initiative that can be beneficial across the whole of community and primary care – but we will specifically seek to ensure that it is a key part of developing Locality working and Care Coordination. The Locality Link Worker will be a key point of liaison for local community and voluntary support.

2.6 The lack of dedicated resources for the programme of work has already become an impediment to progress at the pace and scale necessary. Resources, from within the existing staffing establishments, will be identified as a matter of urgency to work on this programme.

[1] Noting that part of integrating the Home First approach will be emphasising that Home First is not a team but is a way of working that requires staff from across the entire System to contribute.

2.7 We will build on the initial work undertaken with the NHSI&E to better understand demand, capacity and the financial effects of the projects within the target operating system. In some instances this will be more straightforward as there are obvious measures that will indicate success. In others, it will be less straightforward as the initiative, as acknowledged by the NHSI, is about changes that position us to start realising day-to-day efficiencies and savings rather than bringing about immediate direct savings. For example, we have identified measures around reducing waiting times for the OT/JCR initiative which will clearly evidence benefits to patients; and we can also collect data that will evidence that therapy capacity has been released into the System to where we believe it can make the greatest difference. These measures are essential in order to support the roll-out of HomeFirst pathways which have the potential to deliver significant financial savings to the System as the evidence shows[2] that Home First can have a .

2.8 We will therefore work closely with the System PMO to assist them in scoping a piece of work that will baseline the current position in order to be able to quantify the impact of the changes we are making. The baseline will describe:

- the services provided in the integrated community model
- the outcomes sought from the services
- the capacity of services (this will indicate where it is necessary to develop and share skillsets)
- the anticipated level of demand on services
- the financial data associated with the current model

This will support the development of KPIs and financial targets for the programme of work.

[2] In addition to the national evidence about the success of the Home First approach the two pilots run in East Sussex in November estimated a saving of c. 4 bed days per patient.

Appendix A

Draft Phase 1 Target Operating Model

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