West Midlands Regional Networking event

How transformed and integrated health and care could improve outcomes and cost-effectiveness

Thursday 27 April 2017

The Better Care Fund
Contents

- About Total Transformation of Care and Support
- Developing a co-produced vision for integration
- 5 ways to transform health, care and support
- Evidence-based models of care
- ‘Size of the Prize’: modelling impact
- Implications for integration and BCF
Total Transformation

- Total Transformation explores the potential for scaling up the most promising examples of care, support and community health services
- First version published in November 2016 looked at care and support
- Second version published in January included health care.
- Involved Birmingham City Council, Shared Lives, Nesta and PPL
- BCF offers a platform for using the Total Transformation approach
“Total transformation must change systems and processes, but first it must change hearts and minds. We need language that we all understand – that enables managers to explore ways to improve services whilst balancing budgets, but also helps people to think about how their communities can flourish.”

Clenton Farquharson, person who uses services and Director, Community Navigator Services
Vision for transformed care

- Health and care systems are under unique pressure from falling budgets and rising demand.
- System needs to be rebuilt not only around a better understanding of people’s needs, but also around the creativity and capacity of individuals and families and leadership within communities.
- Starting point for total transformation is question: “What does a good life look like in this area and what are we all willing to do to achieve it?”
- Evidence suggests that there are five ways to consider how we develop person-centred, transformed care.
- Every local area needs to build its own solutions, but there are also many transferable features which the most promising models have in common.
5 Ways to transform care

1. Helping people and families to stay well, connected to others, and resilient when facing health or care needs.
2. Supporting people and families who need help to carry on living at home.
3. Enabling people with support needs to do enjoyable and meaningful things during the day, or look for work.
4. Developing new models of care for adults and older people who need support and a home in their community.
5. Equipping people to regain independence following hospital or other forms of health care.
## Promising models for transformation

<table>
<thead>
<tr>
<th>The Five Ways</th>
<th>Models of care</th>
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<tbody>
<tr>
<td>Helping people and families to stay well, connected to others, and resilient</td>
<td>• Local Area Coordination</td>
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<tr>
<td></td>
<td>• Community connectors</td>
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<tr>
<td></td>
<td>• Social prescriptions</td>
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<tr>
<td></td>
<td>• Community agents *</td>
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<tr>
<td>Supporting people and families who need help to carry on living at home</td>
<td>• Age UK Living Well *</td>
</tr>
<tr>
<td></td>
<td>• Reablement</td>
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<tr>
<td>Enabling people with support needs to do enjoyable and meaningful things</td>
<td>• Community enterprises</td>
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<tr>
<td>during the day, or look for work</td>
<td>• Employment enterprises</td>
</tr>
<tr>
<td></td>
<td>• Kent Pathways Service *</td>
</tr>
<tr>
<td>Developing new models of care for adult and older people who need support</td>
<td>• Shared Lives *</td>
</tr>
<tr>
<td>and a home in their community</td>
<td>• Extra Care</td>
</tr>
<tr>
<td>Equipping people to regain independence following hospital or other forms</td>
<td>• Kent hospital discharge *</td>
</tr>
<tr>
<td>of health care</td>
<td>• RVS, Hospital to Home</td>
</tr>
<tr>
<td></td>
<td>• BRC, Support at Home *</td>
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</tbody>
</table>
Scaling up community agents

The scheme focuses on people aged over 60, especially those who need help to remain independent and to stay at home. 486 people in Redcar & Cleveland benefitted from the service in 2013/14. The evaluation found that 2% of the people referred to the scheme are staying in their own homes for longer, and 9% of people need lower-level care packages as a result of this intervention. Additionally, those referred to the scheme reported a perception of improved health and wellbeing, including feeling less anxious and isolated, and more confident.

• For every person who stays in their own home for longer, there are estimated savings of £12K per year.
• For every person who uses the service, whose need for an increased care package is delayed, there are estimated savings of approximately £3K per year.
• The costs of the service per person are £192 per year.

Total net savings to Redcar & Cleveland Borough Council are £158k per year

What benefits can Birmingham experience from implementing Community Agents?

Assuming this service was available in Birmingham, aiming to support approximately 2,700 older people a year (which would be the same proportion of older people supported by the scheme in Redcar & Cleveland), and assuming the same per person benefits could be achieved as in Redcar & Cleveland, we estimated the following benefits are possible:

Community Agents could provide net savings of approximately £900k per year for the local authority in Birmingham
# Modelling evidence-based models

<table>
<thead>
<tr>
<th>Area</th>
<th>Promising models</th>
<th>Primary characteristic of target population</th>
<th>Existing beneficiaries (Birmingham)</th>
<th>Potential Beneficiaries (Birmingham)</th>
<th>Potential net saving PA (Birmingham)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community Agents</td>
<td>Older people living alone</td>
<td>N/A</td>
<td>2,702 users</td>
<td>£900k ASC</td>
</tr>
<tr>
<td>2</td>
<td>Living Well</td>
<td>Older people with LTCs</td>
<td>N/A</td>
<td>1,000 users</td>
<td>£1.0m ASC; £1.4m NHS</td>
</tr>
<tr>
<td>3</td>
<td>Kent Pathways Service</td>
<td>Adults with a learning disability</td>
<td>N/A</td>
<td>146 users</td>
<td>£250k ASC</td>
</tr>
<tr>
<td>4</td>
<td>Shared Lives</td>
<td>People with learning disabilities or mental health needs</td>
<td>78 people with learning disabilities and live-in arrangements; 10 people with mental healths</td>
<td>52 additional users with live-in arrangements</td>
<td>£1.3m ASC</td>
</tr>
<tr>
<td>5</td>
<td>Kent acute discharge</td>
<td>Mostly older people</td>
<td>N/A</td>
<td>N/A</td>
<td>£4.6m ASC</td>
</tr>
<tr>
<td>6</td>
<td>BRC Support at Home</td>
<td>Older people whose day to day activities are limited a lot</td>
<td>N/A</td>
<td>1,357 users</td>
<td>£170k ASC; £450k NHS</td>
</tr>
</tbody>
</table>

Total financial benefits: £7.2m ASC*; £1.8m NHS
Transforming care – BCF and beyond

- **Citizen conversations** to build a vision for integrated care
  - Establish shared goals
  - Agree what needs to change (use 5 ways as areas for agreement)
  - Agree how you will approach the development and delivery of work, and agree realistic parameters.
- **Develop logic models** to map out the sequence through which investments and inputs, and specific interventions, will bring about desired outcomes
  - Test extent to which plans will reduce costs and improve outcomes
- **Identifying and scaling up evidence-based models to:**
  - Build credible picture of potential savings
  - Develop business cases for investment
  - Develop understanding of what needs to change to deliver the model
Citizen conversations

- Consider current situation (as-is) and build aspirations for the future (to-be). For each of the five areas this will involve:
  - Describing what is working best in other places and locally, to explore how local people would like resources invested alongside the other local assets. **The aim will be to establish consensus around real shifts in investment to the most cost-effectiveness and high-outcome models.**
  - Describing what we do at the moment and how much it costs and what inspectors, staff and local people say works and what needs to change.
- **Establish citizens’ vision for change**, including what good looks like, strengths and gaps in current services, views on what needs to change and why
- **Explore what will make a difference in relation to the five main areas**, e.g. Supporting people and families who need help to carry on living at home.
**Integrated Care Logic Model**

**Enablers**
- Strong, system-wide governance and systems leadership
- Integrated electronic record and good data sharing across the system and service users
- Service user engagement and a commitment to coproduction, choice and building of people's strengths
- Integrated workforce with joint training and upskilling
- Quality or state of the provider market

**Core Interventions**
- Early identification of people who are at higher risk of developing health and care needs
- Prevention and self-care
- People who need them are able to access a personal budget
- Joint needs assessment, care planning and care management
- Areas use multi-disciplinary integrated teams in community and hospital settings
- Community services available when needed (e.g. reablement, quality care homes and care at home)

**Service User Outcomes**
- I tell my story once
- I am as involved in discussions and decisions about my care, support and treatment as I want to be
- I can decide the kind of support I need and how to receive it
- When I move between services or settings, there is a plan in place for what happens next
- I am supported to return home safely and without delays, and services are in place to support my rehabilitation

**Service User Impact**
- I am able to access community resources that help me stay healthy and maintain independence
- Taken together, my care and support help me live the life I want to the best of my ability
- I am able to live independently at home or in my community

**System Impact**
- Reduction in dependence on hospitals
- Reduction in dependence on residential and nursing care
- Improved flow through the system
- Reduced duplication across the system
- More motivated and flexible workforce
- Sustainable health and care system

**Sustainable health and care system**

**Improved health and well-being**

**Informed and engaged people**

**Integrated, multi-disciplinary and collaborative working**

**Sustained improvement across the system**

**Integrated care**

**Social care**

**Institute for Excellence**

**SCIE**
Building business cases

For each model of care we would assess:

- What is the potential scale of savings?
- Timescales for benefits being realised
- How would it improve the quality of care and outcomes for service users?
- What would happen if we did nothing?
- What are the key factors of each model that need to be in place for it to work?
## Resources

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Link</th>
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<tbody>
<tr>
<td>Nesta Realising the Value</td>
<td>Evidence of impact of preventative, person-centred care</td>
<td><a href="http://www.nesta.org.uk/project/realising-value">http://www.nesta.org.uk/project/realising-value</a></td>
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