BCST Regional Workshop: North

Newcastle, 23 January 2019
10am – 3.30pm
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>10:00</td>
<td>Arrival, registration and networking</td>
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<tr>
<td>10:30</td>
<td><strong>Introduction: aims of the day</strong>&lt;br&gt;Jayne Robson, Better Care Manager, Cumbria and the North East</td>
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<tr>
<td>10:40</td>
<td><strong>Chair’s Introduction and BCF Update</strong>&lt;br&gt;Rosie Seymour, Deputy Programme Director, Better Care Fund</td>
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<tr>
<td>11:10</td>
<td><strong>Delivering Integration: Being relentless in the pursuit of person-centred coordinated care</strong>&lt;br&gt;Deborah Rozanksy, Associate at SCIE</td>
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<td>11:50</td>
<td>Coffee/Tea Break</td>
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<tr>
<td>12:00</td>
<td>- <strong>Workshop 1 - Working together for admission avoidance and discharge</strong>&lt;br&gt;- Stella Krain, Occupational Therapist and Anita Frost, Joint Locality Therapy Lead, Rotherham Foundation Trust&lt;br&gt;- <strong>Workshop 2 - Social Worker participation in Hospital Discharge Management Team</strong>&lt;br&gt;- Norman Devlin, CDDFT and Carmel Reilly, Darlington Borough Council&lt;br&gt;- <strong>Workshop 3 - Mental Health Access Team Pilot: Developing an MDT response within Newcastle RVI for adults with mental health needs</strong>&lt;br&gt;- Lynn Condon, Service Improvement Lead, Adult Social Care, Newcastle City Council</td>
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<tr>
<td>12:40</td>
<td>Lunch</td>
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<tr>
<td>13:30</td>
<td>- <strong>Workshop 1 - Working together for admission avoidance and discharge</strong>&lt;br&gt;- Stella Krain, Occupational Therapist and Anita Frost, Joint Locality Therapy Lead, Rotherham Foundation Trust&lt;br&gt;- <strong>Workshop 2 - Frailty: What the NEL is it?</strong>&lt;br&gt;- Leslie Bainbridge, Lead Nurse Frailty and Integration and Clinical Lead Care Closer to Home Network NENCRHW</td>
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<tr>
<td>14:20</td>
<td>Coffee/Tea Break</td>
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<td>14:30</td>
<td>- <strong>Workshop 1 - Frailty: What the NEL is it?</strong>&lt;br&gt;- Leslie Bainbridge, Lead Nurse Frailty and Integration and Clinical Lead Care Closer to Home Network NENCRHW&lt;br&gt;- <strong>Workshop 2 - Social Worker participation in Hospital Discharge Management Team</strong>&lt;br&gt;- Norman Devlin, CDDFT and Carmel Reilly, Darlington Borough Council</td>
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<td>15:10</td>
<td>Sharing Learning and Panel Discussion</td>
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<td>15:30</td>
<td>Close</td>
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Chair’s Introduction and Update from BCST

Rosie Seymour
Deputy Programme Director
Better Care Support Tea
Better Care Fund - Health and Social care integration

**Rosie Seymour**
Deputy Director, Better Care Support team

Wednesday 23 February 2019
Integration

Prevention
Seamless
Workforce
Aligned targets
Training strengthening skills
Coordinated Care
Local housing
Multi-disciplinary teams
Service User
Primary Care
Joined-up IT

Put the Person in control
Move away from metrics
Continuity of Services
Involving the Voluntary Sector

Health and Social Care
Community engagement
Better Care Programme overview

• The Better Care Fund (BCF), now in its fourth year, is the only mandatory national programme for integrating health and social care

• The BCF is a partnership programme that represents a collaboration between NHS England, the Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and the Local Government Association (LGA)

• Aims to **break down organisational barriers** so health and social care can deliver the right care, in the right place, at the right time, so that people can:
  
  • Manage their own health and wellbeing
  • Live independently in their communities for as long as possible
  • Be at the centre of their care and support to ensure improved experience and better quality of life.
Big Picture

Integration Policy
- BCF review developing options for BCF beyond 2020
- Considering role of the fund and ensuring best value

Spending and wider landscape
- NHS Long Term Plan priorities closer integration at system and place level, with primary care anchoring an improved community offer
- Work underway to improve measurement of integration

BCF priorities
- Identifying the best way to understand impact and progress on integration
- Retaining a focus on person centered care and prevention
BCF 2019-20


- Aims from a programme perspective:
  - Minimise planning burden;
  - Provide consistency;
  - Support areas through the year to prepare for the outcome of the BCF review.

- The BCF Planning Requirements for 2019-20 to be collected via a single template with minimal narrative input rather than a separate narrative plan.

- Assurance of plans will continue to take place at regional level through joint NHS/local government arrangements.

- DToC expectations will continue to be set via the BCF.
BCF and the NHS Long Term Plan

• The NHS Long Term Plan revealed a breadth of ambition for improving healthcare over the coming decade with particular focus on harnessing the power and talents of patients and the workforce.

• The NHS Long Term Plan recognises that the BCF has provided an opportunity for joint working between councils and the NHS.

• Integration of services remain high on the NHS Long Term agenda with plans to roll out the integrated Care Systems by April 2021.

• Sets out NHS commitment to continue supporting local approaches to pooled, joined up health and social care.

• Specific commitments to integrating community services (urgent response, reablement and health in care homes). Clear overlap with BCF which will need to be aligned through the BCF Policy Framework and Planning Requirements.
National Impact of the Better Care Fund

Impact on joint working for integration of care

Positive impact on local relationships and joint working:
- 93% of Health and Wellbeing Boards (HWBs) agreed that the BCF has improved joint working between health and social care in 2017-18 (90% in 16-17)
- 91% of HWB agreed that the BCF had positive impact on integration of health and social care in 2017-18 (88% in 16-17)

Year on year increase in voluntary pooling of funds:

<table>
<thead>
<tr>
<th>Year</th>
<th>£m</th>
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<tbody>
<tr>
<td>15/16</td>
<td>£1.5m</td>
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<tr>
<td>16/17</td>
<td>£1.9m</td>
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<tr>
<td>17/18</td>
<td>£2.1m</td>
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<tr>
<td>18/19</td>
<td>£2.1m</td>
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BCF voluntary pooling
BCF Support Programme

• We are continuing to deliver a broad programme of support, including:
• Better Care Advisory and multi-disciplinary consultancy support
• Peer Reviews for systems
• Transfers of Care support
• National Thematic Workshops
  • 14 February and 28 February
• Regional support funding
• Regional support events and networking
• Weekly Integration and Better Care Fund e-bulletin
• The Better Care Exchange – collaboration platform
• Refreshing series of How-to guides on integrated care
• Case studies, and emerging and local practice examples, including video content
• Briefing papers on a range of integration topics
Learning from targeted support on discharge

As part of the Better Care Support Offer we commissioned Newton Europe to help areas identify key factors causing delays to people’s discharge from hospital.

Of the 27% fit but waiting to be discharged:

- **37% were waiting for an ongoing service** (e.g. for a package of care or for a bed), and

- **37% of them were waiting for a decision about their ongoing care** (e.g. through an assessment).
Better Care Support programme

How many people wait to be discharged from hospital?

• Across 14 systems, we looked at 10,400 patients occupying hospital beds. On average, across the systems, 27% of these had been declared medically fit for discharge, but were still in hospital.

• This means that, not only are they at risk of losing muscle mass, mobility, independence, confidence and contracting infection, but they are also occupying a bed that is needed for others with acute illnesses or injury.
WHEN DISCHARGED, DO PEOPLE GO TO THE RIGHT SETTING TO MAXIMISE INDEPENDENCE?

- Ideal outcomes were achieved in only 58% of cases in the sample.
- 42% of people were discharged to a less than ideal setting, with less than ideal levels of care.

The case reviews we conducted with practitioners in all systems indicated that between 32% and 54% of people are discharged to a less than optimal setting, with a less than optimal level of care.

This has a significant impact on outcomes, staff, resources and budgets.

Reasons for Non-Ideal Decisions:
- Real or perceived lack of capacity in service
- Risk averse decision
- Family disagreement
Better Care Fund Review

NHS Long term Plan
Showcased NHS commitment to continue supporting local approaches to pooled, joined up health and social care.

Social Care Green Paper
Will include section on Integration and BCF.

Spending Review
Long term approach to local government funding.
Any questions?

For more information contact us at

England.bettercaresupport@nhs.net
Plenary

Delivering Integration: Being relentless in the pursuit of person-centred coordinated care

Deborah Rozansky
Associate at SCIE
Delivering Integration: Being relentless in the pursuit of person-centred coordinated care

Deborah Rozansky
Social Care Institute for Excellence

23 January 2019
Overview

- Continuity of integrated care as a policy objective
- Introducing the SCIE Logic Model as a framework
- “Person-centred, coordinated care”: how care systems need to change to deliver better care
- What interventions work to accelerate change
- How to monitor and measure local progress: the local dashboard
- Some instruments and tools you might use to support improvement
Integrated care as an ongoing policy priority

• 30+ years of policies and programmes seeking to bring together health and social care.

• Since 2010:
  - Joint commissioning
  - Integration Pioneers
  - New Care Models (NHS)
  - Better Care Fund
  - High Impact Changes
  - CQC Local System Reviews
  - Integrated Care Systems
Integrated care can be complex
(Canterbury, New Zealand)
Integrated care according to the service user

Focus on improving the service user’s experience

Five domains of person-centred coordinated care:

1. Information
2. Communication
3. Involvement in decisions
4. Care planning
5. Care coordination
Integrated care is really a journey of change...
SCIE’s Integration work for DHSC

2016
- DHSC asked SCIE to test out an Integration Standard with stakeholders and service users through scoping research.

March 2017
- Integration and Better Care Fund Framework was published, alongside SCIE’s research on the Integration Standard.
- The Framework sets out plans to develop a ‘wider integration scorecard’ to enable areas to assess progress on integration.

April 2017
- SCIE carried out further research to continue developing the framework for understanding and measuring integrated care.

Nov 2017
- Publication of Logic Model for Integrated Care and findings on measuring integrated care.
Developing an integration logic model

- The Logic model describes how **different enablers and components of integrated care** lead to improve outcomes for:
  - service users
  - health and care services
  - the wider health and care system
- The logic model drew upon existing best practice, e.g. Vanguards, academic research, CQC Local Systems Reviews
- The logic model also helps set out a number of **measures of impact**.

1. **Enablers of integration**, which are contextual factors that create the pre-conditions for integrated care. This includes factors such as leadership and governance, partnership arrangements and joint budgets.

2. **Components of integrated care**, such as the types of interventions or activities that create integration, from proactive management of care to multi-disciplinary teams.

3. **Outcomes for**
   - Service users
   - Services
   - Systems

4. **Impacts**, which are long term benefits that are more difficult to measure; ours reflect the convention of the Triple Aim: improving health and wellbeing, enhancing quality and providing best value.
Enablers

- Strong, system-wide governance and systems leadership
- Integrated electronic records and sharing across the system and with service users
- Empowering users to have choice and control through asset-based approach, shared decision making and coproduction
- Integrated workforce: joint approach to training and upskilling of workforce
- Good quality and sustainable provider market that can meet demand
- Joined-up regulatory approach
- Pooled or aligned resources
- Joint commissioning of health and social care
- Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)

Components of integrated care

- Early identification of people who are at higher risk of developing health and care needs and provision of proactive care
- Emphasis on prevention through supported self-care, and building personal strengths and community assets
- Holistic, cross-sector approach to care and support (social care, health and mental health care, housing, community resources and non-clinical support)
- Care coordination: joint needs assessment, joint care planning, joint care management and joint discharge planning
- Seamless access to community-based health and care services, available when needed (e.g. reablement, specialist services, home care, care homes)
- Joint approach to crisis management: 24/7 single point of access, especially to urgent care, rapid response services, ambulance interface
- Multi agency and multi-disciplinary teams ensure that people receive coordinated care wherever they are being supported
- Safe and timely transfers of care across the health and social care system
- Care assessment, planning and delivery are personalised and, where appropriate, are supportive of personal budgets and IPC
- Care teams have ready access to resources, through joint budgets and contracts, to provide packages of integrated care and support
- High-quality, responsive carer support

Outcomes

- Taken together, my care and support help me live the life I want to the best of my ability
  - I have the information, and support to use it, that I need to make decisions and choices about my care and support
  - I am as involved in discussions and decisions about my care, support and treatment as I want to be
  - When I move between services or care settings, there is a plan in place for what happens next
  - I have access to a range of support that helps me to live the life I want and remain a contributing member of my community
  - Carers report they feel supported and have a good quality of life

- The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place
  - The model is proactive in identifying and addressing care needs as well as responsive to urgent needs, with more services provided in primary and community care settings
  - Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared user records, joint care management protocols and agreed integrated care pathways
  - Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users
  - Transfers of care between care settings are readily managed without delays

- Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves services user flow
  - Effective provision of integrated care helps to manage demand for higher cost hospital care and to control growth in spending
  - Integrated care shifts service capacity and resources from higher cost hospital settings to community settings
  - The system enables personalisation by supporting personal budgets and Integrated Personal Commissioning, where appropriate

Impact

- IMPROVED HEALTH AND WELLBEING
  - Improved health of population
  - Improved quality of life
  - Reduction in health inequalities

- ENHANCED QUALITY OF CARE
  - Improved experience of care
  - People feel more empowered
  - Care is personal and joined up
  - People receive better quality care

- VALUE AND SUSTAINABILITY
  - Cost-effective service model
  - Care is provided in the right place at the right time
  - Demand is well managed
  - Sustainable fit between needs and resources
Logic model has been widely used

Integrating Better

Local System Reviews

DHSC funded resource

National Audit Office, Interface between health and care

Integration and Better Care Fund

BCF reporting
<table>
<thead>
<tr>
<th>What does good integrated care look like?</th>
<th>How do local systems need to change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service users’ care experiences are improving, becoming more person-centred</td>
<td>Professionals and organisations are working collaboratively to coordinate care for individuals</td>
</tr>
<tr>
<td>Proactive and preventative services are focused on keeping people well and independent, delivering the right care at home or in the community to prevent unnecessary hospital care</td>
<td>System has the capacity and resources are optimally allocated to achieve the other goals</td>
</tr>
</tbody>
</table>
Interventions that accelerate integrated care

- Focusing attention on a small handful of areas will both accelerate on-the-ground progress with integration and represent good value:
  - Care coordination and continuity of care in primary care, community settings and at home;
  - Care coordination and continuity at transitions between care settings; and
  - Eliminating specific barriers to integration, e.g. interoperable care records and fully compatible data systems, as well as investing in MDTs and enabling access to joint resources.
How to use the logic model

- The tool can inform strategic planning, delivery, monitoring and evaluation of integrated care.
- Use the logic model to explore with your local partners:
  - Strengths and weaknesses in relation to the key enablers and components
  - Extent to which robust plans exist for implementing key components of care, such as MDTs, and person centred care and support planning
  - How you measure progress (more on that shortly!)
Why create a local dashboard?

We suggest local integrated care dashboards use a balanced set of metrics, combining national data that is currently and routinely collected with data that is captured locally (often process measures).

This approach recognises current measurement gaps as well as the limitations associated with data sources and other methodological challenges, but it would provide useful data for local accountability and improvement efforts.
Criteria for selecting metrics

- **Meaningful**: Evidence shows a strong association between the metric and outcome we seek to measure, even if a proxy metric

- **Reliable and valid**: The quality of the metric is considered good and methodologically sound for understanding local systems

- **Available**: Data are collected routinely, national datasets are readily accessible

- **Cost-effective**: Data collection burden is not additional to current requirements

- **Useful**: Analysis of the data, especially over time, assists with understanding performance and identifies improvement opportunities
### The advantages and disadvantages of using different metrics sources

<table>
<thead>
<tr>
<th>Source of data</th>
<th>Advantages</th>
<th>Disadvantages</th>
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</thead>
<tbody>
<tr>
<td>National datasets and surveys (NHS Digital)</td>
<td>Collected and reported already (no additional burden or costs)</td>
<td>Not timely or focused on people receiving integrated care</td>
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<tr>
<td></td>
<td>Metrics are understood and already used to judge system performance</td>
<td>System measures = acute care outcomes with multiple influences</td>
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<td></td>
<td>Health indicators</td>
<td>Metrics not assessing integrated care <em>per se</em></td>
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<tr>
<td>Local indicators, drawn from validated tools and instruments</td>
<td>Programme or project-based, often qualitative</td>
<td>Requires collection of data locally</td>
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<tr>
<td></td>
<td>Most useful for testing interventions and making improvements</td>
<td>Aggregation challenges (not scalable)</td>
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<td>Includes process measures</td>
<td>Problems with determining causality</td>
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</table>
## A suggested core dataset

<table>
<thead>
<tr>
<th>Indicators</th>
<th>People's experience of integrated care</th>
<th>Proactive and preventive care</th>
<th>Coordination and transfers of care</th>
<th>Resource use and balance of care</th>
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<tbody>
<tr>
<td>Delayed transfers of care (DToCs)</td>
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<tr>
<td>Emergency admissions (65+)</td>
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<td>Unplanned hospital admissions for chronic ambulatory care sensitive conditions</td>
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<td>Emergency readmissions</td>
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<tr>
<td>90th percentile of length of stay for emergency admissions (65+)</td>
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<td>Proportion of discharges (following emergency admissions) which occur at the weekend</td>
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<td>Total bed days</td>
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<td>Admissions to residential care</td>
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<td>Effectiveness of reablement - still at home 91 days after discharge</td>
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<tr>
<td>Access to reablement - 65+ receiving reablement after discharge</td>
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<td>Emergency hospital admissions due to falls in people aged 65 and over (PHOF)</td>
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<tr>
<td>Hip fracture: Proportion of patients recovering to their previous levels of mobility at 120 days</td>
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<tr>
<td>Proportion of patients who have agreed a care plan and find them useful (GP Survey Q41; Q42)</td>
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<tr>
<td>Proportion of people feeling supported to manage their long-term conditions (GP Survey Q38; Q40)</td>
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<td>Patient involvement in care (GP Survey Q28)</td>
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<td>Service user choice and control (Adult Social Care survey, e.g. Q2c; Q3a; Q3b)</td>
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<tr>
<td>Inpatient experience of care coordination (Inpatient Survey Q32; Q54; Q62; Q66)</td>
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<tr>
<td>Carer involvement (SACE Q18)</td>
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<td>Experience of end of life care (VOICES survey)</td>
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Measuring person-centred coordinated care

Domains and sub-domains of P3C

My goals
- Goal setting
- Empowerment & Activation
- Self-management
- Carer support

Care Planning
- The care plan
- Case management
- Single point of contact
- Care coordination (within teams and across teams)

Decision Making
- Involvement in decision making

Information & Communication
- Relational continuity
- Information gathering/sharing
- Knowledge of patient/familiarity

Transitions
- Continuity of care

Organisational Process Activities
- Valuing physical & mental health equally
- Proactive case management
- Experience of care
- Longer appointment times
- Staff training
- Supporting people to stay at home

Evidence for this model was derived from:
### Local Dashboard – Example

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Aspirations/Objectives</th>
<th>Measurement</th>
<th>Assumptions</th>
<th>Outputs</th>
<th>Measurement</th>
<th>Outcomes</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong Systems Leadership</td>
<td>Implement joined up assessments and reviews (different conversation focussed on what matters to them)</td>
<td>No. and type of community/vol sector groups supported to</td>
<td>No. of people in support</td>
<td>No. of practitioners trained</td>
<td>Person and careers experience questionnaire</td>
<td>Improved wellbeing</td>
<td>Warwick/Edinburgh Mental Wellbeing Scale (CECAP or other well being scale)</td>
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<tr>
<td>Strong GP leadership and input</td>
<td>Strengths-based conversations used to connect people to community based forms of care, support and connections</td>
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<td>Improved health</td>
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<tr>
<td>Dedicated programme coordination</td>
<td>No. and type of community/vol sector groups supported to</td>
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<td>Improved experience of people</td>
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<td>Frontline staff freed up to co-design, test and embed new skills and processes</td>
<td>Staff skilled in person-centred care and guided conversation</td>
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<tr>
<td>Co-design of processes with people and families</td>
<td>Those who need one receive personalised care plan</td>
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<tr>
<td>Joint training of practitioners across the system/MDT</td>
<td>People have a named person responsible for their care - coordinated and joined up approach</td>
<td></td>
<td>Consistent approach to identifying people who will receive joint assessment</td>
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<tr>
<td>Ongoing opportunities for MDT to build relationships and review progress</td>
<td>MDT’s with strong social care and vol sector involvement (if appropriate)</td>
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<td>Data sets linked (or a minimum access to whole system datasets) so we can understand impact and costs of people supported by sites</td>
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<tr>
<td>Build on learning from IPD work on learning disabilities and mental health</td>
<td>Single care record</td>
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### Personalised Care Programme Outcomes

- People with complex needs and their carers have better quality of life and can achieve the outcomes that are important to them and their families through greater involvement in their care, and being able to design support around their needs and circumstances

- Better integration and quality of care, including better user and family experience of care

- Prevention of crises in people’s lives that lead to unplanned hospital and institutional care – so ensuring better value for money
Measuring peoples’ experiences - P3C-EQ (Plymouth University)

1. Did you discuss what was most important for YOU in managing your own health and wellbeing?

2. Were you involved as much as you wanted to be in decisions about your care?

3. Were you considered as a ‘whole person’ rather than just a disease/condition in relation to your care?

4. Were there times when you had to repeat information that should have been in your care records?

5. Is your healthcare joined up in a way that works for you?

6. Do you have a single professional (or several professionals) who takes responsibility for coordinating your care across the services that you use?
7. a. Do you have a care plan (or a single plan of care) that takes into account all your health and wellbeing needs?
   
b. Is this care plan (or plan of care) available to you?
   
c. To what extent have you found your care plan (or plan of care) USEFUL FOR YOU to manage your health and wellbeing?
   
d. To what extent do all the professionals involved in your care appear to be following the same care plan (or plan of care)?

8. Have you had enough support from the healthcare staff to help YOU to manage your own health and wellbeing?

9. To what extent do you receive useful information at the time you need it to help you manage your health and wellbeing?

10. How confident are you that you can manage your own health and wellbeing?

11. a. Do you need/want to have your friends/family involved in decisions about your healthcare?
   
b. Did the healthcare staff involve your family/friends/carers as much as you wanted them to be in decisions about your care?
Assessing local system maturity

Logic Model for Integrated Care

- Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
- Strong, system-wide governance and systems leadership
- Integrated electronic records and sharing across the system and with service users
- Empowering users to have choice and control through asset-based approach, shared decision-making and co-production
- Integrated workforce: joint approach to training and upskilling of workforce
- Good quality and sustainable provider market that can meet demand
- Joined-up regulatory approach
- Pooled or aligned resources
- Joint commissioning of health and social care

SCIROCCO Maturity Model (EU)
Reviewing the status of system enablers, and tackling barriers to integrated care

- The SCIROCCO model and self-assessment tool, also known as the B3-MM, which was tested extensively across Europe. The International Foundation for Integrated Care is presently seeking partners to roll out the tool further.

- LGA Stepping up to the Place self assessment tool, looks at systems leadership qualities

- Manchester Local Care Organisation is working with SCIE on self assessment tool on integrated neighbourhood working
What other tools is SCIE developing?

- Beta version of an online Integration Resource to be launched in January (“How to”, evidence and best practice)
- Developing simple self assessment tool with Manchester Local Care Organisation and others
- We will update the Logic model to take account of new evidence and policy in the early new year
- Government will consider options for improving measurement of integration, especially in regards people’s experiences of care.
Further information


Person centred coordinated experience questionnaire – Dr Helen Lloyd, Plymouth Univ.

The SCIROCCO model and self-assessment tool

Deborah Rozansky: drozansky6191@btinternet.com
Twitter: @DRR_Tweets
Questions

- What would help local areas use the logic model to improve the planning and delivery of integrated care?

- What help do local areas need to effectively evaluate and measure improvement?
Workshop: Working together for admission avoidance and discharge

Stella Krain, Nicky Wear and Anita Frost
Rotherham
Rotherham Place Plan
Urgent and Community Work Stream

Working Together for Admission Avoidance and Discharge
‘Trusted Assessor’ Pilot

Stella Krain, OT
Nicky Wear, Physio
Anita Frost, Joint Locality Lead

23 January 2019
Why Change?

The Rotherham Place Plan

* Challenges of aging population, increased demand, funding gap
* Care Act: Prevent, Reduce, Delay agenda
* 6 interdependent priorities to deliver integrated health and social care working by 2020
* Joined together through Home First golden thread

The Patient View

* Most people don’t want to be in hospital
* Increased risks: infection, muscle loss, reduced mobility, institutionalisation.

Place Plan vision:

to support ‘people and families to live independently in the community, with prevention and self-management at the heart of our delivery’.
The Trusted Assessor Pilot

Aim
To provide community led interventions in ED, AMU and with the Frailty Team to enable adults to be discharged & supported at home as an alternative to admission

Work streams
* 6 month Trusted Assessor pilot, June 2018 (front door)
* Integrated Discharge Project October 2017 (back door)
* Anticipated benefits
  * Reduced admissions
  * Reduced Length of Stay
  * Reduced DTOCs
Defining a Trusted Assessor

* Someone who helps patients “move from hospital back home or another setting speedily, effectively and safely” (NHS England, 2018 - “Trusted Assessor scheme)

* A health professional “trusted” to carry out a generic assessment to decide whether a patient may be able to return home the same day

* Carried out in consultation with other professionals involved in the patient’s care

* Considers social issues as well as therapy issues

* Based on a “Home First” model
Our Trusted Assessor Role

- Band 7 job share to carry out clinical work, develop and evaluate the service
- 9 month secondment
- Community Physio and OT in-reaching
- Generic working
- Working into ED, AMU and with the Frailty Team
Frailty criteria:
- Over 65 years and a diagnosis of dementia
- Over 65 years and from a nursing home
- Over 75 years and fall or delirium

Trusted Assessor Criteria
- Any patient over 18 years of age where it is likely they could return home the same day as referral with therapy input

In-patient Physio Criteria
- Any patient over 18 years where:
  a) their usual level of mobility is known
  b) they have been stood up and their level of mobility has been found to be worse than usual

How it Works in Practice

ED Referrals to Trusted Assessor, Frailty or In-patient Physiotherapy

- Is it likely that following all medical interventions, this patient will be able to return home today? 
  - No → Not appropriate for trusted assessor (Hospital Admission)
  - Yes → Is it a weekday (excluding Wednesday) 8:30-15:30?
    - No → Is it a weekday 15:30-17:30? Or a Wednesday, Saturday, Sunday or Bank Holiday 8:30-15:30
      - No → Is it any day 8:00-8:30 15:30-18:00
        - No → No
        - Yes → Yes
          - Yes → Does the patient fit the frailty criteria?
            - Yes → Refer to the frailty team (X7609)
            - No → No
              - No → Discharge Home
              - Yes → Refer to in-patient physio team (X8177)

- Does the patient have nursing, social or therapy needs that would make discharge home unsafe? 
  - No → No
  - Yes → Contact trusted assessor (Hospital Admission)
    - X8254

- Does the patient simply need a mobility assessment? 
  - Yes → Yes
  - No → No

- How it Works in Practice
Referral Criteria

- Any adult over 18 years whose medical condition can be managed in the community
- but who has other complex needs which may be a barrier to discharge home
- including therapy intervention, equipment provision, social, nursing, mental health, care or enabling input
Generic Assessment includes:

- mobility and transfer assessment
- liaising with all relevant individuals, professional and family/carers to ensure personal & domestic ADLs can be managed.

Followed up by our wider community based therapy team for further home assessment to determine equipment & treatment needs & onward referrals.

- 7 day service aiming to assess at home same day or within 24 hours
**Benefits: Trusted Assessor**

* Positive feedback from patients, families & professionals
* Majority home same day/ just with therapy resource
* Despite limited size of trial, 1 part time therapist, worked as a job share, has had significant impact on hospital admission avoidance as shown.
* Change of culture in acute setting re: Home First
* Closer working between acute and community therapists
  * Greater understanding of risk acceptance
  * Cover in ED/AMU

<table>
<thead>
<tr>
<th>Destination</th>
<th>Number</th>
<th>%</th>
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<tbody>
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<td>Usual Place of Residence</td>
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<td>73%</td>
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<td>24%</td>
</tr>
<tr>
<td>Admitted to Intermediate Care</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Admitted to Alternative Step-Up</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Step-Down Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>213</td>
<td></td>
</tr>
</tbody>
</table>
Contribution to System-Wide Home First Outcomes
Challenges

- Limited resources – 1 band 7 therapist, job share, service development resulted in clinical hours being part time.
- Other established teams unaware of our presence or role.
- Many different pilots undertaken simultaneously and therefore confusion for teams.
- Capacity of other services & teams to support both acute & community.
- Funding being delayed for further timely service development and progression.
Investment of winter monies

* Community Hospital Admission Avoidance Team (CHAAT)
* 7 day cover 8 am – 6pm
* Trusted assessors/Therapists – further developing integration of community in-reaching service & community Urgent therapy team
* 3 Band 6 therapists & 2 band 3 support workers
* Further development of integrated working with both community nursing services, social services and care providers.

Intermediate Care and Reablement Review

* Development of Home First model
* Re-configuration of Community Beds
Contact Details

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nichola.wear@nhs.net

Stella Krain:
stella.krain@nhs.net

Anita Frost
Anita.Frost@nhs.net
Workshop: Social Worker participation in Hospital Discharge Management Team

Norman Devlin and Carmel Reilly
Darlington
Multi-disciplinary Discharge

Darlington
Objectives and approach of the Darlington MDT discharge approach

To facilitate safe, speedy discharge of medically/multi-disciplinary fit patients

Reduce all DToC and deliver zero ASC-attributed DToC

BCF funds two full time Social Workers to be based in the hospital working in partnership with the discharge management team, ward sisters and ward co-ordinators, and multi-disciplinary colleagues.
Daily Discharge Management Team meetings at Darlington Memorial Hospital are attended by Darlington Borough Council (DBC) Social Workers.

Established team members over the past two years, leading to a very good understanding of hospital systems, positive relationships with nurses, ward staff, therapy staff – enabling them to contribute to the efficiency and effectiveness of those meetings.

A shared understanding of objectives and everyone’s roles in achieving them.
The Darlington MDT discharge approach

Provides a natural platform for sharing learning.

The approach is also spread through links with Community staff in the community hospitals.

Hospital staff are part of RIACT (Responsive Integrated Assessment Care Team), so share the ethos/philosophy.

Learning from RIACT team is shared across the community team, and community teams refer into hospital social workers, to take advantage of their detailed hospital intelligence.
The Darlington MDT discharge approach

The embedded social workers also provide a link to expertise to support complex cases, around areas like mental capacity, sharing knowledge and information.

Being present in the hospital facilitates a collective analysis of risk, working in partnership on the complexities of some patients through participation in case conferences, ward meetings, safeguarding discussions etc. to mitigate risk and enable safe discharges.

Care Connect is linked into the discharge planning providing support for patients with low level need, but who need a little support to transition back to the community. SW bring knowledge of these kinds of resources.
The value of a shared understanding

The robustness of the MDT at the “front line” made it possible for managers to get together collectively to review DToC cases as a system, and build a new level of shared understanding at that level about what is a reportable DToC.

This led to greatly reduced reported DToC, and complete confidence in the numbers subsequently reported, and enhanced dialogue in the SitRep validation process.
The value of a platform for learning

In DBC this year, social care is focusing on developing strength-based work, building staff capability and ability.

This led to a letter for patients on admission, setting expectations about discharge and reablement, contributing to busting the “six weeks free care” myth.

This has been shared with colleagues in health and beyond Darlington.

The initial feedback is very positive in supporting discussions with patients and families around planning for discharge.
The value of additional expertise

Social Workers are proactively supportive of hospital colleagues around areas like mental capacity, sharing knowledge and information.

Their access to hospital services and resources means they are able better to liaise with Social Workers on discharge management.

Being present in the hospital facilitates a collective analysis of risk, working in partnership on the complexities of some patients through participation in case conferences, ward meetings, safeguarding discussions etc. to mitigate risk and enable safe discharges.
Key benefits

Significant advantages arising from the proximity of social workers. They are visible, present, responsive, and have acquired a clear profile in the hospital leading to trusted relationships.

Shared understanding and shared agenda across health and social care, supporting safe and timely discharge from hospital

The MDT meetings allow early notification of people moving towards being medically fit for discharge. Discharge coordinators and ward sisters provide a “heads up” that someone is approaching being medically fit, so allowing the LA to respond flexibly to demand, prioritising and de-prioritising continually.

Relationships and trust – a shared agenda – no-one to stay longer in hospital than they need to.

This intelligence helps us identify blips. For example in Q4 17/18 there were some blips in DToC reports (triggered by the introduction of e-notices) which were identified before the data itself was published, allowing a very quick system-wide response to bring things back on track and with significantly improved understanding of the process.
Key outcomes

Low and reducing DToC.

Excellent relationships and levels of trust sufficient to enable system leaders to work together on improving understanding and reporting DToC.

Recent RPIW on patients with packages of care across CDDFT brought out very clearly from hospital staff that having the SW a part of the team was a significant contribution to good performance – they “made all the difference”.

This intelligence and close working facilitates quick identification of changes and quick action to pull things back on track.
Blip triggered by new focus on recording in the hospital.

*Monthly plans are based on quarterly plans (Quarter divided by 3).
Workshop: Mental Health Access Team Pilot: Developing an MDT response within Newcastle RVI for adults with mental health needs

Lynn Condon and Doreen Andrews
Newcastle
Mental Health Access Team Pilot

Developing an MDT response within Newcastle RVI for adults with mental health needs
Who are we?

Doreen Andrews
Acting Service Manager – LDA and Mental Health, Newcastle City Council

Lynn Condon
Service Improvement Lead - Adult Social Care, Newcastle City Council
What is the Mental Health Access Team?

The Mental Health Access Team (MHAT) project is funded via temporary funding from the Improved Better Care Fund (IBCF) between 2017 and 2020.

The project has been set up to pilot a new approach to supporting adults with mental ill health who present to the RVI Emergency Department in a mental health crisis.
Drivers

The project arises from both national and local policy drivers, including:

• NICE paper on Achieving Best Access to 24/7 Urgent and Emergency Mental Health Care,
• Implementing the 5 year Forward View for Mental Health,
• The local Crisis Care Concordat development plan
• Continues to be aligned to the NHS 10 Year Plan
The MHAT Model

MHAT will work alongside existing clinical responses, in particular the Psychiatric Liaison Team, to provide a Multi-Disciplinary approach and social work perspective for adults presenting as the result of a mental health crisis.
The MHAT Model

- NTW Teams inc PLT and Crisis Teams
- NuTH Teams inc ED, MAU and wards
- NCC MH Social Work Teams
- NCC Recovery Support Team (Outreach)
- NCC Hospital Social Work Teams
Pathway

ED presentation ➔ ED Triage/Intervention ➔ PLT Referral

PLT Triage/Intervention ➔ MHAT Referral ➔ MHAT Involvement

MDT Discussion

Possible follow on work with RST, TIAC, specialist MH services
Criteria

- Adults age 18+ (no upper age)
- Primary Mental Health Presentation
- Can have any other secondary support reason eg LDA
- Referrals from Liaison Psychiatry, Crisis Team and ED itself
- Children or Young People (unless MHA)
- Stand-alone alcohol or substance misuse
- Primary physical health presentations eg delirium
- Ongoing support to adults out of the LA area
The role of MHAT

- Short Term Intervention
  - MDT Approach
  - Safeguarding
  - Risk Management
  - Info Sharing
  - Joint Working

- Short Term Assessment
- Signposting
- Screening

Newcastle City Council
Evaluation Framework

• How much we are doing?
• How well we are doing it?
• Whether anyone is better off as a result?
Initial System Findings

Adults who do not wait to be seen by PLT.
Adults who present with lower levels of need who therefore do not meet the criteria for a referral to PLT.
PLT do not have the ability to follow up outside of the hospital environment.
Communication between clinical and social work teams is hampered by lack of shared system access.
Some lack of understanding and application of the Mental Health Act and Mental Capacity Act.
Initial Cohort Findings

Clinical reasons for presentation AND underlying themes emerging from the casework, including:

- Housing support needs
- Benefit or debt issues
- Drugs and alcohol use
Our Evaluation

• Demand analysis
• Analysis of attendances at hospital
• Case studies for individual outcomes
• Effectiveness of the multi-agency approach
Demand

- Able to identify demand from volumes of people worked with
- Evidencing a definite cohort with needs of this type
- Growing as knowledge and understanding of team role improved
Hospital Attendances

An area of initial focus, but some limitations:

- CQUIN timeframe
- Data sharing
- MHAT better able to assess on individual basis
Individual outcomes

Growing evidence of:

- Enabling access to services;
- Achieving quicker, safer discharge plans;
- Ensuring other support is in place and engaged with, or providing a ‘place holder’ until this can be achieved; and
- Providing support for informal carers, whose needs often only become evident outside the hospital environment.
Multi agency approach

What NTW are telling us:

• Strengths in co-location of teams and establishing personal relationships between different practitioners

• Following the person once PLT’s involvement has ended is a strength

• Access to live information within the MDT reviews provides a more comprehensive risk assessment and whole person approach
Any Questions?
Workshop: Frailty - what the NEL?

Leslie Bainbridge
Closer to Home Network NENCRHW
Frailty: what the NEL?

Lesley Bainbridge, Clinical Lead Care Closer to Home Network
North Cumbria, North East England and Hambleton, Richmondshire & Whitby
January 2019
What the NEL?

NHS England defines an emergency admission to be “when admission is unpredictable and at short notice because of clinical need”.

Some emergency admissions are clinically appropriate and are unavoidable.

Others could be avoided by providing alternative forms of urgent care, or by providing appropriate care and support earlier to prevent a person becoming unwell enough to require an emergency admission.
Does frailty exist?
What is frailty?

Frailty is increased vulnerability to stressors because of multiple system health deficits.

Frailty is a state of increased vulnerability to poor resolution of homoeostasis after a stressor event.

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.

A state associated with low energy, slow walking speed & poor strength.

A loss of the ability to keep the conditions the same despite changes in the conditions around it.

Predominantly older people with several conditions resulting in atypical presentation and so

NEL.
Why Frailty and NEL?
Why Frailty and NEL?

- One hospital
- One day
- 97.6% occupancy
- 451 patients
- 71.4% aged 65+
- 322 patients
- Average Age 81.3

Very fit | Fit | Managing Well | Vulnerable | Mildly Frail | Moderately Frail | Severely Frail | Very Severely Frail | Terminally Ill

17% | 27% | 22% | 31% | 3%

Nurse Ambassadors Older People
Lynne Shaw, Angela Fraser
10 days in a hospital bed leads to 10 years’ worth of lost muscle mass in people over age 80
Frailty Syndrome: the 4 I’s

<table>
<thead>
<tr>
<th>Functional Change Presentations</th>
<th>% of patients</th>
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<tbody>
<tr>
<td>Diagnosis</td>
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<tr>
<td>Malignancy</td>
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</tr>
<tr>
<td>Infection</td>
<td>30</td>
</tr>
<tr>
<td>MSK/fracture</td>
<td>14</td>
</tr>
<tr>
<td>Stroke</td>
<td>5</td>
</tr>
<tr>
<td>GI</td>
<td>4</td>
</tr>
<tr>
<td>Other: e.g., acute kidney injury, heart failure</td>
<td>11</td>
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</tbody>
</table>
The Syndrome: intellect

Presentation:
family brought to A&E thinking dad had suffered a stroke because he ‘couldn’t follow what we were saying’

Hospital Admission:
‘family say can’t take home’

Final Diagnosis: subdural haematoma, treated with surgery, steroids and rehabilitation

returning home to care of family!
The Syndrome: immobility

Presentation:
Attended A&E when Age UK Befriender found him stuck in the bath [18 hours].

Diagnosis:
Unable to manage, ‘no rehab potential’, referred to duty social worker who arranged ‘winter bed’.

Community:
Intermediate care nurse - comprehensive assessment, geriatrician liaison, rapid access clinic and CT head

Final Diagnosis:
Stroke and polycythaemia

‘there can be a stage in the face of MDT input that further objective improvement is not seen’

‘treating reversible medical diagnoses reveals rehab potential’
The Syndrome: the 4 I’s

- Poor Historian
- Recurring UTIs
- Poor Motivation
- ‘the historian is the person taking the history!’
- ‘undiagnosed dementia – which oddly does not respond to repeated courses of trimethoprim’
- ‘pain, anxiety, depression, fear of falling etc’
The Syndrome: the 4 I’s

Yew-tee-aye

Faller

Failed Discharge

‘the backache, fluctuating fever and confusion was actually osteomyelitis of the spine’

‘when you listened to what the family were saying, they were right, he wasn’t right, he’d had a stroke’

‘pain, anxiety, depression, fear of falling etc’
Frailty and NEL: alternatives

The role of a Practice Frailty Nurse:

- Significant experience in the care of older people
- Highly skilled in comprehensive assessment, problem identification and care planning
- Order and act upon diagnostic tests
- Make and receive referrals
- Make decisions about admitting or discharging from hospital and intermediate care units
- Coordinate and chair multidisciplinary team meetings
- Case management
- Building of meaningful and caring relationships with patients and their families

North of England Commissioning Support, Business Intelligence
Frailty and NEL: alternatives

- Acute care interface teams
- Community support services
- Primary care contract
Frailty and NEL: alternatives

- Care home partnership
- Link practice
- Lead GP
- Ward round
- Nurse Specialists
- Virtual ward

**SAVINGS**

<p>| | |</p>
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<tr>
<td>Reduction</td>
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<td>Emergency Admissions</td>
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<td>Bed Days</td>
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<tr>
<td>Investment</td>
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<td><strong>Net Savings</strong></td>
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<td>Days</td>
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</table>

Andrew McCarthy, Joanne Gray, Health and Life Sciences, Northumbria University
Frailty and NEL: alternatives
NEL and Frailty: summary

Routine medical care and routine hospital care has not changed in line with the needs of an ageing population. Many older people are admitted to hospital several times in their last year of life. Older people can live with several health conditions and a gradual decline may be missed until a crisis occurs.
Frailty and NEL: summary

- Society generally holds a negative view of ageing
- Loss of functional abilities increases vulnerability
Frailty and NEL: summary

- Lack of recognition that hospice and palliative care is appropriate
- Researching this vulnerable group is challenging but is essential
- Differences in manifestations of ageing reflect differences in genes and environment
Thank You

lesley.bainbridge@nhs.net
Sharing Learning and Panel Discussion

Rosie Seymour, Better Care Fund

Jayne Robson, Better Care Support Team

Deborah Rozansky, SCIE Associate