NHS
Chiltern
Clinical Commissioning Group

NHS
Aylesbury Vale
Clinical Commissioning Group

Commissioning Strategy: Integrated Care for Frail Older People (Final)

February 2015

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Version Number	**Purpose/Change**	**Author**	**Date**
0.1	Initial draft programme board	L Perkin/M Dearing/T O'Connor	05/12/2014
0.2	Updated draft including comments from Rachael Rothero/Ali Bowman/Susie Yapp/Karen West/David Williams/Annet Gamell	L Perkin/M Dearing/T O'Connor	19/12/2014
0.3	Updated draft including comments from key stakeholders	L Perkin	19/01/2015
0.4	Changes made following Integrated Care Programme Board	L Perkin	09/02/2015
Final	Final document	L Perkin	18/02/2015

This document builds on the Integrated Care Outline Business Case – approved by CCGs, BCC (May 2014) and Health and Wellbeing Board (26th June 2014).

It also links with the Better Care Fund templates submitted in February 2014, September 2014 and November 2014.

It underpins the s75 BCF pooled budget agreement between Buckinghamshire County Council, Aylesbury Vale and Chiltern Clinical Commissioning Groups.

Glossary

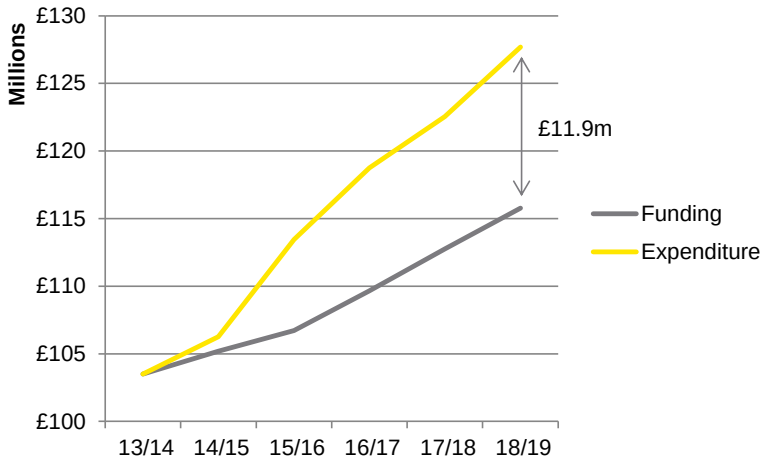
ACHT	Adult Community Healthcare Team
AVCCG	Aylesbury Vale Clinical Commissioning Group
BCC	Buckinghamshire County Council
BHT	Buckinghamshire Healthcare NHS Trust
Bucks Care	Buckinghamshire Care
CCCG	Chiltern Clinical Commissioning Group
Home	Refers the place of "home" which may be another place e.g. residential home
MuDAS	Multidisciplinary assessment service
OBC	Outline Business Case
OPAT	Outpatients Parenteral Antimicrobial Therapy
Patient	Patient and service user are interchangeable terms within this document
Rapid Response	Provide a swift response to people's health and social care needs
Reablement	Services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living
Rehabilitation	Rehabilitation is an active, collaborative process. It uses all possible measures to help an individual to restore or maintain physical, psychological and social functioning
SPR	Single Point of Referral

Executive Summary

This Commissioning Strategy for Integrated Care builds on Buckinghamshire's Better Care Fund submission and the Outline Business Case completed in June 2014 and, along with an accompanying S75, presents the first stage of the case for change for integrated care in Buckinghamshire.

We need to commission and provide person centred care that supports people to stay independent for as long as possible. We know that continuing as we are in a disjointed and fragmented system is not sustainable for the organisations involved and is not meeting the needs of the people who use our services even if at this stage it is hard to prove that there will be significant financial benefit.

Increasing demographic and financial pressures on the health and social care system means that maintaining the status quo is not an option. The OBC reviewed £103.4m of services commissioned by BCC, AVCCG and CCCG and forecast that if these services continue to be delivered as-is, over the next 5 years, income growth will fail to match demographic growth and cost inflation and the annual gap increases to £11.9m by 2018/19, with the total deficit over the period being £41.0m (the assumptions used factor in the effect of QIPP and MTP savings plans). The whole system profit and loss project (P&L) has re-enforced the financial challenge within the system and estimated the affordability gap to be £185m by 2018/19.



We know that the context is constantly changing and evolving and we must design services that promote integrated working and are flexible enough to respond to other system wide changes. The aim is to move away from silos, not create new ones. The scope of this plan is focussed on the development of an integrated approach to commissioning the first £28m of a potential £100m of spend. It is a critical initial step on a journey to jointly finding solutions to the known challenges and developing capability and capacity of the system and the people working in it to effectively manage future challenges.

Given the data currently available and local and national experience this strategy advocates a staged programme of transition to integration supported by a pooled budget. In the first instance commissioners will work with existing providers to align capacity within the system and strengthen the system-wide approach to meeting individual need. As commissioners

and providers develop increased knowledge and understanding around the effectiveness of integrated working they will be able to further innovate to derive even greater benefits to meet the future needs of Buckinghamshire residents. In a changing health and social care economy, locally and nationally, the recommended approach provides a sustainable foundation on which to build.

The context of a developing partnership

It is impossible for health and social care organisations in Buckinghamshire to continue with the status quo of service provision and deal with the rising tide of costs driven in part by the demographic pressure. Whilst there is no cast iron evidence that integrating commissioning and provision will solve the problem there is evidence that it improves the quality of care to the people receiving those services which in turn will yield efficiencies in the system.

The OBC identified over £100m of current expenditure that is being spent on services that operate in what would become Tiers 1 to 4 of the new model. The OBC also identified, from use of the LGA toolkit, that changes to service models in this area can yield financial benefits. For example an extrapolation of the introduction of an integrated rapid response and reablement service in Greenwich[1] suggests that savings of £9m could be made in Buckinghamshire for health and social care partners. Whilst in the first instance this strategy concentrates on the £28m that is spent on tier 3, the potential opportunity is clear.

The Five Year Forward View[2] gives a clear indication that there will be opportunities to develop new service delivery models such as Multi Specialty Community Providers and vertically integrated providers that include general practice. These models are not yet fully defined but any developments in services in Buckinghamshire must be flexible and responsive as the future unfolds.

Work on developing partnership between health and social care is aligned to recent government policies and statements outlined in the table below:

Partnership Working Policy Context		
Policy	**Date**	**Summary**
NHS Restructuring	Health & Social Care Act 2012	Important background for the Better Care Fund as it established much of the current health system, giving a high degree of autonomy to clinical commissioning groups and establishing their relationship with NHS England.
Deficit reduction and rebalancing the economy	2013 Spending Round - plans for government spending, including departmental settlements, for the year 2015 to 2016	The government made better cooperation between local services a main objective for the 2013 spending round with the goal of maintaining the quality of services while reducing the cost to the public. It announced the Better Care Fund (then known as the Integration Transformation Fund)
Local service reform - Sustainable and affordable health and	Autumn Statement December 2013	The 2013 Autumn Statement set out the government's intention to support local areas that want to deliver

[1] Royal Borough of Greenwich Integrated Reablement Service
[2] Five Year Forward View, NHS, 23rd October 2014

social care system		services differently if they can show it will save money, including by: "making sure pooled funding is an enduring part of the framework for the health and social care system beyond 2015-16".
Reform of Adult Social Care	Care Act 2014	Under the Care Act 2014, NHS England can direct clinical commissioning groups to use and pool money to integrate health and social care services. NHS England can also impose conditions regarding plans to spend this money, and may withhold or recover payments where conditions are not met.

Following the agreement of an initial outline business case, and agreement of the Better Care Fund submission, commissioners in Buckinghamshire have all signed up to deliver the vision of integrated for care for older residents in the county. This has been supported by the nationally prescribed requirement for local areas to progress integration across health and social care and create a pooled budget for this.

The partners in Buckinghamshire have clearly articulated in a number of forums that the current delivery model is not sustainable and needs to change to manage increasing demand. This commitment has been supported by national and local experiences demonstrating joint working across health and social care can improve patient outcomes (for example locally in mental health services). In Buckinghamshire there are already well-developed partnerships and examples of integrated care particularly in mental health services.

Nationally there is a lack of robust empirical evidence for the benefit of integration to fall back on and it is recognised that local solutions and conditions mean a local solution is always required (Five Year Forward View). The national direction of travel, as mirrored locally, is being informed by wider strategic ambition for collaboration and an intuitive knowledge that a joined up approach will deliver improved patient outcomes more efficiently.

Whilst at a strategic level the direction of travel is agreed, in building this case for change a number of system wide challenges have been identified which have impacted the partners ability to accelerate the delivery of a new model and evidence the benefits of implementation. These include:

- Data – at a local level there is a lack of consistent data surrounding the demands and costs across the system
- Confidence in partnerships – arguably driven in part by data, there is a lack of service performance visibility, which in turn impacts the level of trust between the partners

- Provision – existing providers deliver a range of wider services and there is a desire to maintain stability within these at a time of rising demand and there are existing contractual arrangements that need to be taken into consideration
- Knowledge – operational teams work in very discrete silos and there is a need for more alignment to allow teams to build improved knowledge of each other's operational practices
- Geography – many of the wider national evidence relates to smaller urban centres where it could be argued integration does not pose the same risk to wider operational delivery

Development of the partnership journey is already underway but current contracts for health and social care services dictate the requirement for a phased implementation approach with the first opportunity to re-commission integrated rapid response and reablement services being in 2016. In the interim period work will start on the alignment between providers of existing services, developing joint understanding of the systems and building the operational, financial and quality performance framework to drive continuous improvement. Staged benefit review points using the key indicators of non-elective hospital admissions, nursing home admissions bed occupancy and proportion of patients not requiring services after reablment will assess the impact and effectiveness of partnership working. Whist often viewed as a healthcare measure, hospital admissions are a key proxy for system wide benefit, given that reductions in hospital admissions and shorter stays are widely known to reduce dependency on health and social care services.

Vision for integrated care in Buckinghamshire

The partners in Buckinghamshire are seeking to remove the overlap within, and streamline patient pathways across, health and social services. This will be supported by the development of joint plans and the pooling of budgets to deliver person centered care in, or as close as possible, to people's homes. Whilst older people will be the primary focus of services, many of the proposed changes will have a wider impact.

Success will be when there is:

- An all-inclusive, personalised service for the citizens of Buckinghamshire
- Service delivery without duplication
- Seamless, high quality, safe and effective pathways of access
- Users driving services and a robust and sustainable model of community engagement
- Evidenced multiagency working through integrated care pathways and excellent care navigation optimising the use of resources
- The full integration of prevention into care pathways

The key partners in delivering the vision are listed in the table below:

Partner	Commissioner	Provider
Ambulance Service		
Aylesbury Vale Clinical Commissioning Group (AVCCG)		
Aylesbury Vale District Council		
Buckinghamshire Care		

Buckinghamshire County Council (BCC)	☐	☐
Buckinghamshire Healthcare NHS Trust (BHT)		☐
Chiltern Clinical Commissioning Group (CCCG)	☐	
Chiltern District Council		☐
Oxford Health NHS Foundation Trust		☐
Primary Care providers		☐
Private sector organisations		☐
South Bucks District Council		☐
Voluntary sector organisations		☐
Wycombe District Council		☐

Closer working across partners in the system will facilitate a model that invests more funding in lower level and wider preventative support, shifting the balance of spending and care over time. Initially the intention is to align existing service provision to develop better system wide understanding, release efficiencies, test new ways of working and monitor benefits realisation. This will allow delivery risks to be managed and as partner confidence develops this may lead to a formal recommissioining of services, which may include provider integration.

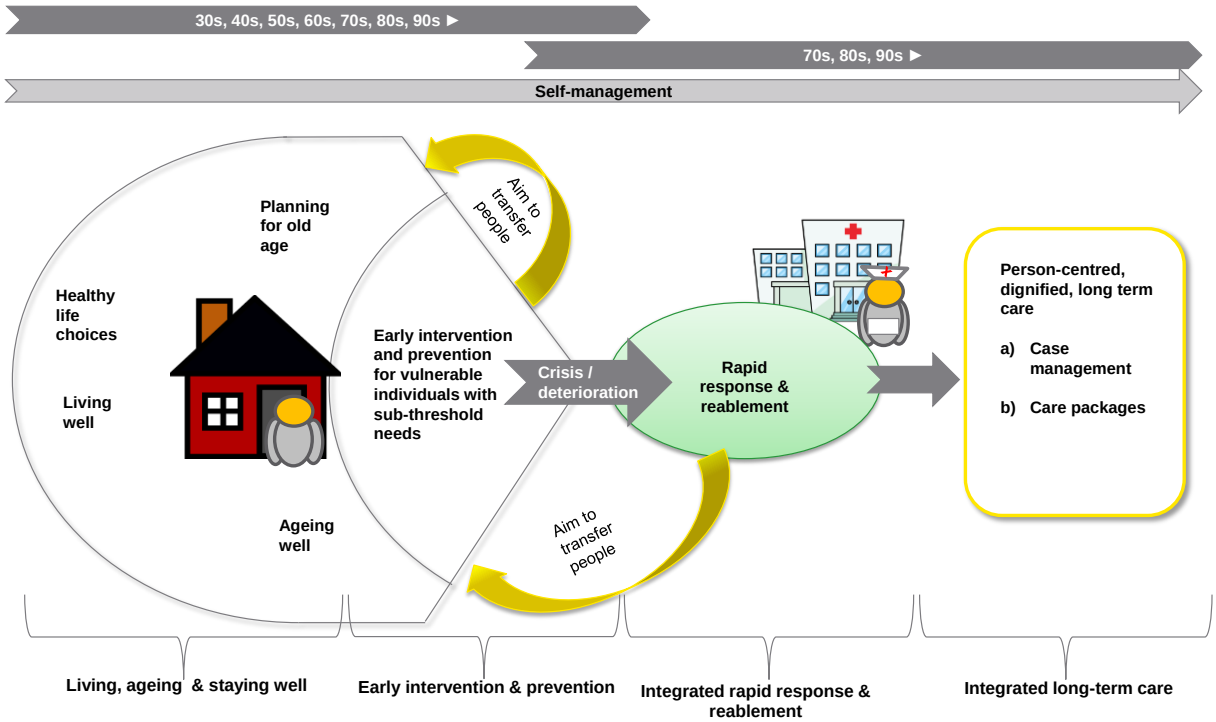
Buckinghamshire has a strong track record of collaborative working, and to ensure maximum buy-in from key stakeholders (providers, commissioners, GPs and other professionals), the integrated care programme will build on the already strong platform of joint initiatives. What this means for Buckinghamshire is optimising and growing the things that are working well, as well as radically transforming elements of provision that are not.

For Integrated Care, Buckinghamshire has used the Kings Fund model of health and social care services to help design 'what better would look like' informing the development of a new, 4-tier integrated model for health and social care in Buckinghamshire. The four tiers of the integrated service are shown in the table below:

Tier	Objective	Components
1. Living, ageing and staying well	Providing coordinated, responsive and sustainable health promotion services, and bringing partners together to tackle negative lifestyle choices, to transform the overall health of Buckinghamshire	a. Multi-agency prevention strategy b. Behaviour Change programmes c. Integrated Lifestyle Service d. Planning for older age
2. Prevention and early intervention	Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future	a. Proactive case finding and referrals b. Integrated case management c. Community based prevention services d. Digitalisation, adaptation, equipment and housing
3. Rapid response and reablement	Co-ordination of services to individuals during a period of rapidly escalating health or social care need, in order to	a. Rapid response b. Reablement Focusing on step up as well as

	avoid attendance at hospital or the requirement for a long-term care package	step down.
4. Integrated long-term care	Reshaping long-term care services around a common understanding of service users' needs and establishing a single approach to market management across the health and social care economy	a. Integrated locality teams b. End of life care

The operating model will be implemented over the next five years and represents a radical shift from traditional models of service delivery. It moves away from providing services that can create dependency, discourage self-care and undermine people's confidence, to those that inform and empower individuals to manage their own health and wellbeing and make informed and personalised decisions. We will provide targeted and tailored approaches that provide individuals with effective support to take personal responsibility for their own health and wellbeing.



There are a number of underpinning national conditions in the Better Care Fund and we are seeking to use these to inform our integrated working agenda. These are:

- Plans to be jointly agreed
- Protection for social care services
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

- Agreement on the consequential impact of changes in the acute sector.

Dependencies and developments

Since the original vision was agreed as part of the outline business case there has been a need for things to develop as the local health and social care system was unable to sit still. There is a need to ensure that these developments and their implications are factored into future delivery plans.

The following table lists the key developments and their leads.

Ref	Development	Impact/Risk	Date	Lead
D1	Primary Care Strategy	Overarching strategy considering future models with impact on activity in Tier 1, 2, 3 and 4 Maintain a programme approach to ensure models of care are aligned	March 15	Dr Chris North, Dr Malcolm Jones, Nicola Lester, Louise Smith
D2	Public Health Strategy	Developing model for Tier 1 and part of Tier 2 Maintain a programme approach to ensure models of care are aligned	March 15	Tracey Ironmonger
D3	Care Act implementation	Implementing early advice activities which links to Tier 1 Maintain a programme approach to ensure models of care are aligned	April 15	Susie Yapp
D4	Profit and Loss	Finance model being developed for the whole system Harder to see system wide impact of changes with model	Ongoing	Robert Majilton
D5	System Resilience Planning	In year service changes Ensure re-commissioning decisions account for future plans	Ongoing	Dr Becky Mallard-Smith, Dr Kevin Suddes
D6	Over 75 Fund	In year service changes Ensure re-commissioning decisions account for future plans	14/15 & 15/16	John Lisle, Colin Thompson
D7	Single Point of Referral	Developing interim SPR to support in-year development	Feb 15	Jeanie Brown (PM)
D8	Estates Review	Review of estate across the system (including community hospital provision) Maintain a programme approach to ensure milestones are aligned	Mar 15 & ongoing	David Williams
D9	IT Interoperability	Enabling integrated IT across the system Maintain a programme approach to ensure milestones are aligned	April 15	Colin Thompson

Section 2 - Operating Model

Tier 1 and 2 – Living well, prevention and early intervention

Preventative services

Introduction to the pathway

Tier 1 comprises a universal, community based primary prevention and self-management offer to all residents of Buckinghamshire. Notably, as demographics vary across the county, delivery of locality based services need to be flexible and where necessary, tailored to particular groups and/or needs.

The key components of this tier will be:

- A multi agency prevention strategy
- Behaviour Change programmes and tools through online support
- An integrated lifestyle service
- Planning for old age

Tier 2 services are for those that have gone beyond the services of Tier 1 but currently drop below the threshold for the crisis response, reablement and long term care services of Tiers 3 & 4. We believe those people include older people with escalating health needs, adults identified as having a moderate to high risk of developing a long term condition, adults with established long term conditions but current social care needs are sub-threshold and residents who have received a period of reablement but do not currently require long term care interventions.

The key components of this tier are:

- Proactive care referrals
- Integrated case management (Link to Tier 4)
- Community based prevention services (including Prevention Matters)
- Digitalisation, adaptations, equipment and housing

The Joint Strategic Needs Assessment identifies the challenge facing Buckinghamshire related to the level of unhealthy behaviours among the adult population. Factors such as a sedentary lifestyle, smoking, obesity and drinking alcohol above recommended levels are fuelling increases in preventable long term conditions such as heart disease, stroke and diabetes. These conditions are contributing to rising social care needs.

Future model for preventative services

The Public Health team in BCC is developing the Buckinghamshire Public Health Strategy for March 2015. This will encompass the key elements of Tier 1 and some of the elements of Tier 2 as well as encompassing the key elements of the Care Act. The following section outlines their initial thinking in developing this approach.

The Care Act identifies prevention as a key component in managing demand for social care services and three levels of prevention defined within the Care Act:

1. Primary prevention – this is aimed at individuals with no current care needs. It includes universal services to promote healthy lifestyles and action to tackle the wider determinants of health
2. Secondary prevention - this is aimed at individuals at higher risk of developing disease, disability and care needs. It includes screening and early case finding and action to prevent deterioration
3. Tertiary prevention – this is aimed at minimising the effects of disability or deterioration in people with existing health and care needs

Primary and secondary prevention require a whole system approach to prevention and multi-agency responses to tackling the wider determinants of health. It aims to enable individuals to be encouraged and where required supported to self manage and take personal responsibility for their health. The action of partners on the wider determinants of health should aim to make healthier choices the easier choices. Tertiary prevention requires prevention activities to be fully integrated into care pathways. The integration activities for all tiers will draw upon the existing County Council responsibilities for public health, the prevention priorities in the new 5 year plan for the NHS, the existing multi-agency strategies and work programmes and be coordinated by the Healthy Communities Partnership.

Buckinghamshire aspires to deliver large scale access to behaviour change support for all and targeted activities to enable those at greatest risk of poor health to improve their health and wellbeing. Work is currently being undertaken to develop a public health strategy and a model for living, ageing and staying well which provides coordinated behaviour change services. The approach for this model will incorporate:

- Action throughout the lifecourse - This recognises the impact of health pre-birth and in early years on health in adult life
- Proportionate universalism – This requires the provision of universal services, but with targeted action where the scale and intensity is proportionate to the risk of poor health.
- Acknowledging and working with the role of communities and social networks – these factors shape social norms. Work will include engaging communities and social networks in the planning and implementation of key programmes and through this shaping social norms and behaviours. This should include innovative approaches to engage communities who are ‘seldom heard’
- Tackling the wider determinants of health

Prevention programmes will focus on a number of key priorities:

- A focus on healthy pregnancy and early years
- The Big 4 lifestyles (being physically active, reducing smoking, maintaining a healthy weight and drinking alcohol within recommended limits)
- Promoting mental wellbeing (including preventing loneliness and social isolation)
- Falls prevention and bone health
- Drugs misuse and alcohol treatment services

A summary of the key components of the prevention programme are provided below:

Level	Objective	Components
3. Primary Prevention - Living, ageing and staying well	Providing coordinated, responsive and sustainable health promotion services, and bringing partners together to encourage and make healthy choices the easier choices, to transform the overall health of Buckinghamshire	a. Integrated lifestyle services, including effective use of digital tools and social media b. Multi agency prevention programmes c. Planning for older age
4. Secondary Prevention early intervention	Identification of and support for individuals who are vulnerable, and at risk of requiring support in the future	a. Proactive case finding and referrals b. Use of behaviours such as being more physically active, stopping smoking and losing weight therapeutic approaches to reduce the progression of long term conditions c. Integrating prevention into the management of long term conditions d. Community based early intervention services such as Prevention Matters

In addition to the existing prevention work programmes, action will be taken within the next year to:

- Commission a web and app based digital personal health management tool to support residents to assess their current lifestyles, identify personal health goals and tools to support lifestyle changes
- Work with the CCG's and Social Care to integrate prevention into care pathways and front line activity. The Making Every Contact Count training programme will be a key aspect of this activity.
- The development of a model for integrated behaviour services to inform a longer term commissioning and resourcing strategy

Proactive case finding and referrals

Buckinghamshire has invested in the development of MAGs (multiagency teams) that operate at almost every GP practice in the county. The model involves key members of all relevant teams coming together to identify and discuss the most vulnerable people on their caseloads that they believe would benefit from a more holistic approach to enable them to maintain their independence.

Early evaluation both qualitative and quantitative has shown benefits from this approach including improved working across teams and reduced hospital admissions. Work will continue in the following areas:

- refine the model

- ensure that all teams can be fully involved for the benefits of all the patients whether known to them or not
- make best use of technology to support team engagement
- support patients who live in boundary areas and evaluate the impact on individuals.

MAGs will be a key component of the future model in terms of supporting the identification of people at risk. It is further expected that the model will develop to link appropriately to Integrated Locality Teams and community geriatricians.

Integrated case management (delivered by Integrated Locality Teams)

The integrated case management element of Tier 2 will be to ensure early interventions are taken which will minimise the risk of a crisis developing that requires a rapid response & reablement response, a hospital admission and/or an increase in long term care packages. This element of care will be delivered in practice by the Integrated Locality Teams who will also be operating at Tier 4. They will be linked to GP practices and attend MAGs, undertake early interventions and support people with long term care needs. The teams will be supported by specialists operating from secondary care to maximise the benefits from long term condition management in the community.

Future enhancements

In the first instance these teams will be created by co-location and alignment but in future we would expect to see the creation of synergies realised between domiciliary care providers, the ACHTs, practice nurses, mental health staff and social workers as well as the integration of various voluntary sector providers.

Tier 3 – Integrated Rapid Response and Reablement

Current model of service delivery

Introduction to the pathway

The focus of this tier is to coordinate the delivery of a range of services to support individuals to remain independent at home with reduced admission of the frail elderly to, and accelerated discharge from, hospital settings and reduced demand for social care support with improved outcomes and reduced costs across the system. Whilst the patient may be deemed as "not in need of acute services" their individual circumstances mean that their ability to function safely at home cannot be assured. As such some form of intervention is required which would traditionally be covered by community health and/or social care. It is well established that a frail elderly person starts to decompensate after 4 hours in a hospital setting which affects both their health and social care needs from then onwards.

This cohort is in part common to health and social care partners and if unmanaged they will become a pressure for all service commissioners. To address this the Rapid Response and Reablement services are intended to put in place support on a time-limited basis to support independence. The preference is for these services to be delivered in the home, but in limited cases it may be appropriate to be provided in a bed based facility.

Overall the outcome is to minimise unnecessary hospital stays and/or delay the requirement for social care packages. This not only improves patient life outcomes, but also reduces costs in terms of acute hospital bed days and a lower complexity of care packages.

The tier is considered from two perspectives:

A. Avoidance (of additional long-term social care services and/or hospital admission – Step-Up) – a range of interventions to support people with health and/or social care needs to stay at home to avoid additional service needs, admission to hospital or other long-term care. The service would apply to people in their own homes or at a hospital
B. Discharge (Step-Down) – Enabling discharge from hospital settings, ideally returning to home

It is the expectation from commissioners that the emphasis is increasingly on the avoidance element of service to use facilities to 'step up' care for an individual to avoid a hospital stay or need for more permanent social care services.

Current model of Admission Avoidance (step-up) services in Buckinghamshire

The entry point is for patients in the community. Patients may self-refer in, but it is more common to be referred in by a professional to either the: Locality ACHT (including rapid response); Hospital via Ambulance; or directly to Social Care (CR&R). The patient undergoes an assessment by the receiving organisation who determine whether a service is required to meet the identified needs.

Where necessary the assessing organisation will seek to put in place a support service or refer on to another organisation – currently the service provided may vary depending on the

organisation and their service contracts. Rapid Response services are currently only Nursing led, whilst there are two different reablement focused services available: one health therapy led service provided by the ACHTs; and one social care led service provided by Buckinghamshire Care (Bucks Care). Whilst there are different service provision arrangements to meet individual needs (e.g. meal preparation vs meals on wheels), there is a recognised level of similarity and service overlap.

Services are intended to be short term, normally 2-3 weeks for ACHT and up to 6 weeks for Bucks Care, (and are not subject to financial eligibility issues), after which the intention is that patients are able to care for themselves at home. Where a patient is not deemed fit for discharge, supporting services continue to be provided, impacting capacity, whilst an assessment for longer-term services (typically social services) is undertaken.

Patients can be referred from a GP into a 'step up', bed which is almost always a community hospital facility. This is arranged by registering the patient on the Strata (electronic referral) system. The community hospital beds are managed by the Elderly and Community Directorate at BHT. At present approximately 15% of the community hospital beds are used for step up services.

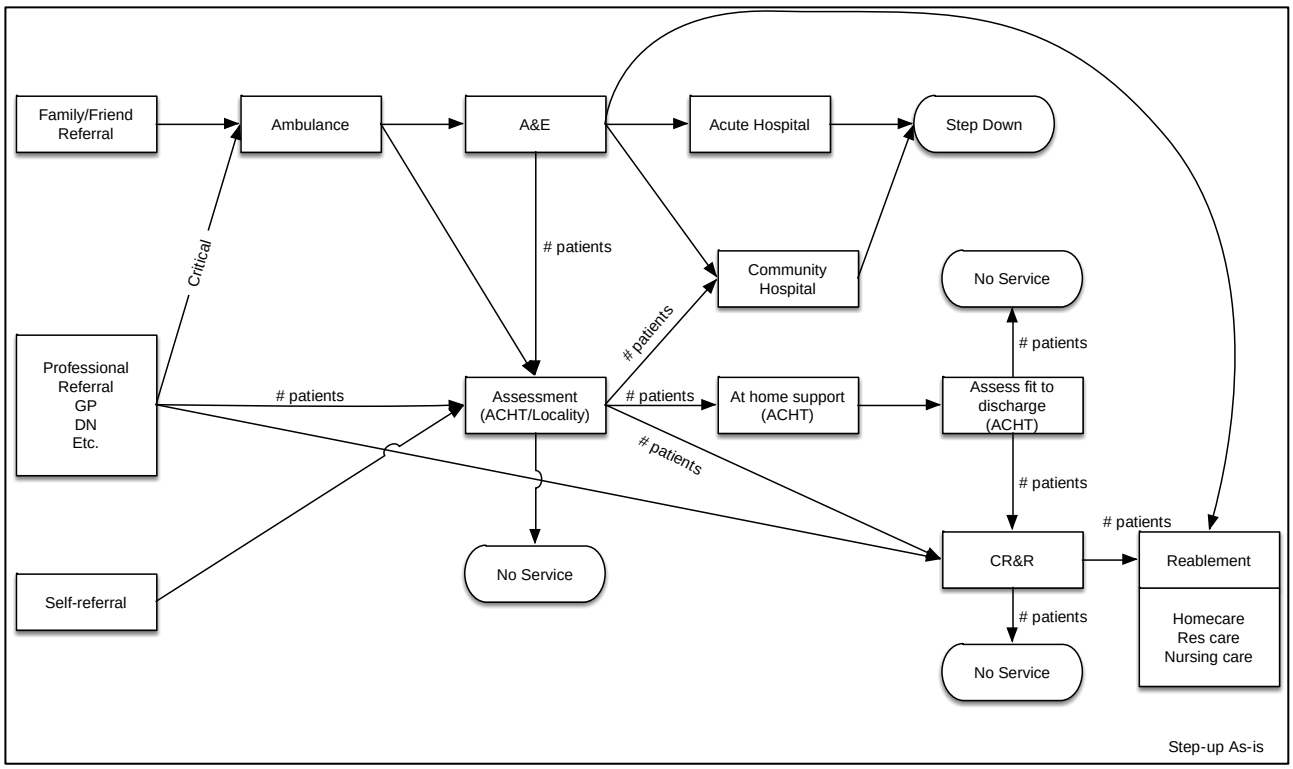


Figure 1 - Hospital Admission & Long-term care avoidance

Current model of Discharge Support (step-down) services in Buckinghamshire

The entry point is for patients in a hospital setting. When the patient is declared medically fit for discharge on the ward (agreed at daily meeting) they are currently either discharged, transferred to a community hospital (referred via the Strata system) or referred for an assessment for support to enable discharge.

The assessment may be undertaken by ward based staff, the Community Transfer of Care Team or for more complex cases the Complex Discharge Team. For routine cases within the acute setting, the ACHT will assess the patient and put in place a package of rehabilitation support to enable the patient to return home. If following intervention, further support is deemed necessary then a referral will be made to the Local Authority for access to reablement and / or a formal assessment for social care.

In the case of a complicated discharge, the Complex Discharge team co-ordinate a range of assessments within the acute setting to review the specific needs of the patient. This could include a continuing healthcare assessment, mental health assessment and local authority assessment (hospital social work team).

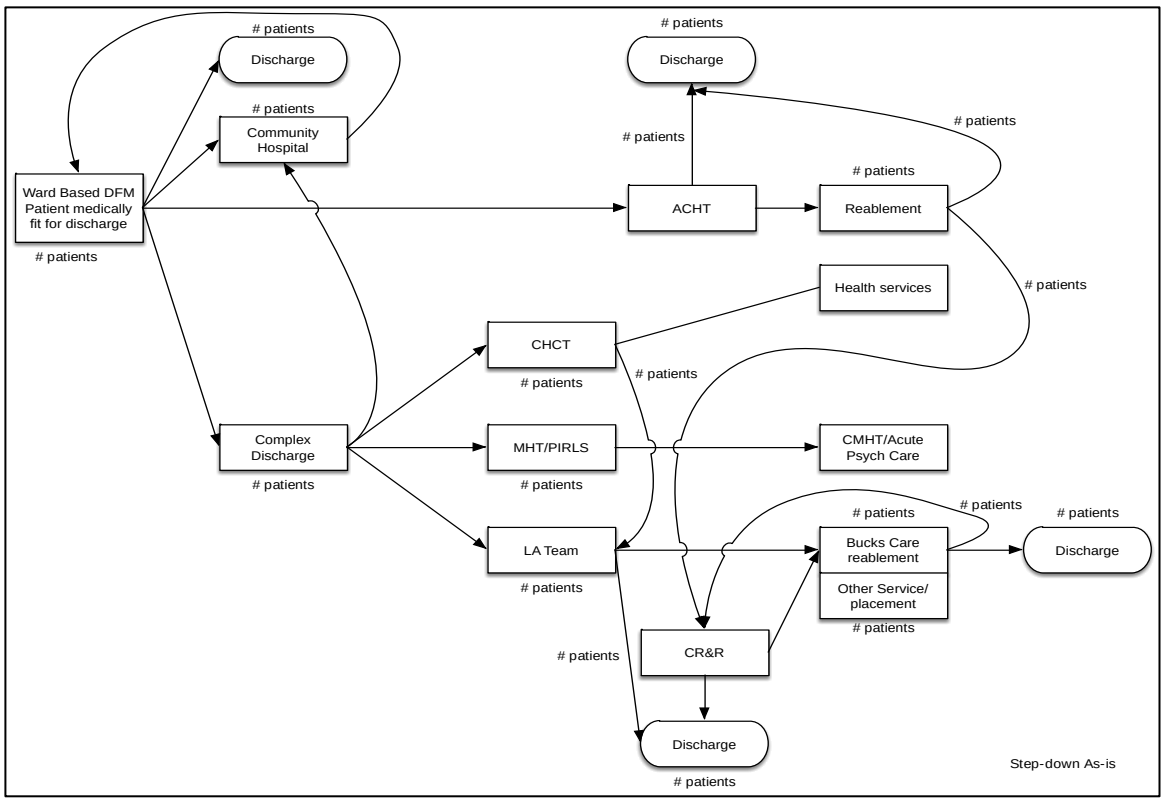


Figure 2 - Discharge support as-is process

Establishing the opportunity and improvement potential

Key opportunities in the As-Is process

Current Model	Improvement Opportunity
Duplicated points of entry for reablement services within ACHT and Bucks Care (reablement assessors). Both go on to assess for entry into respective services, in addition to in hospital assessments.	• Single contact and co-ordination point • Single multi-disciplinary assessment process to streamline care need planning • Confidence in service to deliver services in a timely fashion • Assessment carried out as part of service delivery where possible
Some commonality in service provision across ACHT and Bucks Care – in addition there are some differential service standards between the two providers.	• Pool collective reablement resources to increase access to a range of services available for all patients through the pathway • Ensure most appropriate resource is utilised based on patient need
Professional skills are not optimised – some tasks may be undertaken by overly skilled staff	• Optimise use of professional capacity and maximise available resource
Services are operated from different bases with ACHT's operating from 7 sites across the county and Bucks Care operating a field based delivery model	• Collaborative working and co-location exploited to enable knowledge sharing and joint working (e.g. joint assessments) • Technology used to maximise access to relevant patient insight
Multiple points of referral for ward based teams	• Single point of referral to co-ordinate response • Faster response for patients
Several hand-offs in process to manage transfer from hospital into reablement services	• Reduce handoffs and improve patient experience
Fit for discharge from reablement patients remain in service whilst further assessments and services are being arranged (ACHT/Bucks Care)	• Consider onward service requirement earlier and align start of onward services with the end of reablement • Increase capacity
In-built delay as a result of adherence to statutory timeframe (e.g. section 2s and 5s)	• Application of lean principles to manage demand as it arrives and reduce ongoing dependency
Community hospital/bed based provision used predominantly for step down capacity	• Shift the focus to prevention by putting the control of the beds into the Rapid Response and Reablement team to support the avoidance element of the service
Different operating hours and entry points: limited hospital social work and CR&R at evenings and weekends. ACHT operate 24/7	• Align and extend operating hours to maximise outcomes for patients
Patients can receive duplicate assessments – hospital and community clinical staff, hospital and community social workers	• Establishment of common assessment processes

Future model of Avoidance and Discharge Support services in Buckinghamshire

Overview

The future model will provide an integrated service pathway coordinated and triaged by a single clinically led point of referral. The entry points will be from community and ward based professionals, but at its core will be a common rapid response and reablement function delivered through aligned rehabilitation and reablement services with a focus on preventing the need for admissions to hospital and minimising the need for long term care packages. The services will initially be delivered through an alignment of the existing providers. The principle of continual assessment will be used throughout the reablement service pathway to allow follow-up services to be arranged, enabling a seamless transfer of care as appropriate.

The Reablement service will be directed following the referral depending on need. The most appropriate response and intervention lead will be identified so that the initial response has the best chance of meeting initial needs. The following figure provides a matrix to exemplify the multiple different options which may apply and as a patient progresses they may move from one lead to another.

		Intervention lead		
		Nurse	Therapist	Social care
Response	Rapid (<3hrs)	Y/N	Y/N	Y/N
	Fast (<1 day)	Y/N	Y/N	Y/N
	Normal (<3 days)	Y/N	Y/N	Y/N

Figure 3 - Response / Intervention Lead matrix

The service will be operated as an aligned county wide multi-disciplinary team. However there would be at least 3 bases for the staff across the county from which field based resources can be co-ordinated. This would support a person centred approach that is rooted in a locality. The professionals in the multi-disciplinary team will include: nurses, occupational therapists, physiotherapists, social assistants, and multi-skilled healthcare assistants (drawn from ACHTs) and reablement workers and assessors (from Bucks Care). Some existing social workers will be embedded into the team to reduce hand-offs, facilitate better quality assessment reflective of longer term needs and minimise risk of delay in arranging care.

The multi-disciplinary team could be developed further in the medium term to include consultant geriatrician, pharmacists, older adult mental health, GPs (inc. out of hours) and paramedics. This may then lead in the longer term to the option for the integration of services within a single entity responsible for the multi-disciplinary team.

The rapid response and reablement pathway will be common to both admissions avoidance and discharge processes. The entry points will be from professional referees and is outlined in Figure 4 below.

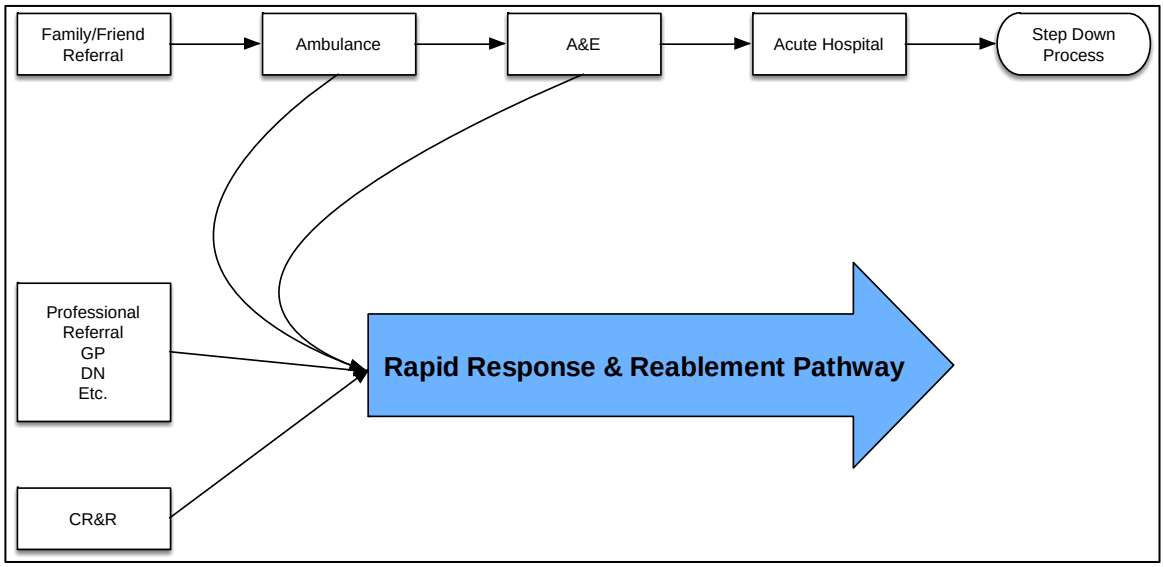


Figure 4 - Avoidance and discharge To-Be pathway framework

The rapid response and reablement pathway (see Figure 5) is delivered through a multi-disciplined approach and comprises three principle steps: a single point of referral (SPR), common assessment and aligned service interventions.

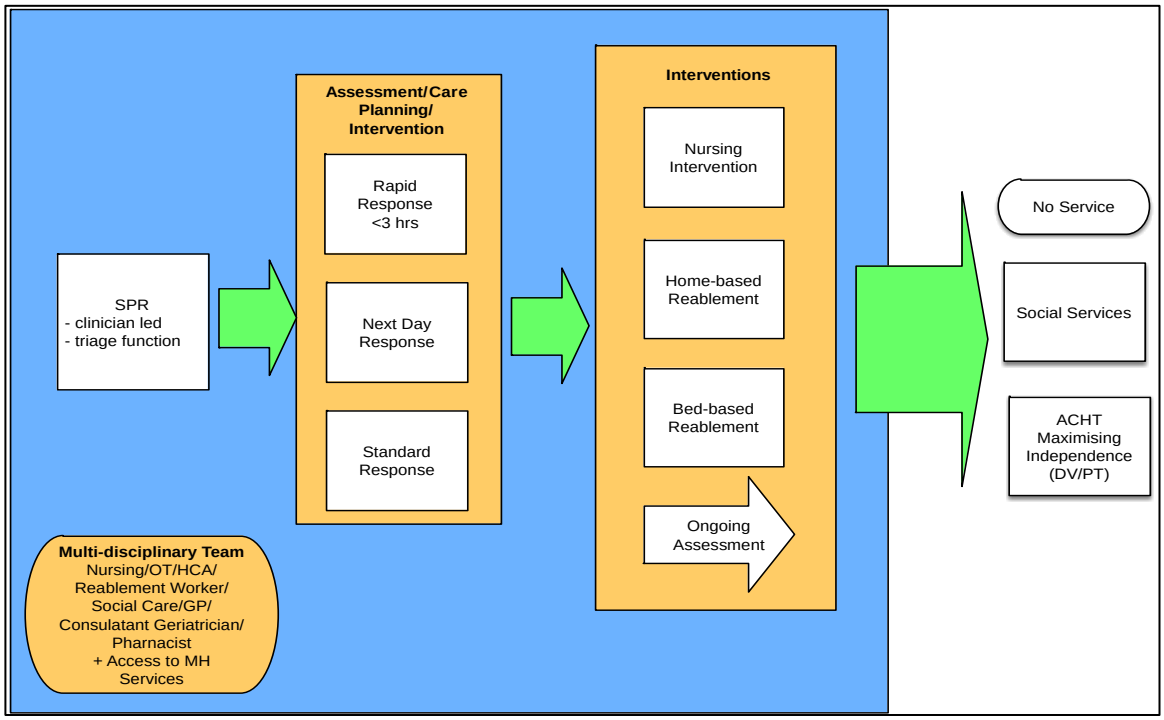


Figure 5 - Rapid Response and Reablement To-Be pathway

Key elements

Single Point of Referral

- Single countywide telephone based referral coordination point to ensure all onward assessment and rehabilitation needs are met. This access point may not be the same contact point for patients once known and in a service.
- Clinically led service with administrative support.
- The service will be operational 24h/7d. To maximise existing operational cover requirements it is proposed that the 21:00-7:30 response will be provided by the ACHT Night Teams to ensure that appropriate rapid response can be mobilised.
- The teams will have access to relevant Health and Social Care systems to ensure all patient records are reviewed.
- GP maintains accountability for the patient, but the SPR team is responsible for getting access to appropriate rapid response and rehabilitation service. (which may include bed based care). Update on action taken will be provided at the end a rehabilitation episode. A future development will be realtime progress updates on the shared patient file.
- Home from Hospital (Red Cross) service would continue to be used to enable supported discharge as part of triage services.
- The service would manage referrals for community hospital beds to support the emphasis moving to step up provision.

The referral point is aimed at professionals including:

- Ward based team (for step-down)
- GPs and practice nurses
- GP out-of-hours service
- A&E and other hospital staff
- Community health and social care services
- Ambulance crews
- Nursing and residential care homes

An initial triage conversation will be undertaken with the professional referee to inform and agree the most appropriate pathway for intervention and assessment. Following this the appropriate service response will be mobilised in line with the options in Figure 3.

The service will be operational 24h/7d to ensure rapid response can be facilitated. The core hours for maintaining a full service will be 15h/7d. Currently there are approximately 24,000 referrals to ACHT, 4,500 to the Hospital Social Work teams and 600 to Bucks Care (in addition to Hospital referrals).It is estimated that 33% of ACHT referrals relate to rapid response and reablement, and 100% of referrals to Hospital Social work and Bucks Care will be seeking a reablement assessment. As such the it can be assumed that the number of referrals to the SPR will be c.13, 000 per year. The staff cover for telephone and electronic referral needs to be sufficient to meet this demand without excessive wait times for professionals and the rota needs to be developed to account for call profile and annual variation in demand.

Experience from elsewhere

Sunderland[3] has created a single point of referral, known locally as the Intermediate Care Hub. This provides a triage function to ensure people are redirected onto the right pathway.

- Currently operational up to 8pm seven days a week, the next step is to take it to 24/7
- Collects and compiles the data on referrals as well outcomes which allows analysis to be undertaken
- Staffed by Band 6 Nurses and Social Care staff, with admin support

Feedback from a range of Health and Social Care professionals indicate that the hub has helped to simplify the supported discharge pathway into intermediate care and reablement services.

- The service deals with 400 – 500 referrals per month, 74% are for step down from hospital and an increasing number of referrals are coming from GPs for prevention to admission into hospital
- Feedback from providers of services indicate they are better informed and are not receiving numerous requests for services or inappropriate discharges

Future considerations/enhancements

- Development of closer operational links with GPs (including out of hours) and CR&R
- Technology used to enable e-referrals from the ward or professionals whilst in the home (reducing need to relay the requirement by phone), options may include web chat
- Technology to enable triage assessment to be undertaken by referring professional to enable automatic allocation to reablement professional
- Development of a single staff scheduling system
- As part of wider service offer commission a single organisation to provide SPR

[3] Integrated Care Hub: A Sunderland Approach, 2012

Multi-disciplinary delivery team

- Countywide aligned team of professionals drawn from a range of providers with a manager to coordinate deployment to respond to needs of patients to provide: nursing and therapy interventions, care planning, short term support and care.
- Professional accountability lines will remain in place and where the whole team is not aligned to the new service, individuals will need to be identified to be part of the team and its operational rotas.
- Operational availability 24h/7d for rapid response, with majority of planned service interventions undertaken between 7:00 and 22:00
- The initial triage screening by the SPR will be used to direct the most likely profession to lead the first response. This professional lead will have access to the wider team to discuss options whilst in the patients home.
- Working to a single rehabilitation assessment and planning tool.
- Able to offer a range of services delivered by different disciplines which could range from: nursing interventions to manage health conditions, therapy interventions to support mobility, reablement to support daily tasks of independent living and an enhanced diagnostic assessment (e.g. MuDAS)
- Combined team will enable resources to be allocated to maximise the utilisation of skills and experience available
- Professionals will have easier access to appropriate support from other disciplines to seamlessly manage the issues presented in more complex cases
- Home based services will be the primary model of care with the same pathway being used for all patients
- Bed-based support could be utilised for part of a patient's pathway where they are not able to safely remain at home or where part of the response is more effectively delivered in a care setting. This could be through utilisation of existing bed capacity across the county (both public and private facilities).
- Where initial assessment and patient response suggest ongoing care is likely to be required the social workers within the team will undertake a care assessment and plan care as required

To illustrate how this would work a couple of fictionalised scenarios have been developed.

Reg's story

Reg lives on his own and is 77 years old. He had an entirely appropriate admission to hospital following a short illness. The ward team decide that he probably can't manage at home and so discuss him at the ward based MDT meeting.

What would have happened before…DFM met, agreed need for ongoing support and send referrals to both the ACHT and the social care team at the hospital. 5 days after the medics had said Reg was medically fit he went home. The ACHT therapist visited and developed a rehab plan for him. After about 10 days they decided that he would probably struggle to fully care for himself at home so referred him to social care (CR&R). It took a week before

Reg was referred to the Reablement service during which tome the ACHTs continued to provide his care. Once the reablement service took over they saw him for a further 6 weeks but during that time they realised that although he wouldn't need four visits a day he would need some long-term care so made a referral back to social care. CR&R completed the full assessment within a week but then it took a further two weeks for the care package to start during which time the reablement service continued to visit.

What will happen in future…with new services in place, the ward would have referred him straight to the Rapid Response and Reablement service who would plan his care. If there were complicating factors they would have sent someone up to the ward to do an assessment but ideally that would have been completed once he was home. He would have gone home under their care and received support to regain as much independence as possible with input from therapists and reablement workers. Throughout his reablement journey the team would have been assessing his ongoing care needs and once it became apparent that he would be unable to manage fully on his own in the future, the social worker in the team would have started the full assessment process and care would have been arranged to start as his reablement pathway came to an end.

Ethel's story

Ethel lives on her own and has been coping since the death of her husband two years ago. She's 81 and has no children living nearby. She felt a bit under the weather last week and didn't go on any of her usual excursions to bridge or the shops. She's now feeling much worse to the extent that she called the GP practice. The GP made a house call a few hours after her call to the surgery. He was concerned that she would deteriorate even further left at home on her own although unable to pin point a particular new medical issue.

What would have happened before…her GP called the medical registrar at the hospital and requested an ambulance to take Ethel to the hospital.

Ethel was admitted with dehydration and put on CDU. Whilst in hospital Ethel was kept in bed and lost confidence in her ability to look after herself.

She stayed in hospital for 6 days and then came home with support from the ACHT. They provided care and support with visits 3 times a day for a fortnight and then referred her to social care via CR&R. Five days later she was transferred to the care of the Bucks Care Reablement Service. They provided visits twice a day for a further 3 weeks and then discharged her.

What will happen in future…with new services in place, the GP would have made a call from Ethel's house to the Rapid Response and Reablement team where a clinician would have made a decision about who to send to see Ethel. That professional would have, provided some immediate support, made an assessment and arranged care from the wider team. If Ethel's dehydration

could not have been managed at home, she could have gone to a bed based reablement service for 24/48hrs which would also have been arranged by this team. She would then have received some reablement support at home for a few days or a week and then returned to normal.

The different disciplines would support the provision of three principle service responses: Rapid (<3hrs), Fast (<1 day) or Normal (<3 days). The most appropriate professional (based on patient need and issues identified by referee/SPR) will be deployed to undertake the initial response and assessment. This will then be used to inform the future reablement care planning and service mix. If when assessed or whist receiving services, it is determined that the primary need would be better served by another discipline then the patient will be transferred to another professional without referral.

It is proposed that the multi-disciplinary team is resourced by aligning staff from ACHT, OPAT, MuDAS, Bucks Care and BCC. This will initially be undertaken without formally changing contracts and providers will be asked to agree to a Memorandum of Understanding to facilitate open and effective improvement and information sharing.

Delivery settings

The intention is that the majority of care is delivered in the person's own home to support continued independence. It is recognised that for a small number of patients a bed-based reablement service will be more appropriate. This may be as a result of an inappropriate home setting or the need for diagnostic services alongside reablement. Whichever setting is used it is intended that broadly the same service response is put in place where appropriate.

The level of bed-based services available for rehabilitation and reablement needs to be appropriately scaled and work is ongoing by BHT to inform this process. The recent acuity audit suggests 50% of the existing community hospital beds in Buckinghamshire are being utilised by patients who could be supported in an alternative residential/nursing care setting – Appendix 1 (Estimating capacity of community beds to support step-down/step-up) includes additional information).

Future enhancements

- Single contract for delivery of multidisciplinary team achieved by either provider collaboration towards an alliance contract or formal recommissioning
- Ensure community bed based facilities are profiled effectively to appropriately meet the needs of patients at the lowest cost
- Community bed based facilities are used as bases for the multidisciplinary teams.
- Night sitting service developed to enable more patients to be supported to live in their own home particularly those on a non-weight bearing pathway
- GP out of hours services to be fully linked in and aligned
- Addition of other professions, e.g. pharmacists

Experience from elsewhere

Greenwich has put in place integrated health and social care teams to provide a whole-system response to intermediate care, hospital discharge, urgent care, and community rehabilitation. The service is configured around three integrated teams:

- Community Assessment & Rehabilitation Teams (CARs) to provide rehabilitation, social care and manage intermediate care beds
- Joint Emergency Team (JET) - Fast immediate multi-disciplinary responses works in A&E, Ambulatory Medical Unit and in the community to prevent ambulance service call-outs and reduce admissions 7 days a week
- Hospital Integrated Discharge Team (HID) - Facilitates discharge by maximising use of the re-ablement services and intermediate care beds

These changes has been achieved with no changes made to the staff employers or contracts, where there is a health team manager, there is an assistant manager from social care, and vice versa.

The operational model has seen improvements across the system including:

- On average, 64% of people entering the new pathway require no further services after completion of the pathway
- Reduction in A&E admissions - 147 prevented in Q1 2013 by working with GPs to refer to JET rather than hospital
- Reduction in hospital admissions - 172 prevented in Q1 2013 by maintaining a presence in A&E and AMU, 8am-8pm, 7 days
- 7% reduction in admission to care homes per annum
- In the first 12 months, the redesign enabled an immediate 5.5% productivity saving on the health services alone. The social care budget was reduced by £900,000

No new investment has been required to achieve the change as savings were made through shared management arrangements.

Tier 4 – Integrated Long Term Care

Current model of service delivery

Introduction to the pathway

There is a disparate range of professionals operating across the county. Some are deployed at a county wide level, whereas others operate at a locality level to provide services across Tiers 2, 3 and 4. Whilst there are some formal interfaces only a limited amount of this activity is currently coordinated.

The main professional groups are:

ACHTs	There are seven multi-disciplinary teams offering rapid response, reablement and maximising independence pathways. Maximising independence is the most relevant pathway for Tier 4 and is delivered predominantly by District Nurses. The service ranges from annual visits to three times per day and is mainly for people that are housebound. Referrals are made from GPs where the patient is at home or from the hospital ward if there has been an in-patient stay to each localities referral access point.
Social Care	There are three teams of Social Workers and Assistants covering the north, middle and south of the county. The teams are responsible for reviewing and changing care packages. Packages are setup by the CR&R team based out of BCC offices at County Hall or hospital social workers – ideally after a period of reablement. The packages of care are provided by private domiciliary care providers and supplementary services such meals on wheels. Referrals from GPs and ACHTs for new packages are sent to CR&R who undertake and assessment and set up services before handing over client to the community team. GPs and other health care professionals contact the social work team via CR&R if they need to discuss a client and their changing needs.
Mental Health	There are two teams for Older Adults Mental Health based in the north and the south of the county. The teams are responsible for providing community based adult mental health services
GPs	GPs are an integral part of this pathway and use MAGS as the mechanism to coordinate all of the above teams around the needs of the patient
Specialist Nurses	In some specialities there are integrated nursing teams , with access to consultant support, supporting GPs and ACHTs to care for people at home, e.g. respiratory and heart failure

Primary Care Team	Each practice has a wide range of staff supporting the GP, in particular practice nurses

The current model of care is not patient centric and given the direction of travel towards a multidisciplinary approach to reablement (see Tier 3), the current delivery model needs to change to ensure sustainability.

Establishing the opportunity and improvement potential

Key opportunities in the As-Is process

Current Model	Improvement Opportunity
Services are operated from different bases with ACHT's operating from 7 sites across the county and social care operating from three bases	• Collaborative working and co-location exploited to enable knowledge sharing and joint working (e.g joint assessments) • Technology used to maximise access to relevant patient insight
Duplication of ongoing care in health and social care	• Ensure that a patients care is being managed to account for wider interventions "health leg vs. social care leg" • Joined up patient experience – not having to repeat condition updates to different professions
Some commonality in service provision across ACHT and Domiciliary Care Providers.	• Account for Health interventions when planning Dom Care • Consider expansion of packages to meet wider needs
Some commonality of assessment across ACHT and Social Care	• Common assessment approach and sharing of data
In new model of Tier 3 – creation of an integrated rapid response and reablement service reduces the size of the remaining delivery organisations	• Merge remaining functions to increase operational scale and associated efficiency benefits

Future model of Integrated Locality Teams in Buckinghamshire

Overview

The future model will see integrated teams operating across the County providing coordinated, person centric care to individuals in their own homes. These teams will be comprised of resources managed at an area level (likely to be three teams). Depending on need they will be assigned to one or more locality bases from which they will provide a seamless service based on the needs of individuals.

It is important that the professionals are able to operate effectively at a locality level and build a sense of team around the patient and GP practices, but they do not need to work or be managed solely at this level. Through the use of technology the field based workers will be enabled to work with their patients and maintain effective links with their teams and managers. For management and synergy purposes three locality teams are proposed but the staff within those teams would be aligned at least to the level of the 7 localities and in some cases to smaller groupings within those where population and geography supports that.

Key elements

Integrated Team

- Three area aligned teams of professionals drawn from a range of providers with a manager in each to coordinate deployment.
- Professional accountability lines will remain in place and where the whole team is not aligned to the new service, individuals will need to be identified to be part of the team and its operational rotas.
- Day time only service with 'roving professionals' being assigned to patients in line with need.
- Streamlined access to local services with a strong sense of local place to build patient trust, facilitate voluntary and community sector involvement and build on wider local opportunities to improve outcomes.
- Clear oversight of all patient interactions (health and social care) to coordinate provision, reduce duplication and exploit wider opportunities for optimising service interactions as part of a wider package and reduce the level of specialist input (e.g. using existing home care to support low-level nursing interactions).
- Individuals will have simpler access to appropriate support to seamlessly manage the issues presented when care needs change.

To illustrate how this would work a couple of illustrative scenarios have been developed, see below.

Mary's story

Mary lives on her own and is 83 years old. Following a stay in hospital and a period of reablement she continues to require ongoing nursing and home care support to manage her diabetes, medicines and tasks of daily living.

What would have happened before…numerous different people from different organisations have assessed Mary's changing needs. Then a variety of workers visit throughout the week to facilitate Mary's different needs. There seems to be little recognition by each visitor of the various other services and Mary can get quite confused and agitated as to whom is due to visit and for what reason.

What will happen in future…a key worker undertakes an assessment for all Mary's needs and arranges with colleagues a holistic package of care. The main care provider agrees to undertake the majority of the requirement, including monitoring Mary's self-medication compliance. This reduces duplication and enables the nurse to visit less frequently. However, when the nurse does visit she is fully briefed on Mary's progress and the services she has been receiving.

It is proposed that the integrated locality team is resourced by aligning ACHT, Oxford Health and BCC staff into three teams. Locality hubs will be created in existing buildings (link to estates review work) with the ability to be public facing and support the development of wellbeing centres (Tier 1).

Future enhancements

- Potential to create integrated access points which take responsibility for contacts within a given area. This would need to be assessed in more detail to establish the synergies with the existing CR&R service and ACHTs.
- Opportunities to use technology to enhance long term condition management.
- Development of organisational efficiency associated with new way of working.
- Consider links to practice nurses as they are experts in managing long term conditions and so there are synergies in working practices.
- Examine skill sets across existing silos particularly in nursing (practice nurses, district nurses and specialist nurses).
- Different organisational models for service delivery.

Experience from elsewhere

Torbay[4] have operated an integrated delivery model for some time with community staff ultimately transferring to the NHS. It is recognised that there is no 'best way' of integrating care. As such the model is reflected in local relationships, structures and networks, but with the following attributes:

- Teams based on GP registration and not home address to enable allocation of work, simplify access and make co-ordination of effort easier.
- Sound, joint governance and shared leadership and single management arrangements for all professionals

[4] Integrating health and social care in Torbay, The King's Fund, 2011

- Flexible use of pooled budgets with prioritisation of continuity of care at home

The operational model has seen improvements across the system including:

- Inter-professional trust and shared assessments – improved relationships with stronger capacity to do their jobs, clear professional identity, improved training opportunities and employment security within a changing health and social care landscape
- Single point of contact within zones improve access and speeded up responses which GPs found invaluable
- Emergency bed day use has fallen on average by 28% for age groups from 75+ and is the lowest in the SW region against a rising national trend
- Reduction in the use of nursing home and care home beds
- Quicker decisions and arrangements for care to be put in place with no arguments on funding responsibility
- Improved performance of the LA against national benchmarking data/CQC