Health and Well Being Board 21 September 2016

Community Transformation – Progress Report

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Purpose:

The purpose of this paper is to provide a progress report on the Community Transformation Programme

Background:

The Community Transformation Programme was set up in 2013 to facilitate the transfer of care from hospital to the community. The priorities reflect many of those already identified in the Better Care Fund Plan. The programme is overseen by a multi-agency Transformation Board. This Board is focusing on the following key workstreams.

1 Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams are likely to achieve better results than those that operate within strict organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team.

- Community-based multi-professional teams based potentially around practice populations
- A focus on intermediate care, case management and support to home-based care
- Joint care planning and co-ordinated assessments of care needs
- Named care coordinators who retain responsibility throughout the patient journey
- Clinical records that are shared across the multi-professional team.

The Community Transformation Programme is leading the development of a fully integrated health and social care team to support the Health Village. The team is now co-located and supporting people who are registered with the GP practice population. The team are about to introduce a single line management structure and joint service specification. The integrated health and social care team includes community nurses, a community matron, social workers and allied health professionals. It will have a single point of access for all referrals. As well as focusing on structure, the process of integration will include a programme of relational transformation aimed out enhancing interpersonal relationships and breaking down cultural/ organisational barriers.

The team will incorporate named care coordinators responsible for supporting people with complex needs. Rotherham FT is developing an IT portal that can be used for integrated care planning and provide visibility of the services that people are receiving. The team has a combined outcome framework which supports the strategic objectives of both the local authority and the CCG.

2. A Reablement Hub Incorporating Intermediate Care

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and delayed discharges. The aim is to support recovery in a non-acute setting, enabling people to achieve optimum levels of independence. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward.

The Transformation Board is working across health and social care to develop a fully integrated intermediate care offer, with the right number of beds to meet demand, more flexible eligibility criteria, increased provision of services and more choice of housing. The intention is to build on our current intermediate service, offering support to remain at home without having to rely on statutory services.

The Transformation Board is working closely with the BCF programme to develop a business case that will focus on the following issues

- Identification of an appropriate site
- Description of the service model
- Timescales for development
- Financial requirements and potential for recurrent savings
- Eligibility criteria
- Outcomes and performance management framework

3. A Multi-Disciplinary Integrated Rapid Response Service (IRR)

Over the last year the Transformation Board has combined a range of community health teams which provide reactive health care interventions. The service incorporates the following legacy services:

- Care Home Support Advance Nurse Practitioners
- The Fast Response Service
- The District Nursing Twilight Service, Evening Service and Night Sister

The IRR service now supports patients who are medically for discharge, can be cared for at home but are waiting for the appropriate health or social care package to be assessed and put in place. It also supports patients who are at immediate risk of hospital admission. The service is accessed through the Care Coordination Centre. The main interventions carried out by the IRR service include;

- Rapid MDT assessment and care planning
- Nursing intervention , including IV therapy if capacity allows
- Falls risk assessment
- Intensive rehabilitation services, including physiotherapy, occupational therapy and reablement
- Respite care e.g. due to carer breakdown
- Co-ordinating alternative levels of care

In line with the BCF Plan, the Transformation Board is now working on extending the IRR Service so that it incorporates social care. If successful the new service will be able to support people with an urgent health and social care need. There will be a significantly stronger link between the out-of-hours social care services with additional enablement support.

4. A Single Health and Social Care Plan for People with Long Term Conditions

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Transformation Board is developing integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes.

5. A Joint Approach to Care Home Support

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. This figure includes those residents that are financially supported by the Local Authority, self-funders and out-of-authority placements. Around 400 older people are admitted to residential care each year with complex needs.

Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care plans for residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives

The Transformation Board has realigned the service specification so that residents at high risk of hospital admission are allocated a care co-ordinator from within the Care Home Support Service. The care co-ordinator combines advanced clinical nursing and therapy practice with the co-ordination of integrated care plans.

In line with the BCF Plan the Transformation Board will support residential and nursing homes in meeting the needs of residents with organic and functional mental health problems. The intention is to conduct an annual mental health assessment of all care homes. The assessment will identify residents with depression and dementia. We will monitor these residents, ensuring that they are sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment.

6. A Shared Approach to Delayed Transfers of Care (DTOC)

Within the Better Care Fund Policy Framework (2016/17) there are new National Conditions which all BCF programmes must action. One of these is the development of a Delayed Transfer of Care Action Plan and a locally agreed target for the reduction of DTOCS.

The number of recorded Delayed Transfers of Care (DTOC) from the December 2015 National DTOC report shows that 2.2% of transfers were delayed. This is significantly lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTOCs within Rotherham.

The Transformation Board has recently endorsed a Memorandum of Understanding (MoU) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which has now been signed up to by all providers. The MoU covers DTOC and all other patients who are 'medically fit for discharge'. The main purpose of the MoU is to ensure that patients are discharged as soon as they are medically fit and that they have the appropriate care packages in place which reduces the risk of readmission

The next step for the Transformation Board is to develop robust risk sharing agreements relating to DTOC as part of further development of the MoU. We will develop reporting systems which incorporate data on DTOC and other patient cohorts who have an impact on patient flow. The Transformation Board will further develop the MoU so that it considers the following issues;

- Predicting times of discharge to enable effective community planning
- Interface with integrated rapid response
- Management of MDT's for patients who change wards during their acute stay
- Discharge arrangements for patients in Intermediate Care.

Relevance to The Health and Wellbeing Strategy

The Community Transformation priorities will support the aims and objectives of Rotherham's Health and Wellbeing Strategy. Table 1 shows how the Community Transformation priorities line up with those of the Health and Wellbeing Board.

Table 1: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	Integrated health and social care Teams	• Improved support for people with enduring mental health needs, including dementia • Reduction in common mental health problems among adults • Reduction in social isolation
	Shared approach to delayed transfers of care (DTOC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Development of a reablement hub incorporating intermediate care	• Reduction in early death from cardiovascular disease and cancer • Improved support for people with long term health and
	A multi-disciplinary rapid response service	

	A single health and social care plan for people with long term Conditions	disability needs
	A joint approach to care home support	

Recommendations:

It is recommended that the Health and well Being Board;

- Note the progress that has been made on community transformation
- Support the programme of activity currently underway