The Rotherham NHS
NHS Foundation Trust

BRIEFING PAPER FOR HEALTH SELECT COMMISSION

1.	**Date of meeting:**	**15th June 2017**
2.	**Title:**	**Evaluation of the Integrated Locality Pilot**
3.	**Directorate:**	**Strategy & Transformation, TRFT**
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5. Introduction

5.1 Ambitions for the future of health and care in South Yorkshire and Bassetlaw have been published in the region's Sustainability and Transformation Plan (STP). This plan sets out the future vision for health and social care services across all partner organisations. The STP is underpinned by The Rotherham Place Plan, which provides a local perspective on how the Rotherham MBC, Rotherham CCG and The Rotherham Foundation Trust will work together in the future.

5.2 This document provides an evaluation of one of the exciting transformational initiatives that is already underway; The Health Village Integrated Locality Pilot. The Pilot is an illustration of the strong partnership arrangements that already exist and being strengthened in Rotherham, and provides insight into how local health and social care communities can improve the quality of care to vulnerable people.

6. Context

6.1 In line with the rest of the country, the most significant demographic change occurring in Rotherham is the growth in the number of older people. The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As at 2014/15 there were almost 13,900 people in Rotherham with diabetes, and nearly 5,400 on GP stroke registers. By 2025 we project that there will be nearly 4,500 people in Rotherham living with dementia.[1]

6.2 The health of the Rotherham population is generally poorer than the English average. We have a growing population, but notably, we will see a significant increase in the 85+ population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing as people are living longer in poor health, resulting in a growing number of people with high levels of need.

Our key challenges are described in the diagram below.

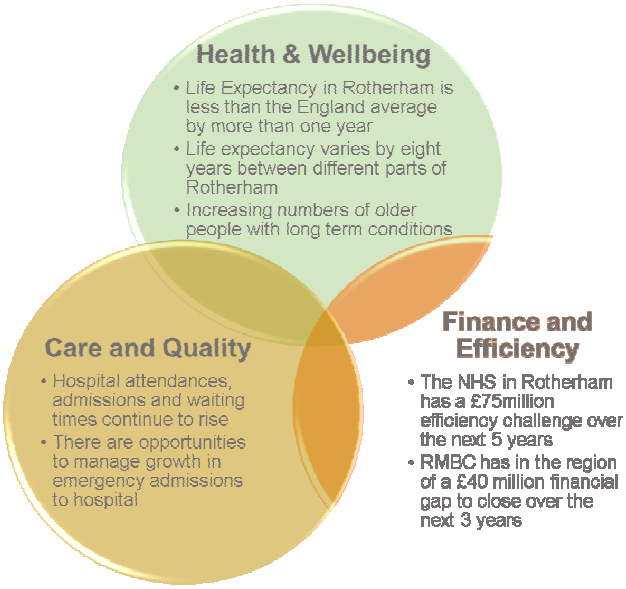

Figure 1. Rotherham's three gaps

The Health Village is one of the transformational initiatives developed to contribute to closing the gaps.

7. Background

7.1 In 2014, The Rotherham NHS Foundation Trust, with support from the local clinical commissioning group, began to undertake a significant piece of work on establishing seven community locality teams. In the first phase, the locality teams were centred around district nursing teams and GP practices, with the plan to develop into broader multidisciplinary teams responsible for local populations.

7.2 The first full multidisciplinary locality team was launched in summer 2016 as a pilot. The team consists of GPs, a community matron, district nurses, community therapists, social workers, a community physician, social prescribing brokers and community link workers. There is also dedicated mental health support. The team proactively manages the care of their locality population (approximately 35,000 people), providing care close to home and where possible helping to avoid hospital admission.

7.3 New technology solutions that have been developed mean that members of the locality team are able to see, for the first time, if and when a patient has attended A&E, been admitted to hospital, or been receiving care in an intermediate care setting. The locality team can also see whether these patients are on the current case load. The locality team has full visibility of patients from the care home sector enabling the delivery of appropriate support. The team can intervene and start to put plans in place to get patients home, or at least back to their local community where they can help them recover and avoid further hospital readmissions. Through the use of the NHS number as a unique identifier, the locality teams are able to share case load information across health and social care. They are able to allocate a lead case worker who is responsible for streamlining interventions, reducing duplication and making things far simpler for the patient.

8. The Approach

There are a number of key features that have developed during the pilot which define the delivery model and differentiate Rotherham from other areas that have adopted integrated ways of working.

8.1 Community Rehabilitation

Therapists lead on case-finding and developing tailored rehabilitation programmes. Social workers identify people on high-cost social care packages with potential, through community rehabilitation, to reduce the cost of or need for formal care, for example, where multiple carers are required. There are plans for reablement support workers to join the team and work with therapists, enabling them to optimise physical function and daily living. Reablement workers will support people through the therapeutic programmes. The aim of this approach is to drive down social care dependency and costs. Figure 2 provides an example of a case study from the community rehabilitation service.

On 30th May 2017 a letter was sent to the Integrated Locality Team, from a couple, thanking the therapists for the time and effort put in to enabling Mr John to get up and walk again, unaided. Mr John was referred in to the Integrated Team after deterioration following a Stroke. He had been isolated to one room in his house due to his inability to move. It required three people to stand Mr John at this point.

His deterioration resulted in him being placed in intermediate care, who referred him to the Community Occupational Therapist (COT) attached to the Integrated team, for a hoist to lift him.

A multi-disciplinary review took place to assess Mr John's needs and the case was to be managed by the Physiotherapy and Occupational therapists with input from the team social worker in relation to the care he would require. The team rehabilitated Mr John from December 2016 and as a result he is now able to function without aids and reports being so much happier. He is spending time in the garden and has three outings planned for the summer, including to London and Llandudno. The team has reduced Mr John's social isolation, enhanced his mental well-being and overall quality of life.

He is now able to attend medical appointments instead of requiring domiciliary visits, the risk of developing sores and District Nursing input has reduced dramatically and his social care package will be reviewed as a result.

Figure 2. Case Study describing the impact of the integrated model (patient name amended to retain anonymity)

8.2 Community Development

Our approach is significantly different to other care models. Rotherham has an award winning social prescribing service which supports GPs on the case management of people with long term conditions. We intend to extend the service so that it supports care planning within the localities. Also, the community link worker is responsible for engaging with the local population and developing the 3rd sector and local communities so that it has capacity and capability to support vulnerable adults. As part of this approach we are developing a bespoke carer service within integrated teams aimed at improving the resilience and mental health of local carers.

8.3 Parity of Esteem

The integrated team includes a mental health specialist, targeting people who are socially isolated, those with anxiety, depression or dementia and people who have recently experienced a significant life event. The capacity within primary care means this cohort is poorly served, despite evidence showing there is significant risk of spiralling into formal care services.

8.4 Case Management and Integrated Care Planning

The Integrated team works proactively with GPs to manage people who are considered at high risk of poor health or social circumstances, specifically targeting those with long term conditions. Multi-Disciplinary Team (MDT) meetings discuss patients who require integrated care and offer joint ward rounds with GPs for high risk residents within care homes. The MDTs develop integrated care plans for high risk residents or those approaching end of life. The locality teams operate a Virtual Ward for people who are at high risk of hospital admission, overseen by the Community Physician, ensuring that they are regularly reviewed and supported.

8.5 Impact of New Model

Our new approach delivers significant benefits to patients, creating an efficient and holistic offer with less duplication, improved patient experience and outcomes. The model does not only generate efficiencies within community services but also positively impacts upon the cost of acute and urgent care.

9. Challenges and Learning

9.1 The locality pilot has presented a number of challenges, which are being used to aid learning in preparation for the roll out across the Borough.

9.2 Organisational, legal or professional boundaries need to be broken down, to enable teams to operate as distinct units. This has been a key challenge. Workers still operate in professional or organisational silos within some integrated care models, which cannot afford to happen upon roll out. Breaking through this in the pilot has required strong leadership that is fully engaging to create a high-trust environment that empowers the team and develops a shared vision. The success of the roll out is highly dependent upon the will and determination of the teams on the ground, making early engagement imperative.

9.3 Our innovative skill mix model aims to address the challenges associated with the recruitment and retention of healthcare staff that is being experienced nationally. By pioneering the transformation of health and social care provision, TRFT is aspiring to differentiate itself, and hopes to attract the health and social care professionals needed to transform and sustain new ways of working.

9.4 Technology is a key enabler but presents challenges, especially in relation to information sharing. This challenge is amplified once other organisations become involved. Significant work is underway to resolve the complex challenges of information governance in preparation for the roll out as well as seeking practical solutions to integrated record keeping.

9.5 Contextual barriers include:

- Adult social care funding pressures
- The potential impact of Brexit upon the workforce
- The abolishment of NHS Bursaries

9.6 There are potential unintended consequences that may occur as part of the roll out process which may include a lack of clarity over who is accountable for statutory health and social care services. There is concern amongst partners that an integrated model could focus on delivering outcomes for specific parts of the health and social care system. For example, the focus on supporting discharge from hospital could place additional burden on primary and social care. Project sponsors are aware of such issues and committed to an outcome framework which supports the strategic objectives and financial viability of all partners.

10. Impact Assessment

10.1 The outcome measures for the pilot are reductions in;

- Hospital Length of Stay
- Non-elective Admissions
- Cost of social care packages

10.2 The pilot's performance indicates early impact. Metrics for the pilot were agreed with partners at commencement of the project, which measure against historical and aggregated data from comparator localities.

10.3 Length of Stay

The working protocols to address hospital length of stay have not yet been fully implemented and therefore baseline data is being captured to measure impact once implemented.

10.4 Unscheduled Hospital Admissions

Whilst the Borough as a whole has seen an increase in unscheduled hospital admissions the Health Village integrated locality pilot has seen a smaller increase. Since the introduction of the Pilot, the Health Village locality has seen a much steeper declining trend in the number of non-elective hospital admissions for its practice populations in comparison to the previous year.

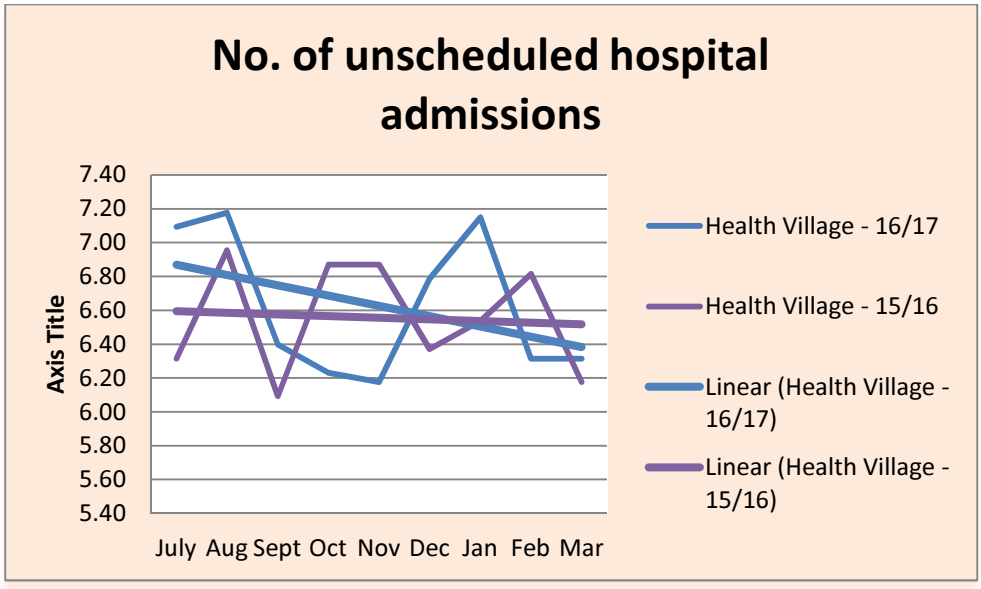

Figure 3: Number of unscheduled hospital admissions for the Health Village: comparing 2015/16 to 2016/17

10.5 Unscheduled Hospital Admissions for Care Home Residents

The Pilot area is engaging proactively with Care Homes to prevent unnecessary admissions, which has resulted in the pilot area having a 35% reduction in comparison to the same period in 2015/16. The Borough has a reduction of 18% overall when comparing the same periods.

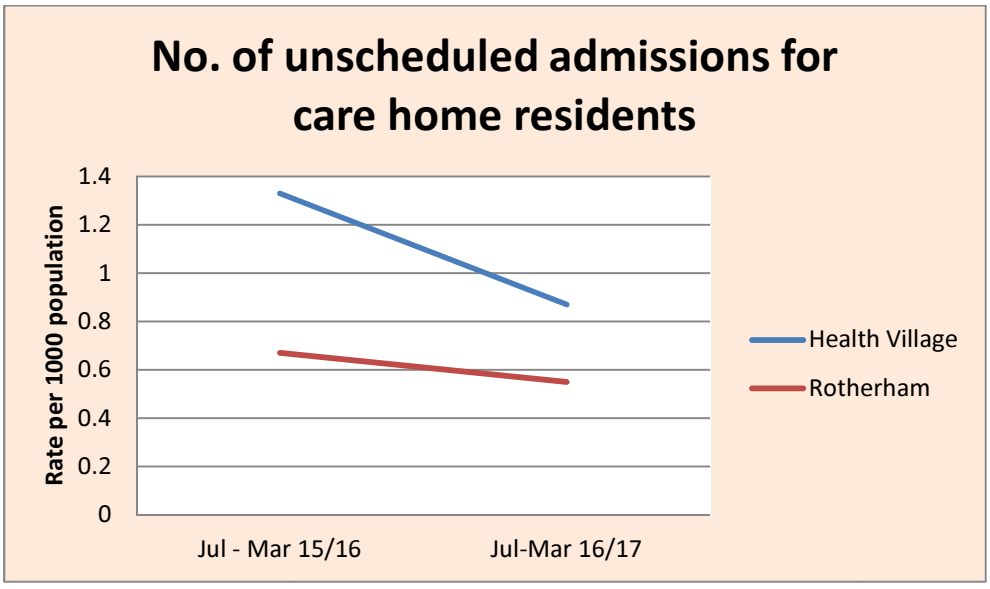

Figure 4. Number of unscheduled hospital admissions for Care Home residents comparing the Health Village Pilot locality to the Borough wide performance.

In 2015/16 the Health Village locality saw a rising trend for Care Home Resident admissions, yet the trend has been bucked since the introduction of the pilot.

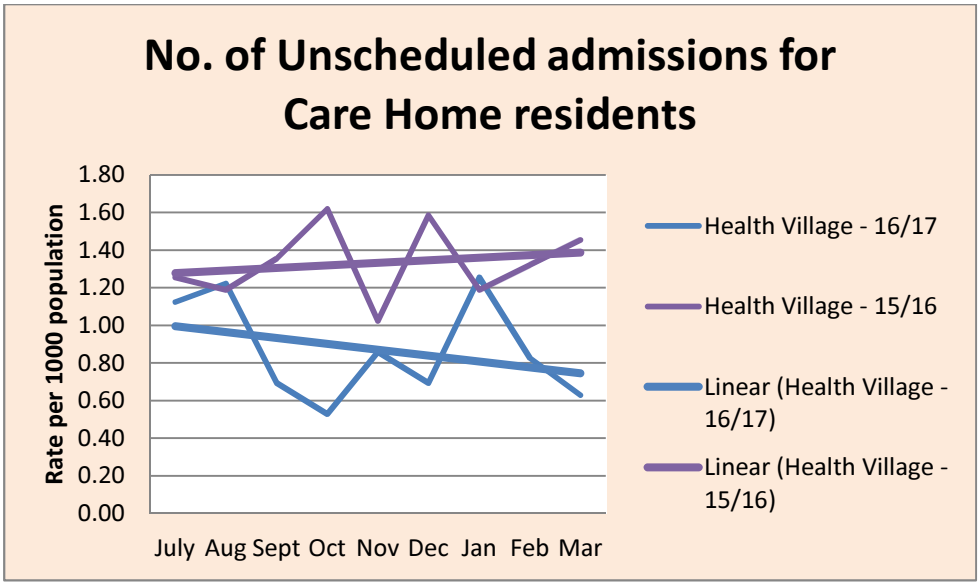

Figure 5. Number of unscheduled hospital admissions for Care Home Residents comparing the Health Village performance since the commencement of the pilot with the same period during the previous year.

10.6 Unscheduled Admissions to the Acute Medical Assessment Unit (MAU)

When comparing July to March 2015/16 to July to March 2016/17, the Health Village pilot locality outperformed the Borough 5% in the reduction of unscheduled admissions to the acute MAU.

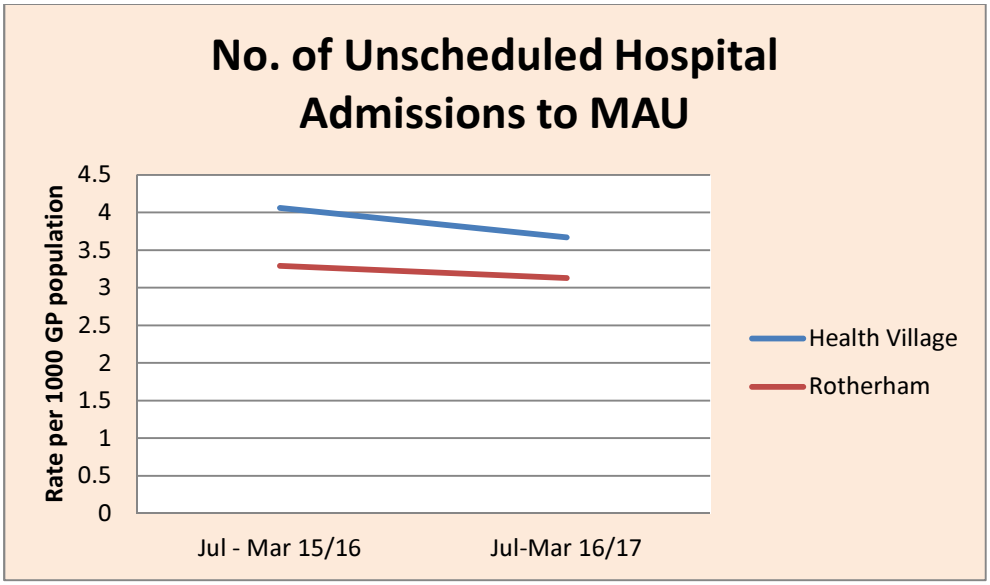

Figure 6. Number of unscheduled admissions to the Medical Assessment Unit, comparing the period before the pilot and the impact since implementation.

Additionally, since implementation of the integrated team the upward trend in admissions to MAU has ceased and, instead, has begun to decline.

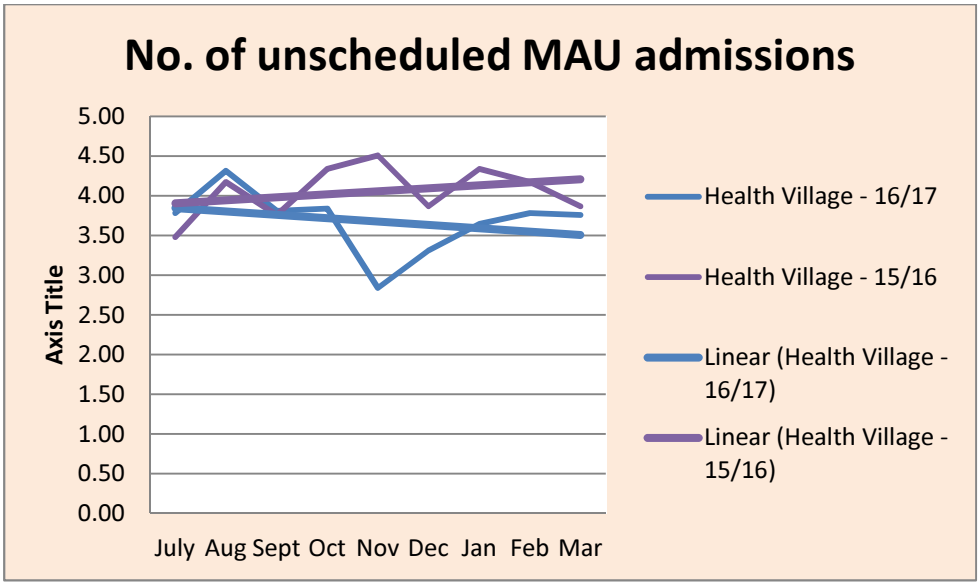

Figure 7. Number of unscheduled admissions to the MAU for the Health Village locality pre- and post- pilot implementation.

10.7 Cost of Social Care Packages

The element of social care resource within the locality pilot is fairly small meaning that it is difficult to accurately compare performance and impact against established ways of working. Consequently, the social care metrics to measure activity are currently under development. Impact is currently being captured using qualitative mechanisms (see figure 2 as an example). More accurate measures will be in place as the scale and volume of the team ramps up in line with wider ambitions for adult care transformation. .

11. Next Steps

11.1 A bid has been submitted to the Health Foundation 'Scaling up for Improvement' funding stream which, if successful, will fund the project management of the roll out and an external evaluation that will coincide with the implementation and conclude with a Lessons Learned Conference 6 months after. Successful applicants will be notified by 30th October 2017 following a stringent selection process.

11.2 Scoping and engagement work has begun in preparation for the model to be rolled out across the Borough. In addition, delivery templates and working protocols are being formulated to assist with adoption in other localities.

11.3 The roll out will be managed utilizing a project plan which includes the following headline milestones;

- Governance and Contracting November 2017-2020
- A contracting model will be designed and agreed with partners by March 2018.
- Scoping and Design November 2017 – March 2018
- Focus will be on developing a shared vision and service, co-produced with patients, carers and stakeholders with a supporting communication and engagement plan.

- Phased Implementation April 2018 – 2020
- Roll out of the project will be phased by locality: south, north and finally, the most complex and largest locality, central. This will manage risk and enable lessons learned to be acted on.
- Evaluation Conclusion & Conference October 2020

12. Enablers

12.1 There are a number of key enablers that will be critical to the success of the roll out. This includes;

- Robust Project Governance and Leadership
- Workforce planning
- Estates
- IT and Information Governance
- Ongoing evaluation

13. Recommendations to HSC

That the Health Select Commission receives and notes the report.

14 Name and contact details

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