Briefing Note for Health Select Commission

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Care Co-ordination Centre and Integrated Rapid Response

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Purpose

The purpose of the report is to update the Health Select Commission on progress in relation to the Care Co-ordination Centre and Integrated Rapid Response

Summary

This project focusses on the development of the Care Co-ordination Centre (CCC) and Integrated Rapid Response (IRR) Services. Both services are currently provided by Rotherham NHS Foundation Trust physical health services. These are predominantly second tier adult services which sit behind the prevention agenda working with individuals who are normally at a point in which provision of services is unavoidable.

The role of the Care Coordination Centre is to provide a telephone based nurse led approach to directing patients to appropriate levels of care. The Integrated Rapid Response Service is commissioned to provide an immediate short term response to meeting community based health and social care needs.

The ambition within the Rotherham Place Plan is to extend both services to include mental health and social care to provide a multi-disciplinary approach to address the whole needs of the service user, resulting in an improved experience and more effective use of resource.

A phased approach is being taken to implementation to realise benefits within the available resource and to manage risk. The first phase of care-coordination will be for physical and mental health, with a later phase for social care. Phase 1 of the rapid response service will be co-location prior to full integration in phase 2.

The Case for Change

Strategic

The Care Act places a duty on the local authority to integrate services to promote well-being, improve outcomes and contribute to prevention, reduction or delay in needs. The NHS Five Year Forward View sets a target of integrated health and social care services by 2020-21. These drivers are reflected in the Rotherham Together strategy, the Rotherham Health and Well Being Strategy and the Rotherham Place Based Plan. In addition NHSE have published/are publishing guidelines regarding Mental Health Hospital Liaison Services (Core 24) and crisis and home treatment functions (Core Fidelity) which will shape the design and development of the integrated CCC and IRR services to facilitate alternatives to acute admissions.

Operational Background

In addition to the strategic case for change there are also local operational drivers which require addressing to improve the service user experience. A triage practitioner commented at a stakeholder event that current arrangements make 'it easier to bring patients into service, than to keep them out' despite evidence that this may not be the most suitable option for them.

The reasons for this have been identified as:

i. There is no single view of options across the health, social care and voluntary sector system. Information is held in silos within respective services, in differing forms: electronic, written and personal knowledge.
ii. Current arrangements are largely based on referral criteria around eligibility for services. This creates an open or closed door which leads to people in need being passed around the system if they don't meet criteria
iii. Criteria are not well understood and require review
iv. Some patients are bought into service as there is a need for support and there is no (known) suitable alternative

Some distressed and isolated people who do not meet the current service criteria frequently contact the Care Co-ordination Centre and other public sector contact centres. These contacts tend to be time consuming and prevent other users accessing the service. An alternative support mechanism is required. In addition there are issues with the current mental health and social care out of hours crisis/urgent care provision, provided by RDASH

i. When Rotherham clinicians are involved with a patient, calls divert to Doncaster switchboard and a message is passed on when clinicians become free, this could take several hours on occasions.
ii. The service is predominantly staffed by specialist (higher paid) social care AMHPs. In the future service model there will be an expectation that social care staff focus on the roles they have been trained for, which will leave a gap in health cover
iii. For safety reasons high risk assessments are carried out in pairs, currently by two clinicians. This is unnecessary and inefficient, a support worker would be a suitable support

Progress Update

The Care Co-ordination Centre

The initial model for the CCC envisaged a structure whereby administrative and clinical staff covered both physical and mental health activity. Detailed analysis of the pathways highlighted a patient safety risk from a shared triage process. Similar models elsewhere have a combined referral process, with specialist triage. A change to the model has been agreed to reflect this. The CCC will therefore receive and record all referrals, with triage by specialist staff on a duty basis in the IRR. There will be a phased approach to implementing this. Subject to suitable accommodation, RDaSH

staff will transfer into the TRFT team from October 2017 initially focussing on physical health enquiries. Transfer of RDaSH referrals will be staged starting with mental health followed by Learning Disabilities and Out of Hours. Triage arrangements will remain as per current arrangements in the first instance and transfer with the development of IRR. Again, this phased approach will manage risk.

Discussions are taking place with the voluntary sector to develop a network of referrals for 'just to talk contacts' ie lonely, isolated and anxious people who use the service inappropriately, but require non statutory support.

Integrated Rapid Response
Phase 1 will bring together the respective rapid response teams from health and social care. The Crisis and Home Treatment teams from RDaSH and RMBC AMHPs will join the already established TRFT teams. Discussions are underway regarding other social care resource including re-ablement.

Phase 2 will be aligned to the roll out of the integrated locality model and the integrated discharge project to manage patients at risk of admission and facilitate early discharge. Evidence from the locality pilot highlights the benefit of a planned and unplanned model, which would reflect the new mental health Care Group structure.

An update on risk management is set out at appendix 1.

Patient, Public and Stakeholder Involvement:

Proposals have been developed from a number of stakeholder events involving service users, carers, commissioners and colleagues from social care, health and the voluntary sector. Consultation meetings have been held with affected staff groups in RDaSH in relation to the CCC.

Equality Impact:

An impact assessment will be completed as part of the project plan. There has been targeted dialogue with traditionally underrepresented groups.

Financial Implications:

Referral and triage is being managed from within the current financial envelope. Initially 3 people will transfer from RDaSH to TRFT to manage referrals. Triage will be done through existing teams and will transfer in line with the implementation of IRR plans. It is intended to move resource to the front end as part of the locality formation process to provide a 24/7 service.

There has been systemic financial benefit from cross organisation working. By working with TRFT RDaSH can access established call centre technology (Netcall), only incurring costs for extension of the system. The RDaSH Unity programme has shared development work done for the Doncaster SPA which has saved significant analysis and development time for TRFT.

Human Resource Implications:

3 RDaSH administrative staff have been appointed into the CCC contact handling roles following an expressions of interest process. The triage service will be developed as part of the next phase of change.

Procurement:
N/A
Approval history:
Summer 2016: approval of recommendations by CCG and Scrutiny Committee as part of the RDaSH Care Group formation process Update to Accountable Care System September 2017
Recommendations:
Health Select Commission is asked to receive and note the update

High Level Issues and Risks **Appendix 1**

Risk Description / Consequences	Risk / Issue	Mitigation	RAG
The RDaSH Unity programme may not deliver in time for the CCC go live timescales	Issue	Unity implementation has been delayed from October 2017 to April 2018. Alternative arrangements are being put in place. Development work from the Unity programme will benefit implementation	*Green*
If issues raised by GPs and the CCG are not resolved with the business as usual CCC and sepsis pilot, there is a risk that GPs will not support the development of the service	Risk	TRFT are working with the CCG to address the issues and develop solutions which work for primary care and the acute hospital. The CCC are monitoring the situation and reporting to the CCG	*Amber*
There is a risk that RDaSH staff will not want to join a physical and mental health service	Risk	This risk was managed for the CCC admin through targeted engagement highlighting the benefits. 3 wtes successfully appointed through an expression of interest process. The risk remains live for subsequent phases which will be managed in a similar way	*Green*
Staff do not have sufficient skills and knowledge to respond effectively to physical and mental health enquiries	Risk	This risk has been closed as it has been agreed to take a different approach with triage through specialist roles	*Closed*
The IRR co-located teams continue to work in individual silos rather than providing an MDT approach, drawing on the best use of resource available.	Risk	A clear brief and protocols will be co-produced with the teams. Out of hours management responsibility will be agreed. Monitoring procedures will be put in place.	*Green*
Staff will not have access to records held on different systems for decision making purposes. Patients and professionals may need to repeat information	Risk	Interim arrangements are being developed. Funding from the IBCF will ensure the development of the Rotherham Health Record for an integrated physical health, mental health and social care record.	*Green*
Information governance requirements may limit access to information	Risk	This is being managed through a cross organisation information governance group	*Green*
If the teams are not aligned with national Core 24 and Core Fidelity requirements there will be penalties These initiatives also have associated funding assumptions which are required to assume sustainability.	Risk	Proposals to be developed and cross referenced against Core 24 and Core Fidelity. Advice to being sought from NHSE regarding non compliance if there is a significant issue that cannot be resolved	*Green*