Notes from Health Village Evaluation Sub-group 1/5/2018

Present: Cllrs Evans (Chair), Elliott, Jarvis and Short
Apologies: The Mayor Cllr Keenan
TRFT - Dominic Blaydon, RMBC - Cllr Roche, Nathan Atkinson

Introduction

Cllr Roche introduced the session stating there were many positives from the pilot but greater integration with adult social care was needed and this was seen as the way forward.

Presentation by Dominic Blaydon

Background

- Commenced July 2016
- Based at The Health Village, Doncaster Gate
- 2 GP Practices supporting 36,000 residents (Clifton and St. Ann's)
- Co-located multi-disciplinary team (multi agency)
- Includes community nurses, therapists and social workers
- Also incorporates mental health workers and 3rd sector (social prescribing and links through Community Link Worker)

The pilot focused on vulnerable adults, mainly older people aged 65+ and aimed to develop a clear, consistent health offer.

Aims of Pilot

- Improve communication – between professionals leading to better patient outcomes
- Develop a holistic approach to care – physical health, mental health and adult social care needs in one package
- Reduce hospital admissions – generates efficiencies
- Reduce length of stay in hospital – inreach from locality team to support discharge
- Reduce cost of health and social care
- Reduce duplication

It was a question of transferring care from the hospital to the community safely and maintaining quality. Achieving the aims would be a challenge, with some barriers existing between organisations and professionals, but it was a good opportunity with coterminous boundaries and the drive towards greater integration.

Purpose of Evaluation

- Impact of the pilot service model – in terms of changes in how services were delivered and on patient experience
- Can the service model be replicated?
- Recommendations for future implementation

What's in the Evaluation

- Literature search - locality working in other areas, national documentation
- SWOT Analysis
- Interviews and focus groups carried out – front line staff, senior managers and clinicians
- Dataset analysis – some evidence on the metrics below

- What has worked well
- Key Issues
- Leadership Model – views from Grounded Research who carried out the evaluation

What has worked well

- Development of an MDT approach – effective communications and reduced fragmentation bringing a more, but not fully, holistic approach
- Long term condition meetings – CCG programme that the pilot linked in with
- Separation of planned and unplanned care – reactive, urgent work moved into a centralised team and away from community district nursing
- Benefits of co-location
- Use of Rotherham Health Record – opportunities to integrate more, with the team able to see which of their patients were in A&E or hospital (including the ward) and then inreach
- Interface with primary care – still some work to do
- Identification of high-risk patients
- Culture of service improvement – front line staff given autonomy and authority to make changes in how they work as they are the ones with the specific knowledge
- Simplification of referral pathways – some still needed formalisation so that patients were not handed on to someone else. One process –> triage –> to right people.

Rotherham was in a strong position due to positive relationships between frontline staff and at senior management level. The Rotherham Health Record was unique nationally.

Key Challenges

- Clarity on aims and objectives – lacking originally through trying to give people autonomy but needed to have been more prescriptive
- Development of joint outcomes – what did we want to achieve from adult social care and how this would be measured
- Project management – lack of dedicated resources
- Social care metrics - for example increasing independence, reducing long term care, reducing cost packages
- Silo working - it was still hard to break down some professional barriers, even with different teams employed by the same organisation, such as community nurses and therapy staff
- Common service model – the pilot could not be replicated across all seven localities and there would be some virtual working
- Leadership arrangements – staff were managed in their own professional groups but it was about trying to bring people together in one leadership team with shared responsibility for the same outcomes
- Contractual issues – TRFT are paid on a block contract from the CCG for community services, which could be a potential barrier

Key Metrics

- Non-elective admissions
- Non-elective bed-days
- Length of stay
- Discharge destination
- Elective bed-days

Data for the relevant patient cohort showed progress on the first three metrics compared with other localities and for the pilot locality compared to the previous year. Less evidence

had emerged for the last two metrics. Positively length of stay remained about the same, meaning patients with greater acuity were the ones in hospital.

Next Steps

- Service model approved by Integrated Care Partnership Board
- Roll out into one Partnership area during 18/19
- Also develop the Health Village (Remove pilot status)
- Separation of planned and unplanned care – some work had taken place already and people would be moved from unplanned to planned care once their immediate additional needs had been met and they returned to their standard long term care
- Selection process underway on which Partnership area
- Initially focus will be on alignment of teams

The seven localities across the borough had been grouped under three Partnership Areas, North, Central and South; one with three localities and the others each with two. This was to achieve economies of scale and also reflected the fact that adult social care and mental health would not be able to work to seven, unlike community nursing. Plans were in place to move to area-based working in adult social care and building the relationships.

Discussions were taking place over which Partnership Area would be chosen but even if the Central one was not selected further work to develop the Health Village would continue with an action plan in place.

The points below were raised in discussion after the presentation:

- The governance structure for the Rotherham Integrated Care Partnership with a delivery board and an executive board that reported to the Health and Wellbeing Board. The pilot was one of the workstreams within the Rotherham Integrated Health and Social Care Place Plan, which in turn formed part of the South Yorkshire and Bassetlaw Integrated Care System, but this work would have been undertaken anyway in Rotherham. Concerns about the timescale for the wider rollout being slow had been raised but the present picture around the locality structure was complex with different services and different partners working to a range of locality structures, which needed to be brought together.

- Delayed transfers of care were important for patients but also for the local health and care system as money was lost if these rose above 3.5%. Current performance was good on this measure.

- From an adult social care perspective the evaluation was fair and with only two staff involved, a social worker and a community link worker, it was difficult to draw conclusions. However the value of multi-disciplinary team working and better communications was clear. Developing this new integrated approach was a challenge as nowhere else in the country had fully achieved it yet; even Greater Manchester was still at a formative stage. There had been learning from elsewhere through visits to Northumberland, Lancashire and Morecambe and officers from Knowsley Council had visited Rotherham.

- National evidence did not show any huge savings from the new models, but it was primarily about better patient experience, including not having to tell their story multiple times, and optimal use of resources. Savings might result at a later stage. The adult social care improvement journey was lagging behind the pilot and had had savings requirements to achieve, but it was hoped to move forward more quickly now.

- The development of the adult social care side needed to be seen in the wider context of the service over the last two years when it had possibly been less of a priority than addressing the assessment backlog, developing the learning disability offer and dealing with some staffing issues, but all were progressing. It entailed a change of culture amongst social workers from being service-centred to people-centred. Team managers played a key role in work allocation and setting the tone for their teams.

- Objectives were in place for developing the adult social care side and the social workers were keen to get out into communities and develop that local knowledge and feel as most were currently based at Maltby. Social workers had an office base for administrative work and for management oversight of the team. Having an office base also helped with trying to change the culture through sharing ideas and bringing in best practice as there was a focus on improving the quality of social work. Other benefits resulted from participation in regular MDT meetings to discuss patients and how best to support them. At MDT meetings everyone usually contributed about their patients and most workers could identify those who were most at risk of hospital admission. Technology would also enable more agile working and help to maximise time in the field.

- Previous long waiting times in occupational therapy e.g. for a ferrule had been successfully reduced following a reduction in the number of forms to complete, so it was a case of changing both culture and processes.

- Interface with community groups would also be part of the development of re-ablement, together with bringing in other delivery partners such as care homes and involving them in the process, but at a later stage.

- Different job roles were likely to result, such as a new blended role for home care staff who could take on some tasks previously carried out by other workers after training to build their skills, also helping to reduce duplication. For example, at one time care workers could do bloods and give medication and reinstating this would free up district nurses.

- Maximising the use of assistive technology also helped to keep people at home and the Council was working with the CCG on re-ablement.

- If things went to plan the roll out would continue this year in one of three Partnership Areas covering a third of the borough, then next steps would be determined. TRFT hoped that the full roll out would be within two years but once operational it would take a few years to become optimal. Any redefining or redesigning of job roles would also mean significant training issues.

- With a number of empty buildings in the borough there were questions about whether these should be disposed of or retained and looked at for new purposes. The estate was important and one of the problems with the pilot was that the building did not lend itself to multi-disciplinary working. Configuration of buildings was critical, with open plan being more beneficial than a number of small offices that could perpetuate silos as it also facilitated informal chats.

- Having a preventative element was also important, for example if someone experienced a major life event such as bereavement this might lead to isolation and depression even if the person did not have a long term condition. Appropriate support could be identified through social prescribing or the Community Link Worker.

- The evaluation report mentioned moving to a whole family approach but realistically the borough wide roll out would be incremental. It would commence with the cohort of older and frail people who comprised the majority of those who needed adult social care before including the community overall. Much would depend on which Partnership Area was selected and it was also hoped to incorporate learning disability for the same cohort fairly swiftly. Once the bases were in place links would be developed with Early Help and dialogue around the whole family. Partners were cautious of being overly ambitious, preferring to concentrate on the core group and then fine tune.

- The greater challenge of implementing the model in rural areas was acknowledged, as in the Central area services and the population were more concentrated. Each Partnership Area had different issues to consider, such as greater rurality in the South and a more dispersed, but strong and stable workforce compared with a relative lack of community nurses in the North. Developing a user-focused, tailored offer that reflected the local community was the key.

- Rolling out the locality model was one element of the place plan and wider integration, linking in with other initiatives such as developing a single point of access, reconfiguration of community beds, the integrated discharge team, and the integrated rapid response for unplanned care. The short stay apartments in Shaftesbury House were viewed as a positive step.

- Dedicated resources for project management were highlighted as necessary in the evaluation report and money from the Better Care Fund had funded a joint RMBC/TRFT post, recognising that the Council was a deliverer of services as well as a commissioner.

- Partners would clarify the joint outcomes desired from the roll out and the set of measures in relation to these. The intention was for teams to have autonomy within an overall framework to deliver a set of specific outcomes.

Agreed actions:

1. Health Select Commission to continue to monitor progress on developing the Health Village and the roll out to the first Partnership Area during 2018-19.

2. Health Select Commission to consider any outcome measures they would like to see included for the roll out and to feed these back to officers.

3. Members of the Health Select Commission to undertake a field trip visit to include the Health Village, Care Co-ordination Centre and Single Point of Access.