Forward View into Action

Registering interest to join the new models of care programme

Q1. Who is making the application? (What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)
This is a joint expression of interest between Thurrock Council and NHS Thurrock Clinical Commissioning Group. The expression of interest has full sign-up from community care provider North East London Foundation Trust (NELFT), and mental health provider South Essex Partnership Foundation Trust (SEPT). Signatories to this expression of interest: Roger Harris – Director of Adults, Health and Commissioning Mandy Ansell – Acting Interim Accountable Officer Malcolm McCann – Executive Director (SEPT) Michelle Stapleton – Director of Integrated Commissioning (NELFT) Andrea Atherton – Director of Public Health Barbara Brownlee – Director of Housing Key contact: Mandy Ansell Acting Interim Accountable Officer NHS Thurrock Clinical Commissioning Group mandy.ansell@nhs.net 01375 365810
Q2. What are you trying to do? (Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)
In Thurrock, we have already established a Health and Social Care Transformation Programme which aims, through whole system redesign, to deliver an integrated vision for health and social care. In the first instance, work will focus on older people aged 65 and above. Our vision and the initial building blocks of transformation activity are detailed within Thurrock's Better Care Fund Plan – and in particular the schemes appended to it. The main aim of our BCF, and of our Transformation Programme, is to reduce the number of people admitted to an acute setting and to ensure as far as possible that those discharged from Hospital are not readmitted and are rehabilitated and supported to live as independently as possible – regardless of the setting. Achieving this requires an integrated yet flexible approach. Broader than this, our whole system development programme focuses on keeping people healthier for longer, which emphasises an approach that will require a focus on prevention and on shifting resources. We have existing approaches that we want to expand and build

on which includes a Borough-wide Local Area Coordination scheme. We want to ensure that we have solutions that are 'right time, right place, right solution', and importantly, we want to develop a system that wraps around the person, with that person firmly at the centre. To do this, we need a 'system' that is not only flexible, but that incorporates for example housing, the voluntary sector, and the important role communities themselves play.

If successful, we will use becoming a 'vanguard site' as a way of accelerating and expanded the work planned, particularly the work that focuses on robust intermediate care solutions to keep people out of hospital and on solutions that keep people well for longer – this includes ensuring that people are effectively supported in their own homes as well as care homes.

Our main objectives

- To provide an integrated single offer to all registered care homes in Thurrock to increase their capacity to maintain people in that setting
- Increasing the availability of step-up provision
- Increased use of telecare and assistive technology in the home
- To explore the potential to develop a single provider arrangement across primary, community, and social care
- To consider how to make the move from a funding model to an investment model – whilst maintaining 'business as usual'
- Integration of both provision and commissioning
- Developing the market to ensure a broad range of choices
- Ensure a focus on the outcomes the individual wishes to achieve
- Building on a focus on prevention and further developing the shift of resource upstream – e.g. via schemes such as Local Area Coordination
- Look at integrated solutions not just across health and social care, but with housing and with the voluntary and community sector
- Delivering an increased range of settings in which reablement, physical and mental health care can be provided – and extending the range of people who can use those settings
- An asset based community development approach – looking at capabilities and strengths and the delivery of outcomes as opposed to a deficit based model
- Ability to identify people at risk of admission at the earliest stage and provide a co-ordinated approach to those deemed at most risk
- Delivering a coordinated approach to overseeing an individual's care and support needs

Key Changes

- Develop and embed a multi-agency risk stratification approach that identifies people at most risk of admission
- Use of the community geriatrician, positioned at the single point of access, to ensure older people most at risk of admission are accessing the right part of the pathway quicker, and helped to navigate through it – this includes identification of people most at risk of admission to hospital from a care home setting
- Co-ordinated approach to care through the commissioning of integrated

provision – including primary care, community care, and social care, and also housing
- An approach that shifts towards prevention
- Build on multi-agency and multi-disciplinary teams – for example MDTs within a care setting
- Increase the menu of choices available for intermediate care solutions – e.g. interim beds, step up and step down, extra care housing, nursing care with independent living – all as part of the integrated health and care agency
- Build on the use of assistive technology and telecare solutions – e.g. building on the success of existing evaluations

What will changes look like for staff?
- Greater and easier access to different disciplines
- Integrated approach across primary, community and social care – development of 'one culture'
- Multi-professional decision making – single approach
- Integrated/single approach to care planning

What will changes look like for the local community?
- Reduced interactions with professionals
- Reduced admissions or repeat admissions as care better co-ordinated
- Ability to stay independent for longer in a home setting
- Ability to achieve a 'good life' – through identification of the outcomes an individual wishes to achieve

Q3. Which model(s) are you pursuing? (of the four described)

Enhanced integration with care homes and social care - this model best fits with our approach for redesign across the health and care system. Our focus is on keeping people healthier for longer – which includes managing the shift upstream. Key to this includes ensuring we develop an effective and resilient approach to intermediate care. Alongside our approach to developing our intermediate care offer, we want to ensure that we are able to identify those most at risk of admission with a co-ordinated approach to keeping those at risk out of hospital and as independent as possible for as long as possible.

As part of this we are going to be reviewing all existing bed based services, including:
- Existing intermediate care beds;
- Existing step down provision;
- Existing nursing home placements; and
- Existing use of extra care housing.

Q4. Where have you got to?

(Please summarise the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

- Development of integrated approach to governance through an Integrated Commissioning Executive
- Establishment of Health and Social Care Transformation Programme –

including Whole System Redesign Project Group
- Appointment of Community Geriatrician
- Commenced review of Frailty Pathway
- Step Up and Step Down beds in place
- Multi-disciplinary Team meetings in care homes
- Well established integrated Rapid Response and Assessment Team
- Well established Joint Reablement Team
- Asset Based Community Development approach in place and developing
- Close working relationship established with key partners – providers, Housing, CCG, Local Authority etc.
- Introduction of Local Area Coordinators across the Borough with evidence of success – e.g. of keeping people out of the system.

Q5. Where do you think you could get to by April 2016?

(Please describe the changes, realistically, that could be achieved by then.)

- Review current intermediate care services and spend
- Strengthened the capacity of local care home sector to manage the increasing complexity of patient/residents
- Fully scoped 'keeping people out of hospital' approach – including business case
- Agreed approach to single health and care organisation focused on keeping people out of hospital or from being readmitted – e.g. across community care, primary care, social care, housing
- Colocation of staff
- Outline incentivised approach for keeping people out of hospital – e.g. PbR-type approach for community rather than acute provider
- Fully developed risk stratification tool
- Single approach to care coordination and planning for those identified as most at risk
- Programme of engagement with the public and users of services
- Establish project plan and project arrangements
- Greater intelligence and analysis through work with GP surgeries
- Potential contractual changes

Q6. What do you want from a structured national programme?

(Aside from potential investment and recognition: i.e. what other specific support is sought?)

Putting in place the organisational and system changes which will support a fully integrated offer in Care Homes, and to help frail older adults remain at home or to return home, will be very challenging. While the Council, the CCG and their providers are confident that the move to integrated delivery set out in out better Care Fund Plan will result in more effective and better co-ordinated care, a number of aspects of the current health and social care system may serve to limit our transformation. We feel that in addition to redesigning our offer we will need to address a range of issues over which the Council, CCG, and providers as local organisations, may have limited control. These include

- Addressing information governance and technical issues related to interoperability of different IT systems so as to enable shared information systems for health, housing and social care across all relevant service areas
- Investigating the benefits of new forms of organisation and delivery structures/vehicles that can host the integrated offer (a one stop shop comprising general practitioner services, a range of community health care services, Care Home provision and step up/step down accommodation and adaptations and equipment services)
- Examining clinical and professional boundaries, and opportunities to develop the workforce capability, so as to maximise the potential for individual members of staff to deliver the range of treatments/interventions a patient/service user may require, while minimising hand offs
- Exploring approaches to procurement and contracting that, while ensuring compliance with the new EU Procurement Directive and the NHS procurement choice and competition regulations, will:
    - enable the delivery vehicle to provide the broadest offer to meet the health, housing and social care needs of patients/service users
    - allow commissioners and providers, with the objective of creating a stable market place in which to innovate and to manage change, a time limited period to focus on redesigning the system within the current contracting arrangements and without the threat of competition
- pricing frameworks which would allow providers maximum flexibility to achieve the desired outcomes while ensuring that all costs are transparent, and gain share arrangements encourage continuous improvements in quality and cost
- arrangements which will cover the commissioner's double running costs where, for example, primary care services are delivered by a community provider to patients/service users who remain registered with a GP Practice.

Please send the completed form to the New Care Models Team (england.fiveyearview@nhs.net) by **9 February 2015**.