Southend Health & Wellbeing Board

Agenda Item No.

Joint Report of
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Melanie Craig, Chief Officer, Southend CCG

to
Health & Wellbeing Board
on
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For discussion	X		For information only	X		Approval required

Locality Approach
&
Complex Care Co-ordination Service

Part 1 (Public Agenda Item)

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1 Purpose of Report

The purpose of this report is to provide Health & Wellbeing Board (HWB) with a briefing and update regarding;

1.1 the formation of commissioning localities for health & social care in Southend on Sea; and

1.2 the commissioning and 'go live' of the Complex Care Co-ordination service;

2 Recommendations

HWB are asked to;

2.1 Note the updates to both the locality approach and the complex care co-ordination service and discuss the risks and challenges (section 5).

3 Background

3.1 The Locality approach and the complex care co-ordination service is the result of a system partnership led by Southend on Sea Borough Council (SBC) and Southend Clinical Commissioning Group (SCCG). The partnership was agreed over 3 years ago through gaining status as an Integrated Pioneer Programme. In April 2015 an integrated commissioning team was formed through joint

resources from both SBC and SCCG, the team has since led on delivering the direction provided by the HWB for integrated health and social care services in Southend.

Locality approach

3.2 The vision for the locality approach is that a locality is the central place where integrated health and social care interventions are delivered and co-ordinated. This is represented by a shift away from hospital centric care into community based delivery through all system partners working in a collaborative and integrated way.

3.3 A number of factors have driven the move towards integrated care provision across Southend. Published in October 2014 by NHS England, The NHS five Year forward view (5YFV) sets out a positive vision for the future based around integrated service provision and new models of care.

3.4 The new models of care outlined in the 5YFW suggest GP practices group into localities and expand to bring together nurses, community services, hospital specialists, community groups and the voluntary sector to provide integrated out-of-hospital care. Through moving the majority of outpatient consultations and ambulatory care to out-of-hospital settings, demand for primary care is expected to be reduced and patients will experience better outcomes. To support the 5YFV approach the Essex Success Regime (ESR) has highlighted the requirement for health and care economies to join up and address problems systematically, rather than in isolation.

3.5 The General Practice Forward View was published in 2016 and set out the vision for transforming general practice and the various schemes at a national and local level being developed to support this. Southend is under-doctored, heavily reliant on locum GPs, has a large number of small practices, significant clinical variation across practices and has 40% of GPs over the age of 55. Recruitment and retention is also proving challenging and as such Southend CCG has been considering how it might support developments in general practice to improve sustainability and resilience. The Southend locality approach includes working with general practices to support them in working differently to address these issues.

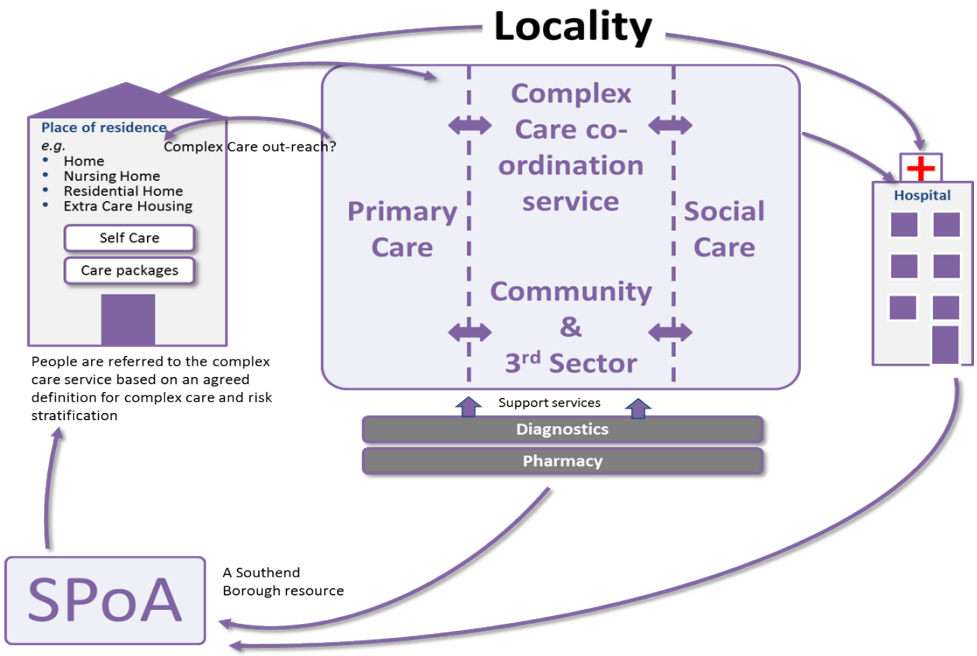
3.6 A specific piece of work is underway to work with GP practices to support them in their approach to locality working. A launch event will be held in February 2017 and a phased approach will be taken to supporting the development of locality working. Possible outcomes from this work could include practices working to share back office services, develop shared call taking, home visiting services, urgent appointments and where the practices wish, practice mergers.

3.7 To further help support the transition towards commissioning integrated care for adults, in May 2016 it was agreed jointly by local health and social care system partners that the number of localities within Southend would be four; (1) West; (2) West Central; (3) East Central; and (4) East.

Diagram 1 – agreed four localities for Southend.

3.8 Each locality will utilise existing (or new) NHS / Council estate to provide primary, community and social care services working in a multi-disciplinary team environment so that patients; (1) receive co-ordinated care and, those that need it, have an integrated care plan; (2) have a named professional for all health and care needs; (3) are empowered to engage with community assets; and (4) receive seamless care. The agreed model for locality working is outlined below in diagram 2.

Diagram 2 – agreed locality model.



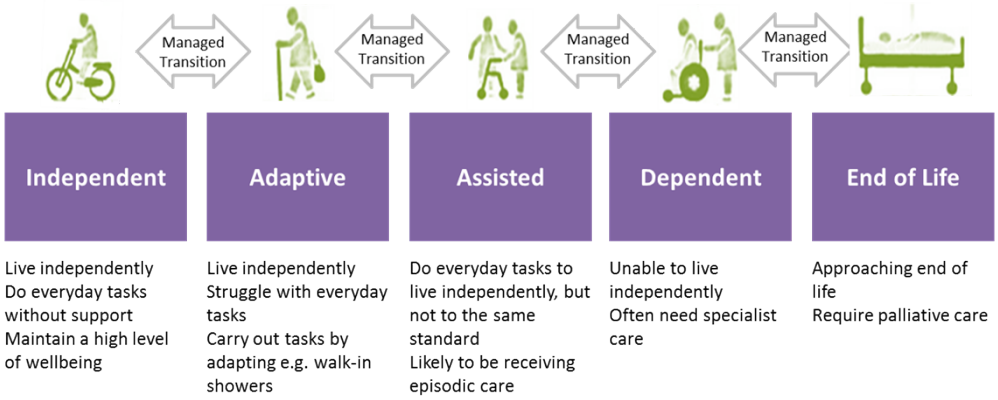
3.9 Through a programme of transformation adult social care is undergoing significant change. The adult social care re-design project will change the approach to adults, families, carers and the community. The re-design is a whole system transformational approach to change and includes community groups, health and social care. Using strength-based assessments and care planning, the focus is on individuals abilities and community assets, rather than an approach that overly focuses on deficits and services to meet need. The approach is empowering, and facilitates the adult in taking control of their own lives rather than being told what is best for them with social workers taking a preventative approach to their practice in community settings. This programme of transformation is aligned to the locality approach.

Complex Care Co-ordination service

3.10 Closely aligned to the locality approach is the transitional pathway (diagram 3) through which patients are assessed and supported. The aim of the locality approach and complex care service is to move patients as much as possible from ‘dependent’ to ‘independent’ and then keep patients as close as possible to the ‘independent’ end of the pathway. Patients are measured via a combination of a frailty index and integrated health and social care data – those

with multiple long term conditions, high volumes of admissions to hospital and presentations at A&E and high users of social care services. These are eligible for the complex care co-ordination service. The cohort is broadly defined as those over the age of 55 years old, and are considered to be between the 'assisted' and 'end of life' part of the transitional pathway.

Diagram 3 – the transitional pathway.



3.11 The complex care co-ordination service, commissioned by Southend CCG, provides a truly holistic and integrated health and social care approach to proactive and co-ordinated care, enabling patients to maintain their independence and wellbeing and the opportunity to re-connect with their community. This support ensures that patients have their care co-ordinated and delivered so as to avoid unnecessary demand on system resource, unnecessary presentations at A&E, unnecessary non-elective admissions and unnecessary demand on social care.

3.12 The vision of the complex care service is to provide complex care patients with a proactive service that co-ordinates their health and social care provision based upon existing services and need. The aim of the service is to ensure care needs are assessed, care plans are co-designed through an established MDT approach and care is delivered in a co-ordinated way.

3.13 Following a period of contractual and commercial negotiation, South Essex Partnership University NHS Trust (SEPT) were commissioned to provide the complex care co-ordination service. SEPT and SBC agreed to work in partnership to deliver the service with the main contract placed with SEPT.

3.14 The service model will work within GP practices and with wider existing system resource and will be staffed as follows;

3.14.1 A clinical lead (approx.0.5 days per week / per Locality) providing clinical guidance and oversight for the care co-ordinators;

3.14.2 A team leader providing managerial support and supervision to the co-ordination service;

3.14.3 Care co-ordinators and care navigators (1 each per Locality) will work as a flexible team in each locality. The co-ordinators and care navigators will work with primary care, community based health and care services and community assets to assess a patient's individual care needs, co-design a package of care and proactively co-ordinate the delivery of the care;

3.14.4 Admin support providing support to both the co-ordinators, navigators and GP practices across the localities to support the delivery of the co-ordination service.

3.14.5 Community pharmacist and prescribing support will work as part of the MDT and closely with the co-ordination service. The pharmacist function will review medications and support GPs to ensure patients receive medicines that will improve quality of life, reduce medicine waste and reduce emergency hospital admissions.

3.15 The complex care coordination system went live on 9th January 2017, a press release, at Appendix 1, was circulated to all partners.

4 Current status

Locality approach

4.1 Following the showcase of the East Central locality in the Success Regime Pre-Consultation business case, the natural next step was to pilot locality working within East Central and develop a multi-disciplinary integrated team approach, which would undergo a period of 'testing and learning'. This was supported by the ESR and East Central has been identified as a pilot area for the ESR programme.

4.2 With organisational and key stakeholder support a core group of individuals from a number of disciplines and spanning all system partners were identified and tasked with developing an integrated approach across the East Central locality. Priorities for East Central were agreed and a workplan was developed that focuses on the following areas;

4.3 Adult social services, through the transformational programme of social care redesign have aligned to the agreed localities. Social workers have been assigned to the larger GP practices in each locality with smaller practices having designated access to social care support.

4.3.1 **Moderate needs Multi-Disciplinary Team (MDT)**. An East Central locality MDT will be created to identify and work with people who have moderate health and care needs, i.e. those who sit between the 'adaptive' and 'dependant' element of the transitional pathway. Through the Electronic Frailty Index (EFI) – a risk stratification tool – we will identify appropriate patients who would benefit from an integrated MDT approach. We expect this cohort to be from the age of 35 upwards, possibly with long term conditions and vulnerable due to factors such as mental health issues, homelessness or substance misuse. The aim is to take a proactive approach, prevent people from deteriorating and their needs escalating. The first MDT will be held on 9th February 2017 and staff attending will drawn from the East Central core integrated team.

4.3.2 **Engaging General Practice (GPs)**. Locality working is designed to build relationships and trust amongst professionals in order to share the both the burden and joy of care and to ensure the best outcomes for the population. GP practices networking together and with key community and third sector staff within the locality is essential for successful integrated working. This will help to divert the public away from hospital and in the longer term from GPs and other services, where people's needs can be better met in other ways. Given their central role it is vital that GPs are engaged in this work. The integrated team is planning to provide support for GPs which will;

4.3.2.1 map various professionals GPs can draw upon in their locality;

4.3.2.2 evidence case studies to GPs to illustrate how different professionals (including domiciliary care and those doing out reach work with vulnerable groups in communities) can help with the care and treatment of different sorts of patients;

4.3.2.3 risk stratify patients such as frail elderly, to help focus attention on priorities;

4.3.2.4 explore and test different ways of working across professions with priority groups in one or two specific GP practices; and

4.3.2.5 bring all GP practices together to share and learn from best practice.

4.3.3 **Community**. Led by Social Care this area of work has three priorities that will focus on;

4.3.3.1 Communication and community engagement to build understanding of how localities are working and learn about how we might design them in a way that will facilitate local people's use of what's available;

4.3.3.2 Asset mapping and co-production which will identify tangible and intangible assets (personal, private sector, public and third sector) that communities can draw upon to develop community capacity; and

4.3.3.3 Behavioural change, by working with people in a different way and bringing community and private sector resources into play a shift in behaviour will be achieved.

4.3.4 Other enablers that are being progressed by the integrated locality team include;

4.3.4.1 IT and record sharing through access to each other's IT systems;

4.3.4.2 Shared assessment tools such as EFI;

4.3.4.3 Training and development of those involved in new ways of working; and

4.3.4.4 Evaluation to demonstrate impact / progress/learning

Complex Care Co-ordination service

4.4 Resource. All posts are fully recruited to with the exception of the clinical lead and pharmacist. Three care co-ordinators and 4 care navigators are in post and operational. The care co-ordinators have a background in health and social care whilst the care navigators all come from a social care background and remain employed by SBC through the partnership arrangements with SEPT. The remaining care co-ordinator will commence employment mid February 2017.

4.5 Recruitment to the pharmacist post has been challenging, the post has been recently re-advertised. The clinical lead posts are scheduled to be fully recruited to by the end of February 2017.

4.6 Risk stratification and patient identification. A significant majority of GP practices in Southend are System One users which has facilitated the use of the EFI risk stratification tool and enabled a consistent approach to patient identification across the localities. The complex care service are also building relationships with the discharge team (Southend Hospital), social care, domiciliary care providers, community health services, substance misuse providers, mental health services, the voluntary sector and housing to support and help identify patients who might be appropriate for the service. The complex care service continues to work with practices and system partners to identify patients and receive referrals.

4.7 GP engagement. All GPs in Southend have been engaged, through various media, re the opportunity to work closely with the complex care service. Engagement by GPs has been varied across localities and the complex care service continues to promote the service.

4.8 Case load, assessments and case studies. Please refer to Appendix 2 for a detailed update.

5 Risks and challenges

5.1 Closer integration and alignment with community mental health services. Community based mental health services presents a significant challenge in Southend. The demand for services is high and continues to increase. Many of the patients identified as being appropriate for the complex care service and many that will benefit from an integrated locality approach will have emerging or established (either diagnosed or undiagnosed) mental health issues. The

challenge to integrate community based mental health services into the locality approach remains a high priority for the integrated team. Work is underway to ensure closer operational integration but it is acknowledged across the system that more works needs to be done on the direction of travel.

5.2 Closer integration with hospital and acute services. The Essex Success Regime continues to reconfigure acute service at pace placing high demand on the locality approach to deliver community based integrated services and an infrastructure to support the reconfiguration of the acute services. Closer engagement between acute services and community integrated teams is required to ensure reconfiguration and transformation activities are aligned.

5.3 Transformation of community health services. Aligned to the implementation of the locality approach is the redesign of community health services. This is required so that they are configured to support and respond to the changing demand within each locality.

5.4 Engagement with GPs. The work required to engage with GPs and transform primary care services remains a significant risk to the locality approach and the complex care service. The challenges within primary care are varied in each locality and through a process of open communication, transformation and partnership, GP practices will in time be integrated with the wider health and social care system.

6 Health & Wellbeing Board Priorities / Added Value

The locality approach and complex care service contributes to delivering HWB Strategy ambitions in the following ways

6.1 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the approach will actively support individuals living independently.

6.2 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

6.3 Ambition 9 – Maximising opportunity; the approach is the drive to improve and integrate health and social services. Through initiatives within the approach we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

7 Reasons for Recommendations

7.1 As part of its governance role, HWB has oversight of the locality approach.

8 Financial / Resource Implications

8.1 None at this stage

9 Legal Implications

9.1 None at this stage

10 Equality & Diversity

10.1 The Locality approach should result in more efficient and effective provision for vulnerable people of all ages.

11 Appendices

Appendix 1 – press release re Complex Care Co-ordination service	Appended separately
Appendix 2 – detailed update re Complex Care	Appended separately

HWB Strategy Ambitions

Ambition 1. A positive start in life	**Ambition 2. Promoting healthy lifestyles**	**Ambition 3. Improving mental wellbeing**
A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population	**Ambition 5. Living independently**	**Ambition 6. Active and healthy ageing**
A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health	**Ambition 8. Housing**	**Ambition 9. Maximising opportunity**
A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment