SCC/15/41
Health and Wellbeing Scrutiny Committee
14 September 2015

REPORT ON PROGRESS OF INTEGRATED CARE FOR EXETER (ICE)

Report of the Head of Social Care Commissioning

Recommendation:

That the committee be asked to note the progress of the ICE Delivery Programme

1. Background

1.1 Integrated Care for Exeter (ICE) Board was established in 2014 as there are things we could do to make better use of public money spent locally rather than continuing to operate in traditional 'silos' created by organisational boundaries. ICE is a strategic alliance of public, voluntary and community sector organisations, working together to provide the infrastructure and architecture for designing and delivering new and better ways of working.

1.2 The ICE vision aims to shift the focus from ***"patients"*** to ***"people"***, and from ***"What is the matter with you?"*** to ***"What matters to you?"*** We have an ambitious vision with a focus on population health, wellbeing, preventative care and support shifting the emphasis from crisis intervention to helping people help themselves to stay well at home.

1.3 We are clear about the challenges facing us and know that our health and care system needs to transform to meet these challenges. This means building a system of care and support, which in future:

– **Empowers** people to take much more control over their own care and treatment. The services we provide need to change to be more engaged with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.
– **Breaks down the barriers** in how care is provided between primary care and hospitals, between physical and mental health, between health and social care, between prevention and treatment, between statutory, independent and voluntary organisations.
– **That no longer sees services fragmented**, people having to visit multiple professionals for multiple appointments, endlessly repeating their details.

1.4 Framed by Health & Wellbeing Boards and New Devon Clinical Commissioning Group vision and strategy, (developed through extensive engagement with local communities), our aim is to create a sustainable system of care which, from the perspective of the individual (patient, relative or carers) that:

- enables people to improve and promote their own health and well-being
- is flexible, local and personalised, delivering a better experience of care
- achieves better health and social care outcomes
- provides care more cost effectively

2. Delivery Plan

2.1 On 12th June 2015 the ICE Board agreed a 3 year delivery programme. This is an exciting stage in the development of ICE as we are now moving from concept to delivery.

2.2 In 2015/16 Priorities

2.2.1 **Deliver real operational change in service delivery:**

- Improve the co-ordination and delivery of existing community services with an emphasis on admission avoidance, better discharge planning and more care and support at home.
- Establish an Integrated health and Well-Being Hub to improve the health of homeless people.

2.2.2 **Design and test new models of preventative care**

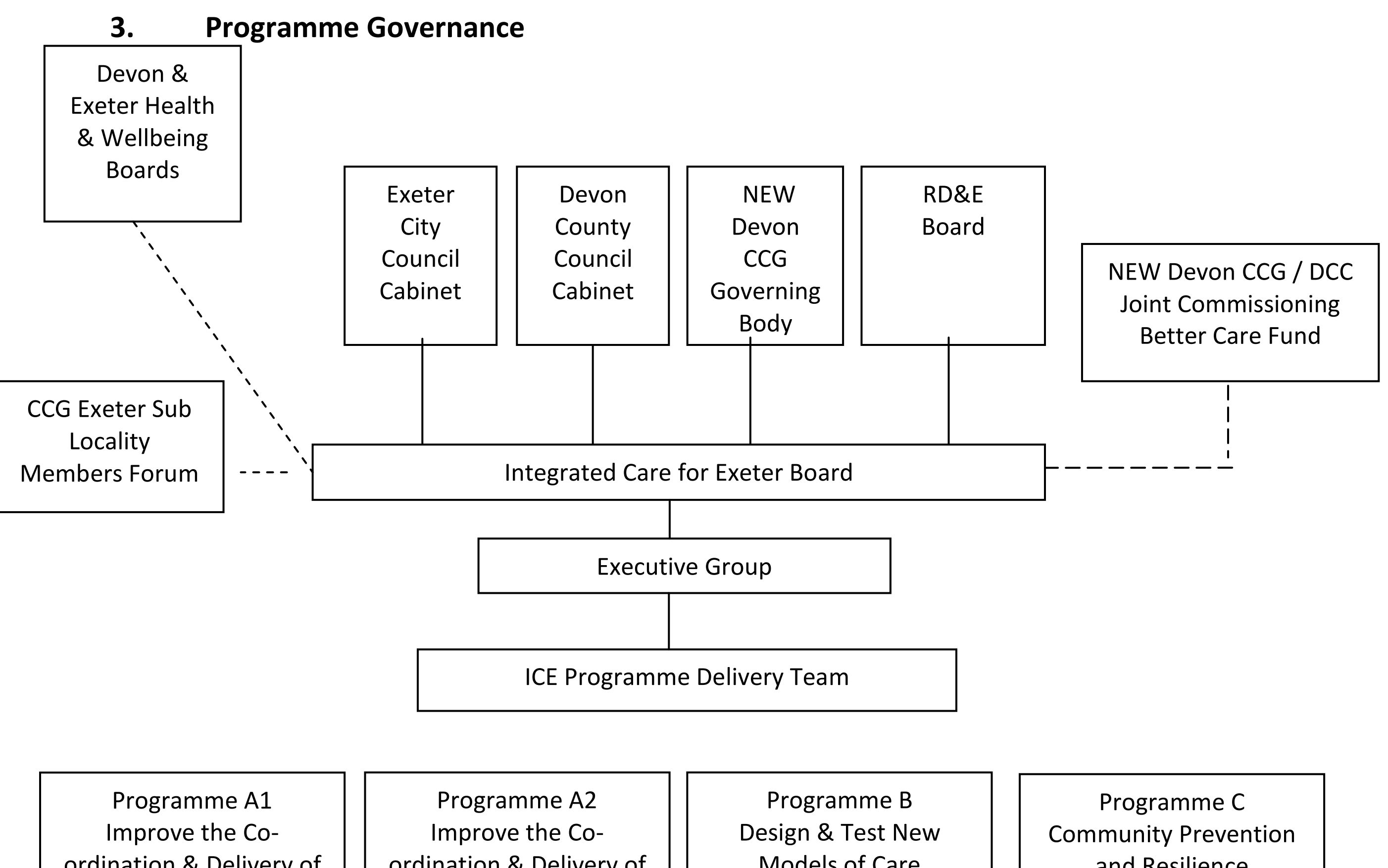
- Establish a risk stratification model for identifying people who could benefit from early intervention which will mitigate, delay or reduce the need for longer term care and support.
- Prepare the groundwork for testing out community prevention approaches that can shape the design of the blueprint for the new operating model for population health and wellbeing.

2.2.3 **Get a greater understanding of what we need to do to support community resilience**

- Identify ways to help more people take a greater responsibility for individual and community health and wellbeing.
- Agree a City-Wide plan for attracting Social Investment to support health and wellbeing

2.2.4 An overview of the plan and the current projects is in Appendix 1. An overview of the key delivery milestones is in Appendix 2 and the Evaluation Framework is set out in Appendix 4.

3. Programme Governance



Considerations

There are no financial, sustainability, carbon impacts equality, legal, risk management or public health impact issues arising from this report.

Summary

The committee is invited to note the contents of this report.

Tim Golby

Head of Social Care Commissioning

Electoral Divisions: ALL

Local Government Act 1972: List of Background Papers

None

Who to contact for enquiries:

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Appendix 1: ICE Delivery Plan on a Page

ICE Delivery Plan

STRATEGIC OBJECTVIES

Design & test a new model of population health & wellbeing

- Enable people to improve & promote their own health & wellbeing
- Deliver a better experience of care
- Achieve improved health & social care outcomes
- Provide care more cost effectively
- Creation of capitated budget and payment systems

DELIVERY PROGRAMMES / CHANGE PROJECTS

Improve co-ordination & delivery of existing services

- Streamline hospital discharge process & introduce discharge to assess
- Create single rapid response, crisis support & reablement pathway for adults with complex needs to create a blueprint for roll out (TCS)
  Includes integration of OPMH and standardisation and roll out of acute care at home services.

Health & Wellbeing Team for Homeless

- Establish health & wellbeing team for homeless people bringing together existing resources into a single integrated team to deliver an improved service to this vulnerable group.
- Create and test out a single capitated budgets to support integrated service delivery.

Design & Test new models of care

- Design & test a population risk stratification model
- Test out enhanced care co-ordination for the frail group to reduce the use of unplanned care
- Test out social prescribing for the pre-frail group

TCA funding for prevention

- Targeted Home Safety & well-being checks
- Living Well Co-ordinators & Neighbourhood Friends
- PROMOTE CARE Home Pilot
- Developing Community Resilience

Appendix 2: 180 Day Key Milestones

Section 1: 180 Day Action Plan Key Milestone Overview July 2015									
Project	**June 2015**	**July - Aug 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Dec 2015**	**Jan 2016**	**Feb 2016**	**Mar 2016**
A! Streamline hospital discharge process & new discharge model Joining up existing services to form a single RRCS&R pathway	Set up Design Team Review work to date	Agree model Co-design LEAN IRRCS&R (& discharge) pathway	Recruit staff Agree operational protocols Brief affected staff Deliver staff training	Dry test model process & revise	New process goes live Daily dashboard & review	Weekly dashboard & 30 day review	Weekly dashboard & 60 day review	90 day review Agree Exeter roll out plan Commissioner informed of requirements Set new policy and procedure for new BAU pathway	Discharge to assess formalised in contracts New pathway and roll out model reflected in contracts
A2: Establishing Integrated H&W Team for Homeless	Set up Design Team Review work to date Set Baseline for improvement	Agree model Identity resources and structure virtual budget			New process goes live Monthly dashboard & review	Monthly dashboard & 30 day review	Monthly dashboard & 60 day review	90 day Review Commissioner informed of requirements	New pathway and roll out model reflected in contracts
B: Create risk stratification model	AHSN CCG & EPC agree approach to model St Thomas and Foxhayes data shared with AHSN	Workshop to review proposed model & implications	Agree model and teat it out in West and model pathway costing	Test model	Review Event Application of model with other Exeter practices			Review Event	Confirm model and agree roll out plan
B: Pilot Enhanced care co-ordination for high end users				Co-design of intensive case co-ordination	Pilot with PoC Team	Monthly dashboard & 30 day review	90 day Review Agree Exeter Roll out plan	Model agreed for further roll out and testing in 2016	
C: Test out social prescribing to connect pre-frail with low level prevention services	Referral process and monitoring agreed with pilot practices	Referrals commence	30 day review	Conference	60 day review	Mandate to deliver city wide strategy for SIB	90 day review	120 day review Commissioner informed of requirements	

Appendix 3: ICE Evaluation Framework

ICE Evaluation Framework

Different

Is it *different?*

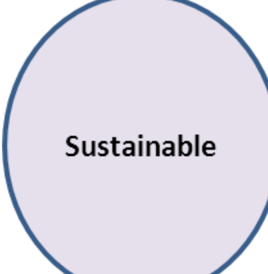
- ✓ More people tell us their needs were understood
- ✓ 80% of the older cohort will have integrated personal care, support and escalation plans
- ✓ 30 people will have integrated personal commissioning plans
- ✓ Half as many people in the acute hospital experiencing a delayed transfer of care
- ✓ Reduced average length of stay by 1 day for unplanned emergency admissions for over 65's

Is it *better?* – lives are significantly better

- ✓ 5 a day fewer unplanned hospital admissions
- ✓ More people tell us the help and care they received has made their lives better
- ✓ More people telling us they feel in control of their care
- ✓ Timely contact with a smaller number of people "in my living room"
- ✓ More people and professionals wanting to join the programme
- ✓ Police report 50% fewer welfare calls about older people

Is it significantly *better value/lower system cost?*

- ✓ Agreed methodology for identifying whole system budgets
- ✓ Agreed methodology for risk and need stratifying and targeting the population
- ✓ Reduced whole system per capita cost for the target group(s)
- ✓ Cost benefit plan identified for roll out of integrated personal commissioning



Is it *sustainable?*

- ✓ Staff report higher levels of job satisfaction and satisfaction with the quality of care delivered
- ✓ 10% increase in customer value added activities
- ✓ Learning from test beds informing next steps and roll out opportunity
- ✓ Expertise, models & implementation methods tested and available to support roll out
- ✓ Improved recruitment and retention with evidence of new career opportunities for local people
- ✓ New care roles created spanning the whole care continuum
- ✓ Workforce plan developed providing wider career opportunities for local communities.