Integrated Care for Exeter Review Draft June 2017

Document Purpose

This document is a position statement from the Integrated Care for Exeter Executive setting out a summary of progress as at May 2017. It has been produced for Board members to share within their organisations and with other interested parties.

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Contents **Page**

1.0 Background

Integrated Care for Exeter (ICE) Board was established in 2014 in recognition that, to meet the needs of our changing and older population, we have to find another way of delivering public services. Demand on service is already increasing as living longer often means people are living with several complex conditions that need constant care and attention. We already have a higher proportion of older people than other parts of the UK (it will be 2027 before the proportion of older age groups in England resembles the current picture in Devon). There is a growing body of international evidence that shows that, by working better together to jointly plan and deliver services in a genuine partnership with communities, there is much the public sector can do to improve the delivery of services, achieve the outcomes people want and provide better value for money.

In September 2014 Devon County Council was successful in achieving a Transformation Challenge Award (TCA) from the Department for Communities and Local Government to support the transformation work of the partnership and a Development Director took up post in January 2015. The TCA funding is non-recurring money to support the programme, test out new roles in the voluntary and community sector; undertake test beds for new models of prevention and to track outcomes to inform whole system transformation.

The ICE Vision document published in January 2015 set out the vision of an integrated system and a programme of change that will meet the challenges facing the health and social care system. Whilst ICE initially will focus on the population within Exeter it is intended to be a test bed for the rest of Eastern Devon.

2.0 Vision and Programme

The ICE vision is that, in the future, local services will be arranged on an individual basis; they will provide preventive care and support, and will be designed and delivered in partnership with communities where people live. A new model of population health and wellbeing will be developed, with a greater focus on early intervention and prevention; more care and support out of hospital and services designed around the needs of individuals and their family.

In future services will be connected, deliver quality outcomes and use resources efficiently and effectively so that:

- Services are easy to explain; access and navigate through and will be provided on the basis of individual need.
- Health and well-being is actively promoted, and health inequalities reduced through concerted community action focussed on early intervention and prevention.
- Only people who clinically need to be are admitted or treated in a hospital and they will only be there as long as is clinically necessary.
- People experience quality services wrapped around their needs
- Public and voluntary sector resources are more effectively used by combining budgets, skills, staff and data.

We will deliver a care system for adults that:

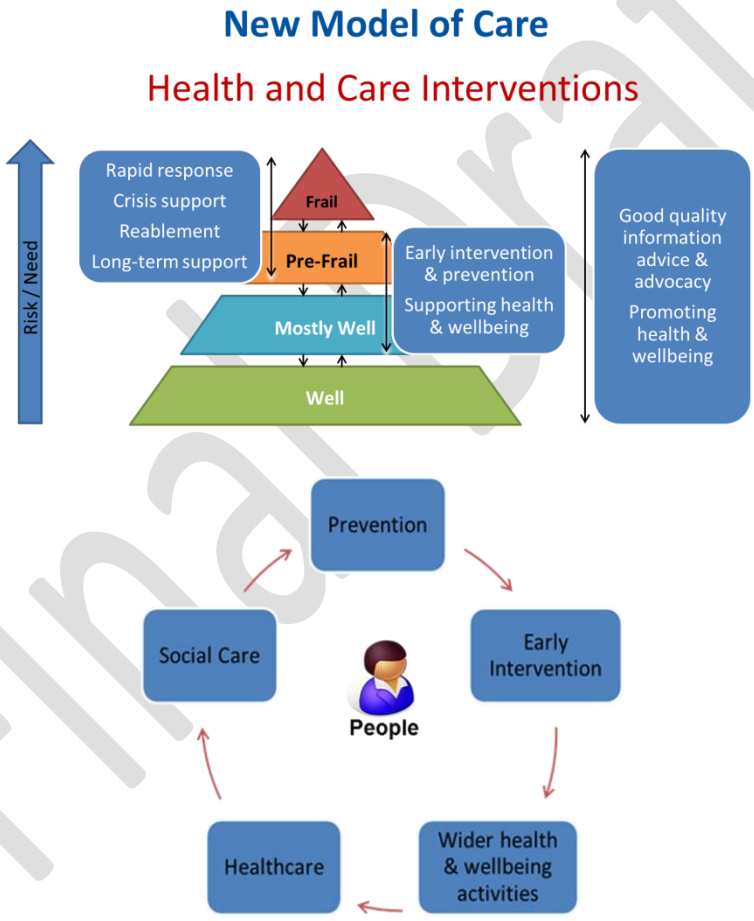
- Enables people to improve and promote their own health and well-being
- Delivers a better experience of care
- Achieves improved health and social care outcomes
- Provides care more cost effectively

System Priorities

1. Helping people to stay healthy independent and socially connected and to live well with long term conditions however complex and however many they have.
2. Providing timely safe support as close as possible to home at times of crisis whilst also providing the very best hospital care where needed and to enable people to return to their home as safely and swiftly as possible.
3. Ensure people have choice and control over their care and support at all times including towards the end of their life.

New Model of Care: Population Health and Well-being

During February 2015, through the work of the ICE partners at a Care Design Workshop facilitated by Royal Devon & Exeter NHS Foundation Trust, a new model of place based care focused on population health and well-being has been agreed.



Between February and April 2015 over 40 people from across the alliance worked together to co-produce the work programme for delivering during 2015/17.

Purpose of the Delivery Programme

On 12th June 2015 the ICE Board agreed a 3 year delivery programme to test out a range of new ways of working to achieve improved population health and well-being in specific areas of Exeter, starting with the West, with a view to rolling out successful projects across the City and the rural and coastal parts of Devon where it is right to do so.

Programme Priorities and Timeline

2015/6	2016/7	2017/8
Deliver real operational change in service delivery.	Test out the new model of population health and wellbeing rolling out the new pathway for adults with complex needs across the City alongside the scale up and roll out of community prevention approaches.	Consolidate the learning from the Exeter roll out and expand where appropriate across Eastern Devon ensuring sustainability is achieved through mainstream commissioning.
Prepare the groundwork for testing out community prevention approaches.	Share the learning with commissioners to inform strategic activity to mainstream effective elements of the programme.	
Get a greater understanding of what we need to do to support community resilience.	Support and encourage community resilience activities.	

Programme Requirements and Design Principles

The key system requirements are:

1. Those working in the care system – from primary to community to hospital to social care, and whether working as public employees, independent practitioners, or private and not-for-profit contractors have to recognise that there is "one system, one budget".
2. We have to get the best possible outcomes for the individual within the resources available across the system rather than the interests (financial or otherwise) of individual organisations and practitioners.
3. The goal is to deliver the right care, in the right place, at the right time, by the right person. The service offer should be standardised so that the population has equitable access to care.

Our values will keep people at the centre of our work by delivering on the outcomes set out as "I" statements. These statements have developed over the course of our engagement with people in contact with services, the public and people who work in the local health and care system.

- I will take responsibility to stay well and independent as long as possible in my community.
- I can plan my own care with people who work together to understand me and my family.
- The team supporting me allow me control and bring services together for outcomes that are important to me.
- I can get help at an early stage - to avoid a crisis at a later time
- I tell my story once, and I always know who is coordinating my care
- I have the information and the help I need to make decisions about my care and support
- I know what resources are available for my care and support and I can determine how they are used
- I will receive high quality services that meet my individual needs and are appropriate to my level of support or vulnerability, that they fit around my circumstance to keep me safe.
- I experience joined up and seamless care across organisational and team boundaries
- I can expect my services to be based on the best available evidence to achieve the best outcomes for me.

Design principles that apply to all ICE service development activity are:

- Single entry point: people service
- Rapid response for all referrals
- One team with one culture
- Single care and support plan
- Care co-ordination and navigation
- Focus on prevention and self-care
- Family, carer, community
- Single assessment process, care, support and contingency plan
- Single care record
- Virtual pooled budgets: permission to act
- Improved outcomes

3.0 What we have done: high level summary of the delivery plan

A programme plan and governance framework was established in June 2015 these have developed overtime into 3 programme areas:

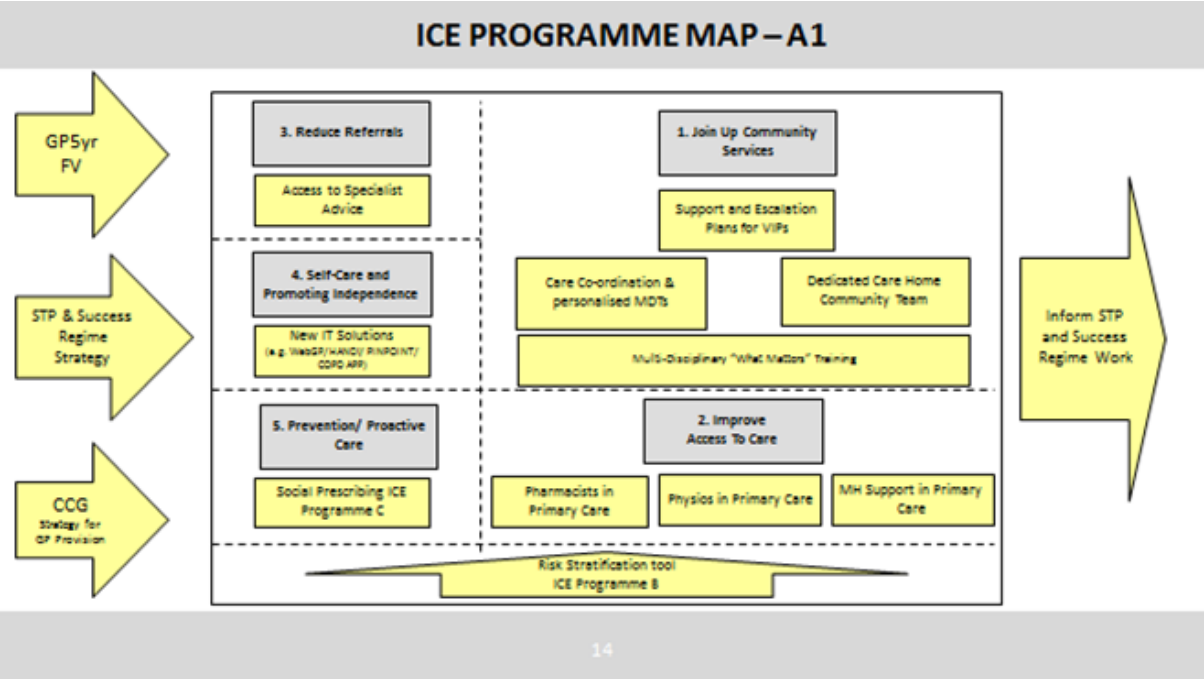
Programme A1 New Models of care: Joining Up Primary, Community and Acute Care: Could we make better use of resources and improve outcomes and experience for people with high level needs?
Programme A2 New Models of care: ***Street Homeless & Vulnerably Housed:*** Could we make better use of resources and improve outcomes and experience for people with high level needs?
Programme B Understanding need & risk stratification: Is there a way to systematically identify communities and individuals who could most benefit from early intervention and prevention?
Programme C Community Resilience and Social Prescribing & Prevention: How do we build more resilient and connected communities and how to we better connect people better connect people so they can do more to help themselves and each other and reduce demand statutory services?

Here is a high level overview of each programme.

Programme A1 New Models of care: Joining Up Primary, Community and Acute Care: Could we make better use of resources and improve outcomes and experience for people with high level needs?		
2015/6 Preparing the groundwork	**2016/7 Building the foundations**	**2017/8 Create the load-bearing framework & make it watertight**
Rapid Review of hospital discharge and interface with community team. Designed and implemented a proof of concept for Discharge2Assess (D2A) TCA funds additional capacity for the Proof of Concept delivery team and for additional home care support to enable the test of change	D2A becomes a business as usual within the RD&E and the learning influences the new model of care published by the CCG for the future transformation of out of hospital care including a single point of professional contact underpinned by "what matters to you" approach. Seven Exeter GP practices volunteer to work together to look at new models of care. **TCA funds GP capacity** for design workshops. Publish primary care strategy and small	Successful application to join National Primary Care Home Collaborative. **RD&E funds Clinical Pharmacist** for 6 months for ToC with Ide Lane (Dr Hilton) and Topsham (Dr Wood). . Dr Govier & other GPs networking through Kings Fund and National Vanguards to learn from others. Mount Pleasant (Dr Hynam) and Foxhayes (Ms Champion) work with RD&E Complex Care Teams to improve joint working on high need patients. Wonford Green (Dr Hoerning) provides

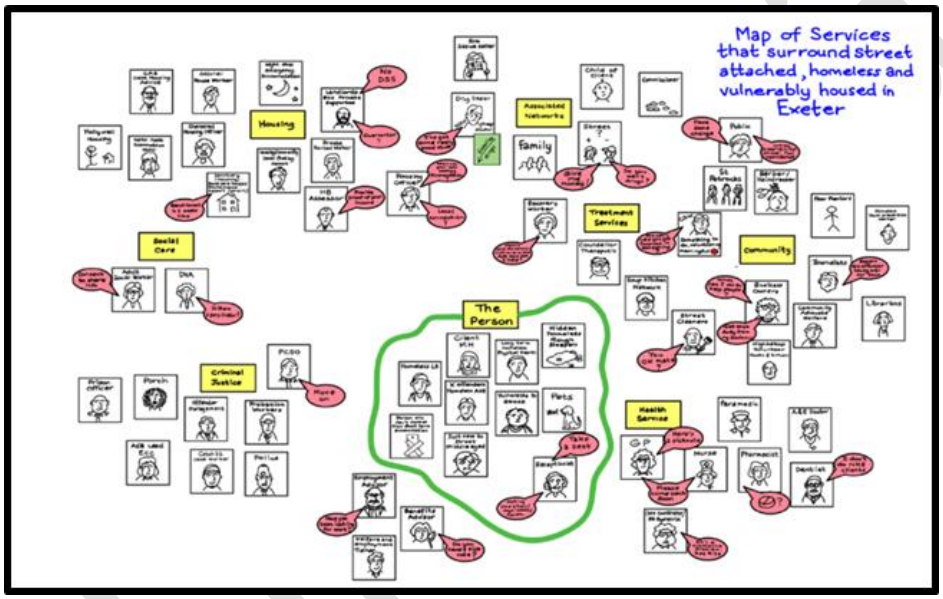
	scale tests of change programme	clinical leadership and mentoring support to Wellbeing Exeter **TCA Funds GP capacity and practices using** "at scale funding". SWAHSN providing evaluation on ToC.

This diagram sets out the current work programme being co-ordinated under this programme.

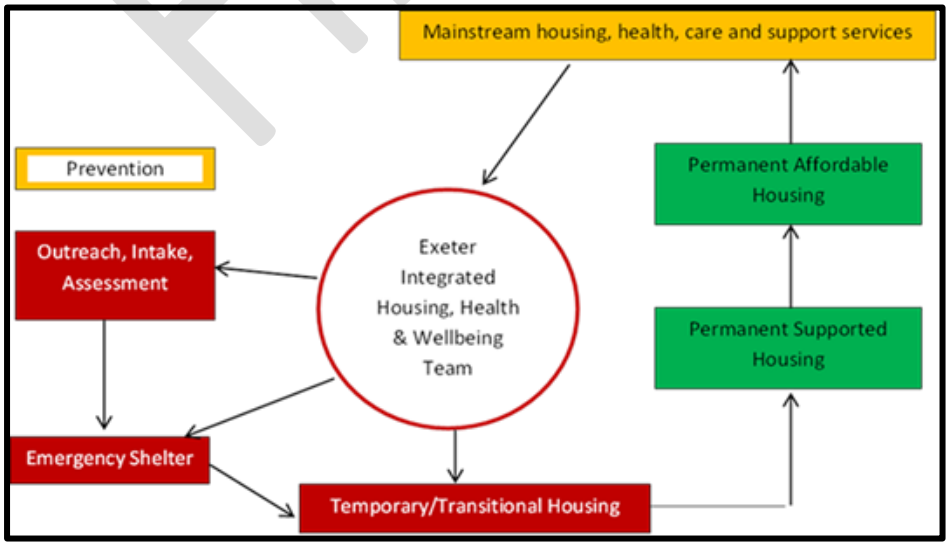


A2 New Models of care: Street Homeless & Vulnerably Housed: Could we make better use of resources and improve outcomes and experience for people with high level needs?		
2015/6 Preparing the groundwork	**2016/7 Building the foundations**	**2017/8 Create the load-bearing framework & make it watertight**
Undertook a whole system review and identified complex system issues including: Fragmented commissioning and provision with contracts designed around individual services. Lack of coherent system and pathways resulting in duplication and gaps: creates competition, reduces collaboration. Differing approaches and thresholds leading to tension between harm reduction & abstinences approaches: lack of engagement with people who are not 'in recovery'. Some services don't like to a.sk	Completed Health Needs Assessment with @ 125 individuals: We know that the health of people who live on the streets is significantly impaired: Life Expectancy: 30 years less than national average: 50% have complex mental and physical health needs: 58% will have substance misuse issues: 45% have significant issues with offending: Street homeless people 9 times more likely to commit suicide Deaths from RTA and falls 3 times as likely and from infections twice. Ethnographic	Delivery plan agreed for analysis of future commissioning options and for tests of change to prove the delivery model concept. TCA Funds Commissioning and Delivery leads appointed April 2017 and a new Stewardship Group established and final recommendations to be published in October 2017

question that are outside their "remit" so opportunities for meeting need get lost. Support/prevention services for vulnerably housed can conflict with housing policy. BUT plenty of good to build on. We reached consensus on the principle of total transformation and the need for political buy-in. We supported for ECVS development of Co-Lab (Integrated Hub) in Exeter TCA funds Bay6 project to support homeless people being discharged from hospital.	research was undertaken with clients and stakeholders Voice of the Customer multi agency design workshops result in the agreement of single vision and delivery model. TCA funds Bay6. ECC wins Homeless Prevention Grant on the basis of this underlying work.	



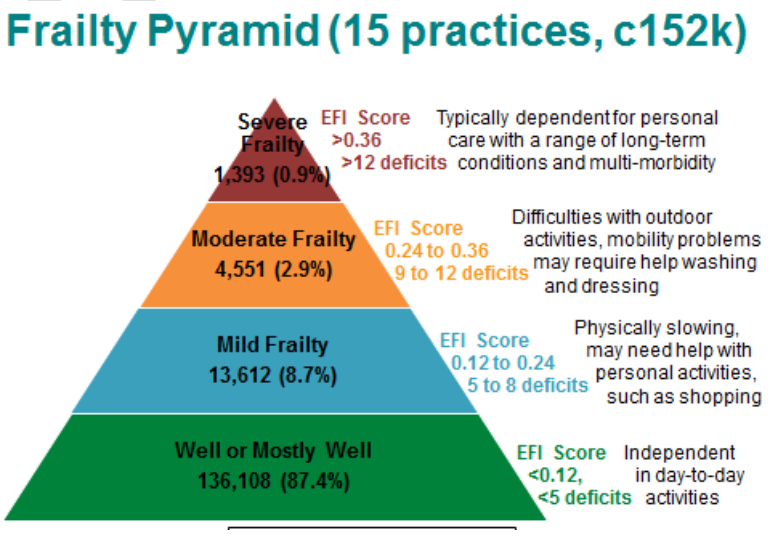
System map illustrating the complexity and fragmentation of the current offer for people in Exeter



System map illustrating the comparative simplicity of the new delivery model to be tested for people in Exeter

B Understanding need & risk stratification: Is there a way to systematically identify communities and individuals who could most benefit from early intervention and prevention?		
2015/6 Preparing the groundwork	**2016/7 Building the foundations**	**2017/8 Create the load-bearing framework & make it watertight**
Delivery team established with GPs, Public Health, data analysts supported by SWAHSN. Key principles agreed and existing risk stratification tools evaluated. Agreed frailty models were likely to be most effective as predictive approaches. Networked with experts including York University. Agreed to test the Electronic Frailty Index based on the validated Rockwood Frailty score as a starting point. Foxhayes practice agreed to test of change: Information Sharing Agreement (ISA) was written and signed. 10 years data extracted and analysed: results demonstrated that the tool could be predictive as it showed frailty changing over time. All Exeter practices were invited to share data to further test out the approach: 6 practices agreed.	Data validation, extraction process and ISA stress tested as more practices come on board. Data dashboards designed for practices. JSNA heat maps are generated. Agreed to include hospital and social care activity and costing data to the tool to see if there are links with high frailty and spend. Complex information sharing issues now dominate this part of the project and development grinds to a halt. Focus shifts to other data sets that could be linked and agreement reached to purchase licence for geo-segmentation data. Evaluation panel set up and consensus to purchase Mosaic licence for 12 months TCA Grants funds Mosaic Licence	16 practices now sharing date: population @ 150,000. ICE A1 GPs start to look at how the data can be used to help target test of change. Reports published with early findings. Particular interest in clear link with housing type and tenure with future potential frailty and the relatively young age at which frailty start to impact. Also shows that octogenarians are not necessarily frail. Geo segmentation data added to the dashboards and heat maps. Wellbeing Exeter Community Builders start to overlay lived experience to contextualise the data. ISA issues finally resolved and activity and costing data will be added in June 2017. Plans underway for automated data extraction process and rolling out across the STP area during 2017.

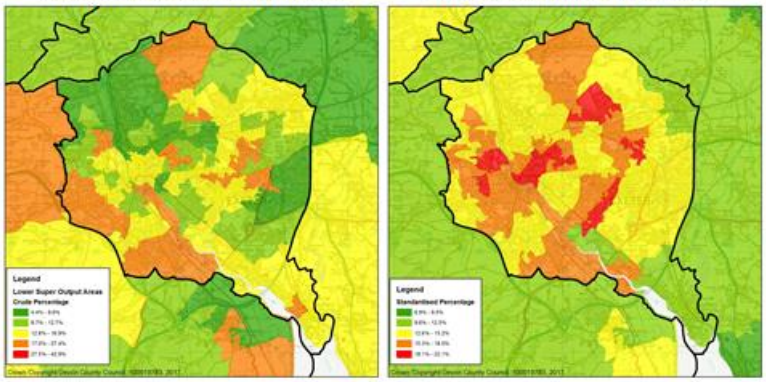
Here are some examples of the dashboards being created from the combined data set.



EFI Maps

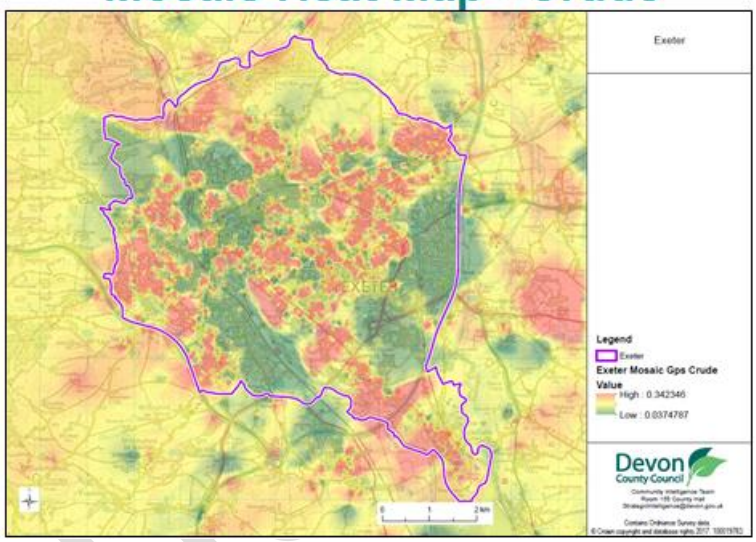
Crude Percentage
Highlights the overall percentage of population in any frailty category. Influenced by age, the location of care homes and deprivation.

Standardised Percentage
This rate is adjusted by age to reveal areas where the onset of frailty is earlier. Influenced by deprivation and proximity to services.



Public Health Devon | Devon County Council

Mosaic Heat Map - Crude



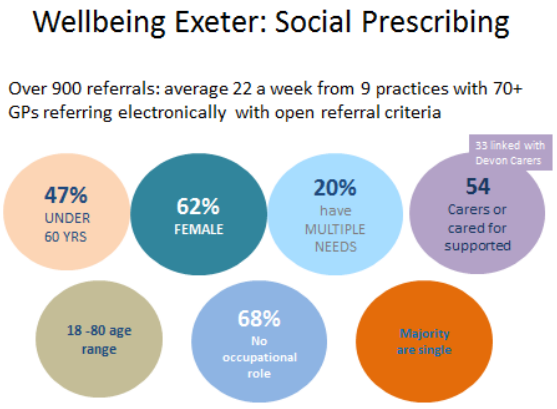
C Diverting demand: Community Resilience and Social Prescribing & Prevention: How do we build more resilient and connected communities and how to we better connect people better connect people so they can do more to help themselves and each other and reduce demand statutory services?		
2015/6 Preparing the groundwork	**2016/7 Building the foundations**	**2017/8 Create the load-bearing framework & make it watertight**
TCA grant funds existing services provided by Age UK (Exeter) and Westbank whose grants from external funders for pilots (Living Well and Neighbourhood Friends) has run out. Agreement is for these services to develop as a community resilience model emerges. Social prescribing	Interim Evaluation indicates potential for approach to reduce system costs as well as improve lives. ICE Executive agrees to proposal to expand social prescribing pilot but also to invest in ABCD. Devon Community Foundation (DCF) appointed as System Leader and Commissioner to expand	Exeter City Council adopts an ABCD policy and facilitated the delegation of £600,000 CIL funding to support ABCD in the City for 3 years from September 2017. Evaluation framework agreed with support from SWAHSN and Plymouth University. Electronic referral process and common operating

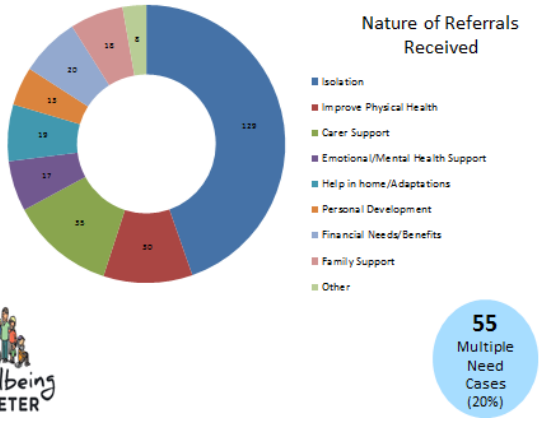
pilot is agreed with Dr John Fox from St Thomas Practice. TCA funds Dr Fox to lead the project. SWAHSN appoint Plymouth University as evaluation partner. TCA funds evaluation. 2 other practices join the pilot testing our different models. 511 referrals come into the pilot over 15 months. Simultaneously discussion take place with local community groups/leaders to consider what community resilience means. Exeter City Council invites Cormac Russell to facilitate a conversation about ABCD . Partners are inspired to consider how this could be taken forward in the City. TCA funds further support from Cormac Russell.	the pilot and develop the collaborative with delivery partners. TCA funding granted to DCF. Wellbeing Exeter is born to test out a pioneering approach to social prescribing, in combination with ABCD to provide firm foundations to enable individuals and communities to improve and promote their own health and wellbeing. DCF appoints delivery partners and negotiates terms. Delivery network commences for both social prescribing and community building A1 GP practices plus original pilot practices sign up as partners to the delivery collaboration. DCC Peer Review highlights approach as best practice.	model agreed with delivery partners and GPs. Mid-term review and qualitative evaluation very positive. External investors show interest. Information governance issues resolved May 2017 allowing for quantitative analysis on service usage using pathway costing methodologies (linked to B) to be prepared for June 2017 Recommendations being discussed in May/June 2017 on: extending pilot until March 2018 and bridge funding for further 2 years.

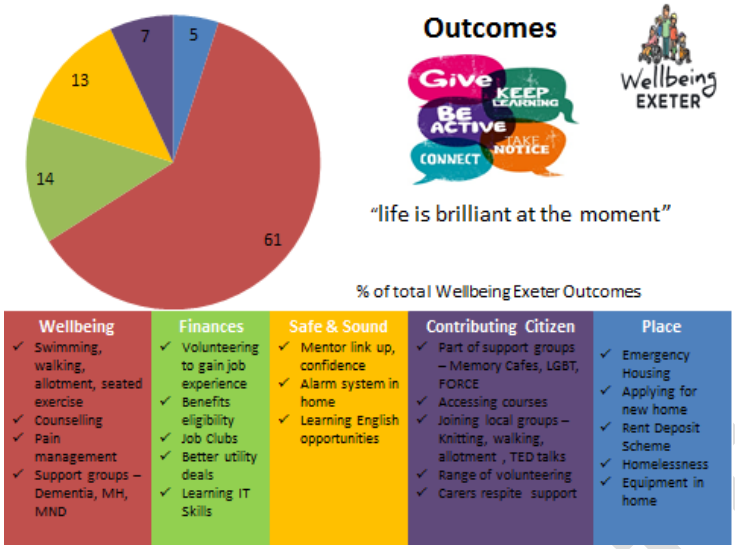
An extract from the draft Wellbeing Exeter qualitative evaluation report

"The qualitative evaluation data suggests that Wellbeing Exeter is successfully delivering the type of support that is highly needed, yet unavailable for patients within primary care. Through signposting and one-on-work, Wellbeing Exeter is helping people to improve their mental wellbeing, reduce loneliness, re-engage with their community and manage their own health".

- Community Connectors' signpost clients to a range of services within the community tailored to their individual needs.
- Community Connectors' approach to supporting clients and the continuity of care they offer helps clients to feel ready and make the first steps towards positive change.
- Clients' narratives exhibits improvements to their mental wellbeing being, social engagement and displays a growing sense of empowerment to begin to self-manage their own health and wellbeing.







4.0 Key Learning

It is important to recognise that, since the commencement of the ICE Delivery Plan in June 2015, there has been significant turbulence in the wider system such as the NHS Success Regime (SR), Devolution (Devo) agenda in local government and more recently the Devon Sustainability and Transformation Plan (STP). Within this context the programme is still in place and key people are "all still in the room" which demonstrates that individuals have been agile and adaptive to external factors and have used the experience of ICE to influence the SR, STP & Devo discussions. We also recognise that nature of organisations and individuals involvement has changed over time which had led to some conflicts as well as benefits. The approach taken to "light" programme management and an embedded matrix delivery model has worked well and has sustained projects during "dark days". The open approach to governance has enabled us to experiment, fail quickly yet safely and deliver on many of the intended outcomes. Access to development funds through the TCA grant has been essential.

The two years of the ICE delivery programme and our focus on evaluation have highlighted some significant learning points for future collaborative working. Many of these points are set out in the formal Strategic Added Value Review conducted by SERIO (Plymouth University) and published in April 2017: the Executive Summary can be found in Appendix 1.

In Summary the key learning points to take forward into future work are:

In Year one:

- **Pace:** *everything* has taken much longer than we expected
- **Complexity and fragmentation:** we have had to involve a ***lot*** of people to get anything done
- **Time & money:** capacity of very busy people to lead the change process and different attitudes to risk have hampered progress
- **Project fatigue:** has made it difficult to engage some "seen it all before.."
- **Perspective:** no single version of the truth so hard to keep focussed on "what" problem we are trying to resolve
- **Unaligned behaviours** resulting in decisions made at strategic level not reflected through the system

In Year two:

There is a clearer understanding at a senior, strategic level of the importance of rejecting heroic leadership in favour of more ***collaborative, system leadership***. It takes time to build relationships and really get to grips with others perspectives and we can only go at the speed of trust. Collaborative approaches require leaders to shift mind-set beyond their own organisational boundaries and deliver without being in direct control of resources. Succeeding in these environments requires a far more sophisticated repertoire of leadership behaviours and a more versatile style than ever before.

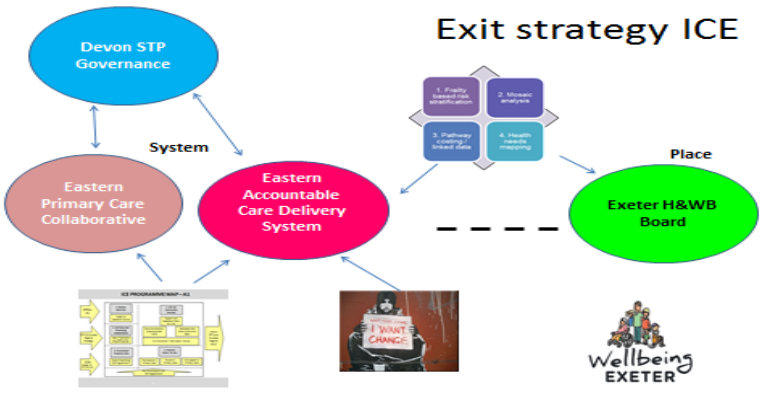
However we found this hard to disperse into our organisations and at times this limited the initial impact of service delivery projects e.g. D2A & Integrated Team for Homeless. This emphasises the need for organisations to become more fluid and supportive rather than silo-ed and controlling, yet we have seen that in the "dark days" there is a strong pull into the familiar command and control. However we have planted some quality seedlings through the project work within the delivery programmes; with the eventual resolution of the information governance issues underpinning the data sharing across the system as one good example.

The role of ***place*** in public services needs to be much more recognised: people have a strong loyalty to the neighbourhoods and towns/cities in which they live and work. The ICE Risk Stratification Tool is a potential game changer in how the "system" views needs in the context of population health & wellbeing. Wellbeing Exeter has shown us that place based approaches have real potential bringing ***new insights*** – there is another way of delivering public services. Recognition that there are ***new suppliers/resources*** – people themselves, neighbours, the community, 3rd sector.

The concept of from **"what's the matter with you to what matters to you"** as a vision is gaining momentum and this is most evident in our Wellbeing Exeter Pilot with GPs responding to the underlying needs of medical presentation through social prescribing and the delivery partners working alongside people through coaching and mentoring. This philosophy has also underpinned the design of the new operating model for street homeless provision which will be tested out during 2017.

5.0 Next Steps

The ICE project is due to come to a close in December 2017 and exit strategies are currently in the process of being deployed. It is anticipated that components of each of the 4 programme areas will be embedded into businesses usual. The starting point for planning is set out in the diagram below and firm decisions are expected to have been made by the end of July 2017.



6.0 Appendix One Executive Summary: Integrated Care Exeter: A Strategic Added Value Review March 2017: SERIO: Research and Innovation, Plymouth University

Commissioned by: South West Academic Health Science Network on behalf of Integrated Care Exeter Executive Team

Despite early challenges, the research identified a high level of consensus on the value and impact of the ICE programme, not just on the packages of work but on the wider working of services and on the individuals themselves. Interviewees highlighted the following impacts:

- A shift in thinking amongst those at the highest levels in each organisation with movement towards a new person-centred model of care, where the focus is on the individual
- Increased understanding and acceptance that a collaborative systems approach was necessary going forward, as the issues being faced were beyond the scope of any individual organisation
- Advanced levels of trust across partner organisations, paving the way for more productive collaborative working
- A broadening of stakeholders' scope and understanding of the wider system resulting from the space and capacity to come together
- Heightened levels of organisational empathy driven by increased understanding of the challenges faced by co-collaborators
- Increased confidence in having robust, challenging conversations in terms of delivery methods and actions
- More actively exploring new and innovative modes of working
- A desire to take the learning from ICE and use it to enhance their own organisations way of working.
- The approach of ICE starting to move into the wider system e.g. GPs referring to themselves as ICE GPs.

There were some early challenges evident in taking the ICE approach forward. These included

- The distribution of power and allocation of programme roles; reaching consensus on when it was appropriate to take the lead or take a step back
- Operating an inclusive partnership, managing engagement and ensuring appropriate partner representation, whilst acknowledging it would not be possible to have all potential parties involved
- The considerable time investment required to build trust and reciprocity across partner organisations
- A degree of cynicism from those external to ICE
- Finding a common language which was accepted and understood by stakeholders from different areas of work, and reaching a shared understanding of objectives
- Agreement and decision making on the mobilisation of financial resources

Finally, stakeholders identified a number of on-going challenges as the programme moves into the delivery phase:

- Embedding the ICE values, making them systemic and permanent
- Continuing to reach consensus around resource allocation
- Sustained stakeholder engagement alongside the pressures of delivering 'business as usual' within their own organisations
- Accelerating delivery progression down to front line services, where stakeholders can gather tangible impact and cultural change evidence

- The need for continued financial investment and further strategic leadership to propel the delivery phase
- Adopting a place-based approach with regards to the wider roll out of ICE, delivering a toolkit with ICE principles intact which can be tailored locally
- Disseminating ICE more broadly in order to share stakeholders' learning across the wider system, and ensure that important lessons are acted upon