HEREFORDSHIRE HEALTH & WELL-BEING BOARD

Integration Pioneer Proposal

Introduction

Herefordshire Health & Well-Being Board is hereby expressing an interest in becoming an Integration Pioneer. The Board believes that it is in a position to move swiftly and with ambition to create a radical redesign of care and support to the population of Herefordshire.

The following organisations are represented on the Health and Well-Being Board and are committed signatories to the proposal:

Herefordshire Council

Herefordshire Clinical Commissioning Group

Herefordshire Healthwatch

Wye Valley NHS Trust

2gether NHS Foundation Trust

West Mercia Police

Herefordshire Public Health

Herefordshire Carers

Herefordshire Housing

Herefordshire Voluntary Services Organisations

This is the right time for Herefordshire to be considered as a Pioneer. Herefordshire will continue to be at the leading edge in executing its strategy to remove cultural, financial and organisational barriers in order

to achieve seamless integration of care and support around the individual and their family. The scale of the challenge is not underestimated but there is real shared commitment, capacity and drive to fundamentally realign services.

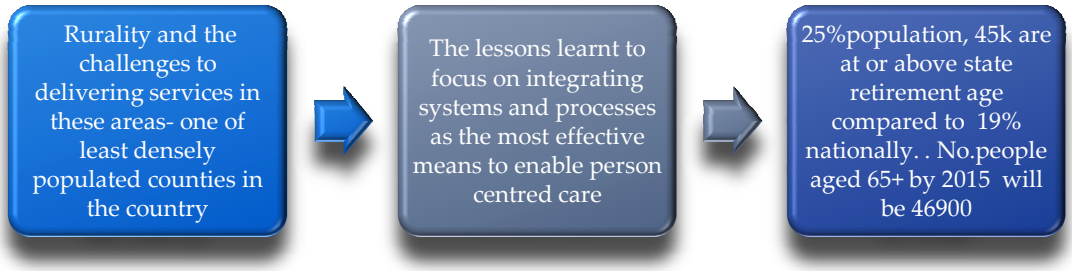
Why Hereford should be considered

1. Herefordshire is a large rural county- it has one of the lowest density populations in the UK with a population of 183,600 in 2011. Nevertheless it has grown by 5% since 2001 largely due to net migration from outside the UK. (Understanding Herefordshire JSNA 2013) There are distinct and significant challenges associated with the delivery of services in rural areas
2. 25% population is at retirement age or above, compared to 19% nationally. The number of people aged over 65 is expected to rise to 46,900 by 2015. Growth will be especially high in those aged 80 plus- numbers are expected to double by 2031. This is particularly relevant when looking at the increasing prevalence of dementia and the associated rise in support needs. Older people tend to live within remote rural communities with its inherent challenges for the delivery of services. **The tidal wave of expected dementia cases provides the driver to ensure that sustainable and cost effective services are in place to support the early diagnosis and management of dementia**.
3. Herefordshire is undergoing a period of challenge with regard to financial sustainability and viability across the whole of its Health and Social Care System. It is only by transformational change that Herefordshire will be able to ensure effective support and care arrangements for its residents on a sustainable basis.
4. Herefordshire has pioneered integration in the last 5 years. Structural integration between the Council and PCT as well as integration of service delivery between the Wye Valley NHS Trust, PCT and Council has resulted in several successful programmes including pooled budgets for adults with complex needs, childrens support and care, integrated community equipment stores and neighbourhood teams, It was also an early pilot for the Health and Well-Being Board. The recent NHS restructure has led to dismantling of the structural integration but the commitment to work together and realign services remains. Many lessons have been learnt from this experience. This learning, which can be shared with others is that the essential elements for integration lie predominantly with system processes, which are directed and

shaped to enable person centred care rather than a reliance upon structural unification.

5. Previous integration has focused primarily upon secondary services. Now the emphasis is to build upon the strengths of the individuals and their carers whilst maximising the use of resources and facilities within local neighbourhoods and communities
6. New management teams, with active participation by clinical staff including GPs, are now in place. They have determination and commitment to drive forward integration across boundaries and to overcome associated barriers to this.

Three key factors, which shape the Herefordshire proposal



The Shared Vision

That the integrated plan for service redesign has the following outcomes;

- Information, advice and support is readily available to help people solve their own problems within their own community
- It builds upon peoples' strengths and relationships
- Communities are supported to develop resources built upon local knowledge
- Services are co-ordinated around people and their families
- There is easy access to specialist services when they are needed

The Immediate Priority- Dementia

Whilst the ultimate aim is to redesign care and support to benefit all those with long term conditions and complex needs, the **immediate priority is to focus on people with dementia. The evidence for doing so is compelling.**

The Integrated Needs Assessment for People with Dementia and their Carers in Herefordshire (Rachel Cox, Public Health SPR, Herefordshire PCT May 2012) identified that Herefordshire currently has approximately 3000 people with dementia but only 34% have a formal diagnosis. In 2011 the All Party Parliamentary Group on Dementia emphasised the high financial and human costs of failing to provide good quality support especially in the early stages of the condition.

Dementia is a long-term condition and a significant percentage of those with dementia will also have additional long-term co-morbidities thus placing them among those with most complex needs and at risk.

At present people with dementia typically present to specialist services at later stages of the condition often via emergency admissions to acute hospital at a crisis point. This is very distressing for the person and their carers and can lead to a cycle of longer hospital stays than those without dementia, delays in discharge, frequent readmission, premature institutionalised care and a loss of independence. Redesigning services is a priority for to bring about improvement in cost effectiveness and outcomes for people

Early diagnosis allows for a range of support mechanisms as well as treatment and therapeutic interventions, which slow the rate of deterioration and assist in maintaining independence for a longer period. Thus in turn leads to improved outcomes for people and their carers as well as more cost effective services

Prevention, Personalisation and Integration

The Herefordshire plan is to shift from the previous focus on secondary care and integration of highly complex cases to a more universal and inclusive strategy. This will initially focus on those with dementia but will ultimately benefit the wider population

The express views and preferences of individuals and their carers, to live independently will determine how care and support is delivered. The plan will build a circle of support within communities using neighbourhood resources and facilities. These will combine to provide a single clear access point and support into a range of integrated pathways. Health and Social Care will be delivered through multi disciplinary community teams working seamlessly with primary care, other agencies and the voluntary sector. They will be supported by innovation in secondary care, which will also shift its focus to provide community based, person-centred approaches.

Currently services are based upon a medical disease centred model that is focused on illness, needs, problems, risks and deficits. It tends to rely heavily on expensive specialist services and a dependency on inpatient and residential settings and under-utilisation of community based assets and resources.

The proposed plan will provide care and support, which is:

- Person Centred- recognising and respecting the unique person, using 'person's journey' as a basis for commissioning, planning and providing support to enable the person to remain in relationships
- Assets-Based- using the persons strengths and those of their family, friends and community, seeing the person as a citizen and part of a wider community
- Proactive- understanding current needs and thinking ahead, anticipating change and planning for the future
- Effective- ensuring safe and effective services and support are in place

This is the basis on which services will be commissioned and designed and they will be characterised by;

- Harnessing and working with the skill and resources of people living with dementia
- Early Diagnosis and pro-active support
- Based at home and the community and led by primary care rather than secondary care aimed at reducing stigma. This will have the impact of reducing the pressure on secondary and specialist care allowing them to focus resources
- Personalised and flexible- people can expect care and support and outcomes that matter to them
- Part of a system, which is proactive and preventative – services that can plan ahead and help prevent crises

- Delivered in partnership with people with dementia and their carers and multi agencies
- Commissioned and provided in an integrated way across different agencies including the third sector- a whole system of services which reduces gaps and overlaps

How the Plan will be Delivered

Within the last year ambitious and innovative plans have been developed to move towards evidence based integrated care. These will be essential building blocks in moving the county towards the vision, which is outlined above. The key elements are outlined in summary below.
The Plans which will initially focus on those with dementia do ultimately benefit a wider group of people at risk with multiple co-morbidities and include:

- 24hr Multi Agency single access point with integrated responses involving housing, voluntary sector, leisure and community facilities, welfare advice, health and social care. This is at the heart of integration and will ease the path for people and their carers by offering advice and signposting, access to neighbourhood teams, housing etc

- Development of dementia friendly community and neighbourhoods, which builds into the community and facilities at large a heightened awareness and more sensitive response to people with dementia and their families. It will work to provide safer environments, signage, village wardens and champions, ‘can I help you “ points within facilities such as supermarkets, banks, hairdressers and a whole range of community resources.

- A range of support and advice services in the voluntary sector to maximise the use of volunteers in supporting people with gardens, DIY, social contact etc

- The development of homes for life using telecare and extra care type support to enable people and carers to remain independent

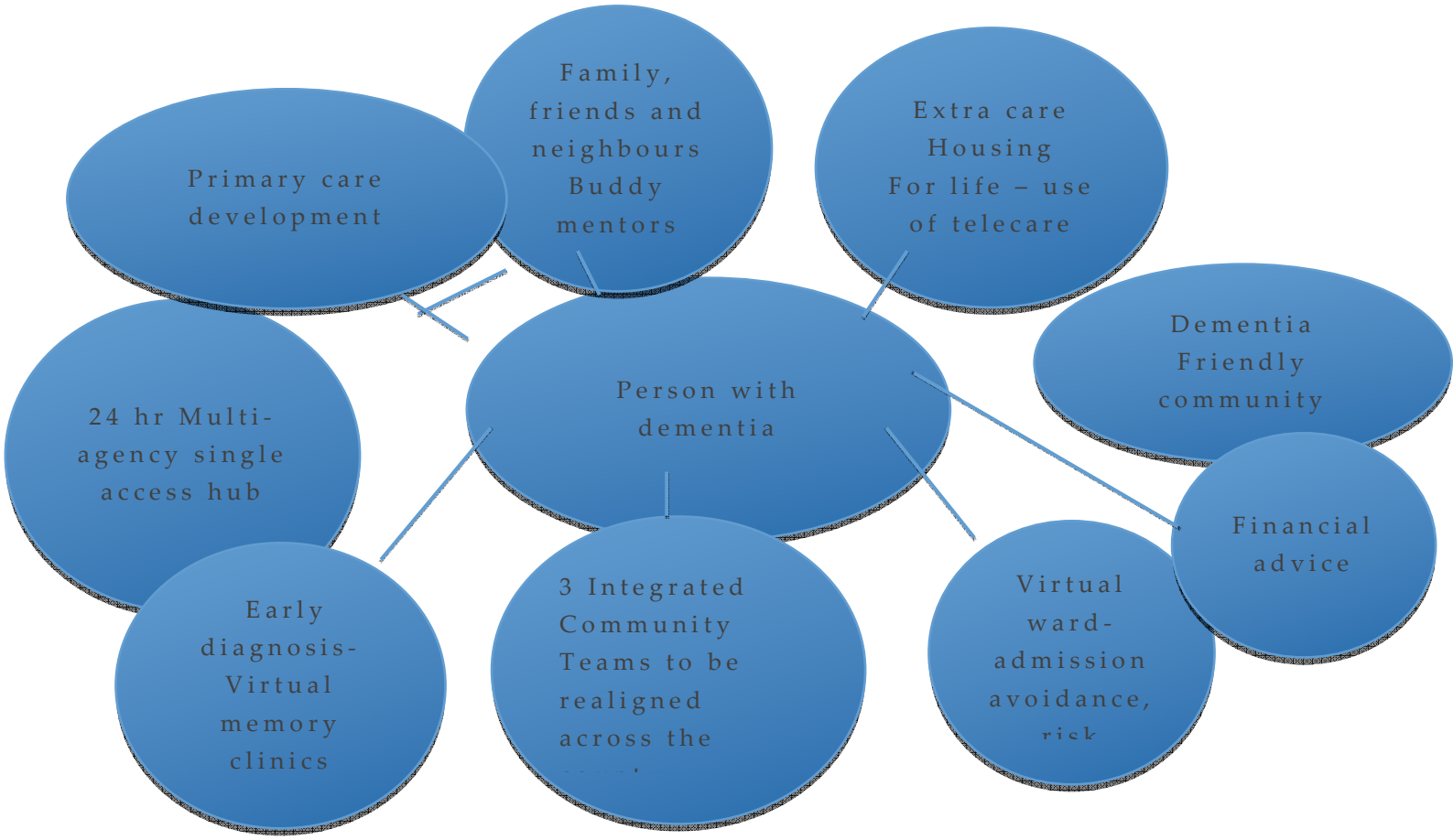
- Integrated Community Teams, which will be multi-disciplinary and provide assessment, proactive planning and delivery of therapeutic services to support and care for people in their homes or the

community. They will work closely with GPs and have access to wider care services, including a:

- 'Virtual Ward' – part of the community teams- people at greatest risk of hospital admission will be identified and using a predictive risk-stratification tool will be 'admitted' to the virtual ward. They will receive personalised care plans, promotion of health and well-being and a focus on reablement, and independence. Anticipatory care planning, including carers planning will be a key feature to prevent crises with clear communication of these plans across all providers. Where successful this method has resulted in 14-22% reduction in emergency admissions and can also result in reduction in length of stay when targeted on early discharge

- Focus on early diagnosis of dementia is a key component. This will then lead to advice and support on health and well-being, and advice on staying healthy and active, life planning, advice on and access to medication as well as information on points of help and support for the individual and their carers

The range of support and care available is shown diagrammatically



Barriers to Integration

It is recognised that the barriers to delivering an integrated approach are significant and challenging and they are not underestimated.

Some of the key issues are listed below:

- Whilst the single Council and Clinical Commissioning Group are contiguous in the county, there are nevertheless cross-boundary issues. GPs and NHS commissioners are funded to provide for their registered patients who may live outside the boundaries of the county. This can lead to funding difficulties especially when a significant proportion may live in Wales with whom there is a significant border and different health policy
- Information sharing- some progress has been made but there remain significant issues in agreeing protocols and practical steps for sharing information and for facilitating this via IT compatible systems.
- The aim is to move towards a capitated and personalised system of funding and until this is fully implemented there will be issues to overcome to ensure providers are able to sustain services and financial stability
- Professional practice and culture can prevent transformation is to be achieved. A development programme is needed to support staff and others through the period of change.
- Political and Organisational differences and priorities often create tensions and pose risks to delivery. The commitment and leadership of Members and Chief Officers is an essential ingredient for success.

Enabling Measures

There is work underway to ensure the elements, which will cut across organisational boundaries, are in place and working alongside and integrated with the service delivery plans. Work has commenced to ensure the enabling elements are addressed in order to allow the service

plans to move forward in such a way to deliver personalised approaches within a short period of time.

These include:

- A systematic and routine methodology for engaging and involving people with dementia (rather than relying upon carers) so that they are involved and at the heart of planning new ways of providing support and care
- The adoption and development of work to engage the broader community, in developing safe and supportive communities. The 'Dementia Friendly Community' work will be embraced so that education, housing, local businesses, community groups and facilities are aware and are encouraged to sign up to and take action to meet the aims of the Dementia Action Alliance pledge
- The development of a single multi agency access hub, which involves a whole range of local services, such as housing, voluntary and welfare support, as well as health and social care services. This is at the heart of moving to an integrated response.
- Leadership is the vital ingredient to achieving the transformation. This can come from variety of sources including people with dementia and the voluntary sector as well as the more traditional professional, clinical and senior management groups. A review of available resources is underway together with a planned development programme to ensure adequate capacity for delivering change.
- Skills and workforce development programme is an essential element if everyone including those in volunteer roles are to adapt and respond differently to people accessing their service.
- Information, IT and financial support will be in place in order to develop and provide the systems, which are needed to enable service redesign and delivery
- Fundamental health and social care service redesign to respond to people in a truly personalised way based upon outcomes
- A plan to move this year to commissioning based upon Outcomes is planned using the COBIC methodology. COBIC stands for Capitated Outcome Based Incentivised Commissioning and is based on person(patient) engagement to define outcomes and engagement with providers. This leads to a commercial model that aligns their

incentives to the delivery of outcomes. It requires providers to work together to deliver capitated care for populations. The COBIC model provides a contractual mechanism that rewards both value for money and outcomes that are important clinically and to patients. It will be focused initially on urgent care responses

- A core team to drive forward this transformational change is to be identified working across organisational boundaries but within agreed shared and individual governance arrangements

Commitment to Participate and Share

Members of the Health & Well-Being Board recognise the importance of this work on a national level and are committed to involvement in national activities to promote and share learning. It will ensure that resources and time are available from those involved including clinicians to actively participate.

June 2013