Herefordshire Council

Health Scrutiny Committee – 2 August 2010

Subject:	Herefordshire Service Integration Programme
Presented By:	Trish Jay, Interim Managing Director of Provider Services

PURPOSE OF THE REPORT:

To provide information on the implementation of the Herefordshire Service Integration Programme and the intensive engagement process accompanying it.

KEY POINTS:

- Summary of the Implementation Plan
- Development of the engagement process on the new service models (care pathways)

RECOMMENDATION:

The Health Scrutiny Committee is asked to note the outline of the Service Integration Programme and the details of the intensive engagement period planned over the coming months.

HEREFORDSHIRE SERVICE INTEGRATION PROGRAMME

IMPLEMENTATION PLAN SUMMARY

1. Introduction

In August 2009, the four sponsor organisations (NHS Herefordshire, Hereford Hospitals NHS Trust, PCT Provider Services and Herefordshire Council) together with the West Midlands SHA formed an independently-chaired Transition Board with multi-disciplinary membership to develop pathways for the integrated delivery of health and social care services within the county which would contribute to maximising health and well being and reducing health and social inequalities in Herefordshire.

The work concluded with a Transition Board report with recommendations which were approved by the PCT and Herefordshire Hospital Trust in May 2010. The proposition was to:

- Create a new integrated model of health and social care provision in Herefordshire, with specific care pathways aimed at providing personalised high quality, safe and sustainable care for local people which promotes personal health, well being and independence; a model which is focused on providing care as close as possible to people's homes, rather than in an institutional setting; a model which is also aimed at identifying our most vulnerable clients and shifting the emphasis from diagnosis and treatment to prediction and prevention.
- Create an integrated care organisation under one management structure composed of an integrated NHS Trust combining community and acute health services that is also integrated with social care so far as is practicable under current legislation.

A supplementary recommendation was to create an Implementation Programme structure with a Programme Team to take forward and co-ordinate the implementation of the key recommendations above.

This paper summarises the detailed Implementation Plan that has been developed to take forward the propositions as set out in the attached summary Transition Board report to sponsors. The attached engagement plan also describes the intensive engagement process that will accompany the implementation phase.

2. Implementation Plan for the Programme

2.1 Programme of work

This is a complex programme of change management across health and social care services in Herefordshire and therefore a comprehensive Implementation Plan has been developed to ensure a co-ordinated and project management approach to this work.

The implementation is split into three main areas:

a) Implementation of the care pathways:

- Frail older people – with focussed changes relating to:
  - Locality teams
- Stroke care
- Unscheduled Care
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Lower back pain

b) Development of an engagement strategy to ensure people using the services, their carers, local communities, clinical and social care professionals. independent and voluntary sector providers are all involved in the implementation of the care pathway changes.

c) Development of the proposed Integrated Care Organisation, ensuring compliance with the required approvals processes.

In order to manage specific change management tasks for each of the programme areas above, a number of workstreams have been set up and prioritised in terms of the timing and urgency of implementation. Some work streams are cross cutting and these are outlined below. Each workstream has its own Executive/Senior Lead supported by Clinical/Practitioner Leads and a team of people working in the relevant areas. The workstreams have an outline of their objectives and outputs, and the key milestones for delivery.

Service Delivery Workstreams	Priority	Cross Cutting Workstreams	Cross Cutting Workstreams
Stroke	1	Localities Diagnostics & Clinical Imagining Risk Stratification (Case Management) Clinical Quality & Safety	Communications & Engagement Estates/Resources Finance & Information IT Workforce
Frail Elderly	1		
Diabetes	2		
Lower Back Pain	2		
Chronic Obstructive Pulmonary Disease	2		
Unscheduled Care	1		
Viable futures	2		

2.2 Programme Benefits and Key Performance Indicators

The benefits against which the programme is being measured were outlined in detail in the Transition Board report to sponsors and are shown in the table below:

For service users

• Sustainable local services
• Services that maximise choice, personalisation and independence
• Improved health, well-being, quality of care and greater clinical effectiveness through:
  o Simplified care pathways, with single point of access, clear referral and access routes, shared assessment and management plans and a shared focus on achieving maximum well being
  o Reducing the focus on inpatient and institution-based care
  o Timely availability and seamless care from healthcare professionals
• For social care users, better integration with health services with improved outcomes for individuals and their carers

For health and social care staff
• Increased productivity and responsiveness to service users • Increased operational flexibility by better integrated working practices,

maximising the skills and knowledge available

- Development of a workforce strategy across the health and social care economy
- Creation of interesting and developmental career pathways between hospital, community and social care leading to improved recruitment and retention
- Ability to train staff across different agencies to raise awareness of well being issues

For the health and social care community

- Increased public confidence
- Led by clinical and social care practitioners, financially sustainable and safe
- More viable and cost effective services with perverse financial incentives removed
- Better outcomes for health and social care service users, via more efficient delivery of safe and high quality care through:
    - Better integration of preventative advice and services with consistent messages to service users and the wider community
    - Consistent support to carers and integrated mechanisms to seek and to receive feedback from service users and carers
    - Identifying and managing risks and measuring the effectiveness of targeted intervention and longer term outcomes
    - Achieving the optimum balance as to where services are provided
- Improved business continuity
- Increasing the input from locality groups in the review, planning, commissioning and delivery of services
- Improved business processes, as information will be more available and shared across organisations and services
- Meeting local and national requirements relating to personalised care and individual choice
- Reducing health and social care inequalities

In order to determine if the benefits of the change process are having a positive impact, a clear set of performance indicators have been developed against which progress can be measured and reported. The indicators have been grouped into the following categories:

- High level indicators on measuring the overall impact of the implementation of the care pathways e.g. admission rates, average length of stay
- Feedback from those who use the services
- Implementation of new service provision
- Service Specific indicators

- Longer Term indicators

3. Planned Engagement Process

3.1 Engagement process on the care pathway implementation

The implementation of this programme of work requires input and partnership working with people who use the services and their carers, as well as health and social care professionals, support services, other providers, statutory and voluntary agencies and a wide range of external stakeholders.

An overarching Communication & Engagement Plan has been produced. The attached, paper sets out the more detailed plans to undertake an intensive period of engagement on the implementation of the care pathways and new service models over the next few months.

4. Development of the proposed Integrated Care Organisation

Work has been completed to understand the approval processes that are required to progress the recommendation to create a new Integrated Care Organisation for Herefordshire.

The initial step in this process is to obtain approval from the NHS Cooperation and Competition Panel (CPP). This body has the right to examine all major organisational transactions in the NHS, including mergers, to ensure that they are not anti-competitive and, therefore, against the public interest. The Programme Team is in contact with the CPP and information will be provided for their consideration at the end of July 2010.

5. Recommendation

The Health Scrutiny Committee is asked to note the outline of the Service Integration Programme and the details of the intensive engagement period planned over the coming months.

Trish Jay
Interim Managing Director for Provider Services