Implementing the Health & Wellbeing Strategy

Inverting the Triangle/Delivery Assurance programme activity

25/04/13

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Purpose

The purpose of today's session:

- Update of work to date
- Share the insights and outputs from the Home Truths programme to position and prioritise Inverting the Triangle/Delivery Assurance programme activity
- Recognise a common position for the Inverting the Triangle/Delivery Assurance Programme(s)
- Outline the next steps for the programme activity to maintain momentum

Inverting the Triangle

iMPOWER was asked to support BMBC to scope and frame the **Inverting the Triangle** vision to deliver whole system transformation across health and social care.

The vision:

- **A strategic shift** from focusing on supporting only the most critical needs, to avoiding need by supporting as many as early as possible
- **Transforming the "front door"** – from gatekeeping and rationing to empowering.
- **A differently focused "tiered" model** of support and intervention
- **A fundamental change in relationships** with the citizen (and partners)

What it means:

- **A genuinely whole systems change**
- **A step change in relationships with Health services**
- **A new way of joint working**
- **A need to make it work (cannot afford not to change)**

This work informs the recommended principles for a joint programme of activity

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Home Truths

Barnsley MBC and CCG are one of six sites who are participating in the iMPOWER Home Truths pilot programme, which has focused on exploring the relationship between GPs and Social Care.

The work to date has identified some key insights and opportunities which will inform both short term activity, but also the step change requirement emerging from Inverting the Triangle.

The key insights emerging are:

- Joint working will be essential to realise step-change, and short-term benefits, and that despite occasionally conflicting priorities this is achievable
- The current relationship between the Council and GPs is difficult, but there is a significant desire for improvement
- There are a number of short term opportunities for improvement and efficiency resulting from joint working, specifically:
  - Signposting
  - Pre and early-diagnosis dementia support
  - Unplanned care
  - End of life care

There is a good opportunity to improve the Council/GP relationship

The Home Truths work has given us a significant insight into the relationships between the Council, and Health, in particular GPs. The key findings are set out below:

Finding	Discussion Points	Impact on Change Activity
GPs respect social care and are keen to improve the relationship	• 67% of GPs trust social care to make the right decisions in the interest of patients • 91% of GPs would value closer working relationships with Social Care	• Overwhelming majority of GPs are keen to have a stronger relationship with social care, which can be leveraged through a joint programme
Current GP / Social Care relationships are difficult	• 75% of GPs surveyed felt they had a poor relationship with Social Care	• Despite the desire to improve the relationship, an early programme focus will be to build trust
Key lower level services are either not known to GPs or perceived to be of poor quality	• Key services such as respite, telecare, reablement and home care, were all identified in the GP survey as being unsatisfactory for a large proportion of respondents • This was supported by GPs having a consistently low knowledge of early intervention / preventative activities – e.g. Exercise Classes (67% were unaware of the service offer) and Social Support groups (50%)	• The lower level activities which will support the introduction of the inverted model are not well communicated to, or received by, GPs • A real focus on clarifying and communicating the service offer will be key to obtaining GP support

Although there is currently a difficult relationship between GPs and Social Care there is a significant opportunity to improve this, and better promote the full range of services offered

GP Survey – Key Findings (1)

GPs trust the Council and are keen to improve the relationships

- 91% of GPs said they would value closer links to adult social care
- 76% of GPs felt that they could be better supported to intervene earlier to delay/avoid admissions into residential care. This is aligned to the national average of 75%
- 92% said having a wider range of options to intervene earlier would enable them to be more effective at avoiding unnecessary admissions into residential or nursing care.
- 88% feedback on referrals to social care would improve joint working, which links to the 91% of GPs stating that having greater faith in referral options having a positive outcome would enable them to be more effective in avoiding unnecessary admissions

GPs do not recognise their influence on older people's decisions on social care

- None of the GPs surveyed in Barnsley felt that they had any significant influence on the care decisions made by older people. This is significantly outside the national position, where 30% of GPs felt that had an impact on care decisions
- After Family, GPs were identified by the Older People surveyed as the second most influential group for their care decisions, with 52% stating their care decisions are influenced by GPs
- These results suggest that GPs in Barnsley underestimate the impact they have on care decisions
- By offering advice to both Older People and their children, GPs have the opportunity to significantly influence and signpost care decisions

GP Survey – Key Findings (2)

GPs have a poor perception of key social care services

- Dissatisfaction with respite services was highlighted - 64% of GPs rated Respite in Barnsley as unsatisfactory or very poor.
- Home Care (39%), telecare (38%), reablement (42%) and exercise classes (25%, with a further 67% unaware of the service option) were all cited as services that were “not working” by GPs
- The Telecare finding is particularly significant as this is a service where there has been a substantial level of local investment and promotion

Addressing GPs’ knowledge and signposting to Ageing Well activities

- The GPs surveyed had a significant lack of knowledge about social classes and activities that might support older adults to stay healthy and independent in the community longer.
  - 67% of GPs had no knowledge of exercise classes,
  - 50% had no knowledge of social support groups
- Taking into account GPs’ influence on older adults as an advisor, improving GP knowledge and signposting to these services could improve uptake and consequently improve the health and wellbeing of older adults

Older People's Engagement – Key Findings

The majority of older people will first ask their family for care advice

- 72% of the Older People surveyed in Barnsley principally rely on their family for advice on care choices. In particular it is spouses, children, and other family members who provide care who are the principle reference points
- This was reflected in the Care Home engagement, where the older people interviewed predominantly commented that they had first discussed their options with their family, although GPs and Social Care were often involved before the final decision was made

Older people do not want to move into residential care

- The survey identified a very strong preference from Older People to remain independent and in their own home. Only 4% of the older people surveyed in Barnsley had a strong preference to move into residential care in the next three years
- This finding suggests there is likely to be a high degree of acceptance for services which are focused on maintaining independence, and for early intervention services

GPs and Doctors have a greater influence on care choices than Social Care

- After family, medical professionals were strongly identified as the most influence on older people's care choices, with GPs influencing 52% of those surveyed, Hospital Consultants 15% and Hospital Doctors 25%
- By contrast social workers were found to have a comparatively low influence on care choices, with only 19% of those surveyed responding that social workers have an impact. However, Home Care workers were found to be influential, with 48% of respondents identifying that there domiciliary care provider would have an impact on their care choices
- There is a significant opportunity for the Council to leverage this influence to signpost older people (and their families) to a range of early intervention and preventative services provided by Heath, Social Care and the Third Sector

Using the Home Truths insight to shape opportunities

The Home Truths work has identified that there is a substantial opportunity for joint delivery of a range of benefits across health and social care.

In the first instance two key activity areas for joint delivery have emerged:

Unplanned Care

This has been identified as a priority area by stakeholders across the CCG and Council. There are two key elements to this work – early intervention and crisis response. The key activities within this chunk include:

- Optimised crisis response (community geriatrician, falls response etc)
- Signposting
- End of life care – avoiding crisis admissions
- Early stage dementia management

Communications and Relationships

The GP survey and our engagement with Social Care staff clearly identified that current relationships are difficult, fragmented and locality driven. However there is a clear recognition and desire from both sides to improve relationships and communications. There are wide range of initiatives which could be piloted based on the outputs of our engagement including:

- Formal presentation & seminar GP engagement
- Regular social care presence at GP time out events
- Production of comprehensive social care service catalogues (including third sector provision)
- Enhanced presence on NHS and Council intranets
- Regular newsletters and updates for GPs
- GPs updated on the progress of patients referred to social care

Scope and potential of joint working

- **The development of joint working initiatives has so far focussed on Health and Adult Social Care priorities**
- **The approach (if proved successful) could be applied to other areas; Children's Services, Public Health etc**
- **This would be achieved through replication or extension**

Joint working previously has failed to deliver

To create a successful step change in the way we work together, we need to learn from experience and recognise:

- shared organisational ambitions and understand organisational motivations
- individual tensions that exist within a 'whole' system
- the danger of moving at the pace of the slowest
- that from a provider perspective, there may be winners and losers
- the responsibilities of statutory commissioning without losing the benefits of commissioner / provider collaborations
- the reasons why joint working has had mixed success to date

a new approach to joint working is required – **this is the opportunity**

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Defining a joint programme of activity

Programmes of activity should be identified as:

1. Activities that remain separate
2. Activities that are led by a single organisation, but development requires input from others
3. Activities that are jointly delivered

- **Ideally group (1.) should be small in number**
- **The direction of travel should then be from group (2) to (3)**

Shaping the joint programme

Based on our work to date, with BMBC and CCG, an understanding of their aspirations and ambition of system wide transformation and partnership working, and the need to successfully deliver the Health and Wellbeing Strategy, we will develop:

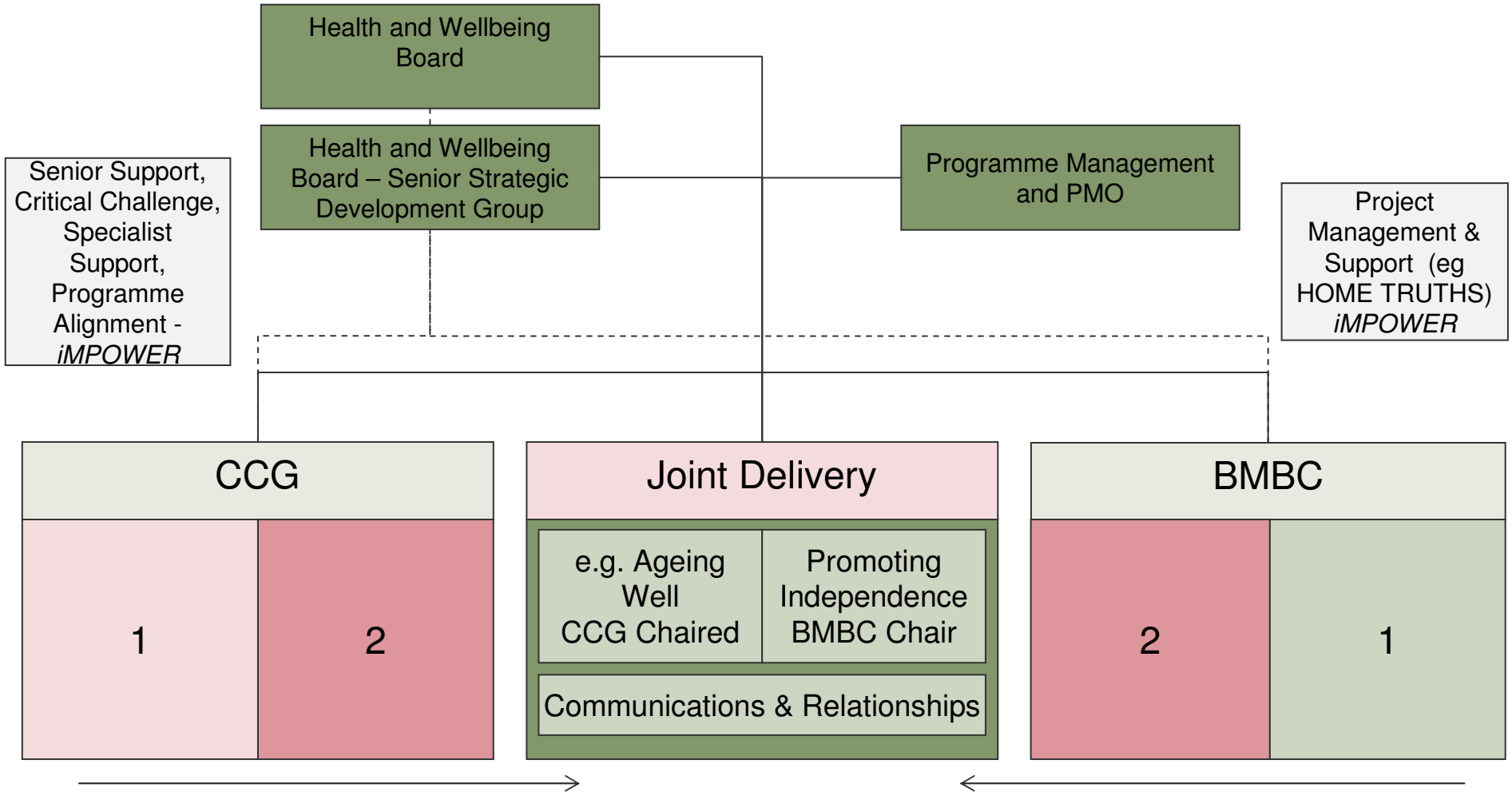
- Fully integrated and joint BMBC / CCG transformation programme

To ensure successful delivery and adoption of the Joint Programme, there will be clear definition and commitment to the following:

- **Scope of ambition** – explicit confirmation of shared aspirations and outcomes for the programme
- **Common priorities** – define which programmes of activities will be jointly and locally owned
- **Critical success factors**
  - **To resource adequately**
  - **To share knowledge and trust**
  - **To define accountabilities**
- **Governance** – the Joint Programme supports the delivery of the Health & Wellbeing Strategy and will report to the Health and Wellbeing Board

It is anticipated that although the programme(s) would be accountable to the Health and Wellbeing board, the Senior Strategic Development Group would be the principle 'operational' governance group. Additionally it is anticipated that the programme(s) will also report through the appropriate routes within BMBC and the CCG.

The Joint Programme Structure



1. Activities that remain separate
2. Activities that are led by a single organisation, but development requires input from others
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Operating principles to ensure success

- A Programme Management Office (PMO) – jointly operated as a single point of delivery
- Each organisation (defined through pre-agreement) will contribute resources to the PMO (financial, staffing etc, including potential redeployment of existing resources)
- Programme activity can only be agreed where there is a shared objective that can be clearly articulated
- Identified programme activity must have a quantitative impact on 2 of the partners
- Contributions to a particular programme activity will be agreed on an individual basis
- Commitment to relationship development; the improvement in knowledge sharing and trust across the system needs to be measured in terms if success (links to OD requirements identified by the H&WB Board)
- Commitment to measuring success, planning and realising benefits, and demonstrating positive changes and improvements to outcomes.
- Explicit alignment of activity to the delivery of the H&WB Strategy
- Documentation and internal 'branding' will be aligned to the H & WB Board

Summary

- There are 3 types of programme activities
  - Delivered as a solo organisation (1)
  - Led by one organisation but co-produced with others (2)
  - 'Properly' Joint (3)

- 'Properly' joint is different than we have done before
- We will set a high bar for joint programme (that of shared resources and objectives)
- Will start small, but aim to demonstrate quickly benefits and grow it
- SSDG to oversee the programme structure and spend resources shaping the Joint Programme

It should be noted that this pack focuses on CCG and the Council, but thinking clearly extends to other partners. Participation in the Joint Programme will require the same commitment of time and resources.

Next Steps

Scoping and resourcing of programme to include:

- Shape, scope and begin implementation of
  - joint programme
  - initial workstream specific activity (x2)
- Development of organisation specific change activity
- Agree resources to deliver scoping phase
- Develop (short, medium and long term) programme funding architecture
- Agree resource profile for initial programme activity and commence recruitment to structure
- Development of outline PMO and governance function to include:
  - Size, scope and terms of reference
  - Programme governance approach, to include reporting lines into HWB and organisational specific reporting requirements

Appendix 1 – Alignment to HWB Strategy

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Linking whole-system programmes to HWB Strategic Priorities for 2013 / 14
Candidates for initial whole-system programmes:

1. Cancer
2. CVD
3. Alcohol Misuse
4. Children's Health
5. Ageing Population

Example:

5. Ageing Population

Rationale:

There are approximately 231,900 people living in Barnsley. This is projected to increase to 238,500 by 2015 and to 248,600 by 2021. These interim projections from Office for National Statistics (ONS) show that the largest projected increase is likely to be in those aged over 65 (increasing by 20.9% in 2021). 20% of the total population will be aged over 65 in 2021.
The demographic trend of an ageing population means that demands on health and social care services will continue to grow. It is important that residents are supported to maintain healthy and independent living for as long as possible, to not only improve the quality of life in elder years but also to reduce the burden on health and social care services.

Priority 5 - An ageing population and the need to support independent living

Proportion of people using social care who receive self-directed support, and those receiving direct payments (ASCOF);
The proportion of people who use services who have control over their daily life (ASCOF);
Permanent admissions to residential and nursing care homes per 1,000 population (ASCOF);
Proportion of people feeling supported to manage their condition (NHSOF);
Unplanned hospitalisation for chronic ambulatory care sensitive conditions – adults (NHSOF);
Emergency admissions for acute conditions that should not usually require hospital admission (NHSOF);
Emergency readmissions within 30 days of discharge from hospital (NHSOF);
Proportion of older people (65 and over) who were still at home 91 days after discharge into rehabilitation (NHSOF/ASCOF);

The proportion of people who use services who feel safe (ASCOF).

Appendix 2 – Indicative Joint Programme Detail

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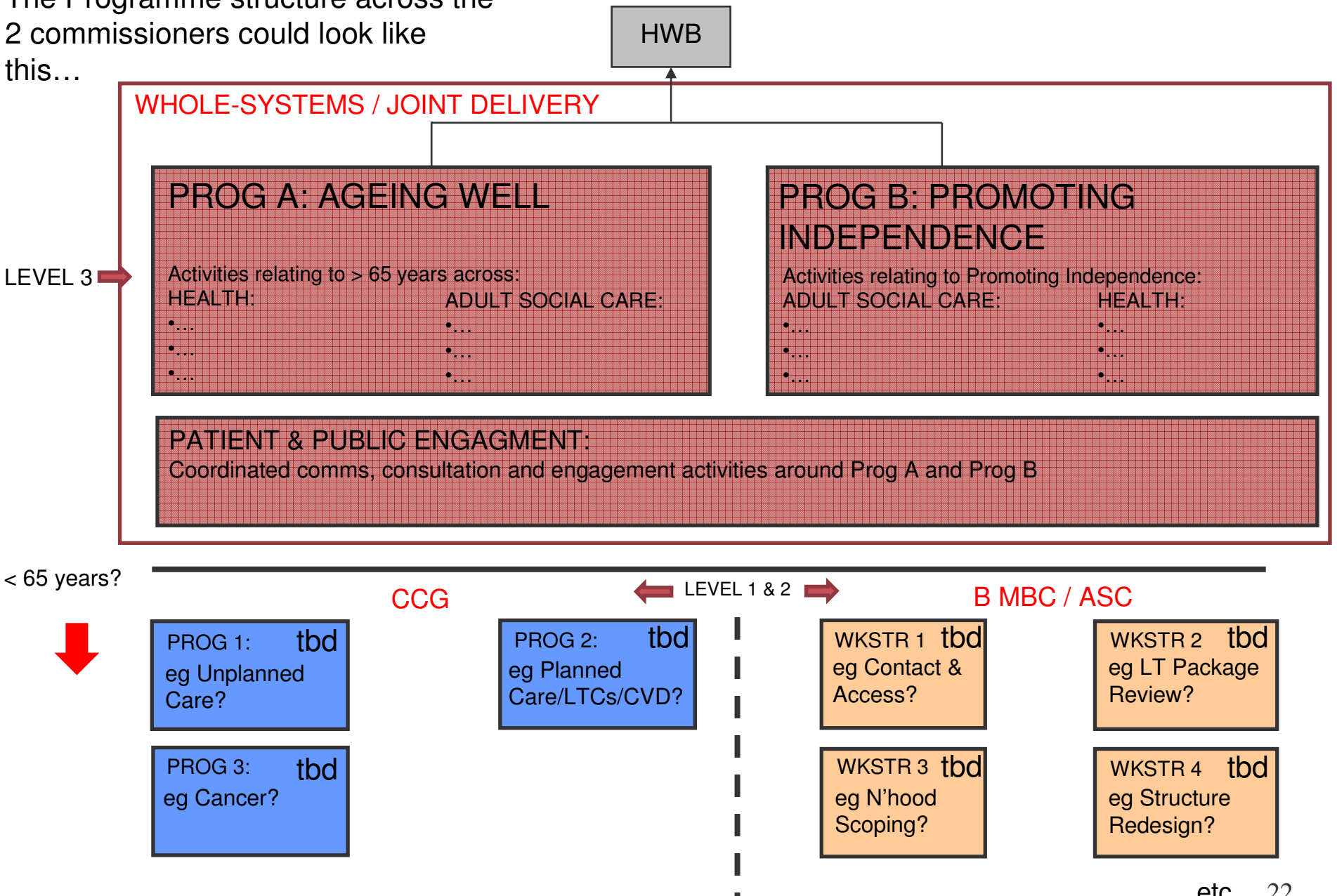
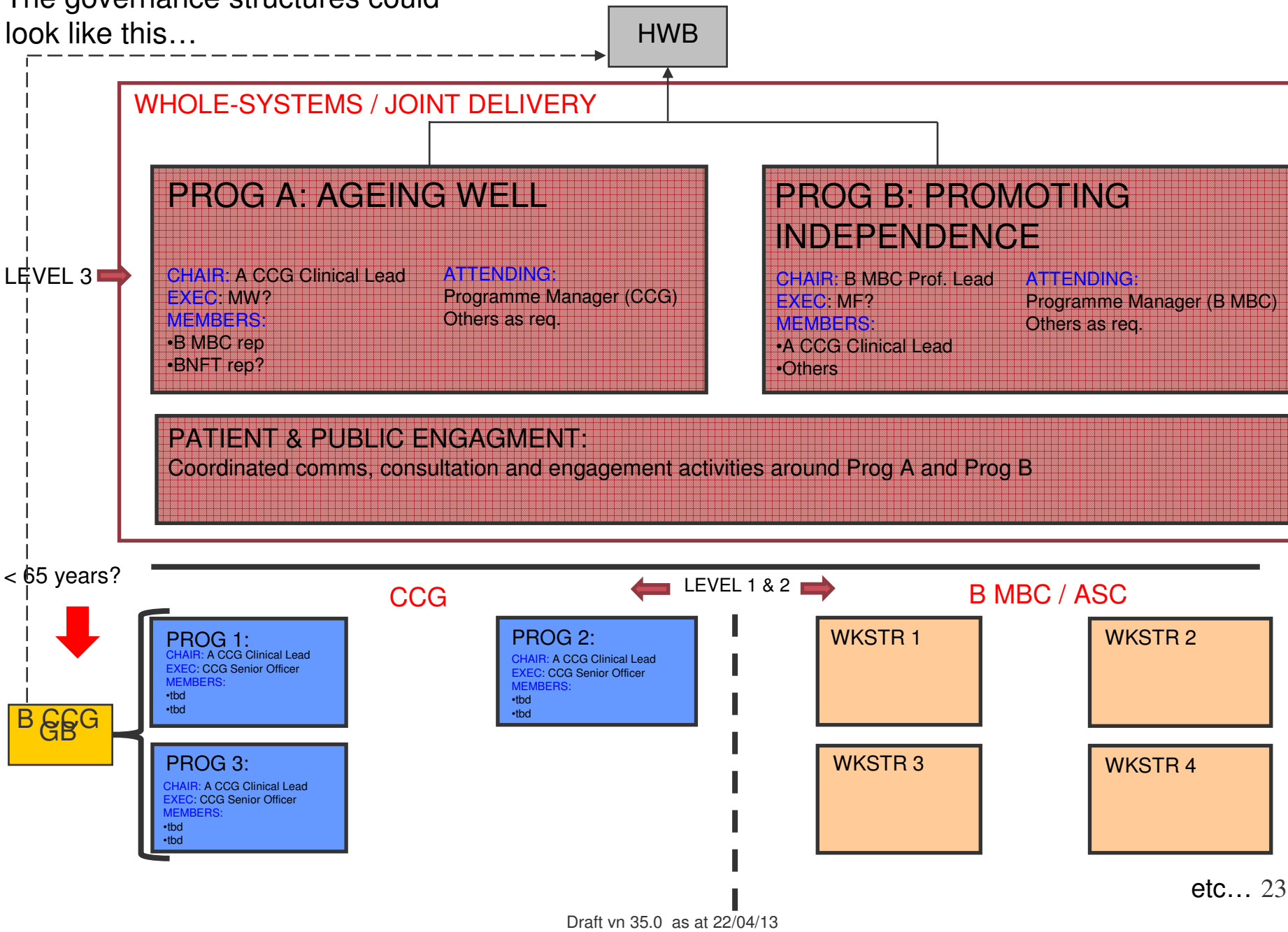
PROGRAMME LEVELS: POTENTIAL INITIAL CONFIGURATION

The Programme structure across the 2 commissioners could look like this…

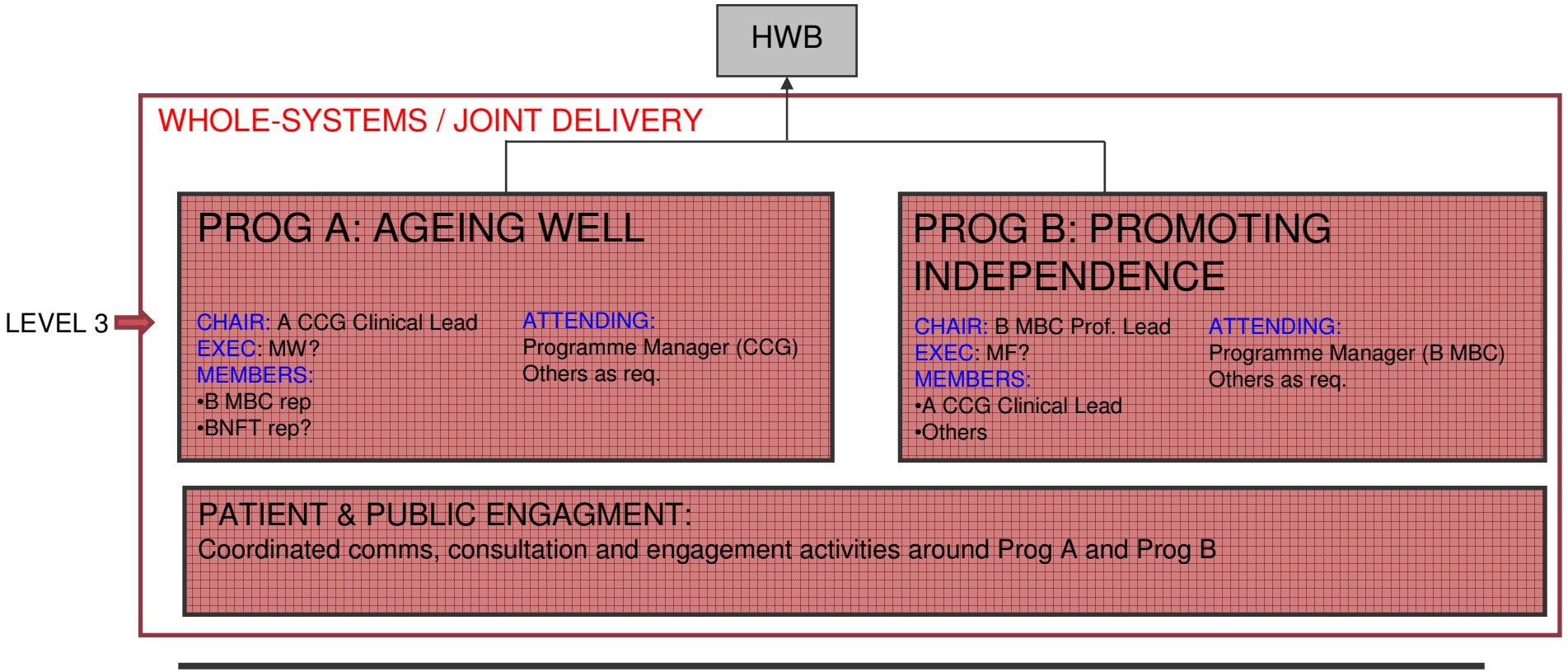


PROGRAMME BOARDS AND GOVERNANCE: EXAMPLE

The governance structures could look like this…



LEVEL 3 PROGRAMMES – DRAFT INCLUSION CRITERIA



DRAFT CRITERIA FOR INCLUSION OF AN ACTIVITY IN A LEVEL 3 PROGRAMME:

- Explicitly supports 1 or more Health & Wellbeing Strategy Priorities for 2013/14
- Supports 1 or more shared objectives that can be clearly articulated
- Involves input from multiple agencies
- Has a measurable impact on at least 2 partnership organisations?
- Other?

Appendix 3 – Home Truths Opportunity Detail

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There is the opportunity to realise benefits throughout the care pathway

Health & social care pathway

Prevention & early Intervention → **Crisis Response** → **Post-crisis support** → **Long Term Care**

Home Truths Insight

- **GPs are unaware of, or dissatisfied with low level services**
- **GPs believe that it is Social Care and not hospital discharge teams who are the experts in shaping long term care**
- **Older people wish to remain independent for as long as possible**
- **Stakeholders throughout the system want to avoid hospital admission**

Shortlisted opportunities

Signposting
- **IN** to GP surgeries to inform staff of early int options
- **OUT** from GP surgeries

Optimise crisis response
- Providing a viable, trusted alternative to A&E
- Putting in place support that avoids hospital admission whilst meeting health and social care needs

End of Life Care
- Supporting older adults to die at home
- Hospice at home

Early dementia support
- Integrated, flexible, responsive support services for people with dementia and carers – with a focus on engaging the third sector to support in the early stages post-diagnosis

Signposting

Context & rationale	52% of the Older People surveyed identified that GPs have an influence on their care choices, with 15% turning to their GP for advice in the first instance. 72% responded that they would turn to their family for advice. These findings signal that GP practices have a significant role to play in advising and signposting older people and their families. However the GP survey also highlighted many GPs were not well informed of early-intervention and lighter touch services. A comprehensive signposting offer will enable older people with mild and moderate needs to be pointed to lighter touch services which will hopefully avoid crisis, and delay the requirement for higher dependency services.
Opportunity Detail	**Inwards: Improving GP (and key staff) knowledge of early intervention and prevention options** Links and publicity for ASC portal(if available) through CCG website Training on social care offer for practice staff – managers, receptionists, nurses •Delivered by social care staff •Outlining care pathways, levels of intervention •FACS criteria, financial assessments and chargeable services **Outwards: Using the GP surgery as an active signposting tool** •Comprehensive introduction and guide to social care offer available to staff and patients •Publicity in GP surgeries for early intervention support - VCS; ASC offer; Carer support. •GP IT systems to link to ASC portal and where possible, to capture more social information (e.g. whether a patient is a carer/ has a carer). •Direct referral to universal/non-FACS services by GPs and District Nurses •Reinforcement of key messages and advice through routine consultations
Benefits and Size of Opportunity	There are two types of cashable saving resulting from effective signposting: •**Short term cost avoidance** through signposting to a lower cost service, and services which represent and alternative to hospital avoidance •**Longitudinal savings** through reduction in residential care placements, following sustained period of embedded signposting Non cashable benefits include: •Appropriate signposting and access to services for older people •Potential for older people to remain independent longer whilst receiving services •Consolidated early intervention activity •Leveraging the role of GP practices within the community to provide improved outcomes across the Health and Social Care spectrum

Enabling and responsive offer for people with dementia and carers

Context & Rationale	People with dementia may not be FACS eligible at the point of diagnosis, but they will meet criteria as their condition progresses. From the point of referral for diagnosis, patients and carers should have access to a range of services MDT enablement approach to managing long term conditions has been shown to have positive outcomes for people with dementia maintaining independence as well as cost saving implications Two thirds of people with dementia live at home in the community and an estimated £12.87 billion worth of support is provided by informal carers of people with dementia (Dementia Report 2007) Good carer support (including peer support) and regular carers breaks enable informal carers to support people in their own homes for longer and reduce the risk of carer breakdown which often leads to "social admissions" to hospital
Opportunity detail	**Service developments** •MDT approach to managing people with dementia – with regular reviews for people with dementia, with referrals to enablement, social care carer support and respite as appropriate •Enablement for people with dementia •Flexible, fluctuating support including crisis response **Case Study** – Enhanced domiciliary care •Flexible and enhanced level of domiciliary care for people with dementia at moments of crisis or strain **Voluntary sector support models** •Volunteer Outreach Service - service using volunteers to help people with dementia stay active and maintain their independence •Dementia Cafes (Alzheimers Society model) •Befriending for people with dementia and their carers •Supporting people with dementia to volunteer
Benefits and size of opportunity	Prevention of admission to hospital savings Prevention/ reduced stay in residential care Improved quality of life for people with dementia and their carers **Case study: Flexible, enhanced domiciliary care model evaluation** •Avoided 46 hospital admissions and 16 placements into residential care •Supported 9 other people who would otherwise either have gone into hospital or into residential care •Avoided at least 25 breakdowns in family care arrangements

Optimising emergency unplanned care

Context & rationale	Hospital admission avoidance for older people is a key area of development for health and social care services. In order to avoid sending people to A&E, GPs need to understand the emergency unplanned care offer. Some services may already exist, but may not be fully utilised. In other areas, comprehensive emergency response services may need to be developed. There are many different models of emergency response including community geriatrician, rapid response services attached to MDT risk stratification teams, falls response services and dementia specific specialist intermediate care offers. Dementia-specific services have been developed to tackle the high numbers of people with dementia in hospitals, the long length of stay and the comparatively poor outcomes for those who are admitted.
Opportunity detail	**Community Geriatrician** Community Geriatrician aligned to GP surgeries and district nurses Co-ordinating step up bed provision and planned use of secondary health care services **Home First Rapid Response** Multi disciplinary teams based around clusters of GP practices. Using risk stratification tool to identify people at risk of hospital admissions Rapid Response service – taking urgent referrals for MDT assessment and support from GPs **Falls Response Service** Social worker(s) accompanies paramedics on call outs to falls 80% reduction in hospital admissions for people who have fallen and have not sustained injuries requiring immediate assistance **Case Study: Specialist Intermediate Care offer** Dementia-specific intermediate care model that includes: domiciliary care, roving night service and assistive technologies that provides an alternative to A&E at moments of crisis or carer breakdown
Benefits and size of opportunity	**Community Geriatrician** This would achieve large direct savings for the acute sector and indirect savings (via avoided costs) for ASC by improving the ability of OP to remain living in their own homes. A pooled budget approach would allow savings to be shared equitably. Models delivered elsewhere show short-term cost neutrality and medium term all-system savings. **Case Study: Specialist Intermediate Care offer** 2 year evaluation •Dementia-specific intermediate care model that includes domiciliary care, roving night service and assistive technologies •25% reduction (57 placements) in funded care home placements over 2year period with potential saving of between £1.5 - £1.7 million •81% of individuals (110 out of 136) provided with a service in 2009 and at risk of residential or nursing home admission were still living in the community on the 1st Feb 2010.

End of Life Care

Context & rationale	The National End of Life Care Strategy (2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations. Two aims were identified: •Promote high quality, person-centred care for all adults at the end of life, across all care settings and health conditions •Support people to live and die well in their preferred place. Most people state a strong preference to die at home rather than in hospital GPs are in an opportune position to make a real difference to a person's last 12 months of life. The care received during this time can have a significant impact on their wellbeing and a long-lasting effect on their loved ones. Social care have a key role to play in supporting people to plan their care and supporting carers
Opportunity Detail	**Training and support for GPs and social care staff** •GP toolkit – how to identify older people at end of life, co-ordinating care, understanding the support available enabling people to die at home •Training for social care staff and care providers (see case study below) **Case study - End of life care training programme for domiciliary care staff** •The Six Steps programme will have two strands, focusing on the organisational change required within the domiciliary care agency and a separate programme for domiciliary care workers •It is hoped the programme will increase collaboration and communication between health and social care providers. **Integrated Care and joint delivery of hospice at home services** •Co-ordinated care delivered by local primary & secondary health, social care and hospices that enables people to die at home **Case study – Rotherham Hospice at Home Service** •Rotherham PCT and Macmillan Cancer Support have developed an integrated hospice at home service to cut hospital admissions •The service includes a Supporting Carers scheme and an equalities link worker •The last year has seen a 500% increase in activity
Benefits and Size of Opportunity	• Reduction in number of people dying in acute settings leading to reduced acute spend • Increase in number of people dying where they choose • Carers supported to plan with and care for person at end of life