Locality Based Integrated Health & Social Care Service

An Operational Framework

Sue Baldwin
Associate Director of Nursing & Adult Clinical Services, Kent Community Health NHS Trust

Anne Tidmarsh
Director of Older People & Physical Disability, Families and Social Care, Kent County Council

James Lampert
Efficiency Team Manager, Families and Social Care, Kent County Council

10th September 2011
V1.0
Unrestricted

Contents

INTRODUCTION 3

AIMS OF THE IH&SC SERVICE 4

KEY FEATURES OF IH&SC SERVICE 4

STRATEGIC FRAMEWORK OPTIONS 5

THE DETAIL OF THE TWO ALTERNATIVE MODELS 6

MODEL A 6
1. SINGLE POINT OF ACCESS 7
2. PRACTICE LINKED MULTIDISCIPLINARY TEAM (PLMDT) 9
3. LOCALITY INTEGRATED HEALTH AND SOCIAL CARE TEAM(S) 11
4.OTHER HEALTHCARE, CARE AND SUPPORT 12
MODEL B 13
1. SINGLE POINT OF ACCESS 13
2. ONE INTEGRATED TEAM WITH STAFF LINKED TO PRACTICES 13
3. OTHER HEALTHCARE, CARE AND SUPPORT 14

OTHER MODELS 14

Appendices

1. Integrated Health & Social Care Models A & B
2. Governance framework for the Health and Social Care Integration Programme

Introduction

The Health and Social Care Integration Programme is a large scale change programme which will bring about improved outcomes for service users / patients.

The experience of care for many patients is fragmented between different parts of the health service and between the NHS and social care or other services.

To improve this, the integration of health and social care is being explored as part of wider changes to both heath and social care. The drivers for this work include the NHS White Paper 'Equity and Excellence: Liberating the NHS', 2010, and support whole system working to 'Benefit health, and to improve overall health gain' (The Operating Plan for the NHS in England 2011/12).

There is a large body of evidence to support this; the recent Kings Fund report 'Transforming our healthcare system: ten priorities for commissioners' (May 2011) recommends the creation of integrated teams to deliver better care co-ordination.

Discussions between KCC and Kent Community Health NHS Trust have resulted in a shared desire to integrate community health and social care to deliver better outcomes to people and deliver more efficient and cost-effective delivery models.

Supported at KCC and PCT director level, the proposal has been shared with lead GPs from the emerging clinical commissioning groups, and received well by most.

Presented to the East Kent Commissioning Strategy Committee in June 2011, the principle of integrating health and social care teams, based around GP practices, was agreed. A similar paper will be presented to the West Kent Commissioning Group in October 2011 for decision. However, informal discussions with West Kent CCG leads have taken place and there is known support for integrated teams.

The overall aim of the change programme is to develop an integrated health and social care service, improving efficiencies and providing more effective support to Kent people. The following objectives underpin this:-

- Enhance health and social care provision to support avoidance of hospital admission and safe early discharge from hospital
- Overcome fragmentation in the delivery of health and social care, providing a co-ordinated experience for patients and carers.
- Address the anticipated growth in demand for health and social care, particularly in view of the ageing population

- Support the principles of personalisation
- Support the delivery of QIPP plans and county council efficiency savings

Aims of the IH&SC Service

- Deliver personalised health and social care support
- Improved service user experience
- Locally focussed
- Improved overall access to services
- Improved productivity and efficiency
- Reduced time –identification of need to delivery of service/support
- Improved personalisation of services
- Simplified decision making processes
- Increased efficiency of assessment process (remove duplication)
- Eliminate hand offs
- Improved outcomes
- Reduced communication failures
- Risk stratification

Key Features of IH&SC Service

- Practice level patient management and co-ordination of health and social care
- Co-located primary, community health and social care staff
- Prevention of crisis
- Critical mass of skill in IH&SC service
- Promotion of independence
- Ability to reduce acute length of stay
- Prevent admission
- Ability to triage through a single gateway
- Training and career opportunities
- Shared caseload with designated key workers
- Shared delegated authority for decision making
- Shared documentation systems
- Improved End of Life care co-ordination
- Shared information systems
- Active profiling of practice level disease registers and development of personalised management plans for patients with long term conditions

Strategic framework options

This paper presents two alternative strategic models that can be used as a framework to support the development of locality based integrated community health and social care.

Model A is an evolution of the one previously discussed in a number of forums including meetings with CCG leads, PCT and KCC commissioners, KCC and KCHT Directors, managers and KCC Members. The components of this model are:

1. Single Point(s) of Access
2. Practice Linked Multidisciplinary Team
3. Locality based integrated health and social care team
4. Access to other healthcare, access to care and support provision.

Model B describes

1. Single Point(s) of Access
2. One integrated team with staff linked to practices
3. Access to other healthcare, care and support.

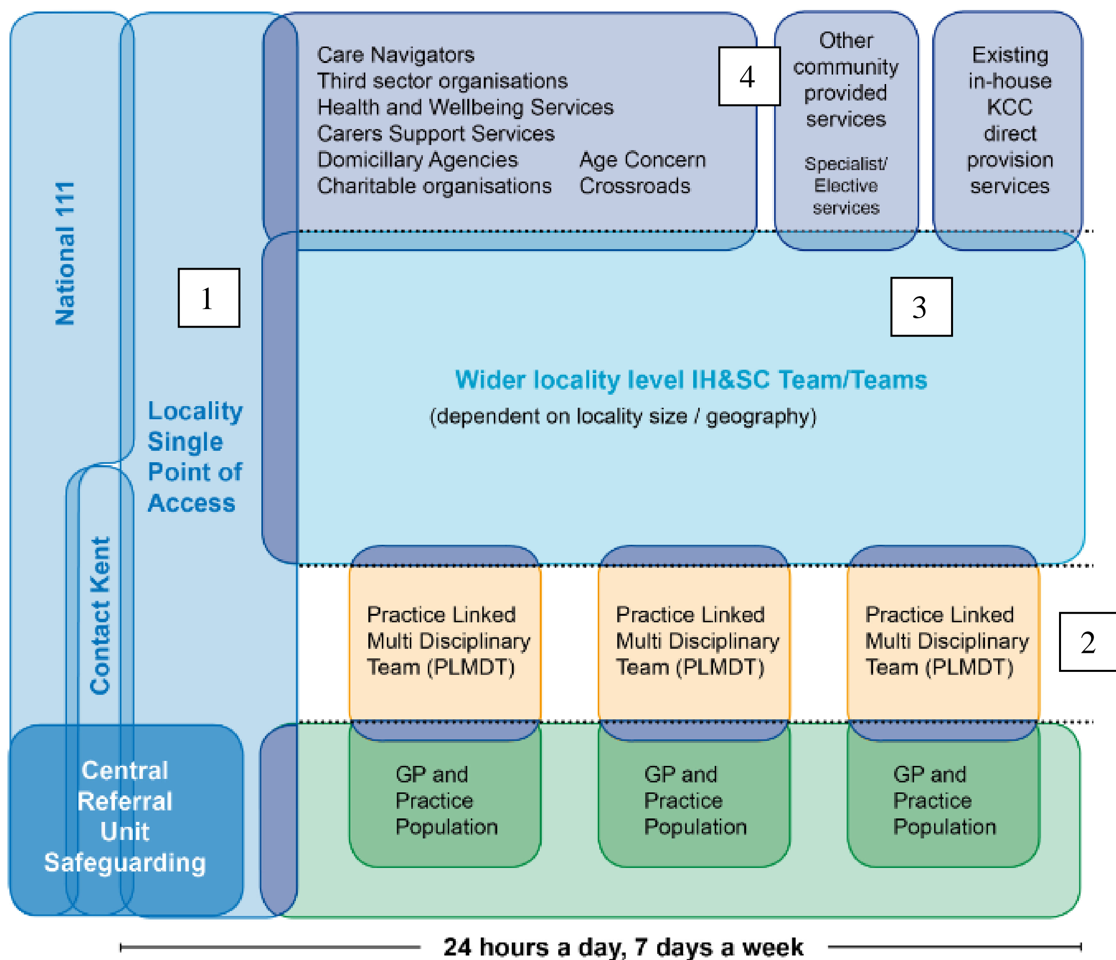
	Model A	**Model B**
Similarities	Single Point of Access Other healthcare, care and support provision Supports the delivery of personalised care and support Includes dementia pathway management within the service	
Differences	• Team(s) focussed on long term condition management based around a practice or group of practices • AND Team(s) with focus on short-term involvement, rapid response, intermediate care and enablement	• All health and social care staff are based in one integrated team (s), dependent on locality size, but with linked workers to a practice or group of practices. • No separate long term condition team.

The detail of the two alternative models

Model A

There are 4 components, or building blocks, to Model A. Each are described in detail in this paper.

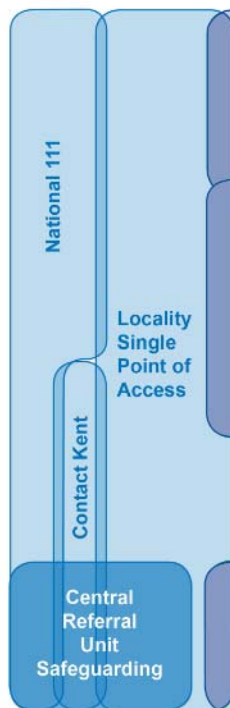
1 Single Point of Access: National / County / Locality (SPA)
2 Practice Linked Multidisciplinary Team (PLMDT)
3 Locality Integrated Health and Social Care Team
4 Other healthcare, care and support provision



1. Single Point of Access

A single point of access model based on a three tier approach is recommended:

a. National – via 111
b. County – via KCC's Contact Kent service
c. Locality – via an integrated locality based Single Point of Access service



National

The anticipated 111 number will provide access to those individuals requiring direct access to health or social care at a national level, with the "directory of services" being used by the provider of 111 to divert people to the right local health and/or social care service.

County

The need to have a countywide single number is recognised for people wanting to self refer into the new integrated health and social care teams or who simply require information, advice and guidance. This single number service is already provided by KCC's Contact Kent service (incorporating the Kent Contact and Assessment Service (KCAS)).

It is anticipated that Contact Kent / KCAS would be used for the purpose of providing health and social care information by telephone. Access will also be available through online and walk-in Gateway channels.

Where a contact assessment is indicated, enquiries would be passed to the locality single point of access (see below).

The Central Referral Unit (CRU), for safeguarding, is also recognised within this model. This new unit, for adults, will include personnel from the police, social care and health. It is anticipated that a CRU service for adults will be up and running as soon as possible after January 2012. The detail of how this service will operate still needs to be determined, but it is expected that any call being dealt with by 111, Contact Kent or the locality Single Point of Access would be transferred to the CRU if it becomes apparent during the conversation that there is a safeguarding issue.

Locality

A locality level single point of access (LSPA) will be established for health and social care referrals for ease of access to a guaranteed response by the integrated health and social care services.

For self referrals, where enquiries cannot be resolved by Contact Kent, they would be transferred into LSPA where competent staff, trained to cover health and social care enquiries, will be able to commence a contact assessment and determine the first response, which may be:

- direct provision of equipment
- a rapid response or reablement service
- a non-urgent face to face assessment or nursing / therapeutic intervention

The LSPA will be able to be directly accessed by GPs if they wish to. The LSPA could also be used as a “back-up” point of contact if a GP is unable to make contact with the link person within the practice linked MDT.

The single point will be critical to services like South East Coast Ambulance (SECAMB) for appropriate admission avoidance referrals. To receive these referrals, the integrated service must be able to respond rapidly to ensure that SEC ambulance can be confident that they can leave the patient and that the IH&SCS staff member will be in attendance within a given time frame.

2. Practice Linked Multidisciplinary Team (PLMDT)

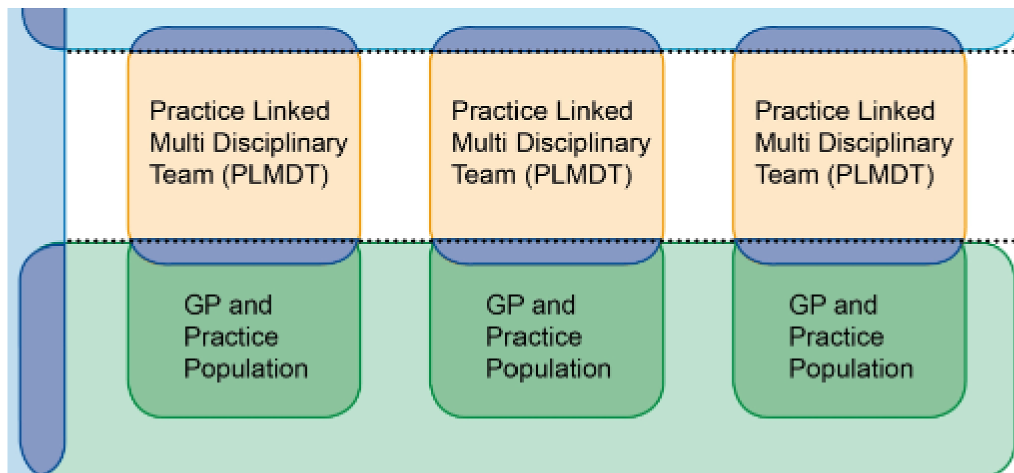
Given that patients residing in the community are the responsibility of general practitioners and their journey, most often, begins and ends in the community, a critical element of the IH&SCS is the practice linked multidisciplinary team that is allied to each GP practice.

These teams will focus on Long Term Condition management.

The PLMDT may cover more than one practice in the locality (dependant on available resources and the requirements of GP practices) but the delivery of the co-ordinated care will be the same for each practice (as per agreed standards).

The PLMDT will comprise of :

- social care case management
- community nursing (matrons, specialist nurses, primary care nursing)
- older people's mental health practitioner(s)
- occupational therapists



The role of the PLMDT

The MDT will be responsible for case management of the practice population that require health and social care ensuring that the patient receives all interventions that are required, no matter what that input / support is, and those with long term needs are case managed on an ongoing basis to ensure continuity of provision that is tailored to their needs and delivered in the most personalised, effective and cost efficient way. This can be achieved through the use of a number of technologies for example telehealth, where it is

appropriate to do so, telecare to promote independence and safety in appropriate patient groups.

The MDT will also be able to ensure cross referencing of caseloads, health and social care reducing and eliminating duplication. This can be done in conjunction with practices. The use of a predictive tool to identify patients at high risk of admission and subsequent use of health and social care resources through the use of SPOKE. This is an IT system, currently owned by KCHT.

Patients from each practice population with long term conditions, identified from disease registers, will be reviewed, assessed and appropriate proactive management of self and supportive care implementation via an individual personalised management plan. Integrated personal budgets (i.e. the joining up of social care personal budgets and personal health budgets) will be used to ensure the best clinical and social care outcomes for patients and added value for money for commissioners. Where patients / service users do not require integrated support, the use personal budgets and personal health budgets will be the norm.

The PLMDT will be accountable for delivery to the practice and practice population.

A critical element of the MDT is the communication and relationship with the GPs and wider primary care team that they serve. This will be by the most effective means and will include access to space in practices where the MDT can 'hot desk ' and have regular (daily if necessary) contact with GPs and other members of the primary care team.

Use and input into the GP IT system to ensure that all patient updates and information is available to ensure that GPs are aware of any input of services to the patients and their ongoing health and social care status is up to date.

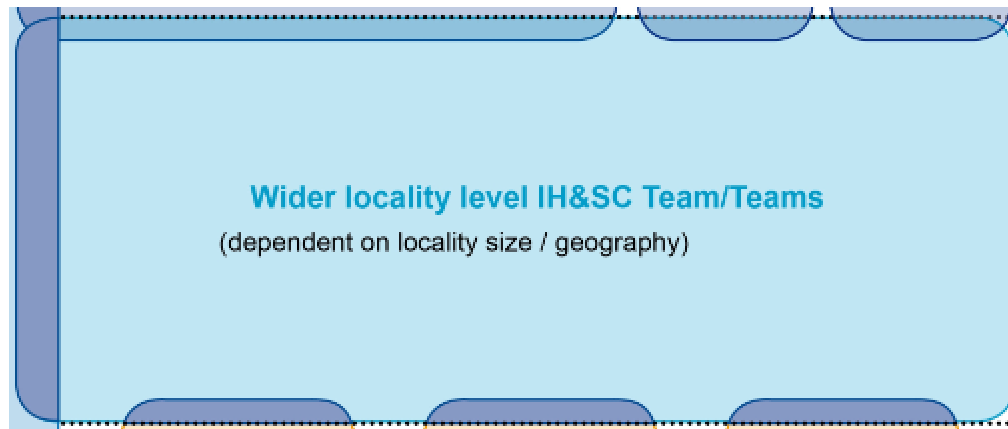
There will be a focus on improving the care, support and management of patients with dementia, end of life care (linking to the Pilgrims Hospice pilot model) and long term conditions through early intervention, optimisation, promotion of self care and ensuring preferred place of care.

The team will deliver:

- Case management of long term conditions (including dementia)
- Case management of end of life
- Support to care homes
- Predictive modelling of practice populations via disease registers for peatients with long term conditions
- Management of cases through the effective use of teletechnology

3. Locality Integrated Health and Social Care Team(s)

Behind the Practice Linked MDT will sit a fully integrated locality service, which will support the work of the PLMDT and also those patients and service users who require short term health and/or social care support or treatment.



It will comprise of:

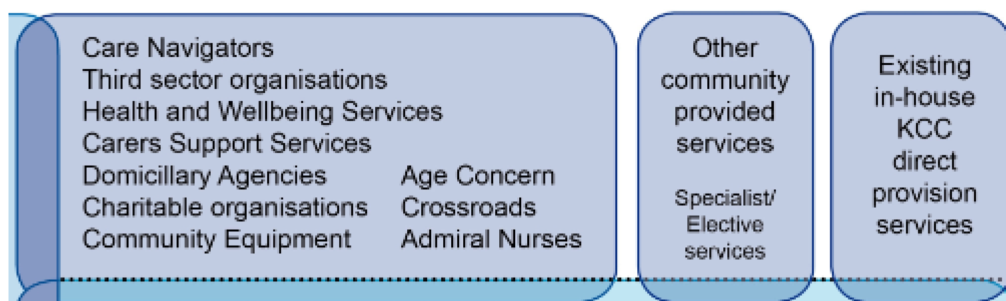
- Adult social care – registered staff (OTs, social workers and nurses)
- Adult social care – unregistered staff
- Rapid response nurses / rehabilitation nurses
- Occupational therapists
- Physiotherapists
- Enablement and intermediate care support workers
- Speech and language therapists
- Dietetics
- Mental Health nurses

The Practice Linked MDTs and locality health and social care team will both deliver:

- Ambulatory care pathways
- Clinic services (non housebound patients requiring nursing care and those requiring social care assessments)
- Promotion of self care - health and wellbeing
- Admissions avoidance – step up facilities and intensive home care support
- Re-admissions avoidance
- Telecare response services

4.Other healthcare, care and support

A range of other services, both statutory and non-statutory, will be utilised to ensure that all service user / patient and carer needs are met. Patients / service users will be supported to use integrated personal budgets, personal budgets and personal health budgets to ensure that they are able to access the right kind of personalised care and support.

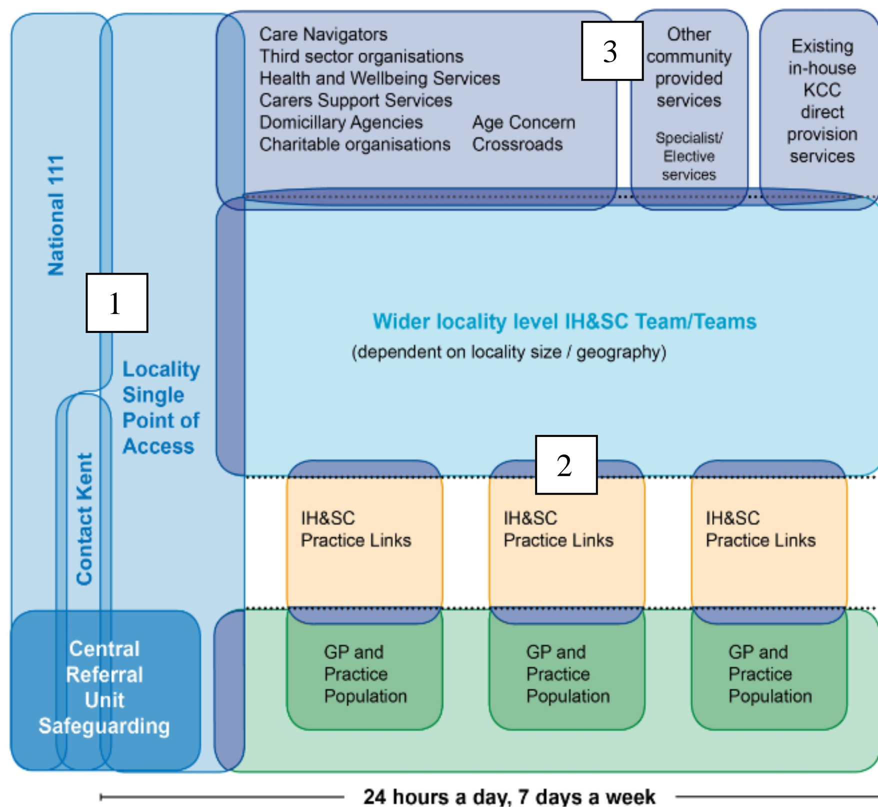


Examples of KCC direct provision services include services provided in integrated care centres. KCC currently has a programme of work in place to review in-house provision to question whether the service is still needed and if it is, to determine who should provide it?

Model B

There are 3 components, or building blocks, to Model B.

1 Single Point of Access
2 One integrated team with staff linked to practices
3 Access to other healthcare, care and support



1. Single Point of Access

Same as Model A above

2. One integrated team with staff linked to practices

Model B proposes the creation of an integrated health and social care team. There may be one, or a number of these teams within a locality, depending on the optimum unit size of the team for management and population / demand purposes.

It will comprise of:

- Adult social care – registered staff (OTs, social workers and nurses)
- Adult social care – unregistered staff
- community nursing, including long terms condition management, (matrons, specialist nurses, primary care nursing)
- Occupational therapists
- Physiotherapists
- Enablement and intermediate care support workers
- Speech and language therapists
- Dietetics
- Mental Health nurses
- older people's mental health practitioner(s)

All these staff would be based within the same team, but have named linked workers who form a "virtual" team and make the connections with GP practices. Depending on practice size, this would be a single large practice, or cluster of smaller practices.

3. Other healthcare, care and support

Same as Model A above

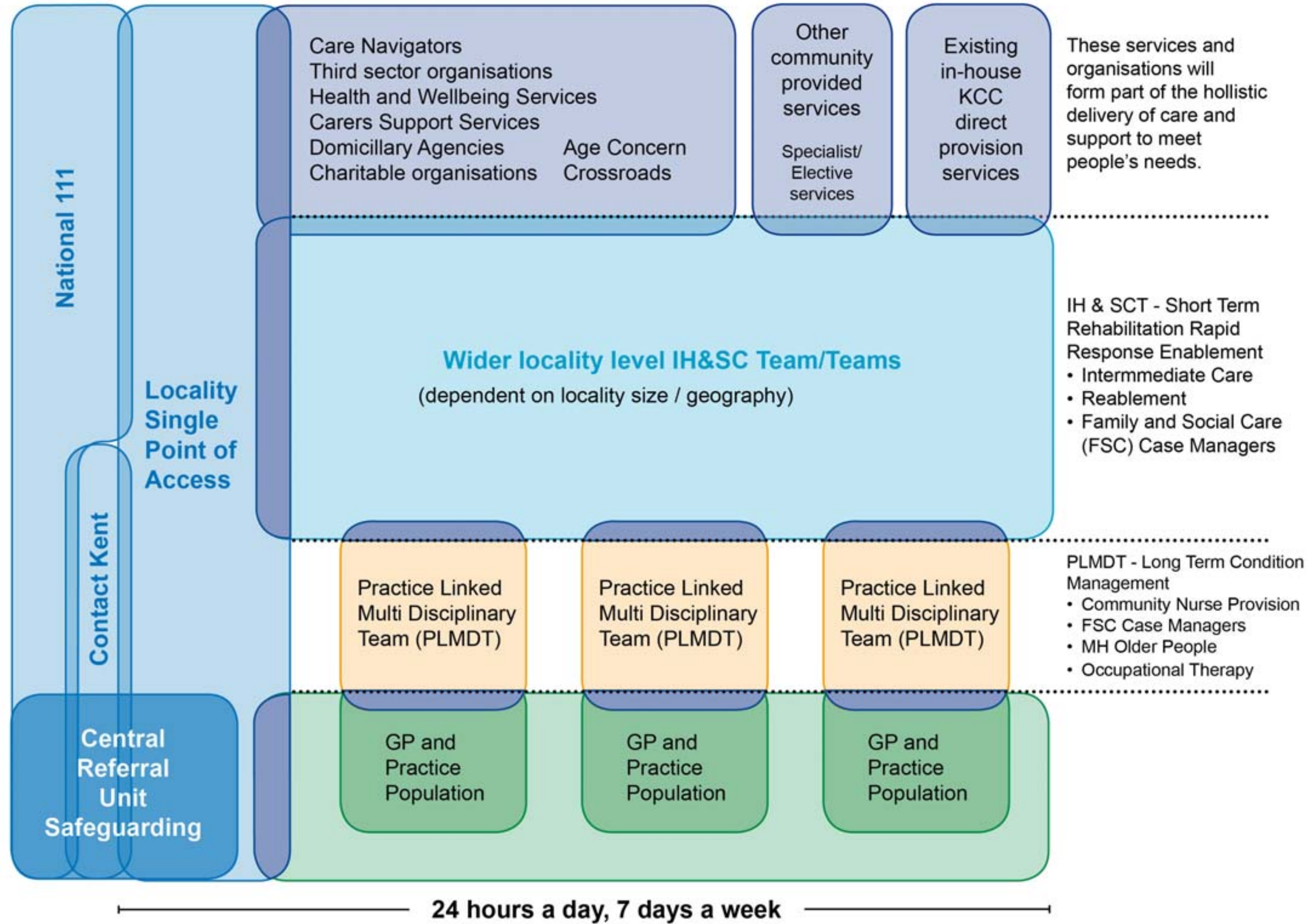
Other models

The authors of this paper recognise that alternative models may emerge.

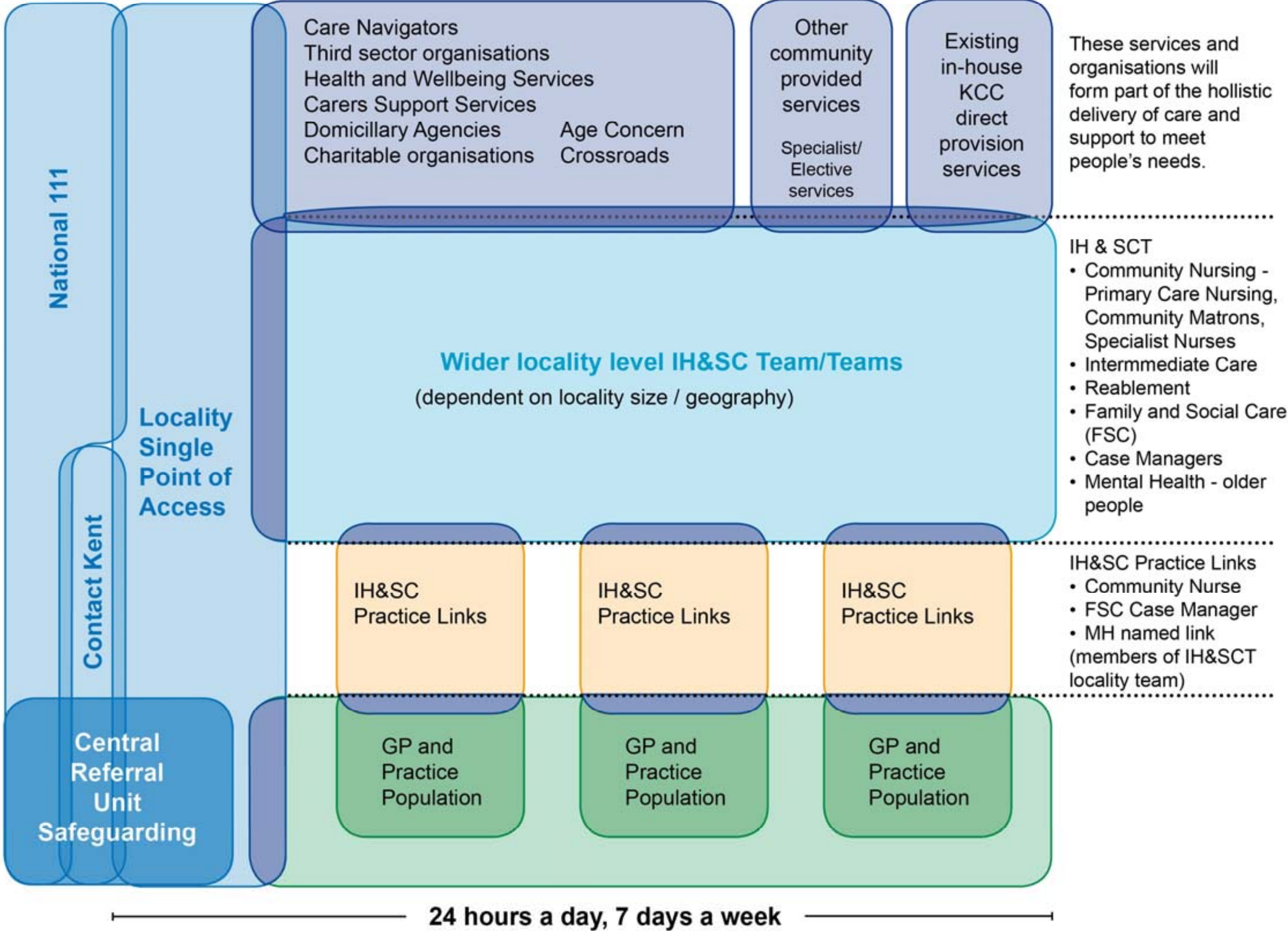
One CCG has proposed that it would like to explore the possibility of a model based on:

- 10 nursing and social care teams, incorporating named individuals as the "single point of access". Teams to include all nursing staff from existing primary care nursing, community matrons and intermediate care nurses.
- A locality based team of therapists (OT, physiotherapists, dietician, Speech and Language therapists)

Model A



Model B



Appendix 2