Integrated Care in Bury & Beyond- the story so far…

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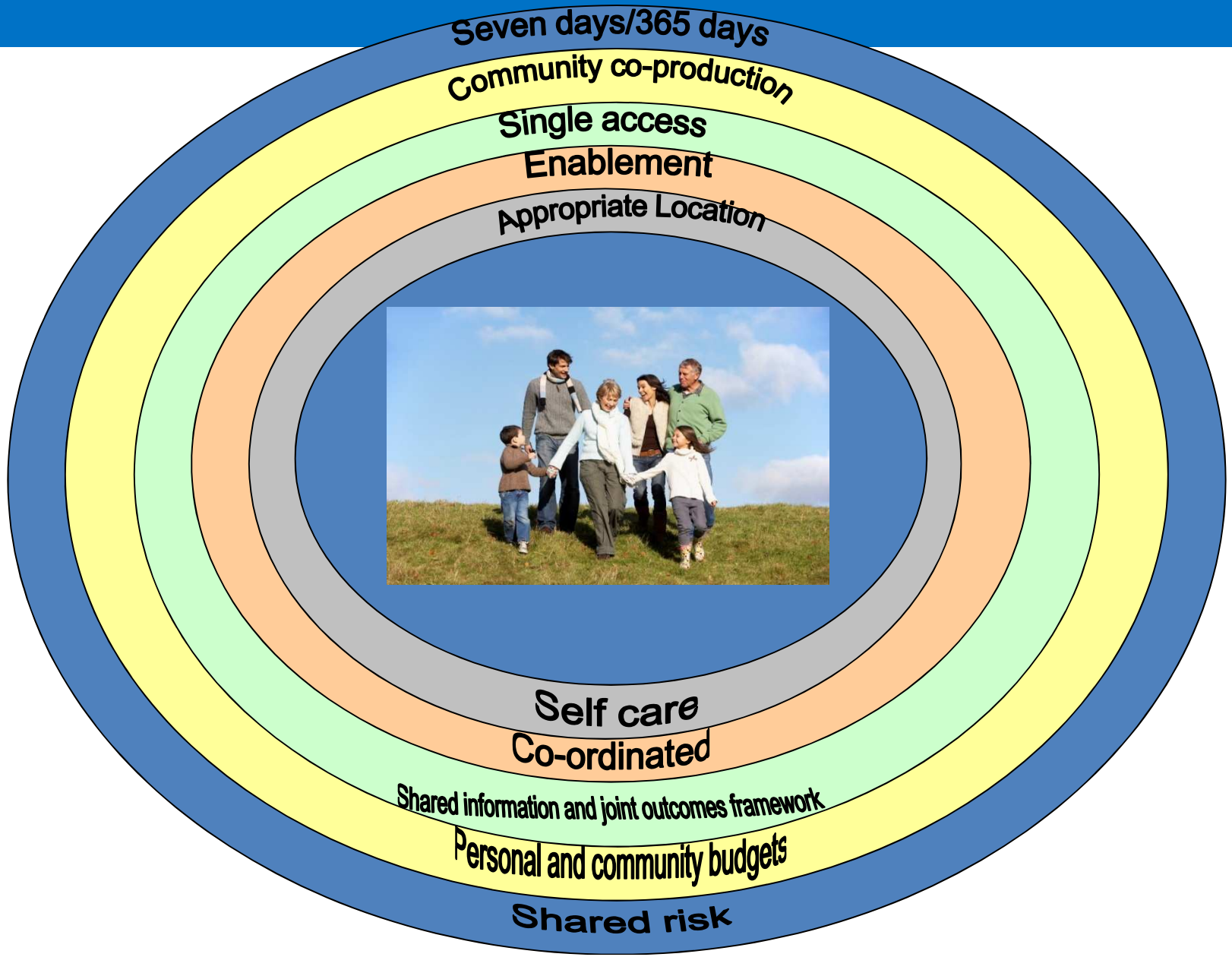
Delivery Plan

Aim

Integrated Care in Bury aims to: –

- Ensure people take responsibility for their own health & wellbeing through self care, ownership & accountability of their lifestyles
- Provision of information and access to advice to help people understand what's available in the community to facilitate them taking ownership & accountability for their life styles
- Where someone requires support; the support will involve the person's/ family's natural circle of support and maximise the use of the community assets
- Integration will help facilitate this approach by providing, by the right workforce in localities, in the right place at the right time

Shared Vision & Commitments



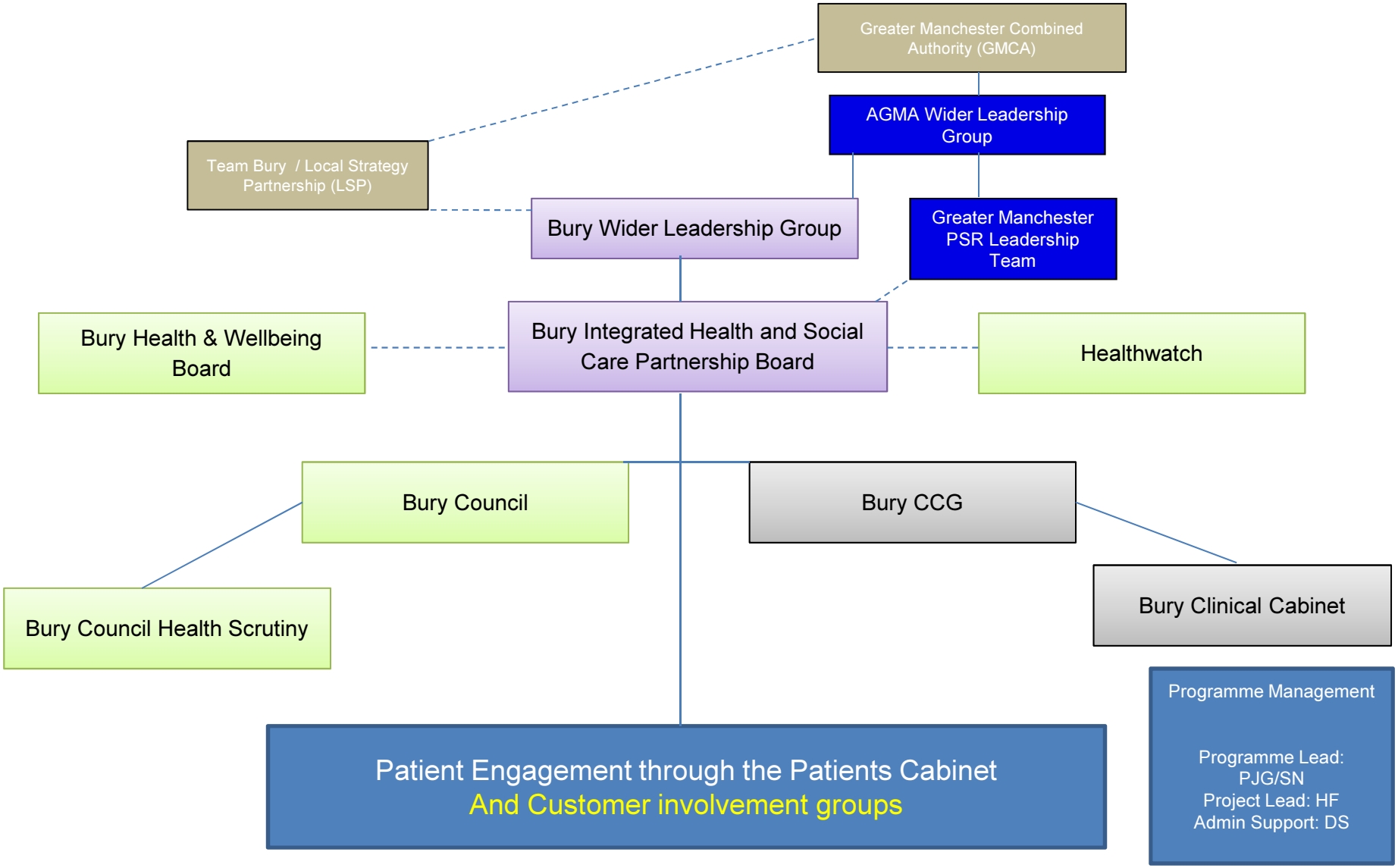
Shared Design Principles

Partners being involved…

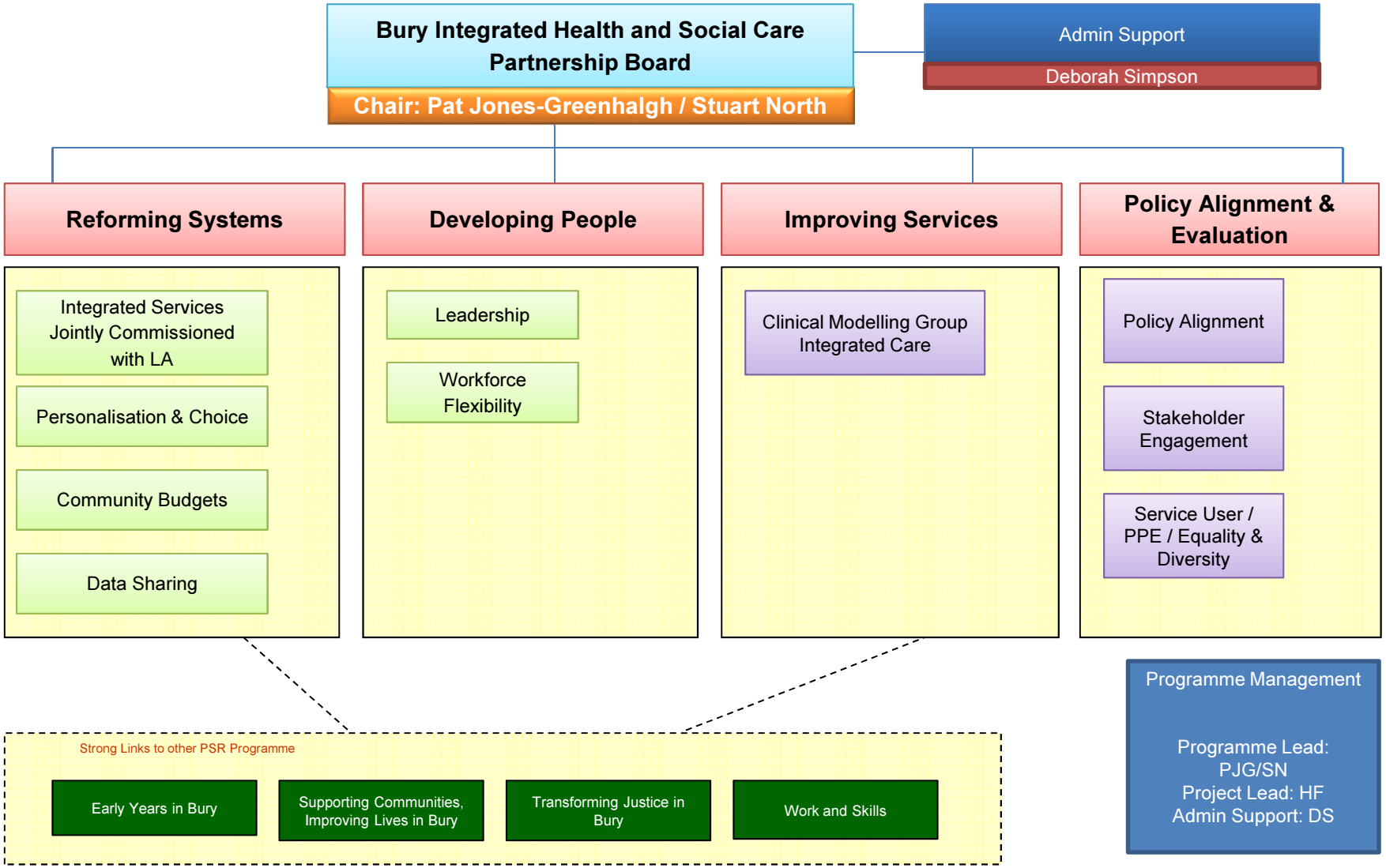
- Bury Clinical Commissioning Group (CCG) and member Practices
- Bury Council
- Pennine Care NHS Foundation Trust
- Pennine Acute Hospital NHS Trust
- GP Federation
- GP Out of Hours
- Third Sector Development Agency

Governance

Governance Arrangements



Programme Structure: Domains & Projects



The Concept Model

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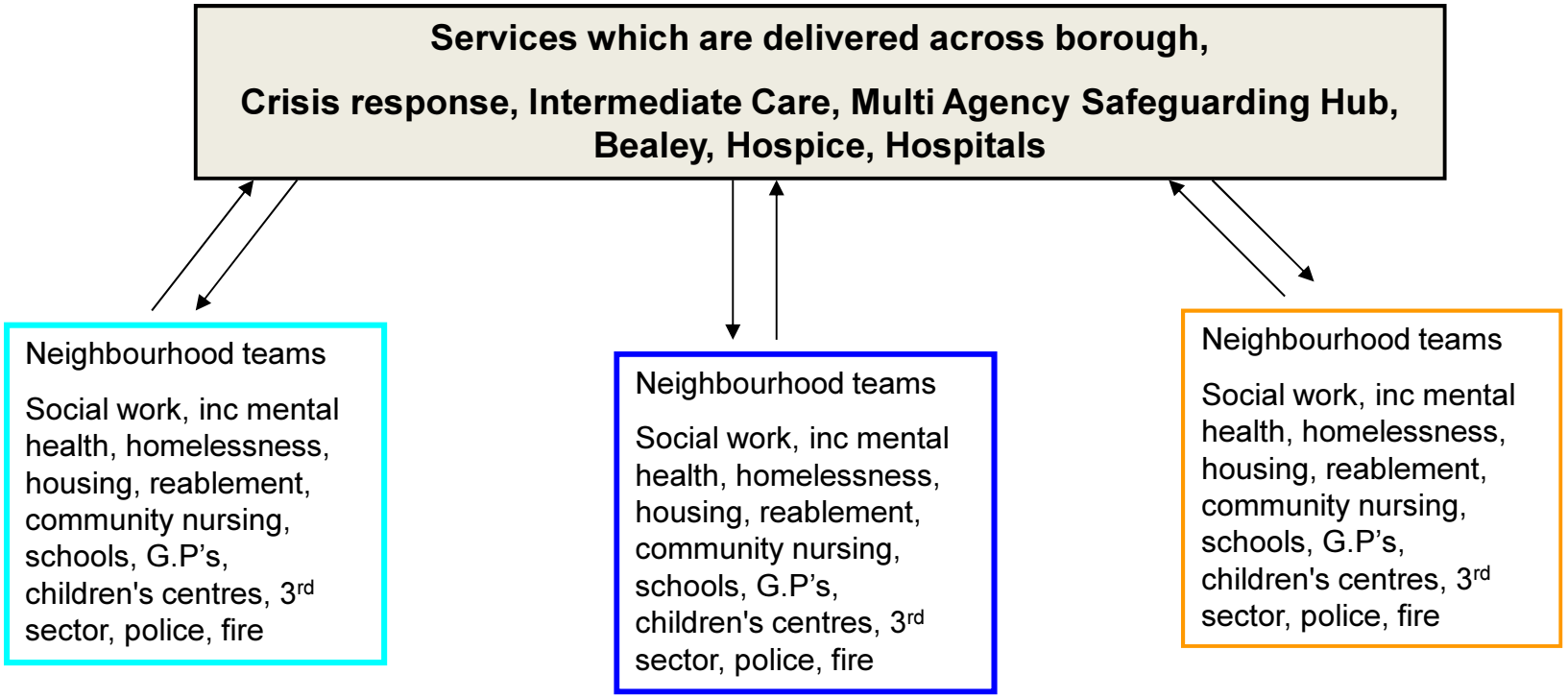


There is in reach from community to keep people in their own homes , more of a focus of step up

Enable primary care to reach its potential, maximise the potential of primary community services

8am -10pm primary care, redesign intermediate care, care home LES, acute services in community

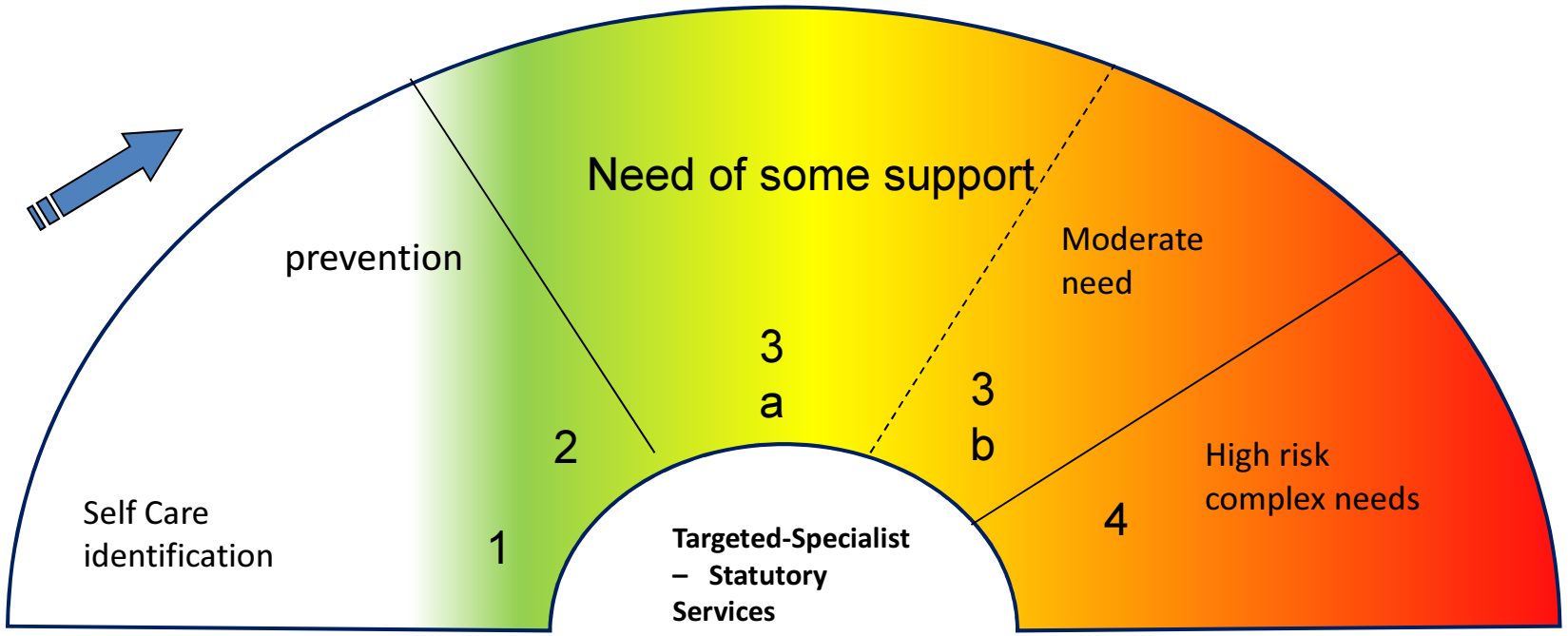
The Concept Model

- Individuals receive care and support from a range of agencies including;
  - Primary Care
  - Secondary Care
  - Community Services
  - Social Care
  - Third Sector
  - Department of Works & Pensions (DWP)
  - Hospice
  - Mental Health
  - Housing
  - Education
- Clinicians are supported by integrated IT and shared records

The Concept Model

June	July	Aug	Sept	Oct	Nov
Each locality team will include groups of GP practices & hold a register	Map the need of the population against continuum of need in each locality	Shared care protocols are agreed between all members of the MDT, including End of Life care, co-morbidity & dementia care	Sign off final proposals with all partners	An integrated person centred plan is agreed with each individual. The content varies according to risk and need, but includes focus on primary & secondary prevention. All individuals are re-assessed though the frequency is determined by their level of need.	
The team stratify the register by risk of hospital emergency admission (and readmission) and admission to care homes. Screening tools are used to identify risk factors.	Continue work on finance models	A small number of individuals with the most complex needs will be discussed at a multi-disciplinary case conference, to help plan and co-ordinate their care. Individals are assigned a key worker to support their needs.		The use of technology is maximised to promote self care and independence Contract negotiations start Oct through March	

Continuum of Need



Progress / plans for enablers of integrated care

Enabling Work stream

Integrated Services Jointly Commissioned with LA	• Jointly agreed local Outcomes Framework which includes expected shift in activity into Primary / Social / Community services. • Jointly define local pathway to integration

Move to Community Budgets for selected areas	• Pilot work
	  • Falls
	  • Complex Care

Personalisation	• Deliver against the personalisation agenda including:
	  • Continue roll out of Social Care Personal Budgets
	  • Pilot CHC health budgets and assess further areas

Enabling Work stream

Remove barriers to data sharing

- Data sharing, particularly between health commissioners and local authority commissioners, is particularly challenging but a necessary prerequisite of integrated work. Local work is being led through Team Bury to define solutions to this.

Workforce flexibility

- There is a need for much greater flexibility in the development and deployment of the staff across the boundaries of the NHS and local government. We flexibility of staff to work differently if we are to deliver the integration required and reduce duplication. Employment across boundaries will have to be the norm. Good Practice include Crisis Response and BUTC.

Achievements to date

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- Crisis Response Services for Adults
- Integrated Health and Social Care Discharge Team
- Pilot integrated care team ‘Radcliffe’ with wider roll out into another sector within the next two months
- Supporting Communities Improving Lives
- Children's Trust Board
- Partnership Boards
- Complex care arrangements

Achievements to date

- Councils effective quality assurance processes can be built on
- Existing links between CCG, Council and some Providers are strong
- Mental health teams
- Substance misuse
- Bury Urgent Care Treatment Centre
- Adults & Children's Safeguarding Boards
- Public Health integration into Council

Wicked Issues

Wicked issues

- Integrated records, integration of systems
- Quality assurance built into the design processes
- Ability to maintain stable Acute services whilst investment in community services
- Changing the various cultures of a number of partners and professionals into one
- Setting performance targets that measure what matters to the community rather than national targets

Wicked issues

- Changing national picture/ political environment
- People's expectations increasing, need to change public attitude to take ownership of their own health and wellbeing
- Overlap and interdependencies of Healthier Together, Primary Care and Integrated Teams
- Current contracting arrangements make it difficult to breakdown spend
- Registered v Resident

What difference will it make?

Mrs Peel is confused……(a theoretical scenario!)

- Mrs Peel, 83 years old, lives alone in a 4 bedroom house
- She has no immediate family, but attentive good neighbours
- Recently she has been noticed to be forgetful and wandering.
- You get a phone-call, Friday, at 5:30 pm to say that she is very confused…
- You visit on the way home…

Mrs Peel is confused……(a theoretical scenario!)

- Patient is dishevelled and not dressed. Looks thin
- Confused in time and date. Short term memory poor, but long-term intact
- Clinically you think she has a chest infection. No dehydration but is very confused and clearly can’t cope on her own…

2003

- Needs admission for infection and ‘social care’ …
- Neighbour persuades her to go. She arrives A & E alone, in an ambulance
- Admitted – gets antibiotics and a drip. Becomes increasingly confused, bed sore… Social Worker does an assessment, ‘patient can’t really cope on her own’
- Prolonged admission for ‘social reasons’, and then discharged to a residential bed. No diagnosis of mental health issues – due to age and infection...

2013

- Doctor does a capacity assessment and makes a clinical decision based on the patients best interests
- Crisis response are unwilling to take as very confused. Lady seen as acutely unwell
- Reablement not able to support as they are full to capacity
- Admitted alone via Ambulance / MAU to hospital. Gets antibiotics and a drip
- RAID does an assessment within 48 hours, patient discharged home, after appropriate investigations, with reablement support. Referred to Memory Assessment Services by Raid…
- GP received discharge letter ‘chest infection’ – no mention of mental health problems, investigations or social care

2016

- Mrs Peel already known to team, on housing register for six months due to move to extra care scheme about to open in her locality. Four bedroom house will become available for family who are overcrowded.
- The tele health equipment that Mrs Peel has triggers to the locality team that her BP has increased above the threshold, and the locality team are informed.
- They contact Mrs Peel via Skype and it is clear she is disorientated.
- Support worker visits and takes bloods, ECG starts IV antibiotics.
- Age UK worker from the team to provide oversight for 72 hours.
- Mrs Peel given information about the importance hydration, and joins the active health group which meets in the park every Tuesday.

2016

- Her patient held record is updated, this is a web access portal which Mrs Peel also has access.
- Mrs Peel has no need for ongoing statutory services.
- The neighbours will continue to meet with her when she moves because she is moving within her locality.
- Mrs Peel has asked the local 3rd sector provider who support young people to gain education and employment for assistance in moving. She makes a donation to the charity.

2016 continued…

- They are only to willing to get involved as this provides an opportunity to help young people confidence , motivation and organisational skills.
- Mrs Peel used to be a regular visitor to at A&E, which she describes as really unsettling. She has not been there for two years, she says;

  “ *That place is for sick people, I have all I need here, I feel safe in my home and I have good neighbours and I am in control of my life, I decide what happens to me.*”