ASC Scrutiny Commission
12th December 2017

Integrated Models of Care

What is integration?

- Essentially joined up working
- Range of ways to help this happen:
  - Collaboration
  - Joint strategies and plans
  - Commissioning
  - Structural change
- In Leicester we focus on a **joined up experience** for people who use health and care services

Drivers for Integration

Legislation	• Health and Social Care Act 2012 • Care Act 2014
National Policy	• NHS Five Year Forward View • Better Care Fund
Population pressures	• Ageing population, rising health needs • Over-use of emergency and urgent care
Local Strategy	• Leicester City Better Care Fund Plan • LLR Sustainability and Transformation Plan

Local Integration Projects

Home First
- Integrated Discharge
- Integrated community responses

Managing Complex Need
- Integrated Locality Teams

Contacting Health and Care Services
- Integrated Points of Access

Integrated Discharge

- Collaborative approach – councils and acute / community health staff
- Colocation within LRI
- Testing models on key wards around timely discharges
- Live since July2017 – early days

Better care together | Integrated Discharge Team

What does IDT aim to do?

- Share information and integrate skills and processes
- Attend board rounds, supporting ward staff where required in planning straightforward discharges and identifying patients who need the involvement of the integrated team
- Help drive dates for discharge and improve the number of people achieving this
- Increase the number of people returning to their usual place of residence rather than having to be discharged into a 24 hour care setting
- Ensure peoples' independence is promoted throughout their stay and discharge journey from hospital
- Reduce delays – including formal discharge delays (DTOC)

What is working well?

- Closer working between City and County ASC
- Improved processes to avoid delays
- Building relationships with clinical ward staff
- Understanding barriers to timely discharge
- Improved access to IT / information due to honorary NHS contracts
- Better communication

What are the challenges?

- Early days and some way from the aims as yet
- Limited engagement / commitment in some areas
- Trusted assessment progress
- Impact of new approach on capacity
- Joining up systems inc IT
- Making a significant culture shift

Mr D

- County IDT worker attended board round – alerted City to proposed discharge
- City attend board round on Saturday – concerns identified re fitness for discharge and health needs not fully identified
- IDT approach used to review and challenge ward decision
- Formal discharge notification received 9 days after work commenced however -
- Planning already well underway because of IDT input to wards
- Successful and timely transfer to a care setting with appropriate NHS funding

Integrated Community Response

- Collaborative approach – City ASC, community health staff, commissioners (CCG / Council)
- Co-location within Neville Centre
- Range of rapid responses to unplanned health and care concerns
- Focus on Home First

What is available?

- 24/7 response within 2 hours to crisis care – "Integrated Crisis Response Service"
- Rapid access to reablement / rehabilitation
- For people at home or in hospital
- Home or bed based care
- Social care, nursing care, therapy input, equipment & technology, handypersons

What is working well?

- Established services through BCF
- Well integrated pathway
- Excellent outcomes – people staying at home
- Improved falls pathway
- Holistic reviews not treatment of symptoms
- Multi-professional trust
- National recognition of model and impact

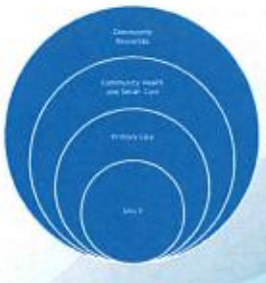
What are the challenges?

- Moving to a more integrated service (to build on the pathway)
- Using the right skills in the system
- Consolidation through a commissioning approach
- Filling gaps in diagnostic and medical cover

Mr & Mrs S

- Mr S caring for his wife – end of life
- Struggling to cope – DN visits and calls in ICRS
- ICRS attend and;
- Provide care
- Resolve equipment / bed
- Give carer support / relief
- Facilitate Mrs S to stay at home until EoL
- Leave Mr S with a more positive experience to remember

Integrated Locality Teams



- Based around GP populations
- Collaborative approach
- Supported by specialists and the voluntary and community sector
- Focus on high risk population
- Aiming to reduce crisis, support self care and condition / independence management
- Outcomes sought are to improve health and well being, increase our citizens, clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

What is working well?

- Multi-disciplinary meetings
- Good outcomes for complex cases
- Building trust and relationships
- Sharing the same footprint
- Starting to make links to wider community support
- Linking with other projects

What are the challenges?

- Consistent engagement
- Capacity – time, location
- Administrative burden
- Making best use of IT systems
- Information governance
- Co-location ambitions
- Moving beyond the priority cohort to business as usual

Mr R

- Living at home with wife, multiple health problems, carer strain, Mr R feels he is a burden
- Brought by GP to MDT discussion
- Review of care – extra support offer / family input
- Surgery –further post-op review
- OT intervention due to stair risk
- Carer assessment – no services needed but valued discussion
- Mr R / wife report feeling supported by local team
- Mr R less depressed / more able to manage his health conditions

Integrated Points of Access

- Leicestershire BCF ambition
- To deliver a single access route for everyone
- Business case → Gateway Challenge → New business case
- But money, function and form, IT = challenge
- LCC has stepped back for now
- Position to be reviewed if a IPOA is developed by others