Derby City Council

ADULTS AND PUBLIC HEALTH O&S BOARD
10 November 2014

ITEM 7

Joint report of the Strategic Director of Adults, Health and Housing and the Chief Officer of Southern Derbyshire Clinical Commissioning Group

Whole system transformation of health and adult social care

SUMMARY

1.1 Health and social care services are facing unprecedented pressures: a combination of a tight fiscal squeeze alongside demographic pressures, advancements in medical science and citizens' expectations for services. The pressures for change are coming from every direction: the short term crisis in Accident and Emergency, the long-term need to move more care out of hospitals, the need to improve access to GPs while reducing their workload, the tightening economics of general practice and the need to improve clinical quality and the relentless squeeze on local authority budgets – altogether make a "perfect storm".

1.2 The size of the financial challenge to the NHS in Southern Derbyshire is **£25m-£30m per year for the next five years**. Adult social care is facing an underlying budget pressure of **£5m** (which is due to be addressed through the Council's medium term Financial Plan) with an annual demographic pressures in the region of £1+m per year and further anticipated pressures due to the introduction of the funding reforms contained in the Care Act. The system, as it is currently configured, is **unsustainable.**

1.3 Derby City Health and Wellbeing Board has agreed a draft vision for the future of services in Southern Derbyshire. This was set out in the Better Care Fund submission and has been endorsed by the Southern Derbyshire Leadership Group (which includes commissioners and providers working within the Southern Derbyshire geography).

1.4 Although originally focussed on meeting the needs of the frail and elderly population, it is now intended to cover all aspects of care, including health and social care, physical and mental health, adult and children's services, and planned and unplanned care. The articulation of our strategy for organising the delivery of services to achieve the vision is summarised via the 'care wedge' diagram (See section 4.3).

1.5 There has been significant progress in moving towards implementing the ideas articulated through the "wedge". However, it has also become clear that there is a pressing need to reach agreement on the future focus and structure of community-based services. Developing community-based services is crucial to delivering the strategic aims of health and social care and will also help define the future role of both secondary care and general practice.

1.6 The Better Care Fund provides for £17.403m worth of funding in 2015/16 to be spent

locally on health and care to drive closer integration and improve outcomes for citizens. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer. At a local level this translates to a total of £17.403m for 2015/16 and an additional £1.153m for 2014/15. The process of drawing up a plan to spend the Better Care Fund resources has helped develop commissioners' thinking and we realise what we need is a five year integrated business plan that looks at the totality of health and social care spend with a view to drawing up a strategic plan that can bring the system into financial balance whilst meeting people's health and social care needs at an acceptable standard.

RECOMMENDATION

2.1 To note the size of the financial challenge facing health and social care services.

2.2 To note and comment on the high level strategic plan for change.

REASONS FOR RECOMMENDATION

3.1 Health and social care services will have to change if they are to be fit for purpose in the 21st century. This means changing familiar models of service that have strong public support. It is important the elected Members understand both the size of the challenge and what may be done to transform services appropriately.

3.2 Members can be strong advocates of change and champion the agreed local strategy with local residents in order to promote understanding and provide reassurance.

SUPPORTING INFORMATION

4.1 **Vision for future services**

The Derby City Health & Wellbeing Board have agreed to work towards services that meet the "National Voices"[1] vision and definition of integrated care which is that:-

"My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes"

Our strategic aim to support people to have the best quality of life, within the constraints of their personal circumstances, is at the core of our health and social care system.

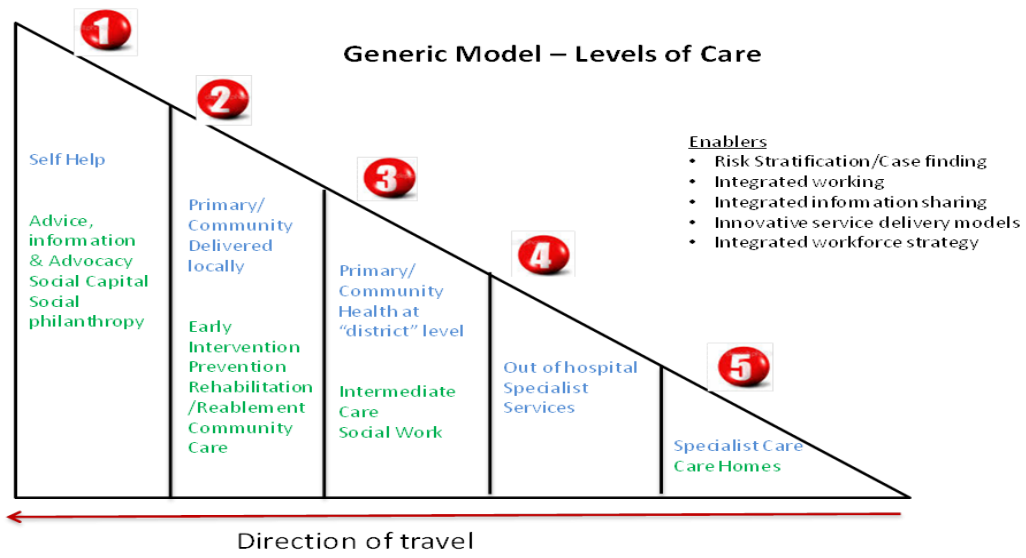
[1] [National Voices – Reference]

This model is underpinned by the following guiding principles where care must:-

- Be organised around the needs of individuals (person-centred)
- Focus always on the goal of benefiting the service user
- Be evaluated by its outcomes, especially those which service users themselves report
- Include community and voluntary sector contributions
- Be fully inclusive of all communities in the locality
- Be designed together with the users of services and their carers
- Deliver a new deal for people with Long Term Conditions (including Mental Health)
- Respond to carers as well as the people they are caring for
- Be driven forward by commissioners
- Be encouraged through incentives in the right place
- Aim to achieve public and social value, not just to save money
- Last over time and allow for innovation

4.2 We have created a simple diagram to explain the strategic shift we want to engineer and refer to it as the "Care Wedge". We are using this with citizens, staff and stakeholders to explain what we intend to achieve. Over the next five years our aspiration is that, as much as possible, people find the support they need in their community and as close to home as possible (at the left hand side of the wedge). To enable this we will need to change the financial pattern of current investment by moving services and resources closer to the individual, away from institutional forms of care and into the community.

4.3



4.4 This is intended to achieve the following outcomes:

1. More people avoiding formal care and support because they have their needs met through natural community support
2. More people able to remain living in their own home for longer, in greater control of their health and well-being
3. An improved experience of using community-based services as our integrated approach means that:
   - They only have to tell their story once
   - The service offer is consistent across all the days of the week
   - They know the name of the person they need to contact if they need help
4. An increased sense of security because citizens know they can get help quickly – whether it be for social, physical or mental health reasons
5. Fewer people with a long term condition(s) living without an informal network of support
6. More people living well with their long term condition due to an increase in the role of peer support and educators who will help people manage their condition and recover
7. More people in direct control of their support because of increased take up of Health and Care Personal budgets.
8. More people able to access 'a good death' at home, or in a community setting if preferred.
9. Significantly fewer unplanned admissions to hospital and care homes through effective admission avoidance interventions
10. An increase in recovery outcomes across all client groups through increased and improved recovery services
11. Significantly fewer people going into long term care from an acute hospital bed because there is a greater level of support available to help people recover
12. A reduction in delayed discharges through increased community-based services and effective care pathways
13. Timely and effective support to carers

4.5 **So what will it look like in five years' time?**

In five years' time we will have empowered citizens, able to access helpful information on a range of subjects that promote their independence and enable them to manage their long term condition/ risk to independence. They will be supported in this through a good network of family, friends and engaged community – perhaps with the help of a peer educator too. The amount of social capital in our communities will have increased through the facilitation of the Local Area Co-ordinators and our voluntary, community and faith sector. Social philanthropy will have increased and contributors will be able to make informed decisions about donating through the *Vital Signs* philanthropic guide. Increased volunteering will make a valuable contribution to tackling social isolation and increasing informal forms of support. Every older person aged 85+ will be offered the opportunity to have an individualised "winter plan". Every person with a serious mental illness will have a Wellness recovery Action Plan (WRAP) that sets out how they can help themselves, or get help when more unwell. Getting help will be easy and dynamic, increasing and decreasing in response to a person's changing needs.

4.6 A more effective involvement of carers at each level will contribute to meeting identified outcomes. Informal carers will be supported to continue their caring role for as long as they feel able or wish to. They will receive a carers assessment and from this support mechanisms to prevent carer breakdown. Increased investment in the carer emergency plan will reduce the 'cared for' being admitted to hospital or institutional care following a carer crisis. Clear pathways of support for the carer will reduce carer stress and the requirement for more dependent funded support from health or local authority.
There will also be an agreement to continue the support to carers who support people with dementia by securing current provision.

4.7 The Community Support Teams (created through integrating social work, primary and community health services) will be at the heart of our community offer and will cover both physical and mental ill-health. They will have a close professional relationship with the Local Area Co-ordinators. They will be effectively reducing planned and unplanned admissions to hospital and care homes through rapid action to support frequent attenders and through proactive preventative work with people with long term conditions/ risks to their independence. Working with peer educators and citizen leaders will be a key part of this work as will the maximum usage of health and social care personal budgets. There will be close working between Community Support Teams and Care Homes for any individual who does need a short stay in a care environment.

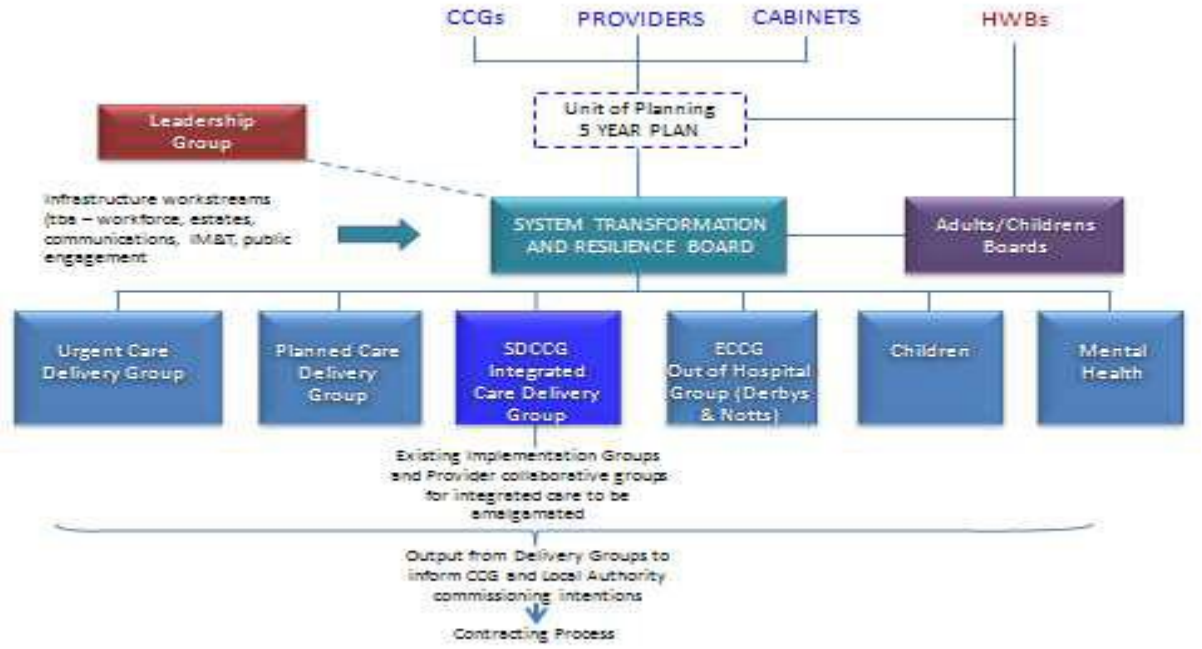
4.8 General practice will be an integral part of Community Support Teams and provide clinical leadership. Practices will be working collaboratively to provide a wider range of services within each geographical area than is currently the case. These teams will be complemented by a rapid response service obtained through a single point of access that GPs have confidence in because it guarantees it will see someone within two hours of referral and has a comprehensive spectrum of services it can call upon to support people at risk of an admission. The work of the service is ably supported by geriatricians who will spend a significant proportion of their practice time in the community. Health and social care support staff will work together to provide a single source of care for patients.

4.9 Recovery capacity and expertise will have increased across physical and mental ill health services. Rather than go to day centres, people with a mental health problem will take part in Recovery and Well-being networks to gain the skills and confidence they need to overcome their illness. Rather than people be assessed in hospital to facilitate discharge, the default position will be to discharge people home to assess, ably supported with intensive support and night sitting if required in the first few days. Only by exception will people receive rehabilitation in a community hospital bed with greater use of care home capacity and people’s own beds with peripatetic therapy support and care workers acting as agents of therapy. It is likely that we will need fewer buildings as services will be delivered in people’s own homes.

4.10 The acute hospital will be free to focus on its core purpose and, as a result of the effectiveness of admission avoidance and supported discharge, will no longer need to expand its capacity to meet demand and may, in fact, be more compact than at present. Community staff will reach in to hospital to provide continuity of care and facilitate discharge; and acute clinicians will provide expert advice and support to community teams and primary care. There will be regular circulation of staff between acute and community settings.

Achieving transformational change

4.11 Transforming health and social care is a complex business and requires tight governance. We have recently reviewed and changed our governance to ensure it is fit for purpose and have put in place the following:



4.12 The System Transformation and Resilience Board (STAR Board) has two main functions: –

- To drive the development of a Five Year Strategic Plan across the South Derbyshire Unit of Planning; agree the programmes of work that are necessary to deliver the Plan and hold all partners to account for delivery.
- To act as the System Resilience Group for the South Derbyshire Unit of Planning. This will ensure that there is systematic planning of service delivery across both urgent and planned care. The detailed work to support this function will be undertaken by the Urgent Care and Planned Care Delivery Groups.

4.13 We have commissioned external support to draw up our five year integrated business plan. It will consider how sustainable the system is in terms of:

- Quality - do people experience good quality care, close to home, in the most appropriate setting?
- Access - do people have access to all services in time, including GP, Out of Hours and social care services at all times?
- Affordability - do we provide services in the most cost effective way?

4.14 To make the future strategy and policy changes fit for purpose, it will look at the following care pathways:

- Urgent care
- Planned care
- Frail elderly and long term conditions
- Mental Health
- Children's

4.15 The timeline for completion of the work is as follows:

TASK	**DATES**
Baseline analysis Demand forecasts "Do nothing scenario" Benchmarking and best practice analysis	29 September to 20 October
Leadership and pathway workshops	3 November to 1 December
Quantify impact of policy changes and run sensitivity analysis Review governance structure	24 November to 15 December
Final report	19 December

OTHER OPTIONS CONSIDERED

5.1 Modelling has shown that the "do nothing" options would result in an ever-widening structural deficit in health and social care funding. It is essential that health and social care transforms itself to be fit for the future – providing the best possible care within the available resources.

5.2 The Care Act places a duty on local government to progress the integration of services to improve people's care. There are many types of integration including structural integration, .e.g. transferring social care services into NHS organisations to create a Care Trust. Structural solutions have not been pursued as a primary strategy as the evidence base for them achieving financial savings is weak. It may be that new organisational structures will emerge from this work but this is more likely to be at the end of a transformational process than at the beginning as form should always follow function.

This report has been approved by the following officers:

Legal officer	Olu Idowu
Financial officer	Toni Nash
Human Resources officer	Liz Moore
Estates/Property officer	N/A
Service Director(s)	N/A
Other(s)	Ann Webster, Richard Boneham

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Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 The size of the financial challenge to the NHS in Southern Derbyshire is £25m-£30m per year for the next five years. Adult social care is facing an underlying budget pressure of £5m (which is planned to be addressed through the Council's Medium Term Financial Plan) with an annual demographic pressures in the region of £1+m per year and further anticipated pressures due to the introduction of the funding reforms contained in the Care Act.

1.2 The Better Care Fund provides for £17.403m worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for citizens. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer. At a local level this translates to a total of £17.403m for 2015/16 and an additional £1.153m for 2014/15.

Legal

2.1 The Care Act places an obligation on the local authority to optimise the use of integrated approaches to improve the care to its citizens.

Personnel

3.1 A transformed health and social care system will require a transformed workforce. This is regarded as a key work stream by the STAR Board. While there are no specific personnel implications in this report – it will be a key component of our transformation plans going forward and may be the subject of future reports.

IT

4.1 IT can be a key enabler of shared systems and customer information. While there are no specific IT implications in this report, it is a work stream in its own right as a "system enabler". We have applied to the Department of Health's Digital Innovation Fund to seek funding for a solution that would allow health and social care practitioners to view people's care records where they have given consent to have their information shared.

Equalities Impact

5.1 As the integrated five year strategy and business plan is drawn up and Equalities Impact Assessment will need to be undertaken to systematically assess the likely or actual effects on people in respect of age, disability, gender, including gender identity, sexual orientation, religion or belief, marriage and civil partnership, pregnancy and maternity and race equality. This will include looking for opportunities

to promote equality that may have previously been missed or could be better used, as well as negative or adverse impacts that can be removed or mitigated, where possible.

Health and Safety

6.1 None specific

Environmental Sustainability

7.1 None specific

Property and Asset Management

8.1 None specific

Risk Management

9.1 The STAR Board is currently in the process of compiling a risk register and will maintain a strategic overview of risk for the duration of the system transformation plan.

Corporate objectives and priorities for change

10.1 The transformation of health and social care contributes to the Council's aim to promote the health and well-being of its citizens.