Nottinghamshire County Council

Report to Adult Social Care & Health Committee

2 March 2015

Agenda Item: 5

REPORT OF THE SERVICE DIRECTOR FOR MID AND NORTH NOTTS

THE INTEGRATION OF HEALTH AND SOCIAL CARE SERVICES IN BASSETLAW

Purpose of the Report

1. The report provides an update on progress in delivering the five strategic programmes to transform services and deliver integrated health and social care in Bassetlaw.

2. This report requests approval for the establishment of four temporary social worker posts as part of the pilot of integrated neighbourhood teams.

3. Committee are asked to agree further work to be undertaken to determine the future configuration of services in the context of integrated health and social care commissioning and provision.

Information and Advice

4. This report is one of a series of three which sets out the work on health and social care integration being undertaken across Nottinghamshire. On 2nd February 2015 an up-date on the mid Notts Better Together Programme was presented to Committee. This report also set out some of the key issues and potential impacts of greater integration requiring consideration for the local authority and social care. The report being considered today covers work within Bassetlaw and the final report on 30th March will up-date on progress within the south planning group.

5. Bassetlaw Clinical Commissioning Group (CCG) is working with Nottinghamshire County Council and other partners on plans to deliver the shared commitment to integrating services where it will improve outcomes for citizens. National and global evidence on integrated models of care shows that this can promote independence through preventing illness starting or getting worse, can improve the early identification and management of people with long term conditions, support self-care and facilitate proactive identification of patients at risk of admission to hospital and residential care.

6. Health and social care partners formed a Bassetlaw Integrated Care Board (ICB) in April 2013 to drive forward the vision for better care along with ambitious plans to improve the health and wellbeing of Bassetlaw residents. The partners involved in the ICB are:

- Bassetlaw CCG and member GPs
- Providers – Doncaster and Bassetlaw NHS hospitals Foundation Trust; Bassetlaw Health Partnerships; East Midlands Ambulance Service (EMAS); Nottinghamshire NHS Healthcare Trust;
- Nottinghamshire County Council (social care and public health)
- Bassetlaw District Council
- Third sector
- Patient and public representatives

The ICB has agreed a joint vision and commitment to deliver five transformational change programmes in Bassetlaw:

A. Integrating Care in the community - improving the pathways of care and integrating local services for frail and vulnerable people

B. Urgent (Same Day) Care – providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including GP out of hours service and patient self-care

C. Care Homes and Specialist Accommodation for Older People – health and social care working better together to improve the quality of care and standards in Bassetlaw's care homes and develop a range of housing and accommodation options.

D. Mental Health Services – improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on acute based mental healthcare

E. Getting people out of hospital after acute illness - helping people to become independent after leaving hospital, providing more re-ablement and rehabilitation support at home and in the community

The aim of these transformational programmes is to align services through the integration of health, care and support across Bassetlaw to improve the quality of care and patient outcomes whilst driving forward efficiency and value for money for the local tax payer.

During 2014/15 the ICB has governed the planning and clinical development of the priorities and new models of care and from April 2015 the CCG and partners will move into the transition phase of change as the integration programme starts to mobilise.

Workstream A - Integrating Care in the Community

7. Community services, primary care, the third sector, mental health and social care services in Bassetlaw are not currently integrated which often results in patients experiencing hand offs from one professional to another throughout their pathway causing unnecessary delay in accessing the right professional at the right time. Introducing integrated working across health and social care is the first of Bassetlaw CCGs five transformation programmes due to be fully mobilised from March 2015. This is a major part of the integrated care programme and is key to achieving the Better Care Fund targets; reduction of avoidable A&E attendances, admissions and readmissions, residential care home placements, outpatient attendances and GP appointments.

8. From March 2015 the existing community services provided by Bassetlaw Health Partnerships will be reconfigured into four Integrated Neighbourhood Teams, teams aligned with GP practices across the Bassetlaw district. Each team will cover one or a number of GP

practices with a population of circa 25000 patients. Within each team will be a full complement of clinicians; district nurses, community matrons, case managers, therapists, and health care support workers. The teams will include social care and support from the voluntary sector (social prescribing: see paragraph 12). The aim is that each of the four integrated neighbourhood teams will initially pilot having a qualified social worker aligned to each as part of the team. This will be evaluated in order that longer term decisions are informed by a full understanding of the nature and volume of the work requiring social care input, type of social care role needed to complete the work and the impact of this new way of working on demand for social care services. It will also consider how this fits with levels of demand, priority work and geographic spread of other social care assessments and care management posts across all of Bassetlaw.

9. The virtual ward model of community care has been introduced for patients with more complex needs. This is a proactive coordinated way of working linked with GPs to provide personalised care for over 75s. Patients are identified to work with through a risk stratification process, in order to target multi agency intensive support which puts the patient and their family at the centre of their care. It will also facilitate quicker discharge from hospital and avoid unnecessary hospital readmissions. The working arrangements of clinical and therapy staff and social workers have been reconfigured to increase the hours of working into the evening Monday to Friday and during 2015 we will enhance this further with seven day working in the community and social care. Staffing levels have been increased above the current establishments to ensure the project can meet its objectives from commencement, accepting that new working arrangements will take time to bed-in. Evaluation will determine the final structure for each team.

10. Geriatrician led care, a community based elderly care service working with the integrated neighbourhood teams, will commence from April. This will provide consultant led geriatric care in the community in addition to acute geriatric care in Bassetlaw Hospital. The service will be part of the virtual ward model linking in with the neighbourhood teams, providing comprehensive geriatric assessments in the community and advice and support to GPs and community teams managing the care for older people.

11. The transition of change will have three stages. From March, Bassetlaw Health Partnership (BHP) staff will work as a team with GPs and practices, integrating pathways, risk assessing and case managing the frail and elderly. The new way of working will be agreed through a memorandum of understanding. The second stage from April is for the introduction of a qualified social worker into each team. This role will carry a case load and will support the integrated team in care planning and case management of patients particularly patients identified at risk of admission and requiring support packages of care in the community. The third stage from May 2015 is to develop links into mental health teams with each team having a named NHT contact to support referrals into mental health services.

12. Social prescribing is a mechanism for linking people with non-medical sources of support within the community delivered through local voluntary services. Primary care professionals can ‘prescribe’ support using a menu of services for patients who are often the frail elderly and people with long term conditions. Support services include healthy lifestyle advice, physical activity, learning new skills to get back to work, volunteering, mutual aid, befriending and self-help, as well as support with, for example, housing, debt or legal advice. The local third sector in Bassetlaw is a key partner in the primary care integrated model and the CCG is working with partners to increase the number of voluntary services available in Bassetlaw

and are exploring opportunities for joint working with the both the County Council and District Council who also run similar schemes in Bassetlaw.

13. The CCG has established a community social prescribing scheme (a one year pilot starting February 2015) that supports patients needing emotional, practical and social support. The scheme will be integrated into the neighbourhood teams with 'social prescribers' assessing need with patients and arranging support with them. This will develop and increase capacity in the third sector and will extend the options of patient support services available to GPs, community staff and social workers. The pilot scheme is initially supporting the frail elderly and people who are socially isolated and pending successful evaluation will be extended in year for people with long term conditions.

Workstream B - Urgent (Same Day) Care

14. Increased demand into Bassetlaw hospital emergency department of patients with minor illness over the last few years has initiated the development of plans for a one year pilot GP led urgent care centre to be co-located on site of the emergency department at BDGH. The pilot will integrate GP out of hours and will provide GP and advanced nurse specialist capacity during specific times of the day. The pilot will start in June 2015.

15. The CCG has agreed a short term pilot with East Midlands Ambulance Service (EMAS) to increase the ambulance and first response vehicle capacity in Bassetlaw via a "Bassetlaw dedicated service". This will increase resources locally and improve the response time to the rural areas in Bassetlaw particularly in the north of the district. If the scheme evaluates successfully discussions will be opened with EMAS through the lead commissioner around further dedicated services within current contract levels.

Workstream C - Care Homes and Specialist Accommodation for Older People.

16. Health and social care are working together to improve the quality of care and standards in care homes supporting people to stay longer in their home of choice and avoid unnecessary hospital admissions. A Steering Group made up of statutory agencies and providers meets regularly and informs identification of the key improvement areas and actions. A number of initiatives agreed as part of the Better Care Fund are now due to start, including enhancement of dementia support to care homes and competency based training packages covering nutrition, hydration and End of Life Care. The other strand of this work-stream is developing a joint plan with the District Council, in to order to offer a range of appropriate specialist accommodation options to local older people.

Workstream D - Mental Health Services

17. The CCG has developed an ambitious mental health strategy that will transform mental health services in Bassetlaw, providing an opportunity to move from what are considered to be traditional mental health services into a more proactive and holistic approach to care putting more focus on parity of esteem, prevention, early intervention and shifting services out of hospital into the community. The strategy has a number of recommendations that will move mental health services in Bassetlaw to a more proactive and sustainable model of care that will offer the highest quality of care to patients. A new mental health unit will be built at Bassetlaw hospital and the Acute Trust, CCG and Nottinghamshire Healthcare Trust are currently in discussions regarding the critical path and timeframe for this.

18. As part of the new model to integrate and streamline mental health services a mental health and wellbeing hub (accessed through both open access and referral) will provide advice and support for people seeking early help from a range of different services such as signposting to early intervention and resilience support in the community/ third sector or debt advice and housing issues which will be linked to the social prescribing scheme and the district council. A single point of access will be a key part of the hub for people that need a referral to specialist mental health support. Offering a multi-faceted approach early in the patient journey could prevent deterioration in the mental health condition and will support people who need more intensive care into the right service in a timely manner. The new model will also offer a more comprehensive discharge support package to prevent relapses and readmissions and crisis house provision as an alternative to acute inpatient care that could potentially significantly reduce inpatient provision in the area. The MH crisis care concordat requirements will be met by the new model around the development of the mental health acute liaison team at Bassetlaw Hospital and out of hours support for patients and professionals.

19. The transformed services will take 3-5 years to implement and changes are currently being made to existing services provided by Nottinghamshire Healthcare Trust in terms of streamlining and integrating services. Non recurrent resources have been committed by the CCG for service and pathway changes required during the 2015/16 initial transition year. These changes are currently being negotiated with NHT through the contract round.

Workstream E - Getting people out of hospital after acute illness

20. Bassetlaw CCG is working with the Council and health care providers to develop options for a more integrated model of Intermediate Care and re-ablement. The scope includes the current services and arrangements for health and social care funded re-ablement (START) and intermediate care. It is agreed that a new way of operating which is less reliant on beds and seeks to re-able more people at home is required. Better integration will aim to remove the current separate pathways, services and duplication in the system, in order to create a service focused around individual's needs. An options appraisal of new potential models of integrated care providing more home and community based support will be considered by the ICB work group leading this project in March 2015 and then taken through agencies respective governance processes.

21. Timely discharge from hospital relies on multi-disciplinary working across health, social care and housing, involving the voluntary sector where necessary. Patients with complex care needs, particularly the frail elderly, sometimes stay longer in an acute bed at Bassetlaw hospital than they may need to, whilst their discharge is fully planned and implemented. This additional length of stay on a ward has been targeted as an area that both health and social care staff can improve, through better and earlier planning for discharge and alternative short term placements. Some people, for example, may be medically fit for discharge but may need a slightly longer period of intense re-ablement before being ready to return home, or may require further assessment, for example, for Continuing Health Care. Others may not be able to return home directly because they need to have minor adaptations completed in their homes. The aim is that these people will not need to wait in hospital, but will transfer to specific short term beds whilst these type of tasks are undertaken. The longer term plan agreed by Bassetlaw ICB is to develop a re-ablement unit in 2016 that will provide some bed based intermediate care and transfer to assess capacity where complex discharge patients will be transferred to for their continued care pathway. In the short term**,** interim options for commissioning local residential and nursing home beds for short term assessment i.e. 28

days maximum length of stay, are being explored. An options appraisal will be completed in March.

Other Options Considered

22. The national direction of travel is clearly towards greater integration of health and social care services where this can evidence improved outcomes for people, carers and organisations. The vision for services has been agreed in Bassetlaw. Then detail of how this can be implemented now needs to be agreed and further reports setting out the options, benefits and risks will be presented to Committee to enable decisions to be made.

Reason/s for Recommendation/s

23. The pressure of increased demand for services means that partners are predicting a rising financial gap if nothing is done to address this and better manage demand. Developing integrated service in key areas is one way to address this.

Statutory and Policy Implications

24. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

25. Bassetlaw CCG has already confirmed that £98,000 is available in 2015/16 to fund four Band B posts for a six month pilot. The CCG are considering whether further funding can be identified to enable these posts to be funded for up to a maximum of one year. A longer length of pilot would improve the set of set to be analysed. It would also allow more time to approve and implement the recommendations of the pilot, which may include review of how staff are deployed within the assessment and care management teams across Bassetlaw.

Human Resources Implications

26. The move to seven day working is requiring greater use by social workers of the enhanced weekend payment rate. Seven day working is a priority of the Better Care Fund and will be rolled out across the county as part of the three Transformation Programmes. Any future integrated team reorganisation offering seven day working will need to consider the impact of this for staff, managers and contractual terms and conditions.

Implications for Service Users

27. Achieving better outcomes for the citizens of Bassetlaw is at the heart of the strategy. The aim is that people will get the care and support they need at the right time and only have to go into hospital if they need to. Care will be more co-ordinated and person centred.

Ways of Working Implications

28. The new temporary posts will be working from CCG office bases

RECOMMENDATION/S

It is recommended that the Adult Health and Social Care Committee:

1) notes the progress in delivering the five strategic programmes to transform services and deliver integrated health and social care in Bassetlaw set out in this report.

2) approves establishment of the following four temporary posts for between a minimum of six and maximum of twelve months (dependent on final confirmation of CCG funds available):

    - 4 FTE Social Worker posts, Hay Band (Grade B), scp 34-39, £37,811 - £43,397 (which includes on-costs) plus approved car user status

3) agrees further work to be undertaken to determine the future configuration of services in the context of integrated health and social care commissioning and provision within Bassetlaw.

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For any enquiries about this report please contact: Sue Batty

Constitutional Comments (SLB 16/02/15)

Adult Social Care and Health Committee is the appropriate body to consider the content of this report. Changes to staffing structure are subject to the provisions of the Employment Procedure Rules regarding consultation with the trade unions and HR advice.

Financial Comments (AGW 16/02/2015)

The financial implications are contained within paragraph 23 and recommendation 2. The £98,000 sum quoted as being made available by Bassetlaw CCG would be sufficient to fund the stated posts for 6 months including on-costs and car user allowance.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Division(s) and Member(s) Affected

- All Divisions in Bassetlaw
- Councillors Campbell, Fielding, Gilfoyle, Greaves, Ogle, Place, Rhodes, Skelding, Yates