Delivering
Integration.

Making integration
deliver.

NEWTON

National direction of travel

Integration is a persistent theme – and a focal point of the national narrative for both social care and health.

Drive towards **integrated and place-based care,** with STPs, ICSs and PCNs:

- "dissolving the historic divide" between primary and community health
- reducing pressure on acute services
- giving more control to those who use the services.

Leaders in Local Government have a clear role to play in recognising the power of place in integration.

2019

WHAT DO WE MEAN BY **INTEGRATION?**

WHAT DO WE DO TO **INTEGRATE?**

Mike’s story.

DAY ONE

Mike, 89, trips at home. He remains conscious and calls 999. He is seen swiftly in A&E and found to have no serious injuries. Mike is admitted overnight for observation, as a precaution, to be sure he is safe to go home.

DAY THREE

Some tests are carried out. They all confirm that there has been no serious or lasting damage and no underlying cause for the fall. He had simply tripped.

DAY THIRTEEN

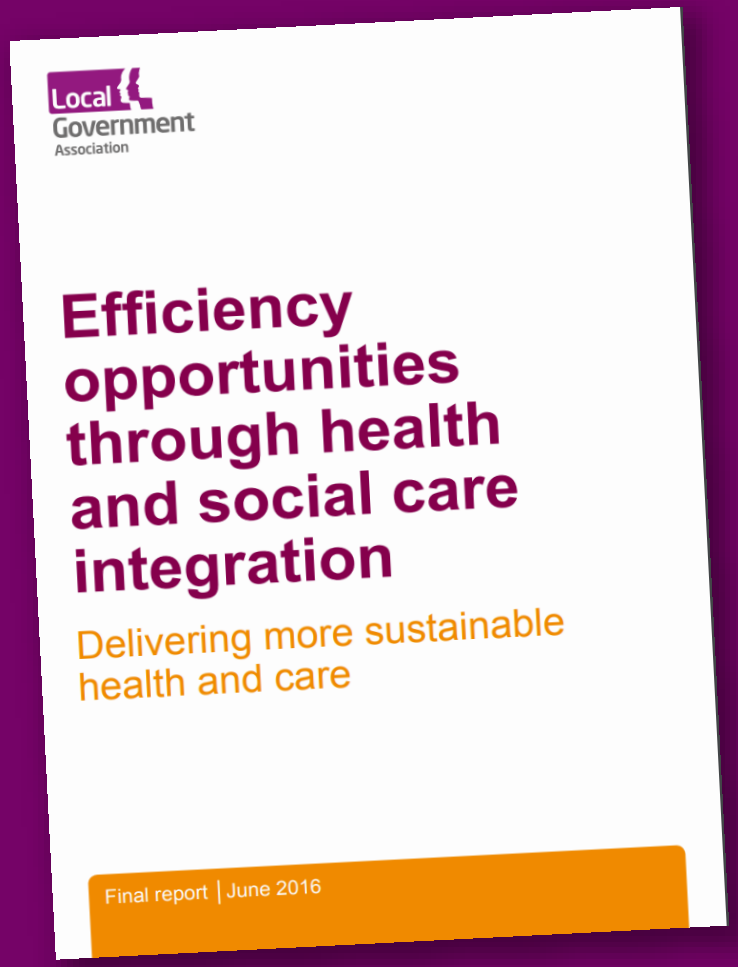
Mike is still in hospital. He has lost a good deal of mobility, so an assessment by the physiotherapy team is arranged. The physiotherapists recommend that Mike needs an assessment by the occupational therapist team and the social work team. All of these assessments take further time to arrange and conduct, and days turn into weeks.

SEVERAL WEEKS LATER

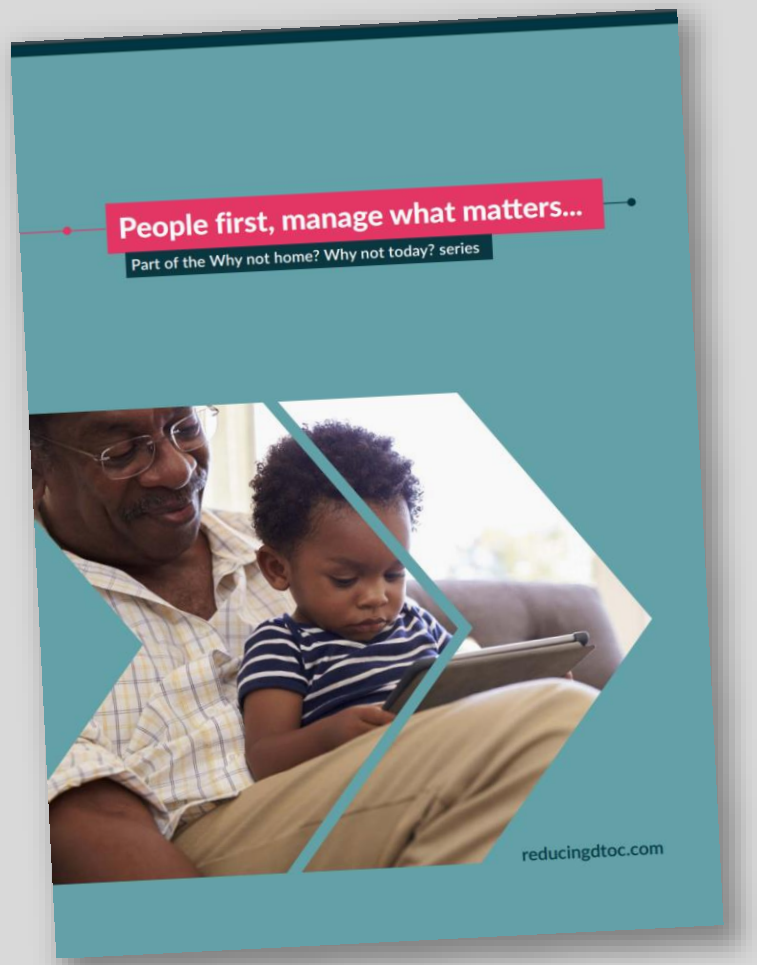
Based on the assessments, a recommendation is made for residential care and that is where Mike is placed.

The OTs opinion - like that of the other teams involved - was that, had they worked more effectively together, Mike could have gone home, with reablement support for his mobility issues.

2016


Local Government Association
Efficiency opportunities through health and social care integration
Delivering more sustainable health and care
Final report | June 2016

2018


People first, manage what matters...
Part of the Why not home? Why not today? series
reducingdtoc.com

2016

‘Efficiency opportunities through health and social care integration’

ADMISSIONS

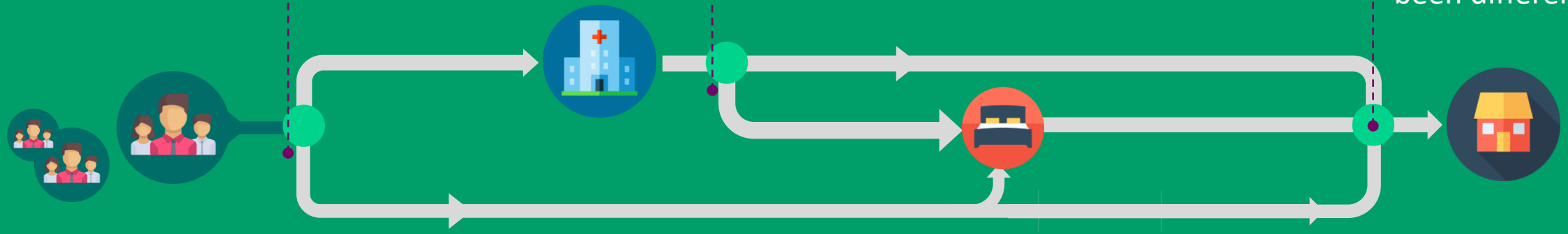
26% of people admitted to hospital didn’t need to be and we were missing opportunities to intervene at an earlier stage

DISCHARGE DECISIONS

24% of people leaving hospital were ending up in the wrong setting, and could have had a more independent outcome

LONG TERM SUPPORT

59% of people entering residential care could have stayed at home had the earlier pathway been different



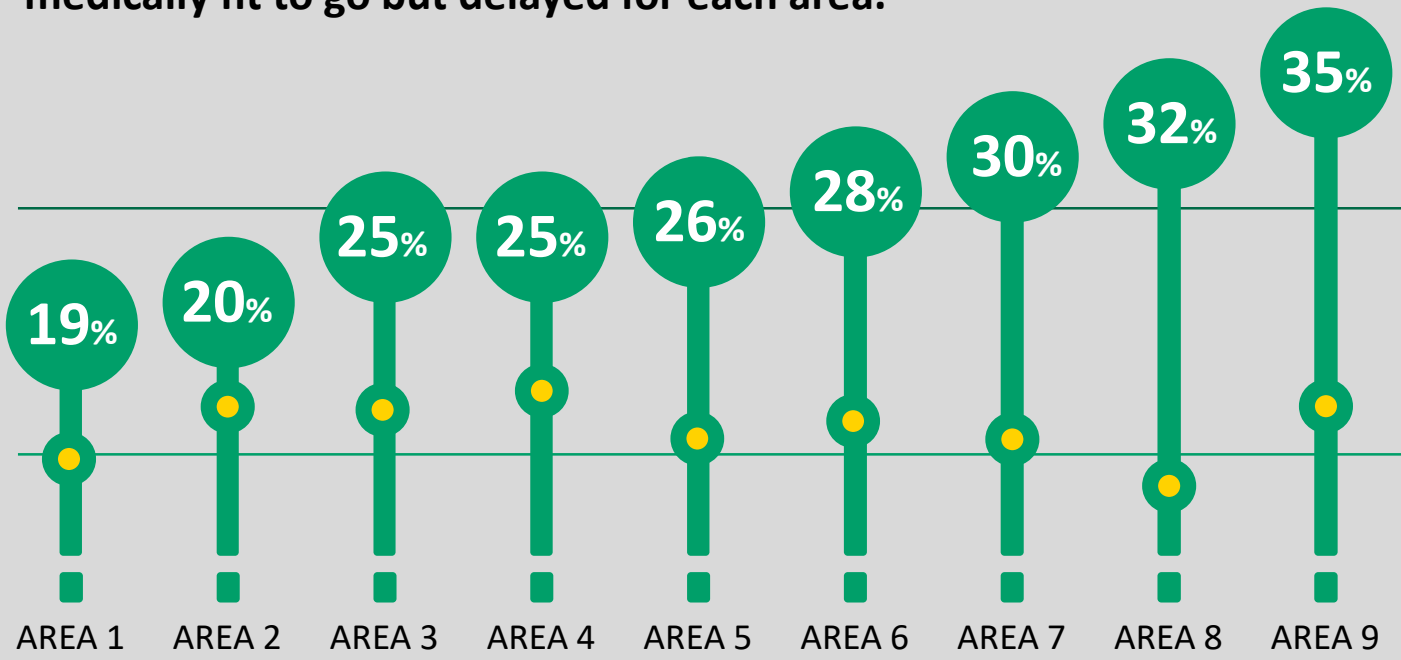
INTERMEDIATE CARE

Up to 45% of pathway decisions could be improved. Robust multidisciplinary reviews would impact this.

2018

‘People First, Manage What Matters’

The percentage of people waiting in hospital, medically fit to go but delayed for each area.



27% **The average for all areas.**

8%
Nationally reported DToC figure for the nine areas, July 2018.

symbol represents reported DToC figure by area - no correlation to the proportions who are medically fit.

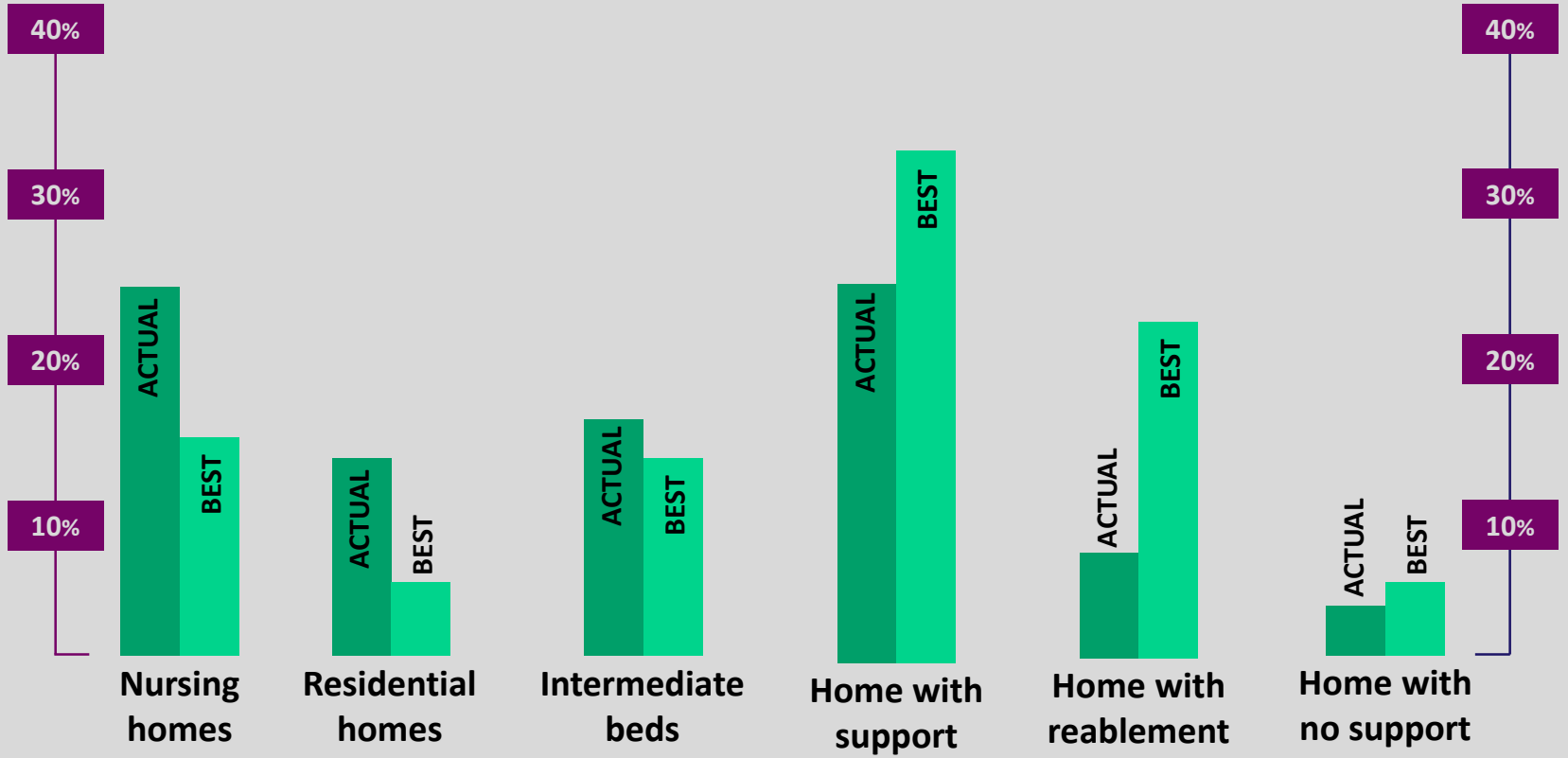
NEWTON

SOURCE: Newton ‘point of prevalence’ snapshot studies; 10,400 general/acute beds; 14 acute trusts; April-July 2018.
SOURCE: LGA Delayed transfers of care extended time series (monthly by Council and Trust) July 2018.

2018

‘People First, Manage What Matters’

WHERE ARE PEOPLE BEING DISCHARGED VS. WHERE WOULD BE BEST FOR THEM?



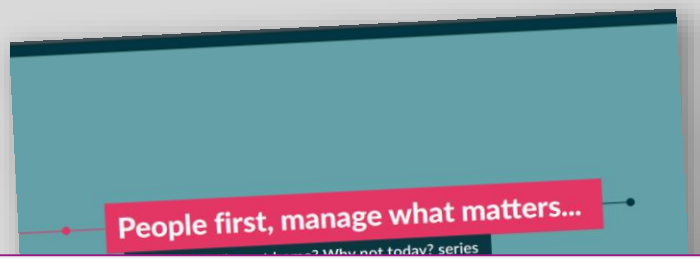
#1 Nursing & residential home placements could reduce by almost half.

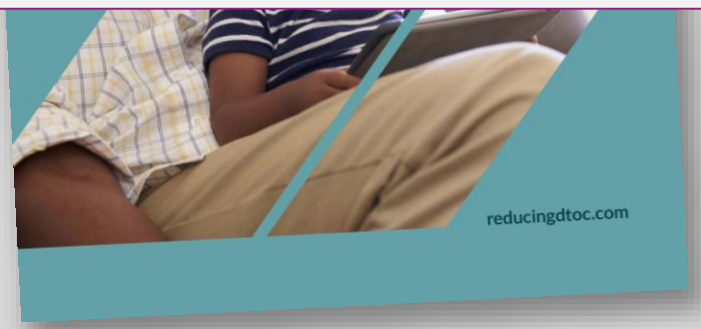
#2 Going straight home with some support could increase by almost a third.

#3 Going home with reablement could increase almost threefold.

2016

2018





IT'S NOT WHAT YOU DO, BUT HOW YOU DO IT.

Delivering integration

Systems taking top-down and bottom-up approaches

A lot of progress made on the more visible **structural integration** – governance, shared vision, ICO etc.

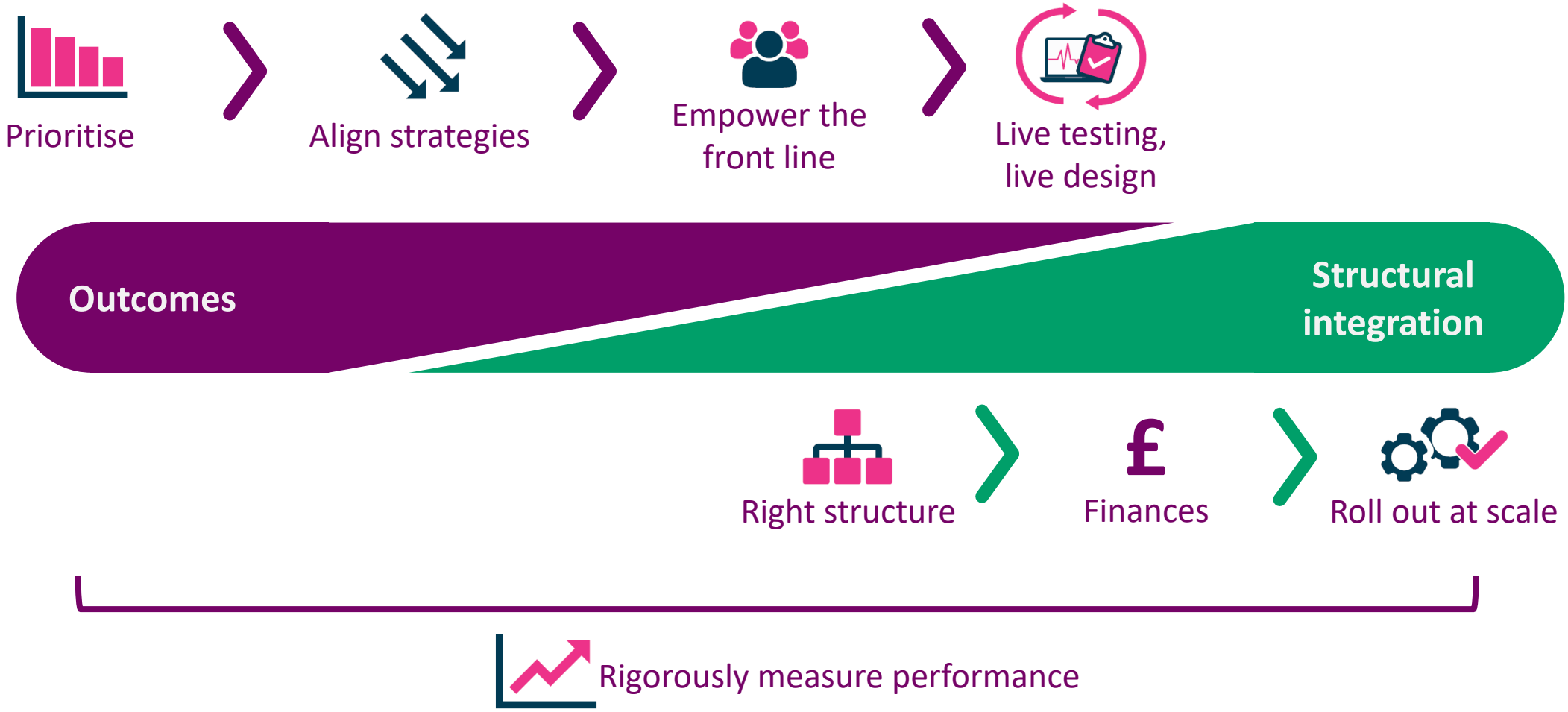
Bottom up changes e.g. co-locating teams, are also be good progress but don't always focus on **outcomes**

We must make sure integration delivers a real, tangible and valuable result

And so we must **turn the thinking around:**

Aim to deliver the benefits to outcomes and finances, and integration will help you get there

Making integration **deliver**



There are different levels of **integration**

ISOLATION

No significant attempts to work together

COMMUNICATION

Organisations talk and share some information when necessary

COORDINATION

Organisations work together on a case-by-case basis to coordinate joined up support

COLLABORATION

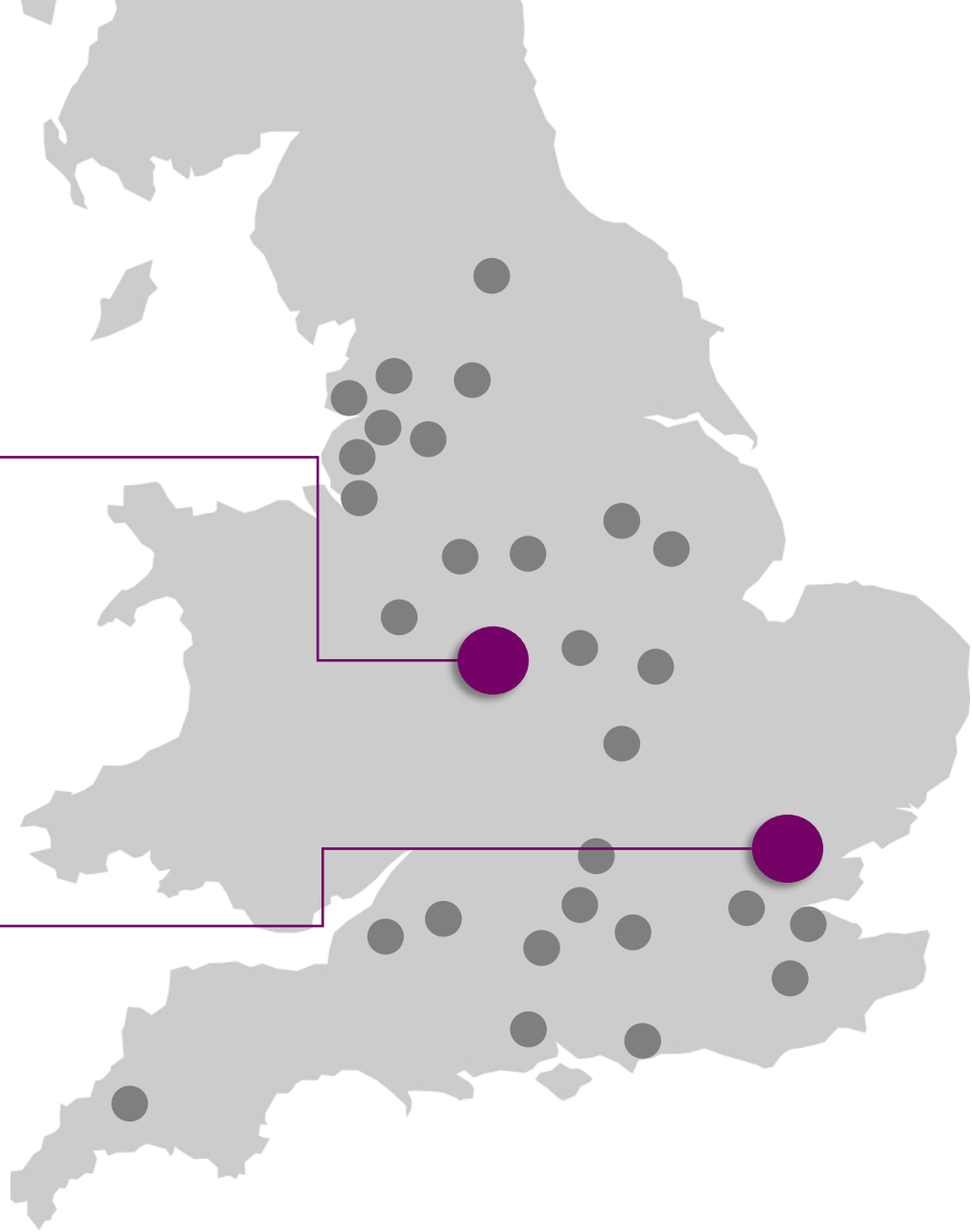
Work together project-by-project, with joint analysis, planning and implementation

INTEGRATION

Organisations are interdependent, sharing resources openly with high levels of trust

NEWTON

System **transformation** support



Birmingham

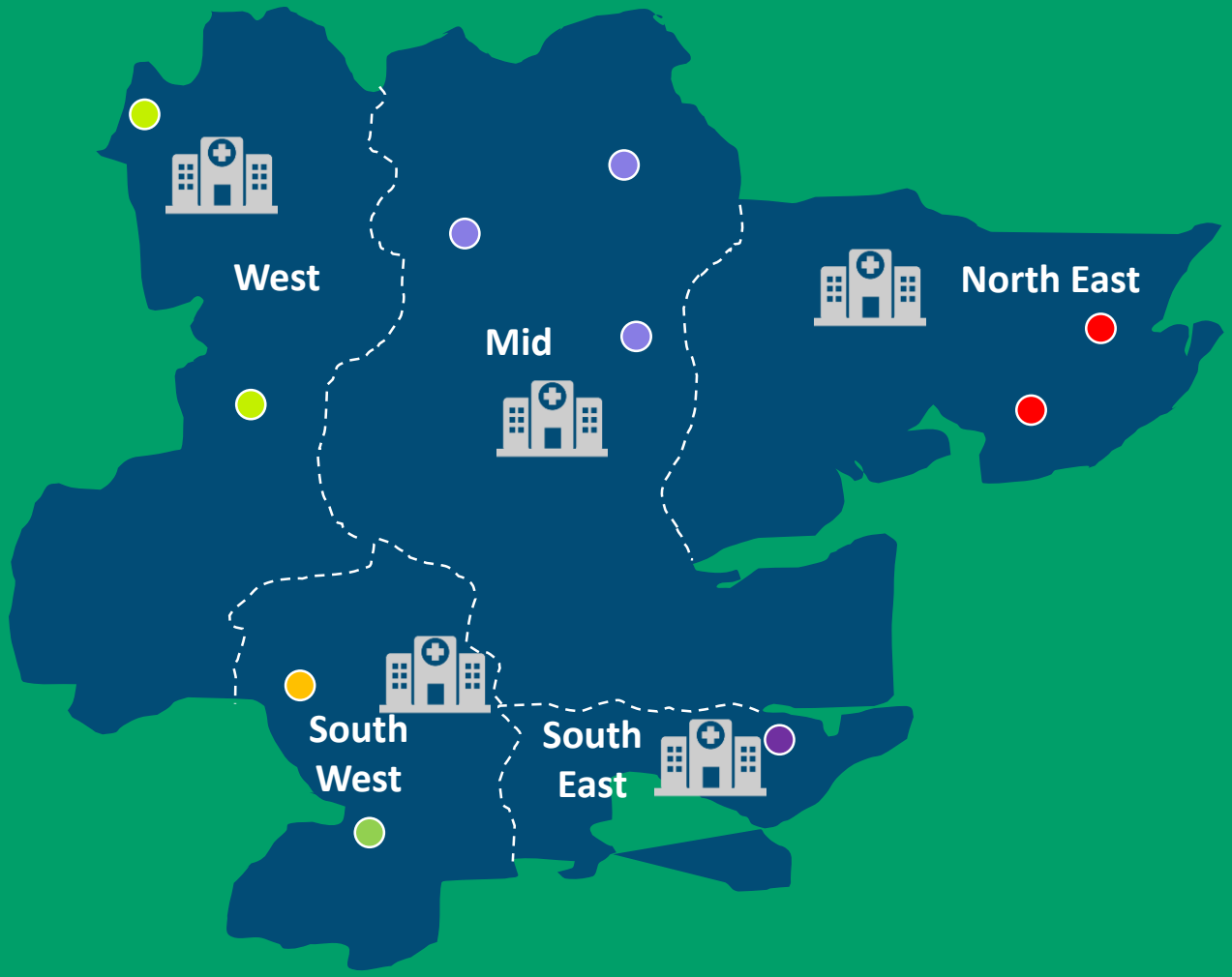
2 year integration programme

Essex

Diagnostic of opportunities

Beginning programme

Case study: **Essex**



NHS Essex Partnership University NHS Foundation Trust

NHS Mid Essex Hospital Services NHS Trust

Southend University Hospital NHS Foundation Trust

ace anglian community enterprise

NHS Mid Essex Clinical Commissioning Group

The Princess Alexandra Hospital NHS Trust

Essex County Council

NHS Castle Point and Rochford Clinical Commissioning Group

NELFT NHS NHS Foundation Trust

Basildon and Thurrock University Hospital NHS Foundation Trust

NHS North East Essex Clinical Commissioning Group

NHS East Suffolk and North Essex NHS Foundation Trust

NHS Southend Clinical Commissioning Group

Provide

NHS West Essex Clinical Commissioning Group

NHS Basildon and Brentwood Clinical Commissioning Group

Positive progress in Essex

North East Essex Alliance

Joint leadership

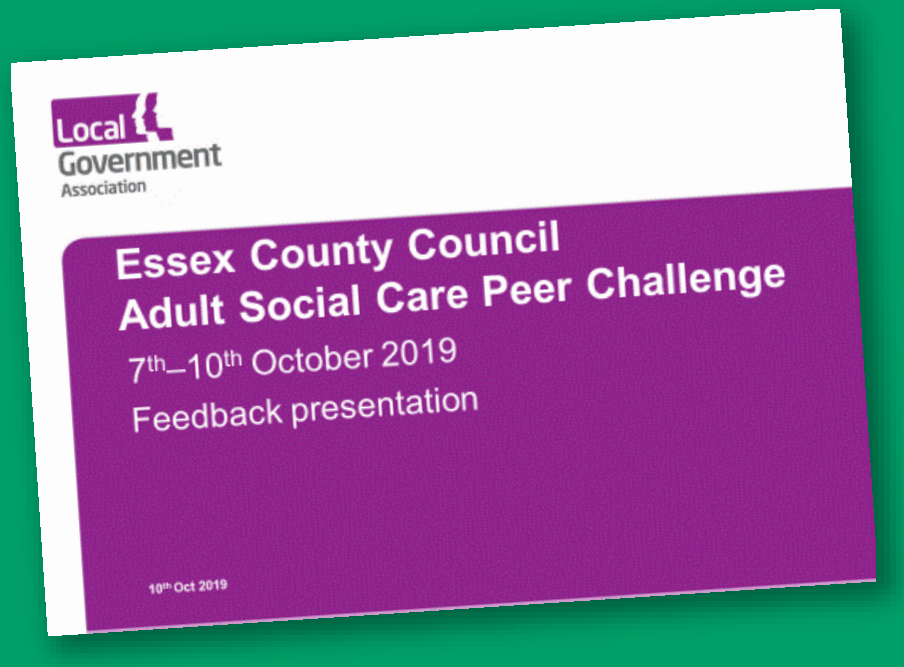
Integrated discharge teams

All health partners at every level believe ASC is now a more collaborative partner

Shared care record

Essex County Council

2019



While we have made significant headway, we recognised that there was more to do in order to deliver sustained outcomes improvements for our residents:

"There is mutual respect between health and social care partners and an understanding of difference in regard to organisational priorities and pressures"

"The system needs to reach a shared understanding of what integration really means (particularly for the workforce)"

"Move away from a culture of short-termism and pilots, towards a model of delivery at scale and pace"

"Improve the links between data, user experience and service/pathway development"

Essex County Council

Outcomes-focused approach

Prioritise

Align strategies

44% of service users did not have the ideal outcome

Intermediate care could be more effective, reducing ongoing need by **33%** more

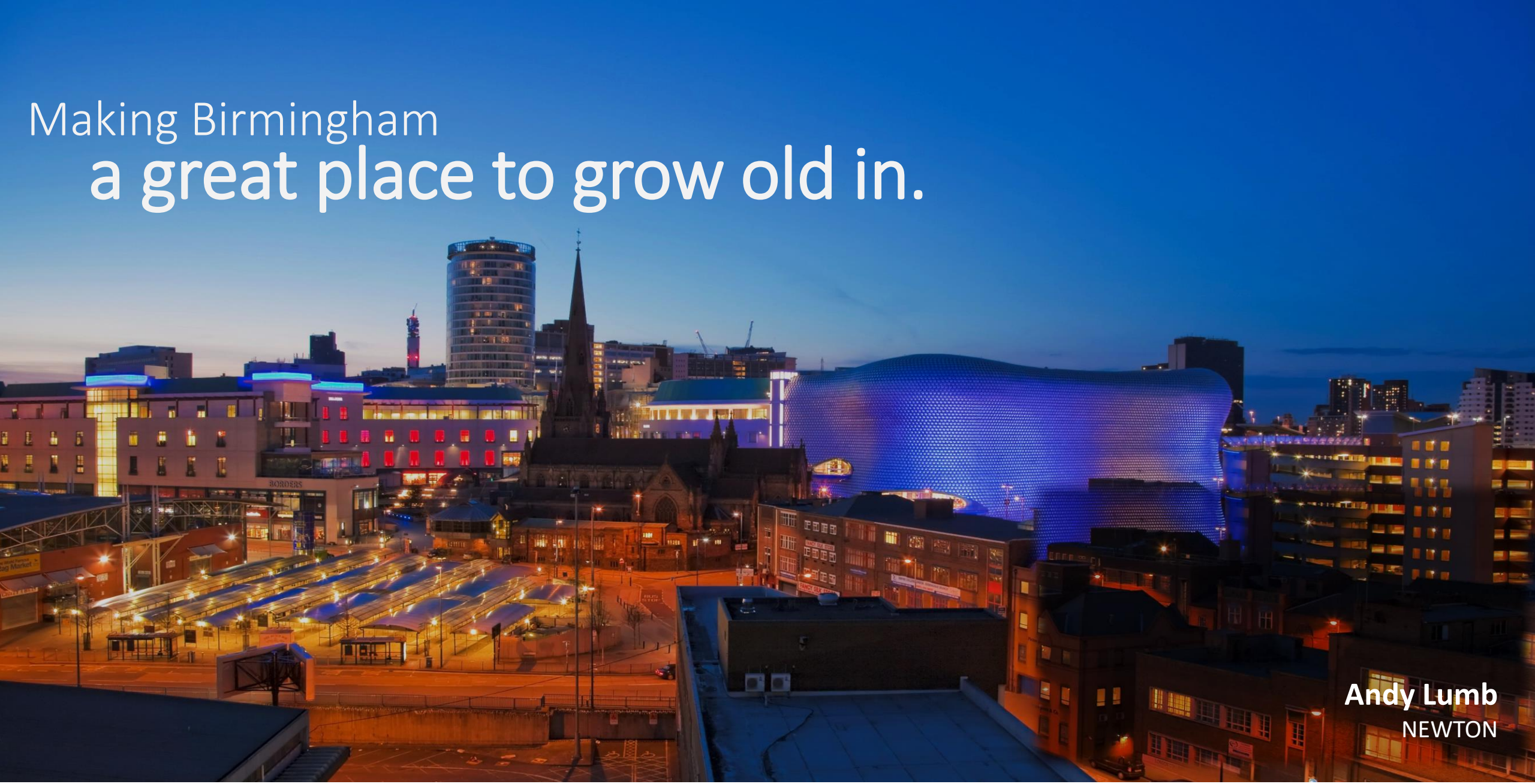
100 people every day don't need to be in an acute bed

- Rigorous evidence base to **prioritise** the changes that will have the biggest impact on outcomes
- Complex organisational landscape, sometimes with competing agendas
- While we need to work together to deliver this, there are also activities we can complete individually to deliver better outcomes for the system
  - Capacity and effectiveness of intermediate care
  - Consolidate and prioritise initiatives
  - Navigation of the systems
  - Social work capacity to unblock the system
- Well received diagnostic – next stage is to **align strategies**

Essex County Council

Making Birmingham

a great place to grow old in.



Andy Lumb
NEWTON

NEWTON

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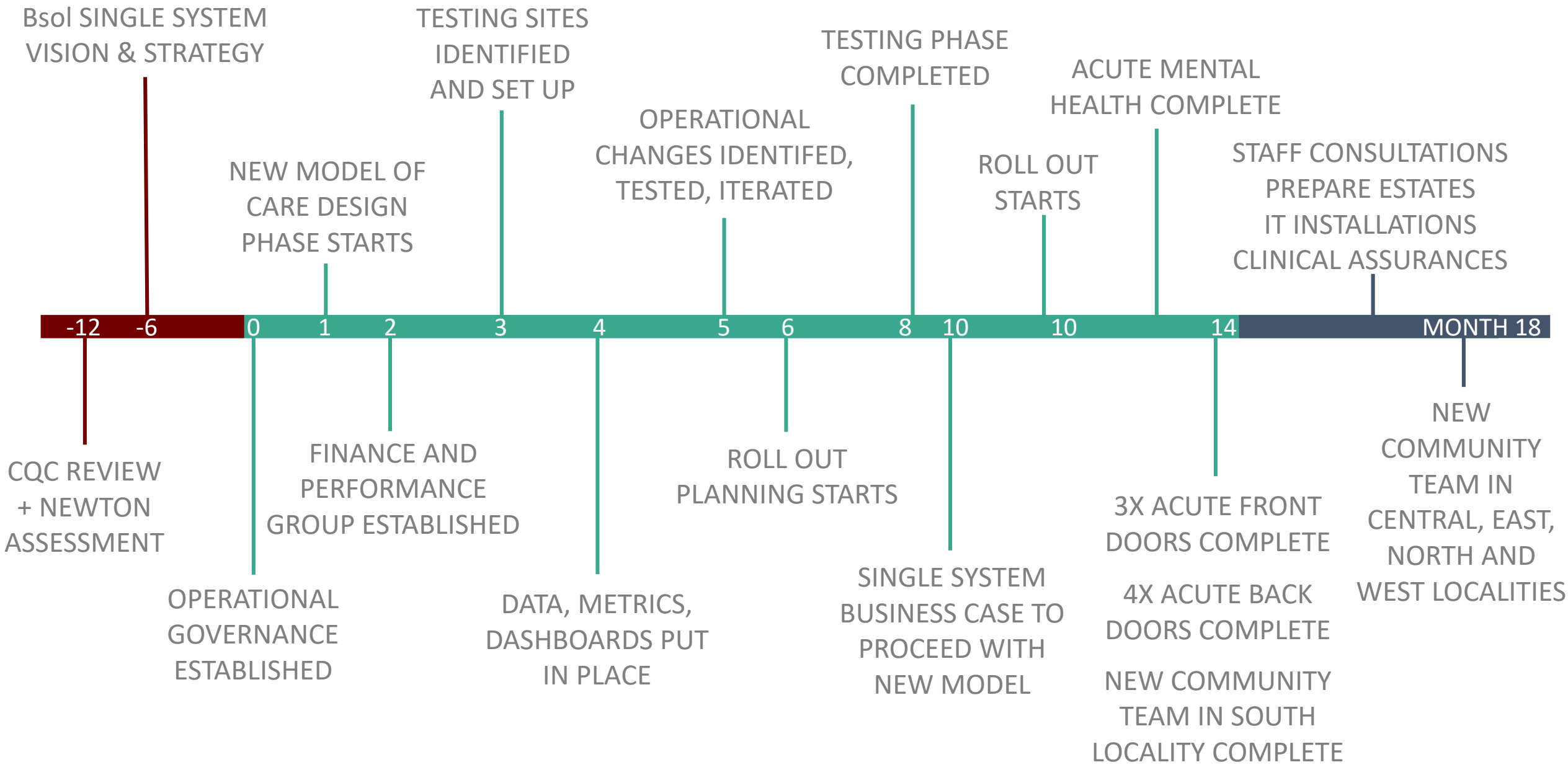
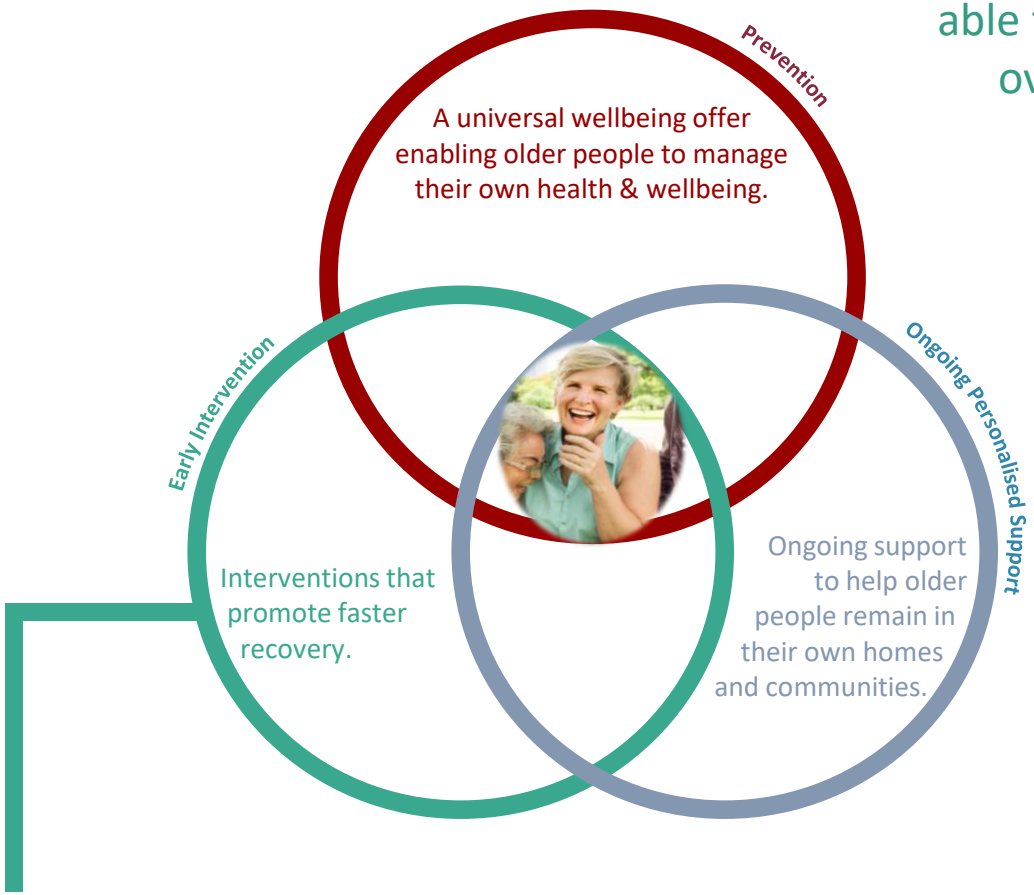
Birmingham City Council

NHS


Bsol SINGLE SYSTEM VISION & STRATEGY
TESTING SITES IDENTIFIED AND SET UP
TESTING PHASE COMPLETED
ACUTE MENTAL HEALTH COMPLETE
NEW MODEL OF CARE DESIGN PHASE STARTS
OPERATIONAL CHANGES IDENTIFED, TESTED, ITERATED
ROLL OUT STARTS
STAFF CONSULTATIONS PREPARE ESTATES IT INSTALLATIONS CLINICAL ASSURANCES
-12
-6
0
1
2
3
4
5
6
8
10
10
14
MONTH 18
CQC REVIEW + NEWTON ASSESSMENT
OPERATIONAL GOVERNANCE ESTABLISHED
FINANCE AND PERFORMANCE GROUP ESTABLISHED
DATA, METRICS, DASHBOARDS PUT IN PLACE
ROLL OUT PLANNING STARTS
SINGLE SYSTEM BUSINESS CASE TO PROCEED WITH NEW MODEL
3X ACUTE FRONT DOORS COMPLETE
4X ACUTE BACK DOORS COMPLETE
NEW COMMUNITY TEAM IN SOUTH LOCALITY COMPLETE
NEW COMMUNITY TEAM IN CENTRAL, EAST, NORTH AND WEST LOCALITIES

Whole-system **vison** & **strategy**…

…for older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them.



To provide an integrated approach to intermediate care services that is person and carer centred and encompasses physical, mental health and social care needs.

November 2018

28 front-line staff from all the partners make recommendations on what needs to change and where the changes need to happen. This provides us with five areas to test our new model of care before we roll it out.

December 2018

Eight members of staff from across the system are seconded full-time to the programme & trained in data analysis, short-interval improvement and change management.

Charlotte Gordon
Senior Practitioner

Shakoor Kahn
Senior Practitioner

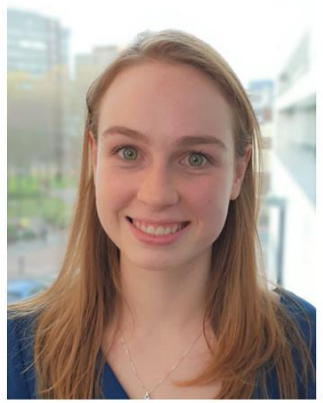
Daniel Brown
Commissioning

Michelle Cook
Contracts & Performance

Cheryl Johnson
Physiotherapist

Abigail Byrchmore
Clinical Lead

Susan Hannon
Group Support



Emily Freer
Project Officer

Early 2019

Staff and five locations to carry out design and testing are identified and set-up.

TEST AREA #1

INTEGRATED SOCIAL CARE, THERAPY & HEALTH HOSPITAL FRONT DOOR

Older People's Assessment & Liaison team at Queen Elizabeth Hospital, Birmingham

The work here is all about helping older people as they enter the hospital to get the support they need ideally back in their own home, thereby reducing the number of people that end up unnecessarily in a ward.

AVOIDED ADMISSIONS PER YEAR

BEFORE: 2,400

NOW: 3,400

POTENTIAL: 5,500

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NHS

TEST AREA #2

INTEGRATED SOCIAL CARE & HEALTH HOSPITAL BACK DOOR

LENGTH OF STAY (POST TOC)

BEFORE: 12 DAYS

NOW: 9 DAYS

POTENTIAL: 8 DAYS

67% GO HOME

Complex Discharge Hub team at Queen Elizabeth Hospital

The work here is looking to speed up the time it takes to get older people out of the hospital. And, when we get them out, we get them to a place that is best suited to their situation because right now we often provide them with care in excess of their actual needs thereby impacting their ability to recover to their previous levels of independence.

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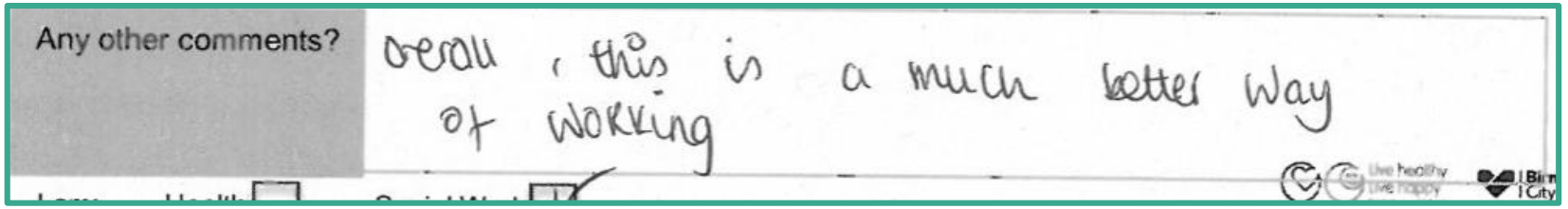
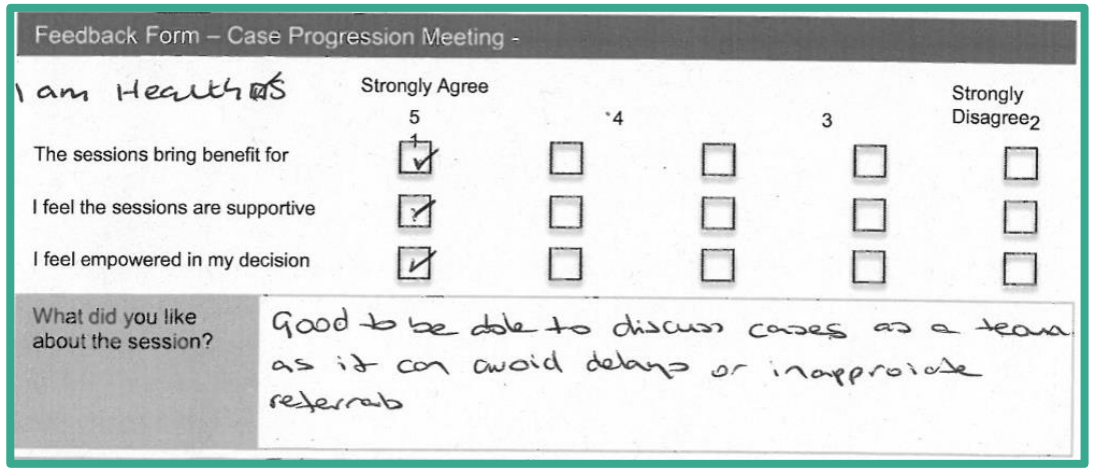
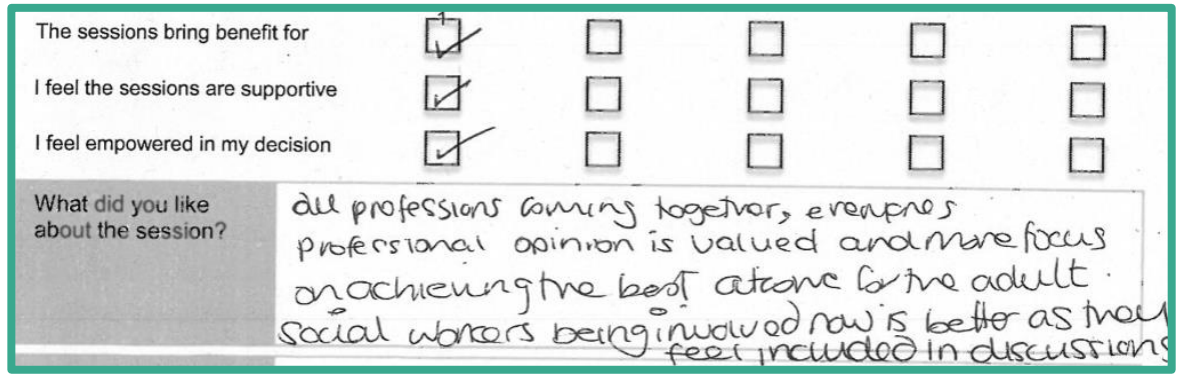
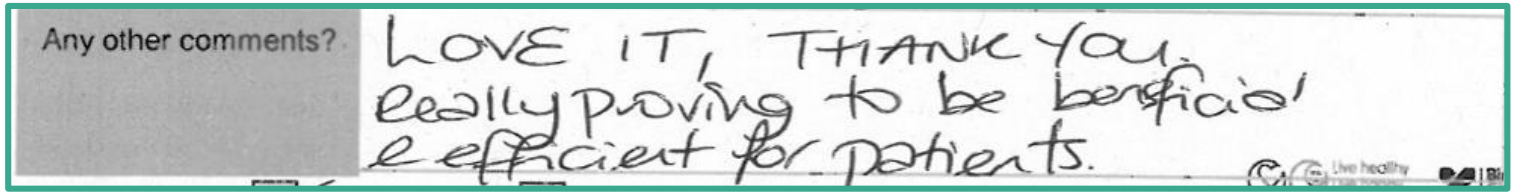
WHAT THE STAFF SAY: Week 1 of rolling out to hospital back doors

Frontline Feedback

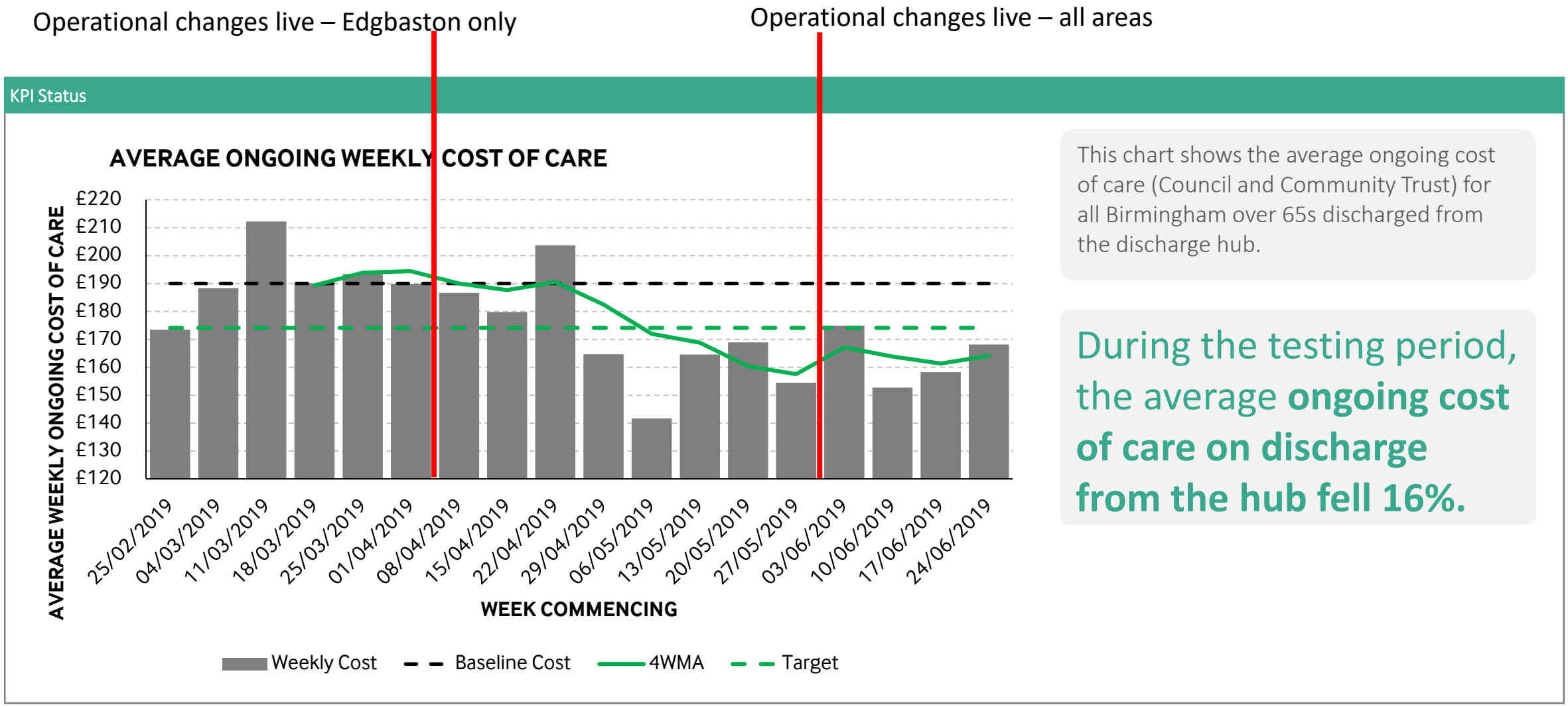








WHAT THE DATA SAYS: Hospital Back Door



This chart shows the average ongoing cost of care (Council and Community Trust) for all Birmingham over 65s discharged from the discharge hub.

During the testing period, the average **ongoing cost of care on discharge from the hub fell 16%.**

TEST AREA #3

INTEGRATED SOCIAL CARE, THERAPY & HEALTH COMMUNITY TEAM

Colleagues from the acute trust, community trust and council come together to form a new 'community team'.

AVERAGE REDUCTION OF **2 CARE CALLS PER DAY** PER PERSON.

100% OF RESIDENTS/CARERS WOULD RECOMMEND THE SERVICE.

AVERAGE TIME WITH THE SERVICE **30 DAYS**. POTENTIAL 19 DAYS.

The work here was to bring the expertise currently found in services such as the Community Trust's 'Rapid Response' alongside other services that, together, would provide the right care in people's homes that helps them regain their independence and stay at home for longer.

TEST AREA #4

INTEGRATED SOCIAL CARE, THERAPY & HEALTH INTERMEDIATE BEDS

The team in Norman Power looking after 32 intermediate care beds for older people.

The work here was to increase the number of discharges from the beds to settings more aligned with the needs of the person. And at the same time, decrease the length of time people stay in an intermediate bed.

% OF PEOPLE GOING HOME

BEFORE: 28%

NOW: 45%

LENGTH OF STAY

BEFORE: 45 DAYS

NOW: 51 DAYS

POTENTIAL: 41 DAYS

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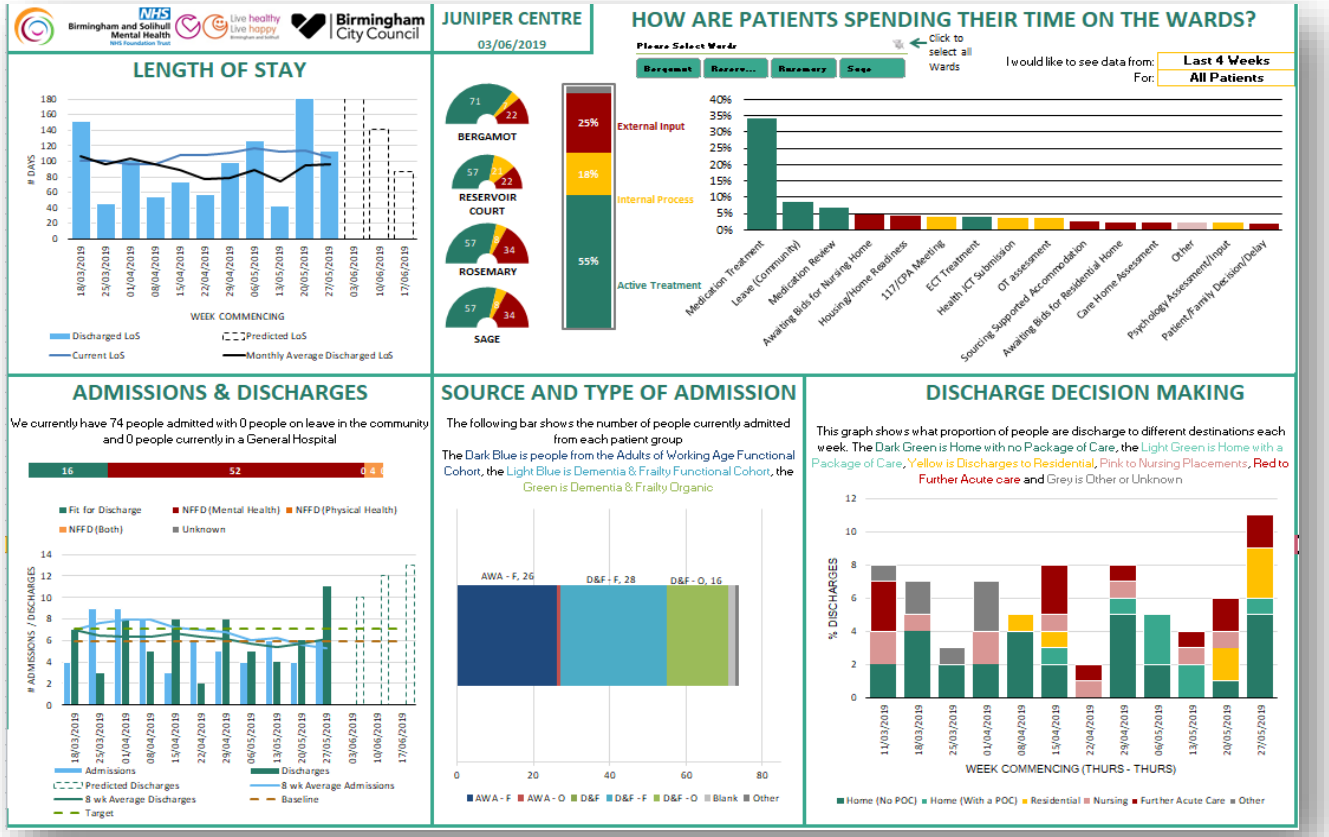
TEST AREA #5

INTEGRATED SOCIAL CARE & ACUTE MENTAL HEALTH



The work here was to reduce the amount of time people were staying in the hospital as a result of unnecessary delays to getting them healthier or getting them home.

NO. DISCHARGES EVERY DAY

BEFORE: 6 **NOW:** 7

% PEOPLE WAITING FOR SOCIAL WORK INPUT

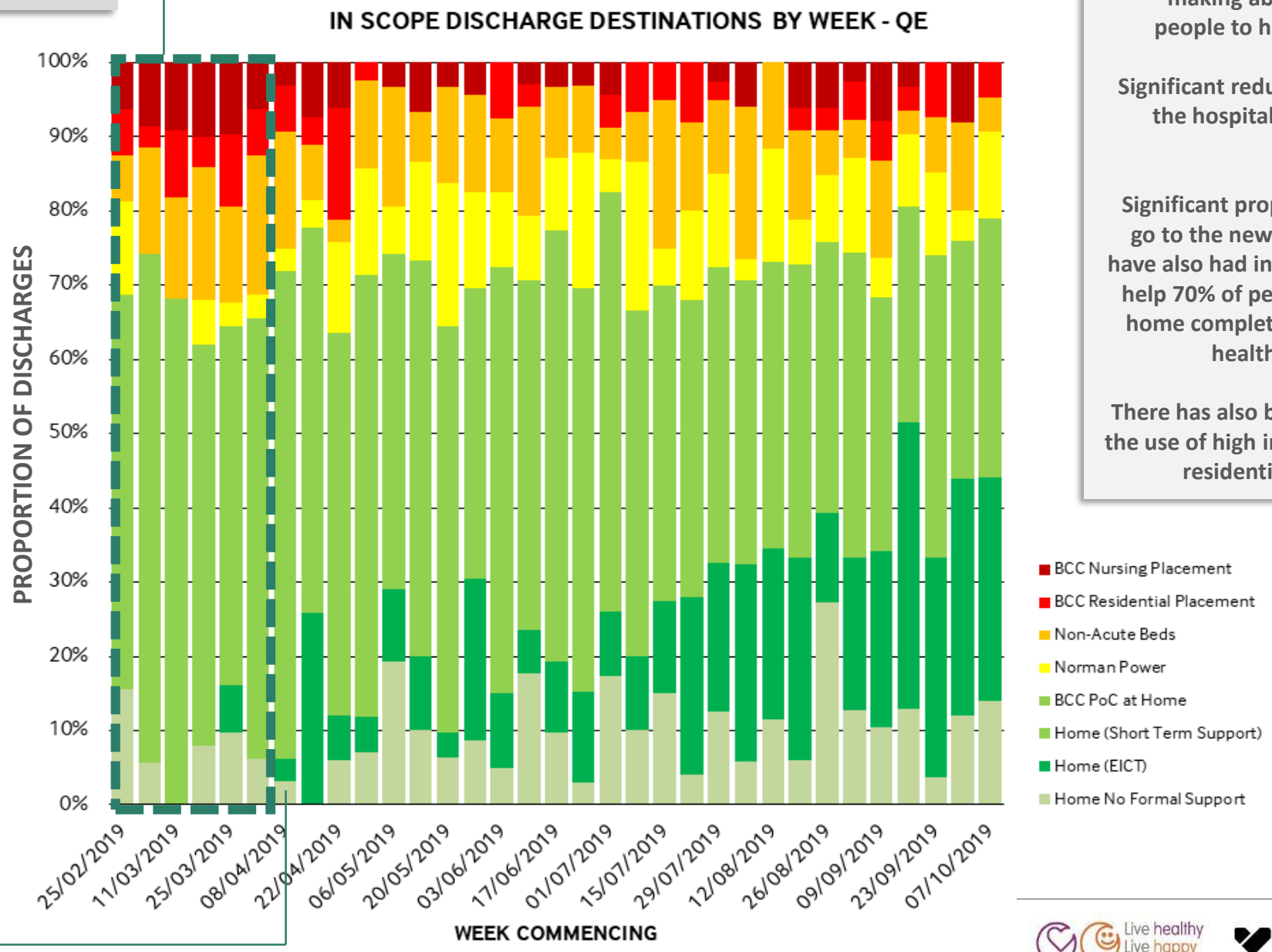
DOWN FROM 14% TO 2%

% OF PEOPLE WAITING FOR 'ACTIVE' TREATMENT

UP FROM 30% TO 58%

A screengrab of the new data, reporting, tracking tool at Juniper that was instrumental in driving up active treatment and daily discharges.

Period before any changes were made.



This graph shows where staff in QE's discharge hub send older people after a stay in the hospital.

Following six months of intense support, the decisions that staff are making about where to discharge people to have completely shifted:

Significant reduction in people leaving the hospital with sometimes costly packages of care.

Significant proportions of people now go to the new community team who, have also had intense support and now help 70% of people they see to stay at home completely independent of any health or social care support.

There has also been a steady decline in the use of high intensity, costly nursing, residential and temporary beds.

Acute back door changes start in QE.

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NHS

Two years later…

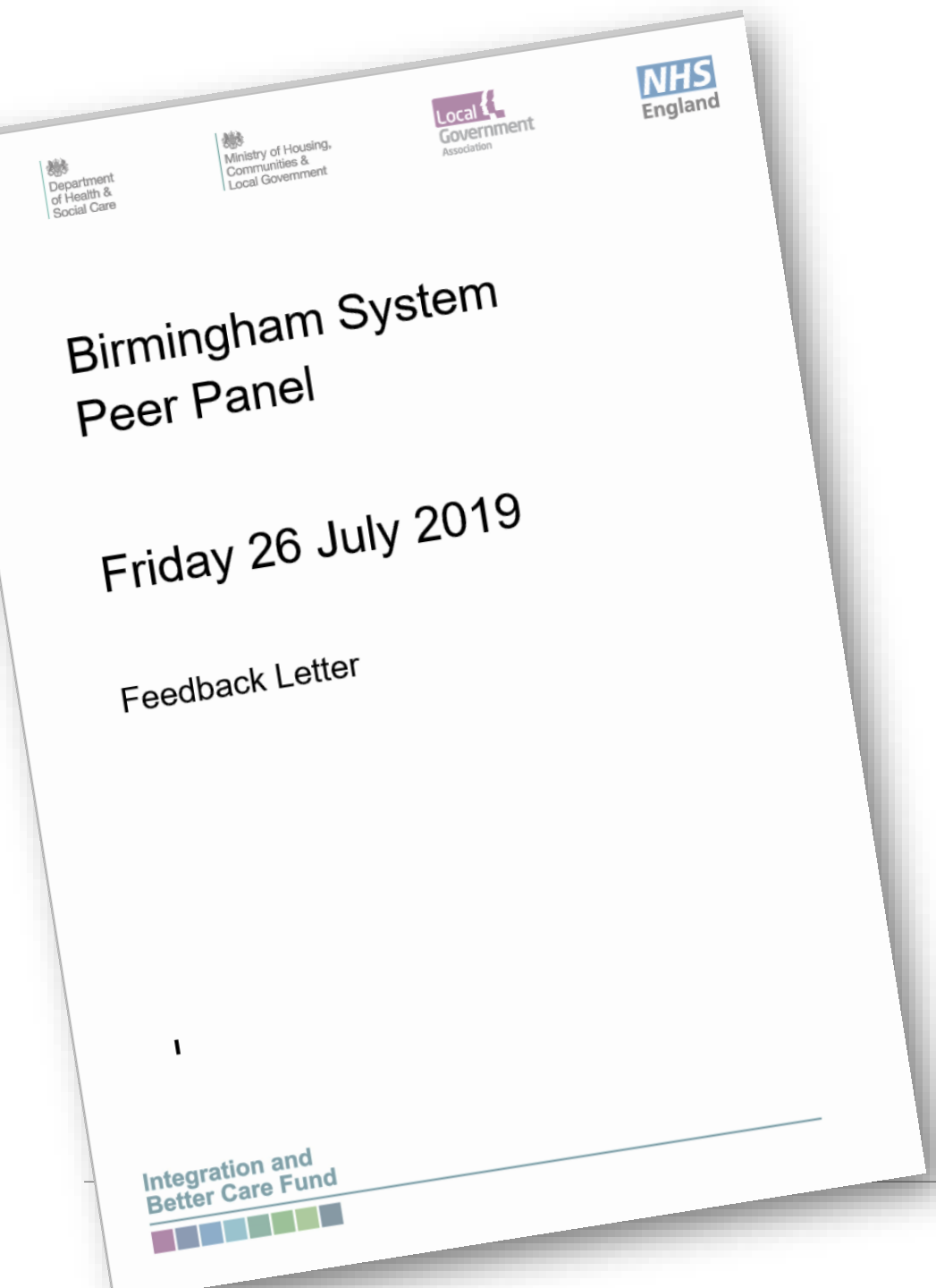
- **Partnership -** cross-system governance; financial & performance group; goodwill shared; nominated lead provider of new community team; rise in mental health profile; Council funded health activity; system level business case; agreement for commissioner/provider alliance…

- **Culture -** front-line designed; front-line trialled; front-line triumph; disparate practice experts working together; performance-led daily management; from gifting care to gifting independence; ownership and accountability…

- **Operationally** - clear, accurate, timely, trustworthy data across the system; processes that help people get what they need, where they need, when they need it; reduced duplication; more efficient use of existing resources; clear, achievable and meaningful KPIs…

- **Improving people's lives** - more people back in their own homes; more people living more independently; more people avoiding hospital admission; more people recovering from a crisis faster….

- **Financially** – by the end of November the programme is on track to deliver annual recurring financial benefit of £15.3m - £21m for the system.



Summer 2019:

"… there is no doubt that Birmingham should be congratulated for grasping simultaneously all of these various elements in order to make a lasting change to the outcomes for older people and to make the best use of the resources that can be deployed to that end. The investment in the programme is clearly very significant in terms of:

- leadership commitment to resource the programmes
- senior leaders' investment of time and passion
- investment in use of local staff across the system as improvement managers
- use of rigorous programme management techniques and formal gateway reviews to quantify whether outcomes and financials are being delivered."

healthwatch

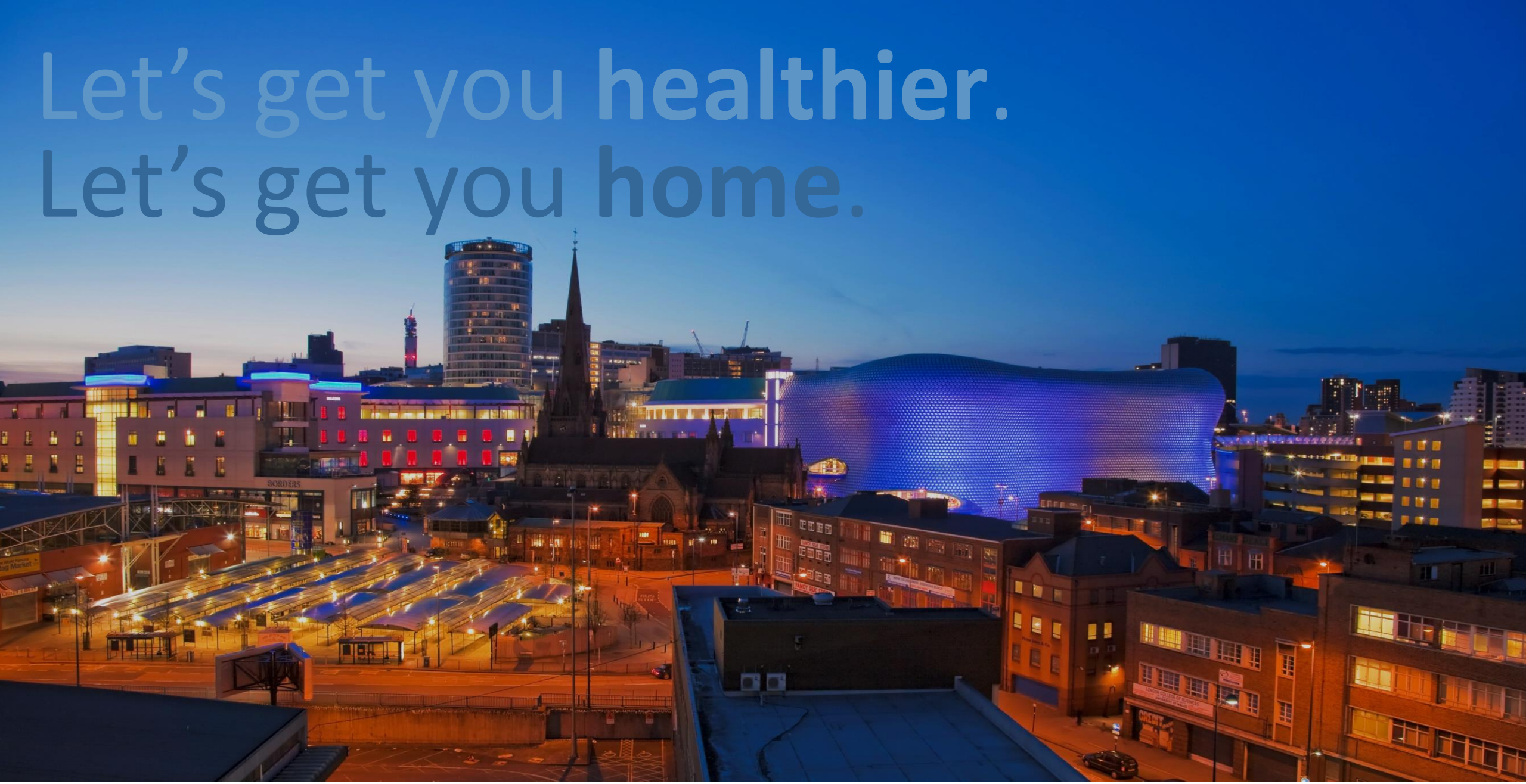
Sir Robert Francis QC

Matthew Winn

Twelve learnings from Birmingham

Arm front-line teams with better information and allow them to get on with making operational changes.	Cross-system governance is easier to map out than make effective.	**Agree a clear vision. Agree what scope to achieve in year one. Fiercely protect that scope.**	Partner agency working at the leadership level – it is not enough to be able to just get on.
Get ready to provide a lot of support to front-line teams as they work outside their 'normal' organisational boundaries.	**Agreeing where operational and clinical responsibility sits is not straightforward.**	When is the right time to talk about a commissioner / provider alliance.	**Be prepared to manage the inequality of organisation effort vs. financial benefit.**
Putting staff with different disciplines together does not spontaneously create multi-disciplinary working.	It is very difficult to avoid making some structural changes even when our focus was on improving our operations.	**Two seasons to prepare for: winter and budgeting.**	Proactive support from property and IT departments will reduce the build up of the 'little things' that signal old behaviours.

Let's get you **healthier**.
Let's get you **home**.



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SUMMARY

Where is your system on the scale?

Are you just delivering integration, or making it **deliver**?

How can you tell?

To make integration deliver we must consider:

Alignment on a measurable outcome – what we are actually trying to improve.

Evidence based prioritisation of what will have the biggest impact for people.

Rigorously measure progress and performance.

Delivering
Integration.

Making integration
deliver.

NEWTON