Wirral Expression of Interest for Health and Social Care Pioneers

Articulate a clear vision of its innovative approaches to integrated care and support:

Our Wirral vision and shared purpose is "to work together to improve the outcome and experience for people with a Long Term Condition by working differently across the whole Health and Social Care system. Through true partnership working and a proactive approach to planning and predicting (risk stratification) a sustainable future across Health and Social Care can be delivered that is of a high quality, safe and cost efficient"

Our patient and public engagement domain has adopted the narrative of the National voices, making it real and developed a strategy based on meaningful involvement and integration. As a group they are collecting individual and carer stories to inform decision making based on real life Mr and Mrs Smith and their family. This powerful literature is driving our model as we listen to those in our community who need us the most.

This group has shared their ideal of a team around the person, to deliver improved patient experience and treat them as a whole people with health and social care working together. This is what our model for integration will deliver.

We have developed through our engagement an outcomes framework (see appendix 1) which will demonstrate our short medium and long term outcomes. This will enable us as a health and social care economy to identify potential efficiencies and measures of success.

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Plan for whole system integration:

The key aims for whole system integration are

- Develop a long term strategy and integrated model for the population of Wirral focusing on risk stratification, integrated teams and Self-care.
- The model will focus on partnership working as the norm and the individual as an expert in the day-to-day management of their condition and other needs, and therefore encourage active participation in all aspects of needs assessment, condition reviews, care/support, planning and decision-making.
- Achieve this through meaningful conversation and dialogue with all key stakeholders, organisations, and their staff.
- Achieve this by engaging with individuals, carers, communities and staff and develop clear credible implementation plan in order to tackle this programme of work.
- Identify the skills, roles and pathways required in order to develop and implement the multi-disciplinary model whilst being able to assess and evaluate its outcomes in line with the outcomes framework.
- Identify those within the Wirral population who are the most regular users of hospital services and are at risk of readmissions, are assessed as having critical or substantial needs - the line of eligibility (Fair Access to Care) or potential users in the future, including those at risk of moving into long term care settings. Classify

individuals according to complexity of need (physical, mental and social) by using the agreed risk stratification tool developed locally on Wirral. The use of this tool will assist with the decision making for the development and location of MDT teams.

- Encourage all on Wirral to join Puffell by registering @ www.puffell.com, a brand new online space to improve health and take control of wellbeing. The self-care strategy adopted for Wirral, launched on the 14th June supporting our public health agenda and delivered jointly by private and voluntary sector collaboration. For those not able to access the internet our voluntary organisation VCAW is providing access at home, in hospital, in one-stop-shops with I pads and mini printers
- Provide governance for the programme and in doing so performance manage the development programme and projects/task and finish groups.
- Develop the implementation strategy and deliver the model.
- Process the evaluation and deliver outcomes.

Progress towards implementation

- Eight working domains have been established to work up the necessary detail to enable the delivery of this whole system re-design integration programme. Each has representatives from NHS organisations and the Local Authority. Our focus is to drive forward to 'change the scale and pace' required to deliver this large scale multi organisational delivery of integrated care.
- A roll out plan is being developed, linked to sustainable application of resources. Initially we expect to have the first MDTs in place in the autumn. The plan is to have 4 Multi-Disciplinary integrated Teams, spread across the Wirral in place by October 2013. The model is as follows;
    - The development of a single point of access for people and agencies to refer to for health or social care support
    - A single referral process which has been developed to establish urgent needs and ensure these are met quickly, and timely needs to ensure these are considered by the MDT
    - A screening tool that has been developed to be used by the MDT to identify the lead professional to be the central co-ordinator of support and care to the person
    - The MDTs are to consider all cases at high risk of admission to hospital or a care home, as identified in the risk stratification, people with long term conditions who require a multi agency approach, and people leaving hospital with the aim of ensuring people are supported at home wherever possible.
    - The risk stratification data will be developed to include social care and mental health data as well as primary health information.
    - It is planned that the MDTs will utilise the risk stratification information to pro-actively offer multi agency support to people at moderate as well as high risk of admission to hospital or care, as the programme rolls out.
    - The core membership of the teams will consist of;
    - MDT coordinator
    - Community Matron
    - District Nurse

- Social worker
- Community Psychiatrist Nurse
- Health Care Assistant
- Access to Therapies – for example - Occupational, Physiotherapist, Dietician & Speech and Language
- Access to Community Geriatrician, Old Age Psychiatry and Mental Health services
- Access to Housing and Housing support services.

- The team structure will be dependent on the local population profile. In other words their location will be largely determined by the risk stratification work developed locally through business intelligence, where we have identified where the pockets of long term chronic conditions are within Wirral and at what stage they are at risk of being admitted to hospital as intensive users of care. This is coupled with work undertaken on the health and social care economy, providing intelligence on our local demographic needs and trends. For example deprivation indices and other indicators. All of this work has been focusing on the mental, physical and social health requirements of the Wirral population. This will be our primary evidence base for the design and location of services required to meet the health and social needs of this population.
- All of the above will help deliver greater prevention of ill health by reducing the duplication present in our current ways of working and thus providing a more integrated approach to caring for our local population, alongside Puffell thus avoiding crisis situations and reactive working.
- The reduction of the deterioration of health and increased personalisation will be achieved through the co-location of integrated teams, a focus on delivering seamless care and the development of more effective sign posting. This will take the form of integrated documentation, budgets and single assessment of individuals referred to the team via a single point of access, therefore providing a coordinated approach to individual care.
- Underpinning the necessary strategic shift are a range of commissioning plans, the Early Intervention and Prevention Strategy and the Market Position Statement.

(Please see October project timeline, appendix 2)

Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area:

- Our Long Term Conditions Integration Programme commenced in 2012 utilising the DH LTC QIPP model. Subsequently the project group were successful and accepted into the AQUA/Kings Fund Integrated Community 2 Programme.
- A Commissioner led Programme Board was established with commissioners, providers and clinicians working together to develop and deliver whole system service transformation through integration.

- Formal Executive Level support and governance arrangements are in place through the Chief Executive Group and the Health and Wellbeing Board. All CEOs have signed a partnership agreement and provide governance to the program (see appendix 3 for governance chart)
- The programme has involvement and support through the Health and Wellbeing Board – report of this bid on agenda for Health and Wellbeing Board meeting in July 2012.
- Communication Strategy to ensure effective involvement of staff groups, and the public.
- Healthwatch, the Older People's Parliament, Patient Forums and Carers groups are fully engaged and are part of the patient and public engagement domain group.
- The 8 domain groups developed from the AQUA/Kings Fund framework are
    - Service Redesign
    - Culture
    - Leadership
    - IT
    - Governance
    - Patients and Carers
    - Finance
    - Workforce

Demonstrate the capability and expertise to deliver successfully a public sector transformation project at scale and pace:

- There is an existing strong culture of joint working between the LA and NHS from a commissioner and provider perspective.
- We are fully involved as part of the AQUA/Kings Fund Integration discovery Community
- We are applying formal programme management – ensuring robust planning and risk identification and mitigation applied.
- There is a full time Programme Manager in place and identified chairs for each of the 8 domain groups.
- Key leaders driving the programme have experience both in the Wirral and elsewhere in designing and delivering complex whole system redesign programmes.
- We are developing a realistic roll out programme, which enables effective implementation and resource, shifts upstream as individuals and carers better supported in their own homes and communities.
- We are planning for a phased roll out from October 13 with a robust delivery plan to support scale and pace.
- There is a risk management process and strategy which is monitored fortnightly via the Programme Board.

- We have recognised that there are significant challenges to be addressed to ensure pace of delivery is maintained. These are primarily related to:

    - Changing culture and workforce expectation and behaviour.
    - Organisational differences and IT challenges.
    - The development of Finance and funding models that support the new model.
    - Ensuring clarity about programme deliverables and timescales.
    - Effective public engagement.

Commit to sharing lessons on integrated care and support across the system:

- We recognise that through involvement in peer-to-peer promotion and through learning networks that there will be a significant mutual learning and benefit.
- We fully recognise that as a Pioneer there is a clear obligation to support the national programme and would ensure the capacity is in place to do so. We have individuals with the necessary experience and skills to do so.
- There is already much Wirral would be able to share on lessons learned so far that would be appropriate to feed through learning networks.
- We have shared learning to date via the action learning sets as part of the integrated community 2 programme
- We have presented our journey and collaborative working at the NHS Confederation Conference in Liverpool 2013, which was well received and generated much discussion and many questions.

Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence:

Plans that have taken account of the latest available evidence

- The plans for integrated care in Wirral have been heavily informed by evidence and support provided by AQUA, and at sessions attended by team members across the North West. These sessions included presentations of the most current evidence for the development and delivery of integrated care for people with long-term conditions, and provided case study examples.
- Development days have been held in Wirral, with support from AQUA, which provided opportunity for Wirral to consider plans and strategies of working in line with current policy and evidence.
- In Wirral, evidence reviews have been undertaken by researchers, to provide an overview of the current evidence, and to inform best practice. An evidence review was undertaken to inform the development of a risk stratification tool, which examined the effectiveness of modelling methods and available tools. An evidence review was also undertaken regarding managing self-care in long-term conditions, which again explored evidence regarding issues and models.

Understanding of the potential impact on the relevant local providers and intended outcomes

- Wirral are undertaking economic modelling to predict the impact of the project on the intended outcomes.
- Two stakeholder engagement events have been undertaken with health professionals and people, with the aim of introducing the concept of integrated care for long-term conditions in Wirral, and gathering evidence regarding issues, acceptability and perceived impact from the outset. The stakeholder engagement

session gathered together health professionals from a range of organisations, including the NHS, local authority and the third sector, and explored health professional's understandings of the integrated team, risk stratification and self-care. The engagement session held with service users and their families explored their understandings and views of integrated care.

- These sessions elicited a number of outcomes that were echoed by both health professionals and service users, including the need for a key coordinator, clear accountability procedures, adequate communication, training and education, working with families and carers regarding patient care plans, and the collection of robust data to measure outcomes. These findings have been incorporated and acted upon in Wirral plans.
- A baseline survey has been undertaken prior to the implementation of the risk stratification tool in Wirral, which explored stakeholder perceptions and expectations of using a tool, and the perceived impact. The survey was implemented using an online survey tool and distributed to a range of healthcare professionals in Wirral, including GPs, nurses, Occupational Therapists, Consultants, and commissioners. The findings of the survey revealed that health professionals understood the need for a risk stratification tool, and their perceived impact of the tool focused around enabling integrated services to support patients appropriately, and reducing hospital admissions.
- The survey also uncovered a number of concerns regarding how the tool may impact on their role, such as increasing the time spent by healthcare professionals on making decisions or undertaking assessments. As a result of this baseline survey, a number of recommendations have informed the implementation of the tool, including considering how and if education could be tailored towards the needs of health and social care services, being clear about the rationale for development, being clear about the anticipated impact of the tool on healthcare professionals, and ensuring that on-going support is provided to staff before and during tool implementation. The survey will be repeated once the risk stratification tool is fully implemented, to explore issues arising and whether expectations have been met.

A commitment to work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support across sectors

- There are clear advantages to mutual development and we have already seen benefits from our participation in regional events organised through AQUA. The Council is currently exploring co-production opportunities with neighbouring authorities. There is strong commitment to sharing best practice learning from others and exploiting opportunity for co-production. This includes the value of learning about producing and testing measures of experience.

A commitment to participate actively in a systematic evaluation of progress and impact over time

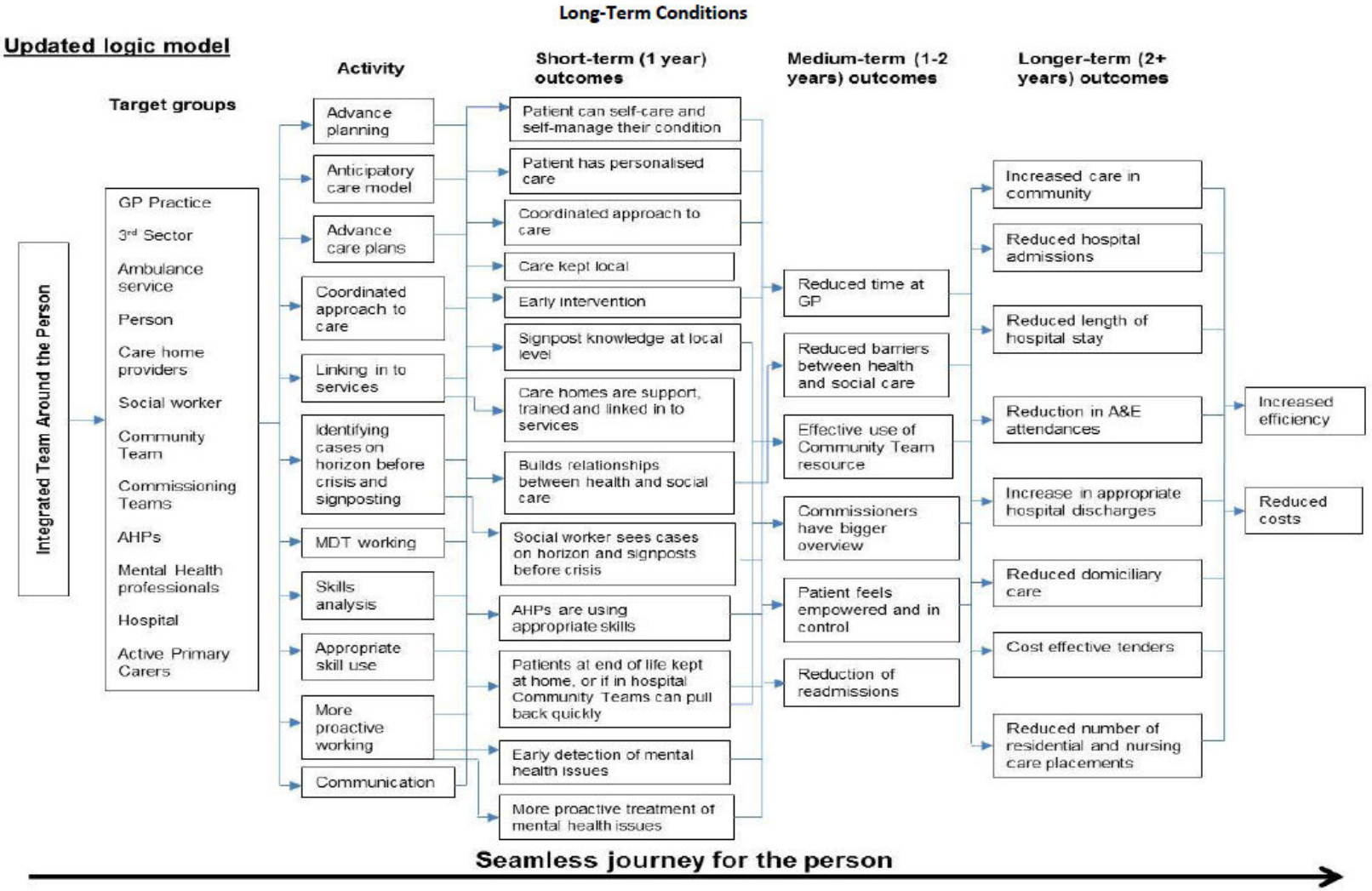
- Wirral have commissioned an external process and impact evaluation of their integrated approach to long-term conditions. The evaluation commenced at a time when the plans for integration were in the early development phases, which allowed a number of activities to take place to inform the development and delivery of Wirral's approach to integrated care. A logic model was developed with project members to outline the activities, outputs and outcomes of the service, and understand priorities for evaluation. The evaluation is carefully managed and is proportionate to the stage of the programme with more in depth evaluation as it is rolled out.
- Process evaluation activities have included gathering evidence of service provider understandings and experience of change (through analysis of engagement activity outcomes and the risk stratification tool), and providing on-going support and evidence to inform development (through evidence reviews).
- Baseline evidence has also informed the local picture of service experience, which has built upon the 'Mrs Smith' case for change model of service user and carer experience, which was used to develop a model for integrated care in Torbay (Thistlethwaite, 2011[1]). This local evidence echoed the national picture, with individual journeys reflecting the need for a clear pathway of communication and action, and further demonstrated the need for change.
- Plans have been developed for an on-going process evaluation throughout the development and delivery of integrated care in Wirral, which will include perceptions of acceptability, feasibility and appropriateness amongst all stakeholders.
- In terms of impact, a number of plans have been developed to ensure impact evidence is captured. Wirral have a well-established performance and monitoring framework, which will explore the impact of the evaluation of a number of quantitative outcomes, including effectiveness of the risk stratification tool, a reduction in inappropriate hospital admissions, hospital length of stay, A and E attendances, domiciliary care, and residential and nursing care placements, and ultimately a reduction in cost. The qualitative evaluation elements will explore how and if integrated care (including the risk stratification tool and self-care interventions) has changed practice, improved relationships across stakeholders (including patients, social care, GPs and Community Teams), improved patient experience, and improved patient care.

The Local Authority and all NHS organisations in the Wirral are fully committed to this application and the LTC Integration Board commends it to the National Partnership for consideration.

27.06.13

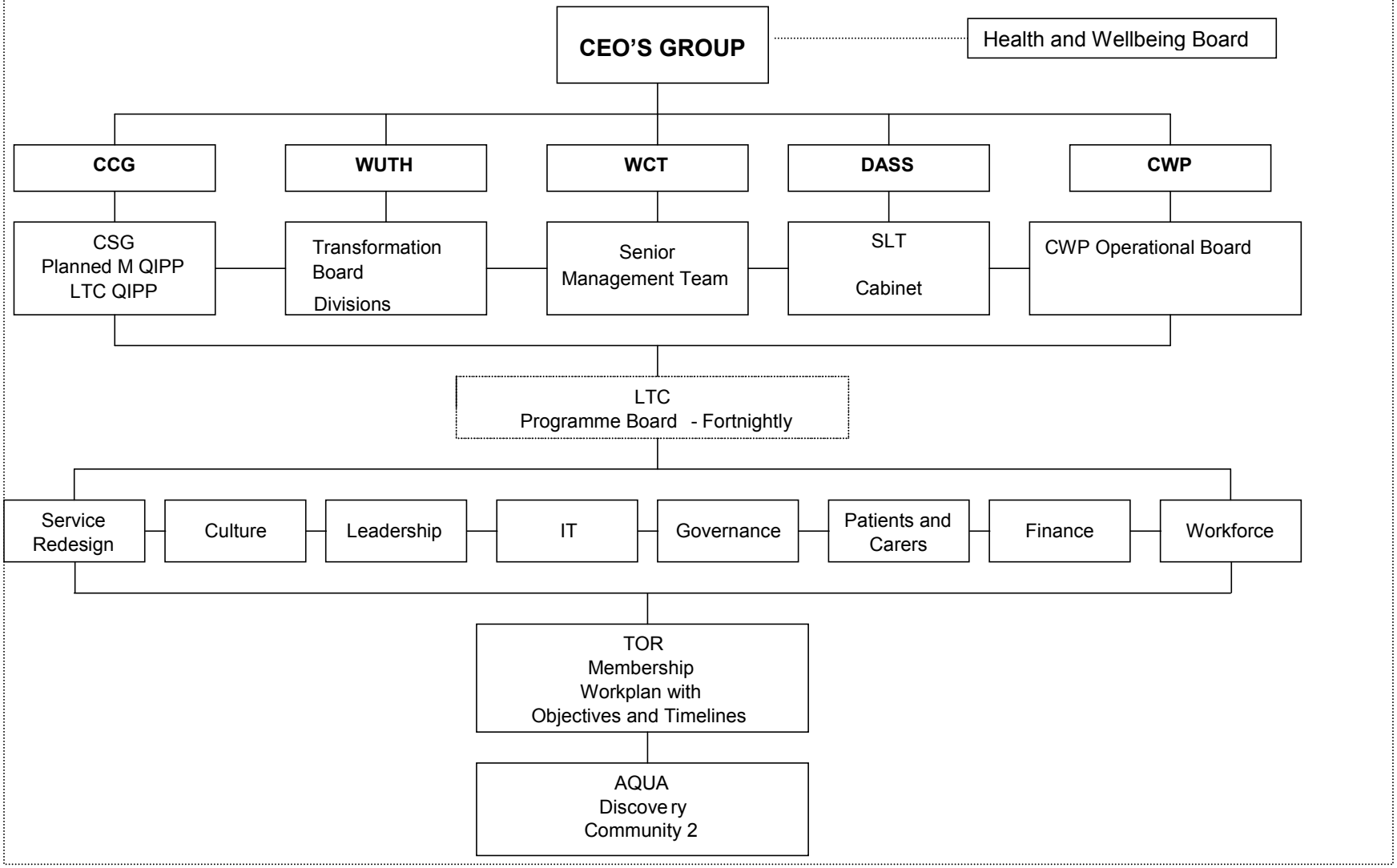
[1] Thistlethwaite, P. (2011). Integrating Health and Social Care in Torbay. Improving Care for Mrs Smith. *The Kings Fund*.

Appendix 1: Outcomes



Appendix 2

INTEGRATED GOVERNANCE STRUCTURE



Apendix 3: Timeline