Transforming Intermediate Care Services in Doncaster

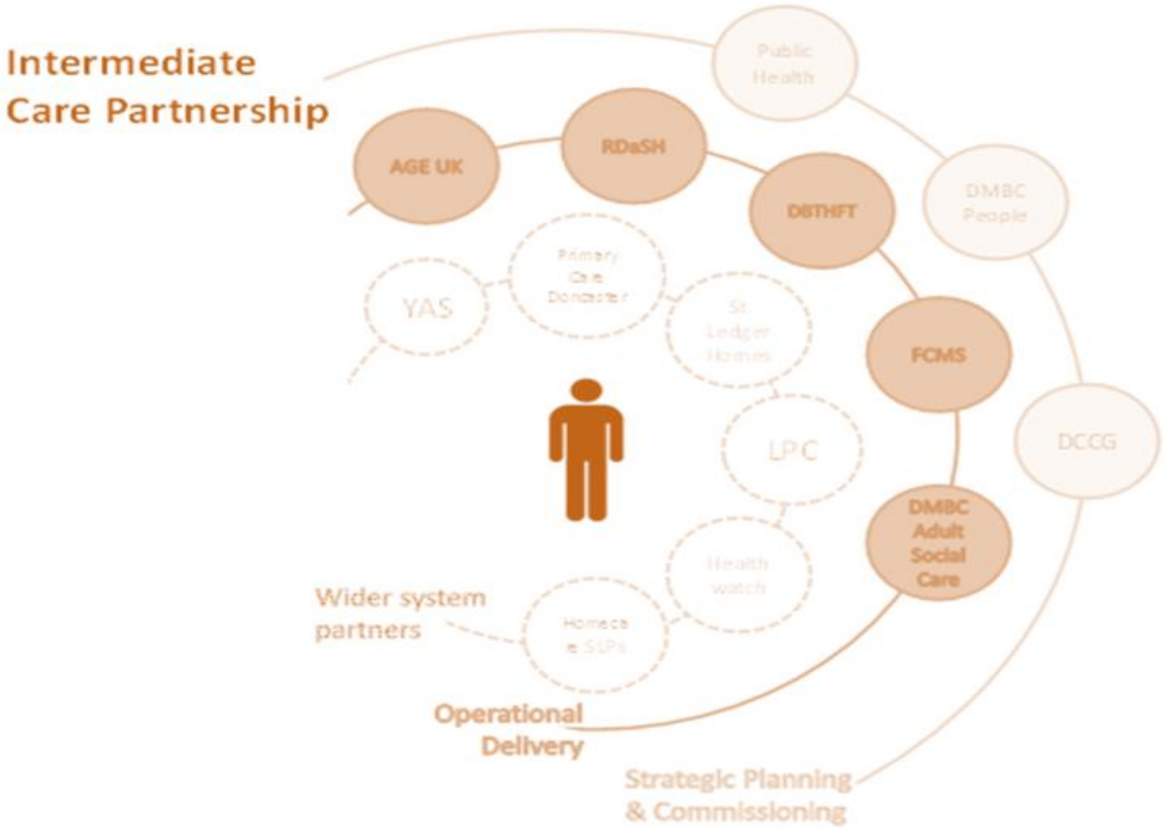
15th November 2018

Local Context

- 2014 identified that we needed a better understanding of current services in Doncaster
- Nationally & locally recognised success in Doncaster but improvements could be made by partners working closely together
- Maintaining health and social care services with increasing financial pressure and an ageing population was a challenge: Redesign on IC could support these pressures
- Consequently the review of intermediate care services was launched resulting in the Case for Change document

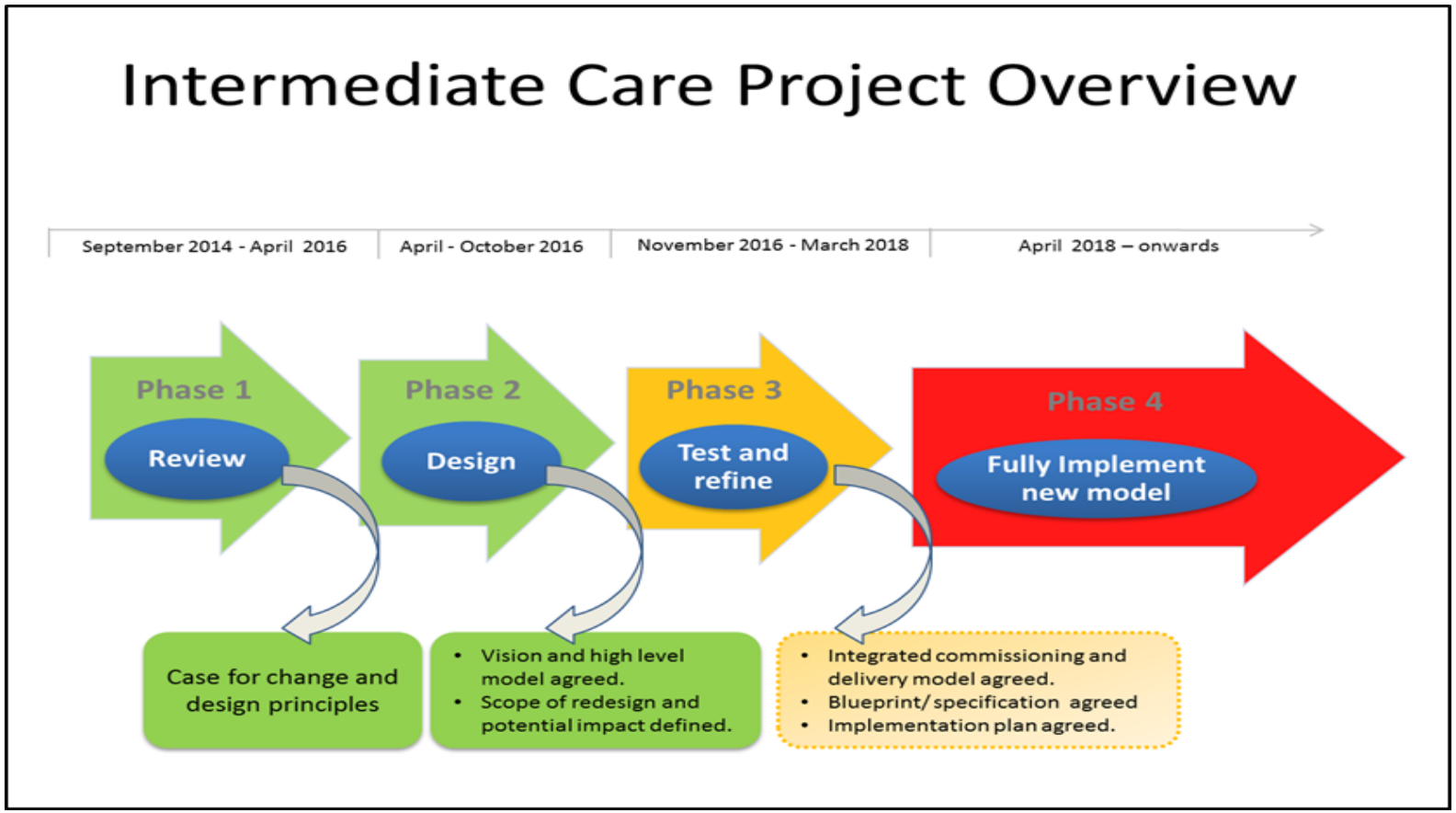
Membership and Governance

The organisations represented fall onto 3 broad categories



- Strategic planning and commissioning
- Operational delivery
- Wider system partners

Overview

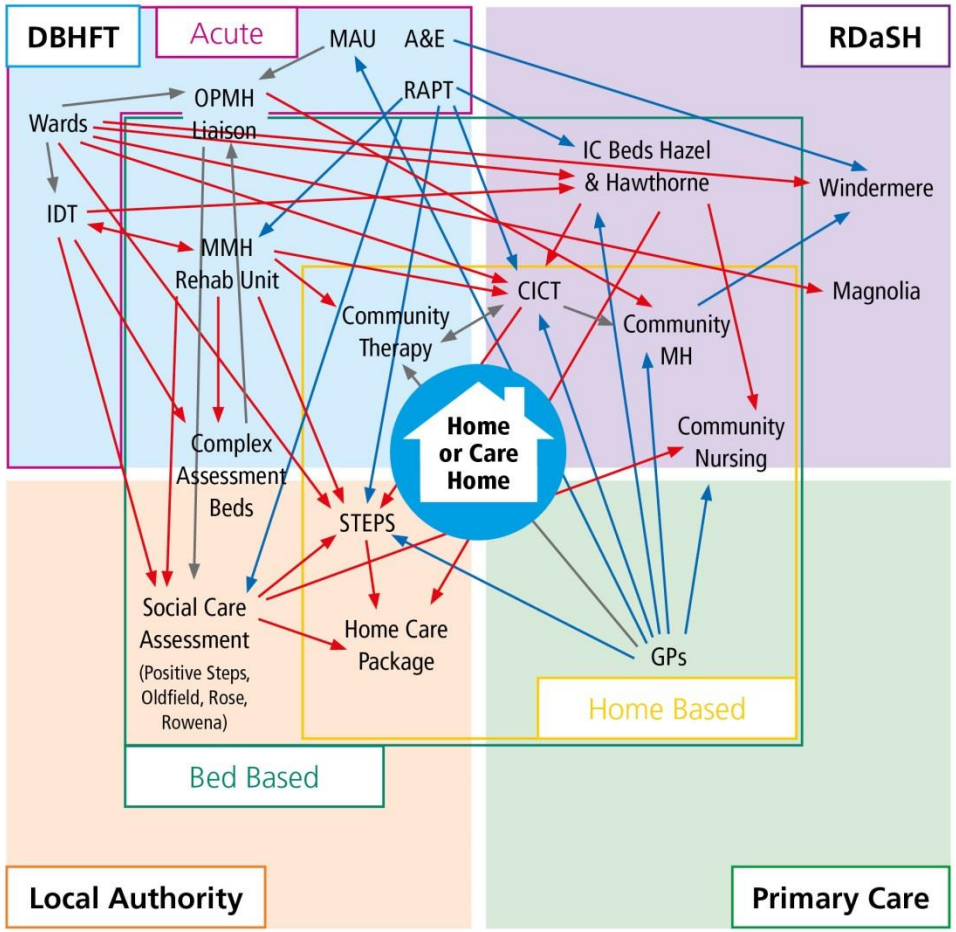

Intermediate Care Project Overview
September 2014 - April 2016
April - October 2016
November 2016 - March 2018
April 2018 – onwards
Phase 1
Review
Phase 2
Design
Phase 3
Test and refine
Phase 4
Fully Implement new model
Case for change and design principles
Vision and high level model agreed.
Scope of redesign and potential impact defined.
Integrated commissioning and delivery model agreed.
Blueprint/ specification agreed
Implementation plan agreed.

Case for change and Evaluation

Phase 1

- Comprehensive in-depth review of statistically significant sample
- Most intermediate care services in Doncaster are set up to support people when they leave hospital and most of the service is bed based
- Lots of duplication and some gaps in provision
- There are not enough home based services to respond quickly at times of crisis and help people maintain their independence in their own environment
- The review found that approximately 50% of over 75 year olds admitted to hospital could potentially have been supported at home with different intermediate care services
- More bed based services than other areas

Services are too complicated, difficult to navigate and are not as efficient as they could be



> *Accessing information and finding out about services could be a matter of chance or luck and was generally more difficult for the socially isolated participants in the study.*
>
> Doncaster Hospital Discharge Pathway Study, Interim findings. October 2015

> *I felt like I was assessed for the same care over and over.*
>
> *Patient quote from face to face interviews.*

Public Engagement

CoCreate & Doncaster CCG worked together to complete:

- Desk-based research
- Scoping meetings with key Doncaster advocates
- Co-hosted a Designing for Diversity Hack-lab
- Co-delivered a number of engagement activities
- Co-delivered workshops to share the findings

This allowed us to include the patient and carer voice within the further development

Key findings

- Difficult to navigate/ unaware of how to get support, especially before an admission
- Repetition of assessments
- Information at the right time
- Loneliness – social support very important
- Complex mix of health and social care needs
- More flexibility in responses offered
- Overwhelmingly people felt they would rather be supported at home rather than hospital as did the majority of carers. It was very important that home based support was available to enable this.

Vision for Doncaster

Phase 2

Delivery model

Central assessment and navigation service, providing…

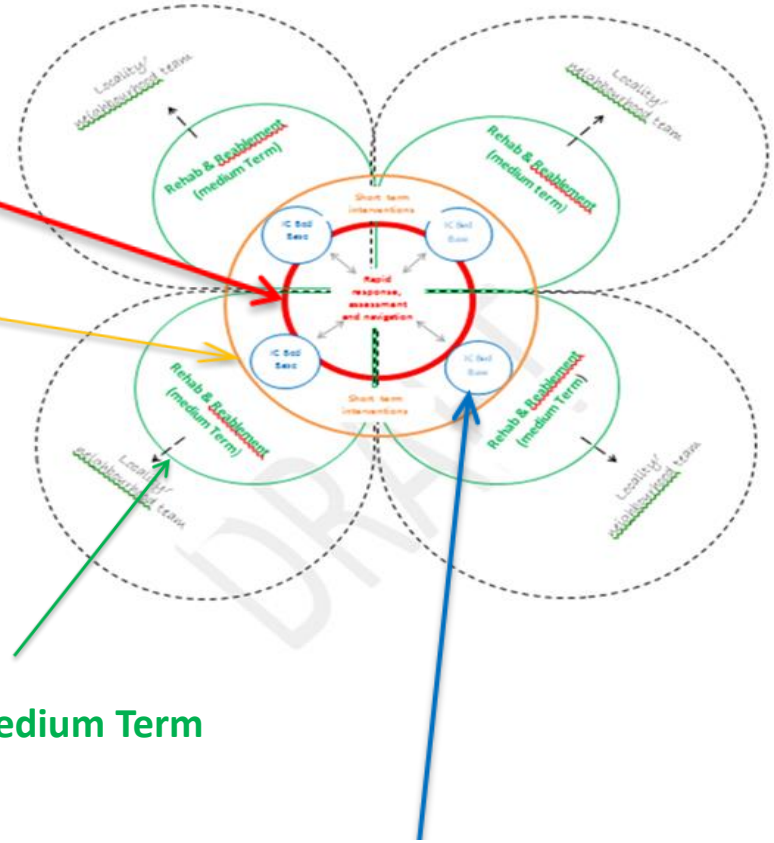
Single point of contact and assessment.

Rapid Response (see and treat or see and solve)

Short Term/ Intensive Response

(see and keep in '*own bed*')

- Co ordination of reablement/ rehab plans -delivered in localities/ neighbourhood teams.
- Provides an overview of intermediate care caseload and closely linked into acute capacity management processes.
- Community based with a presence in A&E and on the wards to pick up face to face referrals.



Locality/ neighbourhood based reablement/ rehab providing the **Medium Term Response**.

Integrated health and social care **Bed Base -** linked to localities. Aligned very closely or staffed by some of the same team as deliver the rehab/ reablement response as would be offering similar interventions but in a '*borrowed bed*'. Longer term the aim is to develop locality based model for bed base, which may mean 4 bed bases, one for each locality as demonstrated above. However the next phase of modelling and locality profiling may suggest that a different number of bases may work better to meet the needs.

Programme Key Aims

To deliver services that are;

- Person centred
- Simpler, easier to access and more joined up, reducing duplication and delivering more efficient services
- More step up support to prevent deterioration, admission to hospital and care home admissions
- A greater range of home based support
- Bed or facility based support for those that cant be safely supported at home

Key Achievements

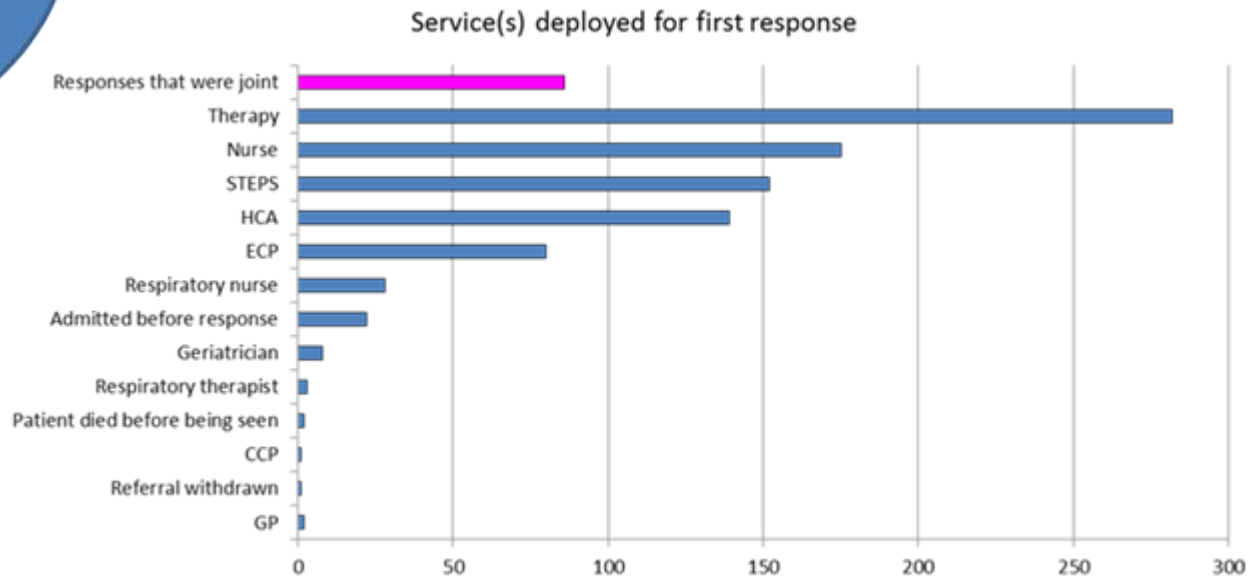
- Rapid response team: Five providers offering an integrated single co-ordinated response to support an individual to stay at home
- Implementation of the Integrated Care Record across Doncaster
- Community service referrals routed through SPA, including an integrated triage process
- Exploring options for alignment of the Council's front door programme and SPA
- Options appraisal completed to redirect the resources from 20 beds into community services, including comparison work to provide a breakdown of resources needed to provide support in the community
- Development of an Integrated Outcomes framework
- Development of a Communications & Engagement plan

Key Achievements

Impacts of Rapid Response (over 1,000 referrals)

By 30 September
76%
of patients accepted by the Rapid Response service were supported at home

Of those followed up by the Rapid Response Service, 66% were still at home after 30 days



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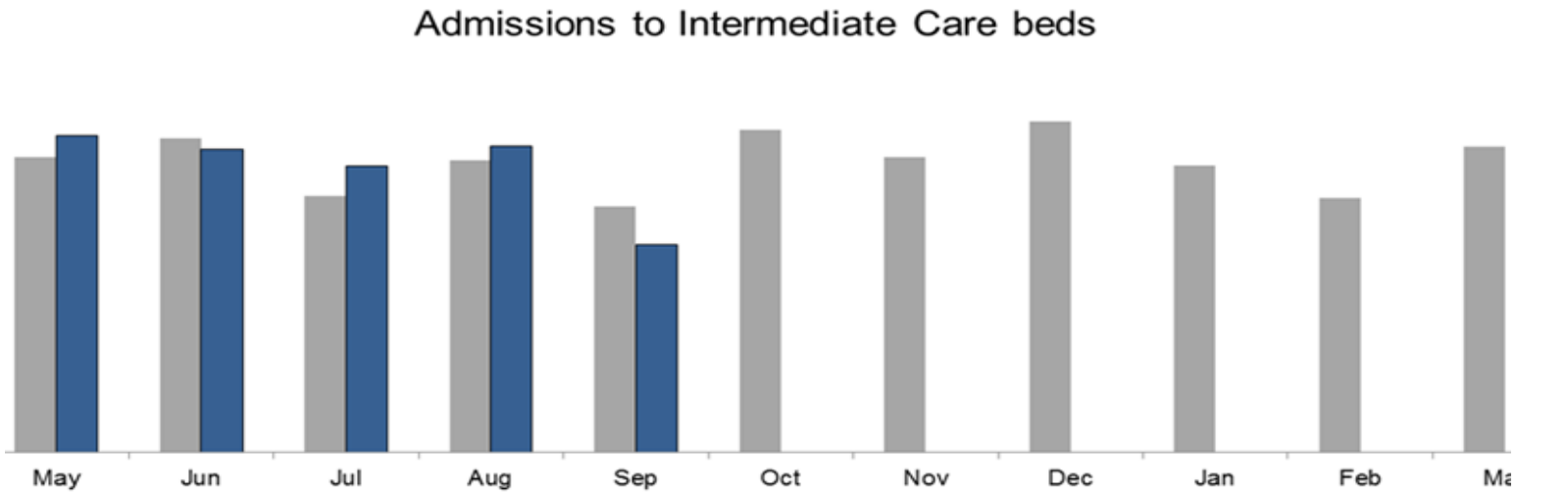
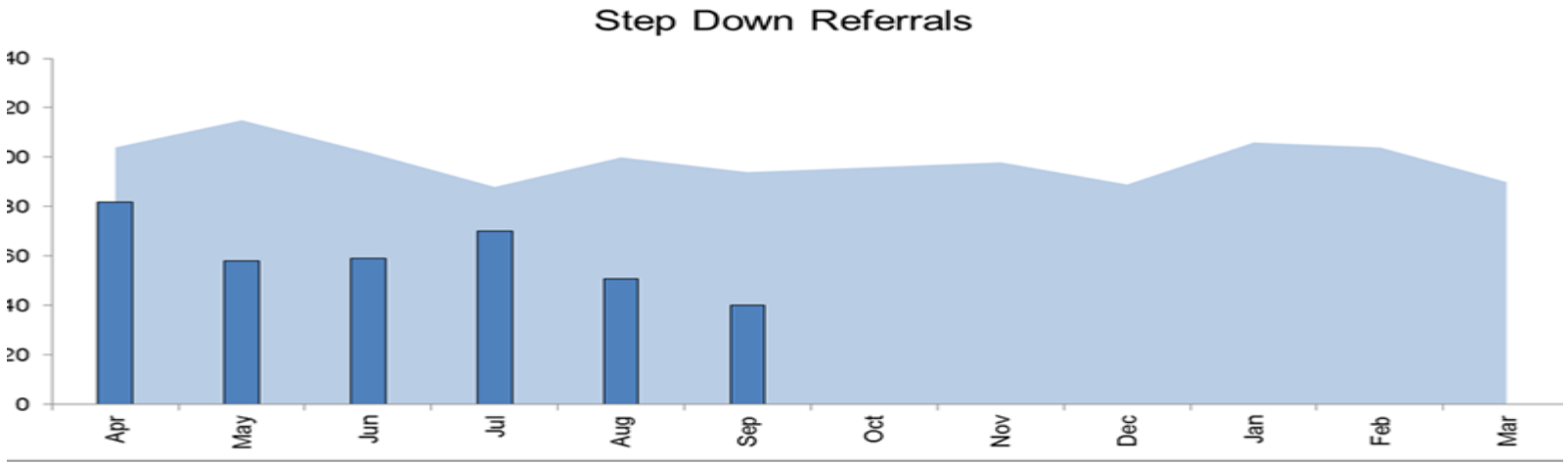


Increase in community based activity linked to reduction in bed activity



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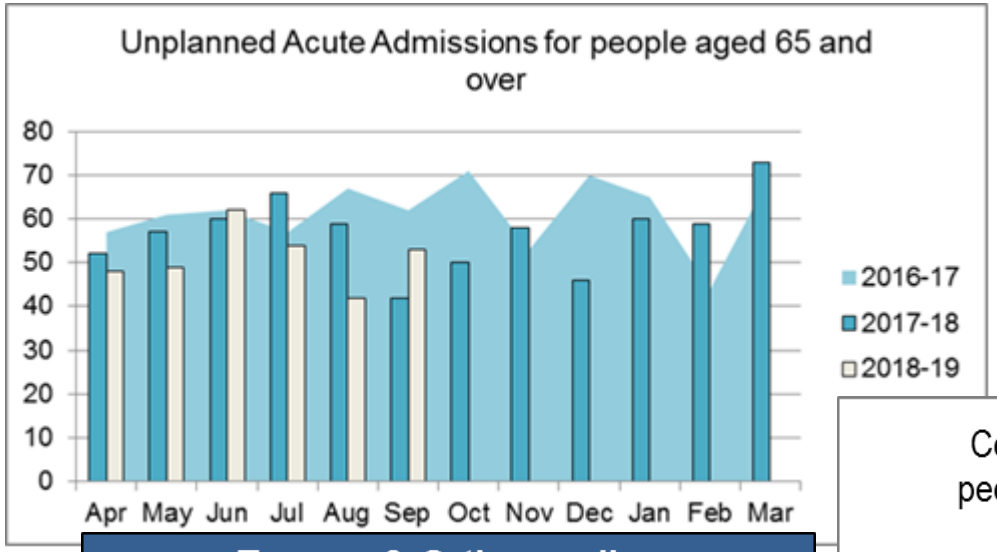
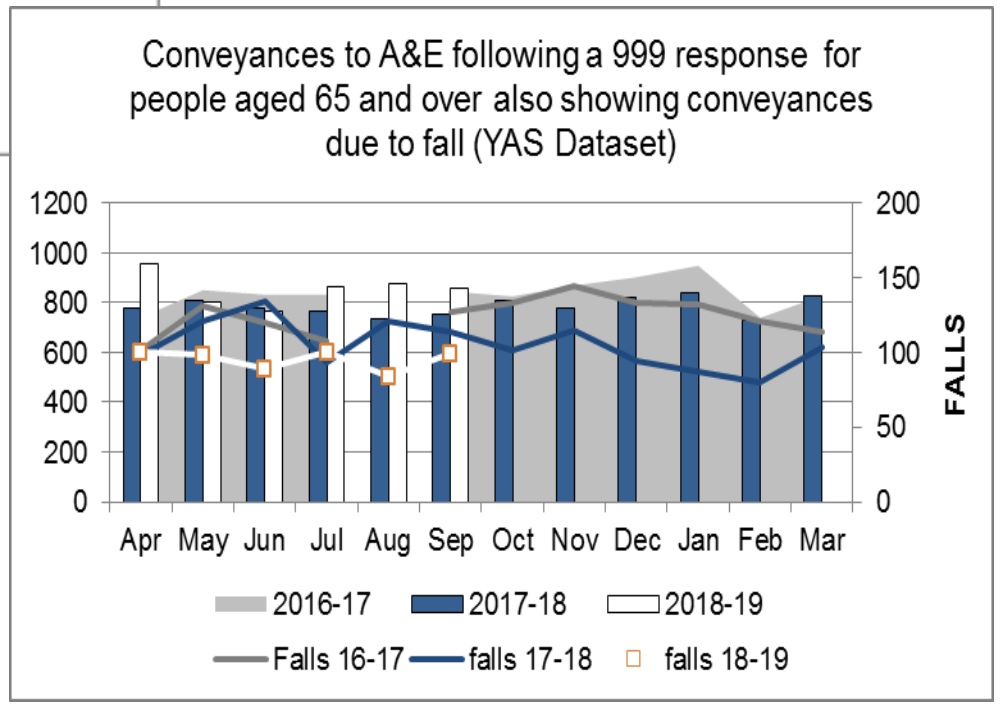


Trauma & Orthopaedics

Wider System impacts



Testing the New Model

Phase 3

- The Programmes Journey

STAGE ONE

January – March 2018

- Establish joint leadership arrangements (providers), set up integrated contracting meeting and identify joint commissioning lead.
- Finalise and agree year one specification for inclusion in 2018/ 19 contracts.
- Confirm target for & savings from reduction in bed base in year one.
- Identify project resource to support implementation/ transformation.
- Sign off outcome model.

STAGE TWO

April 2018- March 2019

- Delivery of year one arrangements (as set out in specification/ included in contracts) by the Doncaster Intermediate Care Partnership, made up of existing core partners – with partnership agreements in place for commissioning and delivery.
- Continue to grow community intermediate care offer and start to reduce bed base to release recurrent funding to support this growth.
- Further simplification of access and streamlining of teams.
- Develop a system wide, integrated workforce development plan and establish single management structure.
- Partnership to work together to scope & model plans for system wide redesign of the bed base, linked to wider estates strategy.
- Implement joint contract management arrangements reviewing against shared outcomes.

STAGE THREE

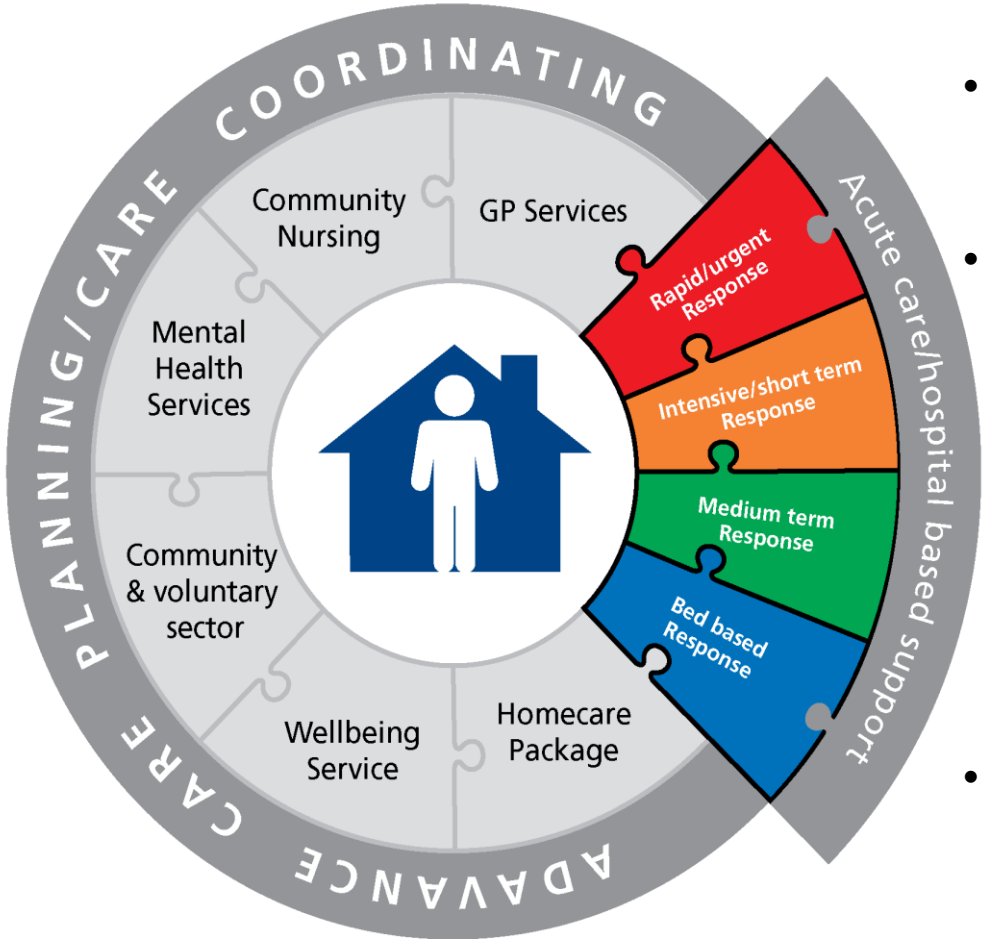
April 2019 onwards

- Formal integrated commissioning and delivery of Intermediate Care by an alliance of providers to be in place from April 2019.
- Implement next stage of bed base redesign.
- Increase scope to reflect work in year 1.
- Implement system wide worforce plan and develop relevant integrated roles.
- Identify further efficiencies/ opportunities to increase productivity.

Benefits

- People are supported to maintain their independence & live at home, prevent admissions to acute care and are supported to return home as early as possible
- Fewer people require long term care
- More people remain at home following an episode of intermediate care
- When intermediate care is needed people receive a simple, responsive & flexible service
- People who use Intermediate care will receive a holistic integrated service & report an improvement in their functioning and quality of life following involvement the episode of care

Long Term Vision



- Simplified access and a single assessment process
- An increased and more flexible community offer providing a range of responses;
  - rapid response
  - short term/ more intensive interventions.
  - Integrated rehab and reablement (medium term)
- A smaller integrated health & social care bed/ facility based offer.

Challenges

- Delays due to Governance framework
- Cost of community services
- Limited engagement from the voluntary sector
- Historically a competitive environment

Commissioning Intentions

- Develop suite of documents to be mirrored in each existing providers contract
- Establish a Financial model to underpin the care model
  - Proposal on how we move from the current funding stream towards the future model articulated In Doncaster's Place Plan by understanding the opportunities to gained around pooling budgets or other mechanisms to make this work
- Understanding contractual levers/incentives and the contractual model to make this work
- Governance

Questions