Integrated Health and Care in Ipswich and East Suffolk and West Suffolk

Service Model Version 1.1

This document describes an integrated health and care service model and system for Ipswich and East and West Suffolk. It has been created by a wide range of partners as part of the Health and Care Review, set up by the Suffolk System Leaders Partnership which took place between January and August 2014. Partners involved included:

- Service users
- Health and care providers
- Health and care commissioners
- VCS partners
- District and borough councils

1. Introduction to Integrated Health and Care Model

The case for change in our health and care system is strong. In Ipswich, East and West Suffolk we are taking action to meet this challenge for change, and to develop a health and care system that works well for people. A system that supports people to lead healthy and independent lives, but that when they do need help provides this swiftly and effectively, with a view to getting them back to their own lives, in their own homes with access to the people and activities that they enjoy. A system that seeks to prevent health and care needs, not simply to treat them when they arise. A system that puts people in charge of their own health and care plans, and takes account of what matters to people.

This document describes the new model we are building together. It opens with an explanation of our key objectives and outcomes, along with a description of the "pathway" through the system. If then sets out the delivery mechanisms for change giving more detail about aspects of the new model.

It is suggested that this document is read in conjunction with the Health and Independence Model and the Integrated Urgent Care Model as these documents provide the detail which underpins the integrated health and care service model.

2. Key Objectives

The Health and Care Review, Better Care Fund (BCF) and NHS Five Year Forward View provide opportunities to address the key challenges facing the public sector and improve health and social care within Suffolk.

1. **Help people to be more independent for longer, whenever possible.** People are living longer, often with multiple long term conditions and increasingly complex needs. Their needs do not fit neatly into "social care" or "health", and cannot be met by addressing these in isolation. People want information, advice and support to help them to live independently for as long as possible regardless of their health diagnosis. By delivering integrated care in Suffolk people will be able to get help earlier and access a wider range of options, including self-help, which reduce the need for intensive and longer term support. Services will be tailored to the distinct urban and rural communities that characterise Suffolk.

2. **Reduce costs of health and social care.** Both local government and the NHS are managing net reductions in budgets, despite the increasing demand and cost of services. A drive to seven day working and increasing patient and customer choice are further contributing to pressures. The current fragmented system leads to duplication, multiple assessments and professional contacts, and sometimes conflicting plans and advice. Integrating care in Suffolk will mean we configure our systems so that people receive seamless, coordinated care and integrated services, which are not duplicated or leave gaps. This will mean we use resources more effectively and take early action which prevents long term costs in the future. For example, a reduction in the demand for hospital based emergency services

through community based health and care services keeping people well in their own homes.

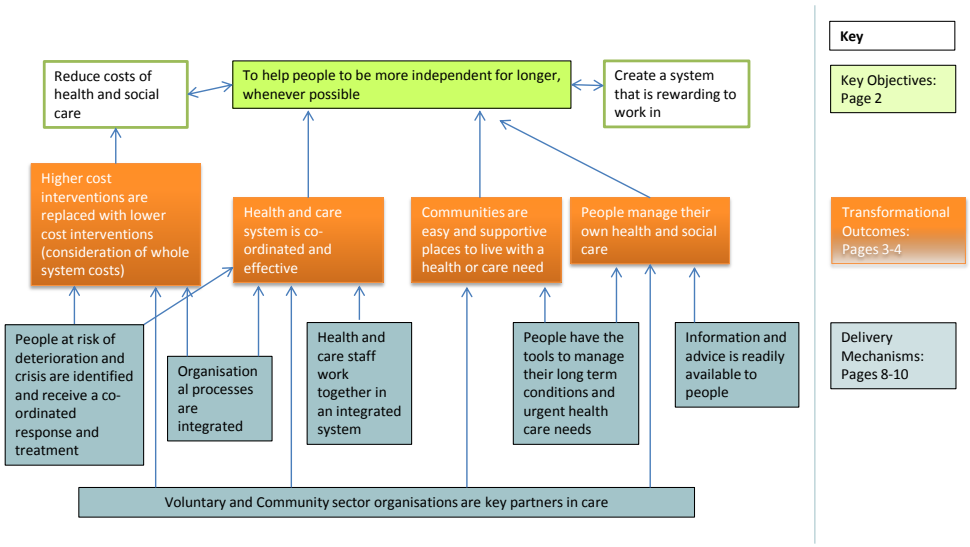
3. **Create a system that is rewarding to work in.** Health and care organisations are increasingly struggling to recruit staff. Integrating care will require professionals to work in a new model of health and care and will make the sector more attractive and rewarding to work in. This will contribute towards more motivated, productive staff that are better able to deliver improved outcomes for people.

3. Health and Care Integration Theory and Outcomes

The Health and Care Review is proposing that in Suffolk, four main overarching outcomes can contribute towards the achievement of the three objectives described above (see Figure 1 below which sets out the Health and Care Integration Theory of Change diagram).

This will be achieved by working in partnership with voluntary and community sector organisations; providing people with information, advice and tools to manage their long term conditions, including information about and connections into their communities; integrating organisational processes; identifying people at risk of deterioration; and providing coordinated responses to meet both planned and unplanned care needs. (Section 5 describes in more detail how these changes will be delivered).

Figure 1 Health and Care Integration Theory of Change



Further explanation about each of the four transformational outcomes is set out below:

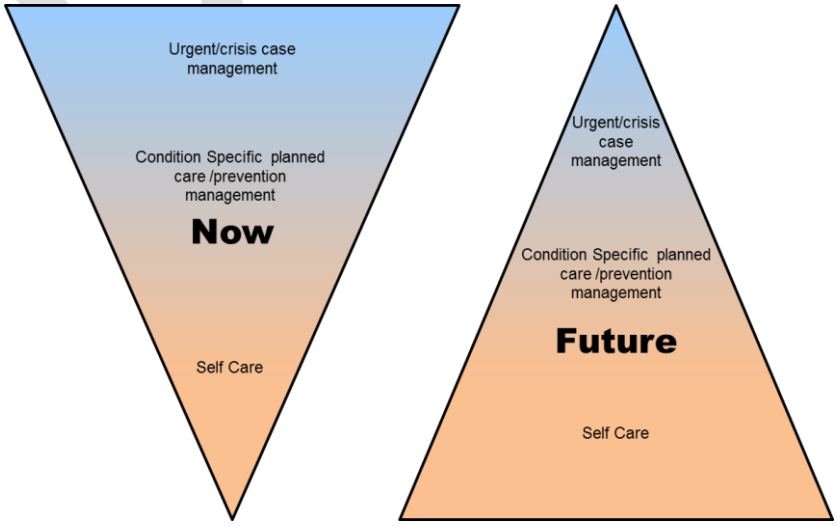
1. **People manage their own health and social care with the right support when needed.** When people have the tools, information and advice to self-manage their health and social care, the whole system will support people and their family carers at every stage to be more independent for longer. This will include information about local Neighbourhood Networks (NNs) and the groups, societies, clubs and other services within the community including help for people to link up with them.

2. **Communities are easy and supportive places to live with a health or care need.** Integrated care in Suffolk will mean people can get many of their needs met within their own community. Integrated Neighbourhood Teams (INTs) will work in a coordinated, collaborative and flexible way. They will work closely with Urgent Care and Specialist Services where needed ensuring that people are treated swiftly and discharged safely to their own homes and will draw support from their NNs made up of voluntary and community organisations. This is shown visually as a pathway in Figure 3.

3. **The health and care system is co-ordinated and effective.** Integrating care in Suffolk will create a single system with common processes and procedures to ensure resources are used in the right place, information is shared and there is good communication around the system. This will blur the lines between hospital and community when more specialist interventions are needed for a person's plan. The vision is for integrated, person-centred care and support achieved through greater integration and co-operation between health, care and support and the wider determinants of health.

4. **Higher cost interventions are replaced with lower cost interventions.** Integrating care in Suffolk will improve care by keeping people as well as possible and helping them to avoid crisis and emergency care, and reduce the demand for hospital based emergency services. When people do need interventions they will focus on helping people regain the independence they want and value, with swift and appropriate support**.** Family carers who are key to helping their relatives regain independence will also be supported. This shift in resource is depicted in Figure 2 below.

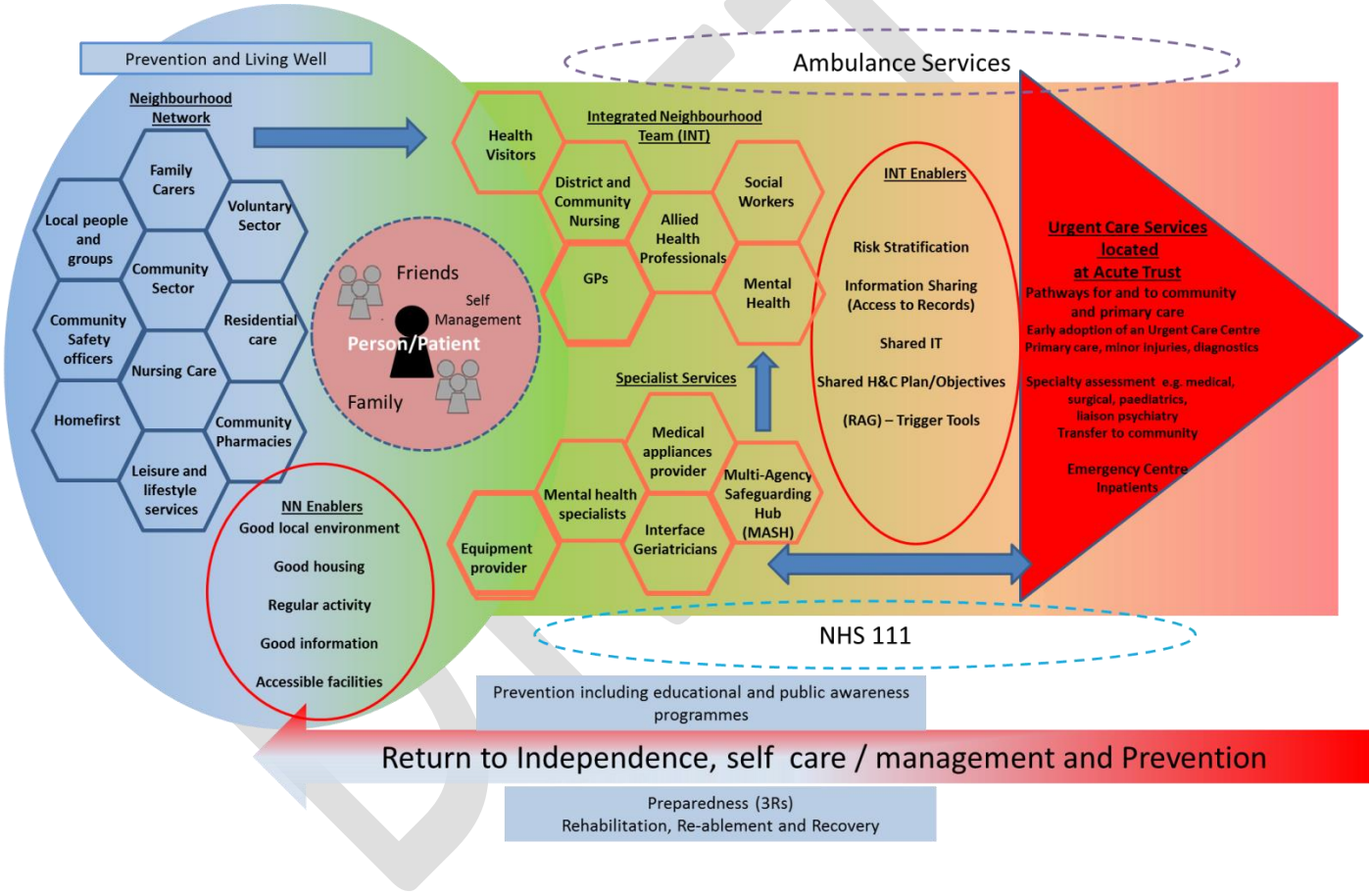
Figure 2: Current and future workload of the Health and Social Care system



4. Integrated Health and Care Pathway

The diagram at Figure 3 below sets out how Suffolk health and care services integrate as a pathway from prevention and care co-ordination through to urgent care response and treatment and finally, returning people back to their home swiftly so that their independence is restored and they are once again able to self-care and manage their own condition.

Figure 3: Integrated Health and Care Service Pathway



a: Prevention: This initial stage of the pathway is primarily concerned with keeping people happy and healthy in their own homes supported by a range of support networks. These networks include the local people, groups, organisations and statutory services which a person uses to improve or maintain their vision of a good life.

The people may be family, friends, neighbours, carers and support workers. The groups could be focused on an interest of hobby or provision of a local service i.e. lunch club, a church or befriending group. The organisation could be voluntary sector organisations, providers of personal care, sport and leisure and statutory services for local area co-ordination such as housing, care and support, GP service, police and district councils. In Suffolk, these support networks will be known as 'Neighbourhood Networks'.

Health and care services will have a key role in the provision of preventative services to people - that is services which help prevent or delay the development of care and support needs, or reduce care and support needs (including carer's support needs). This also includes educational and public awareness programmes linked to public health initiatives such as smoking cessation and weight management and marketing of appropriate health care options e.g. alternatives to A&E

b: Integrated Care Co-ordination: The second stage of the pathway focuses on keeping those people who have multiple or complex health or social care needs well in their own homes or place of residence. These people, who may well be at risk of hospital admission, will be identified by health and care professional such as GPs, social workers, and district nurses. These professionals will work together as a team to assess people care needs and plan and co-ordinate services so that peoples care needs are proactively met. In Suffolk, these health and care teams will be known as 'Integrated Neighbourhood Teams'. The health and care professionals providing the assessment and co-ordinating services will be known as 'Care Co-ordinators.'

In many cases, the Care Co-ordinators will provide the majority of care for people. However, in some instances there will be a need for a more specialist care from other providers such as mental health or geriatricians and the Care Co-ordinators will arrange this input. The Care Co-ordinators will also help people access prevention services or resources via the Neighbourhood Networks for people where this is needed.

c: Urgent Care Response and Treatment: The prevention and care co-ordination stage of the pathway focuses on helping to keep the majority of people happy and well in their homes. However, there will be always be some people who have accidents or who are taken ill suddenly without warning - in these exceptions a clear route to help followed up by a rapid response for assessment and treatment is critical.

In Suffolk, telephone access to urgent care services will be simplified by further reducing the number of telephone access routes available to people so that there is less confusion about who to contact for urgent and emergency care needs.

The ambulance service and NHS 111 service will work closely with services based in the community to agree when it might be clinically appropriate that people are referred onto primary and community services for treatment as an alternative to acute based hospitals. These primary and community services include community hospitals, minor injury services provided by GP practices, minor injury walk in services and the GP Out of Hours service.

At A&E there will be better management of people attending with health or care problems which are not emergencies such as minor injuries and illnesses. Primary care will have a greater role in

and out of hours in assessing and treating people presenting with minor injuries and illness - the Emergency Department will continue to focus their resource on those people presenting with critical or emergency care needs.

People attending A&E with minor injury and illnesses will be encouraged in the future to consider using other services in the community. They will be supported to register with a GP for example or given information about the location and opening times of alternative primary and community services that they could access.

d: Returning to independence: The final part of the pathway focuses on ensuring that people who receive care at acute hospitals sites are supported by the health and care system to swiftly and safely return to their own home or place of residence.

The Integrated Neighbourhood Teams will have a key role in organising reablement and rehabilitation services such as community beds or arranging equipment or home adaptions which would help a person to live at home independently.

Where there is a need for a follow up, the Integrated Neighbourhood Teams would provide this quickly with a view to preventing future acute needs. The Neighbourhood Networks will help people to get back to doing the things that they enjoy in the community.

5. How we will deliver these changes

This section sets out the delivery mechanisms to deliver integrated health and care.

Organise Health and Care Staff Operationally so that they work together in an Integrated System

- **Integrated Neighbourhood Teams (INTs).** The INTs' role is to ensure health and care interventions are planned, proactive, and reduce the need for crisis and urgent intervention. The INTs will enable self-management, support individuals to maintain their independence, support admission prevention activity, support effective hospital discharge and provide an integrated approach to end of life care. The INT will include a core range of generalist services from community health, adult social care, primary care and mental health.

- **Urgent Care.** For people who require an urgent care response the INTs will co-ordinate care to ensure that people are treated promptly by the most appropriate service, discharged and returned swiftly back to their own home from Ipswich Hospital and West Suffolk Hospital, and by the East of England Ambulance Service.

- **Understanding the needs of their local population.** The INTs will flex to meet the needs of the localities they operate in and to deliver service improvements. They will work in collaboration with Neighbourhood Networks and build local health profiles to ensure the needs of the local population are understood. The INT health and care workforce will be trained, experienced and knowledgeable in adult health and care.

- **Specialist interventions.** Some services such as Interface Geriatricians, community hospitals, specialist dementia advice, will be organised on a wider geography. They will be provided by a range of organisations and work to a common set of processes and service delivery principles. Many of these Specialist Services will work alongside the INT, and join them for Multi-disciplinary Team (MDT) meetings to both mitigate risk of exacerbation and to respond appropriately at times of crisis. They may also hold a small caseload for focussed and time limited work where there are complex needs.

- **An INT in each locality.** INTs are geographically aligned to work with a population corresponding of between four and six Suffolk based GP practices. The proposed INT areas are similar to the current social care and community health team configuration. Co-location is a key ambition of the Health and Independence Model and refers to physical co-location where possible of community health and social care professionals (utilising future opportunities through estates).

- **Core skills across the system**. The INTs will include a core range of generalist services from community health, adult social care, primary care and mental health. Although the delivery of the proposed model does not require staff to change employer at this time, the mix of skills and staff will change over time to meet the needs of each local population. The ambition is to move away from traditional boundaries and towards the entire health and care workforce being trained, experienced and knowledgeable in adult health and care systems and able to give good information and advice.

Integrate Organisational Processes

- **Co-ordinated procedures and referral protocols.** The work of the INTs will be supported by a range of operational processes and protocols that ensure that different agencies working across health and care can deliver co-ordinated care, for both planned and urgent care needs. For example, primary and community providers will have protocols with the East of England Ambulance Services Trust and NHS 111 for appropriately diverting patients away from A&E and into services located outside of hospital such as minor injury services provided by GP practices, minor injury walk in services and community hospital services and facilities.

- **Improved telephone access.** There will be simpler access routes for people so that there is less confusion about who to contact for both ongoing and urgent care needs, including through the night when local daytime INT services are not available. Where someone has been in touch with one part of the health and care system there will be better co-ordination across the system to make sure that people get the right help at the right time.

- **Information sharing, Information Management and Technology.** Although initially there will be separately held information and data, our ambition is that appropriate information will be shared between professionals and with people themselves. Information sharing will be enabled by integrated information and technology infrastructure, robust governance, consent procedures and service management arrangements.

- **Joint assessments.** Joint Assessments will be based around a core assessment covering a standardised set of questions. Specialist assessment will build on the core assessment to provide a comprehensive assessment across health and social care. In some cases this will be carried out in specialist teams, for example for people with a mental illness or people with dementia.

- **Joint capacity reviews and planning.** Demand for health and care services is rising and in order to meet this need it will be important for health and care commissioners to join up planning processes to ensure that capacity is meeting this demand. The development of joint priority outcome areas linked to rising demand may be help to focus where capacity review would warrant focus (although this may change year on year).

- **Joint communications.** We will improve communication and coordination between organisations and agencies across health, social care and the voluntary sector. We will develop informal and formal open communication within the INTs and NNs. We will also improve communication associated with integrating services. This will help us to deliver improved outcomes for people using services.

Identify People at Risk of Deterioration or Crisis and provide them with a Coordinated Response and Treatment

- **Prevention.** We will ensure the provision of preventative services - that is services which help prevent or delay the development of care and support needs, or reduce care and support needs (including carer's support needs). This will build on people's individual strengths and assets as well as include the provision of appropriate information, advice and guidance, and integrated reablement and rehabilitation services.

- **Joint Risk Stratification**. Risk stratification will be largely configured around health and social care data; however, there will be established processes whereby local knowledge of people at risk will be used in addition to information generated through the programme. INTs will systematise risk stratification across GP populations to identify people who are at high, medium or low risk of acute or crisis care, and ensure access to services as appropriate.

- **Multi-disciplinary team meetings.** The INTs will hold regular multi-disciplinary team meetings to review the data from the risk stratification process and determine action. For individuals identified as lower risk, the INTs will link with their Neighbourhood Network who will offer the support and other inputs required.

- **Integrated Care Coordination.** A Care Co-ordinator will provide a coordinating role and act as the main point of contact for people with complex physical or mental health needs, and those people who can become more independent through short-term outcome focussed interventions. The Care Co-ordinator will liaise with emergency and urgent care services as appropriate to ensure that people are returned to their home and community as soon as possible following the stabilisation of an acute need. They will ensure that care includes a focus on prevention, preparedness and self-care.

- **Seven day working.** The integrated health and care system will offer consistent outcomes seven days a week by using the INTs to deliver scaled local solutions to people. These will be based around the GP surgery and its operating hours where possible, enhanced by GP extended hours provision, NHS 111 and the GP Out of Hours Service to ensure that there is always a co-ordinated and responsive service.

- **Management of Patients attending A&E with Problems which are not Emergencies.** The intention is to build on local work to date where the GP OOH service is already co-located with A&E at both Ipswich and West Suffolk Hospitals. In particular, at least one early adopter of the Urgent Care Centre model co-located with A&E and staffed by a primary care led team. The role of this team would be to focus on assessment and urgent care treatment for minor injuries and illnesses as well as educating patients about primary care alternatives, help with registering for a GP and for those patients who attend with routine health needs, re-directing them back to their INT for further treatment and follow up.

Ensure Voluntary and Community Sector Organisations are Key Partners in Care

- **Neighbourhood Networks (NN).** A NN is a series of people, groups, organisations and statutory services which people or their carers may wish to use or access to improve or maintain their vision of a good life in their local community. A NN is a person's community as they perceive it and will have at its core the same self-care and preparedness outcomes and culture as the INT. Some elements of the NN will be organic (friends, neighbours, family), whilst others will be commissioned by the individual themselves (e.g. private care) or by statutory organisations (e.g. police, culture, sport or leisure). The INT and NN will have good, timely communication.

- **Local Area Co-ordinators.** The Local Area Co-ordinator (LAC) is a paid position within a locality and that will have a demonstrable impact on people's use of statutory services. LACs will work in two ways; first the LAC will work with individuals to fully understand their skills, interests and resources, signposting them to relevant parts of the NN and supporting individuals' resilience. The LAC also works to understand local community organisations, groups and services and their key offers. In this role, the LAC strengthens connections within a community, working to develop community resilience. The role is likely to include community development which supports the growth and cohesion of the NN and in turn the INT.

- **Voluntary and Community Sector to flag risk.** Risk stratification will be largely configured around health and social care data; however, there will be established processes whereby local knowledge of people at risk will be used in addition to information generated through the risk stratification programme. NNs and the VCS within them will develop the ability to identify when a person's needs are escalating, as well as support a person's ongoing recovery and independence. The NNs are essential to supporting the shift towards planned care through promoting wellbeing, self-care and preventative activities.

- **Links to the INTs.** There will be a two-way interface between organisations which are part of NNs and the INTs, with mutual respect for the professionalism of all parties. INTs will understand the importance of services and activities being offered to people by the voluntary and community sectors in support of their holistic care. Voluntary sector and other partners should be able to have easy access to and contact with the Care Co-ordinator and provide early indications of changes. NNs will keep themselves up to date about sources of support available within the communities they serve.

Ensure People Have the Tools to Manage their Long Term Conditions and Urgent Health Care Needs

- **Self-Management.** Self-management, self-care and primary prevention will be golden threads throughout the Health and Independence model. INTs, Specialist Services, NNs and all others in contact with individuals will ensure self-management approaches are the first option explored for all. This will include relevant training, and information for people on different conditions and sources of support.

- **A Joint Care Plan.** A care plan is the written record of a plan of action and goals negotiated with the person to meet their own health and social care needs. People will be supported to develop their own joint care plans to self-manage their wellbeing, get back to independent living and meet their health and social care outcomes.

- **Core functions of a care plan**. Joint Care plans will identify outcomes, resources and inputs that seek to prevent increased need; they will be person-centred, timely and build on people's skills, strengths and preferences. It should be used and understood by the individual, their families, carers and all professionals to help the person remain well, resilient and prepared for an emergency. It will include a comprehensive needs assessment, a risk assessment and plan for management of those risks. It will also include contingency plans; identify who is responsible for elements of the care intervention, where to get further advice and trigger tools to identify action for when the person needs more help.

- **Carer's assessments.** We will undertake a 'carer's assessment', on the basis of the appearance of a need for support. This will mean many more carers are able to access an assessment, and that the duty is similar to that for the people they support, i.e. it is on the appearance of need.

- **Information and advice on options and choices.** The INT and NN will actively promote information and advice on health and social care options and choices through joint care plans and all interactions with people. People will have access to independent advocates where they have difficulty engaging and do not have friends or family to assist them. Family carers will be supported in their caring role by having access to the right information, advice, training, carers personal budgets and breaks at the right time.

- **Trigger tools.** The model will make use of risk stratification tools to support people at risk of tipping into crisis, providing appropriate services, information and advice so that they remain as well and as independent as possible. This will help people to self-manage and get information about their needs. When care is delivered, it will also address key factors that lead to improved outcomes, such as opportunities for social contact or physical activity. This will mean the VCS provides core elements of care plans and encompasses activities people enjoy doing which improve their quality of life.

Make Information and Advice readily available to People

- **Information and advice for all.** We will make information and advice available to all people so that they can make choices about their treatment and care, including when they have a health crisis.

- **Suffolk information available through the internet.** The Health and Independence model will provide good quality information that is easily accessible and available in a number of formats. The information and access solutions will mirror what people do in their everyday lives using functionalities similar to search engines like “Google”, online encyclopaedias like “Wikipedia”, and reviews and feedback like “trip advisor”. Contact routes will be simple and solutions will be locally based. Online information will be available 24 hours a day and will always route to the correct contact point for escalation. For those who do not have access to the internet, alternatives will be simple to find. All information should be written in a consistent user friendly language and presented in a way that people can follow.

- **Health and Social Care teams and organisations able to give advice.** All organisations should be able to signpost people to the most relevant organisation or service so that people are aware of their choices and can get the help they need within their community. This simple approach will avoid duplicate, irrelevant and out-of-date information in systems.

- **VCS able to give information, advice and guidance.** There is a wealth of organisations in Suffolk in the voluntary and community sector and model will ensure that these organisations can easily be found by people who need them wherever they live in Suffolk. This will deliver the best information, advice and guidance from these sites to people. In addition, websites will link people to sites that promote life planning, including preparedness for life events. This information will help people to find out about technology and equipment they can purchase themselves to help them to live at home, such as community alarms.

- **Social Marketing.** Social marketing will be an integral tool to targeting messages to specific groups of people. For example, public health campaigns targeting smokers and targeted communication of service options to people who are frequent users of urgent health and care services (sometimes inappropriately). The integrated Health and Care Model will ensure collaboration between all partners, organisations, entities and groups who regularly communicate and engage with members of the public to target these messages so that people are aware of the appropriate health and care options.

6. Further Information

For further information about the service model and this document please contact:

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