Home Support

Working together for better care
Welcome!
Agenda

• Arrival, Registration, Refreshments and Networking ...
• Opening Comments & Meeting Outline ... 1300 - 1310
• Sensory Champion Information... 1310 - 1335
• Update: CCG ... 1335 - 1400
• Update: ASC... 1400 - 1425
• Update: Provide ... 1425 - 1450
• Questions and Networking ... 1450 - 1515
• Intermediate Care... 1515 - 1545
• Hospital Discharges... 1545 - 1605
• ASC accessibility, ISPs and reviews... 1605 - 1625
• Close... 1625 - 1630
Opening Comments and Meeting Outline

Simon Froud & Simon Harniess
Sensory Champion
Information

Faye Gatenby & Rachel Williams
Developing all-age sensory services in Essex
Mid Provider Forum
20th March 2019

Rachel Williams, Essex County Council
Faye Gatenby, ECL Sensory Service
Essex Demographics

There are over 200,000 people living with a sight, hearing or dual sensory loss in Essex.

Future estimates: 240,000 people by 2020 and over 310,000 by 2030.

Adults who are blind or partially sighted:

- 2016 - 49,920
- 2020 - 54,850
- 2030 - 71,080

Over 70% of people with a sensory impairment are aged over 65 years.
‘Essex is a sensory friendly county where people with sensory impairments have their needs identified early and lead their lives with the same opportunities and aspirations as other citizens: can access and participate in their local communities; have the same access and information as other citizens to all public services, including health, housing, employment, education, leisure and transport.’
Anyone, any age
Any sensory impairment, irrespective of cause

Information, advice, guidance and emotional support cuts across all areas of the model

Specialist Sensory Interventions

Diagnostic and Treatment Services

Reablement/Rehabilitation

The Model

Integrated Sensory Coordination Service

Support, Advice, Mentoring

Transport

Education/Training

Social Care Services

Communication Support

Equipment

Housing

Employment

Specialist Health and Wellbeing Support
The Co-produced Sensory Pathway

1) Pre-Diagnosis/ Referral
2) Referral/ Diagnosis
3) Information, advice, guidance and emotional support
4) Registration
5) Reablement/ rehabilitation
6) Social care assessment
7) On-going support
Delivering the Sensory Pathway

- Key decision: 3 year (+option to extend by 2 years) contract for ECL to co-ordinate services across the county for all sensory impairments
- In partnership with the voluntary sector, ECL will deliver Elements 3 – 5 for adults:
  - Information, Advice, Guidance (IAG) and Emotional Support
  - Registration and Data Collection
  - Reablement/ Rehabilitation
- ECL will also deliver an all-age co-ordination and IAG service to include children and families.
- ECL will work with ECC and the voluntary sector to continue to develop IAG provision for all-ages, and integrate the service with health and social care.
Our team is made up of Rehabilitation Workers / Assistants, Technical Officers, Coordination Centre Staff,
Commissioned service

In 2015 ECC commissioned ECL sensory service to deliver a coproduced sensory pathway in partnership with voluntary sector providers and other stakeholders.

The service is made up of:

- All-age co-ordination centre.
- CVI / Registration processing.
- Rehabilitation.
- Equipment.
- Voluntary sector commissioned services.
Partnership working

The Essex Sensory Community is made up of ECL Sensory Service and six voluntary organisations commissioned to provide Information, advice, guidance and emotional support.

Other partnerships help us to reach further into our communities and improve access to the services they deliver.
The service today

➢ Our Coordination centre manages on average 360 contacts a month of which around 40 are CVI’s which we process.
➢ The main reason people call us is for Information, Advice and Guidance.
➢ The largest percentage of calls are from ECC community teams, Hospitals, OT’s and directly from people with sensory impairments or their families.
➢ In 2017/18 we managed an average of 70 referrals per month of which 44 were for people a sight loss and 17 for deafblind people.
➢ Our customer satisfaction rating over that period was 96%.
➢ 97% demonstrated an increase in independence, choice or control.
Our customer feedback

We receive 25 / 30 quality assurance feedback forms per month:
Comments this year include:

“Pete was fantastic. To begin with I was very apprehensive and anti-cane training as I was very aware of how I would be perceived by the public. He was incredibly reassuring about the positive impact cane training would have on my independence. I cannot recommend him highly enough. Thank you.”

“Sonia’s visit was extremely worthwhile as she was full of good ideas to help me and has put me in touch with various organisations and I do thank her for this.”

“I feel very lucky to be under the umbrella of ‘sensory’ and Essex Cares for many years, which has been an enormous help to me still.”
The future

➢ ECC have awarded us a new three (plus two) year contract which began in July 2018.

➢ This contract will include a focus on further integration with health and children’s services.

➢ Last year ECC completed cost benefit analysis using RNIB’s Demonstrating the impact and value of vision rehabilitation report. Work is underway with the Clinical Commissioning Groups (CCG’s) to develop business cases for funding to support the service and meet future demand increases.

➢ Development of Sensory Champions across health and social care and creation of the Sensory Action Alliance.

➢ Work to further improve access across the county.
Improving access

Lived Experience training and Charter Mark

- Trained staff
- Accessible buildings
- Accessible information

One to one support

- Hospital appointments
- Personal budgets
- Meetings
- Ad hoc needs
ECL Sensory Service

Email: sensoryservices@essexcares.org
Tel: 033301 33262
Textphone: 01245 261715
SMS: 07921 397547
Web: www.eclsensoryservice.org
Twitter: https://twitter.com/eclsensory
Facebook: https://www.facebook.com/ECLSensoryService/
Update: CCG
Debalina Gupta & Robert Evans
Long Term Plan

- **NHS Long Term Plan (Jan 19)** - Plan confirms that general practices will have to work together to form PCNs

  - £4.5 billion of new investment to fund expanded community multidisciplinary teams aligned with new primary care networks
  - Alongside PCNs, plan commits to developing ‘fully integrated community-based health care’
    - Multidisciplinary teams, including GPs, pharmacists, district nurses, and allied health professionals working across primary care and hospital sites.
  - By 2020/21 PCNS will assess local population by risk of unwarranted health outcomes
  - Identifies PCNs as the essential building blocks of every Integrated Care System
Primary Care Networks (PCN) National Guidance

- **GP Contract 5 Year Framework (Jan 19)** – formalises plans for working in Primary Care
- Announced set of **multi-year** general practice contract changes covering:
  - Workforce, indemnity costs, QOF, PCN DES, digital first, 7 new national service specifications to be delivered by PCNs

- Requires **all individual practices** to enter into a PCN contract Directed Enhanced Service by May 15th
- Will ensure general practice plays a **leading role** in every PCN
- Funding for additional workforce, services, engagement in PCN, Clinical Director posts and in time extended access
What is a Primary Care Network

• General practices to work collaboratively in ‘hubs’ or networks

• Combined general practice registered lists of 30,000-50,000
  • Small enough to provide the **personalised care** valued by both patients and healthcare professionals
  • Large enough to have impact and **economies of scale**
    • Better **collaboration between general practices**
    • Better **collaboration with others in the local health and social care system**, including community pharmacies

• Staff come together as a **complete care community**
  • Drawn from GP surgeries, pharmacy, community, mental health and acute trusts, social care and the voluntary sector

• Focus on **local population needs** and providing **care closer to patients’ homes**
PCNs- Local Plans

- CCG and LMC are working with all practices to
  - Support practices in developing PCNs
  - Ensure 100% coverage by May 15th deadline
  - Support PCNs in their development
  - Support PCNs to ensure they have a named clinical director in place by 15th May
Enhanced Health in Care Homes

- Framework of best practice using learning from Vanguards
- Each section focuses on an element of the EHCH framework, sets out the sub-elements and components a local area should have in place to fulfil the care model, and sets out questions for local areas to consider.
- 6 key sections -
  1. Enhanced primary care support
  2. Multi-disciplinary team (MDT) support
  3. Reablement and rehabilitation to promote independence
  4. High quality end-of-life care and dementia care
  5. Joined-up commissioning and collaboration between health and social care
  6. Workforce development
  7. Data, IT and technology
Enhanced Health in Care Homes

- National service specification is in development
- Is one of the seven specifications that will be part of the PCN DES
- Will start April 2020

- Have completed a self assessment against each section
- Have developed a plan for delivery
- Need to work with the wider system to further develop, sign off and begin implementation
Live Well Wheel
Challenges to Live Well

- **Population change** – 10,000 more people expected to be living in the area, many more of them frail elderly, by 2020
- **Workforce** – there is a national shortage of GPs and nurses that affects our area too
- **Financial** – the CCG has to make significant savings to meet NHS England requirements
Primary Care Foundations - Phase 1

• **Mid Essex Foundations (2018-2019)**- Six pillar programme for Primary Care development and sustainability in Mid Essex
  1. Upskilling staff
  2. Workforce diversification
     • 57 WTE additional staff
  3. Care navigation
     • 89 trained staff in practice
  4. Digitalisation
  5. Systems
  6. Activating Primary Care
Primary Care
Foundation phase 2

- **Mid Essex Foundations (2019-2020)**-
  1. Upskilling staff
  2. Workforce diversification
  3. Care navigation and social prescribing
  4. Digitalisation
  5. Systems
  6. Primary Care Network development
  7. Legs ulcers
  8. Ear Care
Redesign of Community Services

- Review of all community services underway to look at
  1. What services can be delivered on an STP footprint
  2. What services need to be delivered across Mid Essex
  3. What services need to be delivered at a PCN level
Other Primary Care Initiatives

Extended Access

• 4 “access hubs” across Mid Essex (Halstead, Chelmsford, Braintree, Maldon)
• Bookable appointments available up to 8:00 pm on weekdays with weekend and bank holiday appointments available too
• Appointments offered / booked via patients own practice.
• A minimum of 738 additional appointments are available each week through the commissioned service
• Utilisation of the service is variable, but is improving with both overall utilisation and the use of weekend appointments improving
• Further communication campaigns underway
• A local arrangement is in place with our 111 service provider, whereby they can facilitate bookings into the extended access service
Other Primary Care Initiatives

Workforce Development
• EU & International GP Recruitment programme under way.
• Other initiatives to recruit / retain GPs being pursued.
• Additional resource available to practices (through “Foundations”) for recruitment of broader skill mix within practices.
• Enhanced skills training available via CCG Foundations programme.
• Care navigation training and workflow optimisation initiatives also progressing

Care Home Pharmacists
• National pilot
• South and Mid Essex STP received funding to employ additional pharmacy staff to deliver support to some care homes in Mid Essex
• From April 2019 wider roll out through PCNs
  • clinical pharmacist posts funded nationally
  • 1 per PCN
Out of Hospital Initiatives

- Home first
- Red Bags
- Trusted Assessor
- EOL H@H/ECHO
- Care Homes Manual
Mental Health Initiatives

• MH foundations
Mental health primary care transformation to improve the mental health offer across primary care and increase access to services for patients

• Dementia Intensive Support Service
For patients recently been in hospital with memory issues or in a crisis. We provide a 7-day intensive support service for people diagnosed with dementia or suspected dementia 24 hours a day, 7 days a week

• Admiral nurse
Supporting the delivery of care across care home to diagnose dementia and provide advance care planning and other post diagnostic services to patients, family and carers

• IAPT
Launch of a digital IAPT to increase access to talking therapies with the design of a new community resilience model to supplement traditional talking and face to face therapy
Any questions?
Update: ASC

Simon Froud & Brid Boraks
Presentation Summary...

Context-

UPDATE: Year to date progress within Mid Essex ASC

Developing-

UPDATE: Future Work as a System
Year to Date Progress Update

Planned Activity…

Unplanned…
Future Plans…

- Work with system partners to develop our Mid ‘neighbourhoods’ building on primary care networks
- Engage with system partners to develop and scope the future intermediate care offer
- Diagnostic review of system wide intermediate care being conducted by Newton Europe
  - LD Developments – Meaningful Lives Matter
  - ASC Winter Money, Prevention, Early Intervention and Enablement, Safeguarding & Care Market Quality
- Continue to progress the Integrated Community Health and Social Care programme
- Practice development around systemic approaches and personalisation
  - Review of the ASC workforce, competencies and skill mix

Discussion Point
How can we engage better with you as a key system partner?
Working together:

...putting the pieces together, together.
We are *all* part of the journey...

We *all* have something to offer...

**We will shape the future together...**
Update: Provide & ASC Integration Developments

Carol Doggett & Charlotte Cannon
Provide & Essex County Council

Integrated Community Health & Social Care Programme
Provide and Essex County Council signed a Memorandum of Understanding in March 2018 which sets out their agreement to collaborate on the design and implementation of an Integrated Community Health and Social Care model for adult services.

- Joint working has previously not always been formalised or systems put in place to support
- Each organisation historically had its own vision and agenda

**What is not happening:**
This does not mean that there will be a merger of the 2 organisations
The Integrated Community Health and Social Care Vision:

“The population of Mid Essex live well. They have the information and tools to enable them to live healthily and independently for as long as possible, and when support is needed it is provided in the right place, at the right time, every time.”
The Baseline

The Integrated Community Health and Social Care Venn:

Unique Patients known to Provide and Social Care

- Provide (ICT, UST) 7,189
- Social Care 22,715
- Overlap 3,240

The Baseline
The Programme Structure
Some of the Key principles we will need to consider across all work streams are:

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<thead>
<tr>
<th>Principle</th>
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<td>Prevention</td>
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<td>Recover</td>
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<tr>
<td>Sustainability</td>
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<td>Enablement / Supported Self Management</td>
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<tr>
<td>The Market</td>
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<tr>
<td>Trusted Assessor</td>
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<tr>
<td>Technology &amp; Digital</td>
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<tr>
<td>Good Lives</td>
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<tr>
<td>Carers</td>
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<tr>
<td>Inclusive of all protective factors</td>
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The Workstreams

**Workstream 1**

- Early Intervention/Prevention
- Simplified Access – ‘no wrong door’
- Information, Advice, guidance and Support
- ‘Catch and carry’
- Crisis Prevention
- Rapid Response
- Supports Recovery and Independent Lives

**Project:**

- Integrated Single Point of Access with ASC, Provide and EPUT
The Workstreams

**Workstream 2**

- Intermediate Care
- Discharge to Assess
- Supported Discharge
- Integrated Discharge Team

**Project:**

- Integrated Discharge Team Review
- System wide D2A principle
- Crisis Treatment Team
- Trusted Assessor
Workstream 3

- Neighbourhoods
- Planned Support
- Care Coordination
- ‘Team around the Patient’
- Ongoing
- Living Well

Project:
- Chelmsford City Hub/ GP Collaboratives and Neighbourhoods
- Carers
- EOL
- Buurtzorg
Workstream 4

• Enablers of Integration
• Back Office
• Systems and Functions
• Support the other workstreams

Project:
• Performance
• Information Governance
• Legal
• HR
• Population Health

• Estates
• Workforce Development
• Finances
• Digital
• Mutual Ventures
• Venn

The Workstreams
Any Questions...?
Questions and Networking
Update: Intermediate Care

Brid Boraks
<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Pre Transfer</th>
<th>ECL Post Transfer</th>
<th>In Lieu of Reablement Hours</th>
<th>Current Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reablem ent Hours</td>
<td>STSC Hours</td>
<td>Total Hours</td>
<td>Current Delivery</td>
<td>Current Usage</td>
</tr>
<tr>
<td>Mid</td>
<td>1,043</td>
<td>491</td>
<td>1,534</td>
<td>1,045.75</td>
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Intermediate Care
Since the Allied transfer to ECL, between December 18 – February 2019:

- On average 13 starts a week
- In February 2019 86% of service users are Self-Caring/ supported via informal care or other preventative services after the reablement service
- Total 913 referrals accepted since December 2018.

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<th>Dec-18</th>
<th>Jan-19</th>
<th>Feb-19</th>
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<tbody>
<tr>
<td>Number of hospital referrals</td>
<td>128</td>
<td>258</td>
<td>193</td>
</tr>
<tr>
<td>Number of community referrals</td>
<td>81</td>
<td>131</td>
<td>122</td>
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Intermediate Care - ECL
We needed capacity in the system to help adults get out of hospital. We then quickly commissioned emergency reablement in lieu.

Ideal have supported on average 6 reablement in lieu starts per week. We commissioned 500 hours a week from Ideal.

Dial a Carer have supported on average 7 reablement in lieu starts per week. We commissioned 600 hours from Dial a Carer.

Averaging 13 adults a week being supported via reablement in lieu services

Allied starts were 35 starts a week which has been calculated from a 4 month period (in total, community and hospital starts). Hospital activity data has told us that our hospital Allied capacity would vary between 25 – 27 starts from hospital per week.

In terms of purely hospital activity, we are in line with the starts compared to the previous Allied activity offer. This is because our reablement in lieu offer fills the majority of the capacity gap.

We are also commissioning SPOT reablement in lieu where there is not capacity within our block in lieu arrangements to offset any demand challenges. We are awaiting data to advise on the number of SPOT purchases for in lieu.
• **24 hour cover/ wrap around**
  Block capacity for 2 - 3, 24 hr care packages as part of hospital discharge and admission avoidance which can accommodate a gradual reduction.

• **Overnight Support**—(‘Night Sitting’ type service)
  To provide support around hospital discharge and admission avoidance service for adults who need social care support in night time hours. Short term overnight sitting support in an adults own home.

• **Bridging**
  Restarts where the regular agency is unable to start within a reasonable time to facilitate discharge, the bridging service will support to hold the individual in their own home.

• **Contribution to Trusted Assessor**
  A Trusted assessor to complete assessments for new and restarts of packages of care into res and nursing. Resilience funds identified for this scheme, however use winter moneys to support the post over winter.

• **Additional IP Beds**
  x3 beds in Chelmsford
  X6 beds in Halsted Hall
• **ASC Overtime**
  
  *Allocated pot of money to have overtime over winter period*

• **Hilton**

  Ward based scheme to ‘pull’ patients that are declared by MFFD, D2A and Home2Decide model. Can work with adult in their own home for 5 days. Can work with individuals who are MFFD and NWB.

• **SWOT**

  The Student Winter Operations Team (SWOT) aims to help help the discharge process by assisting those that are medically fit to leave hospital but unable to do so due to social concerns.

**Winter Demand**

- Additional Patient Flow Coordinators
- Additional Nurse Assessors
- 8A Position to Oversee Health element of IDT
- Golden Hello

*An evaluation is being complete by system partners to understand impact, success and to inform future commissioning intentions*
• THE HEALTH AND SOCIAL CARE IMPROVEMENT experts
  + £300m saved for the NHS and councils

• ECC has commissioned Newton Europe to complete a system diagnostic review with the intention of realising better outcomes for adults
• The scope of the review is currently being scoped and will be shared with system partners

Intermediate Care
Newton Europe
WE DELIVER CHANGE. WE IMPROVE OUTCOMES. WE ALWAYS PUT 100% OF OUR FEE AT RISK TO DELIVER THE BENEFITS.

A few of the organisations we have been fortunate to work with more recently.
We are mostly engineers, mathematicians and scientists, which makes us particularly good at working with masses of disparate information to turn out logical and informative insight. This means you will get a very thorough understanding of the issues you are facing and help to prioritise them so you can focus your limited resources on the things that will, without question, deliver the biggest impact.

In many organisations, analytical work is handled by one group, who hand off to a second group who decide what to do with their new source of information. Dislocating these skills is a common cause of change programmes to under deliver because it eliminates the potency of reviewing the organisational data live with the people making front-line decisions and, in that moment, making a change - no matter how small - to re-run the data and see the impact.

We always put 100% of our fee at risk upon successful delivery of a programme’s benefits. That’s measured in terms of: better for citizens, better for staff, better for operational performance and better for your bottom line year-on-year financial spend.
• Key benefits of this approach include;
• Ability to deliver large scale, pathway based transformation effectively
• Improved pathways and service user outcomes consistent with a focus on promoting independence
• Reduced costs and improved financial sustainability
• Clarity of top down vision, with bottom up delivery of key strategies
• Alignment with whole system, rather than siloed perspectives – including Health partners, housing and provider markets
• Greater staff engagement and learning and development facilitating wider value
• Nature of approach enables the fee to be 100% at risk against a programme’s success

Intermediate Care
Newton Europe
Update: Discharges

Brid Boraks & Karen Scott
**Context**
- The role of the acute, IDT and ASC in supporting discharge
  - When a patient should be leaving hospital

**Services**
- Overview of services that are available to support with hospital discharge

**Discussion Points:**
- What is your experience of discharges, good and poor with examples
  - What support do you need from the system to enable somebody to remain in their own home as oppose to going to hospital for treatment?
Update: ASC, ISPs and Reviews

Brid Boraks & Julia Lyons
Improving Communication

- Improved induction and training;
- More rigorous quality assurance process and guidance;
- New focus group to look at ways of improving communication;
- Updated managers contact list being shared today
Improving quality

• Managers quality checking ISPs
• Looking for:
  ○ Clear progressive outcomes
  ○ Up-to-date information
• Detail about the exact support needed
• Senior social worker identified to focus on improving quality of ISPs across Mid.
• Meetings held with providers - more planned. Please get involved!
Closing Comments

Simon Froud & Simon Harniess