Appendix 6

Draft Commissioning Strategy and Clinical Model for the delivery of Integrated and Urgent Care Services for the Fareham and Gosport, Portsmouth, and South Eastern Clinical Commissioning Groups

2012 – 2015

1.0 Introduction

1.1 This paper sets out a three year commissioning strategy and service model for the delivery of integrated and urgent care services to support older people and those with a long term condition.

1.2 This strategy has been developed in partnership with Hampshire County Council and Portsmouth City Council to ensure an integrated and complimentary approach to commissioning across the health and social care landscape of Portsmouth and South East Hampshire

1.3 This strategy enshrines the fundamental principles outlines in the *Operating Framework for the NHS in England 2012/13 and the NHS Constitution*. It is recognised that there is the need to maintain strong financial performance and deliver quality whilst addressing changes to service provision to meet the QIPP challenge. In order to achieve this, clinical commissioners will look to adopt and diffuse innovation to enact transformational change.

2.0 Background

2.1 This strategy and the new service model has been developed in collaboration with existing provider stakeholders though a multi-agency 'design group' including partners from Portsmouth Hospitals NHS, Solent NHS Trust, Southern Health Foundation Trust, and South Central Ambulance Foundation Trust.

2.2 This strategy does not specifically cover the following areas:

- Mental Health Services
- Children Services
- Planned care services

These are addressed through separate, respective commissioning strategies although there may be some links and interdependencies with this strategy.

2.3 'Integrated care' is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, frequently for an ageing population which has increasing incidence of chronic disease.

Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about. Achieving integrated care requires that those involved with planning, financing and providing services have a shared vision, employ a combination of processes and mechanisms, and ensure that the patient's perspective remains a central organising principle throughout.

Organisational integration alone is unlikely to deliver better outcomes and effort must focus on clinical and service integration. Action is needed at the macro, meso and micro levels, and multiple strategies should be pursued at all three levels.
General practice commissioning offers a platform on which to develop integration provided that practices involved in commissioning consortia are encouraged to commission and provide services in collaboration with clinicians in community health services and secondary care.

3.0 Strategic Context and National Drivers

3.1 The *NHS Chief Executive Innovation Review (2011)* has lead the way in changing the thinking around the way that services are developed and delivered. Through the leadership of the CCGs, this strategy will build on the previous commissioning approaches.

3.2 The development of integrated services is a key theme within the Health and Social Care Bill, which was introduced into parliament in January 2011.

3.3 The importance of strengthening the commissioning of services, improving integration of services focusing on outcomes, and focusing on improving patient experience were all reflected in the 2012/2013 NHS Outcomes Framework and NHS Operating Framework.

3.4 The *Transforming Community Services Programme (2008)* supports the development of community services and transformational change. This strategy embeds the vision outlined in this document through the objectives section by focusing on care closer to home, shaped around individuals need and integrated care pathways.

3.5 The Department of Health estimates that there are at least 15 million people who have a long term condition. Additionally, it is estimated that 57% of those over 85 years of age are in contact with a district nurse, there will be a 31% increase in people over the age of 85 in the next ten years. (Department of Health,2009). There are around 15 million people living with a long-term condition in England. These people are the main driver of cost and activity in the NHS as they account for around 70% of overall health and care spend. They are disproportionately higher users of health services – representing 50% of GP appointments, 60% of outpatient and A&E attendances and 70% of inpatient bed days.

3.6 The National Long Term Conditions QIPP work-stream seeks to improve clinical outcomes and experience for patients with long term conditions in England. The work-stream will focus on improving the quality and productivity of services for these patients and their carers so they can access higher quality, local, comprehensive community and primary care. This will in turn, slow disease progression and reduce the need for unscheduled acute admissions by supporting people to understand and manage their own conditions.

3.7 The Joint Strategic Needs Assessment (JSNA) analyses the health needs of the local population to inform and guide the commissioning of health services across Portsmouth and South East Hants. The data available is used to identify major issues to be addressed locally regarding health and well-being and the actions that commissioners will take to address those issues

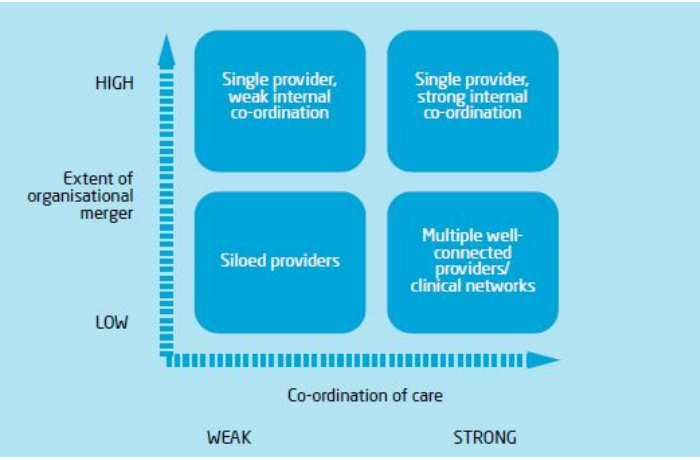
3.8 Health and Wellbeing Boards will have a duty to encourage integrated working between CCGs and service providers across both health and social care. This will be facilitated by joint working between all relevant stakeholders including CCGs, Local Authorities, Providers and the local community.

3.9 The Nuffield Trust and Kings fund report (Integrated care for patients and populations: Improving outcomes by working together) determine many priorities for the future of Integrated Care including:

- Setting a clear, ambitious and measurable goal to improve the experience of patients and service users
- Offering guarantees to patients with complex needs
- Implementing change at scale and pace

The report strongly supports the adoption of a single outcomes framework for the NHS, social care and public health. Health and social care organisations need to be mandated to work collectively to meet common outcomes related to the health and wellbeing of the populations they serve, and this will entail indicators that examine the degree of integration/fragmentation of care given to people with complex conditions.

- Effective care co-ordination can be achieved without the need for the formal ('real') integration of organisations. Within single providers, integrated care can often be weak unless internal silos have been addressed. Clinical and service integration matters most.



4.0 The local need for change

4.1 Portsmouth adults are living for longer. The life expectancy is expected to increase in the city in 2012 by 5.0 years since 2000 (from 77.6yrs in 2000/ 82.6 years in 2012) and by a further 3.2 years (85.8) by the end of 2016. A rise in both life expectancy and the number of residents living with one or more long term conditions illustrates a need for a unified, coordinated and truly integrated care system.

4.2 More than half of the inpatient beds in the system are occupied by the 10% of patients who stay in hospital for more than 2 weeks and 3 out of every 5 admissions are for patients who have been admitted before within 12 months. Frail elderly patients and those with long term conditions often experience disjointed poorly coordinated care and poor customer service. Many of the patients being admitted to hospital, or enduring long hospital stays, could have been better supported elsewhere, including in their home or community setting (subject to the appropriate services being available). In particular, significant numbers of patients being admitted for acute care from nursing homes could have been managed in the community with a different model of care

4.3 Current system wide delays are caused by a variety of factors including multi-disciplinary referral patterns, multiple assessments undertaken, lack of information sharing and awareness of other services currently or previously involved in an individual's care. In addition fragmented provision of community health and social care services has led to duplication and further waste within the system. A considerable amount of work has since been undertaken at organisational level to streamline and improve systems and processes however a truly integrated system can only be achieved with implementation of a coordinated care approach.

5.0 Vision and values

5.1 The vision for Integrated and Urgent Care is to commission the provision of excellent health and social care to enable local people to improve, maintain, or recover health and prevent ill health or decline. Ensuring that care is provided by the most appropriate professional in the correct setting in a timely manner. This will be achieved through:

The application of a holistic person centred approach to care through the delivery of a truly integrated system, embedded across all agencies and within primary, community, acute and social care.

- Support for older people and those with long term conditions to improve and maintain their independence, health and well being
- Focusing on clinical leadership and engagement

- Modernising local health services and securing the best possible evidence based outcomes for patients informed by best practice
- Being efficient and delivering value for money

6.0 Critical Factors for Success in delivering integrated care

6.1 The following have been identified by the Nuffield Trust and Kings Fund as being the critical success factors: -

- *Defined populations* that enable health care teams to develop a relationship over time with a 'registered' population therefore targeting individuals who would most benefit from a co-ordinated approach
- *Aligned financial incentives* that: support providers to work collaboratively by avoiding any perverse effects of activity-based payments
- *Shared accountability for performance* through the use of data to improve quality and account to stakeholders through public reporting
- *Information technology* that supports the delivery of integrated care, especially via the electronic medical record
- *The use of guidelines* to promote best practice, support care co-ordination across care pathways, and reduce unwarranted variations or gaps in care
- *Effective leadership* at all levels with a focus on continuous quality improvement
- A *collaborative culture* that emphasises team working and the delivery of highly co-ordinated and patient-centred care
- *Multispecialty groups* of health and social care professionals
- *Patient and carer engagement* in taking decisions about their own care and support

7.0 Objectives of the Integrated and Urgent Care Strategy

7.1 The principle objective of this strategy is to create a system for commissioning that is designed around individuals health and social care needs and provides clear guidance and direction to health providers and partners in order to meet those needs. All work programmes that are developed to support the delivery of this strategy will be subject to the following objectives:

- To ensure active public and user participation in service design and to listen and respond to user needs in the local community.
- To ensuring equity of access and good health outcomes.

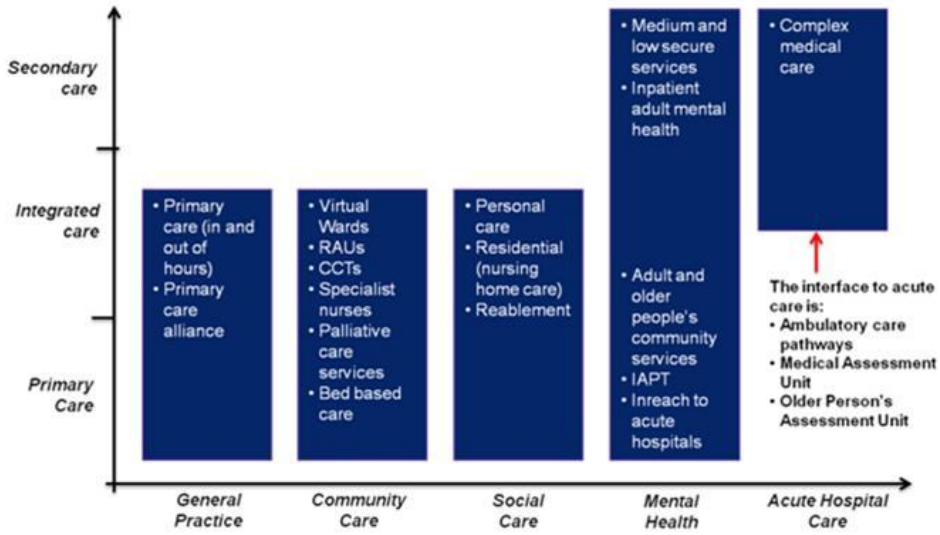
- That all services are commissioned to ensure equity of access to all regardless of race, age or gender
- To develop community based and integrated care services delivered by multi-disciplinary teams with single point of access in primary care.
- To ensure that services delivered in a community based setting are of equal or improved quality compared to existing hospital provision
- To ensure that all services, regardless of where they are delivered, are cost effective and provide value for money by increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge
- To ensure that services delivered in a community based setting do not present risks that undermine the sustainability of the whole health and social care economy
- To continually review all community based services and enhanced services to ensure and assure that they offer best value and performance identifying alternatives as necessary

8.0 A new service model for integrated and urgent care in Portsmouth and South East Hampshire

8.1 Operating Principles of the new model

The new service model will transfom care for older people and those with long term conditions through the creation of a truly integrated health and social care system in Portsmouth and SE Hampshire. Focusing on the development of integrated models of care, built around primary care ('primary care plus') where:

- Primary care, community care (physical and mental health) and social care work more closely together at practice level to manage the health and wellbeing of the practice population – integrated teams identifying those patients at greatest risk of deterioration and proactively managing their health and social care needs
- We identify and respond to patient's needs in a seamless way, offering a rapid and tailored response at the most appropriate care setting and provide high quality and consistent community support for those with multiple pathologies, particularly dementia. This will include the development of new approaches to community based admission avoidance
- The artificial historical barriers that exist between elements of the system are broken down, with the aim of providing a single, co-ordinated service for patients
- Elderly care clinicians, specialists in older people's mental health, GPs, community care staff and social care work together to provide care for frail elderly people and those with long term conditions when they experience an acute deterioration of their health & social circumstances



The integrated and urgent care system will operate a model by which those individuals most at risk of admission, are identified by a case finding and risk stratification process and have a care plan, managed within an integrated care team, with a named care co-ordinator (case managers) to ensure effective liaison and continuity of care for people who need the service and their carers.

If and when crises occur, where the patient is known, then the management of the crisis should be in line with the Advance care plan. Rapid assessment and triage by the most competent trained person will be required. Through use of the DOS, 111 and the ambulance service will be expected to access the most appropriate element of the integrated and urgent care service. In all cases the aim of the service will be to manage the crisis / unplanned event in the person's own home or community based facility where it is clinically safe to do so.

8.2 Values and underpinning principles

The following set of values and principles will underpin the model, which all organisations will be asked to sign up to.

- Person centred care - No decision about me without me
- Trusted assessor approach 'Tell the story once'
- An unplanned admission for 'pro-actively case managed patients' should be viewed as system failure, (excluding accident, serious injury or exceptional event) and reviewed as such

- Discharge to long term care placement from acute hospital viewed as system failure, in all but the most exceptional circumstances and reviewed as such
- Common set of leadership values and behaviours which support integration and collaboration
- Information sharing protocols and governance arrangement

8.3 Key elements of the service model:

8.3.1 Risk stratification

Evidence suggests that whilst we should target the highest % of an 'at risk' cohort in order to prevent avoidable admission. In the longer term we would want to be offering proactive care to a wider cohort, in line with the population stratification in the Department of Health Long Term Conditions Strategy 2005. Risk stratification will be used to ensure that; for the highest %, the output will drive case management discussions between primary care and the community teams. Planning for the remainder should focus on more integrated delivery of care outside hospital including consideration for earlier symptom control and admission avoidance with input from multidisciplinary integrated care team

8.3.2 Care planning approach

The integrated care team will work to ensure an environment in which to create individualised care programmes, to support people emotionally, psychologically and physically to readjust to a change in health need. A single care planning system and approach will be required, bringing together a variety of different approaches together in a single document, which is owned and understood by the individual and which reflects their changing needs, including supporting them through end of life care decisions. The Care Plan system will enable electronically accessible records to be shared amongst all members of the team.

The personalised care plan will be based on a comprehensive current multi-disciplinary assessment of complexity, taking account of the need to promote self-management / guided self-care. Ensuring an individual's dignity, choice and control will be the underpinning philosophy of the care planning approach. The plan will also consider the social care aspects required to support the individual to stay well and enable maximum independence and where applicable, will detail how the individual budget will be used to help them stay well and co-ordinate the range of health and social care support, support from the voluntary sector and natural support available to them.

There will be an anticipatory element which is understood and owned by the individual and their carer which explains the appropriate course of action to take in the case of exacerbation. This information should be shared electronically across the system and which can be accessed by 111 services, ambulance staff, GP OOHs, and acute hospital / ED staff. All members of staff within those services will be expected to use the information on the care plan to inform decisions about the type of care and location in which to provide that care.

8.3.3 **Case management and care co-ordination**

Named care co-ordinator/ advisor (case managers) to ensure effective liaison and continuity of care for people who need the service and their carers and who will work with the individual and their carer to develop the care plan and act as a signpost. The identification of the care co-ordinator or manager will be on the basis of a lead professional model. The care co-ordinator and / or the patient's GP will be the first point of contact for any changes in a person's need or concerns.

Routine treatment and pro-active monitoring in primary care and review of those most at risk of admission to acute care or long term placement will be undertaken. This can be achieved through use of telecare and telehealth systems to deliver a proactive approach to changes in needs to prevent crises and enable early intervention to support the individual to stay well. Access to specialist surveillance and therapeutic intervention to promote self-confidence and competence to self-manage

8.3.4 **Integrated Care Teams**

Integrated care teams (ICT) will be central to the delivery of the approach outlined. The ICT will be made up of the following core team members:

- GPs/Practice Nurses
- Community geriatricians
- Nursing skills – to include generalist and specialist assessment and treatment skills eg palliative care, heart failure etc
- Social Care Workers
- Occupational Therapists and Physiotherapists;
- Admission Avoidance/Urgent Care Response Staff.
- Community Older People's Mental Health teams
- Care co-ordinators
- Healthcare assistants/Care workers
- OOH GP's

The ICTs will operate on a locality basis across PSEH, serving populations of circa 50,000, aligned to cluster of GP practices in accordance with known geographical boundaries. The ICT's will be made up of staff groups across multi agencies, however they will operate under an aligned management structure with shared governance and

accountability arrangements. The team will operate a lead professional model and trusted assessor approach supported via common assessment framework and information sharing protocols, ensuring that individuals are only required to tell their story once. The teams will operate a push and pull model through acute and specialists care, ensuring that care is coordinator and an holistic approach is delivered.

8.3.5 **Crisis management – exacerbation and unplanned events**

If and when crises occur, where the patient is known, then the management of the crisis should be in line with the AACP or Advance care plan. Rapid assessment and triage by the most competent trained person will be required. Through use of the DOS, 111 and the ambulance service will be expected to access the most appropriate element of the integrated and urgent care service.

In order to manage the crisis/exacerbation in a person's own home or community base facility, the service must be able to rapidly mobilise the following aspects:

- Clinical leadership / medical advice to support risk assessment and management. This can be delivered through clinician to clinician advice,
- Access to diagnostics and results available direct from the community – including phlebotomy, pathology, radiology ie near to patient testing kits, routine blood tests, ECGs, and x-rays.
- IV therapy eg fluids, AB and including cannulation need to be available in the community in order to prevent admission where this is solely due to the need for IV fluids.
- Nursing, social and therapeutic skills to enable treatment and management of the individual within their own home, including OPMH, and palliative care support
- Domiciliary care provision and support.
- 'Step-up' community based assessment / treatment beds
- Rapid and appropriate access to equipment
- Transport to and from home and community based facilities as well as to and from acute hospital.
- Access to medication

All of these elements need to be available to ensure consistency of response during the 24 hour, 7 day a week period. The priority will be to respond to prevent admission to hospital, where the problem identified means admission to acute hospital will become the default position unless a 'golden hour' response is able to be put in place within 1 hour. The service must ensure capacity to meet immediate need, ie 'to hold/ manage a person safely', where this is the decision from the initial assessment whilst the care and treatment requirements are co-ordinated

Where acute secondary care assessment, treatment and provision is required, this should be where possible, through an ambulatory care pathway approach. Implementation of these pathways should be in line with the NHS Institute

Ambulatory Emergency Care guide (currently 49 pathways). For those patients being pro-actively case managed within the integrated care service, the requirement for acute care should be planned and arranged through discussion between primary and secondary care clinicians. An unplanned admission for this group of patients (unless through accident or serious injury or other exceptional event) should be viewed as a system failure and reviewed accordingly.

8.3.6 **Early supported discharge**

Where admission to acute hospital is required, every effort should be made to ensure a minimum length of stay as possible. Where patients are being proactively case managed the decisions making should be in line with the care plan. In all cases, discharge planning should begin at the point of admission and should be in partnership between the acute physician and the integrated community care team. Early supported discharge mechanisms and pathways should be in place to ensure that only acute interventions are undertaken within the acute setting. Long term assessments / decisions about long term care needs should not be undertaken within the acute environment. These assessments and therapeutic interventions should wherever possible be undertaken in a community based environment or in the individual's home.

Discharge to a long term care placement straight from acute hospital should also be viewed as a system failure in all but the most exceptional circumstance and reviewed accordingly.

8.3.7 **Rehab and re-ablement approach**

In order to ensure an individual's independence is maintained the approach undertaken must be based on rehab and re-ablement. The period of rehab and re-ablement and assessment should be up to a maximum of 6 weeks in line with National Intermediate Care Guidance (DH 2010). This should be free at the point of delivery and not subject to social care charges or financial assessment (for a maximum period of 6 weeks).

8.3.8 End of Life Care

Delivery of end of life care will be in line within the national 'The End of Life Care' Strategy aims to bring about improvement in access to high quality care for all adults approaching the end of their life. The importance of identifying who is approaching end of life will enable the system to ensure that Advanced Care Planning is implemented therefore ensuring that people can choose their preferred place of death. The approach should also provide Care after death and support for carers both during and after a person's illness and after their death in line with the National End of Life Strategy.

8.3.9 Information Technology and Information Sharing Arrangements

Use of integrated information systems and other innovative IT solutions eg telehealth and telecare, will be integral to the delivery of the new model. Teams will use a shared information system to record any information about the intervention, support and care the service user receives, this information should also be available to the service user. The information mentioned should be shared with other professionals or carers supporting the service user, with their permission. The shared information system will record data used for performance management of the service. The information system will support the implementation of the Common Assessment Framework and lead professional model.

8.4 Outcomes of the new model

- Improved Patient Reports Outcome Measures for older people and those with LTC improved management of Long Term Conditions and End of Life care reported through:
  - An increase in the number of people feeling supported to manage their own - conditions
  - A reduction in the number of falls experienced by older people
  - Reduction in inappropriate unplanned admissions
  - Increasing community- based treatment of LTC's
  - Ensuring patients have a positive experience of care

- Reduction of acute secondary care provision measured through:
  - Achievement of upper deciles performance across PSEH for emergency admissions compared to national benchmarks
  - Achievement of upper deciles performance across PSEH for ED attendances compared to national benchmarks
  - Achievement of upper deciles performance across PSEH for average length of stay in acute bed compared to national benchmarks

- Improved wellbeing and independence of older people and those with LTC measured through:
  - Reduction in numbers and length of stay in long term care placement as compared to national benchmarks

- Percentage of people dying in their preferred place of death

9.0 Challenges and Opportunities

9.1 The current system has many positive features with the delivery of good quality patient care and treatment as well as significant challenges and opportunities. These are identified predominantly as the following:

- Over reliance of acute secondary care
- Limited community care pathways to prevent hospital admission or enable early supported discharge
- Single organisation commissioning pathways and disincentives to deliver integrated care
- IT system constraints
- Change management in a dynamic environment
- Increasing the pace on delivery of the QIPP challenge
- Ability to align incentive payments eg CQUIN and QOF
- Access to diagnostics

9.2 These challenges will need to be addressed in the redesign work that is being taken forward

10.0 Implementation

10.1 Achieving sustainable improvement will mean taking on the challenge of service change, to provide services closer to patients wherever appropriate and to deliver an Integrated Service Model. The CCG clinical leads will take an active approach to understanding the local market and developing plurality of provision.

10.2 The significant changes planned over the next three years in the local profile of health services will require disinvestment with affected providers, innovative new ways of commissioning and intelligent risk sharing agreements to be put in place. This will be led by the CCGs working closely with all stakeholders.

10.3 The CCG will be assessing options for commissioning the market to deliver the new model – it is expected this would include an options appraisal of do nothing, re-specify existing providers, seek a lead provider from within the existing market, conduct re-procurement for some elements of service or conduct re-procurement of all services

10.4 Delivery of the new model and change of culture required to achieve success is being supported by The Kings Fund, to enable leaders from across the health and social care system work collaboratively to deliver the model. The Integrated and Urgent Care Design Group will oversee the redesign work and will monitor delivery against agreed timeframes and milestones.

11.0 Conclusion

11.1 This strategy sets out a vision and framework for the future delivery model for integrated and urgent care services that will deliver a high quality experience for patients and sustainable models of care delivery with more services delivered closer to patient's homes. This will result in improved choice and personalisation for individuals with more care being delivered closer to where they live and will assist with tackling underlying health inequalities. It will also deliver services that are value for money making better uses of resources across health and social care.

11.2 This strategic approach of developing integrated models of care focussed around patients will build on and enhance existing clinical partnerships and ensure that services are deliverable and effective. Clinical leadership will be crucial to driving this agenda forward and giving power to clinicians to exercise their judgement on the best way of improving outcomes for their patients.

11.3 We aim to create a system that is aligned to clear goals, recognises the interdependence of organisations and is based on mature business relationships founded on transparent cooperation. Any changes that are made will take into account the effect on the overall health and social care economy and in particular and potentially destabilising effects that may impact on the delivery of essential healthcare.

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September 2012