Locality Proposal for Implementation of New Models of Care Closer to Home

Proposal Name	Pilot of a Comprehensive Community Service for Oxford City		
Name of Initiator	Ben Riley		
Organisation	OxFed		
Key Partners	This proposal has been developed jointly with Oxford Health FT and OCCG		
Locality	Oxford City		
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Date of Submission	10.12.15		
What Area of the Care Closer to Home Strategy Does the Project Relate to?			
Integration of out of hospital care			
Expected Start Date	15/12/15	**Expected End Date**	15/11/16

Proposal(s)

Aim
The aim of this pilot is to test at the locality level a new model of working between community health, social care, the voluntary sector and primary care which provides a comprehensive community service focused on the needs of the individual and unconstrained by current barriers such as different employers and labels such as housebound or palliative.

Objectives

1. To co-design and test an approach to delivering a primary and communityhealth service at a locality and practice cluster level that matches the skills of an integrated team with individual patient needs, delivering care in partnership with patients and carers through a proactive approach.
2. To move to MDT working, rather than silo teams who communicate via referral
3. To develop and trial a system for identifying and stratifying the health needs of individuals and patient groups within cluster populations and matching this effectively to personalized care provision
4. To increase the capacity of this service to meet increasing demand, so it is able to respond more effectively at times of crisis
5. To help patients and carers maintain their optimal level of wellbeing and to keep them at home and living independently for as long as possible
6. To better co-ordinate and case-conference for people with complex LTC who will benefit from a MDT case management approach
7. To reduce duplication of effort and promote continuity of care for patients
8. To reduce in-appropriate admissions to and attendances at hospital

9. To increase staff satisfaction, aiding local workforce development, recruitment and retention
10. To inform future commissioning

Patient Cohort
The population of Oxford City (i.e. those registered to OxFed member practices).

The approach will be to identify and stratify the needs of the cluster populations and tailor interventions on this basis, rather than defining traditional service siloes. This will enable the patients requiring the most complex interventions to be provided more effectively, focusing on those with multiple long term conditions and complex care needs, those with frailty and those at the end of life.

The service will be based on three core principles. It will be:

- Comprehensive – spanning the preventative, acute and long-term health needs of the local population
- Holistic – incorporating biological, psychological and social aspects of wellbeing
- Personalised – tailored to the identified needs of the individual, their family and their local community

Proposed new way of working, which is in line with the agreed vision of Oxfordshire Community Integrated Locality Teams, April 2015.

Initially, the pilot will require the engagement of the following existing staff groups:
(given the breadth of stakeholders, a phased approach may be adopted)

Oxford Health City Integrated Team consisting of
- District nursing
- End of Life Community Matrons
- Older people mental health practitioners
- Community Physiotherapists and Occupational Therapists
- Oxfordshire Reablement Service
- Circle of Support
- Oxfordshire Dementia

Other Oxford Health Services
- Tier 2 nursing
- Care Home support service
- Other Allied Health Professionals
- Falls service
- CHC
- Hospital at home

The Central Adult Social Care Team
- Social workers
- Occupational Therapists
- Coordinators

Practices and Key Staff
- GP federation practice visiting nurses
- Care navigators
- Practice nurses

Others
- Macmillan nurses
- Consultant gerontologist
- MIND
- Age UK
- Housing Services

In co-designing a new model of working, a population stratification approach will be used to identify the type of support needed for each population group and to agree the best way to deliver this and by whom. This may require aspects of the service to be delivered at a practice level, cluster level, or a locality level. The following design principles will be applied to developing the new model:

- The needs and goals of the patient and carer will be identified through a personalized care planning with a digital care plan produced and accessible to all parties
- 'Lack of capacity' will not be a possible response
- Entry to care will be via one, fully manned number between 8-8 seven days a week
- Teams will hold responsibility for resolving problems through to completion, using the trusted assessor approach, and good communications with no bounce backs, except for advice of issues outside of a practitioners competency
- There will be easy access to medical advice
- Flexibility, problem solving, risk enabling with support to patients and carers to a suitable outcome will be paramount

The pilot will particularly focus on older adults (as they are the highest volume users of the existing community-based services). However, the learning from the pilot, includingthe operational infrastructure, team-working and informatics systems developed, will provide the scope for rapidly extending the pilot to include cluster- and locality-based services for children, young people and families (e.g. children with complex needs or families who are frequent A&E attenders).

The direction of travel will be towards a whole population approach, where care for people of all ages is delivered at the practice, cluster and locality levels in the most effective way that promotes the resilience of individuals, families and communities. This may involve breaking down some of the traditional boundaries in care delivery (e.g. between physical and mental health and between child and adult health services) to create a more efficient family- and community-oriented service.

Resources/Support required

Full engagement and commitment to delivering the pilot will be needed from GP Practices, OxFed, Oxford Health FT and Oxford County Council as key stakeholders. This will include releasing staff to participate in design workshops and supporting effective communication about the project to all levels of staff. Each organization will have a named person who is the key lead for the orgainstion.

A project team which can report into the Community Integrated Locality programme board will need to be formed to enable this pilot to be delivered at pace. This will require:

- 1 clinical session/week of OxFed clinical lead time
- 0.5 day/week of DN/therapist/early visiting nurse/social care time
- Access to analytics and implementation of systems for population stratification work
- 1 project management time
- 0.4 administrative support
- 0.2 data analyst to support interoperability of IT systems
- Other key stakeholder organisations may wish to include costed time for lead staff members

Desired Outcomes / Proposed Benefits

Outcome	Measured By:
A clear single pathway into community services	New standard operating procedure
An integrated model of working that can be tested for 6 months	New standard operating procedure
Increased community clinical capacity to support people at home	Reduction in inappropriate admissions
Increased patient and carer satisfaction: more joined up care for patient / family perspective,	Improve people's experience of integrated care
Improved patient outcomes	Select from CILT outcome set e.g. Proportion of patients and carers who are assessed as having achieved the long term health outcome for functional goal they desire/ planned for with staff
Reduce un-necessary use of A&E and non-elective admissions	Standard metrics
Increase the number of people supported to die with dignity at home or in their chosen care home	Standard metrics
Increased staff satisfaction: reduced duplication of effort, improved staff morale	Survey and improvements in staff retention
Evaluation of the new approach to inform future commissioning	Report

Further work is required to identify the most relevant outcomes and they need to reflect the outcome set developed for the Community Integrated Locality Teams.

Milestones

List the top 5 milestones required to deliver this project

Milestone	Start date	End date
Agree project scope and submit to Transformation Board for system wide sign up.	9.12.15	15.12.15
Agree project governance and resourcing of project team	9.12.15	23.12.15
Scoped and designed model through stakeholder workshops	15.12.15	31.1.16
Developed and agreed new standard operating procedures	1.2.15	12.3.16
Staff briefed to commence new way of working from 1.4.16	15.12.15	31.3.16
Evaluation framework agreed	1.1.16	31.3.16
Model tested	April 2016	September 2016
Evaluation report published		November 2016

Risks

Risk	Mitigation
Variable levels of engagement from stakeholders may delay development of the new model of working and its testing	To secure system wide support at the Transformation Board To co-produce the new approach with all stakeholders including front line staff so that new ways of working are 'owned' by staff To focus on the benefits of change for both patients and staff
The model to be trialed cannot be agreed	To work closely with providers to come to a pragmatic decision and to agree to work flexibly so that if something is not working then there will be scope for change as the pilot progresses
Too much else going on in the system so the appropriate time is not given to the pilot and milestones are missed	Transformation Board to agree that this is a priority for all stakeholders
Inadequate resources provided to enable the project to be delivered	Resources required to undertake this pilot have been identified in the project proposal and submitted to the Transformation Board with the request for support