

Joint Corporate Board/CCG Session

Purpose of today

- Discussion and agreement on vision for community health and social care bidder session and content of presentation
- Discussion on procurement timetable
- Discussion of project management

Community Health and Social Care Information session for potential bidders

Introduction

- **Purpose of session** – analyse/understand context we are working in; contribute to the strategic drivers for change and balance of wider societal drivers from prevention to intervention; benefits to individuals and whole system/societal changes required;
- There is now a need for the CCG and Swindon Borough Council to consider the future of the provision of health and social care services in the light of:
 - Policy drivers in relation to health and social care nationally
 - Strategic commitments made by Swindon Borough Council through the Health & Well-Being Strategy and the Better Care Fund Plan
 - Outcomes we are striving to achieve for our population
 - The benefits achieved through an integrated health and social care contract
 - The challenges that have been experienced over the past three years
 - Options and implications for the future for health and social care integrated provision

National Policy Drivers

- Health & Wellbeing Board statutory guidance to promote integration between health and social care
- Care Act 2014 places a duty on local authorities to promote integration and partnerships across health and social care and greater focus on prevention and reablement
- 5 year Forward View focus on integration of health and social care to address demand particularly from older people
- Better Care Fund Plan guidance requirement to show vision for integration and prevention
- Barker review on future integration of health and social care

NHS 5 Year Forward View – 10 Priorities

- ✓ Improving quality of care and access to cancer treatment
- ✓ Upgrading the quality of care and access to MH and Dementia Services
- ✓ Transforming care for people with LD
- ✓ Tackling obesity and preventing diabetes
- ✓ Redesigning urgent and emergency care services
- ✓ Strengthening Primary care services
- ✓ Timely access to high quality elective care
- ✓ Ensuring high quality and affordable specialised care
- ✓ Whole system change for future clinical and financial sustainability

Swindon

- Population across Swindon and Shrivenham (Health) of 226,000
- 20% of the population in under the age of 20 and
- We expect the population of older people to rise more quickly than those of working age
- Minority ethnic Communities account for 20% of the population
- Health and social outcomes are generally within the national average
- One Local authority, one CCG, one District General Hospital, one mental health Trust and one integrated provider of community health and social care

Population Forecast

Age Group	2010	2015 Projection	2022 Projection
People aged 0 to 4 years	14,805	14,926 +0.8% from 2010	15,437 + 4.3% from 2010
People aged 65+ years	28,857	32,944 +14.2%	38,721 +34.2%
People aged 75+ years	13,892	15,556 +12%	19,391 +40%
People aged 85+ years	3,865	4,681 +21.1%	6,161 +59.4%
Total Population	201,053	211,102 +5%	231,867 +15.3%

Future Projections for Population 65 +

Number of over 65s in Swindon projected to have:-	2011	2015	2020	2025	2030	% Increase 2011 to 2030
• Dementia	2,014	2,289	2,734	3,265	3,941	95.7%
• A long-standing health condition caused by a stroke	673	767	877	1,023	1,191	77.0%
• A limiting long-term illness	13,599	15,412	17,526	20,397	23,762	74.7%
• A fall leading to the need for support	7,716	8,777	10,119	11,698	13,786	78.7%
• A BMI of 30 or more	7,582	8,670	9,717	11,057	12,835	69.3%
• Diabetes	3,617	4,133	4,686	5,379	6,279	73.6%

Vision as agreed in Health & Wellbeing Strategy and Joint Commissioning Intentions 2015/16

- ***To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities***

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

Strategic Commitments made by Swindon Borough Council and CCG

- Health & Well-Being Strategy commits to promoting integration
“Adults and older people in Swindon are living healthier and more independent lives”
 - Strengthening integrated working between health & social care, reducing the number of people with long term health condition, promoting independence, meeting carers needs
- Transformation Network
- Better Care Fund Plan commits to 5 year vision for integration across health and social care with 12 jointly funded schemes

Health & Wellbeing Strategy - Outcomes & Measures

Outcome	Performance Measures
<p>Older people live as independent as possible</p> <p>Older people live healthy and fulfilling lives</p>	<ul style="list-style-type: none"> • Reduce admission of older people over the age of 65 to residential and nursing care • Reduce length of stay in residential and nursing care by bed weeks purchased • Effectiveness of reablement services is good • Reduction in delayed discharge due to social care and health • Social care service users improved score for quality of life • Social care users who say they find it easy to get information and advice • Adult care service users who have the amount of social contact they want • Services are efficient and safe so that people receive the services they need to meet their agreed outcomes • Services are reviewed regularly to ensure they continue to meet needs
People are in control of their lives	<ul style="list-style-type: none"> • All eligible adults are in receipt of a Personal Budget for either health or social care • The number of adults taking their PB as a Direct Payment or ISF increases giving greater choice and control over their support needs • All eligible service users in receipt of a service receive an annual review
People lead healthy lives	<ul style="list-style-type: none"> • Increase life expectancy • Reduce morbidity (ie live independently for longer) • Reduce health inequalities • Emergency admission rate increase/decrease • 4 Hour A & E target at 95% • 100% of patients treated within 18 weeks • Reduced mortality from cardiovascular disease in under 75 year olds • Reduced mortality from cancer in under 75 year olds • Reduced mortality from respiratory illness in under 75 year olds • Number of carers assessments completed increases

What are the challenges with the current model of Health and Social Care delivery?

Older people lead healthy and fulfilling lives

- Too many people go to GWH in an emergency or are referred by a clinician in an emergency which neither health nor social care can afford and despite a wide range of preventative and community services
- Patients stay too long in hospital because of the length of health interventions, access to community health, length of social work assessment and access to domiciliary care
- Clinicians in the hospital, GPs and community health and social care professionals do not work together as well as they could to avoid hospital admission or get people home as quickly as possible

Finance and Budget 2015/16

We are looking for a Lead Contract model with a partnership across providers to deliver the principles, outcomes and pathways outlined later in this presentation.

Budget:

Adult social care approximately £9m

Community Health approx £17m

5 year budget based on 2016/17 figures with 10% held back on incentives , key indicators may have a penalty

Principles for delivery of Adult Social Care and Health services to be tested

People lead healthy, independent and fulfilling lives through early intervention and prevention

All older people and those with long term conditions have a proactive assessment, health and care plan which prevents unnecessary hospital admissions or admission to residential care

Individuals with a long term condition, and their carers, are supported in partnership with primary care to manage their condition at home and maintain their independence.

Advice and signposting to voluntary and community support are made available to all people in contact with community services to support self care and self management of their health

The offer of community , social care and preventative services is effective in helping people achieve the outcomes we have set .

Principles for delivery of Adult Social Care and Health services to be tested

People with long term conditions are supported when there is an acute deterioration of their condition or crisis so they regain their health and independence as quickly as possible and are in control of their lives

- All older people and carers in an acute crisis receive immediate support to avoid hospital admission where possible or reduce the length of stay
- Older people who are admitted to hospital in crisis older people's care plan is reviewed to maximise their ability to regain skills and maintain independence
- All people admitted in an emergency have their health and care plan reviewed to avoid future crisis

Principles for delivery of Adult Social Care and Health services to be tested

People are able to recover from illness and regain their skills to live as independent as possible

Once in hospital, patients are discharged in a timely way and have the right support in place at home or in communities to regain their skills and are as independent as possible

Patients are supported in the community following discharge and during their recovery period so they recover and readmissions are avoided

Patients make a sustainable recovery with no avoidable deterioration in health so that their independence is maintained where possible

Our services are efficient so that there is no duplication and waste in the system

What are commissioners looking for in a new service?

Preventative service are in place for people and those with long term conditions so they maintain healthy and independent lifestyles

Providers demonstrate a partnership with the third and voluntary sector to build capacity in the community to support those with long term conditions

Carers are supported through locally based support and a partnership with the voluntary and third sector

All health and social care professionals work in partnership to facilitate self health and self care

What are commissioners looking for in a new service?

Older people are in need of health care and social support as their health and independence deteriorates (planned care)

- Single Point of Access that primary care and local professionals can refer to for health and social care services to reduce confusion and multiple access points
- Effective community health and social care interventions which tackle long term conditions and prioritise those patients at risk of hospital admission, residential and nursing care and work in partnership with a range of providers and prevent placement/carer breakdown
- A partnership with care homes, domiciliary care, housing and voluntary and third sector to maintain independence and skills where possible

What are commissioners looking for in a new service?

Emergency response in place as older people face a sudden crisis or deterioration

An urgent care service 7 days a week which links/engages with preventative services in the community, primary care as well as secondary care to reduce admissions.

As part of this a crisis/rapid response service 7 days a week that treat patients at home where possible. Where further testing is required, this is provided in such a way that longer term hospital admission is avoided

STEP up and virtual ward which maximise the ability of people to remain at home and avoid hospital admission where possible

What are commissioners looking for in a new service?

Discharge from hospital is effective and timely to maximise independence skills of older people

Community health and social care services which work together seamless to ensure the speedy discharge of patients 7 days a week so that delays due to health and social care reduce and people maintain their independence at home for as long as possible

Services which maximise discharge to assess facilities in the community

Services which enable people to regain their skills and maintain their independence avoiding the need for residential and nursing care

Social care and health staff are trained and able to support carers of patients at the end of their life and patients are looked after in a place they want to be, all care is coordinated for patients

Questions to the market as part of testing

- How would you deliver an integrated approach for older people and those with long term conditions
- What is your experience in delivering integrated health and social care services. What skills and expertise do you bring within your organisation/ consortium
- What is the innovation in your service delivery models
- How would you develop relationships with primary care and other healthcare providers
- Describe your workforce development model, including workforce development, recruitment and retention strategy – what are the challenges

Questions to the market as part of testing

- Population based budgets – what is your approach
- How would you achieve efficiency savings and ensure effective and efficient services
- Describe your quality assurance model to deliver high quality services
- How would you integrate the prevention agenda
- What is the approach you would use to shared care records – governance
- What are the outcomes you believe would be measured
- How do your services help to build resilience for individuals

Next steps July - September

- One to one sessions with providers

Focus groups to test principles and outcomes as well as service models with

- Service users
- Carers
- Staff
- Gps