**Older People’s Joint Management Group**

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<th>Date of Meeting: 2(^{nd}) December 2014</th>
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| Title of Report: Integrated Multi-disciplinary Community Teams |

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**Purpose of Report:** Presenting findings to support the development of integration delivery to individuals across the community in Oxfordshire

**Action Required:** Note the report

**Impact on users and carers:** To improve people’s wellbeing through better use of services and resources

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Integrated Multi-disciplinary Community Teams

Briefing

November 2014

Oxfordshire has commitment to design and deliver integrated adult health and social care community working in partnership with volunteer organisations. There is now a wealth of published findings to support successful integrated care delivery. These findings as presented below will frame the development of integration delivery to individuals across the community in Oxfordshire.

1.0 Why are we doing this?

To meet the changing demands on community health and social care, by the demographic and financial pressures harnessed with the developments in the way care can now be delivered in a person’s home.

Integration is to improve -

- Safety of delivery
- Experience of the individual and of the professionals
- Effectiveness of the care delivered
- Population health
- Use of resources

2.0 What is meant by integrated community teams and services?

Nationally integration in health and social care has over 157 definitions; a working description in Oxfordshire for the community is:

The NHS, Social Care and Voluntary Organisation working together locally

- With a shared vision of good integrated care
- Pooled resources
- Shared information systems

This reflects the evidence below-
2.1 Principles for successful integration

The evaluation of integrated approach nationally and internationally have all agreed there are key principles that lead to success in achieving integrated delivery of care

- Single point of entry
- Shared and owned vision
- Tailored, Holistic Support plans, based on patient led outcome and choice
- Consistent leadership
- Have an emphasis on keeping people healthy,
- That maintains older people and adults with complex needs in the community for as long as possible.
- A defined population that the team works to

2.2 Supporting systems required to make it work

To ensure effective working and delivery of integrated care key support systems need to be part of the delivery

- Pooled financial resources
- Co-location
- 7 day working across the system
- Single patient record
- Robust information sharing protocols
- A joined up workforce plan, financial and service plan
- Technology in place to support integrated care

See Appendix 1 for the frequently used terms and national work programmes

2.3 What Patients and the Public have told us locally and nationally

In 2013 National Voice worked with 130 health and social care charities and Think Local Act Personal to find a narrative for Person Centred Coordinated Care.

“I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me”

National voices

For the Joint Health and Social Care Strategy for Older People 2013-16, the following statements where developed by and with a range of patients and the public across the county.

- I can take part in a range of activities and services that help me stay well and be part of a supportive community.
- I get the care and support I need in the most appropriate way and at the right time.
When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.

As a carer, I am supported in my caring role.

Living with dementia, I and my carers receive good advice and support early on and I get the right help at the right time to live well.

I see health and social care services working well together.

The Joint Health and Social Care Strategy for Physical Disability 2012-15, was extensively consulted on and has similar aspirations within it

At the Older Peoples Partnership Board workshop in June 2014, the people present said that integration will help individuals to take more control if the following was in place-

1. There is a clear, easy to read, one page summary of the persons needs and services provided, and if this is available and accessible by the institutions or organisations involved in their care
2. Patients do not have to repeat the same of similar information
3. There are better information and advice services
4. There is a real understanding that the person is at the centre
5. There is a real cultural change and everyone is involved in this

3.0 What has happened so far in Oxfordshire?

A Programme Director to lead and co-ordinate this work has been appointed

There is a meeting in November of strategic leaders across community health, social care and primary care to outline the strategic model and outcomes for the population and the organisations

Oxfordshire is already leading on new ways of working, as in the new contracting model for adult mental health services that is integrated delivery between health, social care and the volunteer sectors

Oxfordshire has become part of the national System Leadership Programme that will deliver national support of testing out new ways of delivering care in the community

Oxfordshire have applied to be a national demonstrator site for Integrated Personal Commissioning

3.1 What is already in place across Oxfordshire?

Oxfordshire already has many areas of successful integration that will be built on to deliver integrated care in the community

- Large Pooled Budgets for Older People, Physical Disability, Learning Disability and Mental Health
- Areas of integration in commissioning and contracting
- Oxford Health single point of access (SPA)
- 2 Emergency Multi-disciplinary units – EMUs at Witney and Abingdon
- Integrated Out of Hours GP services with Minor Injury Units and Hospital at Home
• The Clinical Stroke Pathway
• Oxford Health’s new Integrated Locality Teams
• Integrated management and delivery of Speech and Language Therapy across the county
• Integrated management and delivery of Nutrition and Dietetics across the county
• Personal health budgets delivered and sustainable in Continuing Health Care
• Older people’s mental health practitioners as part of the Care Home Support Service – integrating the gerontology, psychology and psychiatry approach to patient care
• A cross professional clinical competency framework for Integrated Locality Teams
• Integrated pathway between Supported Hospital Discharge team and Oxfordshire Reablement Service, to ensure timely hospital discharge and supported recovery at home
• A new model of older people’s mental health delivery
• Circle of Support Pilot between Age UK and Oxford Health integrated teams and Age UK, Oxford University Hospital, and Oxford Health in key wards / community hospitals

3.2 Next steps – in development

To have a model of care agreed

To have a programme of work to support the change process to deliver the new model

To have an outline timescale of delivery

To make sure people are engaged

To ensure other developments tie into the new model

Suzanne Jones

Programme Director Integrated Localities
Appendix 1

Explanation of the Common language used in Integration -

Co-ordinated Care

This works best with those individuals who are frequent users of health and social care; this is usually the elderly, those with mental health issues and those who have low social and economic capital. Research has shown that individuals with complex issues plus mental health issues cost two to three times more than those without.

The focus of co-ordinated care is to identify the individual and for a professional to become their advocate working across community health, primary care and social care to have an agreed up to date support plan.

The Coalition for Collaborative Care is a national group of individuals and organisations across the health, social care and voluntary sectors who want to make person-centered, coordinated care a reality for people living with long-term conditions. That means improving the relationship that people have in their day-to-day interaction with the NHS and social care so their care and support is organised around what matters to them. Full details can be found at - coalitionforcollaborativecare.org.uk

Self-care – individuals look after their own health

Self-management – individuals take an active role in managing an existing condition

What is complex?

People with multiple needs that are interrelated or interconnected or a depth of need that is profound, severe, serious or intense

Each individual with complex needs has a unique interaction between their health and social care and require a personalised response from services

Personalisation

This is a person centred approach to decision making, recognising that someone’s experience is socially constructed. It depends on who they are and their personal history and context. It requires professionals to actively listen and value the other persons experience and expertise.

It sees people as an asset rather than a need

It is based around shifting the balance of power from the professional to the individual, and changing both the clinician and the patient behaviours. It required the clinicians adapting their approach to communication, known as changing the conversation that is supported by the ‘Year of Care’.
Whole person care

- This has is also termed as co-ordinated care
- The care aims model – a population based person centred approach to health and well being
- House of care model described by the Kings Fund – see below

Move from Oxfordshire Case Management Model to Care Facilitation Model

Case managers remit was to work with people with long term conditions, over a long period of time, to support them with changes in their condition and refer on to other services when necessary.

In integrated working with people with complex needs who experience a change in that need (either health or social), or deterioration in condition. The approach is multidisciplinary and the most appropriate professional will undertake the first assessment, hold the case short term and identify the most appropriate professional to be the key worker going forward. The team will work closely together in a multi-professional way, to maximise patient benefit.

Dynamic Risk Management

To successfully make the cultural change the risk adverse professional attitude needs to move to an individual dynamic risk agreement. As Sir Mark Hedley in examining the third principle of the Mental Capacity Act said ‘that humans have the right to make foolish decisions’

This is the move from a paternalistic system to an enabling system so that people can live the lives they want to, but those who are vulnerable or cannot manage themselves are still fully supported

Year of Care

This term has two meanings currently

1. Tariff based payments that are based of full needs over a year for an individual, currently being piloted in 6 clinical commissioning groups nationally
2. It is also a training package that came out of the work undertaken in the year of care diabetes work, to train health professionals to deliver personalised care plans. There are a few people trained across the country as train the trainer to deliver this package of training

House of Care

The Kings Fund, Delivering better services for people with long term conditions: Building the House of Care – October 2013. This is the basis that NHS England is using for national development of integration and the management of long term conditions. It is the basis of Coalition for Collaborative Care a policy area in NHS England hosted by the Royal College of General Practitioners. The key area in the House of care is Personalised Care Planning.
The House of Care

Organisational process

Engaged, informed patients

Personalised care planning

Responsive commissioning

Health care professionals committed to partnership working