Attach 5A

Integration Transformation Workshop Notes, Friday 8 November 2013

Attendees:

Name	Title	Organisation
Lucie Waters	Director of Commissioning	WCCG
Kate Macleod	Operations Manager	WBC
Sydney Hill	ACT Manager	WBC
Gareth Williams	Interim Ops Manager	WBC
Stuart Reeves	Director of Ops – Community Services St George's	SGH
Alistair Rush	Assistant Director, Adult Social Services	WBC
James Morton	Reablement Manager	WBC
Alison Kirby	Commissioning Manager, Intermediate Care Services	WCCG
Yarlini Roberts	Head of Finance	WCCG
Trudi Kemp	Director of Strategy	SGH
Clare Ratnayake	Head of Clinical and Service Improvement	WCCG
Rob Persey	Head of Joint Commissioning Unit	JCU
Harold Lo	Clinical Director Community Services	SGH
Paul Smith	Business Manager, Continuing Healthcare Team	CSU
Jane Pettifer	Head of the Continuing Healthcare Team	CSU

The group outlined the vision and aims for the integration agenda -

"Person centred coordinated care"

<u>Patient/Service user</u>

- I want to be at home and independent as long as possible
- In the community I will have a coordinated care plan in one place addressing my needs holistically
- I will have an accountable lead professional
- Services will support me 24/7
- I will be in hospital only when I need to be, but no longer
- I will be satisfied with the services I receive
- I will have a good quality of life

<u>Commissioner /Provider</u>

- Partnership "ownership" of shared performance dashboard
- Achievement of financial efficiencies that both meet targets and sustain the provider market place /landscape
- Staff /shareholders think "whole system" and understand their contribution/feel valued

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Is there a shared vision for improvement in services for the "frail elderly"?

Current service map:

SERVICE SITE	SERVICE TYPE	COMMISSIONER	VALUE (£)
St George's Hospital – Acute	Dalby Ward – Senior Health	WCCG	
St George's Hospital – Acute	Eberden Ward – Senior Health	WCCG	
Queen Mary's Hospital	Mary Seacole Ward - Inpatient Elderly	WCCG	
Queen Mary's Hospital	Day Hospital Services	WCCG	
St John's Therapy Centre	Day Hospital Services	WCCG	
Home	Domiciliary Intermediate Care	WCCG	
Ronald Gibson House	Intermediate Care Beds	WCCG	
In Reach Team	Interim/Intermediate Care Beds	WCCG/WBC	
Home	START re-ablement	WBC	
Home	Community Adult Health Services	WCCG	
Nursing Home	Continuing Health Care Beds	WCCG	
Residential Home	Residential Care Placements	WBC	

Key Issues:

- At any one point in time between 10 – 30% of patients in St George's Hospital are medically fit for discharge who are not discharged for a range of reasons – at least a 10% opportunity. These patients are not Delayed Transfer of Care (DToC)
- The model of care in 'senior health' is significantly different to acute medicine – if appropriate, a change in model of medical care could reduce LOS by up to 10 days
- There is an opportunity to identify a cohort at risk who are different to risk stratification – the "Tescos" model (ACORN database)
- Need to continue work rehabilitation through "Step Down"

- Services silt up because of lack of specialist residential /other care Elderly Mentally Ill (EMI)
- NETA winter monies is allowing a pilot of integrated and seven-day working – is this the future of the ITF?
- How to minimise impact of multiple moves for patients (particularly those in Dementia)

KEY PRINCIPLES

- **No decision about a patient's long term care should be made in an acute bed**
- **Patients should continue to receive rehabilitation throughout the care pathway from admission, right up to a decision that rehabilitation is no longer appropriate**
- **There needs to be a single point of contact for post-acute care to –**
    - **support patient care in the optimal rehabilitation environment,**
    - **to reduce acute LOS,**
    - **to facilitate decision making about continuing healthcare with patients and families**
    - **to commission effectively and efficiently across health and social care for the same cohort of clients/patients**

There was agreement that 'frail/elderly adults' was a significant area of opportunity for integration, improved patient care and efficiencies across health and social care.

Issues for taking forward:

- A presumption in favour of sharing information
- identify risks and governance issues
- use community tariff as an enabler
- pathways costs – reducing acute cost, comparing costs of pathways to shoe efficiencies
- finance – need baseline cost
- struggle of accounting for "frail elderly"
- unknown mechanism for commissioning through the ITF
- What do we stop doing?
- Are there double running /closure costs?
- Engagement and inclusion of NHSE Commissioning (primary care, specialised and public health)
- Stop staff groups becoming tribal
- Outcomes apply across all services
- Social care = Wandsworth residents
- NHS = GP registered population
- need to engage all providers including residential/nursing homes, domiciliary providers/intermediate care providers