SHAPING OUR FUTURE

Cornwall and the Isles of Scilly Health and Social Care Partnership

SUMMARY REPORT		
Transformation Board Meeting In Public	**8 August 2018**	**Item: 06**
Title of report	A progress update on the design and implementation of a new model of place based integrated care	
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Purpose of report	To brief the Board on most recent progress	
Recommendation	To note the contents of the report	
Engagement and Consultation Undertaken to Date	The emerging model has been endorsed by the South West Clinical Senate and Clinical Practitioner Cabinet as a good working draft. It has now been shared with the NHS Kernow Clinical Leadership Group, Shaping our Future Portfolio Board, Overview and Scrutiny Committees and the Health and Wellbeing Boards. The emerging model has been shaped by: • three waves of co-production workshops; practitioners leading and working with work streams; • workshops and discussions with practitioners involved in particular elements of community-based care; • visits to GP locality meetings; feedback from GP localities and community teams testing new ways of working; • feedback from the Citizen's Advisory Panel and HealthWatch, whose members have been participating in the co-production workshops. Members of the Health Overview and Scrutiny Committees have also attended the workshops.	

Executive Summary

The intention is to use 2018/19 as a 'test and learn' year working with integrated care areas, communities and clusters to learn, adapt and refine the model. There has been good progress in identifying test and learn sites across the county with several starting in order to test out new ways of delivering care ahead of Winter.

An Integrated Community Services Redesign Board is being established to oversee delivery of the new model of care.

The content of this report is organised by key project thematically and then geographically to reflect the system's transition to establishing three Integrated Care Areas:

- North & East Cornwall
- Central
- West Cornwall and the Isles of Scilly.

Interdependencies with other work streams (where relevant)	The community based model of care is being developed with reference to the following: - 2018/19 NHS Planning Guidance requirements - Alignment with organisational annual operating plans and change programmes - System quality and performance priorities - The three year system financial recovery plan to contain cost and demand. - Other programmes of work including those relating to mental health, public health, adult social care transformation, One Vision (children's services strategy) and primary care
Financial implications	The model of care must support delivery of the three year system financial recovery plan to contain cost and demand in the NHS. It must also support the delivery of the savings plan for adult social care services. The intention is to shift resources from reactive high cost unplanned care in acute settings towards pro-active preventative services in communities.
Key Risks	None identified.
Sources of evidence in support of proposals	Many of the components in the draft model are based on best practice in other parts of the country.
Equality and Diversity Statement	Any proposed service changes would pay due regard to relevant equality and diversity legislation.
Communications requirements	A Communication and Engagement plan has been developed.

1 Implementing placed based care in three Integrated Care Areas

1.1 The committee will recall from previous discussions and papers the intention to organise place based care in three Integrated Care Areas which contain seven Integrated Care Communities.

1.2 To progress this NHS Kernow Clinical Commissioning Group has sought legal advice which has suggested that the Governing Body can set up sub-committees that are place based committees. Providers can attend the committees and would be encouraged to participate and give advice, all of which the CCG could consider as part of its decision making process. Once a decision was made, the providers would then enact.

1.3 In the first instance however these will be established as partnership groups rather than sub committees and no formal delegation of budgets for example will take place at this time. These would be collaborative groups with health and care partners in a place based location where everyone is taking the best possible actions for the area they serve.

1.4 Locality lead GPs and community and social care colleagues are supportive of developing these proposals and are taking the discussions back into local communities.

1.5 The intention is that they simply provide a mechanism to enable partnership working across all sectors at the local level, and will only work if this is the case.

1.6 They also will not take away the more local work that happens at practice, cluster and integrated care community level.

2 Urgent care update

2.1 A new 111 Online service is on track to go live in summer 2018 – six months earlier than originally planned.

2.2 A review of a minor injury services provided by GPs has been designed and will take place over the summer so the feasibility of expanding the service to increase the number of services available locally can be tested.

2.3 A suite of modelling and analytical tools have been developed to aid decision making on which and how many Minor Injury Unit (MIU) sites could be upgraded to become an Urgent Treatment Centres (UTCS). These include

2.3.1 Urgent and Emergency Care Channel Shift Modelling which has parameters which can be modified to test different assumptions and scenarios and addresses the following questions:

(a) How would the Emergency Department activity in Treliske, Devon and West Cornwall Hospital be affected by the

introduction of new Urgent Treatment Centres as a configuration of possible locations across the county

(b) What does this imply for affordability and value for money

(c) What are the implications of a given configuration of UTCs on accessibility

2.3.2 Travel time analysis for each site to determine accessibility by private and public transport during peak and off peak times.

2.3.3 Mathematical modelling to determine the optimum location of sites for any given number of UTCs and predicted transfers of activity to the Emergency Departments and UTCs if other MIU sites were closed. Again, different assumptions and scenarios can be tested.

2.4 An independent review of all current MIU estates has been commissioned to determine the feasibility and affordability of upgrading current sites to become UTCs.

2.5 All of the above information will be considered in totality and used to inform options for the future configuration of UTCs and minor injury services.

2.6 It is already clear that because of (i) Cornwall and the Isles of Scilly's rural geography and (ii) because there is insufficient clinical need to have a UTC on every current MIU site, Cornwall will continue to need a mixed model of provision. This would include Emergency Departments, UTCs, Minor Injury Units and services provided by GPs and pharmacies. UTCs will need to be geographically spread to ensure equitable access. Because they are expected to see more people overall and have a higher number arriving by ambulance they will need to be located in the most accessible larger sites.

2.7 In the meantime, a pilot to test a rapid access frailty clinic at West Cornwall Hospital Urgent Care Centre, with access to a short stay assessment bed, continues. To date, demand has been lower than expected and the next step is to raise awareness of the pilot amongst potential referrers.

2.8 A similar approach is being planned at Camborne Redruth Primary Care Centre where new point of care equipment is being installed. This will allow people to have blood tests and get results quickly so treatment can be started, rather than having to travel, often by ambulance to the Emergency Department for blood tests that are sent on to the laboratory. For example, equipment is now available that quickly tests dehydration and kidney functioning to safely assess lower urinary tract infection for elderly people. Quicker access to diagnostics will also serve to exclude serious illness in some cases thus reducing unnecessary admissions.

2.9 On the Treliske site, additional GP capacity funded by Five Year Forward View Urgent and Emergency Care Transformation monies will be used to test rapid GP assessment for those arriving at the hospital with a view to turning people around the same day. The trial will start in November.

2.10 The above funding is also being used to trial the use of 'Lab in a Bag' kits which will provide clinicians with the ability to undertake a range of blood tests using portable point of care testing equipment in a range of settings.

2.11 Other sites will also be considered to test new ways of working and create additional capacity over the winter period.

2.12 This year also sees a first cohort of minor injury nurses completing a non-medical prescriber course. This is part of the plan to develop a workforce who can see people with more complex needs in minor injury services and UTC settings in order to relieve pressure on other parts of the system including Emergency Departments

3 Community Services update

3.1 A whole-system group of health and social care practitioners, working with the voluntary sector, has begun work to design the first ever system-wide wellbeing plan. The plan will capture what matters to an individual and their goals accessible to individuals and practitioners electronically. The development of a standard plan will be iterative. The chosen electronic system is Co-ordinate My Care which is currently used across London. For more information please see http://coordinatemycare.co.uk/

3.2 The Clinical Practitioner Cabinet has endorsed a system-wide framework for Multi-Disciplinary Team (MDT) Meetings and good progress is being made preparing six sites (two in each of our three Integrated Care Areas) to test the meeting approach and establish multi-agency 'teams without walls' which include strong links with voluntary sector partners to make best use of all community assets. An early focus will be on working with 999 and Cornwall 111 to identify frequent callers for discussion in MDT meetings, followed by the creation of a personalised care plan and making best use of social prescribing.

4 Mental Health update

4.1 A pilot **all age crisis café** is now fully operational. It is designed to reduce crisis, avert admission and build community resilience. So far data received evidences a positive impact with reduced attendances at the Emergency Department for frequent attenders, reduced self-harm, reduced risk events and activity is increasing month on month. The expansion of the pilot is planned and will establish sites across the county.

4.2 The Psychiatric Liaison service based at Royal Cornwall Hospital Trust increased its opening hours to provide a 24/7 service from the 1st May.

4.3 Performance in the **Improving Access to Psychological Therapies** service which provides support for people with depression and anxiety is now meeting all national standards.

4.4 **Cove ward (Redruth) -** A new 12 bedded rehabilitation and step down unit has been commissioned from CFT to ease local flow and capacity and stop all non-specialist out of area placements as of 1 April 2018. There have been no non specialist out of area placements since April and there has been an increase in the average number of empty acute mental health beds available in the county.

4.5 **Beyond Places of Safety bid -**The team has successfully secured £1.5million capital investment into Cornwall and Isles of Scilly to establish a range of alternatives to avoid admission and reduce risk through the establishment of a multi-agency hub at Royal Cornwall Hospital Trust (RCHT).

NHS England visit - In May, NHS Kernow welcomed the NHS England's National Director for Mental Health, Claire Murdoch to Cornwall. Commissioning leads were able to showcase local achievements, present updates on the delivery of the Five Year Forward View objectives as well as the Children and Adolescence Mental Health Service (CAMHS) transformation programme. Claire's reflections were overwhelmingly positive and we look forward to inviting her back next year to review progress.

4.6 **Suicide prevention:** A suicide prevention project co-ordinator has started to oversee a number of system-wide initiatives designed to reduce the number of deaths from suicide.

5 Self Management update

5.1 A self-management programme for people living with long-term conditions (diabetes, heart disease, respiratory disease and cancer) is being co-produced with people who use services and carers for completion by August 2018.

5.2 A scheme which sees community pharmacies supporting people with Type 2 diabetes through improved self-management, goal setting and motivational coaching has been re-commissioned for a further 200 people.

5.3 The Academic Health Science Network is training 30 community physiotherapists to deliver 'Escape Pain' self-management courses to people with hip and knee problems. The courses will run in community locations including community centres. The courses integrate educational self-management and coping strategies with an individualised exercise plan so they learn how to cope with pain better. The approach has a robust evidence base which proves effectiveness in terms of reducing the need for clinical contact and GP appointment time.

5.4 A specifically designed web based self-management platform is being tested for people with severe COPD to test if it can increase access and use of pulmonary rehab and promote other self-management components (such as education on medicines compliance and inhaler technique) to reduce use of services.

6 Community rehabilitation and reablement update

6.1 This year, we will be testing new ways of delivering hospital and community based rehabilitation and reablement services. Our aim is to increase the ways people can receive care in their own home. Conversations are occurring at a local level with individual clinicians and practitioners and in team meetings about how we want to make improvements to our rehabilitation and reablement services.

6.2 These services are often described as 'helping people to do more for themselves rather than doing it to or for them'. It usually refers to short term, intensive support that enables people to gain the most independence possible. We are being guided by what individuals say is important to change and identifying either where there is greatest need to change or where the change may be easiest to start. A focus on promoting independence and resilience will impact positively on the wider health and care system and its ability to meet key targets. Some examples of these wider system impacts are expected to be winter pressures, delayed transfers of care and readmissions to hospital.

6.3 Cornwall Council cabinet members agreed in July to engage Newton Europe Ltd to support this work along with other initiatives designed to improve adult social care services.

6.4 It has not yet been agreed where each test and learn cycle will occur but frontline staff are considering various options that will help people achieve maximum independence and help make best use of the resources available. Examples of these are:

- eliminating internal causes of delay and optimising care pathways in community hospitals and West Cornwall Hospital. It would make sense to test this in the larger sites where the impact will be greatest.
- considering how the health and social care reablement services may work closer together. This would mean they could share skills and resources and could provide more cover for each other if one service is busier than the other. We would like to consider how these two teams (called Home First/Early Intervention Service and STEPS) can work even closer together.
- considering how the above reablement services can work more closely with other services in the community that may provide more specialist rehabilitation interventions or more acute clinical and nursing needs. This may include working more closely together with services such as the Community Rehabilitation Teams and the Acute Care at Home team.

6.5 **Bed modelling**

A collaboration between RCHT and CFT informatics teams has led to the production of system-wide bed modelling tool for the RCHT facing catchment i.e. one that looks at acute, West Cornwall and community hospital beds in totality. The tool calculates the total number of beds required for different

operational scenarios which can be modified to allow for varying growth rates, occupancy levels and length of stay. The model cannot itself define the model of care, only inform on the impact of changes.

6.6 **What is the relationship between a test and learn approach and the integrated bed modelling tool?**

As we test different models, the impact on occupancy levels and length of stay will be measured. This information, alongside information about future demand and growth rates, can be fed into the bed modelling tool to help calculate potential future bed numbers. For example, if it was found that a particular service configuration in and around one hospital reduced demand and average length of stay, a test could be run to see what would happen to bed numbers if that length of stay in other sites could be achieved. Alternatively, if for example it was found that length of stay increased, perhaps because of increased access to alcohol detox beds in community hospitals, the model could be used to see how many additional beds might be needed in the future.

6.7 In essence, the test and learn sites will help inform how the configurable variables in the model can be set. This in turn will be one of the ways in which the system works out how many bed based services are needed in the future and where they should be. Other important factors include suitability of estates and workforce requirements.

7 System leadership development

7.1 Workforce leads working with the Kings Fund and local staff have designed a new local leadership programme which will be delivered in Cornwall and the Isles of Scilly from September for nine months. Three teams of five to eight multi-agency and multi-professional practitioners will spend a day a month from September to June receiving training in system leadership. Each team will apply their new knowledge and skills to implementing a system transformation project to accelerate implementation of place based integrated care.

8 GP practice integration and working at scale

8.1 Across Cornwall and the Isles of Scilly, in line with the General Practice Forward View vision for strong and resilient primary care, groups of GPs are coming together to work at scale and in some areas, create new types of organisation to enable integrated working and effective use of shared resources. This will enable commissioners to contract with a group of practices for a service for a whole population rather than individual practices. This could mean for example that if a practice had a GP with particular skills in say dermatology that all of the people registered at any of the practices within that area could be seen by this GP specialist.

Early examples include:

- St. Austell Healthcare (SAH) was formed in 2015 after the merger of three practices in St. Austell.
- The 12 practices within the Mid Cornwall locality will formally establish a limited company. This will be a subsidiary of Kernow Health Community Interest Company – called 'Kernow Health Mid Cornwall'
- The two groups of GPs in East and North Cornwall have formed two limited companies, which are subsidiaries of Kernow Health Community Interest Company.
- Eight practices in Penwith have formed a limited company likely to be called Penwith Health Ltd
- The four Practices in South Kerrier have signed a Memorandum of Understanding setting out principles of working together
- The eight Practices in North Kerrier have also signed a similar Memorandum of Understanding.
- Both North and South Kerrier intend to create legal entities and are looking at the options – both in terms of what form that should take and whether to do so within existing locality groups or combine with each other/Penwith/whole of West.

9 Increasing evening and weekend primary care appointments (Improving Access to General Practice) Update

9.1 In line with national strategy, Cornwall and the Isles of Scilly is testing new ways of offering additional routine evening and weekend primary care appointments aligned to local need. A recent Healthwatch survey showed that the order of preference for out of hours appointments would be for evening and Saturday appointments, with the least wanted being Sunday appointments.

9.2 Three test and learn sites are proceeding: :

9.2.1 St. Austell – (started in June). Building on the experience gained from providing this service over the past two winters, their model involves Monday to Friday 6.30pm to 8.00pm nurse appointments and Saturday GP clinics all from Carlyon Health Hub.

9.2.2 Three Harbours (started in June). They will be testing a model that covers Monday to Thursday 6.30pm to 8pm and a Saturday clinic that is rotated across the three practices.

9.2.3 Penwith (starts in August)

10 Primary Care Active Signposting Update

10.1 Around a quarter of calls to GP practices are for non medical issues. GP practice reception staff are being trained to ask people questions in order to guide them to the most appropriate services including community and voluntary sector services. More than 250 staff in General Practice have undertaken introductory training on line and at workshops. Eight East Cornwall practices have completed Care Navigation training provided by Volunteer Cornwall. The Community Education Provider Network is now working with Volunteer Cornwall and Effective Personal Interactions to draw learning from the first wave and develop a bespoke training package for practices that will support sustainable implementation of this new front of house signposting offer. Penwith, Carrick and Mid Cornwall practices have expressed interest and training is due to commence in September 2018.

11 GP eCONSULT trial update

11.1 Sixteen practices across Cornwall and isles of Scilly now offer people access to healthcare information and GP services through an Online Consultation feature on their websites. The triage and consultation service offers a range of facilities 24 hours a day, including symptom checkers, healthcare advice, service signposting, and access to GP facilities and appointments. People can be supported to help themselves with a wide range of information about symptoms, conditions and available services. Or they can complete an online form to request services from their practice, such as administration tasks, test results, health advice or telephone and clinic appointments. Participating practices are listed below:

Practice Name	eConsult Go Live Date
1. Falmouth Health Centre	LIVE 2018
2. Oak Tree Surgery, Liskeard	LIVE 05/06/2018
3. Pensilva	LIVE 05/06/2018
4. Rosedean Surgery	LIVE 05/06/2018
5. Saltash Health Centre	LIVE 11/06/2018
6. Lostwithiel Surgery	LIVE 21/05/2018
7. St Austell Healthcare	LIVE 22/05/2018
8. Newquay Health Centre	LIVE 11/06/2018
9. Wadebridge & Camel Estuary	LIVE 04/06/2018
10. Carn to Coast (Pool, Homecroft, Trevithick)	LIVE 11/06/2018
11. Harris Memorial Surgery	LIVE 15/05/2018
12. Manor Surgery	LIVE 21/05/2018
13. Veor Surgery	LIVE 07/05/2018
14. Bodriggy Health Centre	LIVE 18/06/2018
15. Helston Medical Centre	LIVE 07/05/2018
16. St Mary's Health Centre	LIVE 2018

12 West Integrated Care Area Update

12.1 **Integrated Multi-Disciplinary Team meetings** – East Penwith and West Penwith GP Clusters are running test and learn pilots where multi-agency teams meet to discuss high risk people.

12.2 **West Cornwall Hospital** – Rapid Assessment Frailty Clinic test and learn. Inspired and influenced by feedback from wave three co-production events, a multi-agency team is testing a new service where frail people at risk of admission can have a rapid assessment by a multi-skilled team with the aim of supporting the person home on the same day. If necessary, a person can be admitted to a short stay assessment bed. The pilot is testing aspects of the Urgent Treatment Centre specification that was considered by the Wave three co-production events.

12.3 **Frailty Rapid Home Response Test and Learn:** This pilot is in the early stages of development and is intended to provide a rapid (1 hour) home visit to people initially referred by an on the scene ambulance crew or from the community home first team. The intention is to test in Hayle area and gradually roll out to the rest of the county in phases.

12.4 **Camborne Redruth Community Hospital**. Using the learning from the West Cornwall Hospital Urgent Care Centre, a similar model will be piloted on this site. Point of Care testing equipment is being installed.

12.5 **Community hub and local access points**. Working closely with the public reference group and frontline staff, there is a project underway to map all of the access points that are currently in use – the ways that public and staff contact the various health and care teams in this geography. The aim is to simplify the number of access points and bring together staff from different providers into one team, either virtually or co-located.

12.6 **Fibromyalgia:** Local practices are working with therapy specialists to support people with a recent diagnosis of fibromyalgia. This is a new service for a limited period and with limited capacity, to test whether or not the therapy intervention and advice will improve outcomes for people and reduce demand on primary care.

12.7 **Helston hub:** A successful funding bid to NHS England, supported by Cornwall Partnership NHS Foundation Trust will see the development of additional clinic space at Helston Community Hospital this year, as well as changes to the outpatient waiting room in order to create an information/signposting hub. This is part of the local plan to create better links with local practices and the community/voluntary sector, and develop the hospital as a hub for health and wellbeing services.

13 Central Integrated Care Area Update

13.1 A **leg ulcer group** (based on the local centipede clubs) will be commencing in the Autumn for people at the Narrowcliff Surgery initially. Funding has also been secured and planning commenced to develop a community leg group in

Falmouth to be supported by practices, community nursing team and the voluntary sector.

13.2 **Integrated Multi-Disciplinary Team meetings** (MDTs) – St Austell Healthcare is testing working in integrated care teams weekly MDT meetings that review the high risk people for that area.

13.3 **Active signposting**: The five practices for the Mid Cornwall Rural cluster are developing their model for implementing "active signposting" across the cluster over the next 6-9 months.

13.4 **Community Links**: The Feock Connect Project aims to improve links between health professionals and community activities. A Community Navigator is being recruited to develop and test a community connection model. This is being jointly funded by Peninsula Community Health, Town Councils and the CCG's practice resilience fund.

13.5 **X-Ray Referrals**: Three Spires and St Agnes practices are trialling sending plain x-ray referrals electronically to a single point of access (RCHT) who offers people an appointment at their nearest hospital. This is to reduce paper referrals and to enable referrals to be made more quickly as the referral is made on the same day that the person was seen by their GP.

13.6 **Community Well-being Cafe**: Carnon Downs PPG is working with the local community nursing team to deliver a Community Wellbeing Group.

14 North and East Integrated Care Area Update

14.1 East Cornwall GP practices and the specialist respiratory service are working with groups to promote the use of technology in care. One example of this is testing the implementation of a web based tool that allows people to manage their Chronic Obstructive Pulmonary Disease (COPD). Whilst it is recognised that not everyone has access to the internet or is confident using a computer, this will be an exciting way to introduce people to a new self-management tool that they can access anytime on the internet at home. This will supplement and enhance the existing level of care provided - it will not replace it.

14.2 Following a successful First Contact Physiotherapist pilot at East Tamar Valley Health and Oak Tree Surgery, discussions are underway with Cornwall Partnership Foundation NHS Trust to roll out the model permanently.