| SUMMARY REPORT | | |
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| **Transformation Board Meeting In Public** | **6 April 2018** | **Item: 05** |
| **Title of report** | Community Based Model of Care Development | |
| **SRO** | Jackie Pendleton | |
| **Author(s)** | Tryphaena Doyle, Programme Manager – Model of Care | |
| **Purpose of report** | To brief the Board on the development of a draft community based model of care and next steps. | |
| **Recommendation** | To provide feedback on the emerging model of care to inform on-going development of how we approach care and support in the future. | |
| **Engagement and Consultation Undertaken to Date** | The emerging model has been endorsed by the Clinical Practitioner Cabinet as a good working draft on which to seek further feedback.<br>The emerging model has been shaped by:<br>• three waves of co-production workshops; clinicians leading and working with work streams; At the time of writing feedback from the Wave 3 events held in February and March was being collated.<br>• workshops and discussions with practitioners involved in particular elements of community-based care;<br>• visits to GP locality meetings; feedback from GP localities and community teams testing new ways of working;<br>• 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.<br>The emerging model has now been shared with the NHS Kernow Clinical Leadership Group, Shaping our Future Portfolio Board and the Health and Wellbeing Board. | |

**Executive Summary**

This paper sets out the emerging model of care for community based case. This includes urgent and non-urgent care.

We are attempting a large scale whole system change – it may not have been visible as that so far because the work is being undertaken in separate work streams and out on the ground in different localities. The sum of it all however, is large scale system change. It is going to affect almost everyone providing and using community based care and needs a shift in thinking and behaviour as well as changes in structures and processes.

The model is not intended to be prescriptive and will allow for local variation within the county wide framework. 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.

The Board is asked to provide feedback to inform ongoing development of the model.

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| **Interdependencies with other work streams (where relevant)** | The community based model of care is being developed with reference to the following:<br>- 18/19 Planning Guidance requirements<br>- Alignment with organisational annual operating plans<br>- System quality and performance priorities<br>- The 3 year system financial recovery plan to contain cost and demand. |
| **Financial implications** | The model of care must support delivery of the 3 year system financial recovery plan to contain cost and demand. |
| **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 is being developed. |

## 1. Our emerging model of care and support

This paper provides an overview of the emerging model of community based care. Feedback is sought to inform on-going development of how we approach care and support in the future.

Our future model of care aims to keep people well rather than respond when they are ill:

a) there will be a much greater focus on preventing disease, spotting risk factors that lead to disease early and proactively managing them to contain the risk, anticipating that people may be struggling to cope with long-term conditions or starting to become frail and planning support with them to prevent functional decline;

b) there will be a focus on earlier intervention;

c) self-care will be embedded and supported as the default method of care for managing long-term conditions;

d) support will include connecting people with local community resources to build personal resilience and help people remain active and involved;

e) proactively work on building social capital within communities to develop strong supportive networks particularly addressing isolation and loneliness;

f) for people who will still need help managing long-term conditions or who are frail their care and support will be planned with them to achieve what matters to them and coordinated with them or, for those with complex needs or severely frail, managed as though they were on a hospital ward but supported to stay at home for as long as possible;

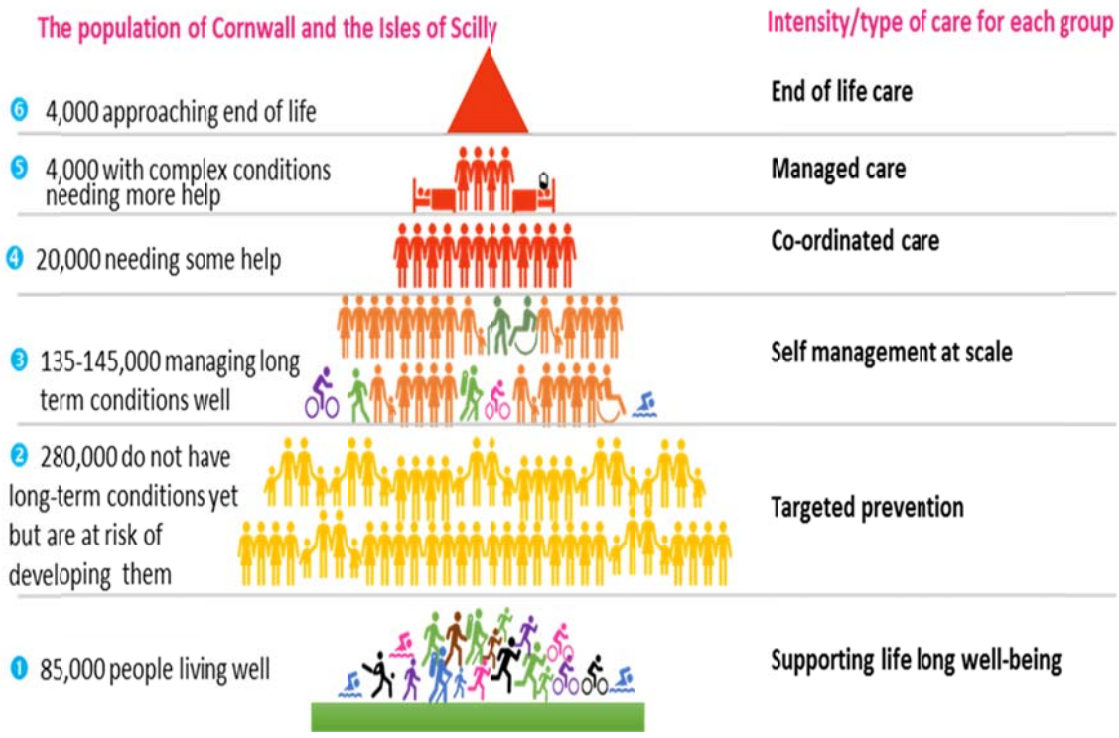
g) when people do experience a crisis and need urgent care, the aim is to keep them out of hospital by providing intensive short-term care and re-ablement where possible in their own home;

h) the capability to provide urgent care in the community will be enhanced by having GP-led Urgent Treatment Centres that will provide acute assessment in local centres with access to short stay assessment beds

The new model is based on understanding our population with the level and type of care matched to each of six population groups (see diagram on next page). The Academic Health Science Network and Cornwall Council's Public Health service are leading work to develop a profile of population health by locality using anonymised GP data, which will help localities shape the delivery of care and support in their area. Additional work is being commissioned to audit current activity and build activity, workforce and financial models – that will further determine what can be included in the new model of care.

We expect delivery of the new model to be built on strong relationships between local multidisciplinary teams and local communities. The foundation for this will be the unique relationship GPs have with their registered practice population and practices will collaborate to deliver primary care at scale and facilitate the development of local integrated teams (integrating practice and community nursing care, health and social care and involving the voluntary sector and local communities).

Some services will need a larger geographic footprint than the six localities and we expect local multidisciplinary teams to be able to draw on a network of specialist support within the system of community based care.

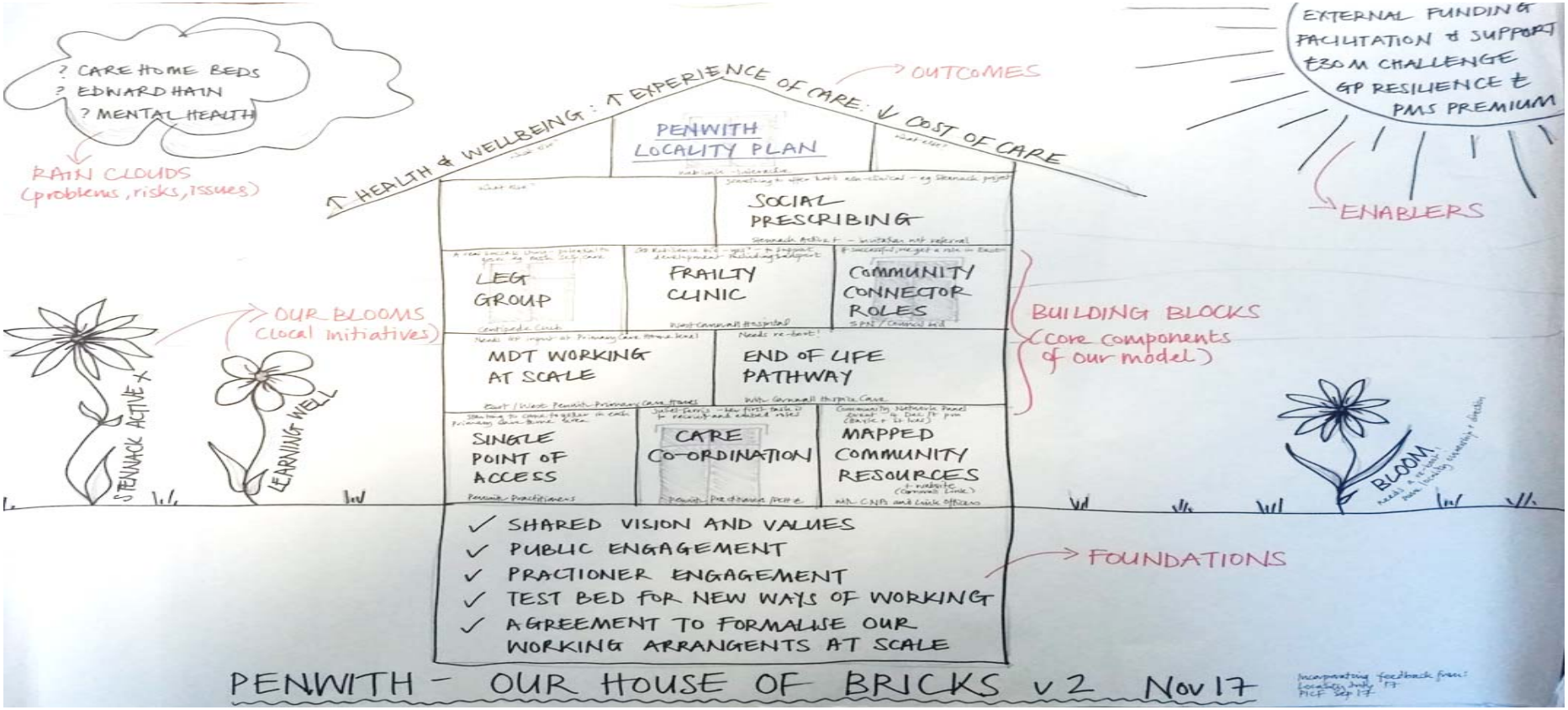



We have identified six population groups requiring differing intensities of care and support and are shaping the core components of our model of care around them.

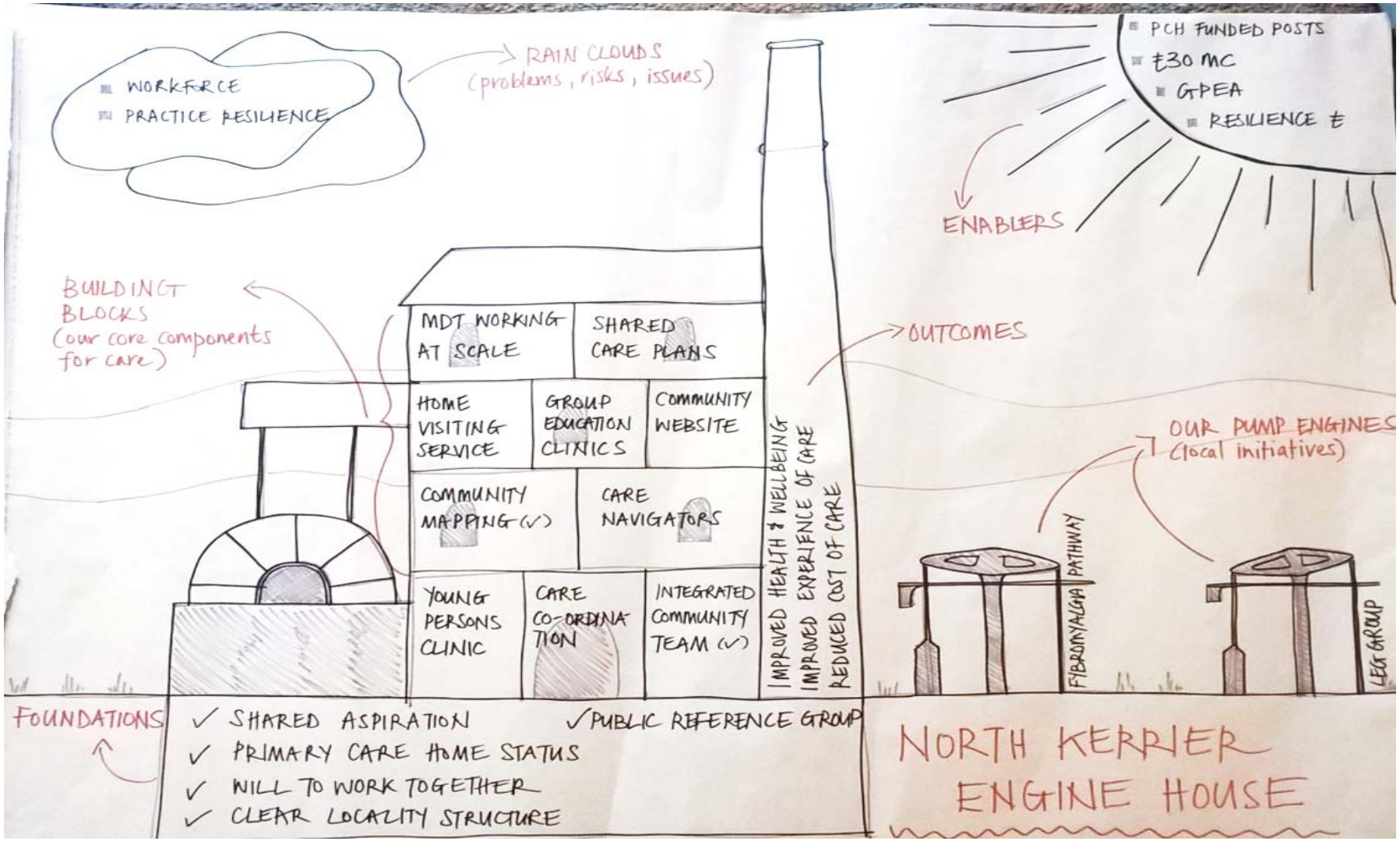
This is a snapshot of our population at a single point in time.

Examples of how GP locality meetings are starting to set out their thoughts on the new approach locally in an easy to share pictorial format that will inform further local discussions

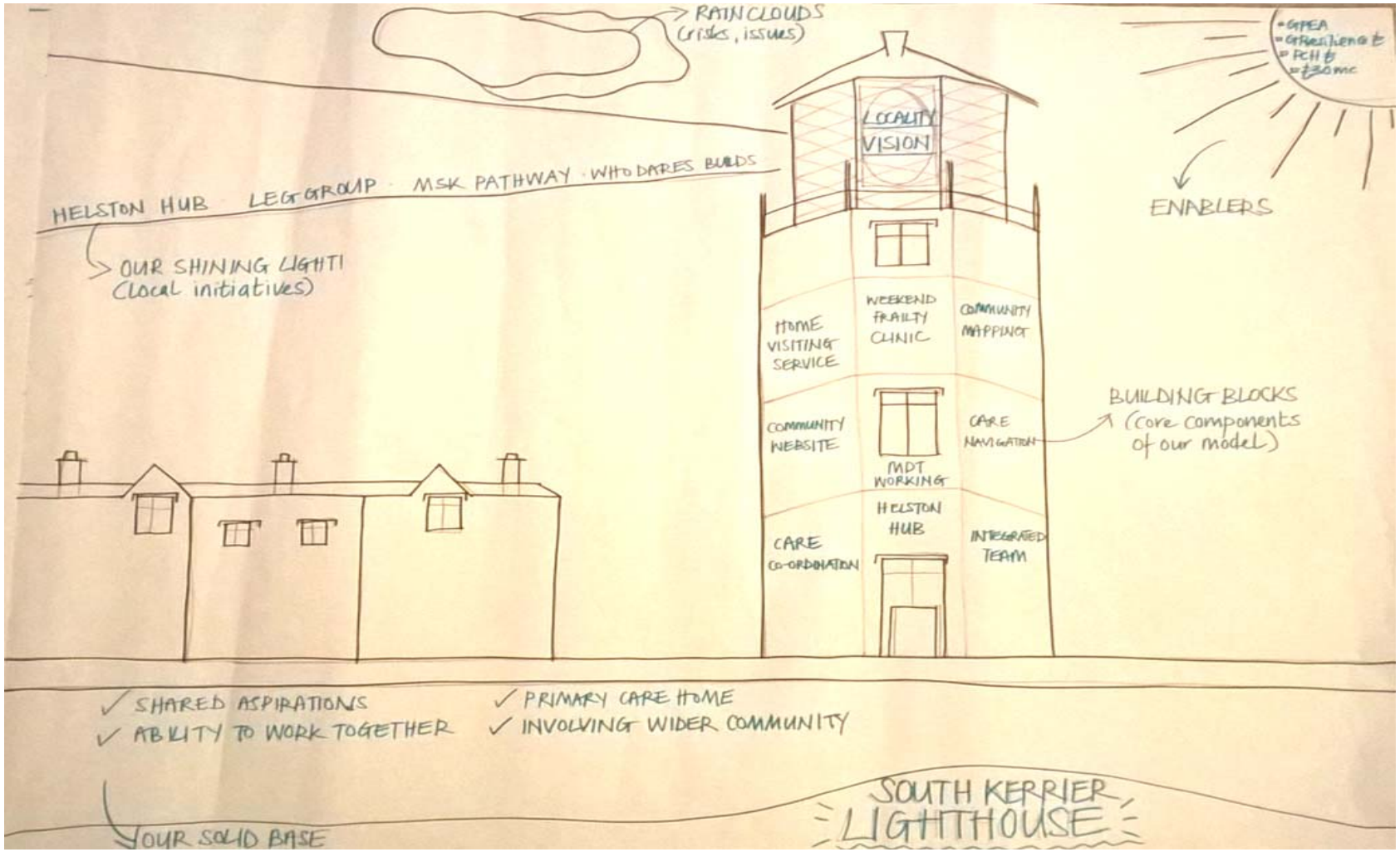
The Penwith House of Bricks with each brick representing a local element of the emerging new model of care



**The North Kerrier engine house**



**The South Kerrier lighthouse**



## Core components of future care and support

| Segment of our population | Type of care | Core components DRAFT for discussion - Version 0.2 |
|---|---|---|
| 85,000 people living well | Supporting life-long well-being | • Support for children to have a healthy start to life<br>• Building emotional resilience in children and young people<br>• School championing healthy lifestyles and setting examples<br>• Information and advice for people to take responsibility for their health and well-being<br>• Creating healthier workplaces<br>• Affordable housing options<br>• Home energy efficiency to reduce fuel poverty<br>• Encourage participation and volunteering in communities developing active citizens |
| 280,000 people at risk | Targeted prevention | • People providing services promoting healthy lifestyles at every contact they have with people<br>• Targeting the 5 most risky behaviours that affect health and wellbeing including increasing physical activity, encouraging health eating, prescribing activities that increase people's social involvement and build personal support networks, lifestyle brief advice (Alcohol and smoking) and Alcohol Assertive Outreach for frequent attenders<br>• Targeting troubled families with mental health problems<br>• Targeting families at risk from domestic violence<br>• Enhanced support targeting those experiencing health inequalities - people with learning disabilities, people with severe and enduring mental illness, people living in areas of deprivation with the lowest levels of life expectancy<br>• Detecting and managing risk factors in each GP Practice population (atrial fibrillation, hypertension, cholesterol, blood sugar, osteoarthritis, osteoporosis, etc.) including recruiting people on to the national pre-diabetes prevention programme<br>• Improving the physical health of people with mental health problems<br>• Targeting people at risk of falling with fracture liaison and falls prevention services<br>• All people aged 65+ who access care and support services are assessed for frailty and the severity of |

| Segment of our population | Type of care | Core components DRAFT for discussion - Version 0.2 |
|---|---|---|
| | | frailty is determined and recorded<br>• Supportive community based networks of bonding social capital |
| 135-145,000 people managing long-term conditions well | Self-management | • Early diagnosis of conditions<br>• Start with a conversation to determine how to support someone: listen, understand what really matters to the person and connect to resources and support that help someone get on with their chosen life independently<br>• Advice on creating a personal plan for how they will manage their health and well-being<br>• Develop people's expertise with educational programmes to understand how to manage conditions including master classes in the evenings and at weekends for young people at school/college and people who work<br>• Support to achieve targets for controlling their conditions – blood tests etc., annual reviews which are available in the evenings and at weekends<br>• Use of new technologies to monitor conditions and provide early warning of any changes<br>• People able to access/update their personal care record<br>• When conditions deteriorate patient decision aids are available to help people decide in terms of how they want to live their lives if they need surgery or can continue to manage without<br>• Online peer support and local support groups<br>• Local facilities providing support e.g. physiotherapy gyms, use of leisure facilities if a GP wants to prescribe more physical activity<br>• Targeted support for young people transitioning into adult services<br>• Support to access employment for people with mental health issues or long-term medical conditions<br>• Immunisation to avoid added risks<br>• Voluntary and community sector support networks encouraging people to become active participants in meaningful activities to reduced loneliness and enhance sense of purpose and belonging. |

| Segment of our population | Type of care | Core components DRAFT for discussion - Version 0.2 |
|---|---|---|
| 20,000 people needing some help | Long-term care coordinated to support independent living | • Start with a conversation to determine how to support someone: what does a good life look like? What resources, connections and support will enable the person to live that chosen life? How do these need to be organised? and include a discussion that helps determine their level of personal activation<br>• Support people to create a personal plan for how they will manage their health and wellbeing and the plan will trigger a request for specific services e.g. falls assessment<br>• Care coordination – support by a care coordinator to ensure the person is following their personal plan, that the care or support required takes place, the person is able to secure any appointments required and attending them when needed across health and social care<br>• A key worker (one of the people providing care) nominated to lead discussions of any issues at multi-disciplinary team meetings where people's progress is reviewed<br>• Use of new technologies to monitor conditions and provide early warning of any changes<br>• Care at home (domiciliary care)<br>• Social prescribing<br>• Local support groups and facilities (e.g. memory cafés, wellness cafés day centres)<br>• Community clinics provided by multidisciplinary teams (including the voluntary sector and volunteers) which combine clinical support (e.g. treatment of leg ulcers) with refreshments and social interaction to promote active ageing and support independence<br>• Advice on management of multiple medicines<br>• Use of equipment, assistive technologies and mobility transport to support independent living<br>• Housing adaptations (disabled facilities grants)<br>• Extra care housing<br>• Support for carers<br>• Personal Assistants<br>• Memory cafés<br>• Integrated Personal Commissioning |

| Segment of our population | Type of care | Core components DRAFT for discussion - Version 0.2 |
|---|---|---|
| 4,000 people with complex conditions needing more help | Long-term managed care | • Start with the same conversation as for people needing some help<br>• A detailed multi-disciplinary assessment of each person's health and wellbeing (including assessment by a care of the elderly physician for older people)<br>• A personal plan developed with them for managing their health and wellbeing, which triggers support by a multi-disciplinary team<br>• A clinician (for example a community matron) orchestrating the integration of care and support around the complex needs of people with multiple long term conditions and who are frail (case management)<br>• Continuity of care - a named GP for each person to consult<br>• 'Virtual wards' or equivalent, managing a person's care at home as though they were in a hospital ward<br>• Support to manage multiple medicines<br>• More intense care at home (domiciliary care) and acute care at home<br>• Residential care<br>• Support by a multi-disciplinary team for care homes who are looking after people with more complex needs<br>• Enhanced support for carers of people living at home<br>• Retain focus on holding the person's story and helping them to achieve their aspirations |
| 4,000 people approaching end of life | End of life care | • People approaching end of life are on an end of life register that sets a flag in other NHS provider systems to check how they want to be supported<br>• Nursing support at home when required at end of life<br>• A single advanced care plan<br>• Advanced prescribing for end of life<br>• Hospice care (both outreach to people who chose to remain at home and in a hospice?)<br>• Bereavement support for carers |
| All | Rapid response and | • Work intensively with people in crisis – understand what needs to change urgently to help someone regain control of their life – put these into an emergency plan and, with colleagues, stick like glue to help |

| Segment of our population | Type of care | Core components DRAFT for discussion - Version 0.2 |
|---|---|---|
| | intensive support in a crisis | make the most important things happen<br>• 24/7 advice for people to take care of a problem themselves<br>• Standard advice on a website or mobile App<br>• Telephone advice via NHS 111 or GP Practices in hours<br>• Is there a community pharmacy open 24/7 in each locality?<br>• 24/7 urgent treatment and short term re-ablement (to avoid admission to acute hospitals)<br>• Same day appointments with primary care practitioners (GPs or others within a Practice or others within an extended team linked to a cluster of Practices)<br>• Extended access to GP same day appointments in the evenings and at weekends?<br>• Home visits by GPs (or others?) (by a multi-disciplinary team?) in and out of hours<br>• Treatment of minor injuries in local facilities<br>• A 999 emergency response which includes hear and treat and see and treat as well as conveyance to an Urgent Treatment Centre when appropriate<br>• Hear and treat by a clinician responding to a NHS 111 call<br>• GPs, 999 and 111 able to refer people to a rapid response by a multi-disciplinary team including generic support workers?<br>• GP-led Urgent Treatment Centres will provide acute assessment in local centres with access to short stay assessment beds<br>• Frailty assessment/comprehensive eldercare assessment by an eldercare specialist in a local facility<br>• Night sitting to enable people to remain at home<br>• Urgent domiciliary care support and support from generic support workers<br>• Support in the community for further recovery following a stay in an acute hospital<br>• Discharge planning starts on day 1 of admission – everyone with physical and mental health needs assessed regularly during their stay, all required specialist support and care packages are in place for when the person is 'clinically optimised' i.e. having reach their full rehabilitation and functional potential<br>• A frailty model of rehabilitation utilising short term local beds and community clinics to target strength, |

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|---|---|---|
| | | balance and falls prevention<br>• Facilities in the community for pulmonary and cardiac rehabilitation and rehabilitation following a stroke<br>• Facilities in the community for rehabilitation following an amputation<br>• Facilities in the community for recovery following a major musculoskeletal operation<br>• Domiciliary care support to enable rehabilitation at home<br>• Physiotherapy in-reach into hospital and immediately following discharge<br>• Occupational therapy in-reach into hospital and immediately following discharge |
| All | Access to care and support – ensure the person is in the most appropriate setting of care | • Sign-posting to appropriate support at first contact in primary care or by NHS 111<br>• Mental health liaison – ensure that people going to the Emergency Department and on acute hospital wards are adequately diagnosed for mental health co-morbidities and referred to the right setting of care.<br>• A single point of access to a multi-disciplinary network of practitioners when a practitioner needs to escalate support that provides multi-disciplinary triage and expedites access to services<br>• Enhanced volunteer support and community based activities to utilise strong social capital |