Safe, well
and at home

Promoting health and well being in Exeter

INTEGRATED CARE FOR EXETER
HOUSING & HEALTH CONFERENCE
DEVON  NOVEMBER 19TH
This Presentation

• National and Local context for ICE
• Aims and Objectives
• Briefing on the Homeless work stream
What is the Problem?

- Population expanding and ageing
- More people living longer with illness and disability & multiple conditions: lifestyle choices
- Rapid advances in technology
- Public expectations continue to grow
- Cost of delivery continually increasing
- Current system doesn’t always get the best outcomes for people or provide a good experience
- Income is decreasing
Integrated Care for Exeter Board

- April 2014 Chief Executives from public & voluntary sector across the City
- Make better use of the *totality* of resources
- Architecture that enables the design and testing of new ways of working
- Evidence base
- Collaboration
- System Leadership

“We can’t afford to go on as we are: there is another way to deliver public services”
Dec 2014
NHS England Five Year Forward View

What will the future look like? New models of care:

- Dissolution of traditional boundaries (primary community, intermediate, secondary, social care)
- Networks and systems **not** organizations
- Out of hospital care bigger
- Focus as much on wellness and prevention as ill health
- Care integrated around the person
- Greater power to people to manage their own health
- Stronger patient voice
June 2015

NHS Success Regime

• Guiding vision is set out in 5YFV

• Northern, Eastern & Western Devon 1 of 3 local healthcare economies to be placed into the Success Regime alongside Essex and North Cumbria

• Purpose is to identify options for transforming services, so they can meet local needs into the future while tackling the potential financial deficit estimated to be £430m by 2019 if no action is taken
Sept 2015
Local Government Devolution

Heart of the South West Devolution Bid

1. To unlock productivity: creating the right conditions for growth, developing our workforce and capitalising on our assets

2. To improve health, care and wellbeing: we will deliver a world-class integrated health and care system within our communities

3. To improve connectivity and resilience: we will ensure our businesses are not hampered by poor infrastructure or extreme weather

Joint bid by all 17 local authorities, National Parks and Heart of the South West Local Enterprise Partnership.
What is Integrated Care for Exeter?

ICE is a strategic alliance of public, voluntary and community sector organisations, working together to provide the infrastructure and architecture for designing and delivering new and better ways of working.

ICE Board was established in 2014 as there are things we could do to make better use of public money spent locally rather than continuing to operate in traditional ‘silos’ created by organisational boundaries.
Whole System Transformation

The ICE vision aims to shift the focus from “patients” to “people”, and from “What is the matter with you?” to “What matters to you?”

We have an ambitious vision with a focus on population health, wellbeing, preventative care and support shifting the emphasis from crisis intervention to helping people help themselves to stay well at home.
The vision is that, in the future, local services will be arranged on an individual basis; they will provide preventive care and support, and will be designed and delivered in partnership with communities where people live.

Services will be connected, deliver quality outcomes and use resources efficiently and effectively.
ICE: where we want to be

✓ I recognise my personal responsibility to contribute to my own health and wellbeing.
✓ I will never be labelled and will always remain an equal citizen, regardless of my needs and the care I receive.
✓ I have one place where I can go to get the information that enables me to make a decision that is right for me.
✓ I will lead all decisions taken about me.
✓ I will only ever tell my story once – to someone who hears and listens – and this will be shared by all those who need to know it.
✓ I am confident that they will work together to make sure my choices are respected.
✓ I know one person who knows me and who helps me retain my independence.
✓ Support to my independence seems to me to come from one organisation.
New Model of Care
Health and Care Interventions

Well -> Mostly Well -> Pre-Frail -> Frail

- Rapid response
- Crisis support
- Reablement
- Long-term support

- Early intervention & prevention
- Supporting health & wellbeing

- Good quality information advice & advocacy
- Promoting health & wellbeing

Risk / Need
<table>
<thead>
<tr>
<th>ICE Programme Timelines</th>
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</thead>
<tbody>
<tr>
<td><strong>2015/6</strong></td>
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<tr>
<td>Deliver real operational change in service delivery.</td>
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<tr>
<td>Prepare the groundwork for testing out community prevention approaches.</td>
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<tr>
<td>Get a greater understanding of what we need to do to support community resilience.</td>
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ICE Delivery Plan

**STRATEGIC OBJECTIVES**

- Enable people to improve & promote their own health & wellbeing
- Deliver a better experience of care
- Achieve improved health & social care outcomes
- Provide care more cost effectively
- Creation of capitated budget and payment systems

**DELIVERY PROGRAMMES**

- Improve co-ordination & delivery of existing services
  - Streamline hospital discharge process & introduce discharge to assess
  - Create single rapid response, crisis support & reablement pathway for adults with complex needs to create a blueprint for roll out (TCS) Includes integration of OPMH and standardisation and roll out of acute care at home services.
  - Establish health & wellbeing team for homeless people bringing together existing resources into a single integrated team to deliver an improved service to this vulnerable group.
  - Create and test out a single capitated budgets to support integrated service delivery.
  - Design & test a population risk stratification model
  - Test out enhanced care co-ordination for the frail group to reduce the use of unplanned care
  - Test out social prescribing for the pre-frail group
- Health & Wellbeing Team for Homeless
- Design & Test new models of care
  - Targeted Home Safety & well-being checks
  - Living Well Co-ordinators & Neighbourhood Friends
  - PROMOTE CARE Home Pilot
  - Developing Community Resilience
- TCA funding for prevention
**ICE Evaluation Framework**

**Is it different?**
- More people tell us their needs were understood
- 80% of the older cohort will have integrated personal care, support and escalation plans
- 30 people will have integrated personal commissioning plans
- Half as many people in the acute hospital experiencing a delayed transfer of care
- Reduced average length of stay by 1 day for unplanned emergency admissions for over 65’s

**Is it better? – lives are significantly better**
- 5 a day fewer unplanned hospital admissions
- More people tell us the help and care they received has made their lives better
- More people telling us they feel in control of their care
- Timely contact with a smaller number of people “in my living room”
- More people and professionals wanting to join the programme
- Police report 50% fewer welfare calls about older people

**Is it significantly better value/lower system cost?**
- Agreed methodology for identifying whole system budgets
- Agreed methodology for risk and need stratifying and targeting the population
- Reduced whole system per capita cost for the target group(s)
- Cost benefit plan identified for roll out of integrated personal commissioning

**Is it sustainable?**
- Staff report higher levels of job satisfaction and satisfaction with the quality of care delivered
- 10% increase in customer value added activities
- Learning from test beds informing next steps and roll out opportunity
- Expertise, models & implementation methods tested and available to support roll out
- Improved recruitment and retention with evidence of new career opportunities for local people
- New care roles created spanning the whole care continuum
- Workforce plan developed providing wider career opportunities for local communities.
Challenges

Systemic failures

Scale & Pace

Leadership

Complexity

Perspective

Alignment
Improving the Health Inequalities of Homeless People
ICE Programme A1
The Cost of Homelessness

Life Expectancy
30 years less than national average

• 1/3 of deaths linked to Drugs or Alcohol

• Homeless people are over 9 times more likely to commit suicide

• Deaths as a result of traffic accidents or falls are 3 times as likely, and from infections twice as likely
Ultimately, homelessness kills and in Exeter alone 2 rough sleepers have died on the streets in the last 3 months.
Rough Sleeping in Exeter

- 34 rough sleepers found on one night in November 2014
- Highest count for over 15 years
- 48% Increase from 2013
- 9th highest count in the country and the highest proportion of rough sleepers per population outside London.
- Twice as likely to be a rough sleeper in Exeter than Brighton

<table>
<thead>
<tr>
<th>City</th>
<th>Number</th>
<th>Population</th>
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<tbody>
<tr>
<td>Westminster</td>
<td>265</td>
<td>219,600</td>
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<tr>
<td>City of London</td>
<td>50</td>
<td>7,375</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>45</td>
<td>275,500</td>
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<tr>
<td>Manchester</td>
<td>43</td>
<td>502,900</td>
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<tr>
<td>Brighton</td>
<td>41</td>
<td>273,400</td>
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<tr>
<td>Bristol</td>
<td>41</td>
<td>428,100</td>
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<tr>
<td>Cornwall</td>
<td>40</td>
<td>533,800</td>
</tr>
<tr>
<td>Canterbury</td>
<td>38</td>
<td>150,600</td>
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</tbody>
</table>

Exeter 34 117,100
### Only a snapshot

Between November 2013 and November 2014 SHOT worked with 281 rough sleepers:

| Gender Balance                     | 20% female  
|                                  | 80% male    |
| Age                               | 15% 18 – 25 Year olds  
|                                  | 84% 26 – 60 year old |
| Complex needs / Dual Diagnosis / Mental Health: | 50% of all clients had complex needs (HRIA assessment tool) with 2 or more primary support needs.  
|                                  | 16% have a sole support need for mental health |
| Substance and alcohol misuse:     | 58% have substance misuse issues  
|                                  | 9% have poly drug use (likely to be higher now due to NPS use) |
|                                  | 12% have substance and alcohol use  
|                                  | 76% of this group are taking legal highs |
| Offending:                        | 45% have significant issues with offending |
Gabriel House Health Audit

Health Snapshot of Gabriel House Residents 23/2/2015 – 17 had significant health issues

- 6 had skin related issues
- 4 had injuries relating to assaults / substance misuse
- 3 undergoing liver function tests
- 9 residents had multiple health issues

Ambulance/Hospital admissions during January 2015
11 visits to hospital, 10 by ambulance and 1 by taxi
- 8 were because of physical health problems
- 2 were in mental health crisis
- 1 was a NPS overdose
What we have learnt about the current system

<table>
<thead>
<tr>
<th>Commissioning</th>
<th>Provider landscape</th>
<th>Risk</th>
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</thead>
<tbody>
<tr>
<td>▪ Fragmented</td>
<td>▪ Lots of providers</td>
<td>▪ Differing approaches and thresholds</td>
</tr>
<tr>
<td>▪ 6 statutory commissioning bodies (+ grant funding bodies),</td>
<td>▪ Organisational silos and cultures</td>
<td>▪ Tension between harm reduction &amp; abstinence approaches</td>
</tr>
<tr>
<td>▪ Contracts designed around individual services</td>
<td>▪ Needs of organisations often come before those of people e.g. target driven</td>
<td>▪ Some services will not engage with people who are not ‘in recovery’</td>
</tr>
<tr>
<td>▪ Lack of coherent system, and pathways resulting in duplication and gaps</td>
<td>▪ Differing access (exclusion) criteria</td>
<td>▪ Some services don’t like to ask questions that are outside their “remit” so</td>
</tr>
<tr>
<td>▪ Creates competition and disincentives collaboration</td>
<td>▪ Concerns about welfare reform</td>
<td>opportunities get lost</td>
</tr>
<tr>
<td>▪ In built in efficiencies in the system with duplication of effort</td>
<td>▪ Lack of non abstinence facilities</td>
<td>▪ Support/prevention services for vulnerably housed can conflict with housing policy</td>
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<td></td>
<td>▪ Committed front line staff</td>
<td></td>
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<td></td>
<td>▪ Many services are ‘office bound’, outreach appears difficult</td>
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<tr>
<td></td>
<td>▪ Lack of joint training</td>
<td></td>
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<tr>
<td></td>
<td>▪ Disjointed approach to information governance</td>
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</tr>
<tr>
<td></td>
<td>▪ Understanding each other’s roles/remit</td>
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...but plenty of good to build on

- Individual workers going that “extra mile” for a client
- Working together informally to get things right for people
- Providing healthcare outside of traditional health settings
- Willingness to build on resources we have and within the people we want to help
- Community & Voluntary sector flexibility
- Mental health first aid programme in probation
- Exploiting social capital
- Peer support
- Helping people with problems that are not really our “day job”
- Some joined up working and forums
- Individual case management across organisational barriers
Ripple Effect: things are beginning to change

- Practitioners challenging each other to deliver more effective, person-centred and sustainable care
- Clock Tower Primary Care re-commencing nurse-led outreach clinics at St Petroc’s Hostel from October 2015
- Street Homeless Health Audit underway across agencies to form a baseline needs assessment
- Co-location services in Watt Tyler House as a result of the Public Health England Capital Grant
- Recognition that the whole system has to change
- Consensus and enthusiasm on the need to test out the “Integrated Team”
Aims of the ICE project: Improving health inequalities of street homeless people

- Establishing a Health & Well Being Team for Homeless People by bringing together existing resources into a single, integrated team to deliver an improved service to this vulnerable group and deliver better value for money.

- Test out a single commissioning budget to support integrated service delivery.
Intended Outcomes

The approach is to be flexible and deliver support to where it is needed and not where it best suits the service providers. The aim is to provide a personalised joined up health and wellbeing intervention focused on prevention and crisis resolution that delivers:

- Fewer Police welfare calls about rough sleepers.
- Reduction in begging and street drinking
- Rough sleepers within Exeter are reporting that there is an improvement in the service they have experienced
- Improvements in health status outcomes from 2015 health audit
- 50% reduced unplanned emergency admissions and length of stay
- Reduction in ambulance call outs for the client group
- 50% reduction in attendance at A&E
- Reduction in number of rough sleepers across Exeter
- Increase in people moving to second stage accommodation due to an improvement in accessing mental health, physical health and drug and alcohol treatment services which were previously a barrier to move on.
From Fragmentation

To Case Co-ordination
Aims of the Integrated Team

- **Prevention, support when in crisis** and **aftercare** – to ensure peoples on-going health and care needs are managed once they have had a crisis with the aim of mitigating or reducing further crisis events.

- The Team will undertake initial rapid assessments to identify the full range of needs rough sleepers have to ensure that support is put in place **alongside** any accommodation solutions.

- The longer term aim is to help **prevent entrenched health problems** by identifying problems sooner and providing rapid support rather than waiting for people to get into crisis.
Commissioning
What we want to achieve

Identify options for integrating the commissioning functions across the statutory commissioners to facilitate collaborative provision of integrated health, care and support for vulnerable people on the streets or vulnerably housed.

- Identifying the totality of spend across all commissioners and map how this is currently spent to “value” the totality of services commissioned for the cohort and start looking for efficiencies & economies of scale.

- Prototyping options for future integration of commissioning to drive better value for money and enable more integrated delivery

- Presenting initial options to ICE Board in February 2016
Next Steps

- Formal Mandate from ICE Board to Proceed
- Project Management Resource and Lead Agency
- Project Delivery Plans agreed (December)
- Plan for go live with integrated team Feb 2016
- Plan for report on commissioning Feb 2016