Living Well
Pioneer for Cornwall and the Isles of Scilly

Supporting people to live the lives they want

"I feel in control."
"I only have to tell my story once."
"I can live the life I want."
"Those around me, and looking after me, get help too."

"The team understands what’s important to me."
"I get information I need, at the right time, to make the choices that are right for me."
Living Well - supporting people to live the lives they want
Our Aims

1. Improve health and wellbeing
2. Improve experience of care and support
3. Reduce the cost of care and support
Living Well video clip
It’s worked in San Diego

**Past**
Transactional
Volume-based
Competitive advantage
Silos and categorical
Sick care/social welfare

**Present and future**
Transformative
Value-based
Integrated system
Inter-operability
Wellness

1 Vision
3 Components
4 Strategies
5 Areas of influence
10 Indicators

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Nuka – Alaska

- Co-designed and co-owned community health
- Evidenced-based generational change reducing family violence
- Over 50% drop in ER visits, hospital days, and visits to specialists
- Significant reduction in primary care use
- Benchmarked data nationally and internationally showing top in class performance in utilisation, quality, satisfaction
What they saw in Alaska

Anchorage area patient visits to ER/Urgent Care per 1000

Source: Southcentral Foundation
What they saw in Alaska

Anchorage area patient admits per 1000

Excludes newborns and delivery mums and length of stay must be more than one day

Source: Southcentral Foundation
What they saw in Alaska

Southcentral Foundation cumulative per capita expenditure changes

Source: Southcentral Foundation
Newquay – measuring our impact

- Non-elective emergency admissions reduced by 30 per cent
- Ongoing care package costs down by 5.7 per cent
- People’s wellbeing improved by 23 per cent
- Reduction in new social care packages
- Increase in staff satisfaction – 87 per cent said integration worked and their work was meaningful
Our population’s health

- Everyone successfully managing their health and well-being themselves: 280,000
- People whose circumstances or personal choices are putting them at risk: 135,000 - 145,000
- People managing long-term conditions well: 21,000 - 31,000
- People who are frail or vulnerable: 4,000
- End of life
Our Vision

Shaping the whole system around the individual

Before

Guided conversation between person and volunteer
Family and friends
Community networks and wrap around support
Integrated health and social care support
Specialist support

After
Coordinated community care models

Shaping care around communities in line with needs and assets
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Building the Future
How do we build tomorrow?

We need to describe the future in detail so we can build it and we need to describe it and build it together.
Principles we’ve applied

1. Place the individual at the centre and coordinate care and support around them
2. We must achieve our triple aim
3. We must deliver our pledges to the people of Cornwall and Scilly
4. It must enable us to quantify, cost and plan business changes and
5. Enable on-going innovation, co-design and co-production by local people and practitioners

“I’m treated like a person again, not just a poor worn out old thing in a chair.”
Annie

Drawn from our original shared commitment in our Pioneer proposal and learning from Newquay, Penwith and the international community

"I only have to tell my story once"
"I feel in control"
"Those around me and looking after me get help too"
Steps in developing the blueprint

**Draft of system framework**
- Developed by commissioners from NHS Kernow and Cornwall Council (Adults and Public Health) with advice from locality and voluntary sector colleagues
- Leadership agree ok so far
- System wide conversations
- Confirm local needs, priorities and resources

**Local conversations in communities and develop options for configuration of services (iterative)**

**Develop local blueprints**
- Financial modelling
- Confirm local needs, priorities and resources

**Finalise local + system wide**
- Implementation of Integrated Care Teams

**Contract negotiations for 2015/16**
- Bed modelling

Evidence and building blocks from CCG’s 5 year strategy
Ingredients of the system framework

• Characteristics that will be common to all Integrated Care Communities
• System-wide functions and standards e.g. 7 day availability of services, intensive support for people with complex needs
• The leadership and skill mix to support new models of care
• New roles for Primary Care
• Development of social capital
• Core organisational components e.g. Integrated Care Teams aligned to GP clusters
• Core expectations in respect of local facilities e.g. urgent care and rehabilitation centres
• System-wide expectations in respect of technology e.g. a single view of a person’s record of care;

“I get the information I need at the right time to make the choices that are right for me.”
Phase 1

- Integrated Care Teams in place within 12 months

Each team’s first task: intensive support provided to the 100 people most at risk of continuing, frequent hospital admissions (which could be avoided) for each 30,000 catchment population.

- Annie sets her goals for her care plan
- The Team plan her care and support with her to help her improve her health and well being and maintain her independence
- The Team help her to develop a personal network of support within her local community
- Success is measured by improved health and well being and quality of life for Annie, reduced attendances at the Emergency Departments and reduced hospital admissions.
Phase 2

**Learning from:-**

- Pioneer work in Newquay, Penwith & East Cornwall
- Challenge Fund initiatives
- Winter resilience projects

**Modelling:-**

- Demand/financial modelling results due end November
- Bed and workforce modelling

**Need to run to March 2015**

**Phase 2**
Implement local services / centres of integrated care and support for planned and unplanned care

**Next steps in modelling which needs initiating**

- System framework (to be updated by March 2015)
- Engagement with local communities
- Locality Plans
- Commissioning Intentions (by March 2015)
Next steps

Commissioner expectations

- Providers from health, social care and the voluntary sector collaborate to develop Integrated Care Teams (in place in 12 months)

- Collectively bring together a ‘Change Team’ with expertise to support and coordinate change across the system

- A joint proposal from providers that identifies options and recommends a preferred option for creating Integrated Care Teams (Outline Business Case) available for the 16th December meeting of the Chairs & Chief Executives

- The Joint Strategic Executive will circulate the criteria it will apply in reviewing options from its meeting on 19th November – to include the triple aim and practitioner and community engagement
Contact us

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