Our Integration Journey
June 2015

Kirsten Major
Director of Strategy & Operations

Ruth Brown
Operations Director
Combined Community & Acute Group
• Sheffield context
• STH’s journey of acute and community integration
• Our approach, results and challenges
• Future vision
Sheffield city context

• Population of 560k and growing
• 20% BME population
• 9% growth in 20-24 year olds since 2011
• 43% of households vulnerable to significant financial stress
• Significant levels of health inequalities – narrowing male life expectancy and widening for females
Sheffield health & social care context

• One of largest FTs in England - £1bn turnover and 16k staff
• Large tertiary provider – around one-third of activity
• Single CCG
• Single local authority – Sheffield City Council
• MH Foundation Trust
• Separate Children’s FT
• Active third sector
• Primary Care – relatively stable and high
Drivers for integration

Sheffield Teaching Hospitals FT becomes an Integrated Acute and Community Provider

COBIC

Working Together Programme

Integrated Commissioning Programme
STH journey of acute and community integration
Approach

INTERNAL

• Single Care Group, maintained the identity of community services
• Senior, visible leadership from Community into the organisational structures
• Identify pathways of care and readiness for integration

EXTERNAL

• Confirm and challenge with external experts
• Building more vertical & horizontal health economy partnerships through Right First Time
• Wider relationships through Working Together
What’s Mine is Mine!

How do I keep it?

What’s Mine Could Be Yours

How do I stop you getting it?

How do I get my hands on it?

What’s Yours Could be Mine...

How do I get you to agree to it?

It could/should be OURS

How do we provide it together?

It’s actually theirs (Client/Patient)

The Road to Integration.....

Courtesy of L Jubb SCC
Successes

• Reduced duplication and replication - Integrated Sexual Health Pathway, Single heart failure pathway, Joint IV pathways, Single transfer of care team

• New continuous models across hospital and community - dental services

• Redesigned care models – MSK, Discharge to Assess Pathways and Active Recovery.....
Discharge to Assess and Active Recovery

STH Acute and community integration opportunities in older peoples care

‘Discharge to Assess’

Community and Social Care alignment opportunities for reablement workforce

‘Active Recovery’
Integration opportunities for older people’s care

- In 2012, geriatric medicine patients were waiting an average of 10 days to go home after their acute episode
- Elective care cancelled and medical patients were being treated on other wards
- Assessments were undertaken in hospital environment
- Equipment delivery would take between 48 hours – 5 days from hospital
Integration opportunities for older people’s care

• Discharge pathways were complex and referrals for ongoing services had to be booked several days in advance
• Appropriate Community Services were available 7 days but discharge for complex patients did not regularly take place at a weekend
• There was a need to build trust, confidence and relationships across community and hospital based colleagues
• Discharge to Assess (D2A) model
Active Recovery

• Oct 2013 umbrella name given to services jointly provided between health and social care including:
  – Community Intermediate Care Service (health)
  – Short Term Intervention Team (social care)
• Rapid response and treatment to support patients in their own homes
• Full inter-disciplinary team
• Aligned health and social care workforce of = Band 2 staff providing reablement
• 12 week pathway of care reduced to joint 6 week pathway
D2A and Active Recovery Results

• Weekly decision making to daily and hourly planning
• Response times are between 2 – 24 hours for ALL patients
• Proportionate assessment process in hospital
• Generic skills training rolled out to hospital therapists in provided by Sheffield Hallam University
• 30% reduction in falls on geriatric medicine ward
• Resilience over 2014/15 winter
Challenges

- Major culture change - challenging historic practice and hospital teams ‘letting go’
- Whole person care in a large acute Trust with multiple sub specialties
- Time to build confidence and trust
- Transport, admin systems, IT
- Capacity to work real time and reshape to 7 day services
- Managing expectations
- Engagement from primary care
- Resilience during winter and impact of flow to independent sector
Take time to make sure you understand each other

#NOF
### The Future

STHFT is now organised into nine Care Groups that, where possible, combine acute and community services to facilitate the delivery of integrated pathways of care and provide care closer to home.

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
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<tbody>
<tr>
<td>Including: Orthopaedics, Rheumatology, Pain, Podiatric Surgery, MSK Physio and Podiatry...</td>
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<th>Combined Community &amp; Acute</th>
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<td>Including: Community Nursing and Therapy; Single Point of Access; GP OOH; IP Geriatrics, Whole pathway Stroke; Palliative Care...</td>
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<th>Oral &amp; Dental – including community dentistry</th>
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<td>Respiratory – including integrated COPD team</td>
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<td>Cardiology – including integrated heart failure team</td>
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## Combined Community & Acute Group

### Integrated Community Care
- Four Integrated Care Locality Teams (ICTs) covering:
  - ICT Nursing 24/7
  - ICT Therapy
  - ICT Pharmacy
  - Active Recovery (Rehab Team)
  - Falls Service
  - Podiatry (including forensic and acute)
  - Flexible Workforce

### Primary Care & Interface Services
- **Urgent Community Care:**
  - Active Recovery incl.
    - Assessment Team
    - Rehab Assistants
    - Rapid Response
    - IV Team
    - Phlebotomy
  - Transfer of Care Team incl:
    - Front Door Response
    - Ward Transfer of Care
    - Care Home Liaison Placement
    - Macmillan Case Management
- **Proactive and Primary Care:**
  - GP Collaborative
  - Single Point of Access
  - Telehealth
  - Active Programmes
  - Assessment and Rehab Centre (ARC)
  - Acute Therapy Services

### Integrated Geriatric & Stroke Medicine
- **Integrated Stroke:**
  - Acute Stroke Unit (RHH)
  - Stroke Intermediate Care Beds (Beech Hill)
  - Community Stroke Team
  - Geriatric Medicine:
    - Care of Elderly wards
    - Frailty Unit
    - Intermediate Care Beds
    - (General, EMI and Ortho)
    - Outpatients

### Therapeutics & Palliative Care
- **Palliative Care:**
  - Palliative Care Unit
  - Hospital Support Team
  - Intensive Home Nursing
  - Bereavement Service
- **Therapeutics:**
  - Chaplaincy
  - Dietetics
  - Psychological Services
  - Speech & Language Therapy
  - Lymphoedema Service
  - Continence
  - Tissue Viability
  - TB
- **Plus host for:**
  - CCA Research
  - Professional Leadership
Combined Community and Acute Pathway Integration
Our patient pathways span the provision of health services across community and acute, including older people, stroke and palliative care. This has provided the opportunity to consider how the delivery of care could be configured and redesigned in the future to transform patient pathways.
We are committed to:

• Providing person centred, co-ordinated care
• Providing joined up care to improve experience and clinical outcomes
• Whole system transformation, supported by staff and patient engagement
• Realising the benefit of acute, intermediate and community integration
Enablers for success

• Flexible, agile workforce
• Matrix working across the Care Group and development of new ways of working
• Single care record / information sharing
• Case finding and care co-ordination by most appropriate professional
• Technology (staff and patients)
• Infrastructure (estates/transport)
• Relationships with GPs / social care / 3rd sector
• Developing new ways of working and use of financial flows
What will be different?

1. Strengthened integration within Community Teams
2. Maximise opportunities at the interface
3. Core model of care for older people
4. Integrated Pathways of Care
5. Culture
1. Strengthening Integration in Community Teams

Integrated patient records

Agile Working

Promotion of Self Care

Interdisciplinary skills

Top Ten Core Skills

- Promoting Self Care / Goal Setting
- Pressure areas
- Mobility & Falls
- Mental Health Screening
- Pain Assessment
- Clinical Observations
- Nutrition & Swallowing
- Communication
- Equipment
- Medicines Optimisation
2. Maximise opportunities at the Interface

• 24/7 Single Point of Access
• Known or not known
• Access to specialist advice pre admission
• Increase links with Ambulance Service
• Empowering and enabling staff to stick to a care plan

Sheffield Teaching Hospitals
NHS Foundation Trust
3. Core model of care for older people

**Primary Care / Community**
- Assessment
- Case management and co-ordination
- Care Plans
- Social care

**SPA / Front Door**
**PLUS**
- More Communication
- Known / Not known
- GP admissions
- Straight to assessment
- Not being in PJs

**Acute / IC Ward:**
**PLUS**
- Visiting hours
- Family & carer involvement
- Not eating meals in a bed
- Medication
- Single care record
- Integrated Workforce
- More comms / Keeping in touch with GP, Care Homes
4. Integrated Pathways of Care

- Stroke
- Parkinson’s Disease
- Palliative Care
- Falls
5. Culture

- Clinical leadership
- Collaborative leadership and matrix working
- Engagement
- Integrated Pathway roles
- Flexible, adaptable workforce
- Boundary spanners
Symbiosis

“A close and long-term interaction between two different species.”

"the living together of unlike organisms."
Future Context

• Integrated Commissioning Programme....
• Collaboration or tendering...
• Front and back door as well as the house in between
• Prime Minister’s Challenge Fund...
• Relationships with Primary Care
• Changing demographics
  – Older People
  – Mental health and physical health...
• Financial context...
Thank you

kirsten.major@sth.co.uk
ruth.brown10@nhs.net