Appendix 2

Health and Social Care Coordination – incorporating a locality re-ablement approach

Project Description - To implement a Health and Care Co-ordination approach through integrating teams within one locality in the Borders to test the change and consider scaling up across the Borders. The approach will support our ambition of delivering enabling services which proactively supports people to maximise, regain and/or retain their ability to carry out every day activities which are meaningful to them. There needs to be a greater a shift from rehabilitation to re-ablement which embraces the social as well as the health related aspects of people's lives.

Alternatively the same model could be applied simultaneously across the localities.

Proposal will include extended working hours until 8pm

7 day working for co-ordinator role and health care support workers

On-call / standby – to assist with crisis intervention out of hours - proposed that Health Care Support Workers are placed on a standby rota and additional support will be provided through an on call rota for the professionals within the team. The aim would be to test the prevention of admission out of hours and facilitate discharge.

Team composition – based around GP practices

Proposal to merge spoke START team with the Community Health Team in the Cheviot area with additional support by transferring a CCA from the SW team and percentage of DN time to support the team utilising a Community Matron model. The Community Health Team (or new name if decided) would provide a crisis response, rehabilitation and re-ablement function.

Additionally a Care Co-ordinator role, based on the Torbay model will be created to facilitate liaison between the team and be a main point of contact for GPs, patients and carers and they will be able to provide small packages of care to prevent crisis.

One team member acts as team leader, or co-ordinator, and the team will meet weekly to discuss cases.

The team should link with specialist teams and other community teams based in the acute hospital to facilitate early discharge of patients with complex needs and to prevent unnecessary hospital admissions.

The approach is however also dependent on a range of other interventions working simultaneously in order to achieve real **transformational** and **sustainable change**. Evidence suggests that all of these elements need to be in place and working consistently; partial implementation is not sufficient to create significant change. (See appendix – supporting statement)

In order to ensure aims are being met and to ensure progress and timely delivery, the proposed governance structure will be in place:

- Project Manager will lead the project team
- Development of a project team
- Reporting to a project board- in this case the PCCP will fulfil the function of the Project Board.
- The PCCP will consider progress of the milestones and delivery of the project every 8 weeks.
- Robust monitoring will be required in order to measure the outcomes. In order to do this baseline data will be gathered in the first phase
- Any impact of the integrated team will be reported through the data change

Project Aims/ Achievements

To develop a Health and Care Co-ordination approach shaped by learning from evidence of best practice across UK.

The main goals of the project will be to improve and restore the quality of life and confidence for people with complex health and social care needs, and reduce avoidable admissions to hospital through a range of interventions and approached to care, specifically re-ablement, self-management, technology enabled care solutions.

The project support the partnership to deliver the National Health and Wellbeing Outcomes, and more specifically;

- Improve Quality of Care to Service Users
- Simplify Access – single points of access
- Reduce number of multiple assessments, avoid duplication
- Improve referral times and waiting time
- Improve independence and quality of life
- Increase personal control and choice over what is best for individuals and provide direct rehabilitation to help people achieve their goals
- Avoid unnecessary A&E admissions for patients with complex needs
- Improve discharge from hospital
- Enable self-assessment through technology to support people to self-manage their conditions
- Improve Social Care and Health Co-ordination – multi-disciplinary teams working around GP practices (improved communication, elimination of ‘buck-passing’)
- Develop the Re-ablement Support Worker role
- Improve the ability to utilise flexible support resources and recycle hours to meet competing demand
- Increased Staff Motivation
- Implementation of sustainable re-ablement training programme
- Reduction in large packages of care at home
- Make more efficient use of budgets

Project outcomes and benefits

- Reduced Use of Hospital Beds – Reduction in Average Number of Occupied Beds
- Reduction in avoidable A&E admissions – some evidence would suggest that around 30% of emergency admissions can be avoided with this approach.
- Further reduction in Delayed Transfers of care
- Decrease in mainstream homecare following a re-ablement approach
- Further reduction in use of residential and nursing care home placements
- Increase in the use of home care
- Reduction in waiting times for assessment
- Improved well-being

What areas of the Borders will the Project cover?

1st option – test in one locality over a 6 month period and then roll out shaping to meet the needs of each locality **(estimated £627k)**

2nd option – test across all localities and model over a 6 -12 month period **(estimated £2.64 million)**

Most of the costs are temporary or required for transition.