My care, my choice
Guildford & Waverley

'My care, my choice' Operating Model

July 2015

Version 0.18

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1. Aims and Objectives

The Integrated Care Partnership, now known as, 'My care, my choice' (MCMC) is Guildford and Waverley's local health and social care system's integration programme which is to support frail older people in the community. The model of care is based upon the needs of frail older adults for two reasons:

- Frail older adults account for high volume use of social care, acute and community health services;
- Frail older adults are more likely to have complex needs and the system redesign will support them in regaining or retaining independence in their local community;

This Operating Model document describes in detail the integration of the existing Locality service and identifies the functions and roles required to deliver the new Proactive Care service. The document also outlines how the new service will interact with other existing services. For completeness a number of appendices cover the enablers that are required to support the success of the service and a more comprehensive list of additional services to ensure success of the Proactive Care service.

MCMC's vision is to have more intensive management of the frail older over time with more resources focused on supporting this group of patients in the community and preventing acute hospital admission. Currently the patient and carer experience of services is confusing and disjointed resulting in a poor experience. MCMC will bring together services in a more streamlined manner, and improve experience for patients and carers, and allow for easier navigation for professionals working with the frail and older population.

Principles

The main principles for the integrated care model, 'My care, my choice', are:

- To ensure that patients and those with caring responsibilities have access to the right service at the right time in the right place;
- That all agencies and organisations work collectively to deliver holistic care that meets the needs of the frail older population and their carers;
- To ensure services are centred around the needs of patients and their carers so that care is coordinated and integrated with care planning centred around need;
- To reduce demand through identifying and supporting patients and their carers to access prevention and early intervention initiatives;
- That there is a culture where staff from all organisations are enabled to work alongside each other to share responsibility for patient outcomes;
- That the voluntary sector is central within the development of integrated care and care pathways.

Aims

The aim of MCMC is to develop integrated health and social care services that support the frail older population over 65 in Guildford and Waverley. This will be achieved by co-designing a whole system that will:

- Improve outcomes for patients and their carers and family
- Create access to better, more integrated care outside of hospital;
- Reduce avoidable hospital admissions;
- Facilitate discharge for patients from acute care with appropriate communication and support to patients, their family and carers
- Enable effective working of professionals across provider boundaries;
- Engage and enable health and social care professionals to deliver the right care at the right time in a joined up approach;
- Empower people with long-term conditions including frail and older people to feel supported to manage their own health and care needs and live independently in their own homes with the right support for their families and carers;
- Support carers in their caring role and in having a life outside of caring
- Ensure best use of resources by reducing duplication and achieving greater economies of scale;
- Develop the role of the local voluntary sector through collaboration with current services;
- To recognise the significant challenge of social isolation for people living alone in their homes;
- To work towards establishing joint commissioning arrangements that align funding streams

Objectives

Our key objective is to improve the quality of patient care whilst delivering financial benefits to the health and social care economy through reducing spend on emergency care, and creating a locally sustainable health and social care system:

- Design and mobilise a new co-created integrated service operating model for the local population over the age of 65 years of age;
- Develop and implement a preventative and reactive Falls pathway for patients over the age of 65 years of age;
- Support the Frailty Initiative commissioned from primary care to deliver
- Implement the Age UK Integrated Care Programme seeking to reduce isolation and increase independence.

Achieving the above will deliver the following quantifiable benefits as presented below:

- Reduction in A&E (Accident & Emergency) attendances for the > 65 population;
- Reduction in emergency admissions for the >65 population;
- Reduce ambulance conveyances for the >65 population;
- Reduce the reliance on care home placements, contributing to reducing the Continuing Health Care (CHC) and social care spend;
- Increasing the number of people supported to remain at home;
- Increasing the number of patients who are cared for and die in the place of their place of choice;
- To support patients to maintain emotional wellbeing and independence in their normal place of residence;

Commissioning Intentions

Health and social care commissioners wish to explore the opportunities to develop alliance or lead provider contract arrangements. This will ensure that the resources available are utilised most effectively to improve outcomes for the locality frail population by bringing teams from different organisations together into an approach of single management.

In 2015-2016, the successful transformation of the whole system will deliver significant savings of £3.16m through reducing A&E attendances for the over 65 population by 7.5% and reducing conversion to admission by 5%. The following table outlines the number of admissions that will need to be prevented per week by each locality if to the system is to deliver a more sustainable local health and social care economy.

		KEY PERFORMANCE INDICATORS (KPI) Number of Emergency Admissions to be prevented	
Practice	**Locality**	**Annual Total**	**Weekly**
Austen Road Surgery	Central Guildford	70	1.3
Dapdune House Surgery	Central Guildford	93	1.8
St Luke's Surgery	Central Guildford	91	1.8
Guildford Rivers Practice	Central Guildford	45	0.9
New Inn Surgery	Central Guildford	18	0.3
Locality total		**317**	**6**
Mill Medical Practice	East Waverley	164	3.2
Binscombe Medical Centre	East Waverley	105	2.0
Wonersh Surgery	East Waverley	133	2.6
Springfield Surgery	East Waverley	60	1.2
Cranleigh Health Centre	East Waverley	203	3.9
Locality total		**665**	**13**
Merrow Park Surgery	Guildford East	85	1.6
Villages Medical Centre	Guildford East	77	1.5
Shere Surgery	Guildford East	79	1.5
Horsley Medical Centre	Guildford East	126	2.4
Locality total		**367**	**7**
Chiddingfold Surgery	Haslemere	50	1.0
Witley Surgery	Haslemere	88	1.7
Haslemere Health Centre	Haslemere	205	4.0
Grayshott Surgery	Haslemere	169	3.3
Locality total		**512**	**10**
Guildowns Group Practice	North Guildford	134	2.6
Fairlands Medical Practice	North Guildford	128	2.5
Woodbridge Hill Surgery	North Guildford	82	1.6
Locality total		**343**	**7**
Total		2205	42.4

2. 'My care, my choice' Framework

The integrated care model has been developed specifically to focus on the needs of frail older people who require support to enable them to remain at home. Those persons are characterised as having:

- Health and social care needs associated with ageing;
- Co-morbidities, including organic and functional mental health needs;
- High level dependencies for activities of daily living;

- Risk of admission to long term care or acute hospital;
- An admission to an acute hospital and require supported discharge;
- Requiring mental health assessment and services;
- Requiring community health services.

The age of 65 is a guide but not a restricting factor. The presenting needs and risk of admission of the individual should be the most important areas for consideration.

The following levels attempt to describe the various interventions and roles involved in MCMC. We emphasise these levels of care as a guide and through a focus on them we have identified opportunities for significant improvement to managed care and improved pathways

- **Level 1** - Information and advice for those who are independent and are able to manage their own needs;
- **Level 2** -Prevention and early intervention services for people at risk of deteriorating physical and mental health, Activities of Daily Living (ADL) and who have multiple or complex needs;
- **Level 3** - Community coordinated assessment, care planning and service provision;
- **Level 4** - Intermediate services for people with deteriorating functional skills and abilities; in need of rehabilitation, recovery or reablement; at risk of admission to a care home;
- **Level 5** - Out of Hospital services care for people who are acutely ill and at risk of admission to hospital or are in, or have recently been admitted to acute hospital.

Service Level 1 - Information and advice for those who are able to manage their own needs
Patient Criteria: • Comorbidities • Conditions relating to ageing • Age 65+ is a guide but not a restricting criteria • Any medical problems are well controlled • No active disease symptoms • Social isolation
Level 1 Interventions: • Signposting to various voluntary/faith organisations • Smoking, weight and alcohol programmes • Influenza and pneumococcal vaccination programmes • Effective medicines management • Screening for Depression, Dementia, etc. • Carer support and assessment • Regular long term condition reviews
Roles delivering Level 1 interventions: • GP and practice nurse • Voluntary and faith sector (ie. Age UK Personal Independence Coordinator (PIC) worker) • Advice and information centres (ie. The Godalming Hub, CAB) • SCC Surrey Information Point Web: surreyinformationpoint.org.uk • Guildford & Waverley Borough Councils

- Pharmacist

Service Level 2 - Prevention and early intervention services for people at risk of deteriorating physical and mental health, Activities of Daily Living (ADL) and who have multiple or complex needs
Patient Criteria: • Comorbidities • Conditions relating to ageing • Long term conditions • Medical conditions at risk of not being well controlled • Age 65 and over as a guide but not a restricting criteria • While not dependent on others for daily help, often symptoms limit activities • Social isolation
Level 2 Interventions: • Engagement with services involved in primary prevention services (isolation, heating, housing, mobility, nutrition) • Adaptations, equipment and practical support in the home • Carer support and assessment • Falls prevention • Effective medicine management • Engagement with voluntary sector • Screening for Depression, Dementia etc.
Roles delivering Level 2 interventions • GP • Voluntary and faith sector (ie. Age UK Personal Independence Coordinator) • Social worker • Guildford & Waverley Borough Councils • Citizens Advice Bureau • Community pharmacist • Practice support pharmacist • Allied Health professionals (ie. Occupational therapists, physiotherapists) • Specialist nurse

Service Level 3 - Co-ordinated community assessment and service provision
Patient Criteria: • Comorbidities and conditions relating to ageing • Age 65+ is a guide but not a restricting criteria • Requires support with activities of daily living needs (ADLs) • Often have more evident slowing, and need help in high order ADLs (finances, transportation, heavy housework, medications). Progressive impairment with shopping, walking outside alone, meal preparation and housework
Level 3 Interventions:

- An identified care coordinator is assigned to the patient
- Identification of organic and/or functional mental health problems that affect functionality and ability to recover and rehabilitate
- Social care assessment
- Use of Telecare and Telehealth to support self-care
- Falls prevention
- Carer support and assessment
- Effective medicine management
- Adaptations, equipment and practical support in the home (planned)
- Prevention and early intervention for mental health (MH) conditions such as depression and anxiety through access to Improvement Access to Psychological Therapies (IAPT), to prevent decline in both physical and MH conditions

Roles delivering Level 3 interventions:

- GP
- Community Matron
- Interface Geriatrician
- Social worker and occupational therapist
- Guildford & Waverley Borough Councils
- Specialist nursing
- Mental health practitioners
- Allied Health Professional
- Community pharmacist

Service Level 4 - Intermediate care

Patient Criteria:

- Significantly impaired function
- History of unscheduled admissions
- Multiple planned care appointments
- Moderately Frail
- Require help and assistance with all ADLs (especially mobility)

Level 4 Interventions:

- Link with services provided by the third sector e.g. falls prevention
- Focus on therapeutic interventions
- Admission avoidance to long term care
- Social care assessment
- Carer support and assessment
- Rapid assessment
- Comprehensive geriatric assessment
- Access reablement services to reduce dependence on high intensity, long term support
- Assess for aids and adaptations in the home (reactive)

Roles to deliver Level 4 interventions:

- Community Matron
- Rapid Response team
- Interface Geriatrician
- Mental Health Practitioner
- Social Worker
- GP
- Specialist nursing
- Allied Health Professional

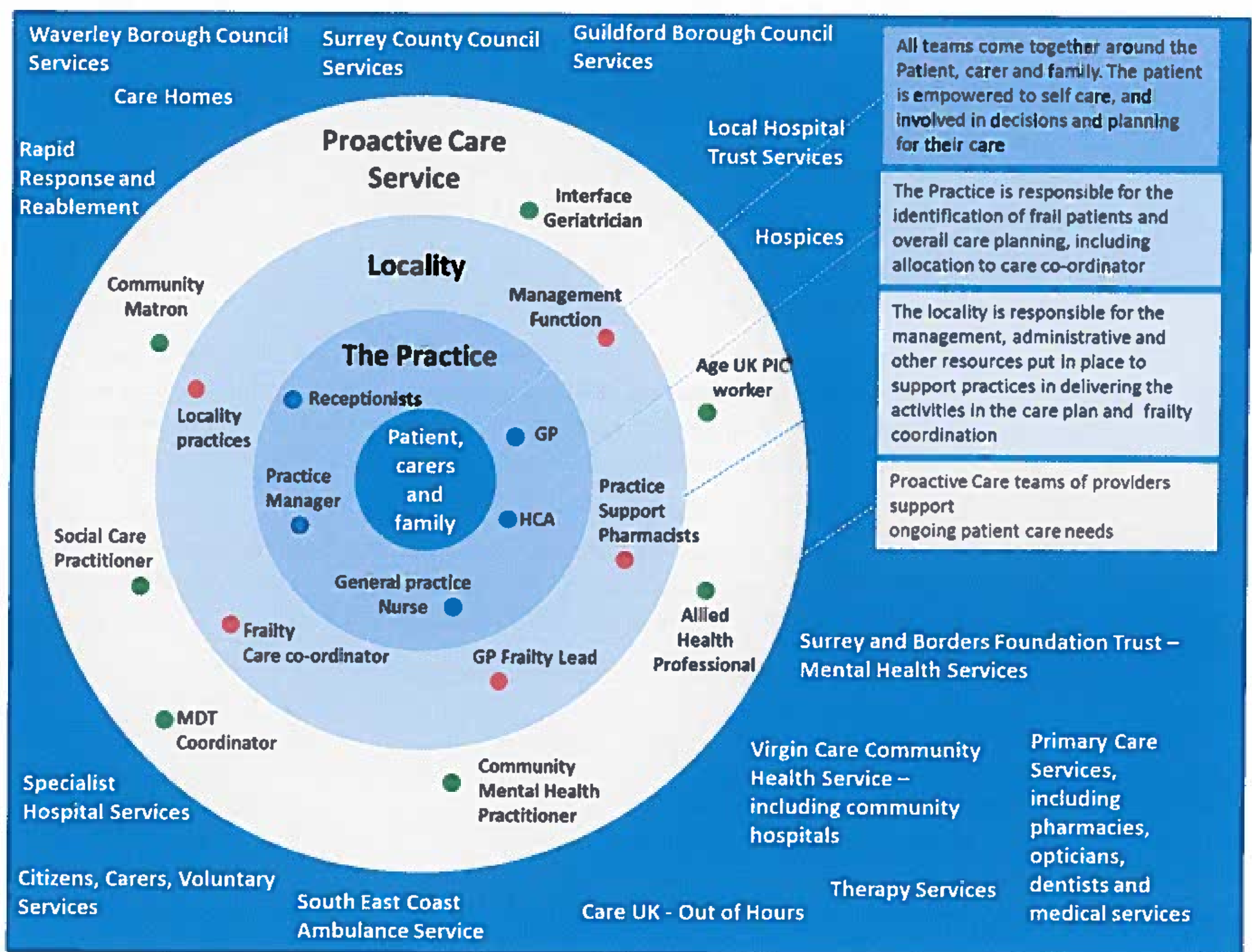
Service Level 5 – Out of Hospital services
Patient Criteria: • Severely Frail • Completely dependent for personal care, from whatever cause (physical or cognitive). • Patient at risk of admission to acute hospital • Require facilitated discharge from hospital
Level 5 Interventions: • Focus on clinical care e.g. IV antibiotics, catheterisation • Manage patients in the community (including care homes) at risk of hospital admission • Assertive in-reach to A&E and EAU (Emergency Assessment Unit) to avert admission • Integrated Care and Assessment Service (ICAS) • Night services (Twilight nurses, night response team and care support) • Out of hours service access • Psychiatric liaison service • Carer support and assessment • Potential for integrated support workers to provide appropriate interventions at the level of healthcare assistant, rehab assistants and personal care elements of domiciliary care
Roles to deliver Level 5 interventions: • District Nursing • Specialist Nursing • Community Matron • Interface Geriatrician • Mental Health Practitioner • Social Worker/Occupational therapist • GP • Allied Health Professional

3. 'My care, my choice' Service Delivery Model

Guildford and Waverley partners are collectively committed in achieving the ambition to transform care that meets the needs of the frail older population. MCMC is established and working at pace to support the co-creation of an integrated locality based service model that brings together health, social care, voluntary and community sector. This model of care will meet the holistic needs of individuals and their carers in the community, by aiming to maintain their normal place of residence with appropriate support. This section describes the key components of the MCMC service model, which includes:

- The Primary Care Frailty Initiative;
- The Proactive Care Service including:
  - The Locality MDT
  - Age UK Integrated Care Programme
- Supporting Services
  - Virtual Ward
  - Locality Multidiscplinary Team (MDT) meetings
  - Single Point of Referral

The following diagram outlines the way in which the MCMC will work with a range of individuals providing functions and fulfilling key roles. Roles have been placed across the practice level, the locality level and Proactive Care Service levels in order to illustrate how services will work together to deliver care.



Primary Care Frailty Initiative

The Frailty Service commenced in June 2014 to support GP practices in providing an enhanced level of care to the practices frail older population >65 years of age.

The Frailty initiative is an integral and critical element of the MCMC and will provide the following service provision for the frail older population:

- Risk stratify the top 5% of their high risk patients of all ages;
- To identify a GP Frailty Lead within each practice;
- Practice level virtual ward meetings to discuss patients at risk of admission;
- Monthly face to face MDT locality meetings with as a minimum GPs, community matrons and district nurses, occupational therapist/physiotherapists, interface geriatricians, social workers/practitioners, voluntary sector and Mental Health;
- Use the Proactive Anticipatory Care planning process (PACe), ensuring care plans are developed for those individuals identified as being at risk of deterioration and acute hospital admission;
- Upload PACe and care plans on to the IBIS system supporting paramedics to meet the needs of patients without conveying to hospital;
- All patients residing in NHS funded nursing home placement are to have PACe care plans
- Review of daily admission and attendance reports;
- Follow up of patients discharged within 72 hours to ensure sufficient care planning and support is in place;
- Follow up of patients admitted to support timely discharge;
- Regular visits to patients at risk, in their normal place of residence.

Proactive Care Service - Core Team

The Proactive Care Service will manage and co-ordinate assessment, care planning, access to treatment and support services and requiring additional care to avoid admission to hospital or facilitate timely discharge. Once established, the service will be accessed through one single phone number; although it is recognised that considerations around infrastructure to facilitate this need to take place.

The development of the Proactive Care Service will be developed through a phased approach. With one locality piloting the Service and understanding the requirements to deliver an integrated approach across all partners as well as the single point of contact.

Members of the Proactive Care Service will include the following practitioners

- Community Matron;
- Interface Geriatrician;
- Mental Health Practitioner;
- Social care practitioner;
- Age UK Personal Independence Co-ordinator (PIC) worker;
- MDT Co-ordinator
- GP

The team members within the Proactive Care Service team will in the short term at least remain fully accountable to their employing organisation but will also have a dotted line of report to the Proactive Care Service. The Proactive Care Team key roles and responsibilities are described below:

Roles and Responsibilities

There are a number of roles that will make up the locality Proactive Care Team but it is worth noting that there will be additional, specialist roles that the team will rely on to deliver the highest quality care to patients in the Proactive Care Service. It is important to recognise these roles and the interface with the core team but for the purposes of this document only those roles in the core team. These roles may be provided by more than one practitioner at each level.

a. Risk Stratification and Patient Identification

The Proactive care team will work with the GP practices and Frailty Initiative to identify patients at risk of deterioration and acute admission. Once patients have been identified they will be flagged as requiring case management by the Proactive Care Team.

b. Case Management (Community Matrons, Mental Health practitioners, Social Worker):

Case managers will be a professional clinician or practitioner role such as a nurse or social worker, who will lead in the planning, coordination, monitoring, and evaluation of services for a patient with emphasis on improving outcomes, quality of care, continuity of services, and cost-effectiveness.

Case Managers will provide planning, coordination, monitoring, and evaluation of services for a patient with emphasis on quality of care, continuity of services, and cost-effectiveness for those with complex needs, requiring a high level of support, either at home or in a residential or nursing home.

Community matrons will act, in the majority of cases, as case managers. They will be a single point of contact for care, support or advice, typically for a caseload of around 50 very high intensity users. Community matrons are usually deemed to be working as advanced nurse practitioners.

c. Care Co-ordinators (Community Matrons, Mental Health practitioners, Social Worker, MH practitioner)

The role will fall to the person who has led the assessment or the staff member who has the lead in providing care. Care coordination is a clearly defined function which assures that the objectives and goals agreed with the patient are achieved through the effective delivery of care by the appropriate agency or provider.

Those fulfilling this function will in many cases may already be part of an existing support role. Care coordination is not an isolated activity but is done as part of being in a team. It works best when there is a clearly identified person undertaking this role within a multidisciplinary team. Everyone in the team knows who the care coordinator is for a specific patient/client and understands that this is a clear function. Queries can be raised with the Care Coordinator by members of the Proactive Care Service, carers or relatives about a patient/client being case managed. Please note that further work by all providers will need to take place on the development of an operational policy to set out more formal ways of working together.

d. Multidisciplinary Team (MDT) Co-ordinators

The Multidisciplinary team (MDT) co-ordinator will be responsible for administrating the MDT meetings, ensuring that all patient information is available to inform the MDT members, enabling real time decisions regarding the patients care. They will capture all tasks and actions raised by the MDT members. They will take action as required to support the team and also track actions have

been taken by other team members. They will be a point of contact for case managed patients for those services outside the Proactive Care Team.

e. Age UK Personal Independence Co-ordinators:

Age UK Personal Independence Co-ordinators will enable frail older people to achieve positive wellbeing outcomes by helping them to manage their long term goals. Assisting older people in navigating health and, where appropriate, social care services as well as developing the knowledge of voluntary and community groups. This role will also be responsible for engaging with the local community services in place as well as recruiting and supporting local volunteers.

Frailty Initiative	Proactive Care Service Core Team Roles and Responsibilities					
GP	Community Matron	Interface Geriatrician	Mental Health Practitioner	Social Worker	Age UK PIC worker	MDT Co-ordinator
• Risk stratification of 'at risk' patients • Physical examinations • Development of care plans with patients, carers • Early warning signs, investigate and diagnose exacerbations of illness and arrange for treatment to be implemented • PACE care planning and ensuring care plans are developed for those individuals identified as being at risk • Review of daily/weekly admission and attendance reports; • Follow up of patients admitted to support timely discharge; • Regular visits to patients at risk, in their normal place of residence	• Physical examinations • Early warning signs, investigate and diagnose exacerbations of illness and arrange for treatment to be implemented • Development of care plans with patients, carers and GPs • Ensures that services such as social care, Rapid Response, voluntary services, Age UK are in place and shared to meet identified needs. • Monitor patient • Care coordination • Complex liaison with specialist services • Support patients, carers and their families. • Act as an advocate for patients • Information and education • Liaise with a range of other professionals. • Liaise with secondary care services	• 'Geriatrician of the Day' providing support and specialist advice • Rapid access clinic – for urgent cases (<7 days) review of complex older people in outpatients • Comprehensive Geriatric Assessment through OPDAS • Same day/urgent domiciliary visits supporting the care of complex older people • Care home training and development • Clinical governance • Specialist advice and support to other members of the MDT	• Ongoing care co-ordination • Care management • A liaison nurse who provides assessment, advice and training to local care providers. • Treatments, including best interest and capacity assessments • Approved mental health practitioner to carry out Mental Health Act assessments • Support for service users requiring Court of Protection • Medication management, advice and support • A dedicated nurse to carry out Lithium monitoring (blood tests)	• Protection for adults that follows local safeguarding procedures • Information and advice • Signposting to relevant services • Assessment • Advocacy • Reablement • Establish eligibility • Capacity assessment and best interest decisions, financial assessment • Support planning for ongoing care including family, friends and community. • Carers assessment and support • Referral OT service - equip or adaptations • Monitoring and review • Liaison with hospital based social care teams if patient admitted to hospital. • Supporting people funding their own care • DOLs (Deprivation of Liberty Safeguards) and deputyship	• Find out what groups and activities are most appropriate to refer the patient to • Introduce opportunities for patients to socialise and meet new people within their local community • Build confidence to assist in the effective management of health conditions • Provide contact information and encouragement to support patients in taking up physical activity	• Facilitate and co-ordinate administration functions • Inform GPs diagnosis, clinical decisions and clinical appointments • Work with MDT to achieve standards of delivery • Manage communication • Manage all MDT meetings including attendance • Minute MDT and distribute notes and track all actions that have not been delivered for each patient • Develop databases to capture patient information • Ensure correspondence, notes, x-rays; results, etc. available MDT meetings • To track patient's progress through the patient pathway • Monitor referrals • Ensure details are on clinical system

Supporting Services

A number of services are in place to support the Integrated Care Service Model. These are described below. The Frailty Pathway is outlines the way patients are identified as frail and at risk of deterioration and admission to acute hospital. The pathway covers the services and teams and health and social care professionals who will work with patients in certain scenarios depending on their level of need.

Virtual Ward

The Virtual Ward (VW) team consists of practice level clinicians, a community matron, district nurse, practice nurse and administrative support. The VW team work closely in managing the VW patients with daily ward rounds. Links to other health and social partners are very strong, with the VW providing leadership to focus on patient centred outcomes.

Entry requirements for patients onto a VW may include

- Unscheduled admissions
- Poly pharmacy and compliance of medication
- Identification of frailty syndromes (falls, immobility, incontinence, etc.)
- Two or more long term conditions

Information from these meetings is to be communicated directly to the patient's registered GP by updating their clinical notes. The virtual ward team will use enhanced tracking to ensure that they can reduce the likelihood of admission, and should the patient be admitted into secondary care, follow their treatment through hospital and attempt to facilitate an earlier discharge back into the community working with the hospital based case managers.

Locality Multi-disciplinary Team (MDT) Meetings

Patients can be referred to the locality MDT if they have proven too complex and challenging for the local VW. GPs will meet monthly with Proactive Care Team to discuss these challenges and to agree next steps in care. Risk stratification tools, clinical experience and data on patient episodes of care are used to identify patients for the MDT discussion, and criteria include:

- Hospital admissions
- Frequent A&E attendances
- Long Term Conditions
- Multi-agency input
- High packages of care

Single point of Referral

The ambition is to establish over the next few months an interim arrangement that ensures referrers of older frail patients at risk of admission or requiring facilitative discharge have a single contact number for the Proactive Care Service.

Proactive Care Service – Referral Pathway v.02

Not eligible for frailty initiative

GP review

Integrated Care & Assessment Service (ICAS)

Followed up by Frailty initiative

Medically stable patient

Care Plan (Community Matron – Care Co-ordinator)

Proactive Care Locality Service

Care Co ordinator to direct care

Rapid Response / Reablement

District Nursing

Community Therapies

Voluntary Sector

High risk

Practice based virtual ward

Amendment to care plan and allocation of care co-ordinator (i.e CPN)

Complex patients

Locality MDT

Complex patients

Acute hospital

Proactive Locality Care Service

Frailty Initiative

Age UK Programme

Key Meetings:
A number of key meetings are required to ensure that the Integrated Care Service model works effectively and that the Proactive Care Team is able to manage the patients effectively.

Meeting	Members	Frequency/key tasks
Practice based Virtual Ward meetings (variable frequency)	- Frailty Lead GP - Community Matron - Mental health practitioner - Practice Nurse - District Nurse	- Variable – dependent on practice population demographics. Likely to be weekly or fortnightly. - Discussion of care management of frail older patients and prioritising limited resources to supported identified need.
Locality MDT meeting – monthly face to face with following membership in attendance:	- GP - Social Worker - Community Matron - Community MH practitioner - Interface geriatrician - Age UK Personal Independence Co-ordinator - Specialist staff invited as required	- Monthly - Face to face (dial in option to support continued communication) - Patients information shared re- meeting all providers to review records to see if known prior to the meeting - Identification of local system service gaps and develop plans to resolve these
Proactive Care Service Daily Triage and Patient Review meeting – able to be done virtually	- Social Worker - Community Matron - Community MH practitioner - Interface geriatrician - Specialist staff invited as required	- Daily - Allocation of new cases to team members - Discussion of complex cases - Sharing of best practice - Prioritising limited resources to support identified need

Other services working to meet the needs of the frail older population

There are numerous other services that are in place which the Proactive Care Team will need to liaise and work closely with to make the Integrated Care Model work effectively.

a. Care Homes
Care homes provide vital services and support to older people, carers and family, including end of life care and continuing health care. A care home is a place of ordinary residence and people are entitled to the same levels of clinical and therapeutic care as they would receive in their own home (including supported living).

Current challenges in the care home system are:

- Threshold for requesting emergency hospital admission where the care home could reasonably be expected to provide the required level of care
- Mental health awareness and appropriate support

- Standards of end of life care

MCMC will work with Surrey County Council and other providers to improve the standards of care in care homes. Providers of general community and specialist mental health services will be required to provide development services, including the option to work with the commissioning and contracting services to improve the range and quality of care in care homes.

b. Carers support
It should be noted that the term 'carer' can be confused with care workers. For the purposes of this document, "a carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support".

Admission avoidance can have an impact on carers, often requiring more input from them. Whilst acknowledging the inherent stresses of a hospital admission, some family carers experience an avoided admission as placing increased demands on them. It is necessary for MCMC to facilitate person centred care where people are considered in the context of families and support networks, not just as isolated individuals with needs. Surrey County Council provides carers assessments and a range of services and all agencies are contributing to the development of joint carers strategies.

The Care Act 2014 introduces new rights and entitlements for carers and the people that they care for as well as putting into law new overarching principles of well-being, new market shaping duties and other approaches such as personalisation. The Care Act requires a more proactive approach to early intervention and prevention for carers as well as increasing responsibilities to meet their assessed eligible needs. The legislation highlights a need for greater cooperation with health that is also reflected in NHS England's Commitment to Carers.

Providers of community health and specialist mental health will work with partner organisations to:

- Identify, support and make necessary referrals for carers who need assistance;
- Contribute to carers assessments;
- Provide appropriate services and support;

c. Interface between community and acute services
The impact of secondary care on community services is significant:

- Patients are admitted where enhanced community services could provide treatment in the patient's own home or interim facilities
- High levels of unplanned discharges to a person's own home creating the need for urgent responses from community services
- Patients being transferred into community beds to create or maintain acute capacity, with the subsequent effect that fewer beds are available for step-up (admission avoidance) services
- The ambulance service (SECAmb) have the ability to redirect patients to more appropriate settings of care where these exist or where case managed patients can receive rapid treatment to safely keep them where they live.

Conclusion

The Guildford and Waverley health and social care system has a significant opportunity to deliver improvements in patient care for the frail elderly and their relatives and carers through the development of the Integrated Care Service Model. This brings together in to a single framework of working the following:

- The Primary Care Frailty Initiative;

- The Proactive Care Service including:
    - The Locality MDT
    - Age UK Integrated Care Programme
- Supporting Services
    - Virtual Ward
    - Locality Multidisciplinary Team (MDT) meetings
    - Single Point of Referral

By implementing the various services and initiatives above, we aim to promote, restore or maintain health and wellbeing by making sure that every person and their family in Guildford and Waverley can access the care that they need, when and where they need it. By ensuring that list-based general practice remains the foundation of the model, care can be delivered in a community setting as much as possible where it makes clinical and economic sense to do so. Our approach has started with understanding the outcomes that matter most to our population; working to develop new models of care to deliver those outcomes and then – creating the organisational arrangements to deliver the new models of care. We believe that we have the leadership, skill and stakeholder commitment to undertake and evaluate the transformational change processes that will result in better outcomes and experience for our patients and their carers.

Appendix 1 – Enablers

A number of underpinning enablers are necessary to make the integrated model of care work effectively:

- Enabler 1 single points of referral
- Enabler 2 Integrated Assessment
- Enabler 3 Integrated information – sharing IT
- Enabler 4 Workforce development and skill set

Enabler 1 Single points of referral - SPR

Function
Get it right first time will require easy access to services. The referring agent should be able to rely on services to work together to manage capacity. We see single points of referral as a key component of managing patient flow.
• Enable timely and easy access to the right service
  o Third sector services
  o Coordinated assessment and service provision
  o Intermediate care
  o Community care
  o District and Borough services

Criteria • Each SPR will have assigned criteria
Other • Single points of referral will be developed within a whole system context. The detail of levels of triage and assessment will need to be developed in partnership with the LCG. • Information sharing protocols and governance arrangements required. G&W CCG are working with local authority colleagues, our community provider and major third sector providers to coordinate referral, assessment and service provision.
Outcomes • Patient has timely access to the right services • Reduction in multiple-referrals from GP

Enabler 2 Integrated Assessment
Function • Provide a system for integrated assessment of individual need, including mental health needs care coordination individual service planning • Third sector prevention and early intervention services can initiate the SAP
Criteria • Persons with complex health and care needs (general and mental health) Persons accessing more than one professional or service
Other • The development of the SAP will require attention to the following issues; Inter - Organisational information protocols and governance • Individual consent Mental capacity • The Integrated Assessment enabler will interface with the information sharing IT
Outcomes • Patients/people who use services have an integrated assessment and service provision Assessment and care provision is coordinated reducing duplication and gaps.

Enabler 3 - IT system for information sharing
Function • Provision of IT system that can: Handle shared patient information across health, social care and the third sector • Deliver timely health intelligence that can be used to continually improve patient care and to inform commissioning requirement. • All parts of the integrated model of care can input and access appropriate levels of information.
Criteria • Patients referred and assessed by the services outlined in this service specification
Other • Information sharing protocols and governance systems in place
Outcomes • IT Systems that enable appropriate information sharing to maximise outcomes for patients and carers • SAP, health and social care plans or summary care records accessible to authorised staff in a range of locations

Enabler 4 Workforce development
Function 2 key functions; • Multi-disciplinary working - care coordination and single assessment process • Right skills right place – staff have right skills to deliver the right services
Outcomes **Multi-disciplinary working** • All workforce will be skilled in multi-disciplinary working, including taking shared responsibility for patient outcomes • All workforce will contribute to the single assessment process • All workforce will work effectively within the community based whole health and care system and interface effectively with acute services and specialist mental health services **Rights skills right place** • All staff will function at the right level to match their skills

Appendix 2 – Description of Services

The services that the Proactive Care Team will directly liaise with are presented in the following diagram. The service mapping is currently being collated and as the model progresses the scope of services included will increase. These services are described in more detail in the next section.

1. Community Health Services

- District Nursing – Provides nursing assessment, care, advice and support to patients in their own home. This includes palliative care, tissue viability, continence assessment and management and medicines administration. Service is for patients usually seen at home by their GP, patients who have specific nursing needs that are best met in own home and patients with palliative care needs
- Community Matron - As well as providing nursing care, community matrons act as case managers. They are a single point of contact for care, support or advice, typically for a caseload of around 50 very high intensity users[1].

  Community matrons are usually deemed to be working as advanced nurse practitioners. These highly-skilled nurses have a variety of tasks and responsibilities, including:

  - carrying out physical examinations
  - decide on and carry out treatment, including the prescribing medicines, or refer patients to an appropriate specialist
  - using their expert knowledge and clinical judgment to identify the potential diagnosis and where appropriate make a final diagnosis
  - use their extensive practice experience to plan and provide skilled and competent care that meets patients' health and social care needs, involving other members of the healthcare team as appropriate
  - ensure the provision of continuity of care, including follow-up visits
  - assess and evaluate, with patients, the effectiveness of the treatment and care provided and make changes as needed
  - work independently, although often as part of a healthcare team
  - provide leadership
  - make sure that each patient's treatment and care is based on best practice.

- Specialist Nursing – Specialist nursing services aim to manage patients with long term conditions to avoid inappropriate acute hospital admissions, support early discharge, support self-care and patient education. Local specialist nurses include: respiratory, heart failure, diabetes, Parkinson's, Multiple Sclerosis and tissue viability.
- Community Mental Health Team for Older People – This team works closely with social care and voluntary sectors by providing assessment, diagnosis, treatment and support to patients over 65 with memory concerns and/or cognitive impairment. The service aims to manage mental health needs in the community, either using outpatient appointments or home visits.

[1] http://www.nhscareers.nhs.uk/explore-by-career/nursing/careers-in-nursing/community-matron/

- Community Pharmacy - Involved in the sale and supply of medicines and to give advice about medicines, symptoms and general health matters. Community pharmacist services are responsible for dispensing medicines, to counsel patients on their proper use, clarify with GPs and other prescribers that dosages are correct, and check that new treatments are compatible with other medicines the patient may be taking.
- Borough Councils provide a wide range of services ranging from the provision of housing related welfare benefits, Social Housing, Disability Adaptation Assessment and Grants, and Community Development. Guildford Borough and Waverley Borough Councils deliver services and commission them from the voluntary sector. For example, Careline, Sheltered Housing, Day Centres, Information and Advice Services, Meals on Wheels, exercise classes, services to help residents downsize from properties they can no longer manage, garden clearance services etc.
- Adult Social Care locality teams operate a duty service for any urgent or emergency issues. Duty operates Monday to Friday 9am to 5 pm. Outside of these hours the County Emergency Duty Team can be contacted for any emergencies. The hospital based social care team at RSCH operates 7 day service.
- Safeguarding adults from abuse is everyone's responsibility and there is a duty to report all concerns. All employers have a duty to protect the adult and take action to protect the immediate safety of the adult and to report the concerns in line with Safeguarding Adults Policies and Procedures.

2. Integrated Reablement and rehabilitation teams

- Rapid Response Service- This service provides rapid access, community-based short-term rehabilitation or support during crisis. Up to 6 weeks of domiciliary support from Occupational Therapists, Physiotherapists, Rehabilitation Nurses & Rehabilitation Assistants is provided through Rapid Response. The service is designed for patients who are medically stable and are able to stay at home, but have had an acute illness, injury or fall, are at risk of hospital admission in near future (e.g. deteriorating mobility). The service also facilitates supported discharge following a hospital admission.
- Reablement Service- The reablement team provides short term support with skills required for activities of daily living. The service is led by occupational therapy and carried out by reablement assistants for patients who require short term help to prevent hospital admission, support through short term crisis and support upon discharge from hospital. Plans are underway to integrate the Rapid Response and Reablement teams, this includes the development of a Discharge to Assess Pathway.
- Community Hospital- Short term rehabilitative inpatient beds are provided for patients following an acute episode (e.g. stroke, fractured neck of femur, episode of illness and injury) as well as for step up/step down of care for temporarily increased level of nursing needs. Beds are available upon referral for medically stable patients who have no complex medical/ rehabilitation needs. It is anticipated that patients will be able to return to their own home following the rehabilitative episode.
- Day Assessment and Treatment Centre (DATC)- A full assessment by Geriatric, nursing and therapy teams is provided at the DATC. This service is for patients with frailty /complex care needs or who have fallen, have had recurrent falls or at risk of falling due to medication or nutritional problems.
- Community Rehabilitation Team – This service is a community based functional rehabilitation programme with Physiotherapy, Occupational Therapy or Speech &

Language Therapy. It is designed for patients with long-term conditions, or following episode of illness/accident who will benefit from a long term rehabilitation programme.

3. Acute Services

- Older Peoples' Assessment and Liaison Service (OPAL) – This service provides an assessment of a complex frail elderly patient by an interface geriatrician in an acute setting. This could be in A&E or EAU, or on an acute non care of the elderly ward (as in patient OPAL) with the support of complex diagnostics, therapists and nurses. The patients receive a comprehensive geriatric assessment, with onward prescription for other services and may be assessed/ screened for suitability for a rehabilitation community bed.
- Geriatrician of the Day (GoTD) - Run by the interface geriatricians for complex frail elderly patients who require specialist input, advice or guidance.
- Older Peoples' Day Assessment Service (OPDAS) – This service provides a planned clinic appointment for patients requiring a Comprehensive Geriatrics Assessment (CGA) from the interface geriatricians,Care of the Elderly team, therapists & community nurses. There is access to RSCH diagnostics same day if needed. This is designed to meet the needs of patients who may be approaching frailty crisis, with the aim of advising on what support/ intervetions are required to support the patient in the community, thereby avoiding an acute admission
- Older Adult Psychiatry Liaison Service – This service provides assessment of patients over 65 years with mental health problems who are at risk to themselves or others whilst under care of acute hospital teams and A&E. This includes risk assessment, treatment and advice for onward care by a mental health practitioner and/or Psychiatry Liaison Nurses.
- Inpatient OPAL team – This team find all frail elderly patients in the hospital and seek to optimise and manage their care as well as coordinating discharge
- Integrated Care and Assessment Service (ICAS) – This is the amalgamation of several teams that had a role in the acute discharge and support of patients in the early post discharge period (ie. HoST; IDT; Discharge Coordinators, Social Care). The discharge of patients is integrated across social care, community care and acute care. The service will ensure that patients are discharged in a timely fashion to the most appropriate setting with suitable support provided. This includes assessing patients to establish needs and suitability for community and rehabilitation services, new/increased packages of care at home and placement in residential/nursing homes. Case Managers linked to specific wards manage the discharge of patients working with the ward staff and locality MDT staff to ensure that patients are able to be discharged as effectively as possible without delay
- Case management by a clinical utilisation review tool –This tool will support decision making with indication of when the patients care can be provided in a less acute setting. Discharges are coordinated by the case management team. This is a new system, as yet not fully implemented. It will have a phased approach. At present it is live on 3 medical wards; soon to extend to the rest of the medical areas and to surgery by year end.

4. **Voluntary Services**
    - Citizens Advice Bureau – The provision of free, independent, confidential and impartial advice to individuals on their rights and responsibilities
    - Age UK – Local based charity that provides support to older people. Age UK are a key partner in the MCMC development as Guildford and Waverley are supporting the Integrated Care pilot. This pilot allows each locality to access a dedicated Personal Independence Coordinator, who will lead a team of volunteers.
    - Locally funded borough/town council services – This represents any locally funded or borough/town/parish council funded services that are aimed at improving the lives of older people through various initiatives, such as befriending or gardening schemes.
    - Carer support services – This includes any work from locally funded/voluntary organisations who support carers across Guildford and Waverley.

5. **Emergency Services**
    - Surrey's GP 'Out of Hours' service is accessed via the national NHS 111 call line. In Surrey, this is a service provided by the South East Coast Ambulance Service (SECamb) in partnership with Care UK, from their base in Dorking. The NHS 111 team will assess a patient's condition over the phone and if it is clinically appropriate, refer on to the out-of-hours service. A referral results in a: (1) A face to face appointment to attend a primary care centre to see a doctor (2) A home visit from one of our doctors. GP out-of-hours services run Monday to Friday from 6.30pm to 8.00am, and for 24 hours at weekends and during bank holidays.
    - Out of hours services will be linked into the initiatives taking place across the system to avoid sending an older person into hospital. This includes understanding the importance of PACE plans, discussing treatments with care home/SECAmb staff and being aware of the services operating locally in the community.
    - South East Coast Ambulance Service NHS Foundation Trust (SECamb) respond to 999 calls from the public, urgent calls from healthcare professionals, provide NHS 111 services across the region and in Surrey, provide non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities). SECAmb are working closely with GPs to enable access to patient care plans and records through IBIS (Intelligence Based Information System). IBIS is a system used for storing anticipatory care plans for patients with long term conditions in order to minimise the need to convey to hospital and therefore reduce admissions. The system allows GPs to upload data about their patient, along with specific care instructions. IBIS provides much more specific information about a patient's specific condition, provided by a specialist health professional (i.e. COPD Nurse), and gives information about what to do in the event of a 999 call. The IBIS system is designed to enable ambulance crews to have up to date information about a patient's health and their care plans and needs, which allows practitioners to make the best clinical decisions when they are with a patient.