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Purpose: For Information/Discussion

Committee report

Committee
and Health
Date

Policy and Scrutiny Committee for Adult Social Care

Monday 16th July 2018

Title

Community Service Redesign Programme - Update

Report of/to

Nicola Longson, Programme Director, Isle of Wight Local Care System

EXECUTIVE SUMMARY

1. This report has been developed to provide the Committee with an update on the work planned across the Island to develop Community Services across health and Care. The report will summarise the changes being proposed, highlight the progress made to date, explain engagement to date and detail future plans/timelines for implementation.
2. The officers will agree with the Committee the timings of future updates on development of community services across the island.

BACKGROUND

3. Following the development of the Local Care Board, to bring together all key partners to unite efforts to improve the overall quality of health and social care on the Isle of Wight, the Local Care Plan was developed. This Plan prioritised 5 initiatives to enable the continued delivery of our new model of care, ensuring personalised care is available closer to home.
4. The 5 Local Care Plan initiatives are Acute Service Redesign, Community Service Redesign, Co-ordinated Access, Mental Health Recovery, and Transforming Learning Disabilities.

5. The Community Services Redesign initiative is the focus of the update at this committee and is summarised in the presentation in Appendix 1.
6. The implementation of the changes will result in the delivery of an improved model of care for the Island which is in line with the vision specified in the Local Care Plan to provide person centred, co-ordinated health and social care closer to home.
7. A copy of the Local Care Plan showing details of the vision can be accessed through the following link [Isle Of W ight Local Care Plan 2017 - 2021 DRAFT](#)

STRATEGIC CONTEXT

8. This work is aligned with the Isle of Wight Local Care System Local Care Plan and the Isle of Wight Council Care Closer to Home strategy and plan.

CONSULTATION

9. Consultation on development of Locality and Community services has been underway for some time across the Isle of Wight. Further plans around ongoing consultation and engagement is included in the presentation for the Committee in Appendix 1.

EQUALITY AND DIVERSITY

10. As required Impact Assessments have been carried out for this work in conjunction with the Isle of Wight Local Care System Quality Group.

RECOMMENDATION

11. The committee is to receive an update on the planned work and agree a suitable timetable for future updates to the committee.

APPENDICES ATTACHED

12. Appendix 1 – Presentation slides to be used at the committee to update on proposal, progress and next steps.

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Isle of Wight Community Services Redesign

APPENDIX 1

Mary's Story



The Challenge

Demand for health and care is growing at a rate that is unsustainable for the current system to manage as people are living longer, spend a larger portion of their life in poor health, with multiple chronic conditions. The Isle of Wight population is getting older and has changing health needs.

Care needs to transform to meet this additional demand in ways that are more tailored around the needs of an ageing population with multiple care needs.

There is compelling evidence that integrating health and care services and providing these close to where people live will deliver:

- ✓ Improved **health outcomes**, reduced avoidable illness and reduced inequalities
- ✓ Improved **personal wellbeing & confidence** of people to manage their own health
- ✓ **More joined up, co-ordinated care**; better experience and quality of life for patients
- ✓ More care delivered at home and in the community, **halting the growth in hospital utilisation**
- ✓ Improved **staff satisfaction**, staff confidence and morale – happier workplaces
- ✓ A contribution to **closing the financial gap**

The Local Care Plan



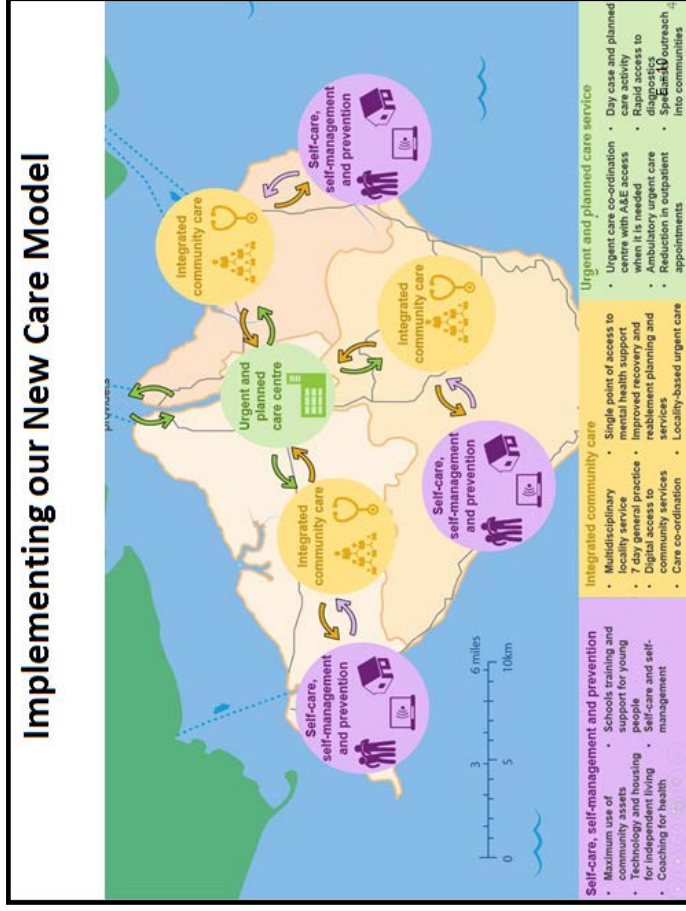
NHS
Isle of Wight
Clinical Commissioning Group



Isle of Wight
NHS Trust

Isle Of Wight Local Care Plan 2017 - 2021

FINAL – OCTOBER 2017



Following the development of the Local Care Board, to bring together key partners to improve the overall quality of health and social care on the Isle of Wight, the Local Care Plan was developed.

The Local Care Plan has prioritised the following 5 initiatives to enable the continued delivery of our new model of care.

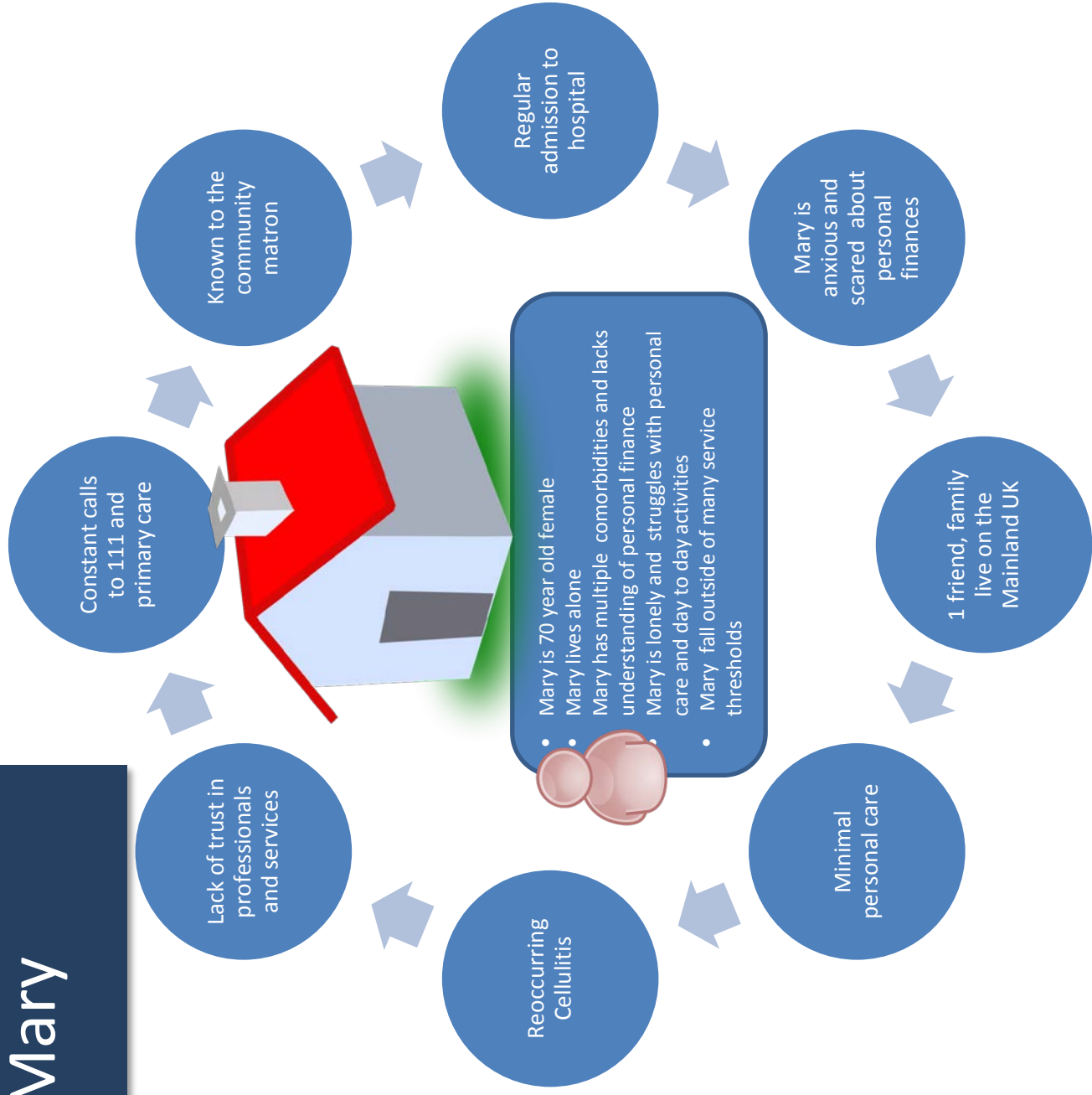
- ✓ Acute Service Redesign
- ✓ **Community Service Redesign**
- ✓ Co-ordinated Access
- ✓ Mental Health Recovery
- ✓ Transforming Learning Disabilities.

Integrated Community Care

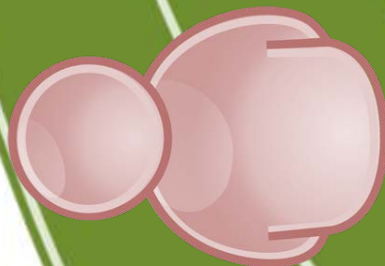
- 3 integrated localities each with a population of approx. 50,000
- Initial focus on frail & vulnerable populations
- Joint leadership arrangements across the IOW NHS Trust and IOW Council
- Aim to establish delegated pooled budgets
- New governance structures to support the new model of care



About Mary



Before changes



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I often call 111/GP up to 20 times a day because I am lonely and frightened and I need some help

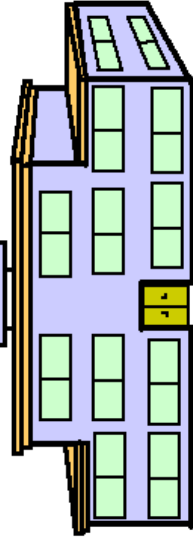
People phone me to ask if they can assess me. I don't know them so I say no thank you

I don't know who all these people are who want to help me so I get very confused



When I went to hospital to be looked after. I lost my confidence to help myself. The nurses and doctors are there to help me . They say I can't cope anymore and want to put me in a home

I am unwell at the moment and feel I can't cope . It's difficult for me to wash and dress. I have some help but not enough, I am lonely and in pain, I need to go to hospital to be looked after.



After changes

The nurse I know visits me & asks if I have considered having some extra help . When I tell her I can't afford it she says she will help look into this.

I have had the opportunity to say how and where I want to be cared for. I feel a lot more in control of what happens to me. I don't have to keep repeating information

When unwell I know I might need to go to hospital but I have confidence now that I could stay at home with extra treatment and support.

The nurse and I discuss what is most important to me. I tell her I want to stay at home. We talk about how this could happen. I agree she can share information with her colleagues and introduce them to me at home.

Now I have help everyday at home life is a lot easier and I don't feel the need to keep ringing my doctor. I've been introduced to a local singing group and have made some new friends.

Progress

What have we achieved so far?

- Staff resources and leadership agreed to drive forward transformation
- Weekly integrated professional Case Review meetings in each locality
- Improved communication and networking between services
- Developed individual outcome plans to support integrated care delivery including early help support
- Developed IT solution to support integrated working
- Different approaches to technology enabled care implemented in number of care settings
- Development of dashboard to enable Integrated Localities to be more responsive to needs of population



Progress

Next steps?

By end September 2018:

- Monthly locality meetings to ensure services meeting needs of local people
- Links with GP Practices established
- Rapid Access to service reviewed and improvements identified
- Agreed end to end Frailty pathway

By end of Mar 2019:

- Roll-out of improved Rapid Access to Community services
- Approach to working with General Practice agreed and being implemented
- Proactively identifying people who need support and care
- Wider roll out of the use of technology to support peoples health and care across communities

• Implementation of Frailty pathway across the community underway



Engagement

- Our plans are based on feedback received through consultation with the public and stakeholders over the last 5 years.
- We continue to engage with service users via
 - Ageing Better Forums
 - Healthwatch
 - Frailty Champions
- We are planning a Localities engagement event

Questions?

