Forward View into Action

Urgent and Emergency Care Vanguards

REGISTRATION OF INTEREST FOR UEC VANGUARD

Q1. Which network or system is making the application?

This SRG level application is submitted by and under the governance of the Solihull Health and Care System as defined by the established Solihull Together For Better Lives Partnership. Solihull Together is a shared value partnership of:

- Heart of England NHS Foundation Trust (incudes acute and community services).
- Birmingham and Solihull Mental Health NHS Foundation Trust.
- West Midlands Police.
- Solihull Metropolitan Borough Council.
- NHS Solihull Clinical Commissioning Group.
- Voluntary and Community Sector providers.
- Primary Care (including confederation of GP practices in Solihull).
- West Midlands Academic Health Sciences Network (WMAHSN).
- Lay members representative of service users, carers and the wider Solihull community. (The vision in this application has been and will continue to be co-developed with representatives of the Solihull population through Experts by Experience, an established stakeholder panel and Healthwatch Solihull is fully involved).

Modelling of the Solihull health and social care economy over the next five years has identified a £30m funding gap, which is a major stimulus to adopt new models of care. Vanguard presents an opportunity to progress this work at scale and pace through transformed and realigned pathways, beginning with prevention and early intervention through to end of life, using best practice and national policy expectations, collaboratively agreed real time metrics and success criteria. This approach is fully supported by senior clinical teams including, but not exclusively Social Care, Nursing, Therapies and Medicine from all of the partners. We are already an established member of the Kings Fund Integrated Care Network.

The project covers both North and South Solihull, extremes of all populations, health and social measures. Solihull is a mostly urban population adjacent to metropolitan Birmingham but also has two thirds of the geographical area being rural. Mapping and modelling of local flows has given a detailed understanding of present / future service usage including those going out of Solihull to the emergency centre at Birmingham Heartlands Hospital and to other specialist units (e.g. Birmingham Children's Hospital). The Hospital Transformation Summit took place on 2/7/15 and system wide agreement was given to the detail of this submission and new ambulatory pathways with the initial focus as detailed below.

Tackling issues and developing shared solutions: Aside from ensuring the quick transfer of any learning from Solihull to the other acute sites at Heart of England NHS Foundation Trust (Good Hope Hospital and Birmingham Heartlands Hospital), we would also share high level expertise to other Vanguard sites including:

- Expertise of two previous National Clinical Directors (Elderly care and Emergency Care – Professor Ian Philp and Professor Matthew Cooke) who have continued international involvement in service redesign
- Expertise from existing partnership with Warwick Business School
- Experience of establishing a whole public sector collaboration gained over last 12 months

This application is made with support of Monitor, Birmingham, Sandwell, and Solihull (BSS) Strategic Urgent Care Network and is led by Dr Patrick Brooke, Accountable Officer Solihull Clinical Commissioning Group and Professor Ian Philp, Deputy Medical Director for Older People, Heart of England NHS Foundation Trust under the sponsorship of the Solihull Health and Wellbeing Board.

For queries please contact Professor Philp. E mail: ian.philp@heartofengland.nhs.uk Telephone: 07867 443 644

Q2. What is your local vision for implementing the UEC review?

Our local Solihull vision is to create a maximally integrated health and care system that optimises preventative and out of hospital care with rapid access to specialist care both in and out of hospital when needed (similar to the Kaiser approach), including access to other wellbeing services including charities, leisure services, council and police. Our ambition is to extend healthy active life and independence with equal focus on physical and mental health through encouraging healthy lifestyle choices, care co-ordination and empowerment for self-management of Long Term Conditions, reducing pressure on secondary care services and altering the balance of care provided in hospital and the community.

This includes:

- Establishment of a Primary Care Centre within a health and wellbeing campus (on hospital site).
- Co-location of GP Out of Hours, Urgent Care Walk In / Minor Injury services into a single Urgent Care Centre.
- Establishment of a GP led step-up / step-down unit within the hospital.
- Improved access to diagnostics and secondary care specialists for primary care / community teams supported by innovative information technologies.
- Mental Health services; building on Rapid Assessment Interface and Discharge, Street Triage, Dementia and Delirium Team, Outreach.
- Supporting Patients/ Carers in their homes and the health and wellbeing campus through open and accessible information and services using various portals, building on the local authority "Solihull Connect" service.
- Integrated Community Teams, supporting admission avoidance.

The scalable and replicable principles of redesign are (seven days per week):

- **Encourage Wellbeing:** Development of information portals and incentives to healthier living, social prescribing, locally developed loneliness prevention projects - developing "sense of community".
- **Get In Early:** Development of systematic approaches to identifying risks in people aged 75+. Mobilise community responses based on the problems of the person and their families. Develop surveillance systems for those at risk. Supporting self-care / carer education.
- **Choose to Admit:** Development of emergency response systems by identifying people with a crisis, making positive choices to admit to acute care, building capacity and responsiveness for safe and effective service provision in people's homes or in step-up care as alternatives to hospital admission.
- **Ambulatory Care:** Full ambulatory same day assessment (including Comprehensive Geriatric Assessment) and investigation emergency care service for acute episodes requiring hospital level support, preventing admission**.**
- **Specialist Acute Care:** Development of acute care systems to ensure that frail older people are identified, have early access to old age specialist teams, and receive Comprehensive Geriatric Assessment in medical / surgical hospital beds / hospital at home services. Increased GP involvement within the hospital.
- **Discharge to Assess:** Develop capacity and responsiveness of community based post-acute care services. Ensure that older people are transferred quickly, receive further assessment and care in their own homes / intermediate care beds, with triage to appropriate settings using trusted assessment systems.
- **Recovery Before Placement:** Development of systems to ensure that older people can access up to six weeks of rehabilitation and reablement prior to provision of long term support services.
- **Every Moment Counts:** Development of systems to provide frail older people and their families with opportunities and information to develop anticipatory care plans ensuring that they have choice and control in decisions about their treatment / care settings in the last stage of their lives.

Underpinned by enabling workstreams; Technology Enabled Care, Mental Health, Orthogeriatrics, Workforce Transformation, User Panel.

Metrics: Higher levels of independence in older people, reduction in long-term placements, reduced non-elective

hospital admissions / readmissions, improved Patient Reported Outcomes and Patient /Carer/ Staff satisfaction.

It is expected that these actions will exceed the efficiencies of the Five Year Forward View, reducing hospital admissions by 10-20% over the age-adjusted expectations / reducing discharges into long-term residential care.

Q3. What have you already achieved?

- Embedded culture of trust, co-operation, co-production and system leadership amongst community, clinicians, managers, politicians.
- Shared Project Management; clear governance processes enabling alignment across the multiple organisations and joint communications delivering consistent narrative.
- Established 'Joint Directors of Finance Board'; cited as best practice, incentivising integration across multiple providers, focussing on alliance contracting, shared budgets, outcomes / incentives.
- Signed Caradigm agreement*;* GE and Microsoft partnership ensuring everyone involved in healthcare delivery can access the right information at the right time. Provides analytics, risk stratification, automates workflow, co-ordinates care across the system.
- EASYCare Pilot; assessment tool used for identifying threats to health, independence, wellbeing, physical, mental and social functioning in old age, mobilising a community response. International EASYCare Research Centre (moving to Solihull).
- Final stage GP provider arm formation incorporating all practices in Solihull. Delivery of Delivering Excellence Contract.
- Integrated monthly care metrics.
- Discharge to assess; including specialist dementia beds.
- 'Frequent Callers' Project initiated with ambulance service.
- Health Service Journal award winning Supported Integrated Discharge Team (integrated with Social Care) and Integrated Community Teams live 1/7/15.
- Mental Health: Rapid Assessment and Integrated Discharge, Dementia/ Delirium Outreach Team, Street Triage with police / ambulance service / Mental Health.
- Admissions avoidance; Integrated Community Teams.
- Joint Masters level clinical leadership programme.
- Oak Group audit; Solihull Hospital has lowest levels of non-qualified admissions in the country.
- Advanced Care Practitioner programme; 250 being trained over 5 years, working across system.

Q4. Where could you get to by April 2016 and by April 2017?

April 2016:

- Deliver 'Frequent Caller' project objectives; reduced attendances / admissions / 999 calls (**Autumn 2016:** Solihull Clinical Commissioning Group).

- 7 Day Solihull Social Services assessment / brokerage (**December 2015**: Director of Adult Social Services).
- Transfer learning to Heartlands and Good Hope sites **(Ongoing:** Deputy Medical Director).
- Highly developed Frailty Programme Board (**September 2015:** Deputy Medical Director).
- Overarching Trust strategy (**September 2015)** with partnership wide plan for Solihull Hospital Community Services / community services (**January 2016:** Director of Strategy).
- Completed Urgent Care Centre procurement (Construction begins **January 2016**. Pathways in situ by **Aug 2016**. Forecast opening November **2016:** Heart of England NHS Foundation Trust Chief Executive, Accountable Officer Clinical Commissioning Group).
- Development of Ambulatory Care Centre (top 10 presenting conditions). Urgent Care Centre opens (**Nov 2016)**. Service moves allowing expansion (frail elderly focus) and ability to perform Comprehensive Geriatric Assessment and social assessment (**November 2016:** Head of Hospital Transformation).
- Effective discharge to assess models, reduction in re-admissions (**April 2016:** Deputy Medical Director, Director for Adult Social Care).
- Established training cohorts of Advanced Clinical Practitioners*. First cohort on Medical Leadership programme. **(Begins July 2015:** Clinical Director for Advanced Clinical Practitioner Programme).

  Cohorts bi-annually (25) for 5 years across system sharing learning. 30 already in place.

April 2017:

- Full-scale implementation of population risk stratification with care co-ordination shared locally and across network / work of national bodies (**April 2017**: Head of Integrated Care and Support Solihull and Deputy Medical Director).
- Meet national benchmark of 30% of all admissions managed through ambulatory care pathways (**April 2017**: Deputy Medical Director).

Q5. What do you want from the structured support programme?

We are committed to engage intensively in the support programme. Requirements include:

- Support / expertise in trialling new payment methods, performance measures , developing new coding and systems fit for transformational models of care of the future.
- Learning from similarly challenged organisations regarding models of care proposed in the Keogh Review and international comparators.
- Legal forms and contractual models, capitated payment arrangements, risk management.