NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group Governing Body
Paper Summary Sheet
Date of Meeting: 26 July 2016

For: PUBLIC session ☒ PRIVATE Session ☐

For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	**GOV/16/07/13 Optimising Integrated Teams**
Author:	Neal Goodwin – Senior Commissioning Manager, Wiltshire CCG
Lead Director/GP from CCG:	Ted Wilson – Community & Joint Commissioning Director, Wiltshire CCG Dr Toby Davies – Wiltshire CCG Community Services Clinical Lead
Executive summary:	In 2014 Wiltshire CCG led a programme of work to optimise the provision of adult community care through Community Teams. The work programme also included the creation of the infrastructure around which Integrated Teams (IT) could be built. Integrated Teams are an integration and collaboration of the providers of Primary Care, Community Health Care, Adult Social Care, Mental Health care and voluntary care, in a virtual and physical team whose purpose is to look after the physical, mental and social care needs of their local populations. Integrated Teams however are not actually commissioned by any one single organisation. As such there is no accountable organisation responsible for their direction or output. The different elements of the Integrated Teams are commissioned separately by different organisations and are therefore managed separately against their respective contracts. Integrated Teams in Wiltshire have subsequently developed differently in their respective localities and at different paces. There is a lack of clarity around what ITs are expected to 'deliver', how they should be operating and who is accountable for them. There is however a set of outcomes that have been previously agreed by all stakeholders against which the outputs of ITs can be measured. These outcomes are at Appendix 1. This paper has been taken to and discussed at the Wilts CCG 'Out of Hospital Clinical Executive Board' meeting on 12th July where it was agreed that the future development of the Integrated Teams should be led by the Groups in support of their ITs in their localities.

	GPs are expected to champion the leadership of their teams supported by their respective Locality Managers. The Groups should support the ITs to develop their own local approach with success on the delivery of patient outcomes measured locally within the Groups through peer review. The CCG should be supportive where required and Locality Managers should work with the Integrated Teams to facilitate their development and progress. Learning should be shared amongst teams locally and more widely as appropriate. The purpose of this paper is: • To reiterate the rationale for Integrated Teams – 'Concept of Operations' – The higher intent • To reiterate the expectations if Integrated teams – what should they be delivering • To highlight key enablers and barriers • To investigate the role of the MDTs • To make recommendations The Governing Body is being asked to consider the following recommendations: • The Executive Groups should action and support localities to deliver successful ITs with a focus on patient outcomes. • The Executive Groups should compile evidence of what each of their ITs have undertaken. • The Executive Groups should consider organising learning events to showcase the ITs work and encourage peer review. • The Executive Groups and ITs to consider how they engage with the local public regarding their experiences and expectations
Evidence in support of arguments:	The creation of ITs was part of the Transforming Community Care initiative, the aims of which were to create a sustainable care system built around individuals and local communities, with leadership from Primary Care. Health and Social Care professionals would be supported to work together more effectively to promote independence improve self-care, prevention and early intervention and reduce the costs to the Health and Care economy of inappropriate crises in the system. Wiltshire Council, Wiltshire CCG and Community services provider committed to work together to develop a programme of work which would involve customers, health and care providers and the voluntary sector in the process. Integrated Teams are a critical component and enabler of the CCGs 5 year plan and the vision of the Health and Well Being Strategy (H&WB) where health and social care services in Wiltshire should work seamlessly together to support and sustain healthy,

	independent living. Specifically the 'I' statements in the IT outcomes align directly with the Empowered Lives aim in the H&WB strategy. "*The vision we have is that in cluster areas we will develop Integrated Teams who can look after the physical and mental health and related social need of their local population in one Integrated Team*." (Dr Simon Burrell, August 2014)
Who has been involved/contributed:	Ted Wilson – Community & Joint Commissioning Director, Wiltshire CCG The paper has also been shared with stakeholders from the Acute sector, Healthwatch, Wilts Council, community and other health economy providers
Cross Reference to Strategic Objectives:	Aligns with Wiltshire CCGs strategic objectives for Transforming Community services in its 5 year plan Aligns with the strategic objectives of the Joint Health & Well Being Strategy 2015-18
Engagement and Involvement:	This paper has or will be taken to: • Wiltshire CCG EMT • BCP Steering Group 6 July 2016 • Wiltshire CCG Out of Hospital Clinical Executive Board 12 July 2016 • Joint Commissioning Board 2 August 2016 • Wiltshire CCG Governing Body 26 July 2016
Communications Issues:	None
Financial Implications:	There are no financial implications
Review arrangements:	To be discussed and agreed
Risk Management:	There is a risk that Integrated Teams will not achieve their full potential without the total commitment of all strategic partners to their development. The purpose of this paper is to raise this issue for discussion and decision.
National Policy/ Legislation:	Five Year Forward View
Public Health Implications:	Public Health has a significant role in providing up to date data and information for Integrated Teams. The mechanisms for facilitating this need to be explored further.
Equality & Diversity:	An Equality and Impact Analysis is attached

Other External Assessment:	This paper has been shared with Healthwatch
What specific action re. the paper do you wish the Governing Body to take at the meeting?	The Governing Body is being asked to consider the following recommendations: • The Executive Groups should action and support localities to deliver successful ITs with a focus on patient outcomes. • The Executive Groups should compile evidence of what each of their ITs have undertaken. • The Executive Groups should consider organising learning events to showcase the ITs work and encourage peer review. • The Executive Groups and ITs to consider how they engage with the local public regarding their experiences and expectations

Optimising Integrated Teams

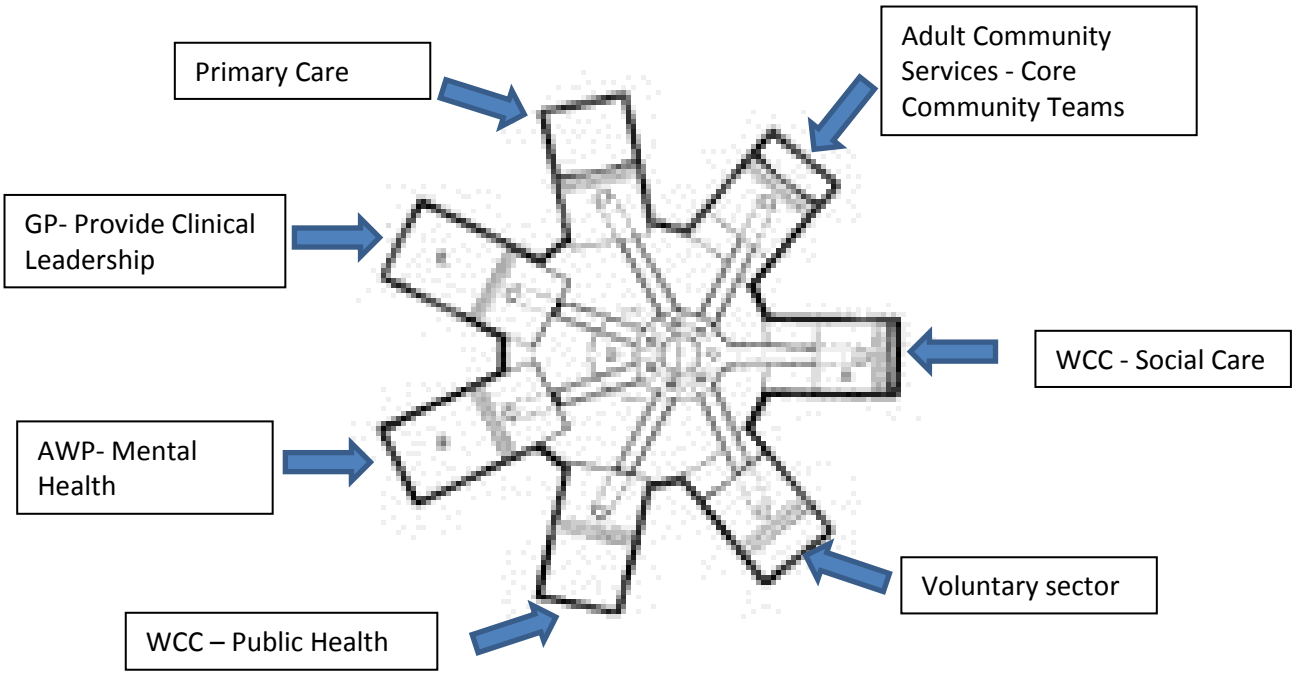
Purpose

- **To reiterate the rationale for Integrated Teams – 'Concept of Operations' – The higher intent**
- **To reiterate the expectations if Integrated teams – what should they be delivering**
- **To highlight key enablers and barriers**
- **To investigate the role of the MDTs**
- **To make recommendations**

The Context

"*Integration will only improve the experience of people using services when we all work together to ensure that we are integrating services as an effective means for achieving better outcomes. When we refer to 'integrated health and social care', we mean services that are planned and delivered seamlessly from the perspective of the patient, service user or carer*."(Scottish Government)

For the purpose of clarity throughout this paper, Integrated Teams (IT) are made up from the core community team (nurses, therapists etc) representatives from Adult Social Care, mental health services and the voluntary sector, all based around and clinically led by GPs and primary care. The core community team element of the IT are part of the adult community services contract and therefore directly commissioned by the CCG, as are the mental health services. Integrated Teams are a 'concept' based on key strategic partners working more effectively together; they are not actually commissioned. The best way to describe an Integrated Team is as an engine.



Each of the cylinders represents a partner in the team. For the team to be optimised they all need to be firing and working in time. The general perception at the moment is that in many ITs across Wiltshire, some cylinders are not firing at all and those that are, are not in time.

The Integration, or the delivery of any outcomes associated with Integration or Integrated Teams, cannot happen without unequivocal commitment and ownership, both intellectually and practically at the most senior level down by all organisations involved in its delivery. This should deliver:

- continuous dynamic and motivational leadership
- Real support in the availability of people, time and resources

It is widely agreed that integrated structures themselves do not automatically lead to integrated practices. Integration is not simply about infrastructure; rather it is a way of thinking, requiring a shared vision and values and a commitment to compromise across all stakeholders.

The core components of a successful integrated care strategy are:

- Defined populations that enable multidisciplinary care teams to develop a relationship over time with a 'registered' population or local community, and so to target individuals who would most benefit from more co-ordinated approach to the management of their care
- Aligned incentives that encourage the management of health and care need in primary and community care settings that help prevent admissions and length of stay in hospitals and nursing homes
- Availability of data to improve quality and accountability to stakeholders through public reporting
- Information technology that supports the delivery of integrated care, especially via the electronic medical record, the use of clinical decision support systems, and through the ability to identify and target 'at risk' patients
- the use of guidelines to promote best practice, support care co-ordination across care pathways, and reduce unwarranted variations or gaps in care
- An effective partnership between Health and Care professionals and Management to make the best combined use of their respective skills
- Effective leadership at all levels with a focus on continuous quality improvement
- A collaborative culture that emphasises team working and the delivery of highly co-ordinated and patient-centred care
- Multispecialty groups of health and social care professionals in which, for example, generalists work alongside specialists to deliver integrated care
- Patient and carer engagement in taking decisions about their own care and support in enabling them to self-care – 'no decision about me without me'

Below are some key enablers and barriers to effective Integrated Care:

Enablers

- A shared vision of the case for change between GPs, local authorities, and other partners
- Strong, courageous and persevering leadership, particularly from local professionals
- Sufficient time spent building relationships, developing a shared culture and Governance between organisations
- Involvement of people and communities as key partners in designing services
- Proactive provision of information and support to help people make decisions about their own care
- Sharing information between all providers involved in an integrated journey of care
- Joint commissioning between health and social care based on shared vision and ideally budgets
- Using flexible funding models and innovating around existing incentives
- Alignment of governance procedures, staff management and training

- Leadership investment in supporting behavioural change and shared ambitions within providers
- Responsiveness to feedback of frontline staff
- Strong commissioners prepared to follow through on a vision to integrate around the needs of patients
- Sharing of activity and performance data between commissioners and providers
- Anticipation and mitigation of side effects of service changes, such as initial 'double-running' of services

Barriers

- Repeated structural change prescribed centrally
- Lack of clear shared vision and expectations among all parties involved
- Lack of strong leadership or organisational alignment
- Lack of attention to issues of culture, staff engagement, behaviour and training to deliver change
- Lack of interest from local GPs, local authorities or other organisations in new ways of working
- Lack of shared culture, language, governance and operating procedures between organisations and sectors
- Insufficient investment in service improvement and project management
- Failure to remove or address conflicting incentives
- Existing payment regimes and information systems
- An expectation that integration will always improve care or reduce costs
- Disparities between commissioners in funding available – particularly between health and local authorities
- Reluctance among providers to share performance data
- Lack of suitable premises in the community for new services
- Provider financial models which dis-incentivise integration

What's Happening Now

In order to provide an understanding of the rationale for Integrated Teams from a CCG perspective and how the above core components can be delivered, there is no better way than to quote from the letter sent from the Clinical Lead for Community Services, Dr. Simon Burrell, to North and East GPs (and made available for WWYKD and Sarum) at the start of the process in August 2014.

"The vision we have is that in cluster areas we will develop Integrated Teams who can look after the physical and mental health, and the related social need of their local population in one integrated team. That team and its leadership will be based around local GP practices; they will have access to specialist support and will be connected to secondary care by a simple point of access. Under the current commissioning arrangements the teams will also have a significant responsibility to ensure the local health care budget is managed effectively.

There are many reasons why we are doing this; we are experiencing on a daily basis the effects of our growing frail elderly population and the increasing need for primary and community based care and support. We all want to do more and the only way to genuinely achieve this is for all of us to work together, as one integrated team, sharing knowledge, experiences and responsibility for the care and well-being of our population.

What this means is that we aim to increase the number of people who feel supported to manage their own conditions, reduce where possible emergency admissions to, and the lengths of stay in hospital, and reduce the number of permanent admissions to residential or nursing care homes. This will be achieved by effective collaborative working.

All successful teams need good leadership. It has been proposed by the CCG that the new Integrated Teams are led by the GPs in the practices they encompass. This leadership will need to be co-ordinated between the practices and take account of your local circumstances. The CCG has no blueprint for how this will work but plans for how things develop in each area will be formulated by the practices in each cluster working together with the community staff within the Integrated Team to decide the best way forward for all parties. This view has been agreed with the community provider trust and with social care.

As the changes take place we expect to see closer working between practices and the rest of the wider community teams. For many the first stage of this might be to look at how do we as practices in the team work together, do you share a common view? At your first meetings together you may also want to ask yourselves:

- *As an Integrated Team, how can we work together for the benefit of our patients and customers?*
- *Are there any issues or hurdles that are preventing that happening right now?*
- *If there are, are they in our gift to resolve?*
- *If not how can we work with or around them until we can engage others to help resolve them?*

Over the next few months we expect not only the existing community teams to work more closely with practices, but also some elements of social care and the community elements of mental health care. To be successful the practices will need to extend themselves towards the community staff as well as the community staff moving to work more closely with practices. For some this may be common practice but for others it may be a new way of working. Either way this collaborative way of working where the patient is truly at the centre of all decision making is the only way that genuine integrated care can be delivered. A two-way process is more likely to ease the overall workload more effectively than one where practices sit and wait for the community teams to make all the changes.

As part of the process to develop the formal documentation for the procurement of the adult community services contract in April 2016, the CCG has developed a draft 'outcomes framework' which essentially sets out what we want to achieve from the whole community transformation process. The list of outcomes is not exhaustive and practices have the opportunity to add to them and adopt and flex them to match more local needs.

The framework sets out a simple view of what we are expecting of the Integrated Teams. Teams need to interpret and translate the outcomes described in the document and turn them into benefits and outcomes that are meaningful to them at a local level. We should all have a set of outcomes that, at a local level, we own and support, that feed the delivery of the benefits of the wider programme." (Dr S Burrell, T Wilson Aug 2014)

The Prize

Better care experiences and improved care outcomes delivered more cost-effectively are the benchmarks by which integrated care should be judged. Integrated care is best understood as a strategy for improving patient care. The service user is the organising principle of integrated care.

"*It was clear from what we heard around the country that patients and carers are often the most passionate advocates of integration, and the most effective agents for delivering it. Patients and their families live with and manage their conditions day-in and day-out, unlike professionals. Every day, patients and their carers navigate and improve their complex care journeys. They obtain information, seek explanations, make choices, chase lost appointments and fill gaps in data. Carers, patients and non-professionals can become a greater part of the solution and their contribution and input should be recognised*." (Integration – A Report from the NHS Future Forum 2012)

In recognition of the importance of integrated care to service users, Wiltshire CCG, Wiltshire Council, the adult community services provider and other partners have agreed a set of outcomes. These are shown at **Appendix 1**. Within these wider outcomes are some patient focussed outcomes formulated as 'I statements'. Any measure of the success of Integrated Teams and their services should seek to evaluate the user response to the effective delivery of these outcomes:

- My care is planned with people who are working together to understand my needs and those of my carers
- I am involved in all decisions about me and my care
- I am always kept informed and always know who to contact if the need arises
- I don't have to keep repeating myself to lots of different professionals
- I have a named person to go to when I need them
- I understand my condition and how it will affect me
- I have a plan to help me cope If things get worse
- I have good advice and sufficient information so I know how to look after myself and stay well
- I have a local support network around me that meets my wider (holistic) needs
- I am clear about what personal responsibility I hold for managing my ongoing health and wellbeing
- I know that the needs of my family, carers and friends will also be taken into account

The patients that are likely to benefit most from these programmes need to be identified, and a combination of predictive software (Risk Stratification) and professional judgement across health and care providers, including mental health, seems to offer the best approach.

Delivery - The MDT

The Multidisciplinary Team (MDT) approach is at the heart of any initiative to deliver integrated care and one that has been adopted by The CCG, Wiltshire Council the adult community services provider and other key partners and stakeholders. How that operates and is led in practice is pivotal to its success. The importance of leadership however cannot be overstated:

- Leaders play a pivotal role in the success of integrated care
- Effective leaders are characterised by their sustained long-term commitment, enthusiasm and involvement to integrated care locally
- Leaders will exist and are essential at all levels
- Leaders need the skills and strategies necessary to understand, influence and lead the local agenda in the design, commissioning and delivery of integrated care
- Leaders in the NHS, local government and the third sector must take the initiative and promote integrated care, rather than adopt a fortress mentality focusing on the survival or growth of their own organisations

Whilst there is no 'blueprint' for a successful MDT, evidence shows that whilst co-location is the preferred position, regular face to face meetings, shared data, frequent open communication, shared experiences and trust are all essential. Teams should identify from their own perspective (Health, Social Care or Mental Health) their high risk patients, share any appropriate information and discuss, in their MDT, a coordinated approach to care. The output of a successful team is a shared and crucially 'jointly owned' care plan with a coordinated approach to future care. The outcomes will be those experienced and reported by service users listed in the 'I Statements' above.

A report carried out by RiPfA (Research in Practice for Adults) on the three demonstrator sites recognised the variations in approach between the three teams and made recommendations on how to improve the operation across all other teams. The CCG with its strategic partners must decide how prescriptive it should be in providing direction to the Integrated Team and in particular the operation of the MDT.

What Next

The optimisation of Integrated Teams and therefore the delivery of seamless, integrated care seems to have slowed in parts of Wiltshire. Before attempting to address this however, the CCG with its key strategic partners must be clear on what it wants the ITs to achieve, what are the expectations of them.

How closely should the ITs be 'managed' in order to achieve greater optimisation. How prescriptive should the guidance be for the operation of ITs? There is a balance to be achieved between localism and strategic control and direction? The key to this is agreeing the expectations of ITs, what IT optimisation looks like and what will it deliver?

Previous decisions by the CCG have allowed ITs to develop locally and at their own pace led by GPs and primary care. Previous attempts to apply a structure around that with 'Team Development Plans' were rejected early in the development process.

Raising the profile once again therefore of ITs and the expectations of them will necessitate the engagement of GP leaders and having in place the unequivocal backing and support of executives (clinical and non-clinical) from all stakeholder organisations.

This paper has been taken to and discussed at the Wilts CCG 'Out of Hospital Clinical Executive Board' meeting on 12th July where it was agreed that the future development of the Integrated Teams should be led by the Groups in support of their ITs in their localities. GPs are expected to champion the leadership of their teams supported by their respective Locality Managers.

The Groups should support the ITs to develop their own local approach with success on the delivery of patient outcomes measured locally within the Groups through peer review. The CCG should be supportive where required and Locality Managers should work with the Integrated Teams to facilitate their development and progress. Learning should be shared amongst teams locally and more widely as appropriate.

Recommendations

- The Executive Groups should action and support localities to deliver successful ITs with a focus on patient outcomes.
- The Executive Groups should compile evidence of what each of their ITs have undertaken.
- The Executive Groups should consider organising learning events to showcase the ITs work and encourage peer review.
- The Executive Groups and ITs to consider how they engage with the local public regarding their experiences and expectations

Appendix 1

Outcomes and Principles Framework Document for Integrated Teams (incl Core Community Teams)

This document reflects the vision articulated in the CCGs 5 year plan for the delivery of integrated community health and social care services across Wiltshire based on Integrated Teams (ITs), covering populations of circa 20,000 people across a number of local GP Practices and providing holistic and seamless care for their populations in a predominantly community setting**.** Integrated Teams will test out how integration around clusters of GP practices will interface with Community Areas and Community Area Boards.

Primary and community teams are currently made up of a variety of individuals, from a variety of different agencies working from a variety of different premises using a variety of different IT systems that all converge together around the patient. There are examples of duplication, administrative inefficiency with deficiencies in communication and coordination. This can result in at best delay and at worst inappropriate pathways of care.

There is an increase in numbers of elderly residents, both at home and significantly in residential and nursing accommodation and an increasing dependence on expensive social and secondary care medical services. With increasing regulation, such as CQC, organisations are becoming risk averse with a risk of over-medicalisation. Patients and their carers can feel increasing insecure, unsupported and lose confidence in their capabilities to self-care.

This document outlines the Outcomes, Outputs and Activities that are required to deliver the transformation of community services outlined in the CCG 5 year plan

IMPACT:

To change and improve the way adult health and social care services are delivered in Wiltshire by shifting the priority for and the provision of care to the home or the community.

Ultimate OUTCOMES:

- Effectiveness of primary and community care is maximised.
- Delayed transfers of care from hospital are reduced.
- Non elective admissions which can be influenced by effective collaboration across the health and care system are reduced.
- More people feel able and supported to manage their (long term) condition(s).
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes reduced.
- People die in their preferred place of care.

Intermediate OUTCOMES:

- Wiltshire Community Health and Social care services are able to support the care of more people in or closer to their own home
- Patients are encouraged and supported in prevention and self-management
- Quality of patient care is improved
- Access to and speed of response of care is improved
- The customers/patients express satisfaction with the health and care services they receive
- People with mental health issues are seen and treated with the same priority as other long term conditions
- Communication processes and collaborative ways of working are in place and delivering effective holistic coordinated care
- Patients/customers are ideally getting one assessment (that meets the requirements of all agencies involved in the care of the person)

Immediate OUTCOMES:

- Community Teams and primary care are working collaboratively and in partnership to deliver care
- Appropriate patient information is being shared effectively within the teams to support quality care
- Patients are ideally getting one assessment (that meets the requirements of all agencies involved in the care of the patient) and have a personalised care plan that they have been involved in creating.
- Improved use of community resources will be made
- Family carers are supported appropriately
- Each Team is proactively managing the health and social care needs of the residents of Care Homes within their population
- Teams are proactively working with secondary care providers to support the timely discharge of medically stable people
- Effective end of life care is provided by all teams that meets the CCG recommendations (TBC – to include the replacement of the LCP)

OUTPUTS:

- Community Teams with the appropriate skills and competencies to manage complex patients with a higher acuity (than managed currently) are in place
- Fully functioning Integrated Teams in place with access to partners from Social Care, Mental Health, Domiciliary Care and other voluntary sector organisations
- Agreed effective ways of working locally agreed and in place
- Training programme developed and delivered
- Local arrangements for MDT working agreed
- Effective community geriatrician service agreed and in place
- Community diagnostics are available when and where necessary
- Team 'at risk' lists have been created and care plans for those individuals are in place
- An effective data/information sharing and access protocol is in place

ACTIVITIES:

- Restructure and create (Community Teams and) Integrated Teams
- Agree shared values and vision
- Develop and deliver a training programme to enhance core skills
- Develop effective partnership ways of working between primary care, community teams and other integrated team partners
- Discuss and develop agreed and effective communications processes
- Set up and agree MDT local ways of working
- Agree outcomes and shared performance measures
- Develop an effective community geriatrician service
- The availability of community diagnostics is discussed and a plan agreed

OUTCOMES For individuals – (the patients/people)

- My care is planned with people who are working together to understand my needs and those of my carers
- I am involved in all decisions about me and my care
- I am always kept informed and always know who to contact if the need arises
- I don't have to keep repeating myself to lots of different professionals
- I have a named person to go to when I need them

- I understand my condition and how it will affect me
- I have a plan to help me cope If things get worse
- I have good advice and sufficient information so I know how to look after myself and stay well
- I have a local support network around me that meets my wider (holistic) needs
- I am clear about what personal responsibility I hold for managing my ongoing health and wellbeing
- I know that the needs of my family, carers and friends will also be taken into account

OUTCOMES for Staff – (within the Community Care Teams/ Integrated Teams)

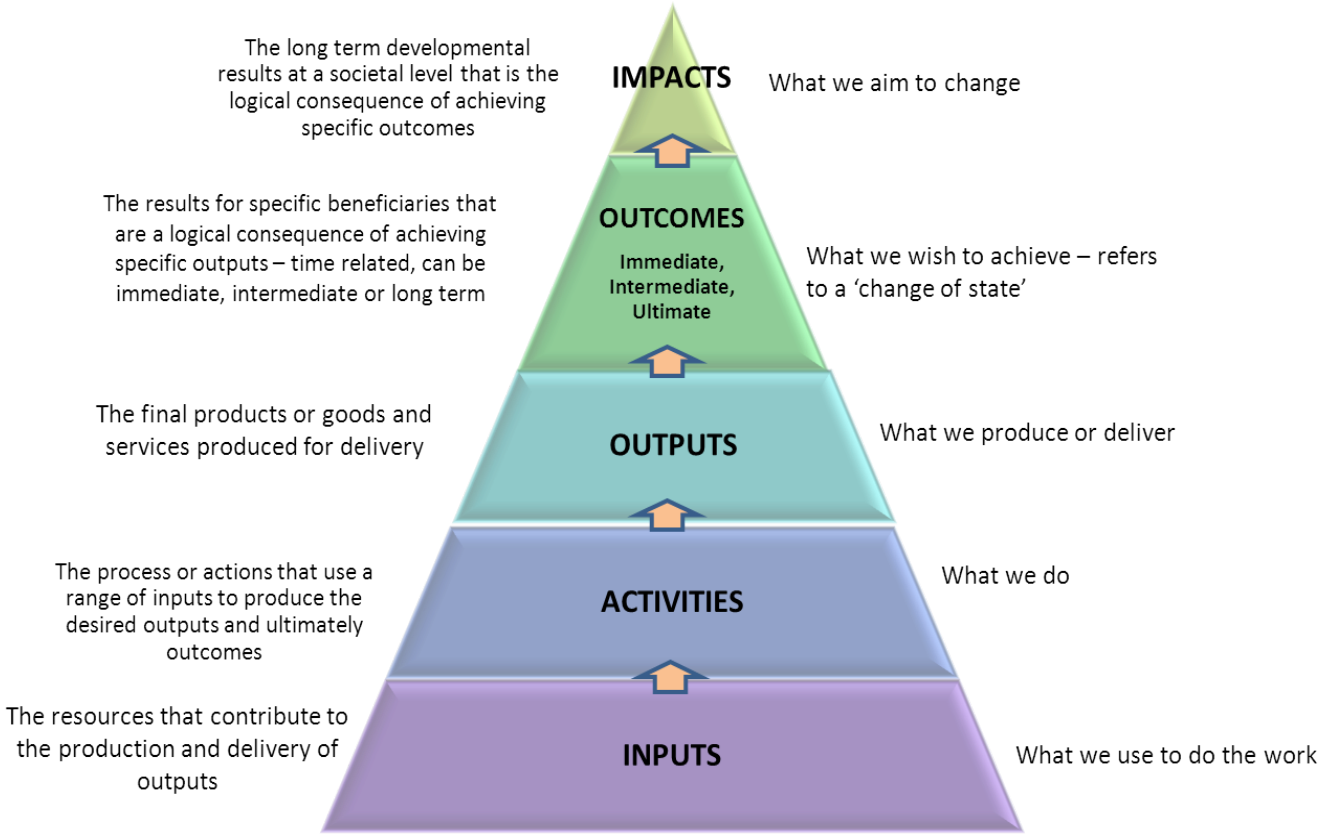
- I work as part of a team which has enough shared resources (staff and equipment) to carry out the tasks required of it
- I understand my role the roles of those within my Team and how my role fits within the team
- I know who to go to for a response if I have questions or am concerned about an individual patient or customer
- I have the right information or know where to get it to be able to provide the right support and care
- I have the right skills to meet my patient's needs and a plan to develop my skills where necessary
- I am part of a team that is well led, well managed and well supported at all levels
- I am part of a team that works in a collaborative way to put the patient at the centre of all of its decisions
- I am part of a team that has been empowered to take responsibility for its decisions and actions relating to its patients
- I am part of a team that has devolved responsibility and accountability for appropriate commissioning (and in time budgetary) decisions
- I am part of a team that is encouraged and supported to think innovatively about the care it provides
- I am encouraged and supported to talk to patients and their carers about how they share and take personal responsibility for their healthcare and wellbeing
- I know that the right relationships are in place above me to ensure that I can function as part of a team in the health and social care system.

Guiding Principles

- Services will be developed locally based on experiences and evidence from people who use services
- Services will be focussed on delivering positive outcomes for patients/customers
- GP Practices in each cluster to work together and learn from each other to provide clear and effective clinical leadership and direction for the wider Integrated Team (IT)
- The CCG and Community Services Provider(s) to provide clear and understood devolvement of governance to teams
- Each Team will need to have clear and agreed ways of working and communicating with other providers, to include mental health; social care, domiciliary care, friends and family networks and voluntary sector workers
- GPs within each Team provide clinical leadership for the whole Team and take clinical responsibility for the local health provision of their cluster population.

- Each organisation contributing to Integrated Teams will be responsible for line management and professional leadership of the different roles within the team. Organisations will work together within the spirit of collaboration to ensure services are coordinated.
- Each Team ensures that any barriers between domiciliary and non-domiciliary care are broken down to enable the delivery of care in the most appropriate place by the most appropriate person
- Each Team promotes self-care as far as possible
- Every over 75 year old and those patients "at risk" in each cluster is assigned a named GP from their GP Practice
- Care is co-ordinated for all older people, particularly to support those cohort of patients "at risk" of deterioration and hospital admission so that the person at the receiving end feels in control.
- Specialist clinical staff are working with the Teams to support, mentor and develop their levels of competence and are available to provide more expert advice and support when necessary
- All services will be measured on outcomes
- The Teams will have a clinical governance and in time a budgetary responsibility and accountability for the health needs of their cluster population
- The Teams are clear about what return on investment means and the outcomes they are expected to achieve e.g. admissions avoided
- Each team will create and optimise the alternatives to hospital to reduce reliance on (hospital) secondary care
- Personal responsibility is articulated to patients and carers

The outcomes pyramid below shows a simple view of the outcomes based model.



NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: **Optimising Integrated Teams**

For the record	
Name of person leading this EIA: Neal Goodwin	Date completed; 08/07/2016
Names of people involved in consideration of impact: Ted Wilson	
Name of director signing EIA – Ted Wilson	Date signed – 08/07/2016

What is the proposal? What outcomes/benefits are you hoping to achieve?

In 2014 Wiltshire CCG led a programme of work to optimise the provision of adult community care through Community Teams. The work programme also included the creation of the infrastructure around which Integrated Teams (IT) could be built. Integrated Teams are an integration and collaboration of the providers of Primary Care, Community Health Care, Adult Social Care, Mental Health care and voluntary care, in a virtual and physical team whose purpose is to look after the physical, mental and social care needs of their local populations.

Integrated Teams however are not actually commissioned by any one single organisation. As such there is no single accountable organisation responsible for their direction or output. The different elements of the Integrated Teams are commissioned separately by different organisations and are therefore managed separately against their respective contracts.

Integrated Teams in Wiltshire have subsequently developed differently in their respective localities and at different paces. There is a lack of clarity around what ITs are expected to 'deliver', how they should be operating and who is accountable for them. There is however a set of outcomes that have been previously agreed by all stakeholders against which the outputs of ITs can be measured.

The following recommendations are to be considered:

- The Executive Groups should action and support localities to deliver successful ITs with a focus on patient outcomes.
- The Executive Groups should compile evidence of what each of their ITs have undertaken.
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Benefits of effective Integrated Teams:

- A multi-disciplinary team focus for customers and patients
- Assessment, diagnosis and delivery of interventions and agreed packages of health and social care for people in a range of settings and at a level of quality that meets national and locally agreed standards
- Improvements in the health and social well-being of individual customers/patients and their carers
- Patients able and supported to self-care and self-manage

- Reduced dependency on hospital in-patient services through the use of admission avoidance pathways
- Proactive support for hospital discharge in order to reduce length of hospital stay
- Timely and accurate diagnosis and referral to other services (statutory and non-statutory)
- Joint working across all relevant agencies and service providers to ensure seamless service provision across care pathways and timely transfers of care
- Reduced health and social inequalities
- Reduced duplication of care
- Personalised action/care plans for people with long term conditions especially those at risk of repeated admission to hospital.

Who's it for?

All adult Wiltshire residents registered with a Wiltshire GP identified as being 'at risk' of requiring a hospital admission

How will this proposal meet the equality duties?
Wiltshire CCG has a duty to promote: equality of opportunity, good relations and positive attitudes, and to eliminate unlawful discrimination. This proposal is for all adult customers/patients without exclusion irrespective of gender, race, disability, religion, sexual orientation or economic status

What are the barriers to meeting this potential?
Customers/patients not registered with a Wiltshire GP will not be able to access this service

2 Who's using it? Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?
Current analysis of activity data suggests that predominantly it is the frail and elderly patients with multiple long term conditions who will come under the auspices of the Integrated Teams. It is also recognised that some patients who are referred to the Integrated Teams may not have English as their first language.

How can you involve your customers in developing the proposal?
Service users have been engaged and involved throughout the transforming community services process and will continue to be.

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)
No Gaps currently identified

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation
and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?

Children are not supported by the Integrated Teams. They are however supported by the commissioning of services nationally and locally through children's community services and Public Health.
Homeless patients who are not registered with a GP will be supported by the voluntary agencies and will sign post patients to a GP

What can be done to change this impact?
Currently no further action is required

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for

other groups?

The proposal will create benefit in particular for elderly patients with multiple long term conditions. Any patient deemed at risk of emergency admission with comorbidities/LTC may benefit from the service.

Does further consultation need to be done? How will assumptions made in this Analysis be tested?
On-going engagement will take place during 2016/17 with stakeholders including Healthwatch

4 So what? Link to business planning process

What changes have you made in the course of this EIA?
None

What will you do now and what will be included in future planning?
Evaluations will identify any changes required to service provision in the future

When will this be reviewed?
EIA will be reviewed if service provision changes

How will success be measured?
By monitoring locally developed metrics designed to gauge success at delivering agreed outcomes and by engaging with the public to seek their thoughts and expectations.