South Devon Healthcare NHS
NHS Foundation Trust

Torbay and Southern Devon Health and Care NHS
NHS Trust

# South Devon Integrated Care Organisation (ICO)

## *'Right care, right place, right time, ONE TEAM'*

## How will it feel different?

Rob Dyer, Consultant Endocrinologist and Clinical Lead for the ICO

# Integrated care and support: a bid for pioneer status

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."


South Devon and Torbay Clinical Commissioning Group
South Devon Healthcare NHS Foundation Trust
Torbay and Southern Devon Health and Care NHS Trust
Torbay Council
Devon Partnership NHS Trust


**Supported by:**

Devon Health and Wellbeing Board
Torbay Health and Wellbeing Board
Devon County Council
Rowcroft Hospice
South Devon and Torbay Strategic Public Involvement Group
Northern, Eastern and Western Devon Clinical Commissioning Group



This bid is submitted with the backing of our neighbouring Northern, Eastern and Western (NEW) Devon CCG.
As a pioneer, we would work closely with NEW Devon and our joint partners to extend the learning across a combined population of more

# Formation of an Integrated Care Organisation (ICO) through the merger of South Devon Healthcare Foundation Trust and Torbay and South Devon Health and Care Trust

***Just*** the joining together of 2 provider organisations?

# We want our services in the ICO to

- Improve people's experiences of health and care;
- Ensure that people have a bigger say in the priorities we set and the care we provide;
- Support people in taking responsibility for improving their wellbeing and in managing their own health;
- Reduce inequalities in health and care;
- Continue to support and develop a motivated, flexible workforce with the right staff and right resources in the right place; and
- Maintain a financially stable and sustainable health and care system for the long term.

# Financial challenges and advantages of ICO

Merger of SDHFT and TSDHCT is the best solution to:

- Achieve integration of services at scale and pace and to achieve associated economies
- Reduce running costs of the 2 organisations
- Ensure the long-term viability of both organisations

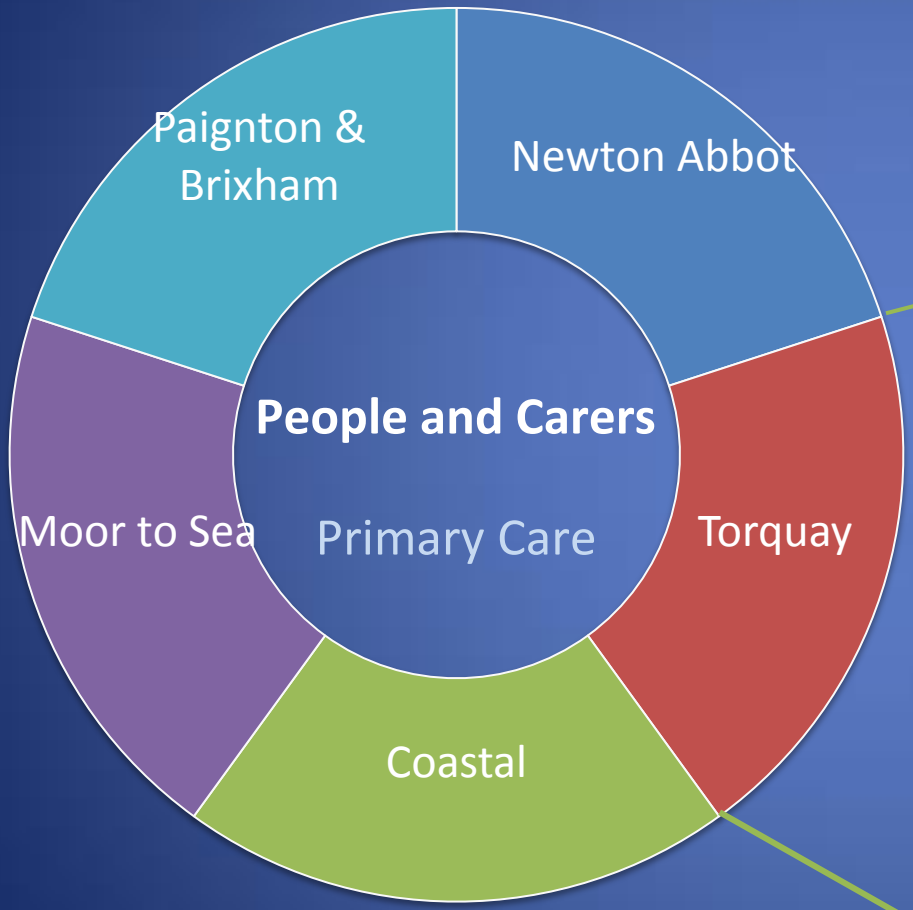
# Care Model Headline Projects

# Characteristics of the ICO projects

- Promote integration of services – across boundaries
- Promote integration for people using services
- Promote self-management  and self-reliance
- Promote preventative interventions at all levels
- Move care closer to home
- Change models of care with alternatives to traditional outpatient referral and follow-up
- Prevent admission or shorten length of stay when admission is unavoidable

‘The hospital will be smaller’

# Locality-based services within the ICO

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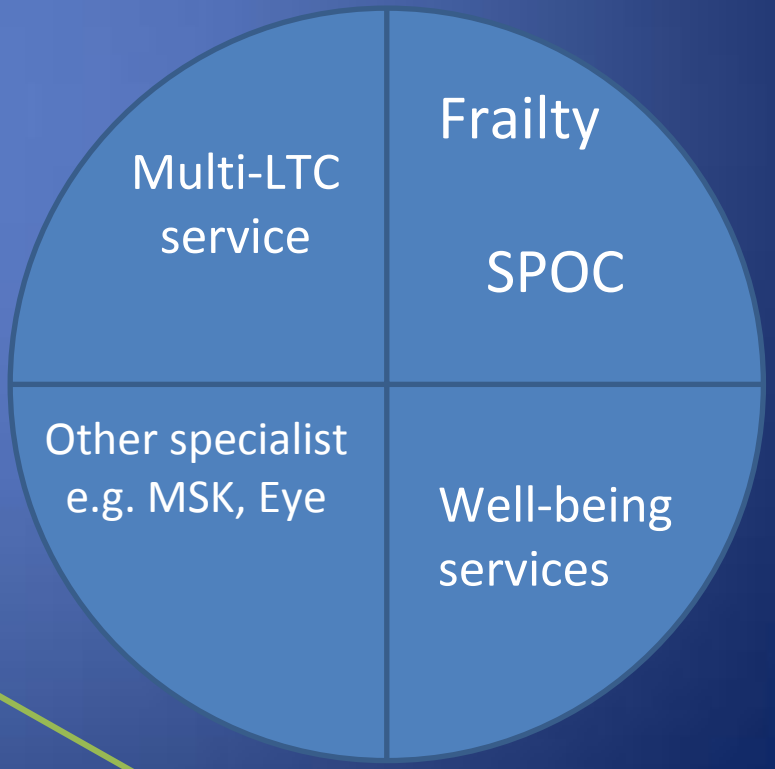

# So how will it feel different?

# Mrs Jones's last year of life  Aged 90

**2013**.  Becoming increasingly frail though still living alone.

- September 2013 - Admitted to hospital with a heart attack. Discharged home 2 weeks later with POC.
- October  - further admission with heart failure and kidney problems.  Complicated by chest infection
- December.  The day before discharge – fell and fractured NOF.
- February 2014.  Discharged to Nursing Home.
- April  - admitted with chest pain (1 day)
- May – admitted with chest pain (2 days)
- July  - admitted with heart failure and confusion
- August – died in hospital.

Mrs  Jones's family wrote a letter of thanks for the care their mother received.

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## How it could be in the ICO

- September 2013 Admitted to hospital with a heart attack. Seen by the acute frailty team on day 1. Discharged to assess by community OT/Physio on day 7 after visit by community matron. Supported by Heart Failure Team and community matron.
- October – intensification of heart failure treatment at home,
- November – saw GP after frailty assessment revealed increasing problems. Enhanced social care package arranged.
- March 2014 – Admitted to a Care Home. Advanced Care Planning discussions with GP and heart failure team.
- April – Episode of chest pain managed by paramedics without admission to hospital
- May - Episode of chest pain managed by GP without admission to hospital
- July – End of life plans made. Hospice at Home team involved.
- August – died at the Care Home with her family around her.

# A person with multiple long term conditions

Mr A is 72 and lives in Totnes
He has 4 LTCs – Atrial Fibrillation, Congestive Cardiac Failure, Chronic Kidney Disease and Type 2 Diabetes.

2013/14

Attended 3 separate consultant LTC clinics and saw 2 specialist nurses and 2 different dieticians

Total of 25 hospital appointments

Another 12 appointments at his GP's surgery

He takes 14 medications

Confused and doesn't know what to do for the best.

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**New ICO Multi-LTC service**

Attends new service in Totnes.

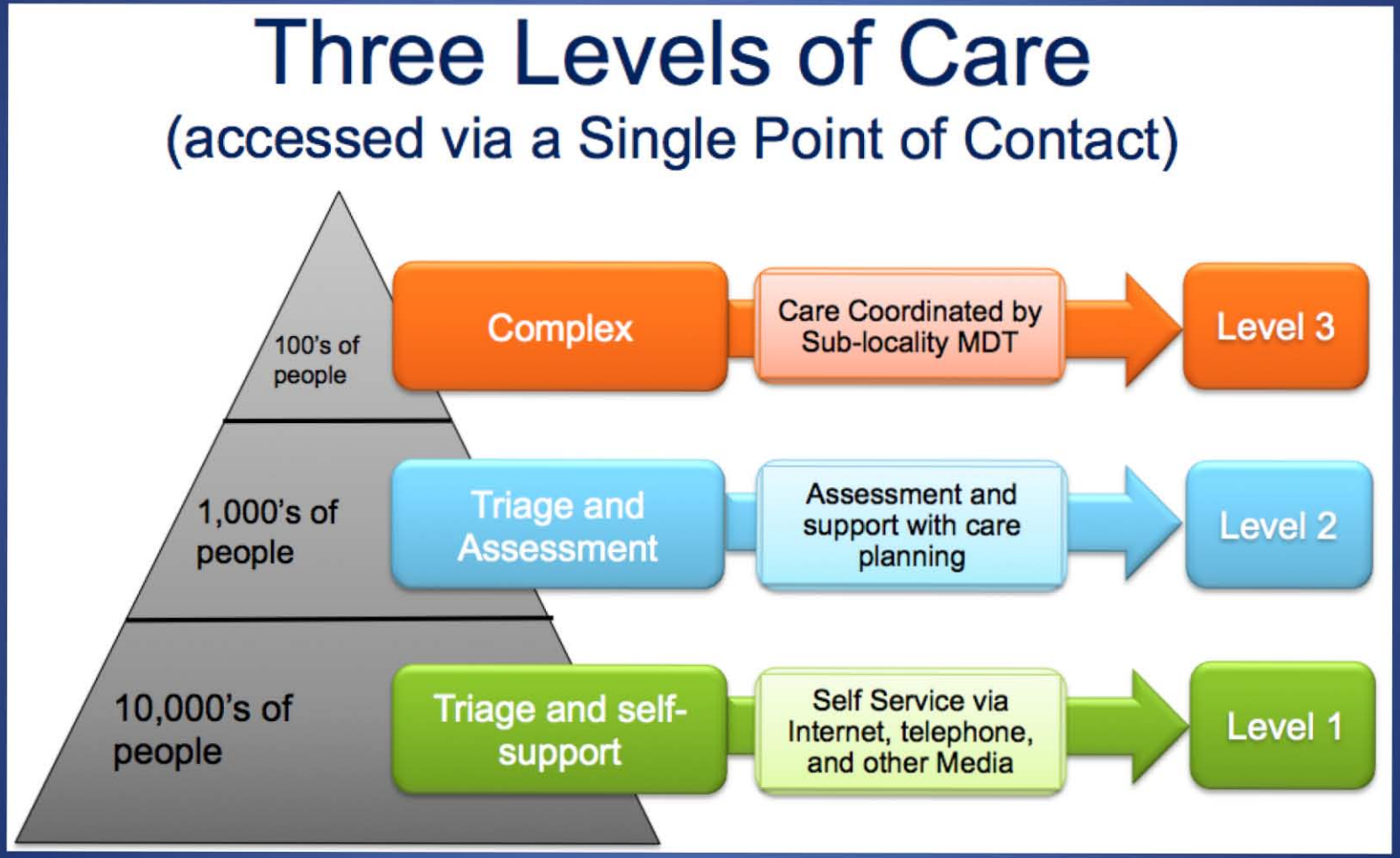
Sees one team which consists of a doctor, a nurse and a dietician for all his problems. 6 appointments per year.

Better communication with only 3 GP appointments needed.

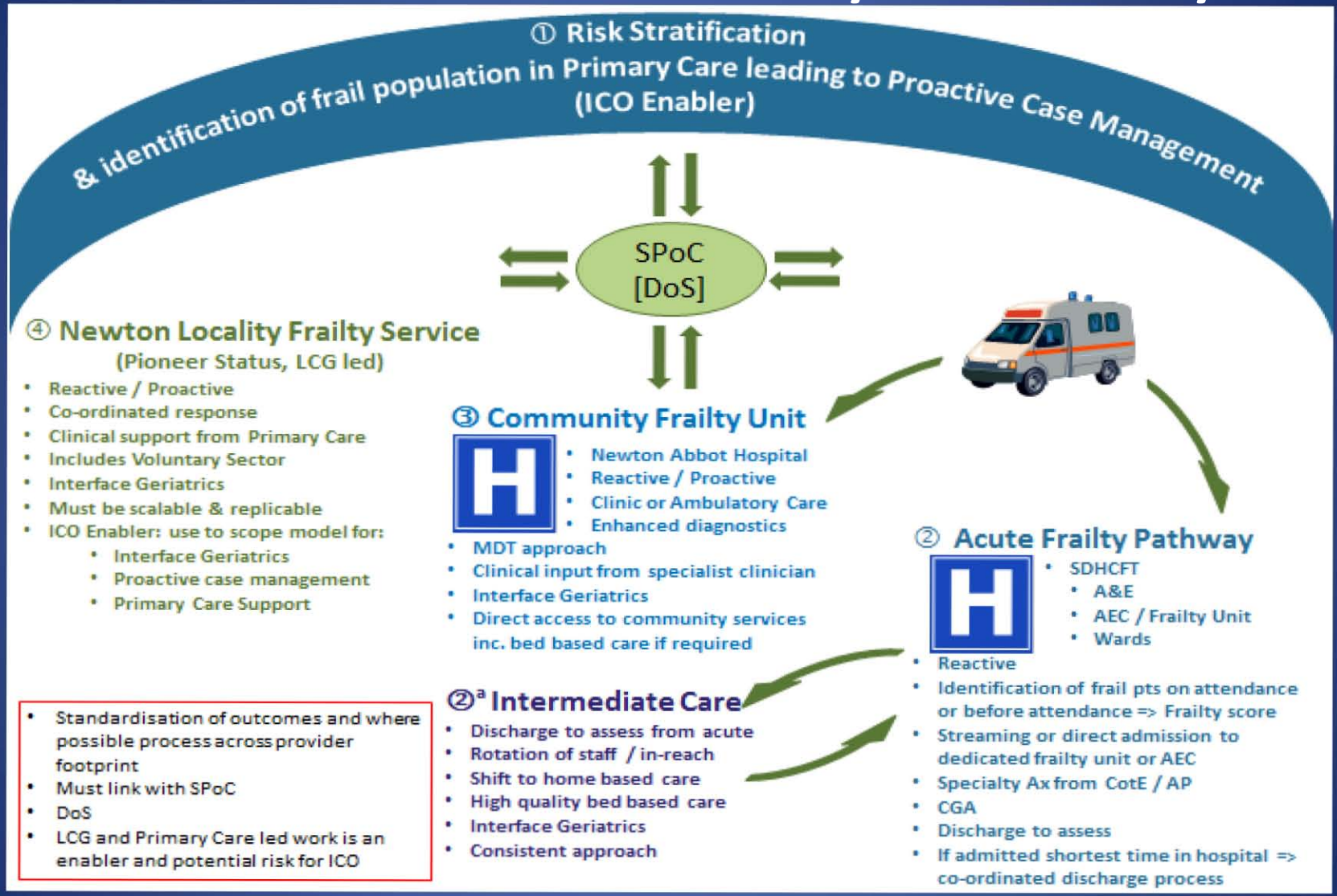
Understands his treatment now and has reduced to 9 medications.

He has determined that the priority this year is to get his heart failure under control so he feels better.

# Single Point Of Contact



# Frail Elderly Pathway



# Multi Long-Term Conditions

- A new service for people with multiple LTCs to allow coordinated multidisciplinary management of coexisting medical conditions in one place and at one time.

# Outpatient Innovation

- Review of Referral Management
- Gastro projects for IBD, IBD, Abnormal LFTs
- Triage of MSK referrals
- Development of Well-being services
- Development of Dermatology skills in the community
- Review of specialist nurse care models
- Breast cancer follow-up
- Virtual Ophthalmology clinics
- Development of pathways of care and self-management programmes for all LTCs

# A LTC specialist nurse

With the formation of the ICO I see a big improvement for my patients and that makes me feel better in my work. We have been able to develop training packages for GPs and practice nurses and I have been involved in developing self-management training for patients as well.

I was based in the community. With the ICO I have been able to build relationships with staff who work mainly in the hospital and they seem to really value the information and knowledge about a patient when they are in hospital. I can also help get them home sooner because I know their circumstances well. Some patients are now looked after in new services in the community and I link with the staff there and with community matrons. The new IT links really help with that communication and save loads of time.

I now feel part of a single team of nurses across the hospital and the community and meet regularly with consultants and other team members involved in caring for our patients. I share in cover at weekends. Because it is well-supported it isn't scary and has improved the way we do things enormously. We are also linking in better with other specialties which makes so much sense for patients who have more than one problem.