Joined up Care Derbyshire: Sustainability and Transformation Partnership (STP)

Care principles and standards

1.0 Purpose

These care principles and standards for Derbyshire have been designed to support delivery of our vision to keep people:

- ***Safe and healthy*** *– free from crisis and preventing ill health wherever possible*
- ***At home*** *– out of social and healthcare beds*
- ***Independent*** *– managing with minimal support, avoiding institutional care where appropriate*

Our vision is founded on building strong, vibrant communities.

The foundations are based on a 'triple aim' developed by the Institute for Healthcare Improvement (IHI). This seeks to make the best use of available funds in improving people's health and wellbeing. The triple aim has a vision of '***simultaneously improving the health of the population, enhancing the experience and outcomes for the patient, and reducing the per capita cost of care for the benefit of communities***'. The approach is complemented by seeking to remove any existing boundaries between physical and mental health, community and specialist services, and health and social care.

These care principles and standards are also based on the aims of NHS England's 'Next Steps on the NHS Five Year Forward View' (March 2017). This sets out three aims: to improve health and wellbeing, improve care and quality, and tackle financial challenges. The *Forward View* further proposes a 'triple integration' of community (including primary) care and specialist hospital care, of physical and mental health services, and of health and social care.

It is the view of Joined Up Care Derbyshire's clinical and professional reference group that simply continuing 'doing what we do' is not sustainable.

2.0 Ensuring our approach is consistent and connected

This set of care principles and standards has been designed to enable all involved in Joined Up Care Derbyshire to meet the IHI 'triple aim' and objectives set out in the *Forward View*. The diagram below seeks to show how all these aspects are connected.

Figure One: The connections between the Derbyshire care principles and standards, the 'triple aim' and the Forward View

The clinical and professional reference group has promised to (1) produce a tool to enable organisations to work together in a consistent way, and (2) provide a 'checklist' to ensure that all developments enable delivery of the triple aim and STP objectives.

Enabling plans are being put together in support of this covering the areas of information management and technology, communications and engagement, and workforce.

3.0 The care principles and standards

Joined Up Care Derbyshire has a set of agreed strategic principles, confirmed as part of the governance arrangements. These care principles and standards have been designed to dovetail with those strategic principles rather than replace them.

The care principles and standards must demonstrate:

- Consistency with national and local strategic direction and plans - so that improvements in population health are achieved in an ***integrated way***
- Improved delivery of care which maximises the potential benefits for local people to improve their ***experience of care*** in a way which is safe, effective and person-centred
- Measurable ***improvements in population health and reduced inequalities***
- ***Reduction of the per capita cost of care*** by driving more efficient and effective use of resources

For each of the 'triple aims' set out in the table below there are specific principles which can be used as a checklist to ensure delivery of our ambitions.

Aim	Principles
Delivery of care which maximises the potential benefits for the people of Derbyshire to improve their ***experience of care*** in a way which is safe, effective and person-centred	• Care is dependent on fewer hospital beds with inappropriate admissions avoided. People cared for as close to home as possible; moving from bed dependent care to a community-based system of care (delivered through 'Place') • People are treated in the lowest intensity setting. Where bed-based care is required, the length of stay is kept to that needed for a safe discharge (eliminating periods of stay which add no value to the individual) • Records will be accessible electronically by all health and social care colleagues working with a person and their family • Enables the transition to 'place based care', delivering integrated care which treats physical, mental and social health equally • Care is delivered by integrated multi-professional teams, working to shared governance and accountability. Reduced handoffs between teams. As a result, the person/patient only has to tell their story once • Creates leadership (clinical and non-clinical) and a consistent clinical vision, values and culture • Duplication of effort by those delivering (and accessing) services is eliminated

	• Clinical pathways are based on patient need and best practice guidelines. There are shared clinical standards from point of referral from primary care onwards • Reduces unwarranted variation in clinical practice • Care provided in the wrong place is a failure of the whole system • Delivers care which is safe and consistent in all settings, seven days a week, whether emergency care or otherwise • Creates a flexible workforce that is valued, empowered and supported • Staff work to the very best of their capabilities, making every contact count • Maintains safe staffing levels in all care settings to ensure effective patient care • Supports workforce resilience • People are fully informed and involved in decisions about their health and social care. They are supported to decide whether any intervention is in their best interest • Focuses on what is important to people by understanding their needs - asking 'what matters to you' not 'what is the matter with you?'
Measurable ***improvements in population health and reduced inequalities***	• Local people are empowered to take responsibility for their own health and wellbeing. A system-wide approach which supports individuals, families and communities to live resilient, purposeful and independent healthy lives, reducing the need for costly interventions during their lives (health and social care, housing, education, criminal justice) • Services are designed based around the specific needs of people in a particular community. Services address health inequities • Health promotion, wellbeing and prevention initiatives (primary, secondary and tertiary) are embedded at every opportunity through person-centered approaches • The citizens' voice will be considered and reflected in all developments through meaningful engagement • Enhances opportunities to enable healthy ageing
Reduced ***per capita cost of care*** by driving more efficient and effective use of resources	• Resources (funding and workforce) follow patients and enable delivery of new pathways and models of care • Removes barriers (organisational, attitudes and behaviours) that prevent services coming

	together and delivering seamless person-centred care • Eliminates ineffective and inefficient working practices and treatments • Transformational changes are planned based on sound modelling and testing to make sure that concepts developed are robust • Makes the best use of resources to ensure the money we spend achieves the optimum improvements in health and wellbeing • Addresses workforce pressures and challenges • Provides greater financial sustainability and supports system productivity • Services are delivered as locally as possible within the constraints of quality and affordability. Each place area will have different needs. More specialist services will require larger populations to ensure safe, effective and financially sustainable care

4.0 Anticipated impact on our patients

The following scenario examples illustrate the way in which we see care being increasingly delivered in the future.

The patient story previously	The patient story in the future
1. Joan, 80, is in hospital following a stroke. Following the initial emergency response and care in an acute hospital, Joan was transferred to a community hospital. She has been in a bed at the community hospital for many weeks. Indeed she has been in the community hospital for so long that she is beginning to feel dependent on being there. Her body strength is not what it was and she is feeling sad at being away from home and her friends.	Joan has received her emergency care for the stroke and is now back at home recovering well. Thanks to the Better Care Closer to Home programme, members of the integrated care at home team, including therapists and social care workers, are providing all the support she needs. Joan is confident of making a very good recovery and resuming her normal hobbies and interests with friends.
2. Joe, 75, has always been happy in his home and neighbourhood, he's lived there all his life. He has a couple of long-term conditions for which he needs health and social	Joe is being helped by an integrated health and social care team to remain at home. Joe and his daughter went to the local community centre and spoke to a representative of Talking Points, the

	care support. Increasingly he thinks he needs some changes made around the house to help him with everyday tasks. His family have noticed him struggle more of late and thinks he might have to go into a care home but Joe's reluctant to make the move. The family thinks there could be support out there but don't know how to access it.	adult social care service that tours the local area. They were able to make some quick adaptations in Joe's home, prior to a full assessment. Joe feels content that it will be a case of 'home, sweet home' for a lot longer yet. His family are reassured that he is being supported to stay well, and safe, at home.
3.	Pat, 63, has not been steady on her feet for a little while. She had a minor fall recently and went to A&E having hurt her knee and injured her wrist. She is recovering ok but Pat's GP is concerned that she may be liable to fall again without additional support at home. He is reviewing her medications while seeking the advice of other support services but has little time to put in the phone calls and organise the care required.	Pat is recovering well from her minor fall and is now receiving additional support from a new falls prevention programme as part of Joined Up Care Derbyshire. She is learning more about the risks of falls and how best to avoid them thanks to an education programme. She has been referred to a local falls prevention class, and is not only learning more but making some new friends. A falls co-ordinator has carried out a review and is suggesting a few interventions including a vision assessment.
4.	Jay, 32, has had symptoms of paranoia, psychosis and depression. Signed off sick from work, he has become anxious and is reluctant to leave the house. The medication he was prescribed has caused weight gain and his physical health is suffering. Owing to his anxiety Jay often calls 999 because he does not know who else to contact. He is taken to A&E, assessed by a liaison team and admitted as there is not enough community capacity to help when he needs intensive care. Jay has no hope this cycle of despair will ever end.	Jay has been offered a health check in hospital and is being helped to become more physically active with peer support. Liaison with his employers has helped negotiate a phased return to work. Through an individual wellness plan, Jay is learning coping strategies to help with problems such as anxiety. His GP has set up a walking social prescription for him. If and when Jay needs additional support, intensive home treatment services are available as an alternative to hospital. Jay is beginning to feel more positive about the future.