## 8.1 Health and Social Care Integration

Walsall has one of the most deprived urban populations in the UK. Despite the foundations having been put in place to significantly improve the care of older people, the current system lets down these individuals and their carers; most care, inappropriately, remains institutionalised. Current demand for emergency admissions has also increased over the last year by about 14%. The vision is that by 2018, the older people of Walsall and their carers will experience a largely home‐based model of care, centred around the specific needs of individuals. The approach is to work in partnership, building on the successful parts of the system we have got right and taking steps to systematically implement a transformation at scale and pace. **We envisage integration as a means to designing the health and social care system to deliver the outcomes we have all agreed**. This is summarised in the diagram below.



Figure 1 Walsall Health and Social Care Integration approach (Source: Health and Wellbeing Board paper on Health and Social Care Integration

**Integration and the Frail Elderly**

In order to reduce health inequalities Walsall CCG, Walsall Council, Walsall Healthcare NHS Trust and Dudley and Walsall Mental Health Trust recognises there is a need to achieve a more rapid improvement in health and well‐being for people living in the deprived areas than those living in the more affluent, but this cannot be achieved without meaningful input and ownership from the population served. This ownership and contribution from local people would provide the input and creative solutions needed to generate positive changes to health and in turn impact on aspects of community life which are themselves determinants of health.

A range of measures demonstrate that older people in Walsall are high users of institutional care, receiving much of their treatment and care away from their homes in bedded facilities provided by general acute hospitals, mental health hospitals, nursing and residential homes. Walsall’s Health and Well‐ being Strategy sets us the challenge of changing the way in which we use resources so that there is a better balance between ensuring those that need acute services get the quality they need but that overall the health and well‐being of the population can improve so that fewer people need institutionalised care.

The response to this seemingly enduring challenge which produces poor outcome and experiences for people is twofold:

**First:** responding to the identified individual needs of older people, the core skills and competences traditionally provided by professionals in primary, secondary and social care, will be combined in teams with the skills of others including community volunteers and the unpaid contributions of carers, to enable to people to live well at home. For people with high care needs, there will be an intensive community response available to care for them at home where possible.

**Second**: even in a transformed model of care for older people which is largely home‐based, some people will need short periods of inpatient care. To respond to these specific short term needs, there will be an integrated team of professionals with health and social care competencies, to swiftly and safely transfer people back to their homes by accessing a range of services and/or interventions which give people the ability and confidence to live as independently as possible.

Indicators

The local health and social partnership has a track record of achieving whilst working together. For example we have achieved the following results: -

*Frail Elderly*

1. Reduced average length of stay from 13.8 day to 10.5 days in the frail elderly over 3 year period
2. Reduced the number of bed days by 15% from 7,989 days to 6,680 days over a 3 year period

*Trauma Orthopaedic Musculoskeletal*

1. Reduced the average length of stay from 14.10 days to 5.8 days over a 3 year period
2. Reduced the number of bed days by 57% from 1498 days to 642 days over a 3 year period

During this programme of work specific measures of outcomes and experiences relating to individuals receiving services and their families/carers, will be developed. Nevertheless all partners are agreed that the key outcomes which we will use as our measures of success for our integration programme are the following: -

* Lower emergency non‐elective admissions to Hospital
* Lower readmissions to hospital
* Low delayed transfers of care
* No admissions from hospital to residential and nursing care
* Lower admissions to residential and nursing care
* Reduced demand for on‐going care and support (because our preventive services can demonstrate that they are successful)
* Evidence that our investments in commissioning health and social care can demonstrate that they are delivering their intended outcomes for the people of Walsall.

*Priorities for action*

* *We will review the Hospital Integrated Discharge Team to enhance its effectiveness and clarify the range of services available for patients through a* ***single point of access****.*
* *We will utilise a tool that will* ***risk stratify patients*** *using a range of health and social care datasets – this process will allow us to understand individual needs of people to enable them to stay at home*
* *We will further develop multidisciplinary coordinated Locality Teams.*

**Further Information on Integration proposals in Walsall then follows the link below.**

<http://www2.walsall.gov.uk/CMISWebPublic/Binary.ashx?Document=13543>