Name of meeting: Calderdale and Kirklees Joint Health Scrutiny Committee
Date: 14th June 2016
Title of report: Implications for social care and public health in Kirklees

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	**No**
Is it in the Council's Forward Plan?	**N/A**
Is it eligible for "call in" by Scrutiny?	**N/A**
Date signed off by Director & name **Is it signed off by the Director of Resources?** **Is it signed off by the Assistant Director (Legal Governance and Monitoring)?**	**Richard Parry Director for Commissioning, Public Health and Adult Social Care.** **3rd June 2016** **N/A** **N/A**
Cabinet member portfolio	**Prevention, Early Intervention and Vulnerable Adults**

Electoral wards affected: **All**
Ward councillors consulted: **N/A**
Public or private: **Public**

1. Purpose of report

To provide the Panel with information to help them assess

1) The level of engagement of Kirklees Council in the Strategic Review that led to the proposals for hospital reconfiguration
2) The implications of the development of specialist hospitals for hospital discharge arrangements, hospital social work teams, reablement services etc.
3) The contribution that social care services can make to the implementation of a specialist hospital model.
4) How will health and social care work together to reduce admissions, re-admissions and discharge waiting time
5) The impact that hospital configuration will have on Kirklees social care services
6) The current workforce issues that will impact on the delivery of social care services
7) The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Greater Huddersfield
8) The contribution that public health initiatives will make to "taking demand out of the system"
9) The alignment of the hospital reconfiguration proposals with the Kirklees JSA and the priorities identified in the Kirklees Joint Health and Wellbeing Strategy

2. Key points

2.1 Engagement of Kirklees Council in the Strategic Review that led to the proposals for hospital reconfiguration

The Health and Wellbeing Board has received regular updates on the development of the Calderdale and Greater Huddersfield Strategic Review, the development of the Strategic Outline Case and more recently progress with the Right Care Right Time Right Place programme.

There has been protracted and repeated engagement with senior officers from the Council over the lifetime of the Strategic Review. For example senior officers have been invited to attend the Calderdale & Huddersfield Strategic Review Programme Executive. More recently social care has been much more actively engaged around the current proposals.

The Council recognises that this is a complex set of changes and there have therefore been a wide range of stakeholders involved. The intention has clearly been to enable the maximum amount of engagement, however at times this resulted in too many meetings for the Council to be able to engage effectively.

2.2 The implications of the development of specialist hospitals, the contribution that social care services can make to the implementation of a specialist hospital model and how health and social care work together to reduce admissions, re-admissions and discharge waiting time

The Council is working with a wide range of partners to deliver more integrated services. Some of the most significant services are

- **Reablement service**
  Council staff work alongside physiotherapists and occupational therapists to support people for a period of up to six weeks to relearn daily living skills and to regain abilities and confidence in their own home. The aim is to reduce avoidable hospital admissions, support timely discharges and prevent re-admissions.
- **Intermediate care**
  Based in Moorlands Grange, Netherton and Ings Grove, Mirfield the intermediate care services is delivered by Council and Locala staff following an assessment by a health or social worker at home or in hospital people who have mobility, dietary or emotional needs and who need support to help them regain or adapt their day-to-day living skills. The aim is to make sure that people who would otherwise be admitted to hospital, or who need to be in hospital for a long time, remain as independent as possible, reducing or delaying the need for long-term care.
- **Hospital avoidance team**
  Based in each of the main hospital sites the Hospital Avoidance Team work with emergency department staff and community nurses to ensure people presenting at A&E have a pathway to services to avoid admission (where medically appropriate) after treatment/ exploratory tests. Social care assessments are also available seven days a week to support discharge from hospital and intermediate care.
- **Mobile response service**
  The Mobile Response service supports Carephone users by providing an alternative response to Telecare alerts when Carephone officers are unable to get in touch with family or named emergency contacts, or where family are unable to respond. Operating 24/7, responders intervene in circumstances where it is

considered that the request for help does not require any of the emergency services to attend. The service reduces in emergency YAS callouts; preventing unnecessary hospital admissions, helping to manage the demand for intensive people based services alongside improving service user's health & wellbeing through the promotion of self-care, choice & control.

- **Kirklees Integrated Community Equipment Service**
  The service is jointly commissioned by the Council and both CCGs and provides a truly integrated approach to ensuring frontline staff from across health and social care can ensure their clients are getting the equipment they need as quickly as possible.
- **Integrated Community Care Teams**
  Locala and the Council have been working closely together for a number of years to develop Integrated Community Care Teams (ICCTs), bringing together health & social care services. The model was initially implemented on a 'pilot' basis with a full review/audit taking place in 2014 which helped shape the further development of an integrated model. The core services involved are shown in Appendix 1.
  The early stages of implementation of the ICCTs was managed through a joint programme management structure with key people from across Locala & Adult Social Care. Whilst a great deal has been achieved in terms of delivering services in a more co-ordinated way and minimising duplication there is still work to be done to improve, including the operation of the Integrated Night team which is made up of nursing and social care staff delivering unplanned and some planned interventions.
  This work in now being led by the Integration Board, which has officers from the Council, CCGs, Locala and South West Yorkshire Trust. The aim is to further develop ICCTs, linking the Care Closer to Home contract, and the Council's Early Intervention & Prevention programme. The current focus is on developing a 'pilot' locality team.

Commissioning

The current integrated commissioning arrangements with the CCGs were established in September 2013. Since then a significant amount of work has been undertaken by the 3 organisations, through the Integrated Commissioning Executive and the Integrated Commissioning Groups which sit underneath this. The Chief Officer Group has overseen this work.

Proposals for strengthening these arrangements were endorsed by the Health and Wellbeing Board in May 2015. The focus is development and implementation of the Better Care Fund plan, continuing care, nursing and care home provision, mental health commissioning, children's commissioning, and performance and intelligence.

Each of these areas now has an action plan that identifies the priority areas of work along with actions, timescales and responsibilities for taking these forward. In addition, each of the Integrated Commissioning Groups are identifying areas where further pooling and aligning of resources has the potential to improve the commissioning of services for the benefit of the residents of Kirklees.

Better Care Fund

The Better Care Fund, a national programme to support the integration of health and social care including a requirement to pool funds in a Section 75 Agreement, has been a major focus over the last 18 months. The BCF includes a range of schemes covering

- Preventative services including; support to voluntary and community sector organisations; self-care, alcohol liaison workers
- Intermediate Care
- Aids to Daily Living: including Kirklees Integrated Community Equipment Service, Assistive Technology and adaptations
- Carers Support
- Community Health Services
- End of Life Care
- Mental health (inc Psychiatric Liaison Services)
- Supporting Social Care.

Discussions locally about the Better Care Fund have highlighted the need to evaluate the impact of existing schemes more thoroughly. We have invested in a pilot project with Care Trak that can draw together both NHS and social care data for the first time to support this. This has also enabled us to start resolving some of the Information Governance issues, although there is still more work to be done to ensure the necessary data flows both for commissioning and care planning and co-ordination for individuals.

A key focus of activity to ensure we deliver the commitment under the Better Care Fund in 2016/17 will be developing more integrated and effective approaches to

- Named care co-ordinators, individualised care plans & case management
- Intermediate care, reablement and rehabilitation

The BCF Plan also identifies the importance of strengthening the links between the Integrated Commissioning arrangements and the local System Resilience Groups (SRGs) for both Calderdale/Huddersfield and North Kirklees/Wakefield. Especially around patient flows and delayed transfers of care.

Urgent care and transfers of care

The Calderdale and Huddersfield SRG, which has representatives from the Trust, CCGs and the adult social care has developed an action plan to implement the High Impact Change Model for Delayed Transfers of Care (see appendix 2).

This builds on the work that the local partners, including adult social care, have been doing as part of the Emergency Care Improvement Programme (ECIP) with the Emergency Care Intensive Support Team (ECIST) to deliver the changes set out in ‘Safer, faster, better: good practice in delivering urgent and emergency care’. There have been a series of Improvement Programme events and this has enabled partners to look at ways of improving joint working arrangements between health and social care in acute settings and internal social care systems.

2.3 The impact that hospital configuration will have on Kirklees social care services

Whilst there was extensive work done on modelling the impact of the changes on the NHS system, as yet there has been no detailed analysis of the impact on social care delivery and the funding implications of the proposed changes.

Without this work being done it is only possible to comment on the more obvious operational impacts, these include

- Splitting the social care customer base over two sites makes it more difficult and costly to manage, for example we will need to ensure a social work presence at both sites, plus the increased mileage, travel time etc.
- Assessors often leave the hospital base to visit clients at home due to Safeguarding, Admission Avoidance and Reviews. If Assessors are traveling to and from Halifax to Huddersfield a number of times daily/ weekly this will cause a significant reduction in assessment hours.
- The Hospital Avoidance Team currently take people home from A&E at HRI, which means they are away from the site for around an hour on average. Obviously, taking people home from CRI will increase this significantly.
- Local care homes and care providers come into hospital to complete assessments on the wards for complex patients before discharge, if Kirklees providers were to travel further to assess Kirklees residents this process will become more drawn out and probably increase delays.
- Managing a larger proportion of Kirklees residents at Calderdale Royal will have some risks because due to working onsite with a different host Local Authority. This has already been our experience working at Pinderfields in Wakefield. Although this experience has shown that whilst it is more challenging it is possible.
- There is a high risk of losing staff due to relocation if their working base becomes Halifax as meant people applied for their current posts to work in the area they live in order to achieve a certain work life balance not to work out of area.

2.4 The contribution of the hospital reconfiguration proposals to improving health outcomes people living in Greater Huddersfield

Greater Huddersfield CCG has, through continuous engagement with partners, given assurance that they expect no negative impact on health outcomes for their population and that new arrangements will be monitored closely to ensure this remains the case. It is clearly stated that the aim of the reconfiguration is to improve standards of care.

The new model of service delivery has described urgent care facilities in Huddersfield that the Kirklees population will be able to access if they have a need that requires immediate attention. The intention is that all emergencies will travel to Calderdale where there will be the right level of expertise to deal with that level of need. Contribution to the improvement in health outcomes will depend on the right people accessing the right service at the right time with the right level of expertise to address their needs. There is evidence across the country that centralisation of services improves patient care and their outcomes.

Given the willingness of Greater Huddersfield to engage with the Council and its partners on these proposals to date we expect this to continue through the implementation so that impact on our population can be monitored and plans adapted where necessary to ensure the best possible hospital services for our population.

2.5 The contribution that public health initiatives will make to "taking demand out of the system"

Public Health works across all 3 levels of prevention – preventing people needing health and social care by keeping them healthy and well, reducing the need for health and social care intervention when people are identified as having a health or social care need and delaying the need for complex care packages. A lot of this is

done by working in partnership with health and social care colleagues to understand population needs and what works.

The challenge we face is that we need to focus enough on prevention, in order to have a real impact on future demand while dealing with the immediate challenges we face now in terms of taking demand out of the system from people who already have health and social care needs. Specific public health initiatives that will contribute to "taking demand out of the system" include:

Self-care – there is a wealth of evidence that supporting people to take more control of their health, their long term condition or their care leads to greater independence and people using services in a different way. In Kirklees we have built up a comprehensive programme over the past 10 years that gives people with a long term condition a range of individual and group based options to give them the skills and knowledge they need to do this. Public health have also worked closely with both CCG's and Locala to embed a culture of maximising independence and supporting self-care in the delivery of community services and care closer to home.

Demand caused by obesity, alcohol, smoking – public health commission a range of programmes to help people tackle behaviours that contribute to poor health and increase the likelihood of needing services. The proposal for the future is to develop a "wellness" model that will deal holistically with a range of lifestyle choices that impact on health and wellbeing rather than traditional single issue services. This will allow us to support people with a range of issues in one place and make more efficient use of resources as well as increase the chances of helping individuals achieve real change.

Healthy Ageing – as people get older the likelihood of them needing health and social care services increases and it is therefore important to focus on healthy ageing. In terms of "taking demand out of the system" public health is coordinating work on falls prevention and the development of a falls pathway with colleagues from the CCG and acute sector. Work has been ongoing for some time on nutrition and hydration in older people with a particular focus on improving standards in care homes through education and training of staff. Both falls and dehydration are common causes of hospital admission that can, in many cases, be avoided.

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission (see table below). Emergency admissions for ACSCs cost the NHS £1.42 billion annually. Influenza, pneumonia, chronic obstructive pulmonary disease (COPD), congestive heart failure, dehydration and gastroenteritis account for more than half of the cost, and those aged 75 years and over are most at risk. Influenza and pneumonia account for the largest proportion of admissions and expenditure - many of these cases are vaccine-preventable[1]. Reducing levels of obesity, alcohol misuse and smoking, improving confidence of people to take control of their long term conditions and focussing on healthy ageing, including amongst the frail elderly, can all have a positive impact on reducing demand caused by ACSCs.

[1] Kings Fund (2012) Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf

The 19 ambulatory care-sensitive conditions

Vaccine-preventable	**Acute**
1. Influenza and pneumonia	11. Dehydration and gastroenteritis
2. Other vaccine-preventable conditions	12. Pyelonephritis
Chronic	13. Perforated/bleeding ulcer
3. Asthma	14. Cellulitis
4. Congestive heart failure	15. Pelvic inflammatory disease
5. Diabetes complications	16. Ear, nose and throat infections
6. Chronic obstructive pulmonary disease (COPD)	17. Dental conditions
7. Angina	18. Convulsions and epilepsy
8. Iron-deficiency anaemia	19. Gangrene
9. Hypertension	
10. Nutritional deficiencies	

2.6 The alignment of the hospital reconfiguration proposals with the Kirklees JSA and the priorities identified in the Kirklees Joint Health and Wellbeing Strategy

The Kirklees Joint Health and Wellbeing Strategy sets out a clear direction of travel to more integrated commissioning and delivery of health, social care and public health. This reflects a clear national political consensus about the need to create a more coherent, person centred health and social care system that focusses on moving care closer to home wherever possible and promoting independence and prevention. The JHWS sets out a range of outcomes, the reconfiguration proposals could help deliver many of these, but has a particularly important role in relation to

- Having the best possible start in life
- Development of positive health behaviours
- Enhancing self-care and resilience
- People feeling safe and include in their care

The JHWS also sets out a range of 'system change priorities'. Again the reconfiguration proposals can make a contribution to many of these, but ones of particular importance to how the proposals are developed and implemented include

- Being person centred, taking a holistic view of the individuals, valuing their strengths and involving them in creating solutions, increasing their sense of control over the life and their care
- Creating a clear way for individuals to navigate through services and systems
- Co-ordinating care that also recognises and supports informal carers
- Providing consistent and appropriate quality information
- Using consistent messages and language across services and organisations
- Improving quality of and access to services and reducing variation
- Being evidence based in outcomes and what works
- Minimising the unintended consequences of service changes
- Prioritising according to need and impact
- Eradicating duplication
- Using a shared approach to digitisation
- Building a workforce that is adaptable and that can span health and social care

The most recent update of the JSA overview highlights the positive steps in increasing life expectancy and increasing healthy life expectancy, but the major challenges of more people ageing with multiple long term conditions, the levels of obesity and poor mental health and the significant inequalities in health outcomes particularly for those people living in poor social and economic circumstance. It sets out a number of key challenges which the hospital reconfiguration proposals could make a significant contribution to:

- The need to focus on prevention and to intervene early
- Narrowing the inequality gap
- Enabling people to start, live and age well
- Improving resilience and enabling healthy behaviours

2.7 Implications for the Council

The Council and NHS partners have committed themselves to developing a more integrated approach to the commissioning and delivery of health and social care services.
There is now a national expectation that there will be an integration plan by 2017 which will be implemented by 2020. Whilst there has been significant progress on many fronts this report highlights the range of opportunities to widen and deepen integration across Kirklees.

2.8 Consultees and their opinions

Not applicable

2.9 Officer recommendations and reasons

That the contents of this report are noted**.**

2.10 Cabinet portfolio holder recommendation

Not applicable.

2.11 Assistant directors responsible

Keith Smith
Assistant Director for Commissioning and Partnerships

David Hamilton
Assistant Director

Rachel Spencer-Henshall
Director of Public Health

Appendix 1: Integrated Community Care Teams core services

N.B Not exclusive list

Appendix 2:
Calderdale and Greater Huddersfield SRG: Implementing high impact changes – managing delays in the transfer of care from hospital beds (Huddersfield/Kirklees footprint)

Change 1: Early Discharge Planning.

Actions to be taken	a) Complete development of an integrated discharge model business case and agree with all partners including strengthening the role of primary care b) SRG to agree case and funding (Q1) c) Implementation Plan for new model agreed by DTOCB (Q1) d) Begin implementation of relevant recommendations from the January 2016 ECIP report (Q1) e) Implementation of operational SAFER bundle activity in CHFT and with partners as necessary (Q1) a) Ensure all partners are sighted on plans to integrated health and social care teams to support discharge (Q1)
Leadership	TOC Board
Measurement	• Provisional discharge dates set upon admission (non-elective care) - % to be locally agreed. • 100% of discharge dates are set prior to admission for (elective care) • Patient experience KPIs to be confirmed • Delivery of KPIs in business case for integrated model • Delivery of KPIs/ECIP recommendations

Change 2: Systems to Monitor Patient Flow

Actions to be taken	a) Continuation of work to strengthen flow information in advance of an agreed system (Q1) b) Further development of proposals to new system to manage flow – as discussed at SRG (Q1) c) Agreement on system BI and informatics support needed for current and future system (Q2) d) Being implementation of relevant recommendations from the January 2016 ECIP report (Q1)
Leadership	TOC Board
Measurement	• Performance data available for DTOCB and SRG • New system in place and supporting improvement

Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector

Actions to be taken	a) Build on current processes are in place for tracking and action planning the number of outstanding assessments; the list should reflect new cases daily and how many days existing cases have been waiting and how many cases were completed and taken off list previous day (Q1) b) Ensure process in place to tackle long waits an integrated health and social care focus group and action plan for each case with clear discharge dates as a matter of priority (Q1) c) Complete development of an integrated discharge model business case and agree with all partners (Q1) d) SRG to agree case and funding (Q1) e) Implementation Plan business case agreed by DTOCB (focus on initiation of MDTs and Discharge to Assess) (Q2) f) Commence delivery of relevant recommendations from the January 2016 ECIP report (Q1) a) Implementation of operational SAFER bundle activity in CHFT and with

	partners as necessary (Q1)
Leadership	TOC Board
Measurement	• Number of joint MDTs taking place • % patients covered by joint MDT working • % MDTs with community/third sector involvement • No/% of patients discharged to assess

Change 4: Home First/Discharge to Assess

Actions to be taken	a) Continue work to strengthen current joint reablement services, including strengthening KPIs, response times and capacity and demand analysis (Q2) a) Confirm SRG views on involvement in the national programme "Shared Lives" (Q1) b) Further work to be done with care homes who are unresponsive to requests to speed up assessments in hospital – linked to contractual levers where possible (Q1) a) Pilot discharge to assess with care homes in Calderdale (Q2)
Leadership	TOC Board Care Homes work-stream in Kirklees
Measurement	% people discharged into joint reablement services and no. of days taken for discharge to take place % people in receipt of joint reablement still at home 91 days after discharge %care home assessments undertaken in hospital within 48 and 24 hours of agreement to discharged % assessments undertaken at home/care homes rather than hospital % people discharged home % people admitted into permanent residential/nursing care

Change 5: Seven-Day Service

Actions to be taken	a) Confirm current 7DS offer locally through local stakeholder event delivered by NHSE Improvement Team (Q2) b) Confirm progress with negotiation of staff contracts for health and social care (Q2) c) Confirm progress on provider negotiation on homecare assessment and re-starts at weekends (Q2) d) Full action plan to be agreed to delivery on 7DS national expectations, with recognition of current acute site constraints (Q2) a) Take learning from public consultation on acute configuration (CHFT footprint) and agree the future care model (Q3)
Leadership	SRG agreement on governance and leadership required
Measurement	• Contractual monitoring of 7DS delivered across a range of providers • Response time for 7DS already in place • KPIs and timelines developed within system plan • KPIs and timelines developed for hospital change programme in line with consultation

Change 6: Trusted Assessors

Actions to be taken	(a) Agreement to develop to "trusted assessor" arrangements based on good practice elsewhere (Q1) (b) Implementation timelines agreed and shared with SRG (Q2)
Leadership	TOC Board
Measurement	To be agreed with the TOC Board as part of implementation plan

Change 7: Focus on Choice

Actions to be taken	(a) DTOC Board to keep a watching brief on Policy implementation and issues and escalate to SRG as needed (Q1)

	(b) Develop SOP confirming expectations around the pace of delivery interventions for those whose discharge is delayed – this will be updated regularly with latest guidance codes and will reflect changes in daily weekly and monthly reporting recommendations (Q2) (c) Strengthen links between CHFT and voluntary sector who can support post/on discharge and ensure staff are fully aware of offers – via CC2H plans (Q2) (d) Update on SHFT to SRG as part of evaluation of winter schemes (Q1) (e) Feedback to SRG on implementation of new Discharge Policy, including impact on LOS (Q2) (f) Ensure third sector play a key role in the development of emerging new care models (Q2)
Leadership	TOC Board CC2H Contract Board
Measurement	• LOS for medical patients • Reductions in long lengths of stay • No of third sector organisations involved in integrated discharge planning/% patients covered • KPIs for patient and family satisfaction with discharge • Reductions is SIs related to poor discharge planning

Change 8: Enhancing Health in Care Homes

Greater Huddersfield/Kirklees footprint	
Current Rating and rationale	Level 3: Care Home Pilot in place Stimulating the market and creating resilience is currently a challenge for Local Authorities and CCGs and we have capacity issues in step-up/step down/intermediate care beds and nursing and EMI beds. Agreed focus locally includes the need to also strengthen the home care market in order to support flow. *Caveat on level 3 is the need to test quality and safeguarding plans are in place within care homes*
Actions to be taken	(a) Ensure shared learning across the two different care home models (Q1) (b) CCG and CHFT working to establish any joint opportunities to develop a new approach to community beds (Q1) (c) SRG work-stream is established but there is a need to strengthen planning, reporting and challenge (Q1) (d) CCG working with CMBC working at a place-based level to develop a short, medium and long-term plan to strengthen the care home and home care markets. Implementation Plan to be agreed SRG (to include other elements of this plan including discharge to assess and improving speed of assessments (Q2)
Leadership	SRG through Care Home Work-stream CC2H Board for place-based work
Measurement	• Care Home Pilot dashboard • Variation in admissions by individual care homes • Patient experience improved • Reductions in care home SIs