North Kirklees CCG

Transformation Programmes

Update on the Development and Implementation of Transformation Programmes which support the Management of Demand for Hospital Services

1. Background/Introduction

Our ambition for the future is to move towards population based commissioning where we break down silos in current service delivery so the focus is on integrated patient centred care and health and wellbeing, whilst reducing health inequalities for our local population. This will include the development of integrated models of holistic care pathways provided by a collaboration of organisations enabling and empowering patients and their carers to access proactive care, at the right time, provided by the right person, in the right place. This will result in a shift in activity out of hospital and into more appropriate community settings; ensuring patients are managed more effectively at or as close to home as possible.

Our vision is based on the principles of the new models of care within the NHS Five Year Forward View and the Kings Fund, Place Based Commissioning Model.

The implementation of this vision has been in progress for a number of years and is supported by a number of changes which we have implemented/are in the process of implementing. The first major step change in delivering this was the commissioning of an integrated model for community services through Care Closer to Home and the recent commissioning of an integrated model for children's services through the Healthy Child Programme. Both programmes support delivery of the Acute Services Reconfiguration at Mid Yorkshire Hospitals, 'Meeting the Challenge'.

We recognise that we need to do much more to deliver this vision by focussing on a more proactive, planned and preventative approach to care across North Kirklees. We have plans which are in place or in development to do this. These plans are described in the CCGs Operational Plan and the Kirklees Health and Wellbeing Plan which are currently in working draft status.

2. Identified Programmes: Progress and Next Steps

2.1 Long Term Condition Management

Using data from the Right Care Packs it has been identified that a number of key areas require whole pathway reviews, in particular Respiratory, Diabetes and Muscular Skeletal Conditions (MSK). Work is ongoing to review current provision and to identify and address any gaps. The respiratory work includes the prevention, management and care for; Chronic Obstructive Pulmonary Disease (COPD),

Asthma, Tuberculosis (TB) and Influenza (Flu) alongside reviewing the provision of the Oxygen service. Diabetes work is focussing on the prevention and reducing variation in primary care. The MSK pathway aims to standardise referral pathways; improve access and quality of care. This work is supported by the development of clinical threshold management across pathways. We are working with partners and clinicians across the system to develop and implement standardised pathways for a number of disease areas using a formulary developed in Devon as a baseline and adapting for local use. The clinical threshold management approach will be underpinned by the procurement of a clinical system which will support clinical decision making and on-ward referral, maximising patient choice of provider.

We are also looking to review how we partner with our patients who have long term conditions to consider their needs over the longer term. This links in closely with our frailty work as more of our older population has more than one long term condition and extends to incorporate those in the last 12 months of life, therefore helping people live well, age well and die well. We will do this by embedding the use of our care plan menu (self-management plans; personalised care plans; emergency care plans and end-of-life care plans) though early identification; annual reviews and holistic frailty reviews which seek to ensure person centred co-ordinated care supported through appropriate care planning.

2.2 A&E Improvement Group

A&E Improvement groups were set up at the request of NHS England and replace the old System Resilience Groups (SRGs). The groups cover acute hospital footprints with a focus solely on Urgent and Emergency Care, and are attended at the executive level by member organisations.

The A&E Improvement Group has been tasked by NHS England to deliver against the following 5 key areas:

1. Streaming at the front door – to ambulatory and primary care.
2. NHS 111 – increasing the number of calls transferred for clinical advice
3. Ambulances – code review pilots; Health Education England increasing workforce
4. Improved flow – 'must do's that each Trust should implement to enhance patient flow
5. Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models

Two task and finish groups have been established (Primary Care and Discharge) which have developed and implemented work plans.

Progress follows a 'hospital reset week (12/12/16)' where a number of Plan, Do Study Act (PDSA) cycles were tested resulting in significant improvements with regards to ambulance handover performance. As a consequence of the 'reset week',

the following changes have been made to improve the flow of patients through hospital services at Mid Yorkshire Hospital Trust:

- The Walk-In Centre at Dewsbury now accepts a wider referral criteria and a GP is available during the evening (until 11pm), 7 days a week.
- A new discharge model has been implemented which is intended to improve the quality of discharge planning and reduce length of stay.
- GPs are being asked to rapidly respond to and prioritise patients who require a home visit (usually through early telephone assessment and a duty doctor rota) with the rapid provision of an ambulance, if required.

The impact of these changes will be monitored via the A&E Improvement Group which links directly into CCG Governing Bodies for both North Kirklees and Wakefield.

The requirement to take a systems approach to improve the quality of care and flow of patients through hospital services, ensuring that people are seen by the most appropriate clinician for their needs, first time is an outcome within the Kirklees Health and Wellbeing Plan which is our local response to the delivery of the West Yorkshire and Harrogate STP. The measures being taken by the A&E Improvement Group to deliver this and key in delivering our ambitions.

2.3 Frailty

Across the North Kirklees 'place' (acute, community and primary care footprint) , all stakeholders have recognised that there is an increasing number of older people attending emergency departments and accessing urgent health and social care services with a rising demand due to the projected growth in the number of people aged 85 over the next twenty years.

There is a consensus that we need to change how we care for the needs of older frail people now which will lead to improvements in quality, outcomes and efficiency.

We are therefore working to develop a 'new model of care' for frailty bringing together the local health and care system to redesign care for our local population. A Frailty Steering Group attended by a wide range of stakeholders has been established and has been tasked with agreeing a joint Frailty Strategy. The emerging vision for this strategy is:

'Our frail population will be identified early and supported to live as safely and independently for as long as possible avoiding unnecessary admission to hospital through an integrated proactive approach to frailty across the health and social care system.'

Working collaboratively with Locala we have begun to develop a robust frailty identification and assessment process which is currently being used for the following cohorts of patients:

- Patients aged over 65 years and living in a Care Home
- Patients aged over 85 years and living in their own homes

Once assessed and diagnosed with frailty, these patients will undergo a holistic assessment and care planning review and will be supported by the Locala Single Point of Contact who will provide a reactive response service within 2 hours for moderate or severe frail patients who require an urgent review. We intend to expand the frailty work to include early identification of frailty risk in primary care and provision of specialist frailty assessment by April 2018.

An urgent care and frailty clinical summit is planned for the 1st February 2017 and will bring together partners with an aim to better understand current work plans for urgent care and frailty alongside aspirational plans from each organisation. We need to identify interdependencies and agree a joint vision for North Kirklees. We will seek to use the event to gain commitment from partners to work collaboratively to develop new models of care utilising resource differently to support transformation and change across the system. Following this, a new governance structure will be agreed which will likely include a Frailty Board made up of representation from each organisation, underpinned by the current Frailty Steering Group and identified task and finish groups.

The Frailty work is a key development in supporting us to deliver the Kirklees Health and Wellbeing Plan, which will deliver a number of ambitions set out in the West Yorkshire and Harrogate STP.

<u>2.4 Review of the Urgent Care System across North Kirklees</u>

Provision of Urgent Care services at Dewsbury Hospital has been under review by the CCG for some time. To meet the needs of our population a strategic outline case will be developed which will cover the whole care pathway for urgent and emergency care and will be in line with national guidance.

Current work (as identified in 2.1) includes a review of how the Walk-In Centre works with the A&E minor injuries team to provide a seamless team with extended roles, this is now being explored. We are also exploring the co-location of our GP out of hours provider within A&E at DDH.

Better use and development of the Ambulatory Emergency Care Unit at Mid Yorkshire Hospitals is a key requirement alongside the development and enhancement of the primary care offer for urgent care (extended access; home visiting; medical care home provision).

Discussion between Locala and Local Authority around how the current admissions avoidance teams (HAT and Locala In-Reach team) could work more collaboratively is ongoing.

We have also recently started a review of our flexible bed base; domiciliary care and reablement packages to better understand how we can ensure medically fit patients can be discharged from hospital sooner with the appropriate care to meet their needs.

Recent PDSA cycles within the Walk-In Centre based within the A&E Department at Dewsbury District Hospital has led to a review and extension of the referral criteria. This has resulted in an, increased the number of patients streamed into the Walk-In Centre from A&E from 13% to18%. The existing contract for the Walk-In Centre is currently being reviewed with plans for a new service to be in place by 1st October 2017. We are exploring how the current service can be merged with the minor injuries unit to provide a more expansive 'primary care stream'. Meanwhile this and the other initiatives mentioned, including the clinical summit, will inform a strategic outline case for urgent care which is in development and aims to implement a urgent care service for North Kirklees in-line with national guidance.

3. Meeting the Challenge: Hospital Reconfiguration at Mid Yorkshire Hospital Trust

Plans to reconfigure Mid Yorkshire Hospital services were approved by the Secretary of State in March 2014 following formal public consultation and referral by the Joint Health Overview and Scrutiny Committee. The plans are part way through implementation.

Reconfiguration of women's and children's services was completed in September 2016. As a result, Dewsbury Hospital now has a children's assessment unit open 10am to 10pm daily and children requiring admission to hospital are transferred to Pinderfields. Consultant led obstetric services are now centralised at Pinderfields, which also has a new midwife led birth centre. Dewsbury Hospital has a new purpose built midwife led birth centre.

Reconfiguration of surgical services also commenced in September 2016, as a result of which acute surgery is now centralised at Pinderfields, with the exception of some minor procedures which can be carried out in 'hot clinics'. Dewsbury will provide an increased range and volume of planned surgery.

When services are fully reconfigured all complex surgery will be centralised at Pinderfields. Currently bariatric and complex colorectal surgery is still being provided at Dewsbury.

The final phase of changes is currently scheduled to take place in May 2017. This will involve reconfiguration of acute medicine as outlined below:

- Dewsbury hospital will continue to have an emergency department (A&E) which will be open 24 hours a day, seven days a week
- The emergency department will be led by a consultant and will have senior specialist doctors working in it around the clock, who will have the right skills to be able to assess and stabilise any patient who turns up
- There will be consultants in the department during the daytime and early evening, which are the hours when attendances are highest. At other times the team will be supported by an on call consultant just as they are at night now
- Currently, about 70% of people who come to Dewsbury emergency department can be treated without needing to be admitted to a hospital bed. For those people the plans mean there will be no change
- People will notice a change if they are more seriously ill and need very specialist care which is likely to mean they have to stay in hospital
- This is because the plans will change the way specialist and inpatient care is provided to ensure people are seen more quickly by a clinician with the right skills.
- People who are very ill and are likely to need a stay in hospital will be taken directly to Pinderfields if they call a 999 ambulance
- If a person comes to Dewsbury Hospital and the clinical team find they need inpatient care, they will be stabilised and transferred to Pinderfields
- When the changes happen our advice will be that people should still take themselves to Dewsbury Hospital unless they need an ambulance: if they call an ambulance the paramedics will decide which is the best hospital for their needs
- Critical care services will be centralised at Pinderfields
- Bariatric and colorectal surgery will be centralised at Pinderfields.

Currently the Trust is undertaking a review of the original capacity assumptions in the Full Business Case to take account of changes in demand and length of stay, largely driven by an increased number of admissions of people with conditions that require longer lengths of hospital stay, such as frail older people, stroke and respiratory disease. If more beds are retained than originally planned this will result in an increase in the beds remaining at Dewsbury Hospital (as there is limited space to increase beds at Pinderfields).

Rigorous risk assessment of the implementation plans is being undertaken and a decision as to whether to proceed in May 2017 will be taken by the system (Trust, CCGs and local authority) at the end of February 2017.