Care Closer to Home

Update on Development of Community Capacity in Calderdale and Kirklees

June 2021

1. Background

For several years Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) have worked collaboratively with community groups, health, social care, and voluntary sector organisations in Calderdale and Kirklees to deliver ambitious plans for integrated community services.

The plans in each Place align with the NHS Long Term Plan and with the West Yorkshire and Harrogate Health and Care Partnership's strategic plans. Regular updates on this work is reported to the Calderdale and Kirklees Health and Wellbeing Boards and to Calderdale and Kirklees Place-based Scrutiny Committees.

The COVID-19 pandemic has affected every community in Calderdale and Kirklees with some of the biggest impacts seen for the most disadvantaged people and BAME communities. The experience of the pandemic has made the need and importance of providing integrated care in local communities even stronger.

In December 2018 the findings of an independent review, commissioned by the CCGs, was completed. The purpose of the review was:

> "*To clearly quantify the impact of interventions in primary and community care on reducing demand in acute settings, by being more rigorous about: which interventions work; how we could standardise their application; and the utilisation of underpinning data driven modelling to give confidence in delivery*."

The independent review had a specific focus on identifying best practice interventions that could potentially reduce demand for hospital services. However it is important to note that the plans for reconfiguration of hospital services across Calderdale Royal Hospital and Huddersfield Royal Infirmary (described in the Strategic Outline Case approved by NHSE and DHSC in 2019) confirmed that hospital bed capacity across the two hospitals will be maintained.

2. Purpose

The purpose of this report is to provide an update, since the independent review was undertaken in 2018, in relation to:

- the 'best practice' interventions identified in the review that have been implemented in Calderdale and Kirklees;
- the investment in Community services across Calderdale and Kirklees since the review;
- the observed impact since 2018 on demand for hospital services.

This report provides a summary of the work that has been undertaken to develop community services enabling more patients to be cared for appropriately, for longer, in community settings helping to manage demand for hospital services. More detailed information in relation to the developments in each Place will be reported to the Calderdale and Kirklees Health and Wellbeing Boards and to Calderdale and Kirklees Place-based Scrutiny Committees.

3. Best Practice Interventions Implemented

The independent review undertaken in 2018 identified 13 best-practice interventions which were grouped under three main approaches:

i. Prevention and proactive care;
ii. Swift and appropriate access to care; and
iii. Supporting people with care transition.

The definition of these, under the three categories, is shown below.

1	Prevention and pro-active care	a	Case management: Pro-active case finding, assessment, care planning and care co-ordination for patients with long term conditions, putting them, their families and carers at the centre of decision making
		b	Multidisciplinary teams: A regular whiteboard session with a core group of professionals to pro-actively discuss patients or users who are at risk of requiring increased input. Additional professionals may participate ad hoc
		c	Care co-ordination: Provides a single point of contact and helps the patient and their supporters to navigate complex services. Often provided by a care navigator, or care co-ordinator, but this can also be the patient
		d	Individualised care plan: Develop a patient-centric care plan based on their current and future needs, focusing on what is important to the patient, beyond clinical treatment. It takes a 'whole life' approach
		e	Frequent touch points: Pro-active, regular and frequent contact with health professionals for at-risk patients to reduce the risk of crisis events
		f	Scheduled service user follow-ups: Use of regular scheduled follow-ups to reduce the requirement for urgent care services
		g	Self-empowerment and education: Patient education programs and use of technology to support self-care, with the aim of empowering the patient to become independent and resilient, taking responsibility for their own health
2	Swift and appropriate access to care	h	Rapid response: A multidisciplinary team that can be deployed to assess patients and prevents hospital admissions by providing health or social care support for those experiencing an episode of illness or injury
		i	Rapid access to primary care: Facilitating access to primary care in the acute setting, after appropriate triage. Also includes improved access from extended opening hours or other channels, eg eConsult
		j	Access to specialist care: Access to consultant support and specialist care in the community, including diagnostics
		k	Appropriate referral and medication practices: Avoid unnecessary interventions by only referring patients as appropriate
3	Support with care transition	l	Discharge support: Community, primary and social care in-reach to support early assessment and discharge of patients from acute care. Dovetails with intermediate care and overseen by a care navigator
		m	Intermediate care: Provision of step-up or step-down care in a patient's home or a community hospital inpatient facility to prevent unnecessary admissions to, and to facilitate early discharge from, acute care

In Calderdale and Kirklees many service developments based on these best practice interventions have been implemented. Mapping of the service developments implemented since 2018 to these interventions is provided at Appendix 1.

This includes (for illustration) the following examples:

- Virtual Frailty Service that runs 7 days 24 hours to prevent admissions to hospital;
- Digital Capabilities - to support early and preventative remote monitoring such as; Telecare/telehealth in care homes and people's own homes; Pulse Oximeters @ Home; Blood Pressure Monitors;
- Urgent community response service to provide a 0 – 2 hour response for patients diagnosed as moderately or severely frail, in order to prevent avoidable admissions and readmissions through management of the patient at home with appropriate ongoing community support;
- Primary care support to care homes aligning general practices with care homes to improve continuity of care and introducing weekly home rounds.
- Community Discharge to Assess (D2A) – that embeds the Home First ethos and Discharge to Assess approach and includes provision of additional funding for up to 6 weeks to support recovery following hospital discharge.

4. Investment in Community Services

There has been significant additional investment (totalling £62m over three years) to increase community and primary care capacity in Calderdale and Greater Huddersfield in the period 2018/19 to 2020/21. CCGs have also planned for further investment in 2021-22 as shown below.

CCG	3 Year Additional Investment 2018/19 to 2020/21 £(000)	Planned investment 2021/22 £(000)
Calderdale	28,014	15,826
Greater Huddersfield	34,500	23,000
TOTAL	62,514	38,826

This investment has been used to enable implementation of the best practice service developments summarised in section 3.

5. Workforce Capacity Impact

The significant investment has enabled an expansion of primary, mental health and community workforce to increase capacity of services and meet the needs of our population.

For example this includes the establishment of additional roles such as: Advanced Nurse Practitioners, GPs, Care Navigators, Rapid Response Support Workers, Clinical Pharmacists, Pharmacy Technicians, Social Prescribers, First Contact Physiotherapists, Health and Wellbeing Coaches, Dieticians, and Physician Associates.

The approach has not been based solely on increasing numbers of staff but also to enable people to work differently providing skills development and training to make better use of the overall system resource, and importantly to support colleague health and wellbeing.

Through the pandemic there has been a recognised cultural 'shift' in the behaviour of the health and care workforce across the Calderdale and Kirklees system, which has enabled and encouraged working across organisational boundaries. Cross boundary working is a long-standing aspiration, as an enabler to support people to receive the most appropriate care, in the most appropriate setting, first time. The fast paced, responsive environment through the pandemic has required us to mobilise and implement new ways of working. As partner organisations we will retain the positive learning and changes as much as possible to ensure that the benefits are maximised for both our population and staff.

6. Impact on Hospital Demand

The impact of the COVID pandemic, means that comparative data only exists up to 2019/20 and therefore can only (and only partially) reflect community developments that were already underway at the time of the 2018 review. The pandemic has also, and will continue to result in, changed casemix in 2021/22 and beyond as we transform the design and delivery of services and recover and reset the system.

We are therefore unlikely ever to be able to demonstrate a robust causal link between the increased and redesigned capacity in the community, and changes in secondary care demand. However the limited data we do have is consistent with the benefits we expected from the community developments implemented at the time of the 2018 review.

The impact on hospital activity we have observed in the period 2017-18 to 2019-20 is summarised below:

- **Mitigation of the impact of demographic growth -** between 2017 and 2020 non-elective admissions were broadly constant per 1000 population

- **Reduced unplanned admissions for people aged over 90 years –** in Kirklees there has been a 9.1% reduction in unplanned admissions for people aged over 90 years in the period since 2017/18.

- **Reduced length of stay (LoS) for adults** - the LoS reduction has been particularly marked in older age groups. In Kirklees the LoS reduction for people aged 70-89 years has been 7%, equating to 131 bed days per 1000 population and in the 90+ age range the reduction is 16%, equating to 1080 bed days per 1000 related population.

7. Summary and Conclusion

This report provides evidence of significant investment in community and primary care services across Kirklees and Calderdale over the past three years. The investment has increased capacity and enabled the development of integrated services that are well matched to the key interventions identified in the 2018 review as internationally-evidenced to have high impact on population health management.

The limited data available is consistent with our expectations that these developments are enabling more patients to be cared for appropriately, for longer, in community settings and helping to manage demand for non-elective hospital services.

Alongside the investments referenced in this report the Calderdale and Huddersfield health and care system benefits from having some of the most highly developed systems of digital connectivity and inter-operability currently available in UK healthcare. The application of digital technology has been accelerated during the Pandemic and this has enabled many more people to access the care and support they need at home and in more convenient ways over the past year. We will continue to develop these opportunities and benefits whilst ensuring this does not widen health inequalities.

We will continue to work with our communities and partners to deliver integrated care that provides a consistent and high quality experience for patients which is in line with the vision and ambitions articulated in Calderdale and Kirklees place-based plans.

Calderdale – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Calderdale	(1) Prevention and pro-active care							(2) Swift and appropriate access to care				(3) Support with care transition	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Name of initiatives selected													
End of Life Care	x	x	x	x	x		x			x	x	x	
Frailty Service	x	x		x	x	x					x		
Digital Capabilities	x			x	x		x			x	x	x	
Diabetes Prevention Programme	x	x		x	x	x	x		x	x	x	x	x
Enhanced Health in Care Homes (EHCH)	x	x		x	x	x	x	x	x	x	x	x	x
Learning Disabilities	x	x	x		x	x	x			x			
Adult & Older Adults Mental Health and Autism	x	x			x			x		x			
CYP Thriving	x	x	x		x	x	x			x			
Anticipatory Care DES	x	x	x		x	x	x						
Primary Care Additional Roles Inc Social Prescribing Link Workers	x	x	x		x	x	x						x
Well-being Hub	x	x	x		x	x	x						
Long Covid (0-12 weeks)	x				x	x		x	x		x		
Managing Demand in Primary Care	x		x	x	x	x			x		x	x	
Community Discharge to Assess (D2A)		x	x	x		x	x				x	x	x

Calderdale – Overview of Service Developments Implemented Mapped to ‘ Best Practice’ Interventions													
Calderdale	(1) Prevention and pro-active care							(2) Swift and appropriate access to care				(3) Support with care transition	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Reablement/2hr Response		x						x			x		x
Post Covid Pathway and Virtual Ward (12+ weeks)	x	x	x	x	x	x	x	x	x	x	x	x	
System Coordinator	x	x	x	x	x	x	x	x	x	x			x
Designated Beds (COVID)		x	x					x				x	x
Step Up and Step Down (IMC Beds)		x	x					x				x	x
Pulse Oximetry @Home		x			x		x	x	x				
Cross Cutting/Enablers													
PCN development; population health management													
Carers Count													
Calderdale Integrated Commissioning Executive													
Personalised Care													
Facilitation of provider alliances													

Kirklees – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Kirklees	**Prevention and pro-active care**							**Swift and appropriate access to care**				**Support with care transition**	
	a	b	c	d	e	f	g	h	i	j	k	l	m
Medicines Optimisation	x	x	x	x	x	x	x				x	x	x
End of Life care programme, including Hospice investment.	x	x	x	x	x					x	x	x	
Thriving Kirklees (CYP)	x	x	x		x		x			x			
Anticipatory Care	x	x	x		x	x	x						
Healthy Hearts	x	x		x	x	x	x	x	x	x	x	x	x
Respiratory (Community services)	x	x		x	x	x	x	x	x	x	x	x	x
Frailty Programme / Ageing Well	x	x		x	x	x	x				x		
Diabetes (Early identification & prevention; specialist nursing; improving outcomes)	x	x		x	x	x	x		x	x	x	x	
Care Homes (Including Enhanced Health in Care Homes DES and additional primary care support)	x	x		x	x	x		x	x	x	x	x	x
Community Mental Health	x	x			x			x					
BP @ Home	x		x	x	x		x				x		
Primary Care Equitable Funding (Capacity, resilience, consistency)	x		x	x	x	x			x		x		
Digitally-enabled care	x			x	x		x			x	x	x	
Wheelchairs (Engagement; investment)	x			x								x	
Discharge to Assess		x	x	x		x	x				x	x	x
Kirklees Independent Living Team (Intermediate Care)		x	x					x				x	x

Kirklees – Overview of Service Developments Implemented Mapped to ' Best Practice' Interventions													
Urgent Community Response		x						x			x		x
Primary Care Additional Roles			x	x		x	x		x				
Personalised Health Budgets			x	x			x						
Shifting services to community (MSK & Pain)			x				x			x	x		
Community IV (Training & expansion)					x						x	x	
Health Checks for People with Learning Disabilities					x	x	x						
Healthy Weight declaration							x						
Acute Home Visiting								x			x		
Home First								x				x	
Extended Access & Extended Hours									x		x		
Primary Care On-line consultations									x				
Community diagnostics											x		
Covid Oximetry @ Home	x				x	x		x	x		x		
Covid Virtual Ward	x	x		x	x	x	x	x	x	x	x	x	
Long/ Post Covid pathway		x	x	x		x	x			x	x	x	
Cross-cutting / Enablers													
PCN development; population health management													
Carers Count													
Kirklees Integrated Health and Care Leadership Board													
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