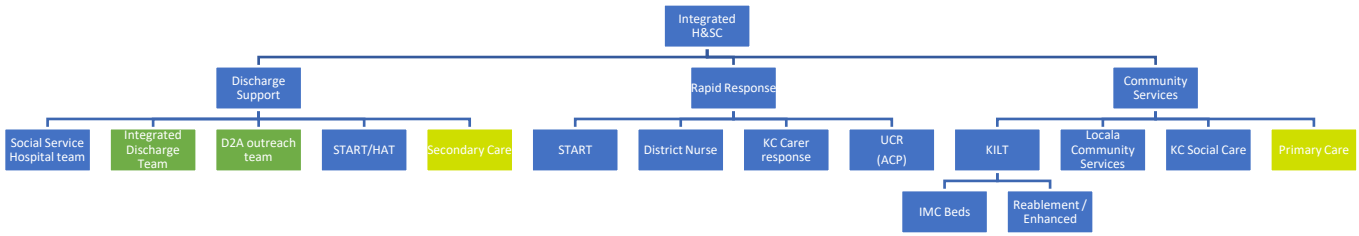
The progress and effectiveness of community care services delivered by Locala to include examples of the co-ordinated approach to providing care and support in Kirklees and how this integrated way of working has helped to reduce unnecessary A&E and hospital admissions and delays in discharge.

During the last 18 months Locala has worked in partnership with the Local Authority, improving the development work started as part of the Kirklees Independent Living Team (KILT) project. This enhanced significantly in response to national guidance being introduced relating to the Urgent Community Response (UCR) and Discharge to Assess (D2A).

In response to the guidance introduced last year, Locala and the Local Authority moved towards a more integrated Health and Social Care service, broadening out the services under KILT to include Urgent Response (UCR, START, LA Rapid, District Nurse 0-2 hour response), short term response [Care beds, IMC community (reablement / Enhanced reablement), D2A outreach team (providing health and therapy support in an allocated D2A bed whilst undergoing social care assessments)] and Hospital support (integrated discharge team – Locala and Social Care working in partnership with the acute trusts).

Some of the great development work that has taken place saw the introduction of one health and social care integrated referral route for KILT services and the one discharge form (that includes both health and some LA services on one form for the Trusts to complete). This is jointly triaged and there are daily Multi-Disciplinary Team meetings to discuss the most complex patients to ensure they receive the right support and care in the community. For those where further support or assessment is needed, they are transferred to a D2A bed in the community which supports that rapid discharge (avoiding delays) whilst still receiving appropriate care during this interim period.

The structure below shows the integrated structure across Community Health and Social Care and how it interlinks with wider services including Primary and Secondary care.



Urgent Response

In relation to existing urgent / rapid response there was an increase in the number of referrals into services with START seeing a 20% increase in 0-2 hour response, District nurse 43% and the Local Authority Rapid response service showing 40% increase during the 2020/21 reporting period all contributing to supporting admission avoidance.

During this year's reporting period (April – August 2021) 92.49% of patients who were seen by a District Nurse within 0-2 hours remained at home and 87.9% of patients who were seen by START also remained at home after their 0-2 hour intervention.

In relation the new service offer which commenced November 2020 as a phased approach. Locala has been working as part of an alliance with the Local Authority, Curo and Local Care Direct to deliver the accelerator pilot, introducing a 0-2 hour crisis response with ACP's attending patients in need and at risk of admission. In the most recent reports over 80 % of patients were seen in 0-2 hours with over 90% not being admitted to hospital during the 2 days that followed. This service is constantly improving with the move to a 7-day service offer from the 4th October and the introduction of a social care only offer in the new year (complimenting the current rapid carer response and START).

Short Term Care

Locala are working in close partnership with the Locala Authority to improve the service offer for patients coming through Intermediate Care (IMC) services, including working in a more integrated way to support the patient's journey. Improvements are ongoing to support the home first approach, ensuring patients are coming home as their first option with support and those who need some more intense support are cared for within a residential setting.

During the period of 2020/21, 551 patients were supported within an IMC bed setting and 950 patients received therapy support in their own home as part of the integrated health and social care offer. In relation to the community offer, there has been a 17% increase over the last 3 years of patients accessing reablement at home indicating the success of the home first model.

During the reporting period of April to August 2021, 848 patients were supported within an intermediate care service, 654 of those were supported at home with 91% not being readmitted to hospital during their integrated care with Locala and the Local Authority.

In relation to patients who have been supported through the rapid hospital discharge route as part of the D2A guidance, between May 2020 and April 2021 548 patients were supported in a D2A community bed receiving health and social care support. Of these Locala commenced an enhanced service offer from November 2021 and supported 387 within a D2A bed, ensuring a smooth transition onto their next destination.

During the reporting period of April to August 2021, 240 patients have been supported with their health and social care needs within a D2A bed setting with 90% patients not being readmitted to hospital during this period. This has improved over the last year and we are continuing to work in partnership with the Acute Trusts to improve this further.

Hospital Support

The D2A pathway has continued to improve over the last 18 months with the success of securing recurrent funding for Locala to continue to provide the health support in the system through hospital discharge and outreach to D2A caseloads. The approach taken as part of progressing the business case was a positive process including an integrated presentation with the Local Authority and CHFT, with Mid-Yorks Acute Trust also in support.

The presentation demonstrated ongoing need for the services offered as part of the new guidance during COVID, with CHFT reporting a significant improvement in discharges within Kirklees, with a length of stay in hospital and reduction in the average time taken to discharge complex patients. This shows a positive response to some of the improvements and enhancements made across integrated ways of working.

During this year's reporting period (April – August 2021) Locala, in partnership with the Local Authority, have supported 4705 (average 941 patients per month) with their discharge from hospital to the community. This is broken down below:

- Pathway 1: 4009 (home with package of care)
- Pathway 2: 467 (interim residential (IMC))
- Pathway 3: 229 (Long term residential/care setting)

Out of these patients, 87.9% had not been readmitted to hospital within a 93-day period and 92.4% were still at home at 31 days. Previous data showing this has improved by 8% for those not admitted within 31 days.

Locala continues to work across the integrated system to improve the service offer and patient journey, whilst supporting hospital discharge and admission avoidance. One of the projects we are working on with primary care looks at how we can improve the transfer of patient care from secondary care to primary care, including testing an integrated co-ordination of care approach with a GP practice. This aims to improve the communication from the Acute trust and to see how we can ensure the patient care is co-ordinated in a more integrated way with the GP practice. We are also looking at how we can engage more with social prescribers and how this links with our mental health provider colleagues.

Developing a Same Day Urgent/Emergency Response Model in The Community in Conjunction with the Primary Care Networks.

Scope

In response to the quantitative and qualitative evidence that Emergency Departments (ED) come under significant pressure when dealing with patients who could have been better accommodated on alternative pathways, the idea of developing same day community responses for appropriate urgency.

The priority target group will be patients requiring same day care who, for whatever reason, are unable to access this through their GP Practice after contacting them, and who then present at Emergency Departments.

There is an overlapping group of patients who may attend ED without initially contacting their practice who may also benefit from this service.

Objectives

1. To determine if a community-based pathway for patients needing same day care can provide a safe and effective alternative to ED attendance, thereby reducing pressure on those departments
2. To determine the best organisational model for the delivery of the pathway
3. To implement a pilot, to run through winter 2021/22 for the delivery of the pathway

Proposed Model

In considering the delivery model for the Same Day Emergency Care service (SDEC), two options are being evaluated:

- integration into the already established Urgent Care Response service (UCR), an Alliance project and a national accelerator site. The SDEC objective is closely allied to that of the UCR, which is,
  "To rapidly respond to Kirklees residents (aged 18 or over) who require a 0-2 hour response in the place of their residence in order to prevent avoidable admissions and readmissions by managing the patient at home with appropriate ongoing community support. "

  Enhancements would be required to the UCC to enable it to fulfil this additional role. These will need to include
  - Enhanced capacity for telephone clinical triage
  - New system links with GP practices
  - Enhanced pathways for disposition of patients as alternatives to ED
  - Enhanced access to outside resources (e.g. access to secondary are consultants in Gerontology and Emergency Care)

Specific attention will be paid to support for care home residents.18% of UCR calls currently involve care homes but there remains a significant demand upon secondary care. The model will aim to enhance direct ED support for assessment and signposting of care home residents while still in the community.

As the UCR is a national accelerator site and part of a national programme led by NHS England, any change in the remit or operations would need to be approved by them, which may cause delays in delivering implementation for the coming winter

- In addition, consideration will be given to the possible role of the Dewsbury Walk In Centre (WIC) as either a first point of contact for primary care (using bookable appointments) or as an alternative service option for patients arriving at the ED

  The enhancements required to the WIC would include
  - Introduction of a visible booking system accessible to primary care
  - Strengthening of the workforce to ensure consistent availability of Advanced Care Practitioners
  - Introduction of a GP presence to support the above and broaden the clinical capability of the WIC

Progress to Date

Priority has been given to the likely demand from primary care and the following have been developed

1. An analysis of current usage of alternatives to use of primary care (e.g., ED and WIC) broken down by practice to determine patterns of activity within PCNS
2. A relationship has been established with an individual practice and initial analysis of same day demand, capacity and likely SDEC demand is in process of completion
3. A Quality Improvement Workshop is to take place with key staff, including the practice. The purpose of this is prepare the way for possibly offering the additional UCR and WIC pathways to multiple practices, we agreed to shape the workshop by separating the new pathways from the interface at Grove House where patients are identified and routed into the two new pathways.
4. An update has been delivered to the Urgent Care Board and Kirklees LMC about the SDEC work to date with a view to publishing a wider, post pilot, service

Update on The Proposals to Merge the Gateway to Care Service and The Locala Single Point of Contact Service

Background

The concept of an integrated health and social care single point of contact is not a new one. Across the UK various models have been developed in order to simplify the access to services for the local population.

In Kirklees this has been identified as an area for improvement for a number of years and in the last 2-3 years this has been further highlighted as an issue by several groups of service users including patients, GPs, health and social care staff, who have all indicated their frustration in having 2 points of contact, one for health and one for social care. Stakeholders identified that users of health and social care often have overlapping issues and its often difficult to understand which services would best meet the service user or citizen's needs.
Initial investigations noted that:

- There was a significant overlap between the patients on the Locala caseload and those using social care services.
- Both GTC and SPOC identified a number of calls, where they were unable to help as the call was for its counterpart and staff had to direct the caller to call its counterpart in health or social care. This was often met by frustration from the caller
- Service users identified in a series of workshops that they were frustrated with having to decipher which number to use and could not understand why they were not integrated.
- In a number of deep dives into calls received by both services it was identified that patients / service users often had both health and social care needs and one integrated service could have simplified their journey and improved the quality of service offered.

Progress to date

- A steering group is in place to support the ongoing work and report to the integration board on progress.
- Workstreams underway to explore and plan the different elements of integration; these include, Workforce, IT, coproduction, and communication.
- Engagement with colleagues to keep them updated on the project, including a survey and a number of workshops to facilitate their co-creation of the integrated model and establish what they feel would be the benefits and concerns around integration.
- Colleagues have shadowed their counterpart service, to facilitate understanding across the teams.
- A shared office space has been identified for both teams once Covid restrictions allow mixing of staff.
- The development of shared training programmes for new starters as well as the development of training for staff in relation to health and social care for existing staff.
- Development of a system to transfer calls internally across organisations.
- Potential models are under development for evaluation.

Next Phase of Development

Pilot one call handler operating across both health and social care. Training of 2 Locala call handles was initiated on the 27/09/2021. 2 Gateway staff will join the pilot once capacity allows.

The plan is to evaluate the complexity of having one call handler dealing with both health and social care issues and the benefits and challenges this could present in understanding both health and social care service offers. Training and support will be required throughout the process and the development of new algorithms will be required going forwards to support colleagues piloting the integrated role.

Training will take between 2-3 months and colleagues will then receive calls from both the health and social care lines. The plan is to run this pilot for 6 months with constant adjustment of the service on offer from any learning gained during this time from the colleagues involved.

Learning from the pilot will be evaluated throughout and next steps will be considered in March 2022, although adjustment to the integration pilot will be applied throughout this period.

A blueprint is in place underpinning the integration project to support the process of consultation and coproduction. This is a live document under constant review. This is appended to this report at Appendix 1.

Jane Close
Chief Operating Officer