Kirklees Scrutiny Committee

NHS West Yorkshire Integrated Care Board

Kirklees Scrutiny Committee

Joined up Care in Kirklees Neighbourhoods

Data & Intelligence Pack

Catherine Wormstone
Director of Primary Care

December 2022

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Questions raised and addressed in relation to Joined up Care in Kirklees Neighbourhoods

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Section 1

An overview of the new statutory arrangements that are in place as a result of the new health and care act to include a short history of the development and introduction of PCN's and the work that is/will be done for integrating primary care as outlined in the Fuller Stocktake report.

Section 2

A Focus on the capacity of out of hospital care to include all aspects of community care including adult social care capacity, community services capacity, and primary care support.

- Community Pharmacy to help alleviate demand in hospitals.
- Context to the work being done to prevent and reduce demand through the focus on early prevention and building capacity in the community.
- Details of the additional community based roles in GP practices and other services including data (numbers of roles etc.) to include the development of personal care roles across PCN's.
- Examples of existing and emerging initiatives that demonstrate how PCN's and community services work together such as urgent care, walk in centres and the "Canterbury Model"
- Data supporting the work being done through Urgent Community Response and Virtual Wards.
- Assurance regarding efficiencies that will be needed in the provision of adult social care and community care in order to accommodate the growth in demand.
- Work being undertaken to manage and improve hospital discharge (to include data).
- The changes that have taken place and the work to be done on developing the model of care that enables/will enable more people to receive treatment at or closer to home.
- Update on Community Diagnostic hubs including funding.
- All above to be demonstrated by some examples of real life patients stories (short and concise).

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Section 1

Statutory Arrangements, PCNs & Integration

Fuller Stocktake – May 2022

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At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

1. Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
2. Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
3. Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

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Our Vision for integrated Primary Care

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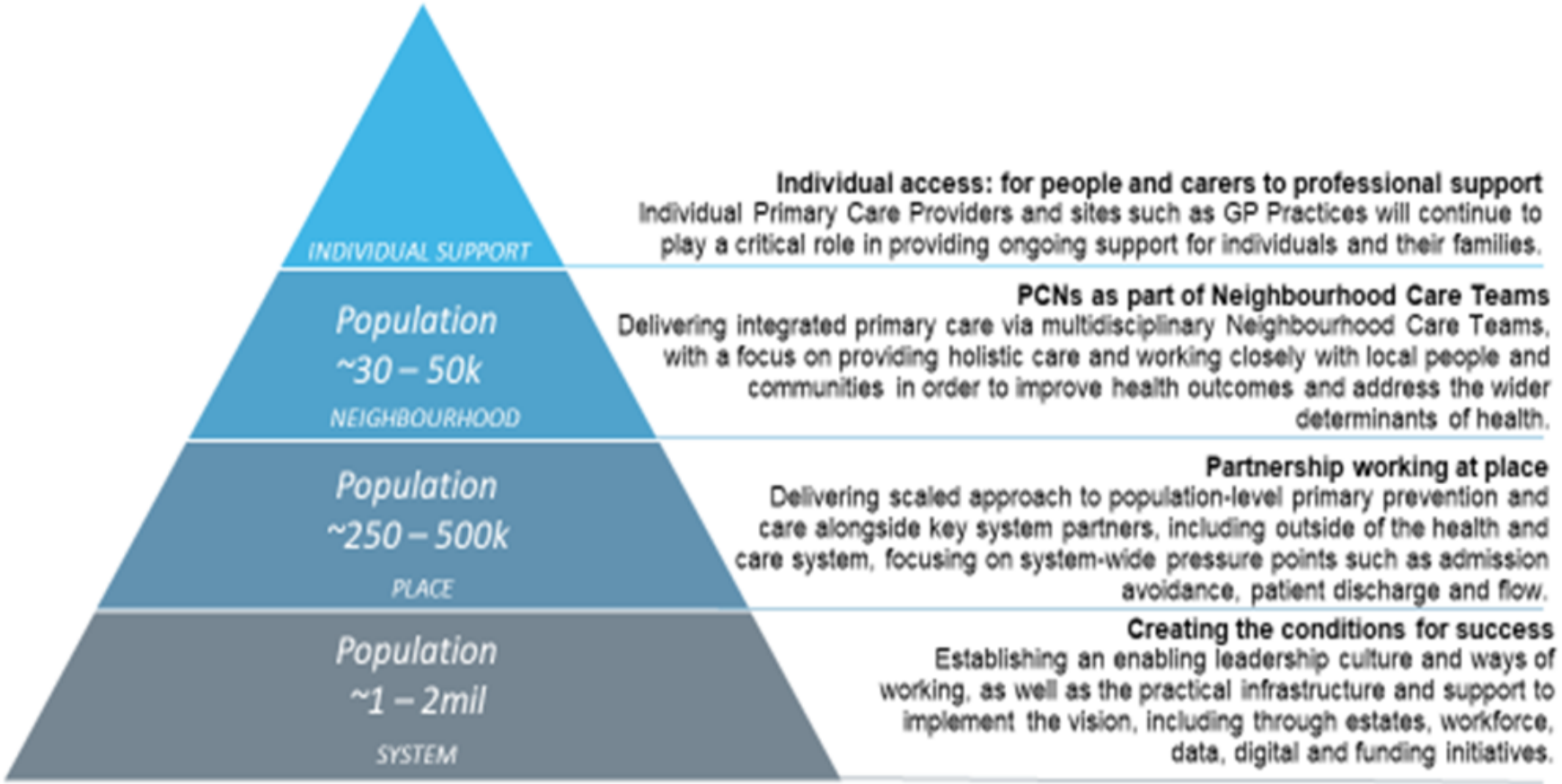

Individual access: for people and carers to professional support
Individual Primary Care Providers and sites such as GP Practices will continue to play a critical role in providing ongoing support for individuals and their families.

PCNs as part of Neighbourhood Care Teams
Delivering integrated primary care via multidisciplinary Neighbourhood Care Teams, with a focus on providing holistic care and working closely with local people and communities in order to improve health outcomes and address the wider determinants of health.

Partnership working at place
Delivering scaled approach to population-level primary prevention and care alongside key system partners, including outside of the health and care system, focusing on system-wide pressure points such as admission avoidance, patient discharge and flow.

Creating the conditions for success
Establishing an enabling leadership culture and ways of working, as well as the practical infrastructure and support to implement the vision, including through estates, workforce, data, digital and funding initiatives.

Summary of the Fuller Report (1)

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Building integrated teams in every neighbourhood (pages 6 and 7)

- enable all primary care networks to evolve into integrated neighbourhood teams
- alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints'
- making available 'back-office' and transformation functions for PCNs
- a shared, system-wide approach to estates, with organisations co-locating teams in neighbourhoods and places.
- create a clear development plan to support the sustainability of primary care, across all neighbourhoods – focusing on unwarranted variation in access, experience and outcomes

Working with people and communities (pages 7 to 9)

- focus on community engagement and outreach, across the life-course.
- work alongside local people and communities in the planning and implementation process
- continuing to develop how PCNs, work effectively in partnership with communities, VCSE and local authority colleagues.
- role of anchor institutions, inclusion health, addressing the wider determinants of health

Improving same-day access for urgent care (pages 10 to 12)

- Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.
- enable primary care in every neighbourhood to create single urgent care teams
- connect up the wider urgent care system

Personalised care for people who need it most (pages 12 to 13)

- Extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests.
- Develop approach to personalised continuity of care, including holistic anticipatory care for people with more complex and chronic long-term conditions
- Increase secondary care outreach into neighbourhoods and increase range of diagnostics – maximising opportunities from community diagnostic centres.

Summary of the Fuller Report (2)

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Intensive community support / intermediate care (page 13)

- At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams.

Preventative healthcare (pages 14 to 17)

- Role of primary care and neighbourhoods in improving healthy life expectancy and tackling health inequalities
- Addressing deprivation and Core20PLUS5, shared approach to primary prevention
- Effective use of population health data

Workforce (pages 18 to 22)

- Embed primary care and community workforce as an integral part of system thinking, planning and delivery – with integrated workforce solutions
- Increase in GPs and wider primary care team, neighbourhood recruitment, innovative employment models, inclusive employment culture
- Development of ARRS, MDTs and multi-agency 'team of teams' development (training, leadership and OD)
- Development and support of clinical directors and consultant in general practice model

Estates (pages 23 to 24)

- Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care

Data (page 24)

- PCNs and neighbourhoods having tools to make routine use of population data with greater data sharing
- Joined-up business intelligence and data analytics

Digital (pages 25 and 26)

- Interoperable IT systems
- Technology enabled care – telehealth, telemedicine, on-line consultations etc.

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Development of Primary Care Networks (PCNs)

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PCNs in Kirklees

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- At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations. This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.
- In May 2019, the two former Clinical Commissioning Groups in Kirklees (Greater Huddersfield CCG and North Kirklees CCG) registered 9 Primary Care Networks with groups of GP practices covering populations of 30-50k.

Primary Care Networks in Greater Huddersfield CCG Area	Registered Primary Care Networks in North Kirklees CCG Area
1. The Valleys Health and Social Care Network	1. Spen Health and Wellbeing (Primary Care) Network (SHAWN)
2. The Mast Primary Care Network	2. Batley and Birstall Primary Care Network
3. Viaducts Care Network	3. Three Centres Primary Care Network
4. Greenwood Network	4. Dewsbury and Thornhill Primary Care Network
5. Tolson Care Partnership	

PCNs in Kirklees

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Each Primary Care Network

- Covers a geographically contiguous area formed based on GP practice boundaries (not ward based)
- Has a signed Network Agreement
- Has a Clinical Director (clinician from the PCN – we have 8 GPs and one Advanced Nurse Practitioner) who provides leadership for the PCN's strategic plans, working with PCN members to improve the quality and effectiveness of its delivery of the Network Contract DES
- Is able to employ additional workforce as part of the Additional Roles Reimbursement Scheme (ARRS) – currently 17 roles
- Must deliver a number of prescribed national specifications – Structured medication reviews/medicines optimisation, Enhanced Health in Care Homes, Early Cancer Diagnosis, Social Prescribing, CVD prevention & Diagnosis, tackling Neighbourhood Inequalities
- From 1 October 2022 – must deliver the Enhanced Access Service (evening and Saturday appointments)

- What PCNs are **not** – formal organisations with significant infrastructure

PCNs in Kirklees

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- Each PCN has aligned models of community services provision, voluntary sector involvement and joined up support for care homes across the patch.
- Pandemic saw many national specifications pause or delay – but close working relationships outside of traditional organisational boundaries were formed during this time
- Range in focus depending on the populations they serve, the health needs and the ambition of the PCNs
- Recently updated PCN data packs to support neighbourhood discussions and population health management approach
- https://observatory.kirklees.gov.uk/wp-content/uploads/PCN_data_pack_2022_Kirklees.pdf
- ICB ambition to accelerate the development of neighbourhood teams far beyond the initial set up / approach of PCNs
- Integrated neighbourhood teams will use a population health management approach to proactively tackle health issues and health inequalities.
- What PCNs are not – formal organisations with significant infrastructure

PCNs in Kirklees

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Additional Roles Reimbursement Scheme 2022/23	
Clinical Pharmacist	Occupational Therapists
Pharmacy Technicians	Nursing Associate
Social Prescribing Link Workers	Trainee Nursing Associate
Health & Wellbeing Coach	Paramedics
Care Coordinator	Mental Health Practitioners
Physician Associates	Advanced Practitioners
First Contact Physiotherapists	Digital Transformation Leads
Dieticians	GP Assistants
Podiatrists	

138 WTE staff currently in post and a further **55** planned in year

Issues Raised at the ICB Board Discussion – Deep Dive into Primary Care (Nov 22)

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- Pressure building for many years, accelerated by the pandemic
- Good examples of integration and working with partners
- Estate limitations and availability of capital
- Variation across practices, particularly re access
- Patient experience is variable – Healthwatch feedback and patient surveys
- Workforce challenges, including ARRS
- Infrastructure support – supervision, management, admin
- Public understanding of model of delivery
- Digital opportunities and challenges
- DES can be inflexible
- Strengthening of neighbourhood approaches as outlined in the Fuller Report

Section 2

Capacity of out of hospital care including adult social care capacity, community services capacity, and primary care support.

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CKW Neighbourhood Programme Model

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Desired outcomes from our work together

- Contributes to meeting the 10 big **ambitions of ICS**
- Joins-up care better '**at home and close to home**' in a way that supports communities to stay healthy and well,
- Provides a more **seamless** experience,
- Reduces **unwarranted variation**,
- Tackles **health inequalities**, using population health data to focus efforts in the most needed places, and to measure overall impact too
- Enables a shift to more **proactive and preventative** models of care, and
- Secures the **sustainability** and the development of the teams and services that support our neighbourhoods.

Also - behaviours and culture of how we work together as partners, focusing on patient and community needs, and working together in a **truly 'one system' integrated** way to achieve this.

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Focused on key areas from Fuller Report

Integrated urgent care – our populations receive optimum response depending on the nature and urgency of their need.

Intensive Community Support and Intermediate Care, including **Proactive multidisciplinary team** care for those with more complex needs including those with multiple long-term conditions, who benefit most from continuity of care

Personalised Care, long term condition management and continuity of care, including community nursing support and EoL

Helping people to stay well for longer as part of a more ambitious and **joined-up neighbourhood-based approach to prevention**, linking together health-based interventions with those that address the wider determinants of health

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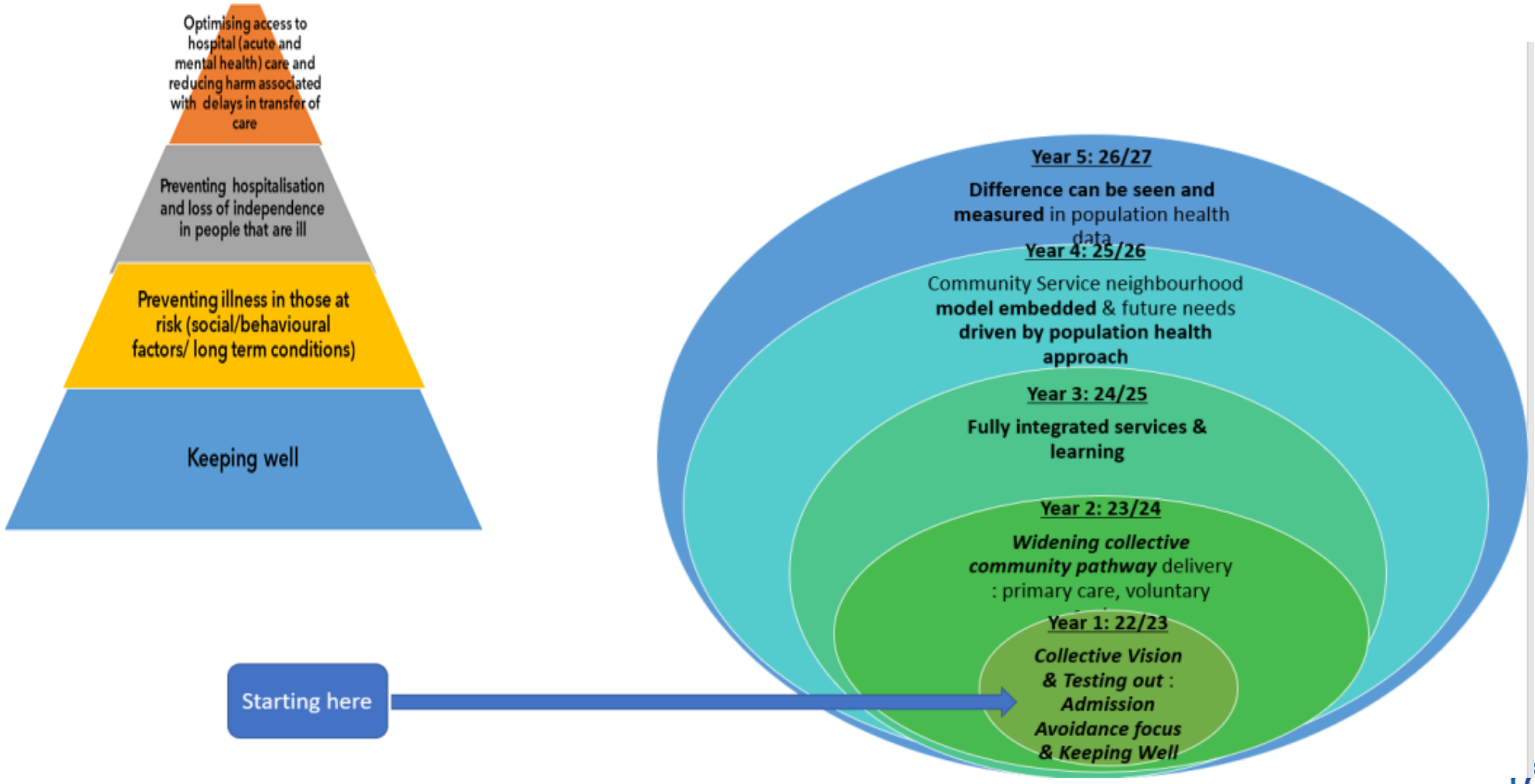
Five year programme



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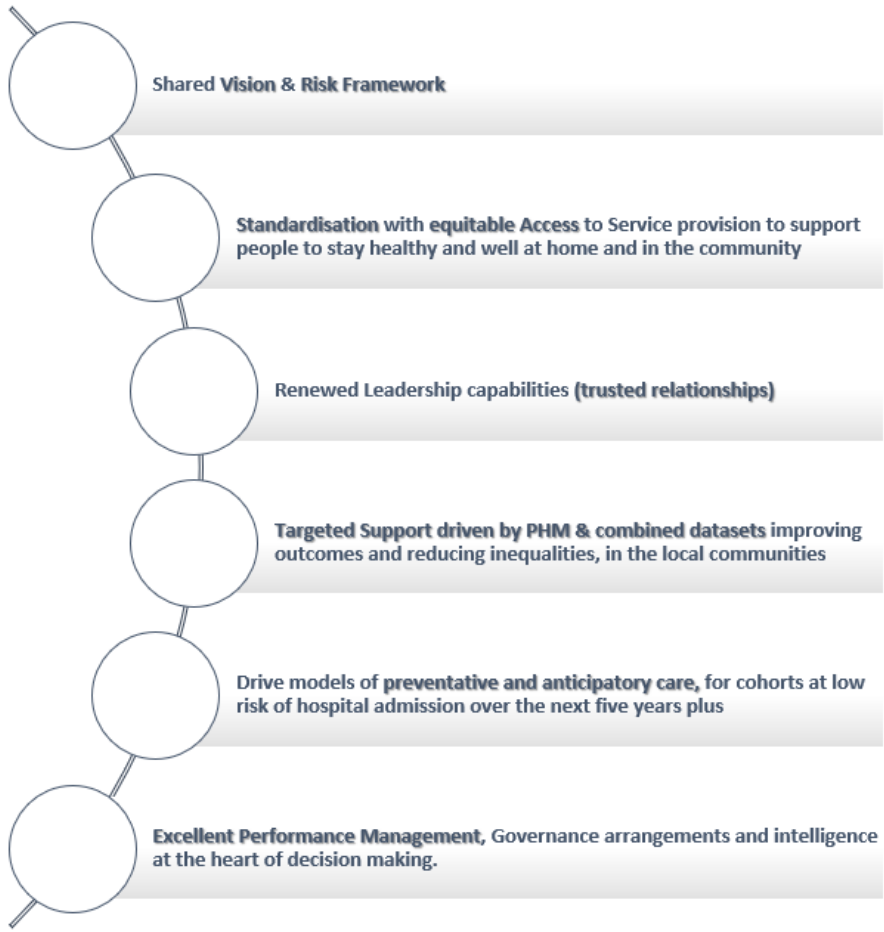

Enablers

- Digital Platform
- Data Sharing
- Interopability
- Strong Governance
- Freedom in a Framework
- Commissioning Framework
- Scalability
- Business Planning & demand modelling
- Shared Workforce pool & rotation
- Less Bureaucracy
- Self management

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Community Support to enable people to stay well – November Progress

Small group of leaders from CKW – Locala, Mid Yorkshire Hospitals , Calderdale & Huddersfield Trust , ICB, Local Authority, YAS, Care Association, Age UK, Voluntary & Community Association

Collective ideas generated across CKW focused on proactive community support to enable people to stay well

A range of ideas identified – all with potential to make a difference to people and communities in CKW

Recognise range of work already underway – some in one patch and can be spread, other ideas where opportunity to develop further

Reviewed and prioritised ideas that would have the most impact now, and going forward

4 ideas identified to take forward now – community support movement, falls prevention with fire brigade, proactive follow up support with specific patient groups following discharge, and self management support

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Building on existing work across CKW

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Community Support Movement

Use principles of ‘Look out for our Neighbours’, Every Contact Counts and C19 mobilisation

Build on existing work through LA Community teams and voluntary sector

Maximize full benefits of community assets to proactively support people in our communities – to self care, reduce social isolation, signpost early to support that will help people stay well

Development of enhanced community pathways, infrastructure, sign-posting and information.

Range of places and interactions where vulnerable people could benefit from proactive support including: Hairdressers, supermarkets, gardeners, window cleaners, small cafe in small communities, milkman, drama groups, libraries, bin men/women, opticians, Monday club in Wetherspoons, postmen/women etc. Religious spaces, Funeral directors (support for people left behind), National Volunteering Service - linking with people who are vulnerable, aligning younger isolated people with older isolated people

For winter warm spaces = include advice available re grants, citizens advice, meds cabinet 'choose well' and potentially site heath and social care link workers for specific interventions

Plan to scope what there is already in place, gaps in provision and alternatives and additionality that would make the most difference.

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Falls Prevention

National and local statistics provide the backdrop the problems associated with falls, loneliness, and winter cold.

One third of people aged 65 and over suffer a fall each year, that the risk of falling increases as people grow older, and that falls are the leading cause of death due to injury among the elderly. In addition loneliness increases the likelihood of mortality by 26%. Age UK figures state around 1.2 million older people are chronically lonely.

Scope to introduce further preventative measures to reduce the risk of falling, and also consider proactive support to extend these initiatives to other areas, including reducing social isolation, and addressing winter cold

Idea that will be progressed for spread (already underway in Calderdale) embraces the making every contact counts approach.

Utilise West Yorkshire Fire and Rescue Service to undertake an enhanced home fire safety check service for identified priority groups. These enhanced safe and well visits would include multi-factorial falls risk assessments, referrals to the Occupational Therapy Team, enrolments onto balance/falls prevention programmes, assigning social workers to vulnerable people, follow up visits by the Staying Well (CKW equivalent) Team, fitting handrails in households, and Age UK befriending individuals

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Proactive Follow up following discharge

Proactive follow up support via VCS and volunteers across CKW (potentially staff volunteers) to do check phone call for every discharge, day after discharge

Supportive check-in, signposting to additional support and pathways as helpful

Focused on ensuring people are able to stay well at home, and reduce re-admissions

Initial priority cohort over 65 emergency admissions (pathway 0 and 1). Later expansion to elective admissions in high risk patients

Next step to explore community support workers being part of frailty ward rounds. This would enable carer groups to be included in discharge process, and provide proactive support

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Self management support

People to go into the wards and teach pts to do eye drops, insulin and other activities where self management is possible and beneficial

Resources, videos and information then also available

This would increase self management and patient / carer empowerment as well as reduce need for district nurse support (freeing up time for more urgent and complex patients)

A number of options will be explored including: C19 volunteers - revigorated. Retired police officers. Retirees. C19 vaccination people. Peer support who are trained to provide

Build on learning from Leeds Community Health who have adopted this model

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Additional Ideas for more work up

Community Support police officers	Longer term idea. Potential for targeted support in specific communities. Develop referral pathway
Wider use of community responders	Due to current pressures on YAS - not possible now. In future explore how this role could provide other proactive support
Domiciliary carers	Develop pathway from Dom care providers to other support. Open access to pathway , and know where to signpost to. Proactive support via care homes for isolated people
TV Channel for support and connecting patients	Work up further
Additional digital opportunities - need to map these and test out	Work up further
Mental Health Vehicle expansion	Work underway - understand further opportunities
Use the care home environments to support people who are currently isolated which then leads to further demands on other services - if we tackle isolation at source will it reduce this need?	Ability for care home to have more open access (on respite / day care basis) for older people to reduce social isolation
Foster Care for Older People	Option to go to someone's house for support, for short period. Funding. Discharge from hospital. Respite care. Shared lives Kirklees(LD) - can learn from this

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Next Steps

- Follow on meeting in process of being arranged to track progress of ideas
- Community Model workshop in December to consider the other ideas generated as part of the proactive approach to the development of a community neighbourhood model
- System leadership groups considering ‘Canterbury Model’ and work across WY
- Improve engagement with General Practice, Community Pharmacy, VCSE and Independent Sector

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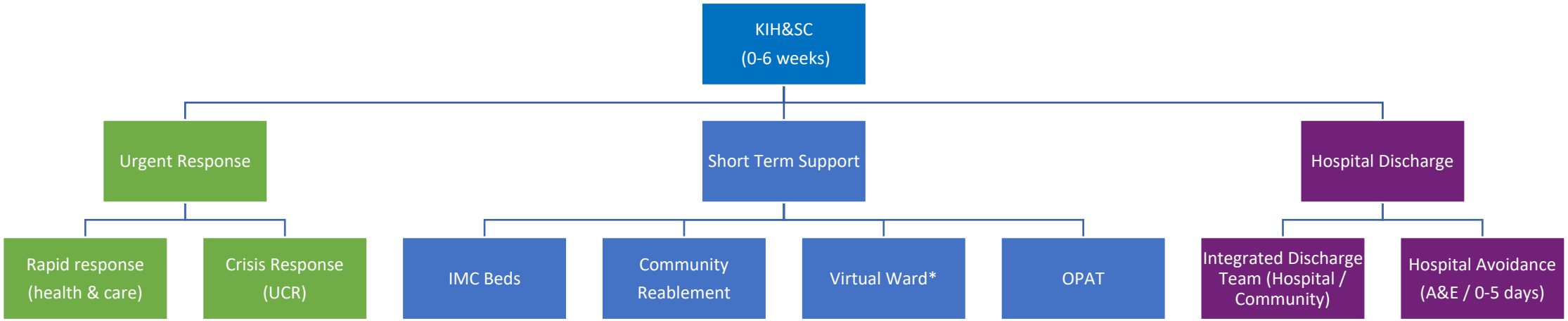
Kirklees Integrated Health & Social Care (KIH&SC)



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Kirklees Integrated Health & Social Care (KIH&SC)

Kirklees Council and Locala are committed to taking a joint approach to delivering Integrated Health and Social Care (KIH&SC) service. The Integrated Health and Social Care Team works within an integrated structure with a vision to deliver joint care across Kirklees.

- **Kirklees Integrated Health & Social Care (KIH&SC)**
  - **Working Groups**
    - Joint performance metrics group – Integrated performance dashboard
    - Intermediate Care quality forum
    - Beds management
  - **Delivery and oversight of the KIH&SC**
    - Monthly Operational Group Meeting (Operational deliver review and planning with escalation to Management)
    - Monthly Management meeting (Management review and support with escalation to Business Meeting)
    - Monthly Business Meeting (Oversight group)

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Integrated Locala and Kirklees Council Service offers

- **Integrated Transfer of Care Service (Hospital Discharge)**
  - **Integrated Hospital Service – Onsight support**
    - Integrated team health, social work and care working in a hospital setting in partnership with Trust- Referral review, Multi-Disciplinary Team (MDT), assessment and discharge plan support
  - **Integrated Transfer of Care - Community Support**
    - Integrated team health, social work and care working to support patients on a Discharge to Assess pathway for an interim period whilst further assessment is completed or package of care in place
  - **Hospital Avoidance (0-5 day)**
    - Integrated team with a presence in hospital A&Es and supporting patients who were in hospital 0-5 days

- **Urgent Community Response(UCR)**
  - Multi-disciplinary team providing crisis and urgent response within 0-2 hour (Advanced Clinical Practitioners, Nurses, Therapists, Health Care Support Workers, Social Care Assessors, Assistant Practitioners) – Holistic assessment, medical 48 hour follow up, clinical and social up to 7 days support, transfer of care to planned services [Locala & Kirklees Council working in an alliance with Local Care Direct and Curo)

- **Short Term Care**
  - **Intermediate Care Beds**
    - Short term (up to 6 weeks) rehabilitation within a residential setting for patients who cannot be supported at home. MDT offering care to maximise independence to transfer home
  - **Reablement**
    - Short term (up to 6 weeks) rehabilitation at home to maximise independence to maintain at home

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Integrated Locala and Kirklees Council Service offers

In addition to the joint service offers described earlier, Kirklees Council and Locala have worked in partnership to deliver other services, have joint roles and are working towards an integrated front door.

- **Integrated Single Point Of Contact (SPOC) / Gateway to Care (G2C) project plan**
  - Locala & Kirklees Council are 18 months into an integrated Single Point of Contact project with the intention to move towards from contact centre from April 2023

- **Health & Wellbeing Service**
  - Kirklees Council delivered an 18 month Health & Wellbeing service offer providing community health checks. As part of the model, Locala provided the clinical support to the service working in partnership with Kirklees Council colleagues

- **Integrated Head of Service (Locala / Kirklees Council)**
  - Locala and Kirklees council have provided an opportunity to have a joint Head of Service to oversee and manage a range of Locala and Kirklees Council services. The aim of this role is to support a team of health and social Managers to deliver quality care as part of the vision of a joint strategy and shared roles

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Community Pharmacy

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Community Pharmacy

Community Pharmacy is part of the NHS and provides NHS Services.

85-95% of a pharmacy's total income is from the NHS. Like GPs, community pharmacies are independent NHS contractors.

Pharmacy staff **reflect the social and ethnic backgrounds of the community they serve**, and they are **accessible to deprived individuals** who **may not access conventional NHS services.** An opportunity to reduce health inequalities (NICE QS196).

Pharmacies in England dispensed nearly **one billion** prescription items in 2014/15 (average 870,000 per pharmacy).

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The accessibility of Community Pharmacy

Community pharmacy provides **accessible** healthcare in local communities. Most services are available as walk-in, without the need for an appointment.

89.2% of the population can reach their local community pharmacy within a **20 minute walk**

Over **99%** of those in areas of **highest deprivation are within a 20 minute walk** of a community pharmacy

Many pharmacies are **open during the evening and at weekends -** times other parts of the system consider to be out-of-hours

An estimated **1.6 million visits** to community pharmacies take place daily (avg. 137/pharmacy). Community pharmacists and their staff generally see patients more regularly than any other healthcare provider.

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NHS Services

All pharmacies provide NHS **Essential Services:**

Dispensing Medicines
Dispensing Appliances
Repeat Dispensing
Unwanted Medicines
Health Campaigns
Signposting
Self Care
Healthy Living Pharmacy
Discharge Medicines Service

- **More than just the supply of medicines**

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NHS Advanced Services

Advanced Services are provided by many pharmacies

Community Pharmacist Consultation Service
Flu Vaccination Service
New Medicine Service (NMS)
Pandemic Delivery Service (temporary service)
Pharmacy Collect – LFD collection (temporary service)
Hepatitis C testing service
Appliance Use Review
Stoma Appliance Customisation

Helping people get the most from their medicine

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Local Services

Local services may be provided if they are commissioned locally

- Stop smoking
- Needle and syringe exchange
- Supervised consumption
- Emergency hormonal contraception
- Minor ailments service
- Care home service

- Sexual health screening
- Vaccinations
- Alcohol screening and brief interventions
- Weight management
- Falls reduction
- Independent and supplementary prescribing

Locally commissioned and funded

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Opportunities – link between CPCF and general practice

- Improving prevention and health inequalities
  - Flu – aligned incentives (through Investment Impact Fund (IIF) and PQS) to increase uptake
  - Cardiovascular disease diagnosis and prevention – DES link with community pharmacy hypertension service
  - Inequalities – PCN, local commissioners and LPC to agree an approach, link with NICE QS196 and supported by PQS
  - Healthy Living Pharmacy (HLP)
  - Pharmacy commissioned services – emergency contraception, stop smoking, Hep C
- Improved primary care access
  - Community Pharmacist Consultation Service (CPCS) – within IIF
  - Community pharmacy open and providing services within OOH

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Opportunities – link between CPCF and general practice

- Delivering better outcomes for patients on medicines
  - Structured Medication Reviews (SMR) – link with pharmacy services, Discharge Medicines Service (DMS), requests for Multiple Compartment Compliance Aids (MCCAs)
  - Community pharmacy PQS anticoagulant audit
  - Antimicrobial Resistance – PQS supporting this work
  - New Medicines Service – opportunity for GP practice to routinely refer patients starting a new medicine to the service, link to SMR referral from community pharmacy for patients with unresolved issues
  - Relationships – improve and grow, PCN SMR DES includes role of Pharmacy Technician in developing a relationship with community pharmacies
- Sustainable NHS
  - Reducing carbon emissions – supported by PQS inhaler return for destruction
  - Inhaler changes – link to NMS for patients who change device

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Mental Health Transformation Primary Care Network (PCN) Hub

By 2023/24 the programme will ensure that each Primary Care Network will benefit from a co-located, mini-mental health team, working together to provide a seamless service with interventions of varying intensity, appropriate to the individual level of need – with integrated pathways to the core specialist hub

Additional Roles Reimbursement (ARRS)
Mental Health Practitioners

Advanced Clinical Practitioners (ACPs)
Provide holistic assessment and support MDT triaging. Providing evidence based/ Psychosocial interventions and connecting people to appropriate support in the mini team & Hubs.

Mental Health Pharmacist
Providing access to mental health pharmacy, medication management, reviews and education.

Mental Health Social Prescribers
To provide mental health knowledge /expertise

SMI Physical Health & Wellness Team
Provide health checks and support to improve physical health. Co-facilitation of psychoeducation courses.

Community Connectors
Employed within VCS – to reflect community demographics, these roles are more focused on the specific needs of people with serious mental illness and complex needs.
Navigating through a range of activities to support wellbeing, connecting people with their community and supporting the transfer of stable individuals out of Recovery and Older Adults Teams enabling them to engage with and receive community support.

IAPT
Improving access to Psychological therapies

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Blended Mental Health Pharmacists Model covering all 9 Kirklees PCNs

Implementation		
Role	Whole time equivalent (wte)	Start date
Lead Pharmacist	0.5	January 2023
Advanced Clinical Pharmacist	2.00	January 2023
Foundation Pharmacist	1.00	January 2023
Medicines Optimisation Technician	2.00	January 2023

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Blended Mental Health Pharmacists Model covering all 9 Kirklees PCNs

General details of service to be offered:

- Medication reviews for complex mental health regimens
- Patient consultations and medication counselling
- Empowering patients to make informed decisions on their care plan
- Medication reconciliation post mental health discharge
- Rationalising and optimising medication, mental health medications (for people with severe mental health problems, particularly those with complex co-morbid physical health problems)
- Answering queries from other practitioners
- Prescribing medications for mental health related conditions
- Switching medications
- Signposting
- Discharge follow up
- Providing mental health support for those with long term physical health conditions
- Writing policy
- Education and training
- Deprescribing
- Assessing overuse and suitability of PRN medications
- Medication advice – including use of herbal and OTC remedies

- Addressing adherence issues, poor communication, drug errors

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Mental Health progress to date and 23/24 plans

Implementation			
		2022/23 Year 2	**2023/24 Year 3**
Role	In post	PCN coverage	PCN coverage
Mental Health Social Prescribers	Yes	9	9
Advanced Clinical Practitioners (ACPs)	Yes	8	9
SMI Physical Health & Wellness Team	Yes	5	9
ARRS Practitioners	Yes	2 (soon to be 3)	9
Mental Health Pharmacists	Yes	9	9
IAPT	Yes	9	9

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Adult Social Care

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Adult Social Care capacity to support out of hospital care.

ASC investments in the front door, community services, reablement services and the social care occupational therapy team are all designed to reduce the flow of demand for formal assessment and care.

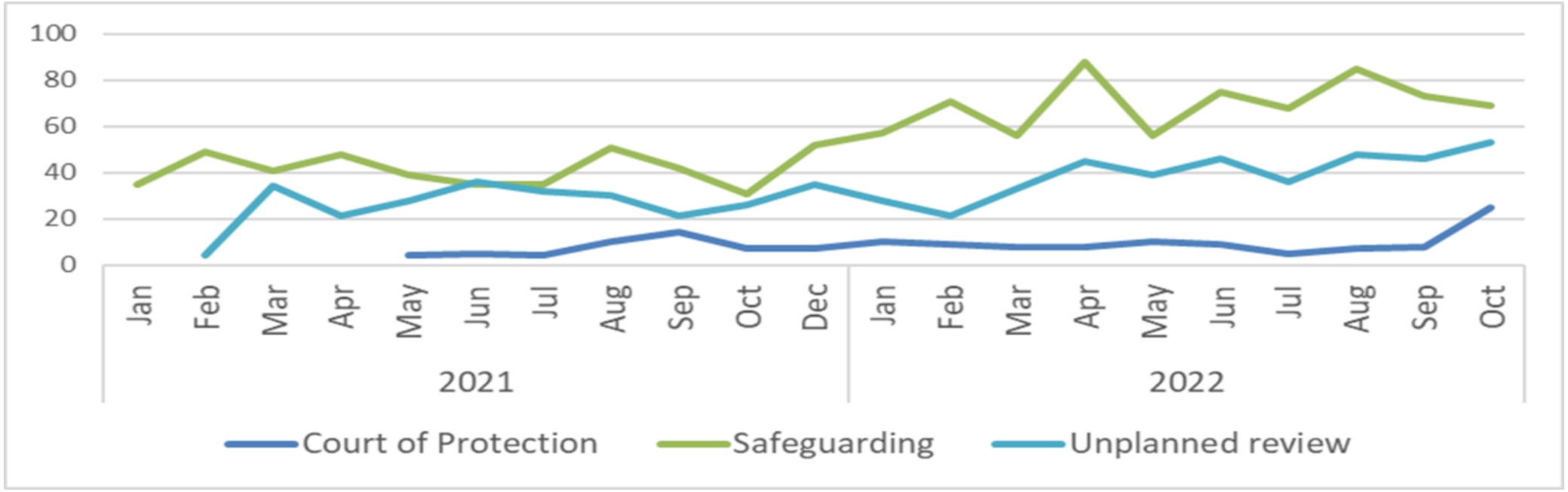
Increasing interaction opportunities through the development of self serve digital access. Linked to the Vision this will put people more in control of their care and support planning and review.

Working with PCNs to support anticipatory care ensures collaboration across community partners to improve outcomes.

Through investment in a new case management system and in redesigning our pathways we will make the tasks of our social work teams shorter, more efficient and better connected

Kirklees Health & Care Partnership

A key part of delivering our Vision is to keep people at home and independent for as long as possible. This does mean that when cases do reach formal care, they are increasingly complex, but the duration in formal care should be reduced.



Kirklees Health & Care Partnership

Workforce

- The national challenges in recruitment and retention are reflected in Kirklees with a vacancy rate of 17% in our assessment teams impacting on capacity to meet demand.
- Range of measures in place sees turnover of staff slightly less than other areas.

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Market capacity

- Support to care homes with additional funding drawn down by Kirklees and working with the private sector to mitigate cost rises and staff pay increase.
- Care home placement at pre pandemic levels with significant increase in domiciliary care provision – 9,000 hours in 2020 to almost 19,000 hours. Current waiting list is at 21 hours (29/11/22)
- Domiciliary care- additional payment in place since end of February in recognition of the higher fuel/mileage rates with the cost of fuel increasing (over and above the inflationary increase agreed in the budget)

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Work being done to prevent and reduce demand through the focus on early prevention and building capacity in the community.

Ambition to resolve low level issues at the point of contact (Gateway to Care) with signposting to appropriate support including; community plus, equipment prescribed by G2C and a referral route for Social Care Occupational Therapists ensuring timely and proportionate responses that support prevention and to promote independence.

Integration of the G2C and Locala front door contact teams ensures those with health and social care needs are responded to in one call.

Collaboration with the Accessible Homes Team, community health and social care to ensure improved outcomes for people and their carers making best use of shared resources.

The redesign of Care Navigation and Brokerage into Support Options to focus on preventative and community support solutions rather than formal care is fully embedded and expected to generate benefits in support package size and range of support considered.

Rapid response as part of Urgent Community Response provision prevents inappropriate hospital admissions and is now aligned with Mobile Response Services.

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Work being undertaken to manage and improve hospital discharge

Discharge to assess pathways embedded with integrated triage into rehab and reablement services to support recovery at home.

Home first approach being supported through development of night sitting arrangements and increased use of technology.

Enhanced carer support in place over winter.

Discharge to beds sustained, although not a long term solution.

Close partnership working with care providers to ensure flexibility and understanding that supports a D2A approach

Significant increase in demand for equipment to support discharge.

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Urgent Community Response (UCR)

Kirklees Health & Care Partnership

UCR in Kirklees

Kirklees has an alliance approach to delivery, with four providers:

- **Local Care Direct** provides the advanced clinical assessment within the single point of access. Local Care Direct operates urgent primary care services across West Yorkshire.
- **Curo** and **Locala** both provide advanced clinicians to undertake the face to face visits. Curo is a GP federation within Kirklees and Locala is a community healthcare provider.
- The majority of UCR cases requiring a face to face will go to the dedicated UCR team, some go to community nursing, based on presenting clinical condition.
- **Kirklees Local Authority** offer social care input within the UCR.

- **Programme SRO**: Helen Carr, Chief Executive - Local Care Direct

Kirklees UCR Model

Referral in

LCD triage to determine suitability for 0-2 hour response

Criteria met

Criteria not met

Appointment booked for Face-to-Face visit within 0-2 hours. The booking is made for a time that will not allow the patient to deteriorate between referral and seeing a practitioner

Case able to be dealt with in the hub and closed remotely

Signpost / Close Call

UCR Practitioner attends patient in place of residence

UCR Practitioner assess / plan / onward referral

Kirklees UCR System Integration

NHS West Yorkshire
Integrated Care Board

November 2020:
Kirklees UCR launches

December 2021:
Calderdale UCR launches, with LCD providing clinical triage

October 2021:
UCR Operates 8am-8m 7 days per week

October 2022:
Locala's Short Term Therapy Assessment Response Team and urgent social care referrals for unplanned Social Care Response and Rapid Response are integrated with Kirklees UCR

December 2022:
LCD to receive Wakefield UCR referrals from YAS as a pilot

April 2023:
2 hour district nursing visits integrate with Kirklees UCR, offering a 24/7 service (aspiration)

Hub activity

NHS West Yorkshire
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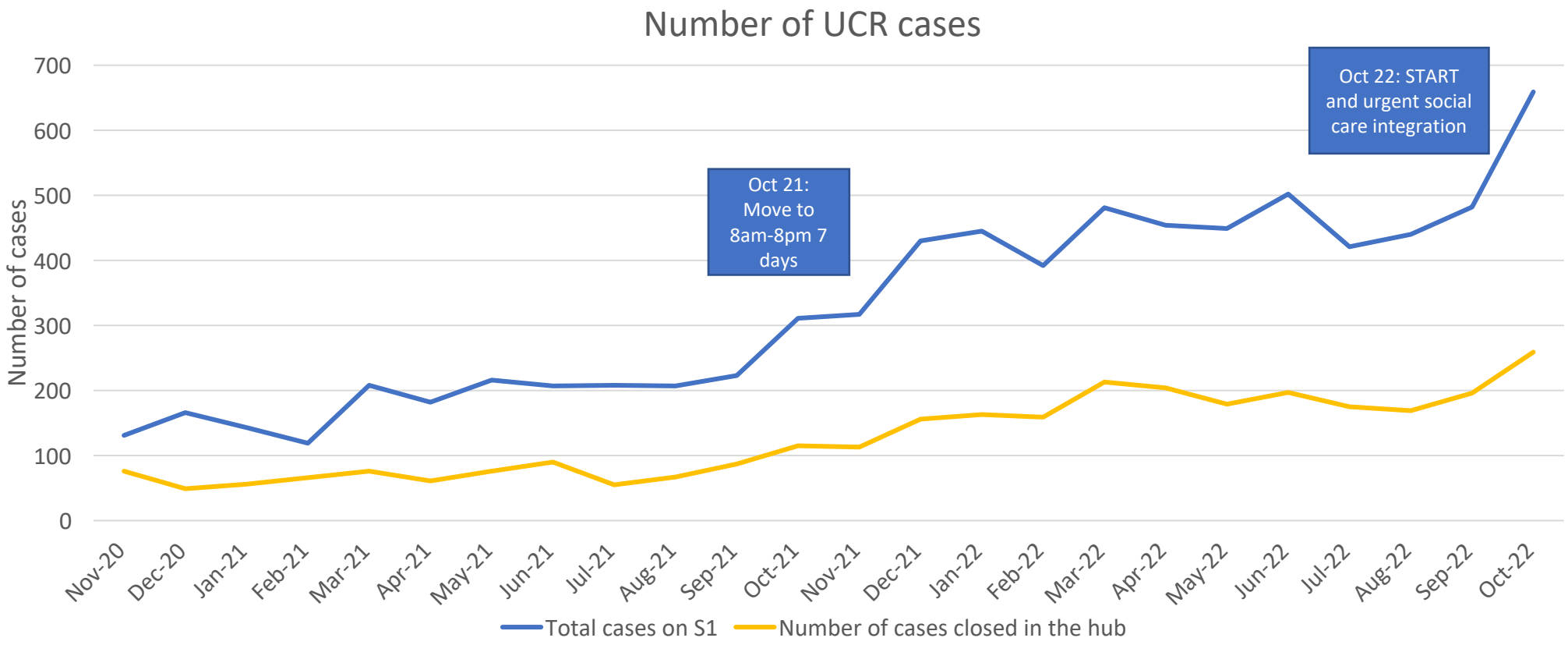
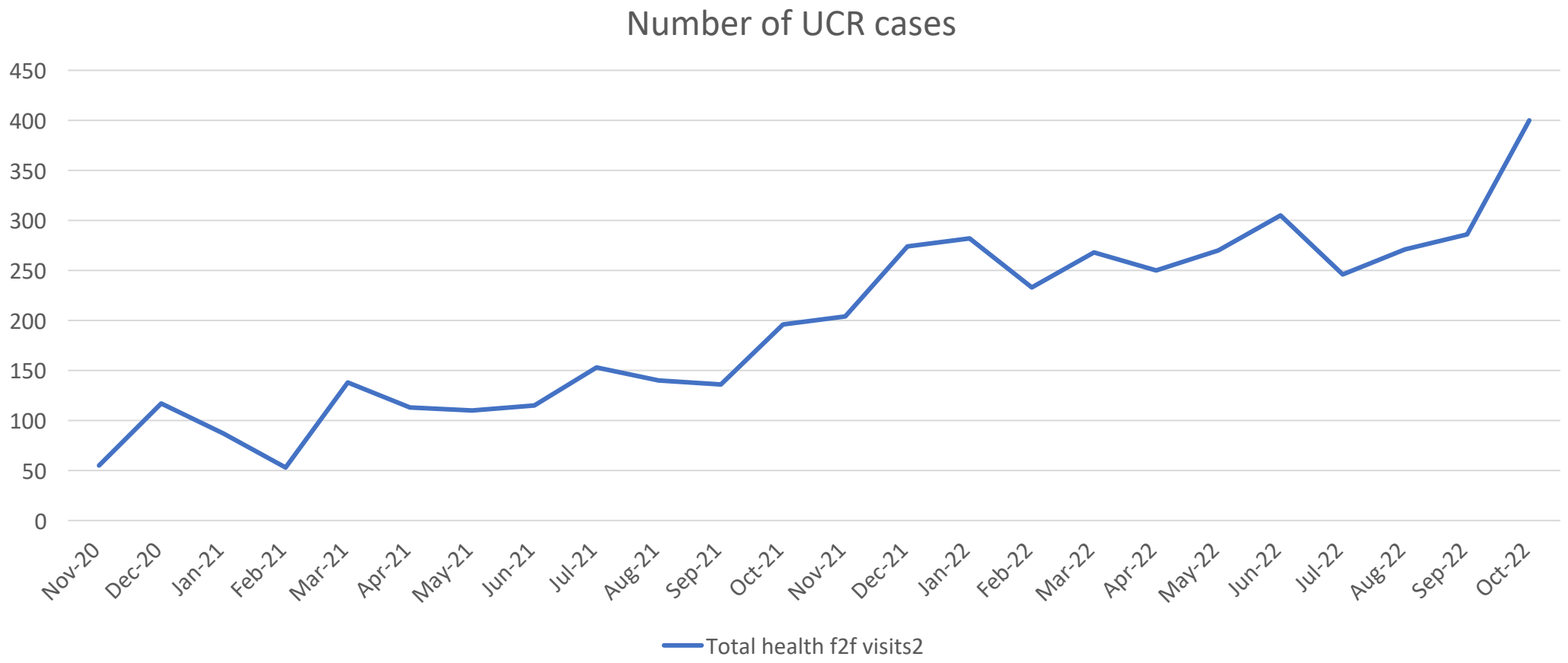


Health face to face activity

NHS West Yorkshire
Integrated Care Board



Future Service Ambitions

NHS West Yorkshire
Integrated Care Board

- Aligned to NHS LTP ambitions or integrated out of hospital point of contact UCR continues to collaborate with other same day urgent care services – moving towards creating a single point of contact, enabling streamlined services for residents and referrers
- Partnership working is extending the UCR offer to shift towards a 24/7 response service, through District Nursing integration
- Kirklees UCR is aligned with place urgent social care response and is moving to better link with the Local Authorities Night Sitting Service
- Aligned to NHS Winter Planning expectations Kirklees UCR is working closely with The Yorkshire Ambulance Service and 111, aspiring to take more referrals from them, avoiding ambulance dispatch, A&E attendance and hospital admission rates
- The partnership approach continues to develop, with providers recognising each others areas of strength – increasing autonomy of service delivery. Contractually speaking the future of UCR, in Kirklees, is to utilise the expected Provider Selection Regime, ensuring the alliance evidences: quality, innovation, value, integration/collaboration, access, inequalities, choice, service sustainability and social value

Kirklees Resident Feedback

NHS West Yorkshire
Integrated Care Board

Spoke to care staff. All work together as a team for the needs of the patient. Service is excellent.

Very nice staff, explained everything in full to patient.

UCR told patient and family everything they needed to know.

Nice to see someone who cared

Got more support at home now

Proud to be part of West Yorkshire Health and Care Partnership

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Community Diagnostic Centres (CDCs)

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Community Diagnostic Centres (CDCs)

We have received approval for 2 CDCs, one based in Huddersfield and one based in Wakefield.

We are preparing a business case for 5 further smaller CDCs, one in Dewsbury and locations in Calderdale and Wakefield.

The Trust are in discussion regarding the exact location of the Huddersfield CDC. We continue to work with the University to explore the opportunity to bring a CDC to the town centre.

The CDC in Huddersfield will provide additional MRI and CT scanning facilities, plain film, ultrasound, cardio- respiratory testing and phlebotomy in a community location. It will ensure people can receive planned diagnostic tests in a good time. Reducing waiting times and improving access.

We don't currently have a date for the opening of the diagnostic centre, but we will keep you briefed.

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