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

September 2023

Proud to be part of West Yorkshire Health and Care Partnership

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NHS West Yorkshire
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Primary Care Access and Recovery Plan (PCARP) and Capacity and Access Improvement Plans (CAIP)

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The plan headlines

1		**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy
2		**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity • Rapid assessment and response
3		**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs • Priority of primary care in new housing developments
4		**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources

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Cloud based telephony and access to records

Cloud Based Telephony

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- Funding has been secured through the Primary Care Access Recovery Plan and is required to be invested in year.
- Telephony remains a practice responsibility, funded through the Global Sum, and any ongoing cost associated with the solution post implementation will be the responsibility of the practice.
- The funding is to support practices with exit costs and implementation to enable the transition from analogue/evergreen contracts to cloud-based telephony.
- The funding is not for retrospective use.
- Practices that have already received funding to support the move to a CBT contract are not eligible, including those that have not already completed the transition

Cloud Based Telephony

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- Practices had to confirm to ICB by 1st July request to move from analogue to digital telephony
- 20 practices signed up to the process in Kirklees
- Process is being co-ordinated by the National Procurement Hub
- 31 August ICB Webinar held with all signed up practices and procurement hub to outline process
- Sep 23 –Mar 24 National Procurement Hub working with practices to negotiate exit costs from current providers, select new approved provider and arrange contracts form those listed on the Better Purchasing Framework

Prospective Access to Medical Records

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- Since 2014, patients have had the right to view limited parts of their medical record as part of the GP contract
- In 2019, this was updated and the contract set out requirements for general practice to promote and offer online access to coded and prospective information in the medical record, or when requested in writing, access to the entire historic record
- The GP contract regulations have been amended so that patients will have online access to their prospective medical records (unless they have individually decided to opt out or any exceptions apply) by 31 October 2023 at the latest.

Prospective Access to Medical Records

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- Currently we have 35 Practices live providing prospective access to their patients

- We continue to offer support advice, support including access to national guidelines webinars and case studies in order for them to be compliant by 31 October 2023.

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National GP Patient Survey 2023

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National GP Patient Survey Background

- 17th year that the survey has been carried out in England, fieldwork January to April 2023, results published July 2023
- The survey provides data at practice level using a consistent methodology, so it is comparable across organisations. The survey also provides data at Primary Care Network (PCN), Integrated Care System (ICS) and National level
- Minor changes were made to the questionnaire in 2023 to ensure that it continued to reflect how primary care services are delivered and how patients experience them.
- All patients aged 16 years or over and registered with the practice for at least 6 months are eligible to be sampled
- Participants sent a postal questionnaire, also with the option of completing the survey online or via telephone.
- As well as the online and paper versions, the questionnaire was available for online completion in British Sign Language and in 14 additional languages as well as over the phone, in large print or Braille

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Response Rates

	Number of surveys sent to adults registered with a GP practice	Completed Surveys	Response Rate
England	2.65m	759149	28.6%
West Yorkshire	122,582	30,874	25%
Greenwood	4759	1102	23%
Batley and Birstall	3341	935	28%
Tolson	3737	876	23%
Viaduct	3600	867	24%
Spen	2849	859	30%
Dewsbury and Thornhill	3923	802	20%
Valleys	1932	760	39%
3 Centres	2531	580	23%
Mast	1466	564	38%

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Patient Satisfaction Rates

- Overall, a decrease in patient satisfaction is noted nationally, with access remaining a key issue. Nationally, the proportion of patients reporting a good overall experience of the GP practice decreased to 71.3%, its lowest level for six years, and less than 2022 percentage of 72.4%. This had steadily declined from 2018 (83.8%) to 2020 (83.0%).
- The effect of the pandemic should be taken into account when looking at results over time.
- The trend is also reflected in PCNs in Kirklees, with three PCNs reporting overall experience below the national average, from 58% to 66%. Five PCNs achieved between 74 and 79%. One PCN, the Valleys, achieved 89%, the highest ranking PCN in West Yorkshire.

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Variance in Different Patient Groups

- Nationally, variance is noted among different patient groups regarding their experience of their GP practice, for example, people's gender, age, ethnicity, sexuality, religion, deprivation, and the number of long-term conditions experienced.
- Locally, further analysis is required to understand how this is affecting members of PCN populations. However, the PCNs noted with the lowest ratings are areas of higher deprivation.

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Overall Experience of GP Practice

PCN	Table ranking (lowest to highest out of 52)	%age of patients saying their overall experience of their GP Practice was good
Dewsbury and Thornhill	5	58%
Batley and Birstall	13	65%
Greenwood	14	66%
Tolson	25	74%
Spen	31	75%
3 Centres	32	75%
Viaduct	39	77%
Mast	45	79%
Valleys	52	89%

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Experience of getting through to the practice by phone

PCN	Table ranking (lowest to highest out of 52)	%age of patients saying it is easy to get through to their practice by phone
Dewsbury and Thornhill	14	38%
Batley and Birstall	19	47%
Greenwood	23	49%
Spen	25	49%
3 Centres	26	50%
Mast	35	55%
Tolson	38	56%
Viaduct	39	56%
Valleys	52	73%

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Kirklees HCP and Practice Actions

- All practices are encouraged to discuss their survey results with their patient participation groups and to agree actions to make improvements
- Primary Care Networks are discussing results among their practices and learning from each other
- KHCP Primary Care Team will discuss survey results and actions at the annual visit which takes place with every practice between October and March
- Results have been discussed at the Kirklees Primary Care Operational Group and the Kirklees Quality Committee
- Results will be presented to the Kirklees Patient Refence Group Network in October

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Primary Care Appointment data

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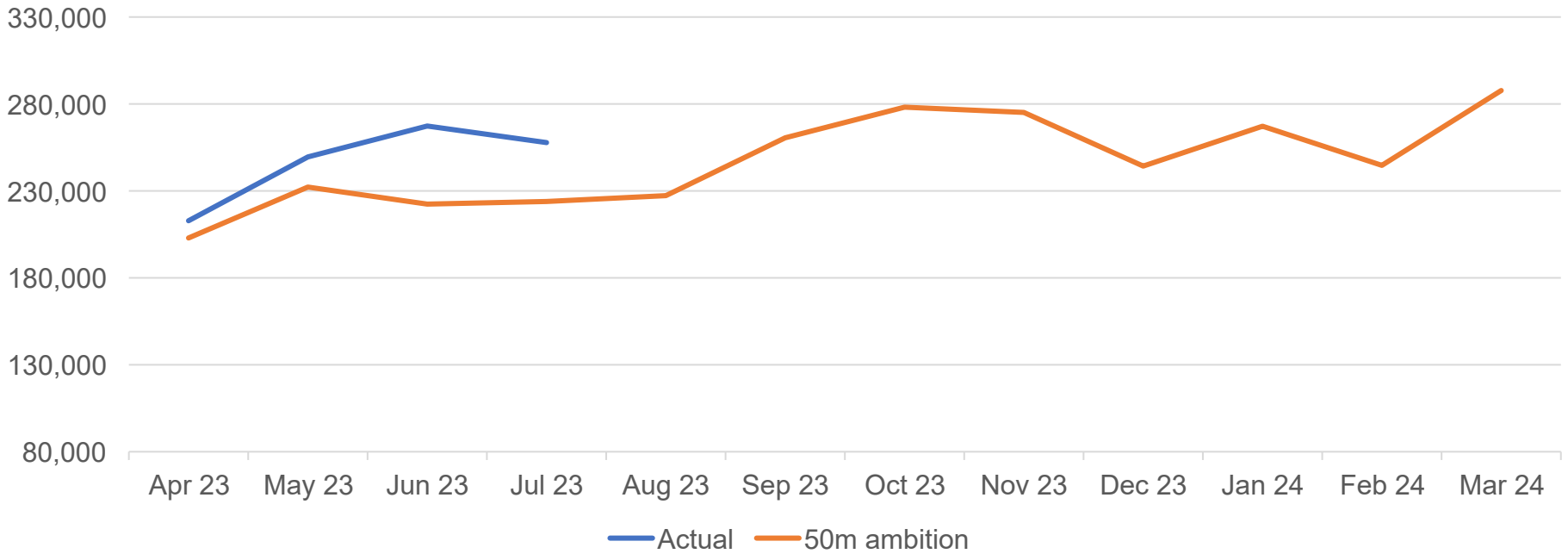
GP Appointments tracker against additional 50m ambition

Kirklees Health & Care Partnership

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Variance to ambition	% Variance to ambition
Actual	212,830	249,539	267,312	257,789								106,009	12.0%
50m ambition	202,928	232,208	222,410	223,916	227,277	260,539	278,155	275,127	244,274	267,203	244,690		



Appointments in General Practice

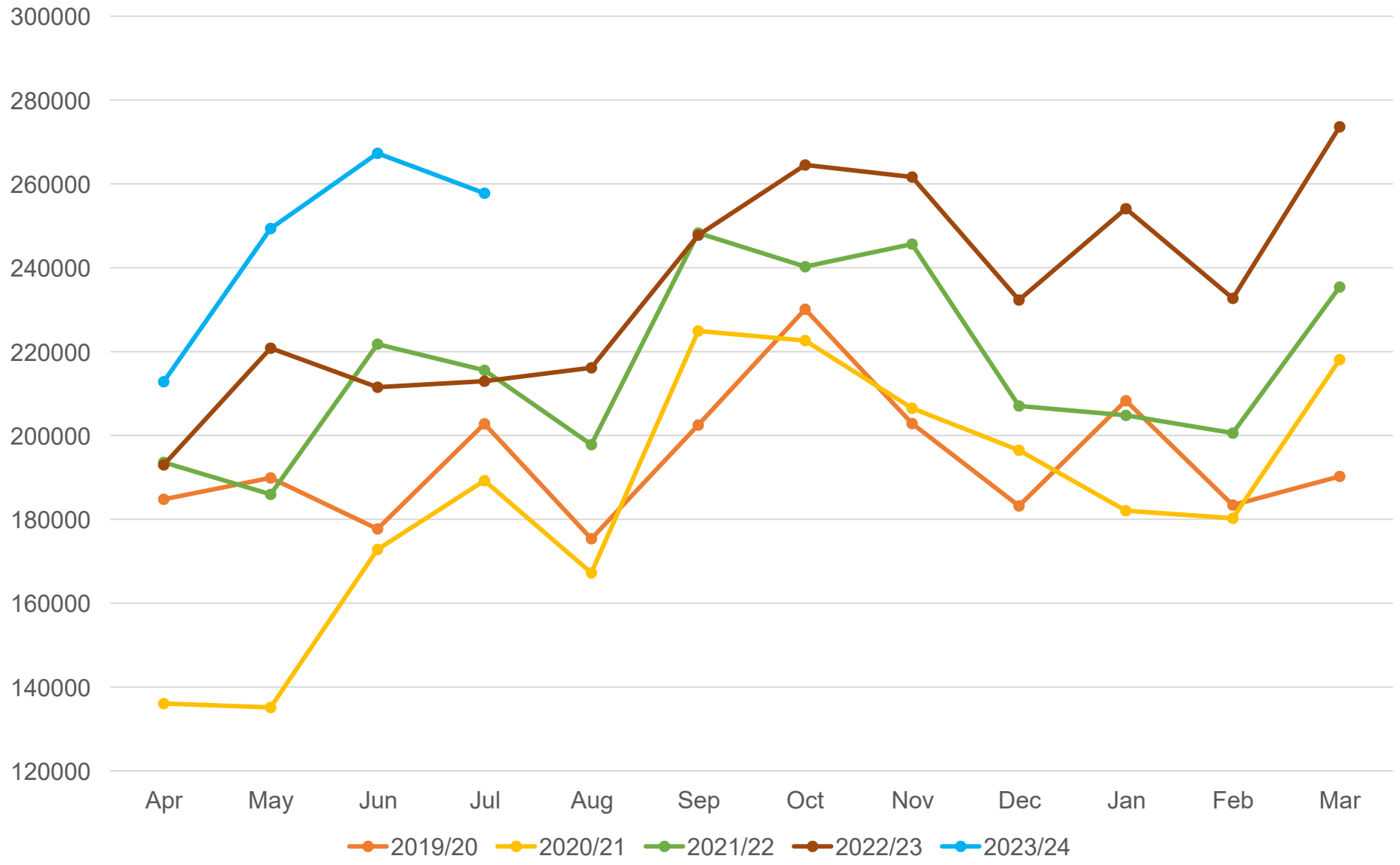
Kirklees Health & Care Partnership

Overall Appointments	Kirklees Overall
Full year 2019/20	2,331,113
Full year 2020/21	2,231,390
Full Year 2021/22	2,596,768
Full Year 2022/23	2,821,176
Full Year 2023/24	987,290
Change between 2020/21 and 2021/22	365,378 (16.4%)
Change between 2021/22 and 2022/23	224,408 (8.6%)
Change between 2022/23 and 2023/24	↓ - 1,833,886 (-65.0%)
May to July 22	645,301
May to July 23	774,460
Change	↑ 129,159 (20.0%)
July 22	212,949
July 23	257,789
Change	↑ 44,840 (21.1%)

Source: NHS Digital Appointments in General Practice https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

Appointments in General Practice

Kirklees Health & Care Partnership

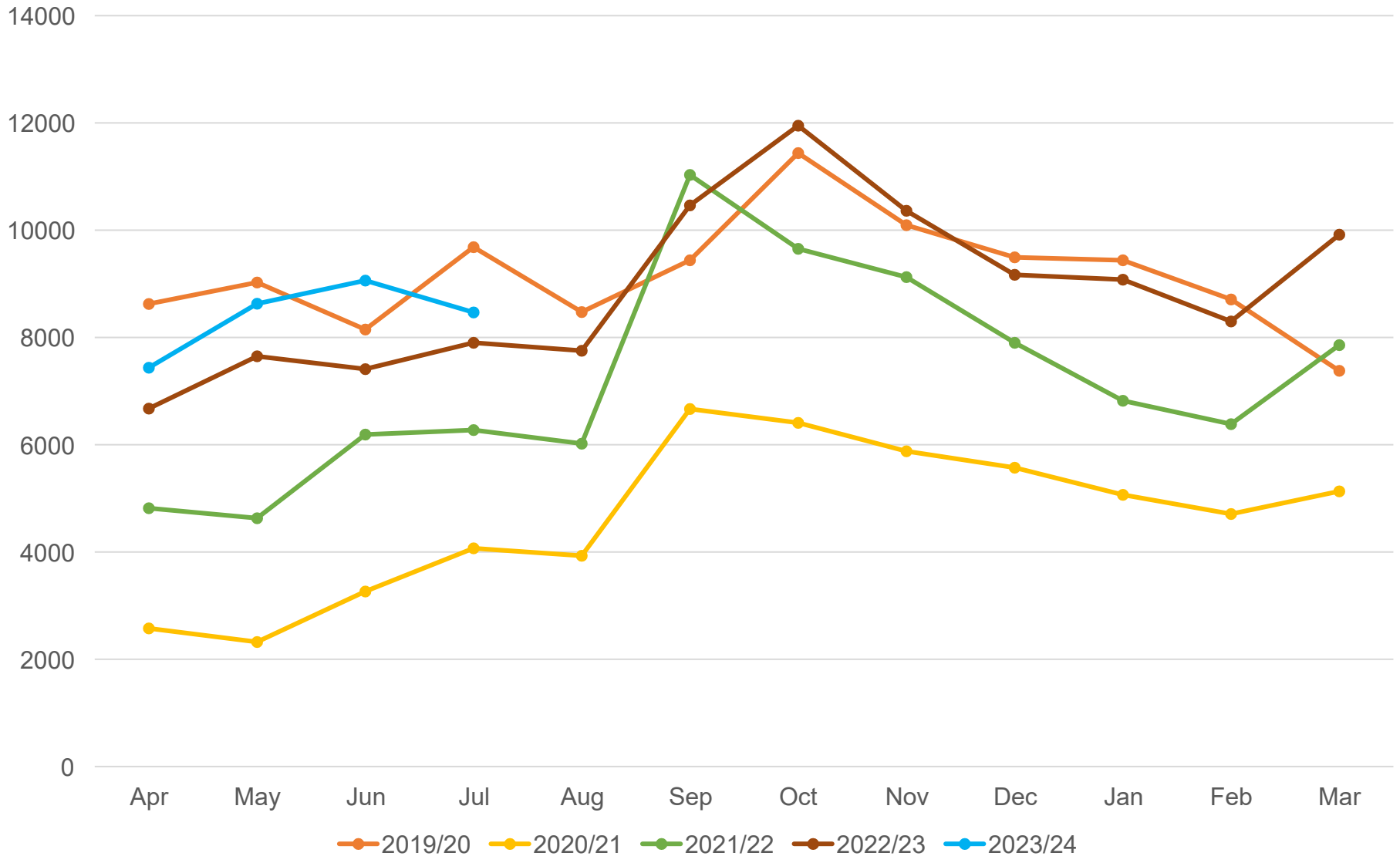


Appointments in General Practice

Kirklees Health & Care Partnership

Did not attend appointment	Kirklees Overall
Full year 2019/20	109,955
Full year 2020/21	55,599
Full Year 2021/22	86,709
Full Year 2022/23	106,629
Full Year 2023/24	33,596
Change between 2020/21 and 2021/22	31,110 (56.0%)
Change between 2021/22 and 2022/23	19,920 (23%)
Change between 2022/23 and 2023/24	↓ -73,033 (-68.5%)
May to July 22	22,962
May to July 23	26,159
Change	↑ 3,197 (13.9%)
July 22	7,902
July 23	8,468
Change	↑ 566 (7.2%)

Did not attend appointment



General Practice Improvement Programme

Over the next two years the General Practice Improvement Programme will provide:

1. **Support for improvement**
   - 5 topic areas
   - 3 levels of support for practices or PCNs (universal, intermediate and intensive support)
2. **Support for capability building** in practice teams to sustain change
   - Fundamentals of change management
   - GP QI leadership programme
   - PCN and Digital and Transformation leads training
3. **Support for shared learning** supporting ICBs to create local peer networks to share challenges and learning alongside a national peer community

Improvement support for practices and PCNs to move to a model of modern general practice

NHS England

Tiered Support

- **Universal:** webinars, drops in and online content
- **Intermediate (practice)**: 13 weeks of support with a facilitator
- **Intermediate (PCN)**: 12 half-day in person facilitated sessions over a flexible time period
- **Intensive (practice)**: 26 weeks of support with a facilitator
- ICSs nominate practices and PCNs for intensive and intermediate support based on an assessment of need
- Nominated practices will need to have access to data from their telephony system

Content

1. Understanding demand and capacity
2. Enhancing care navigation and triage
3. Implementing high quality telephony journeys
4. Implementing high quality online access journeys
5. Workload management

All units have measurement baked in at the start

Outcomes

- Improving staff experience
- Improving patient experience
- Improving continuity of care
- Reduction in avoidable appointments and failure demand

Improvement Indicators

- Patient satisfaction
- Staff experience measure
- Avoidable appointments audit including where continuity of care needs not met where needed
- Online consultation submission rate
- Reducing telephone wait times and abandoned calls
- Use of CPCS

Bank Holidays

- Each PCN can provide up to 6 hours additional capacity on bank holidays
- Curo Federation is providing bank holiday cover for North Kirklees PCNs
- Patients can pre book appointments
- LCD can direct book into appointments
- All bank holidays are covered

April & May bank holiday utilisation (5 days)

Hours delivered	244
Total number of appointments available	895
Booked through practice	820
Booked through LCD	37
Total number of appointments utilised	855
% Slot utilisation	96%
Total number of face to face appointments	746
% face to face appointments	87%
Total number of remote appointments	112
% Remote appointments	13%
Total number of DNAs	141
% DNA rate	16%

Sundays

- Each PCN can provide up to 4 hours additional capacity on Sundays
- Curo Federation is providing Sunday cover for North Kirklees PCNs
- Patients can pre book appointments
- LCD can direct book into appointments
- Pilot was run 16 & 23 July, full roll out 13 August 2023
- Currently not all PCNs offer Sunday appointments (The Valleys & Tolson)

4 week utilisation

Hours delivered	126
Total number of appointments available	474
Appointment booked through practice	418
Appointment booked through A&E	2
Appointment booked through 111/YAS/LCD	26
Total number of appointments utilised	446
% Slot utilisation	94%
Total number of face to face appointments	380
% face to face appointments	85%
Total number of remote appointments	67
% Remote appointments	15%
Total number of DNAs	41
% DNA rate	9%

Acute Respiratory Hubs

- 2 Acute Respiratory Hubs covering Kirklees population (1 North Kirklees and 1 Huddersfield)
- Monday to Friday providing a minimum of 8 hours of additional capacity
- Delivered during the afternoon/early evening
- 15 minute same day face to face appointments for Childrens or adults with acute respiratory symptoms
- Avoid patients going to A&E when practice appointments are full
- Service start 1 December 2023
- 15 weeks until 15 March 2024

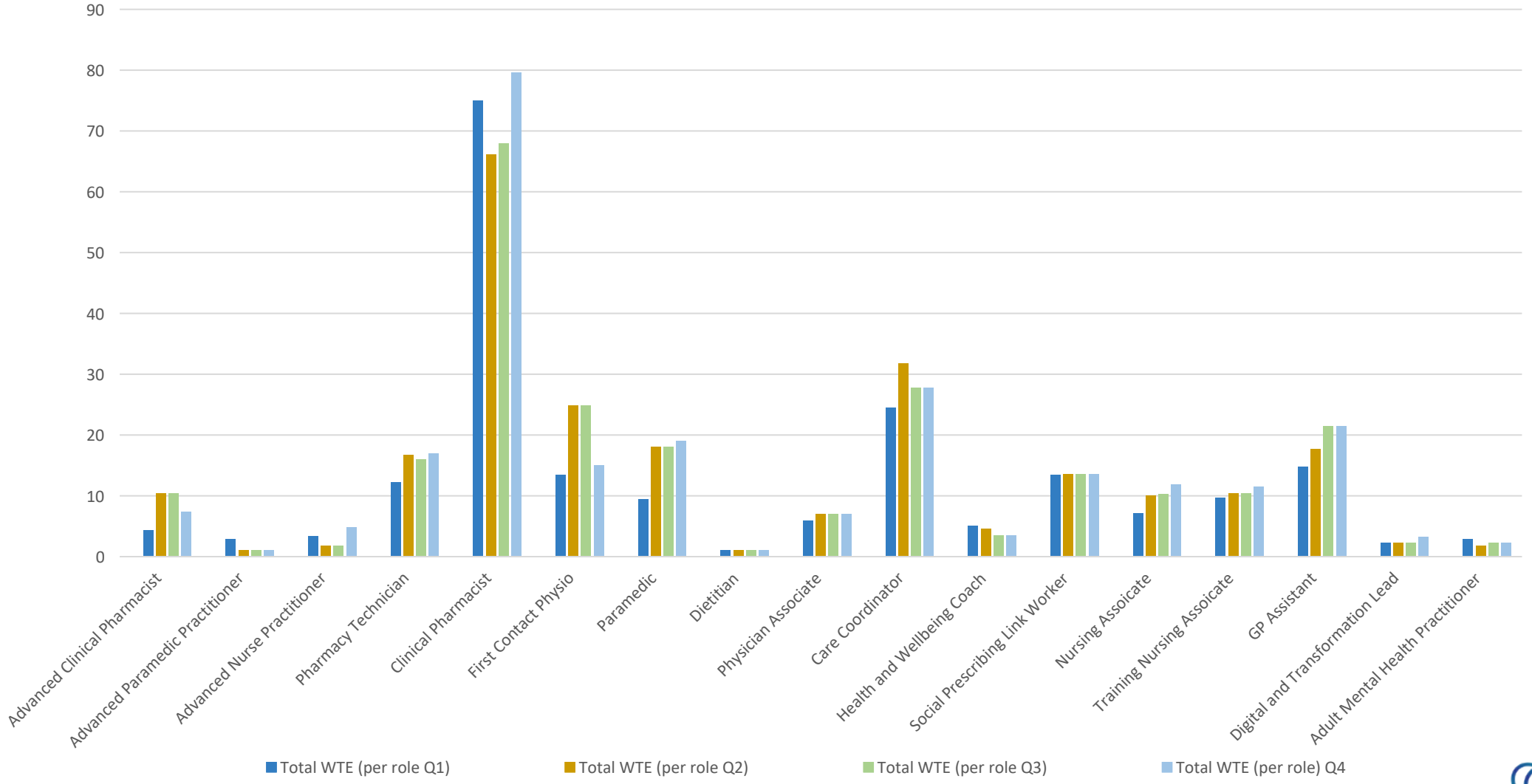
ARRS Workforce Plans

Kirklees Health & Care Partnership

ARRS WTE Overview

	Batley and Birstall	Dewsbury and Thornhill	Greenwood	Mast	SHAWN	Three Centres	Tolson	Valleys	Viaduct	Total WTE (per role) Q4	Total WTE (per role Q1)	Total WTE (per role Q2)	Total WTE (per role Q3)
Advanced Clinical Pharmacist	2.11	3				1			1.28	7	4	10	10
Advanced Paramedic Practitioner									1	1	3	1	1
Advanced Nurse Practitioner	0.89		3			0.6			0.32	5	3	2	2
Pharmacy Technician	2	2		4.11	2	1		4.8	1	17	12	17	17
Clinical Pharmacist	10.13	9	9	4	9.19	9.9	8.5	7.3	12.55	80	75	75	77
First Contact Physio	3		1.75	1.61	2		2	3.1	1.53	15	13	15	15
Paramedic	6	2		1.75	4.9		4.4			19	9	18	18
Dietitian							1			1	1	1	1
Physician Associate		2	5							7	6	7	7
Care Coordinator	6	11	2	0.8	1	6.97				28	24	32	28
Health and Wellbeing Coach				1.5			2			4	5	5	4
Social Prescribing Link Worker	3	1	1	1.06	1.5	1	1	2	2	14	13	14	14
Nursing Assoicate	2	2		1.47	0.6	1.96		1.8	2	12	7	10	10
Training Nursing Associate		2				5.43		4		11	10	10	10
GP Assistant	4	3	4		2.8	1.96		5.7		21	15	18	21
Digital and Transformation Lead		1		1		0.27		1		3	2	2	2
Adult Mental Health Practitioner					0.5		1	0.76		2	3	2	2
Totals	**39.13**	**38**	**25.75**	**18.3**	**24.49**	**30.09**	**19.9**	**30.46**	**21.68**	**247**	**207**	**239**	**239**

ARRS WTE Overview Q1 – Q4



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National Care Navigation Training

PCNs	No of practices signed up	No of practices in PCN	Foundation Level	Knowledge transfer	Advanced Level
GREENWOOD PCN	**8**	10	8	1	
TOLSON CARE PARTNERSHIP PCN	**7**	8	7	1	2
SPEN HEALTH & WELLBEING PCN	**2**	7	2	2	
3 CENTRES PCN	**1**	5	1		
BATLEY BIRSTALL PCN	**3**	8	3	1	
DEWSBURY & THORNHILL PCN	**3**	7	3	2	
THE VALLEYS HEALTH & SOCIAL CARE PCN	**5**	6	5	1	
VIADUCT CARE PCN	**6**	8	6	2	
THE MAST PCN	**3**	5	3	3	1
	38	**64**	**38**	**13**	**3**

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Impact of Access and Workforce on Primary Care Estates

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Impact of Access and Workforce on Primary Care Estates

Growth of access to primary care services and workforce will have an impact on the current limited estate resource available to deliver patient facing services from.

Post Covid there was a desire to retain a higher level of virtual consultations, providing an opportunity to use space more efficiently. However in reality face to face appointments are in demand from a patient and a clinician point of view, to allow for a productive discussion and examination.

The Additional Roles Reimbursement Scheme (ARRS) has exasperated the capacity of primary care facilities by accommodating as many ARRS as possible, which in some cases has meant less space for visiting social and community services.

Kirklees Place has mechanisms in place for looking at how the utilisation of primary care estate should evolve in the medium and longer term to address patient need, at both a practice and PCN level.

In relation to GP Practice estates development and improvement work - there is a very limited amount of capital funding available for GP practices to apply against to make practice estates improvements or carry out new estates developments.

Any applications from practices for capital funding are assessed against a criteria list and all the bids received are prioritised to receive this funding from bids received from practices across West Yorkshire.

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Impact of Access and Workforce on Primary Care Estates

Kirklees Place – Planning for Future Estate Utilisation – PCN Planning

North Kirklees PCNs Estate Strategy

- Undertaken in 2021
- Delivered by AA Projects
- Gaps in workforce data and prioritisation

Greater Huddersfield PCNs Estate Strategy

- Delivered by PCC
- Completed December 2022
- Provides an indicative order of prioritisation

Individual PCN Clinical and Estate Strategies are in the progress of being developed for:

- Spen PCN
- Batley and Birstall PCN
- Three Centres PCN
- Dewsbury and Thornhill PCN

Individual PCN Clinical and Estate Strategies are in the process of being developed for:

- Greenwood PCN
- Tolson PCN
- Viaduct PCN
- Valleys PCN
- Mast PCN

Further estate strategy work is being planned to standardise prioritisation across both areas of North Kirklees and Greater Huddersfield.

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Impact of Access and Workforce on Primary Care Estates

When future planning for both GP practice and PCN estates requirements, the following WY ICS Core Estate Principles are taken into consideration:

- Make the most of buildings and other assets available to us
- Plan for future changes as more and more people become flexible and take positive advantages of hybrid working
- Bring teams together to wrap around and support people, unpaid carers, communities and 37 neighbourhoods
- Extend beyond traditional health and care, looking at how we can use our estates across our wider partnership to truly integrate the way in which we work together
- Estates are led by the clinical strategy around the services that we provide
- Support organisations to deliver their services in a safe and effective way.
- Develop and prioritise bids for capital funding to ensure high quality buildings support us to deliver health and care safely, collaboratively and in an innovative way.

(West Yorkshire Integrated Care Strategy - 2022)

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Community Pharmacy

Kirklees Health & Care Partnership

Primary Care Access Recovery and community pharmacy

Pharmacy's role has been increasing in recent years. Working to embed and integrate community pharmacy into the NHS, delivering more clinical services and making them the first port of call for many minor illnesses.

Expand pharmacy oral contraception and **blood pressure** (BP) services this year, to increase access and convenience for millions of patients,.

Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions.

Nationally, this could save 10 million appointments in general practice a year once scaled.

Kirklees has 100 community pharmacy contractors.

Kirklees ambition for Primary Care Access Recovery and community pharmacy

The importance of the role of Community Pharmacy is prominent within the Primary Care Access Recovery Plan.

Within Kirklees – since their inception, encouraging PCNs to work collaboratively with CP and PCNs have a link Pharmacist to support discussion.

Some practices have already embraced the use of Community Pharmacy Consultation Service (CPCS) and are seeing the benefits to workload.

Six of the 8 PCNs in Kirklees have included that they will increase the use of the Community Pharmacist Consultation Service (CPCS) as part of their access improvement programme plans, with one further PCN reviewing the use of CPCS.

Key to releasing these ambitions is integration and collaborative working between GP practices and Community Pharmacies.

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Next few slides provide information on the community pharmacy services within the Primary Care Access Recovery Plan and data to show current position in Kirklees.

This data is from the WY CPCS Steering Group which brings together each of the 5 Places in WY to review data, share good practice and support place ambitions for the NHS services provided by community pharmacy. The aim of the group is to work cross the ICS to help get the best value and fully reach the potential for our population from community pharmacy programmes and services.

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Hypertension Case Finding through the BP Check Service

- NHS England ambition for hypertension is that 80% of the expected number of people with high BP are detected by 2029, and that 80% of the population diagnosed with hypertension are treated to target. Estimated less than 60% of people with hypertension have been diagnosed.
- Current hypertension prevalence in West Yorkshire is 14.82% of adults and the ICS has a target to increase this to an expected 30%
- NHS Hypertension Case Finding Service aka BP Check is an Advanced Service provided by 74% of community pharmacies in WY and has two stages:
    - Stage 1 – Identifying people at risk of hypertension and offering them the opportunity to have their blood pressure measured.
    - Stage 2 – This is offered if a person's blood pressure reading is high at Stage 1. A person will be offered waking hours ambulatory blood pressure monitoring (ABPM).
    - At the request of a general practice, undertake adhoc normal and ambulatory blood pressure measurements.

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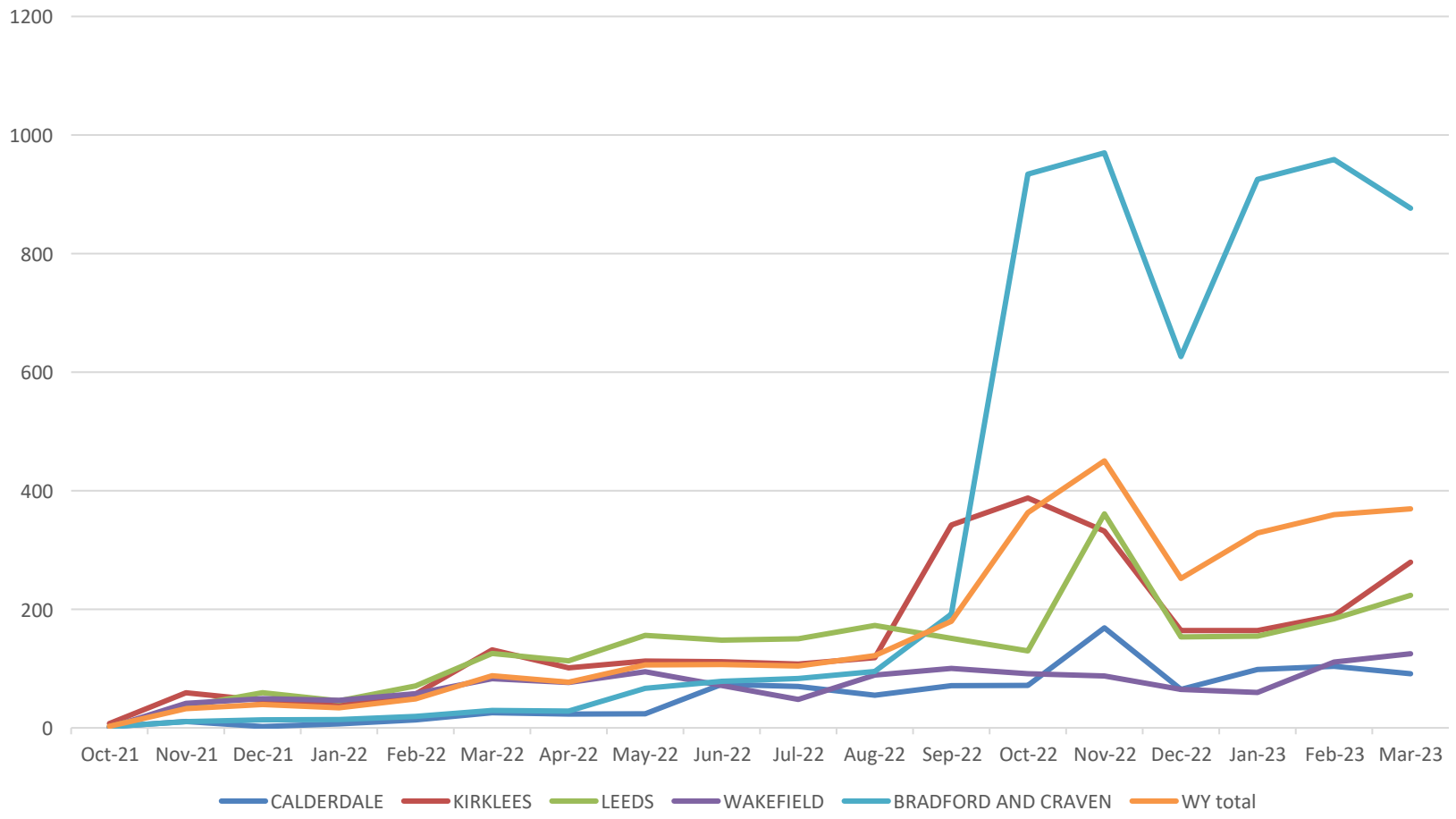
BP Checks per 100,000 GP registered population



Locally analysed data from: https://future.nhs.uk/PharmacyIntegration/view?objectId=36986416

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NHS Community Pharmacist Consultation Service (CPCS)

A referral to the NHS Community Pharmacist Consultation Service (CPCS) offers patients same day minor illness consultations with a community pharmacist supporting people being seen by the right healthcare professional, in the right place, at the right time. The service aims to reduce pressure on the primary and urgent care system, particularly Accident and Emergency and GP out of hours.

CPCS requires a formal referral from one of 3 referral pathways

- NHS111 CPCS (inc 1111 online) – minor illness and urgent medicine supply
- GP CPCS – minor illness
- UEC CPCS – minor illness and urgent medicine supply

The pilot for GP CPCS showed that an average practice can refer 50 patients a week to CPCS for management by community pharmacy – a significant opportunity to supporting primary care access.

Common Ailments service (part of Pharmacy First) as outlined in Delivery plan for recovering access to primary care will enable community pharmacy to complete the episode of care for additional cohorts of patients; sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women.

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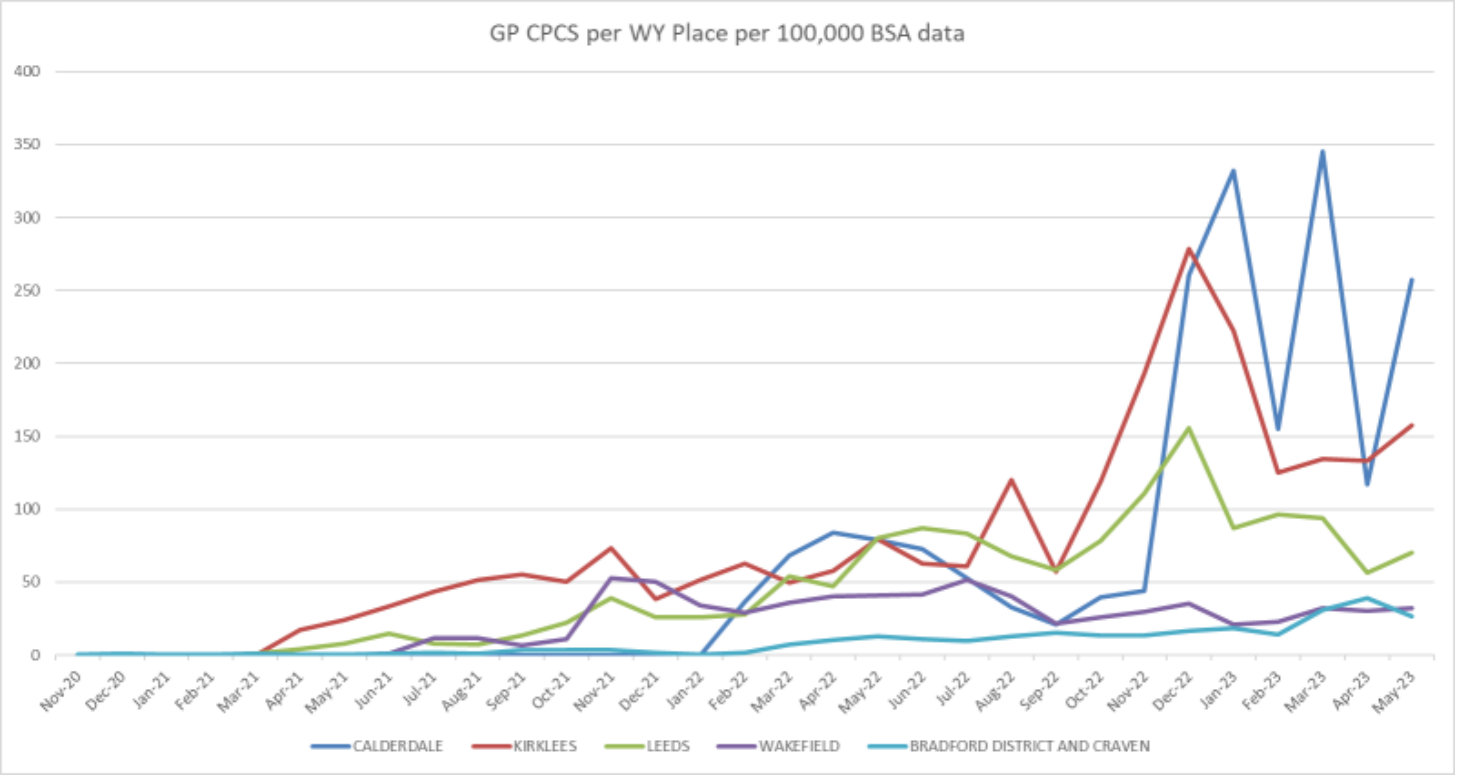
Community Pharmacist Consultation Service – GP CPCS



Locally analysed data from:
https://future.nhs.uk/PharmacyIntegration/view?objectId=44473328

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Community Pharmacy Contraception Service

The aim of the Pharmacy Contraception Service (PCS) is to offer greater choice from where people can access contraception services and create additional capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments.

This is a new service for 2023.

The community pharmacy provides ongoing monitoring and supply of repeat oral contraception (OC) prescriptions to continue the provision of oral contraception supplies initiated in primary care or sexual health clinics (or equivalent).

Note activity data not available for the service.

14% of the pharmacies in Kirklees have registered to provide the service

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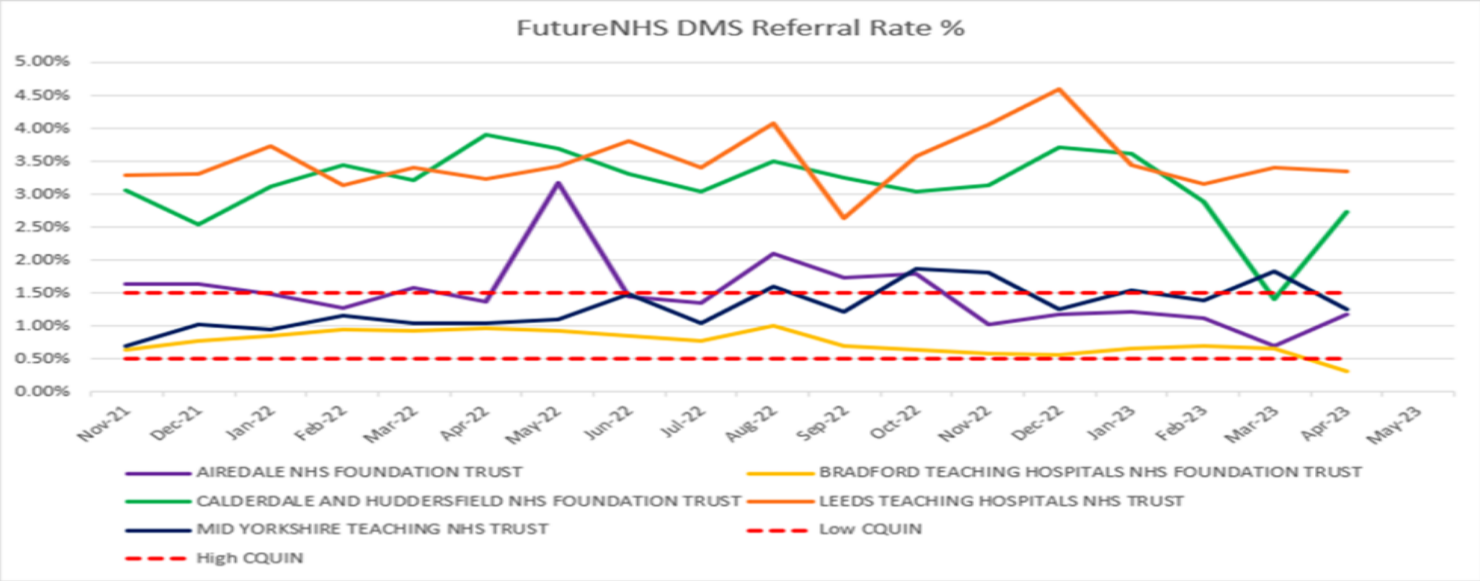
Community pharmacy integration

Other services support the continued integration of community pharmacy e.g. DMS

- The NHS Discharge Medicines Service (DMS) enables the referral of patients who would benefit from extra support related to their medicines regimen after they are discharged
- Every 10 community pharmacy DMS consultations will prevent one readmission
- Even if readmitted DMS will reduce Length of Stay by six days



Source: WY DMS data analysis [DMS Referrals Report - North Analytics - FutureNHS Collaboration Platform]

Kirklees Health & Care Partnership

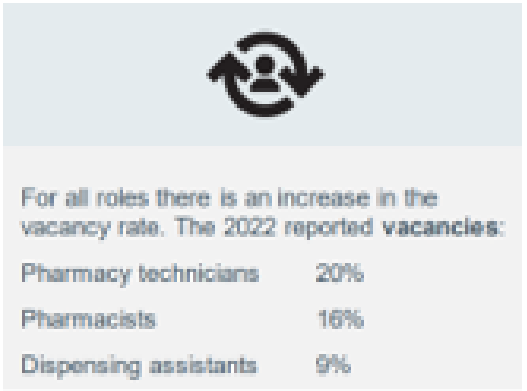
The current reality for community pharmacies – update from Community Pharmacy West Yorkshire

Workforce

71% of pharmacy businesses are experiencing shortages of pharmacists, and 73% are experiencing shortages of other staff.

Staff shortages inevitably lead to increased pressures on pharmacy teams. 98% of pharmacy team members said that staff shortages had resulted in increased pressure on staff.

The negative impact of the PCN ARRS recruitment has been recognised in the Hewitt Review. The ARRS funding and the recruitment of PCN Pharmacists from Community Pharmacy continues to strip out long standing experienced healthcare professionals from Community Pharmacy (and other sectors). Where we lose a regular pharmacist this reduces the local relationship between patients and a known regular community Pharmacist and makes the consistent delivery of community pharmacy services challenging especially when running on locum Pharmacists for the medium to long term due to the challenging recruitment position.



Kirklees Health & Care Partnership

The current reality for community pharmacies – update from Community Pharmacy West Yorkshire

Stock shortages

This year has been particularly challenging. Multiple factors have impacted on drug availability causing drug prices to fluctuate which has affected the ability to obtain drugs.

The shortages of drugs has made the process of dispensing and supply much more labor intensive.

Serious Shortage Protocols have been issued for a limited number of drugs.

There have been several high volume lines this year where Pharmacy contractors have made a significant loss on a specific drug line due to the price concession granted at the end of the month not meeting the purchase price.

Community Pharmacy England is fully aware of the difficult challenges faced by Community Pharmacy owners when the final prices granted or imposed by DHSC fall below the purchase prices they have paid. This can have a disproportionate effect particularly on those pharmacies dispensing large volumes of any affected lines. Concerns about the process for setting price concessions have been raised to senior Government officials responsible for medicines supply.

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Update regarding the proposals from Government and NHS on price concessions reform

There has been no significant change since the last update to committee in Dec 22. Legislative and regulatory changes discussions are ongoing nationally. There is currently no updates or expected changes to the concession process in the near future.

As outlined in the previous slides this has significant impacts for community pharmacy but it is noted that the impacts of this are felt wider than community pharmacy

Our patients continue to face medicines shortages which mean they may need to try more than one pharmacy to find stock or need to have their medication changed to one that is available.

Shortages lead to increased queries and requests to GP Practices.

Shortages and price concessions are having a direct impact on the prescribing costs meaning significant pressure to remain in budget. This is being seen across WY and Nationally. Concerns have been raised from WY to the national teams by way of escalation.

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Pharmaceutical access and Pharmaceutical Needs Assessment

NHS (Pharmaceutical and Local Pharmaceutical Services) (Amendment) Regulations 2023 came into force 25 May 2023. Changes in some pharmacies to reduce hours in line with regulations and some pharmacy closures.

Regulations aim to give contractors greater control and flexibility over their opening hours and reduce the impact of rising business costs.

Nine 100hour pharmacy contractors have reduced their hours in Kirklees and 3 Contractors have closed their premises.

Fewer opening hours and less pharmacies does not necessarily mean that pharmaceutical provision isn't adequate. There are 100 pharmacies within the Kirklees area who between them provide services 7-days a week and into the evenings.

Health and Wellbeing Boards (HWBs) are responsible for the Pharmaceutical Needs Assessment, which determines if provision is adequate and aids decisions around the provision of pharmacy services.

Assurance to HWBs that closures and amended Regulations applications are dealt with in accordance with the Regulations.

Kirklees Health & Care Partnership

Community pharmacy - overview

Despite the current pressures that our community pharmacy teams are reporting the network continue to support the people they serve through engagement with and delivery of NHS services.

Community Pharmacy teams continue to support self-care, healthy lifestyle choices and behaviour change and for many are the first port of call for our local population with non acute illness and health concerns.

This includes the shift to better using the clinical skills within community pharmacy. Community pharmacies are currently supporting development of the ten West Yorkshire community pharmacy independent prescribing pathfinders sites.

View the Meet your community pharmacy team and Your Community Pharmacy animations here: https://www.wypartnership.co.uk/our-priorities/primary-and-community-care-services/useful-links-and-resources

Kirklees Health & Care Partnership

CKW Neighbourhood Model

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Recap - 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

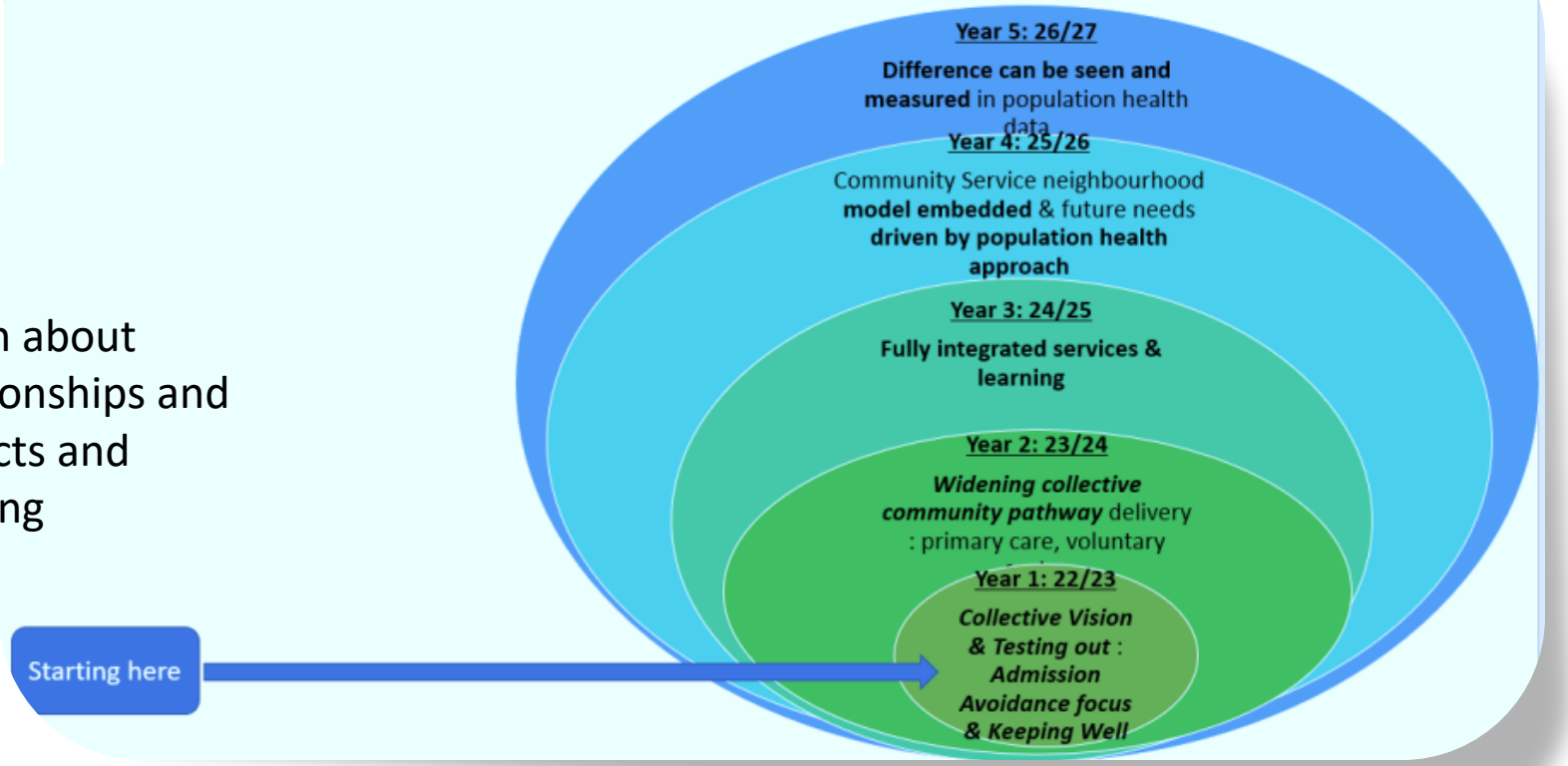
Personalised Care, long term condition management and continuity of care, including community nursing support and EoL

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

Kirklees Health & Care Partnership

Five-year programme

Year one has been about building the relationships and scoping out projects and sharing any learning



Kirklees Health & Care Partnership

Community Support to enable people to stay well

Progress on the 4 ideas previously identified to take forward –focus on Kirklees

Kirklees Health & Care Partnership

Community Support Movement

These projects build on work already ongoing and/or piloted during the pandemic

- **Warm Spaces** – including advice and support signposting
- **Loneliness Strategy launched**– making loneliness everyone's business
- **Community Champions** –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

Falls Prevention

This work takes the learning from Calderdale

- Initial discussions have taken place with the 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. Further work is required to identify the cohort of patients

Kirklees Health & Care Partnership

Proactive Follow up following discharge

This area is focused on ensuring people can stay well at home, and reduce re-admissions

This project goes live in September 2023. Community Plus will contact patients that meet the following criteria:

- have been in hospital less than 72 hours
- Discharged on pathway 0 or 1

The work is supported by a detailed specification, data sharing agreements and honorary contracts.

Self-Management

- This work focuses on effective use of resources
- **Ophthalmic Services** – ensuring that discharge includes self-management resources
- **Self-management team** – A new self-care team has been established promoting independence, provides training and a support line should the patient need additional advice.
- **Ward Based Support** – Additional resources to support the training of patients in self-care promoting independence prior to discharge

Kirklees Health & Care Partnership

Additional Neighbourhood Projects

Integrated Urgent Care examples within Yorkshire Ambulance Service (YAS), Urgent Community Response and Virtual Ward. There are ongoing strategic oversight and working groups in place to develop and progress these areas in partnership.

Personalised Care, Long Term Conditions and Continuity of Care – community services are aligned to PCNs, named lead individuals working with complex patients.

Health and wellbeing - Working with Huddersfield University to include considerations for the development of the health and wellbeing campus

Workforce – Locala and YAS are establishing projects to share learning, benchmark systems, understanding of service pathways and potential rotation systems for learners

Digital – speech and language and dental series developed to support early years development to be launched September 2023

- **Digital Wound Care project** – testing and evaluating different digital solutions.
- **Digital technology** - Working with care homes to review how additional training can be provided to support delivery of care using technology.
- **Workforce** – working with care homes to identify areas where additional training can be provided to support the development of the workforce
- **Mobile Van** – 12-month pilot to work across a number of geographical and clinical areas
- **Kirklees Community Services** – Collaborative approach to developing new specifications
- **End of Life** – Joint working between Locala and The Kirkwood, jointly funded nurses' part of the discharge team and developed pathways from Hospital Discharge to The Kirkwood
- **Women's Health Hub** – working collaboratively across the system to support the development of this initiative

Kirklees Health & Care Partnership

Mobile Clinical Van

- Priority focus on health inequalities and access to services
- **Homeless communities** in partnership with Huddersfield Mission clinical focus of lower leg wound care
- **The Whitehouse Vulnerable clients** – of the patients seen 48% would not have accessed healthcare, 28% would have gone to A&E and 24% would have been seen at a GP Practice
- **Immunisation Team** – targeted over the school holidays attended galas and carnivals. Delivered 255 Immunisations to 135 patients.
- **Sexual Health** – attended Huddersfield PRIDE event in June 2023, Provided screening for STI and signposting
- Overall feedback from patients has been very positive

Kirklees Health & Care Partnership

Homeless Wound care Partnership – The Mission

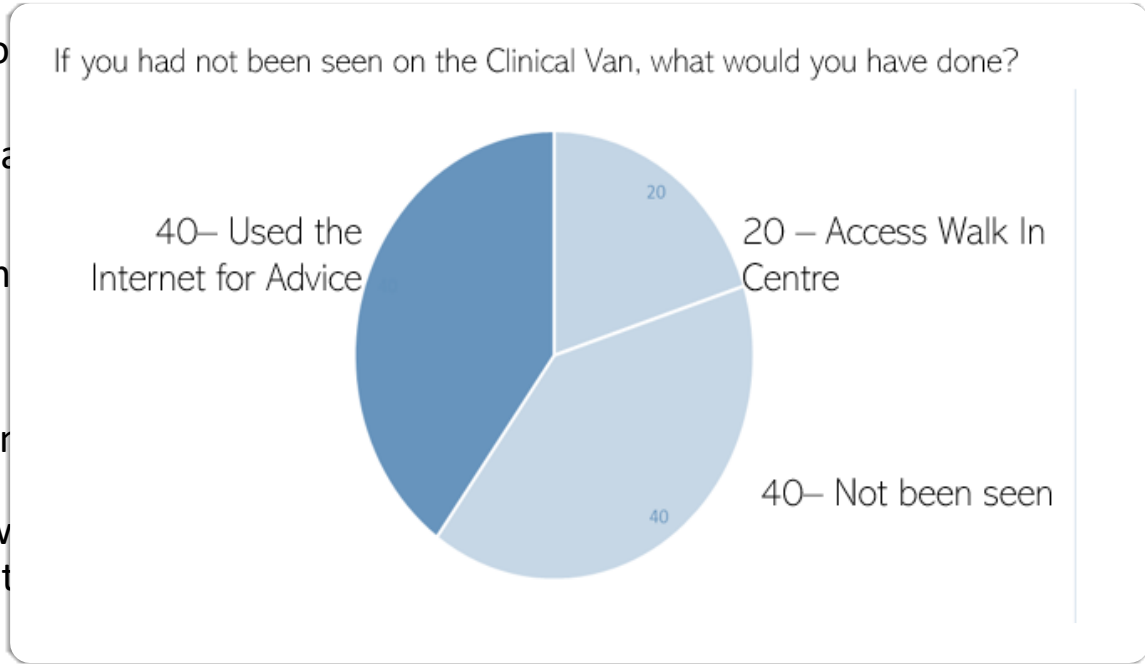
Snapshot of 4 Sessions run June/July

11 homeless patients in total with:

- 5 of these patients accessed leg treatment and wo
  care.
- 6 patients received information and advice about a
  Locala health services.

One patient (a drug user) who attended the van for treatm
had been brought over to Huddersfield from Dewsbury by
another service user.

Another example is the relationship building with others ir
community – A parking warden in Huddersfield has
relationships with Locala colleagues over the past few w
referred a homeless man to the van that he met in the t
centre.



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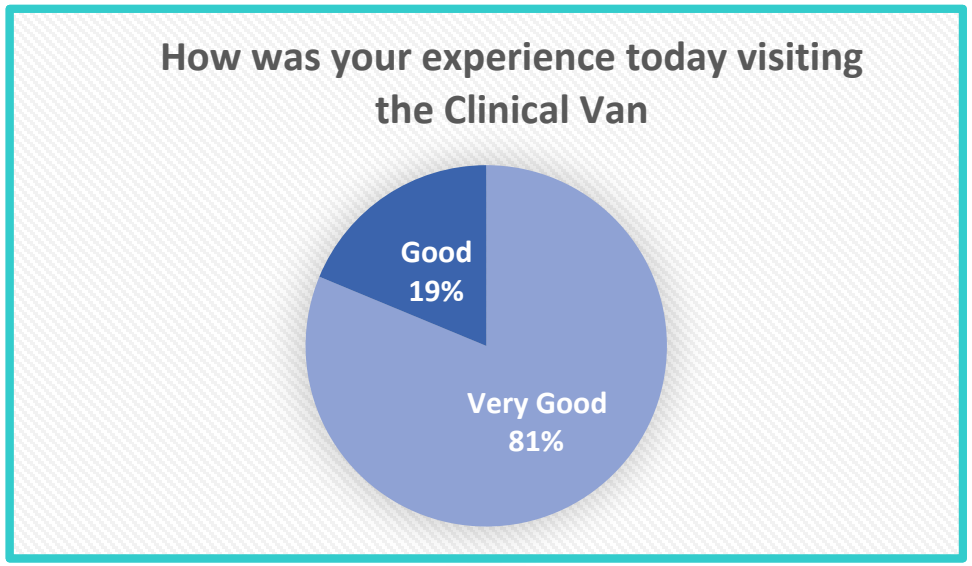
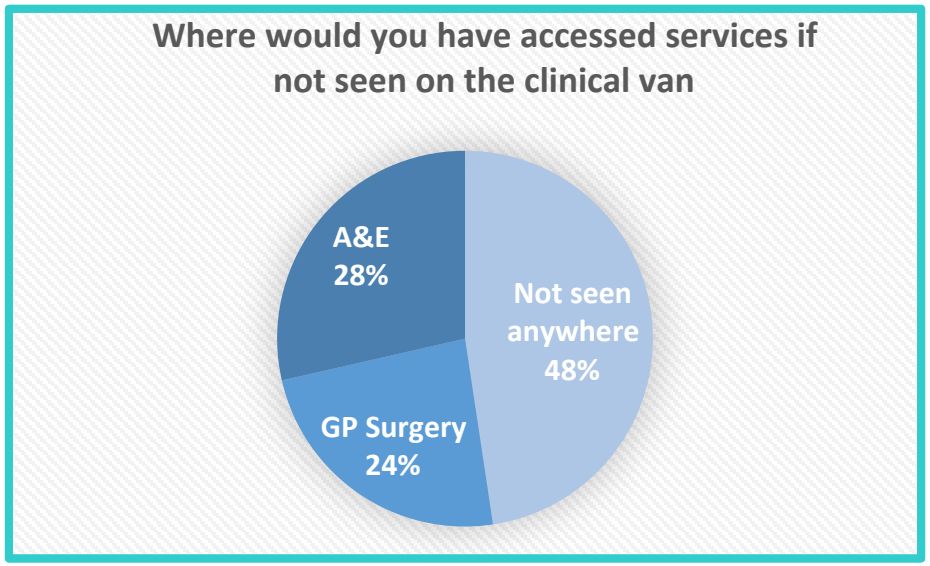
The Whitehouse – Snapshot of June

33 Patients

Variety of mental health and acute conditions

6 patients registered that were homeless





100% of responders would like future appointments in the clinical van

The Whitehouse Feedback

Friendly staff who were very welcoming

You Came to us

Within easy access of my hotel

Much better than going to the Doctors, as I struggle with English

Could you come here more often?

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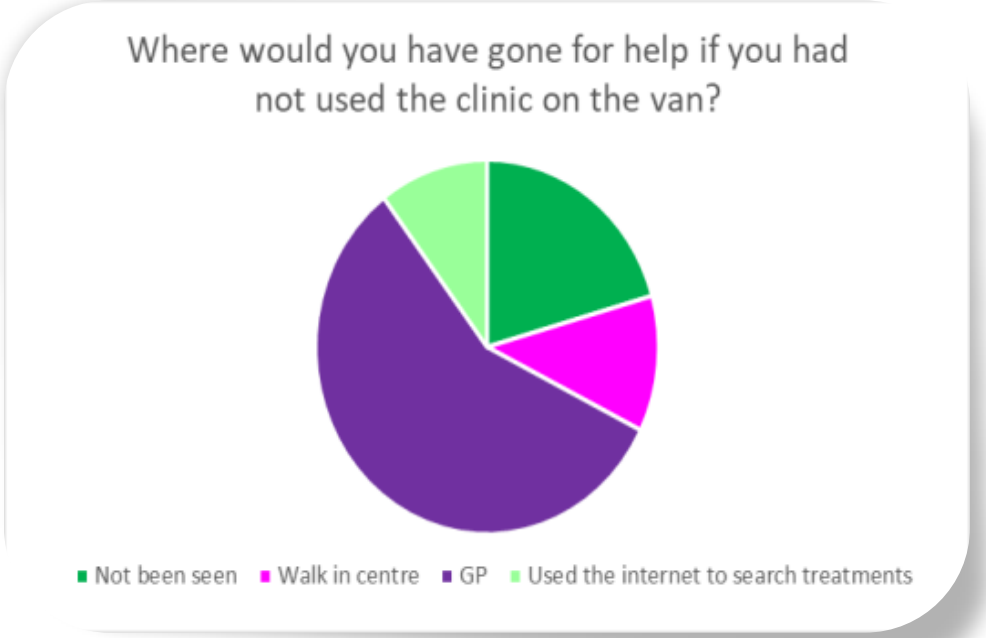
Immunisation Team – August Snapshot



Kirklees Health & Care Partnership

NHS West Yorkshire
Integrated Care Board

Immunisation Team Case Study

Whilst attending a Huddersfield Gala a young man who is in the police cadets came to the Clinic van along with a few other cadets and asked what we were promoting. We explained it was about Teenage Immunisations. We asked if everyone was up to date and most of them said “yes” except one, his mum had not consented to them. We asked if he knew why, and he said “no”. We advised the cadet that if he wanted the vaccines, he would be able to consent for himself if he understood what we were giving and why. He said he would go and speak with his mum and get back to us. We asked a fellow PC if they would need the Diphtheria, Tetanus and Polio vaccines to be in the police force and he said “yes”.

The young man came back around mid/ late afternoon with his peers and asked for the vaccines to be given. We went through his vaccine history. We explained that he required 3 vaccines, his teenage boosters Diphtheria, Tetanus and Polio, Meningitis ACWY and the 2nd MMR vaccine that he had missed at preschool. We asked if he had spoken with mum, but he said he wanted to consent for them himself as he was 17 and old enough to make that decision”.

Kirklees PRIDE event June 2023

NHS West Yorkshire
Integrated Care Board

Huddersfield pride event took place on 17th June
Many users engaged wanting information and advice and **14 patients were screened** for STI's.
A new Syphilis infection was diagnosed for a trans woman who had not tested for over 10 years and had been engaging in lots of sexual activity throughout that time. The patient was over 60 years old and was noted to have eye problems and had been attending the eye clinic however this had not been linked to syphilis. This patient presented at the clinical van identifying as female, attended SH clinic as female, however when liaising with other healthcare providers they attend other health appointments as male and under a different name, which effected the continuity of care. This patient is now under the care of the GU consultant with a care plan in place. (Untreated syphilis can sometimes lead to permanent loss of vision).

Next Steps

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Integrated Care Board

- Continue to build on existing projects
- Evaluation/continuation of on-going projects
- Implementation of Kirklees Community Services specification
- Improve engagement with General Practice, Community Pharmacy, VCSE and Independent Sector
- Sharing of learning across CKW

NHS West Yorkshire
Integrated Care Board

Personalised Care

Personalised Care Kirklees

Proud to be part of West Yorkshire
Health and Care Partnership

Kirklees Health & Care Partnership

Personalised Care

NHS West Yorkshire
Integrated Care Board

Workforce

There has been a reduction in the personalised care workforce as two of the PCN's reviewed their priorities to focus on access and capacity, resulting in a reduced number of care coordinators and heath and well-being coaches. The current workforce consists of;

14 Social Prescribing Link Workers, 5 FTE Mental Health Social Prescribing Link Workers, 2.5 Care Coordinators, 2 Health & Wellbeing Coaches

Improving Access

- Proactively identifying patients who will benefit from personalised care e.g. frequent attenders and DNA's, anticipatory care
- Supporting the appropriate use of clinical appointments
- Supporting the development and integration of Care Navigators in primary care

Tackling Health Inequalities

- Using data intelligence and population health management to focus on local health inequalities e.g. poor housing conditions for asthma patients

Working with neighbourhoods and communities

- Creating community based support e.g. Monday's at the Museum, Mindful Monday's, cost of living drop in's
- Funding anchor organisations to create and develop neighbourhood networks

Making Social Prescribing accessible

NHS West Yorkshire Integrated Care Board

Working in partnership with Huddersfield Fire Station the Viaduct PCN personalised care team delivered a series of 6 accessible drop in sessions, focusing on anxiety, loneliness, financial and housing. The sessions were delivered to make social prescribing more accessible to patients and promote the service.

The drop in's improved access to social prescribing and by being delivered in a community setting and proactively promoted to patients reduced the demand on primary care.

16 people attended in total.

Patients were supported with;

- Connected to local community activity
- Techniques to manage stress and anxiety
- Connected to specific services e.g. KBOP, housing, foodbanks
- Access to social prescribing

One person who attended the session was homeless and through visiting the drop in session was connected into housing support and supported into emergency accommodation. He continued to work with the Social Prescribing Link Worker on other social issues.

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Urgent Community Response

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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 for all unplanned community cases. This assessment closes ~40% of cases remotely.

- **Curo** and **Locala** both provide clinicians to undertake the face to face visits through a multi-disciplinary team – offering a personalised approach.

- **Kirklees Local Authority** offer social care support – crisis and reablement.

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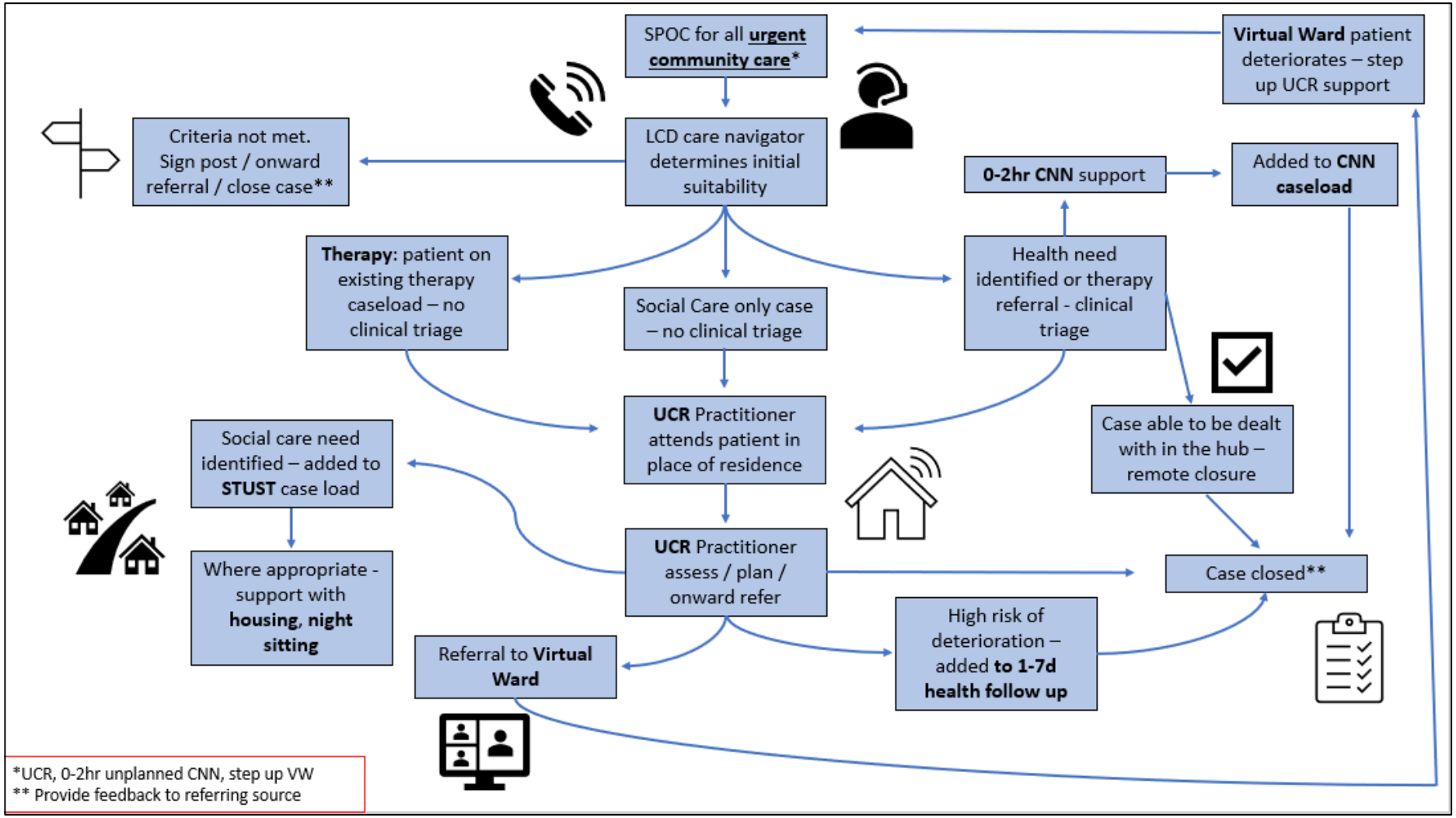
UCR in Kirklees



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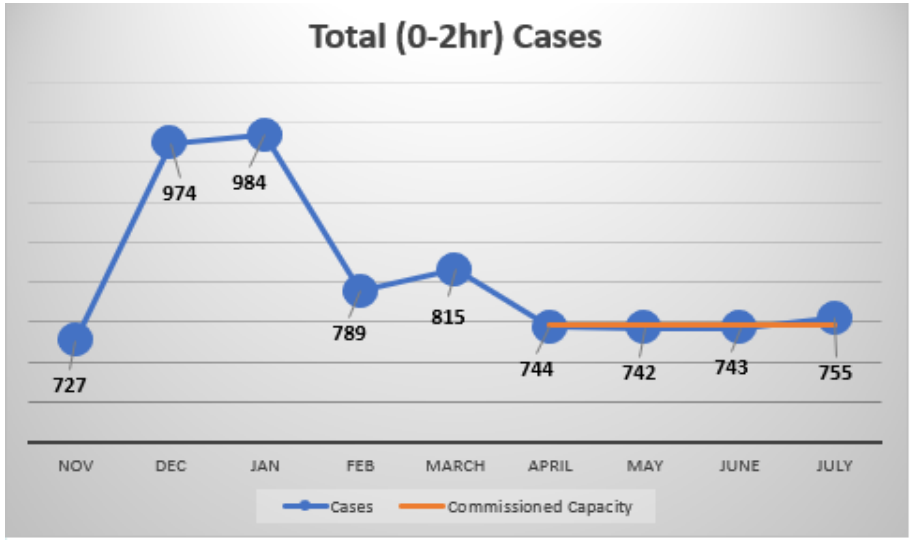
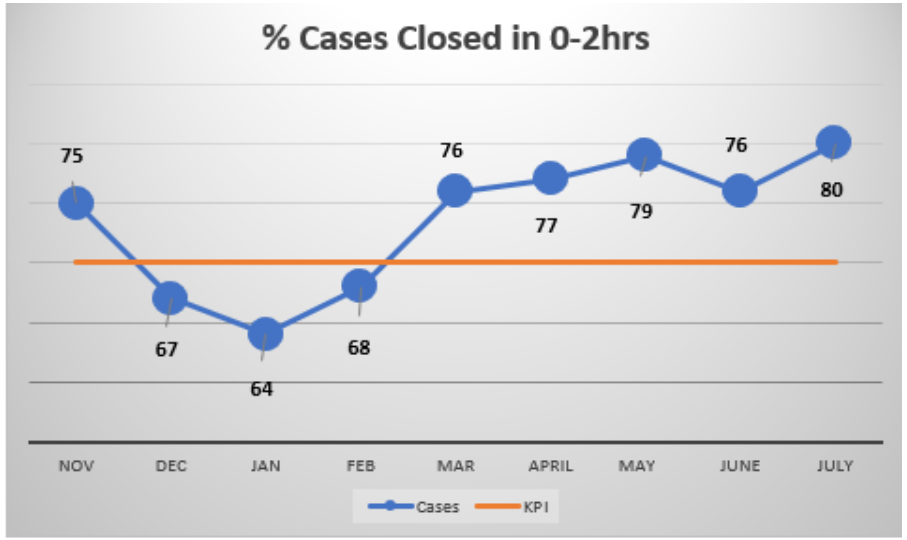
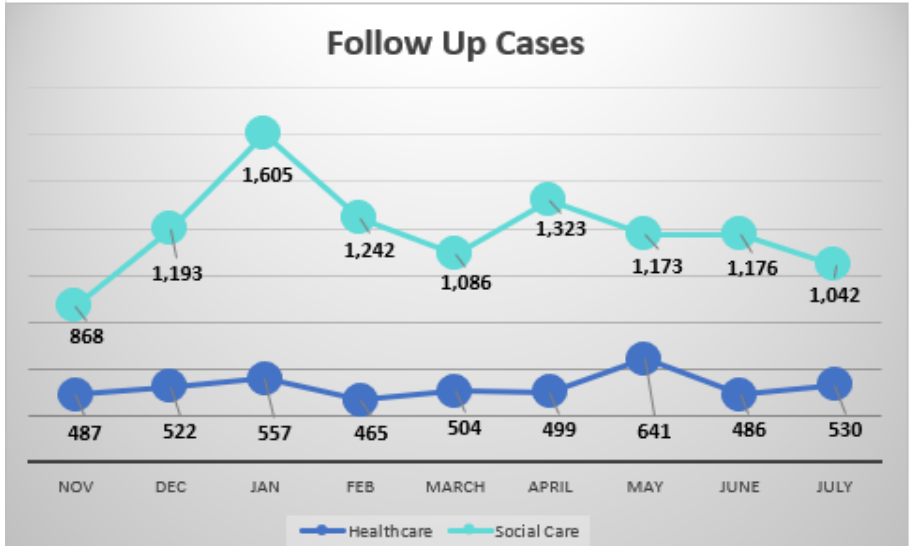
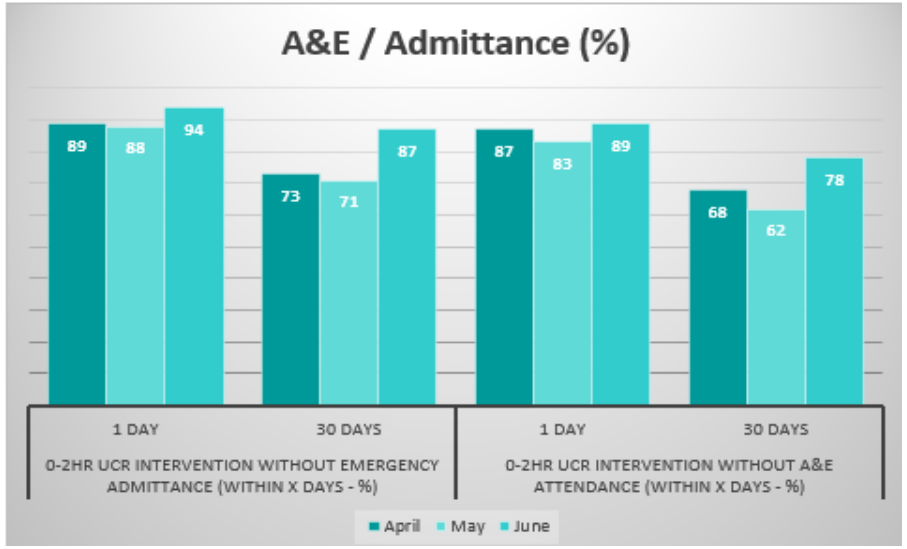
UCR Performance









Kirklees Health & Care Partnership

Hospital Discharge

Kirklees Health & Care Partnership

Overview

1. Admission avoidance

- Urgent community response & social care responders
- 999/111/ambulance services
- Mobile response service
- Enhanced care in care homes/settings

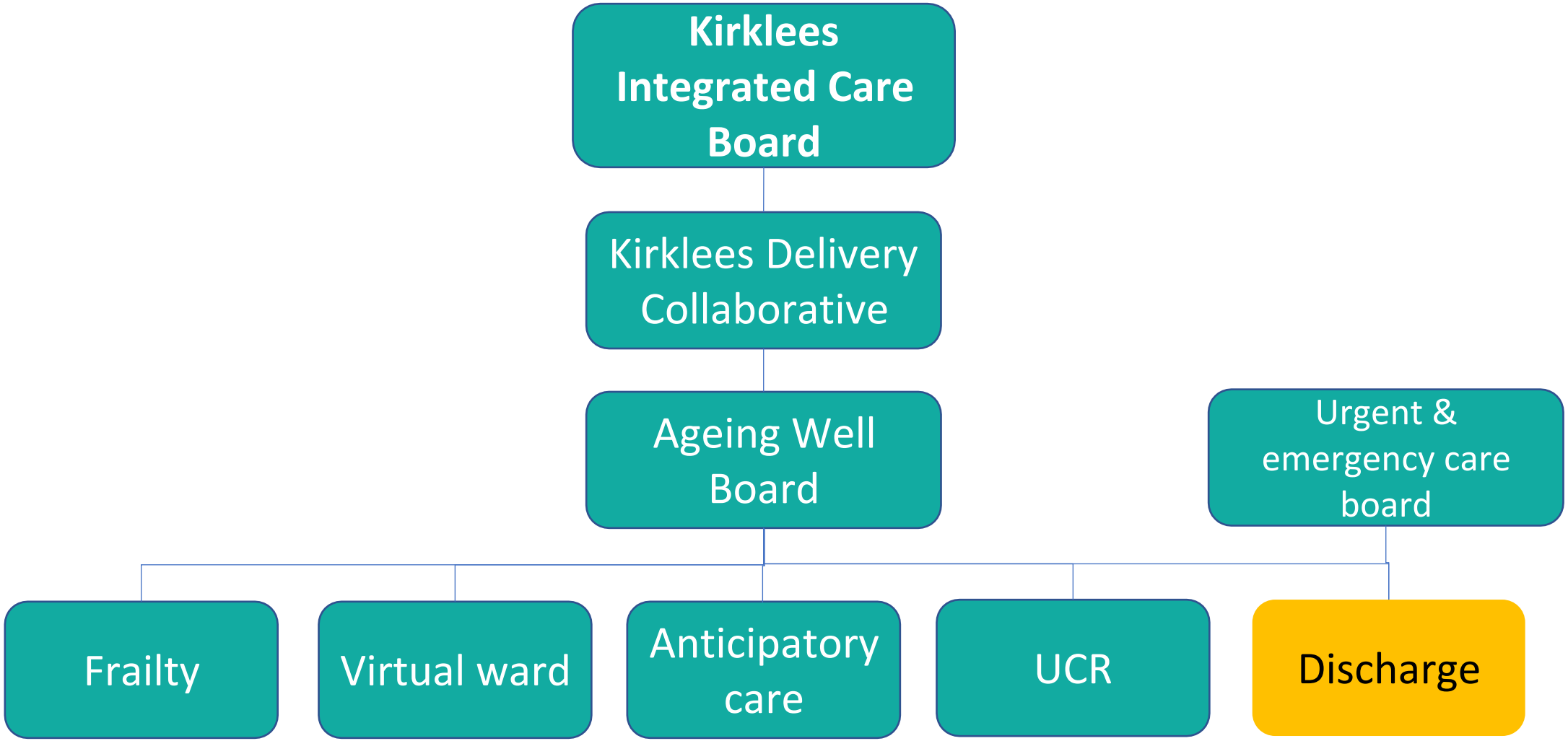
2. Speeding up discharge

- Virtual wards
- Age UK transport services
- Hospital based integrated discharge hubs

3. Post-hospital

- D2A/ITOC team
- Home/domiciliary care
- Night offer
- Reablement team
- Assistive technology
- Carers support
- D2A/short stay beds
- Intermediate care beds
- Long stay residential placements

Decision making



Right sizing services

The Overview:

- Understand the capacity and demand variations for post hospital care provision, and
- Develop scenarios and recommendations for addressing capacity gaps and meeting current/anticipated levels of discharge demand flows

Summary conclusions:

- Discharge planning is becoming more and more complex, if the right capacity is not in place to assess and support transfers from hospital in a timely manner, the system will continue to encounter delays at point of discharge from hospital.
- We have adequate capacity at a global level, with the exception of reablement and intermediate care at home, where additional capacity is required.
- The issue is the way in which ‘demand’ presents itself. This means that we don’t have the right capacity in the right place at the right time (capacity mismatch)

Demand and Capacity Modelling – The Approach

Reviewed demand flows and service data from the IHSC dashboard

- Discharge to Assess Pathways
- Discharge to Assess Beds
- Intermediate Care Beds
- Reablement, Mobile Response and Rapid Response

Deep dive on key service lines including:

- D2A/ITOC Team
- Hospital Social Work
- Reablement
- IMC Beds
- D2A Beds
- Domiciliary care
- Residential and Nursing Care

Current (as is) Discharge Model

- Overview of discharge Spend
- Overview of discharge activity and pathways
- Discharge pathways patient referral map
- Discharge Pathways patient referral profile

Key Findings – Discharge Activity and Pathways

- Short term funding through Covid19, winter initiatives and the D2A beds introduced during the pandemic have resulted in a **variety of fragmented initiatives** to support the acute trusts with patient flow.

- There is an ambition to reduce the reliance on discharge to assess beds in the long term by enhancing the range and capacity of other initiatives that result in improved outcomes for individuals and their carers and reduced demand for long term care and support.

Key Findings – D2A Pathways ('as is' model)

Pathway Destinations for Hospital Discharges April 2022 - March 2023

Hospital Discharges
22,540

Pathway 0 (Assumed)
11,270

Actual	Target
50.0%	50%

Simple Discharge - No formal input from Health and Social Care needed once home

Pathway 1
9,544

Actual	Target
42.3%	45%

Support to Recover at Home; able to return home with support from Health and/or

Pathway 2
1,122

Actual	Target
5.0%	4%

Rehabilitation or short-term care in a 24-hour bed-based setting

Pathway 3
604

Actual	Target
2.7%	1%

Require Ongoing 24-hour nursing care, often in a bedded setting. Long term care is likely to be required

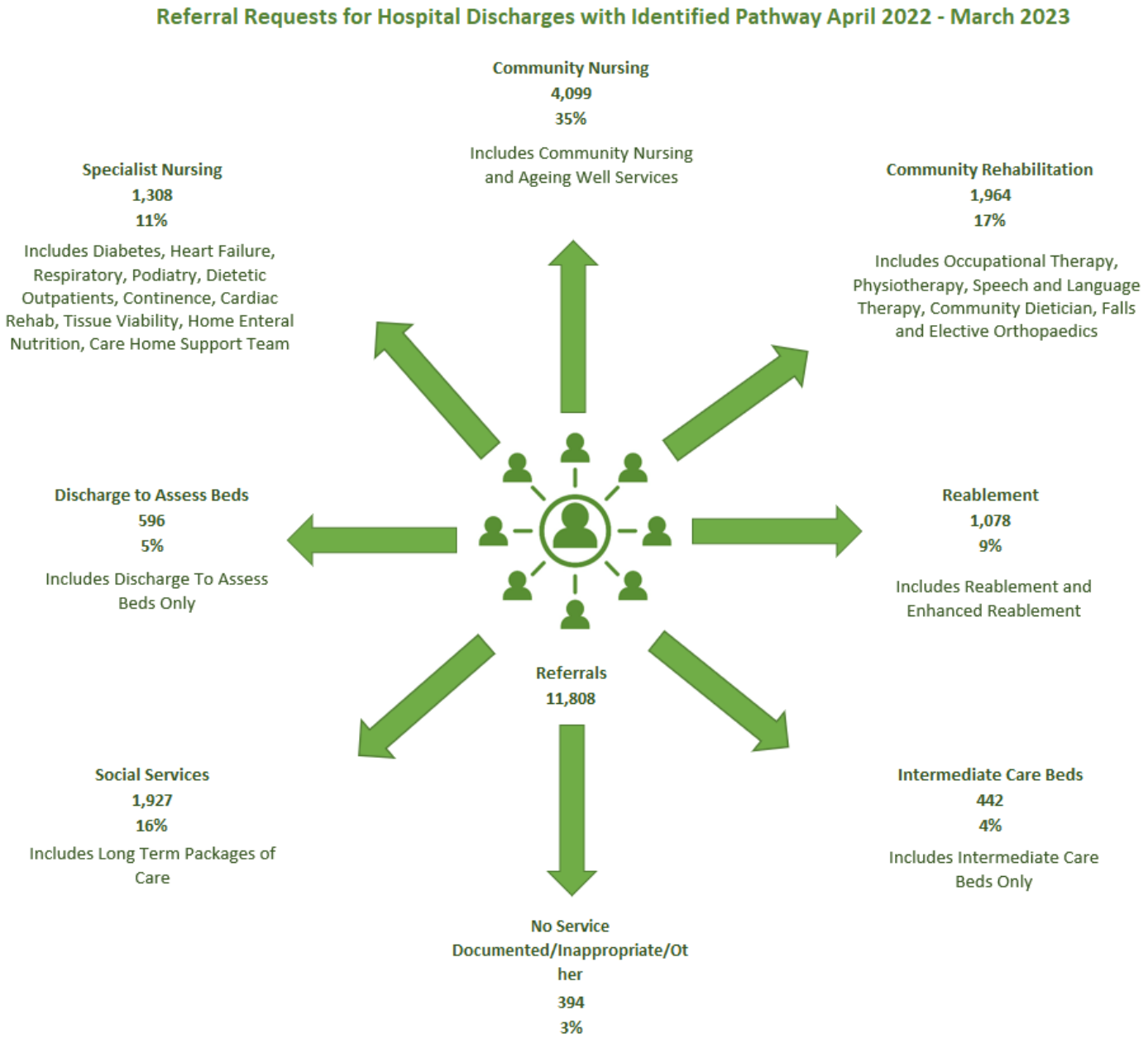
Source Data: *Locala Discharge to Assess/KILT One Discharge Form Dataset*

Key Findings – Discharge Activity and Pathways

- Our local model has a continued over-reliance on bedded support
- Outcomes for patients/service users through bed based solutions are not consistent with the outcomes we want to pursue as a system - - 78% of people remain as ‘short stay’ residents at 28 days - on average an additional 3 weeks LOS*
- There are opportunities to take a prevent/reduce/delay approach by maximising the opportunities for patients/service users to benefit from short term reablement support at home, further embedding the home first ethos and maximising independence

Modelling estimates indicate that to achieve the 45% national expectation for Pathway 1, **approx. 3 additional patients a day** would need to move from being admitted to a **D2A bed** to being discharged **home first** with the necessary health and care support.

Key Findings – D2A Pathways Patient Referral Map



Visual on the left shows the ‘web’ or ‘map’ of support for each typical patient supported through D2A pathways 1 to 3

Highlights that 3 out of 10 patients supported through D2A receive a referral to Community Nursing which highlights potential patient flow impact on wider community services

18% of patients supported through D2A are referred in to KILT IMC services in the current model which presents some opportunity for additionality/growth

Key Findings – D2A Pathways Referral Profile ('as is' model)

Number of Referrals Made Per Hospital Discharge by Pathway April 2022 - March 2023

Pathway 1
9,544

Number of Services Referred To	Hospital Discharges	%
1	8862	92.85%
2	404	4.23%
3	18	0.19%
4	2	0.02%
No Service Identified/Inappropriate	258	2.70%

Service Referred Onto:	Total Referrals:	%
Community Nursing	4057	40.61%
Community Rehabilitation	1903	19.05%
Reablement	1078	10.79%
Other	10	0.10%
Social Services	1538	15.40%
Specialist Nursing	1146	11.47%
No Service Identified and Inappropriate	258	2.58%
Total Pathway 1 Referrals	**9990**	**100.00%**

Pathway 2
1,122

Number of Services Referred To	Hospital Discharges	%
1	962	85.74%
2	38	3.39%
3	0	0.00%
4	0	0.00%
No Service Identified/Inappropriate	122	10.87%

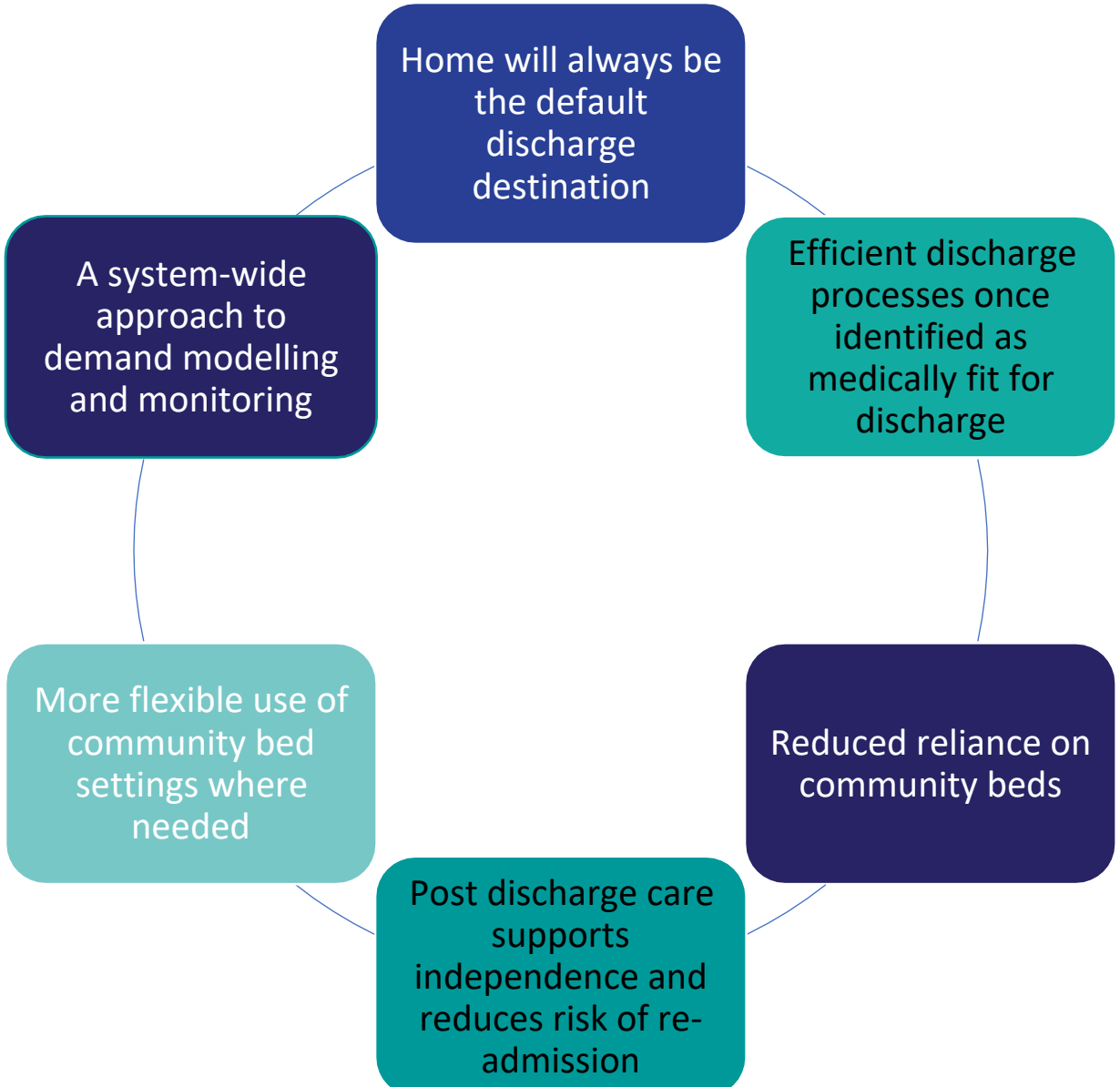
Service Referred Onto:	Total Referrals:	%
Discharge to Assess Beds	596	51.4%
Intermediate Care Beds	442	38.1%
No Service Identified and Inappropriate	122	10.5%
Total Pathway 2 Referrals	**1160**	**100.0%**

Pathway 3
604

Number of Services Referred To	Hospital Discharges	%
1	551	91.23%
2	44	7.28%
3	5	0.83%
4	0	0.00%
No Service Identified/Inappropriate	4	0.66%

Service Referred Onto:	Total Referrals:	%
Community Nursing	42	6.4%
Community Rehabilitation	61	9.3%
Social Services	389	59.1%
Specialist Nursing	162	24.6%
No Service Identified and Inappropriate	4	0.6%
Total Pathway 3 Referrals	**658**	**100.00%**

Proposed model and ambition



Scenario – D2A Reablement Model (Home First)

- Left shift diversion of D2A bed volumes to Pathway 1 – Home first (reablement) should be the default pathway
- Each additional patient supported via Reablement would equate to (service estimates of direct contact time):
  - 10 hours of reablement per week (note package drop off of 33% from week 1 to week 6)
  - 8 hours of night support per week
  - 1 hour of therapy input per week

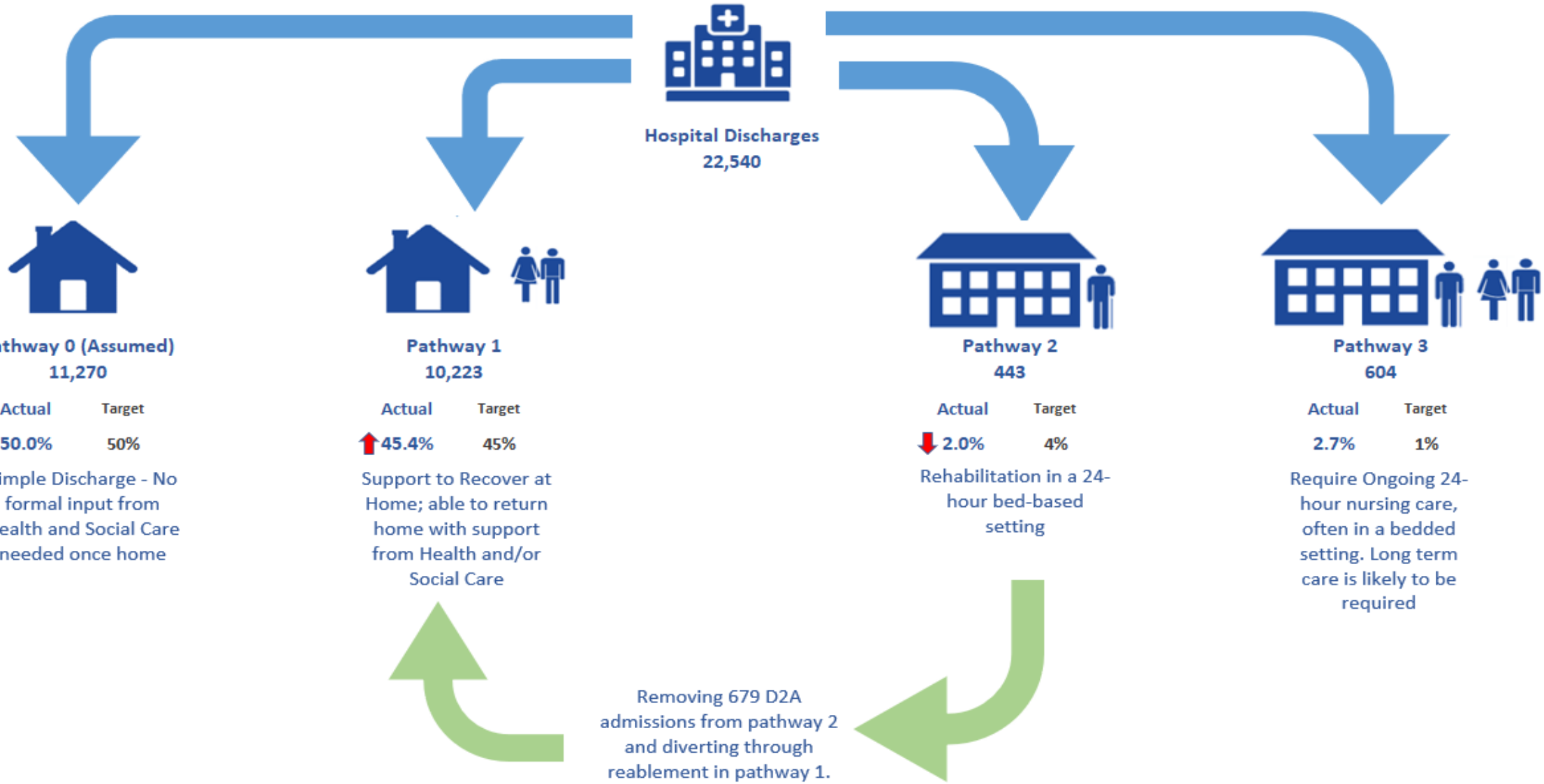
Community bed stay:

- 7-week bed stay at £850 a week = £5950

Home First:

- 7-weeks of home support at £760 a week = £5320
- Assumes each home first patient would need:
  - 10 hours of reablement including 1 hour of therapy and 8 hours of night support per week
  - Based on an estimated high unit cost for each service component (@ £40 an hour)

Pathway Destinations for Hospital Discharges - Proposed Remodel



Scenario – D2A Reablement Model Referral Profile

Pathway 1 Patients
10,223

Service Referred Onto:	Total Referrals:	%
Community Nursing	4057	38.03%
Community Rehabilitation	1903	17.84%
Reablement	1757	16.47%
Other	10	0.09%
Social Services	1538	14.42%
Specialist Nursing	1146	10.74%
No Service Identified and Inappropriate	258	2.42%
Total Pathway 1 Referrals	**10669**	**100.00%**

Moving 679 (Service Actuals) D2A Bed Admissions from Pathway 2 and Diverting through Reablement in Pathway 1

Pathway 2 Patients
443

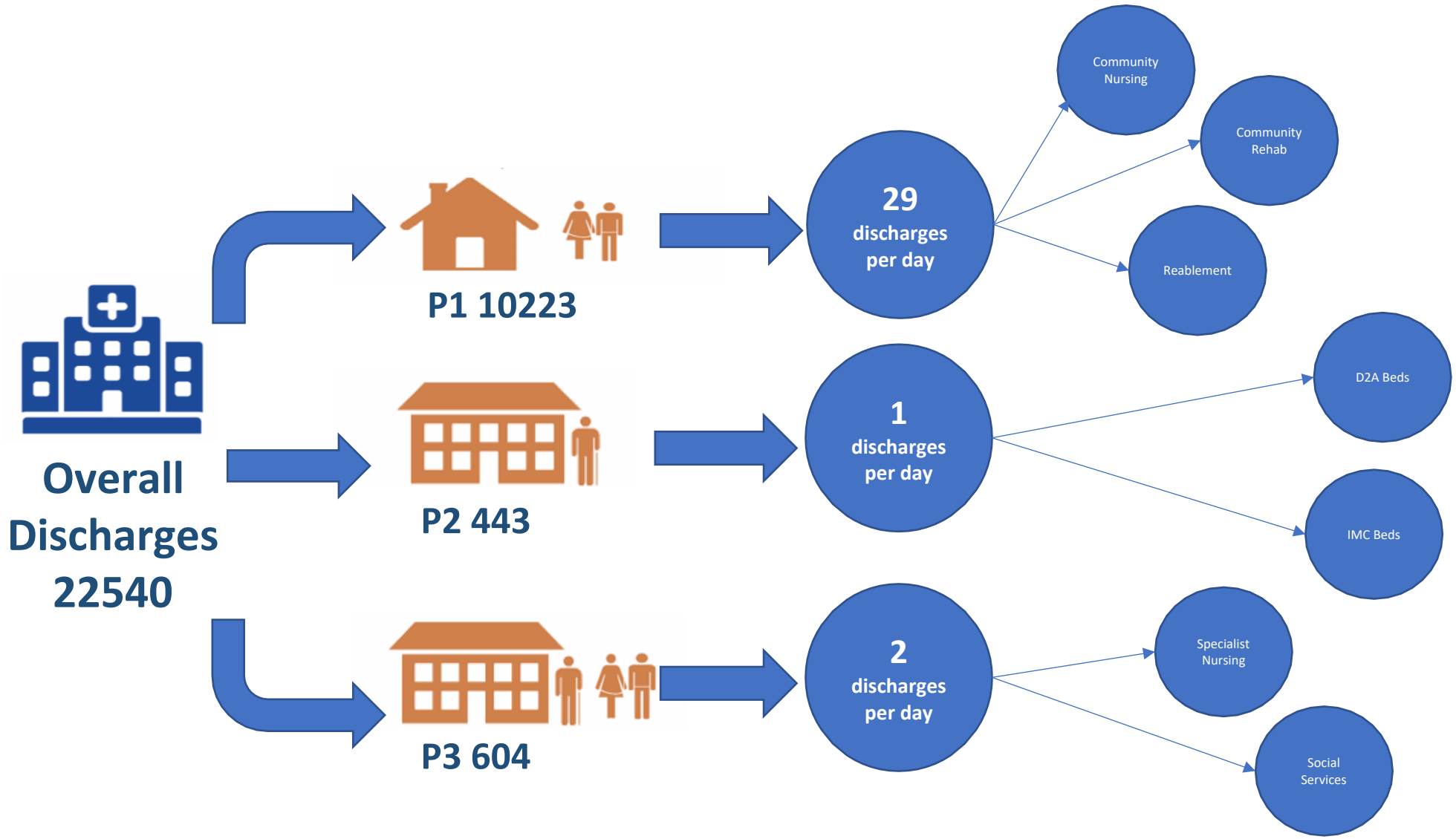
Service Referred Onto:	Total Referrals:	%
Discharge to Assess Beds	0	0.0%
Intermediate Care Beds	442	78.4%
No Service Identified and Inappropriate	122	21.6%
Total Pathway 2 Referrals	**564**	**100.0%**

Moving 679 (Service Actuals) D2A Bed Admissions from Pathway 2 and Diverting through Reablement in Pathway 1

Pathway 3 Patients
604

Service Referred Onto:	Total Referrals:	%
Community Nursing	42	6.4%
Community Rehabilitation	61	9.3%
Social Services	389	59.1%
Specialist Nursing	162	24.6%
No Service Identified and Inappropriate	4	0.6%
Total Pathway 3 Referrals	**658**	**100.00%**

Scenario – D2A Reablement Model



Developing a discharge improvement workplan

Six broad areas….

- Hospital
- Community D2A
- D2A beds
- Community social workers
- Intermediate care model
- Non-weight bearing patients

LA and Locala partnership working

1. Admission avoidance

- UCR Integrated Pathway (7 days) SCR offer 8am – 9pm 7days a week
- 0-2 A&E Assessments (7 days)

2. Speeding up discharge

- MAT Meetings
- Frailty Assessments (7 days)
- KILT
- Bed Managers
- Reablement Triage (7 Days)
- Kirkwood EOL Nurse pilot

3. Post-hospital

- IH&SC Management Group
- Integrated health and social care working within beds and community provision

Some helpful measures to determine how system is working -

- The percentage of requests for a service for an older person that are met within 48 hours – **close to 100%**
- The percentage of older people who are delayed when medically fit for discharge – **close to 0%**
- The proportion of older people who are discharged from hospital to a new permanent residential care home for the first time – **0%**
- The proportion of older people who are discharged to a bedded facility who eventually return home – **close to or over 75%**
- The proportion of older people who are discharged home with some care and support who don't require further care after two weeks, six weeks and twelve weeks – **close to or over 66%**
- The proportion of older people who are discharged without a recovery/ or palliative care plan – **close to 0%**

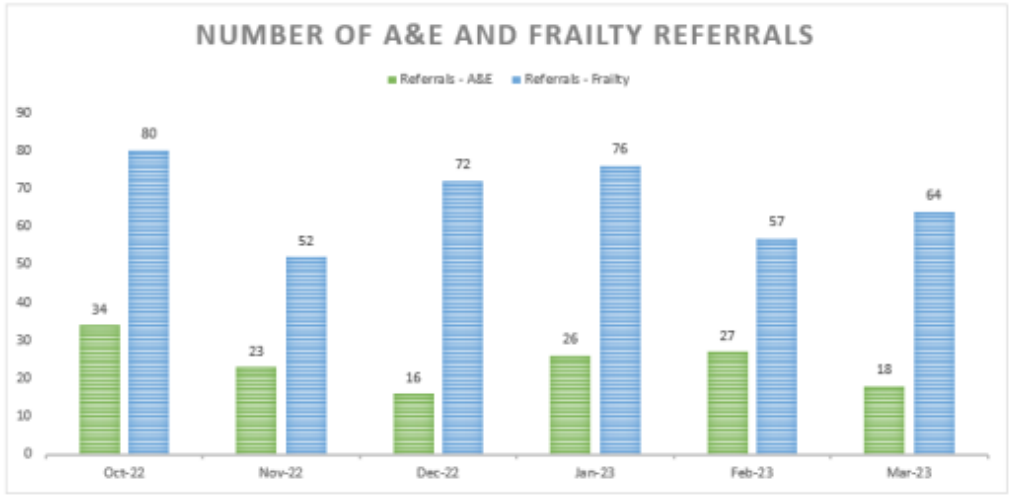
Source Data: *National Discharge Measures, Prof. John Bolton*

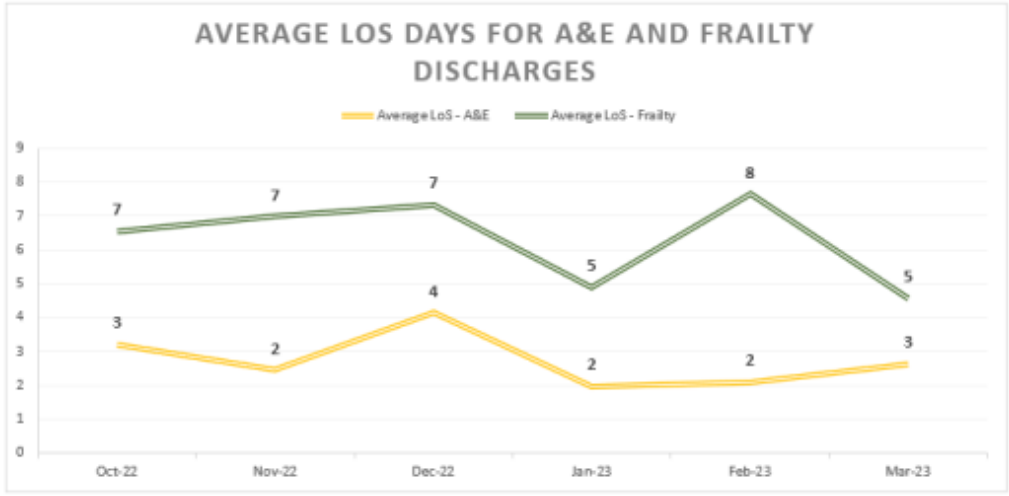
Some key data – help the finances

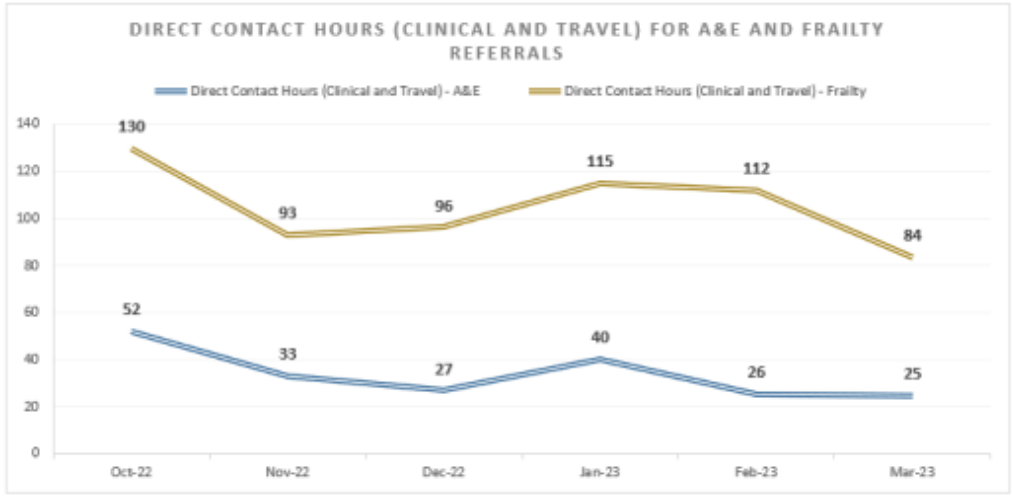
- The percentage of new people diverted at the front door – **should be more than 75%**
- The percentage of older people discharged from hospital with a care package who require no further care after 10 weeks – **should be more than 66%**
- The percentage of your net spend on older people that is spent on residential or nursing care – **should be less than 33% (best practice less than 25%)**
- The percentage of your net spend on younger adults who are in residential care – **should be less than 15%**
- The percentage of your hours on domiciliary care that is for less than 10 hours per week – **should be less than 10%**

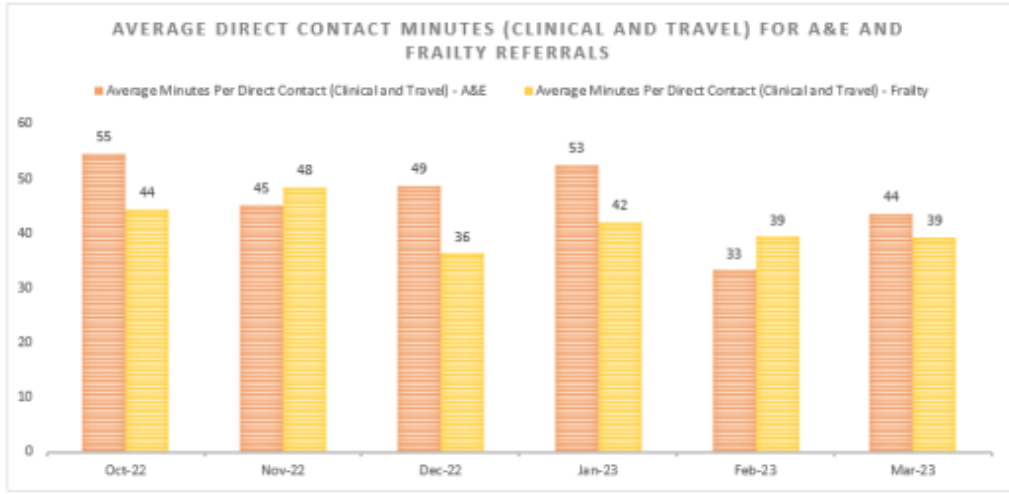
Source Data: *National Discharge Measures, Prof. John Bolton*

Key Findings – ITOC/D2A Service



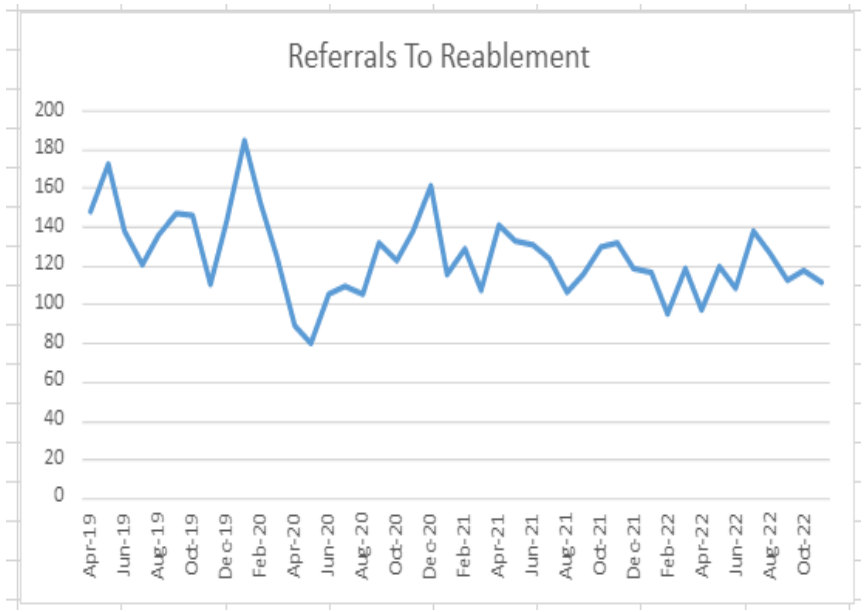






Source Data: *Locala A&E and Frailty Referrals, Discharges and Associated Activities – Service Actuals*

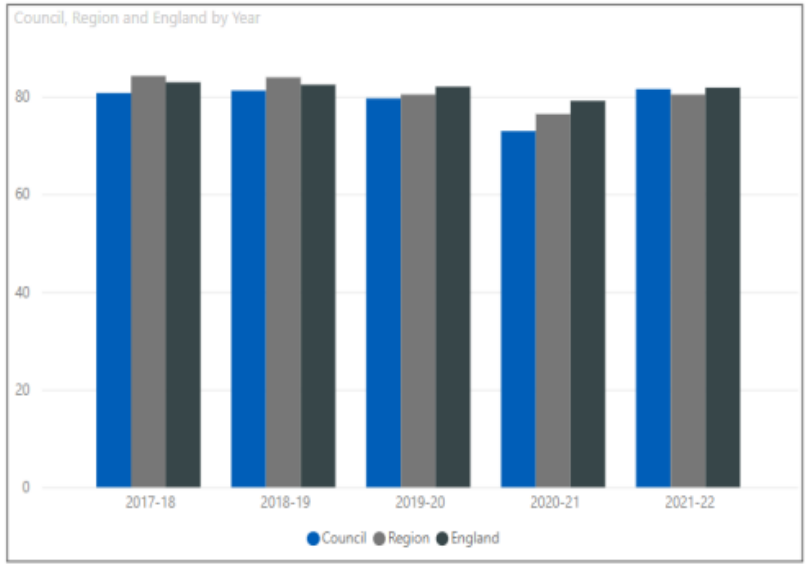
Key Findings – Reablement

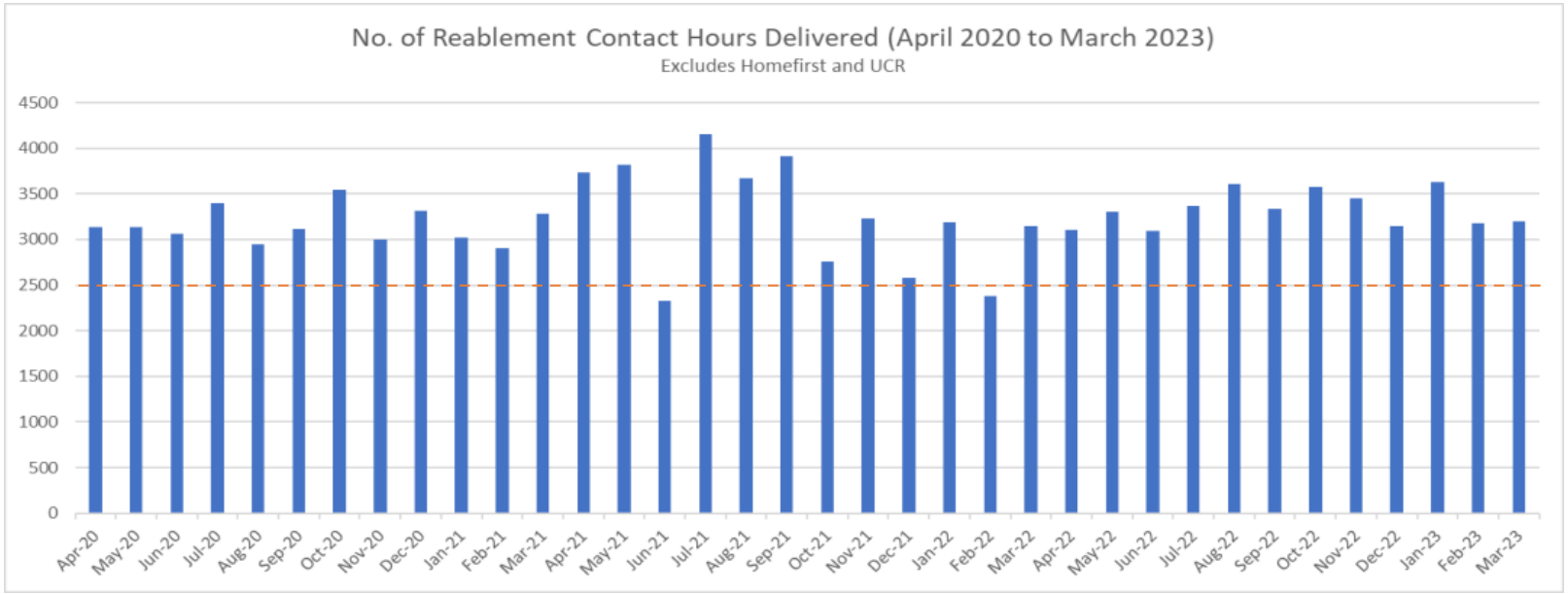


Since April 2020, the Council has delivered a 6% increase in reablement capacity – with 3332 average contact hours per month during 2022/23 (against a 'commissioned' block of 2500 hours)

Circa. 15% of capacity is used to support provider failure as the Service of Last Resort. If this was commissioned differently, it would release capacity in the reablement service.

Diverting demand away (left shift) from D2A beds to reablement would require TBC



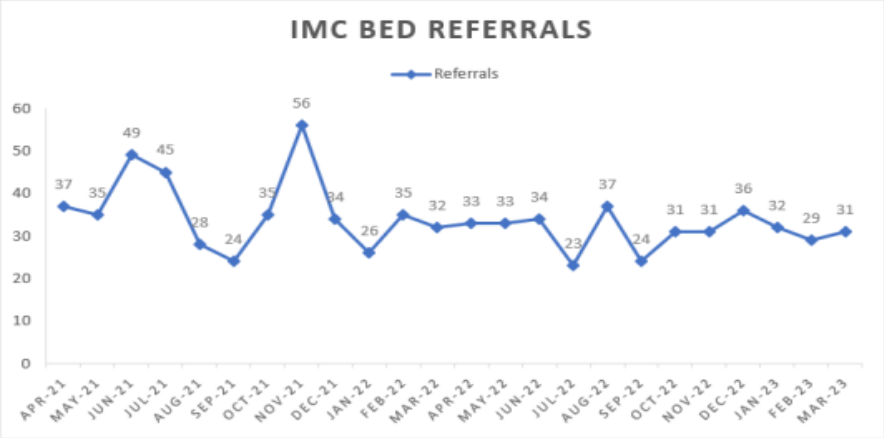


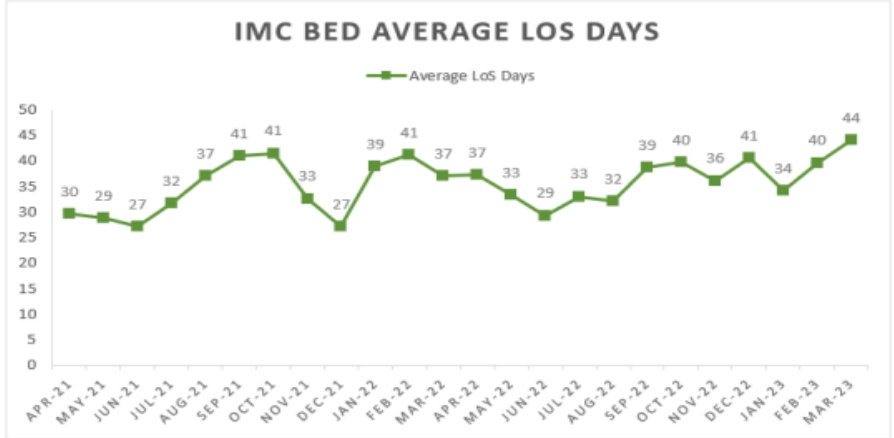
The Chart above demonstrates the % of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

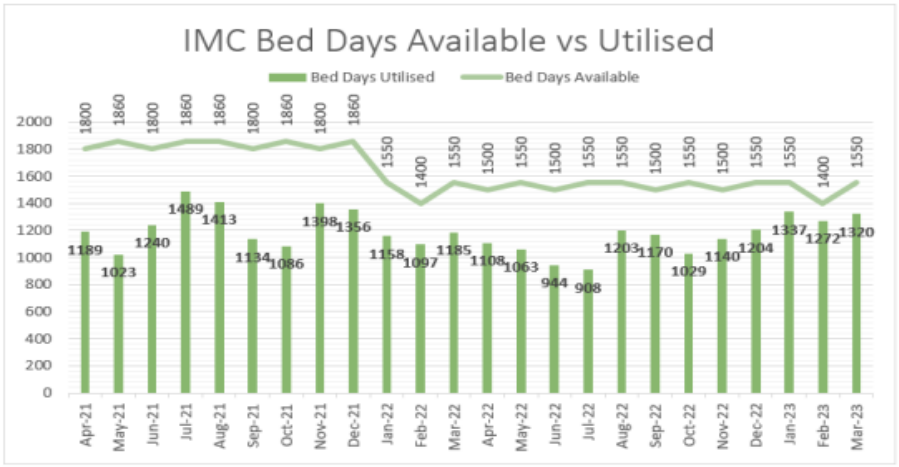
The latest position shows an improved position in relation to the regional and national average with Kirklees ranking 95 out of 146 councils (Higher is better)

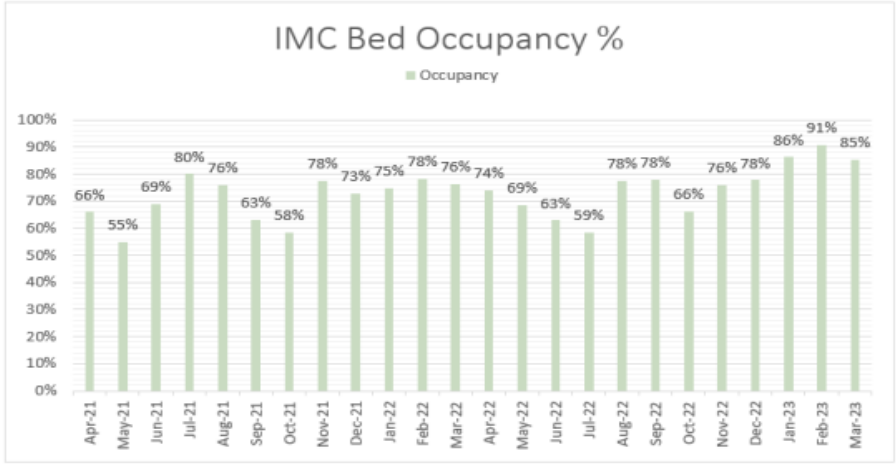
Local data shows that on average 3 out of 4 people regain their independence with no ongoing support following an episode of reablement

This evidences the opportunity in outcomes through this service model in mitigating ongoing pressures on the wider system





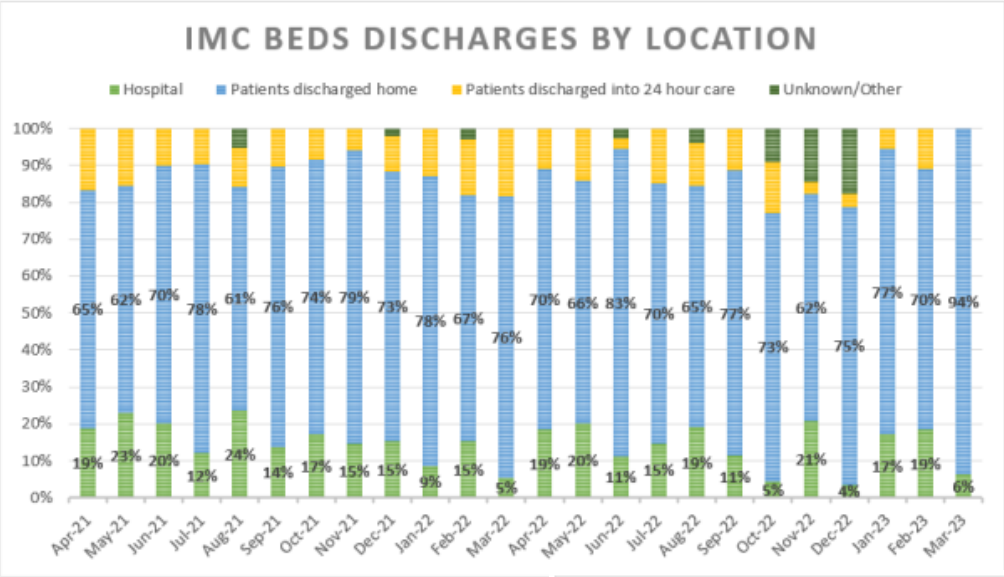


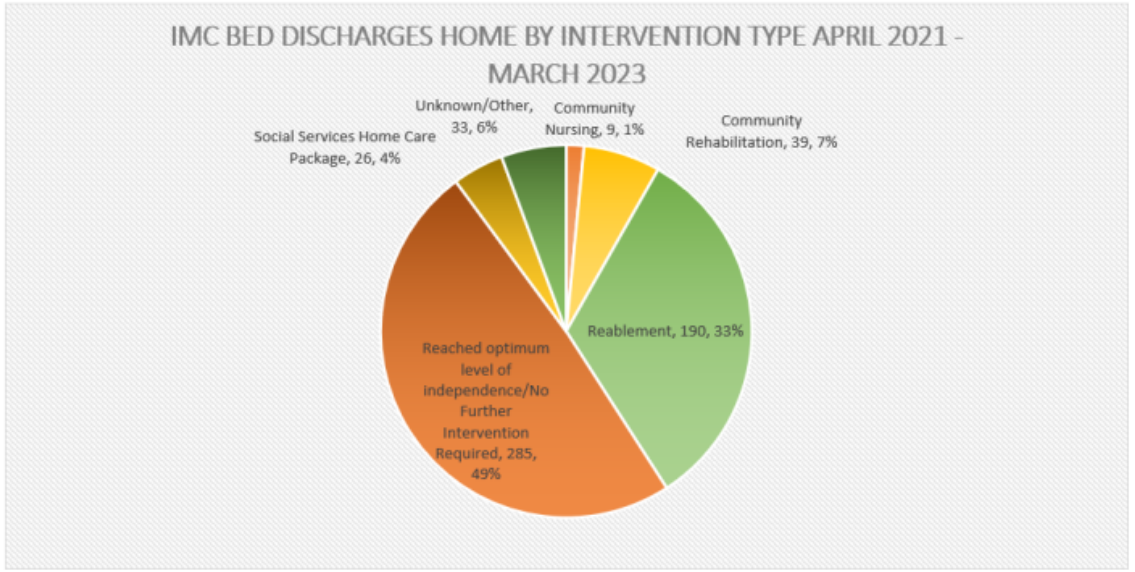


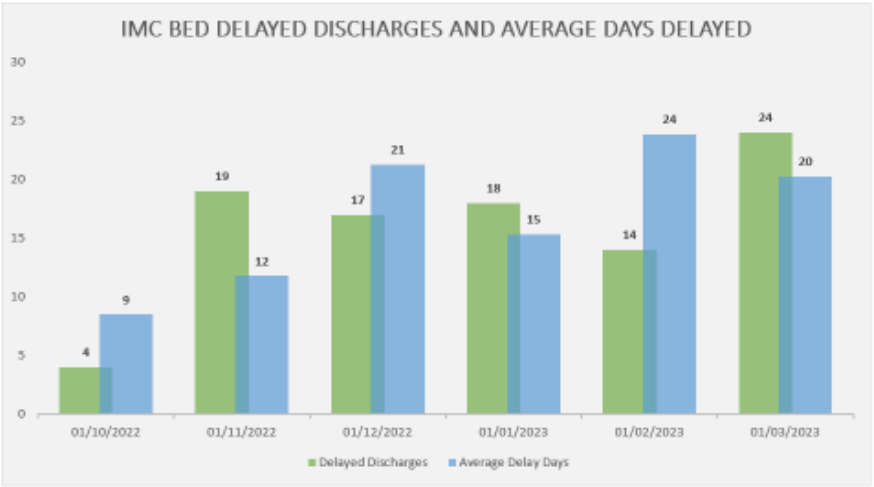
Source Data: *Locala Intermediate Care Beds Referrals, Discharges and Associated Activities – Service Actuals*

- Intermediate care services are delivered jointly by Locala and Kirklees Council through the KILT (Kirklees Independent Living Team) approach
- Promoting independence and shifting care away from acute settings has been a shared policy objective in Kirklees for many years
- Intermediate Care and a shift towards a proportionate and flexible bed model is an important approach in our continued efforts to integrate health and social care - ensuring a ‘home first’ approach is maximised, with an ambition to divert more people to home based intermediate care support

Key Findings – Intermediate Care Beds Outcomes and Delays







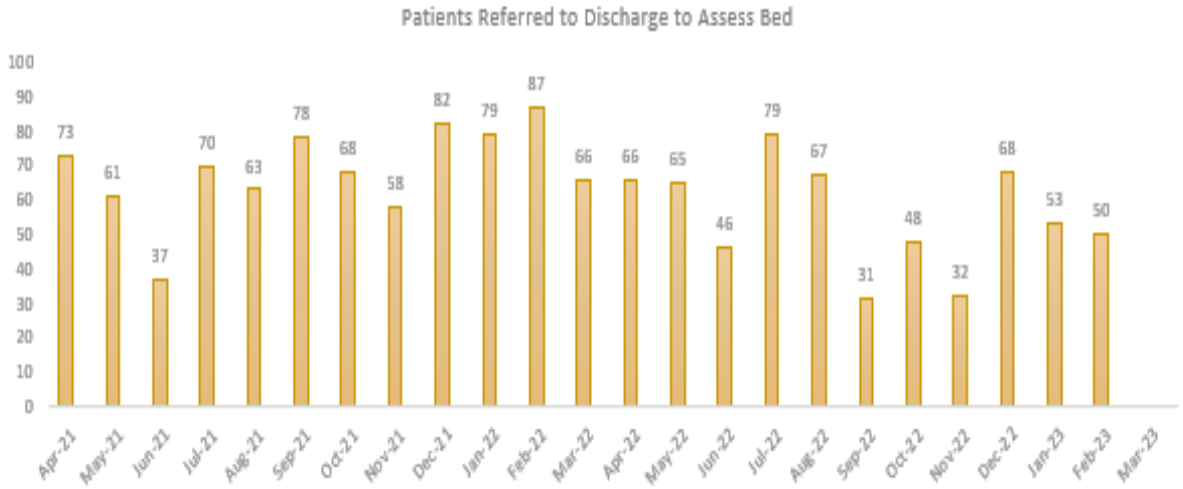
Source Data: *Locala Intermediate Care Beds Referrals, Discharges and Associated Activities – Service Actuals*

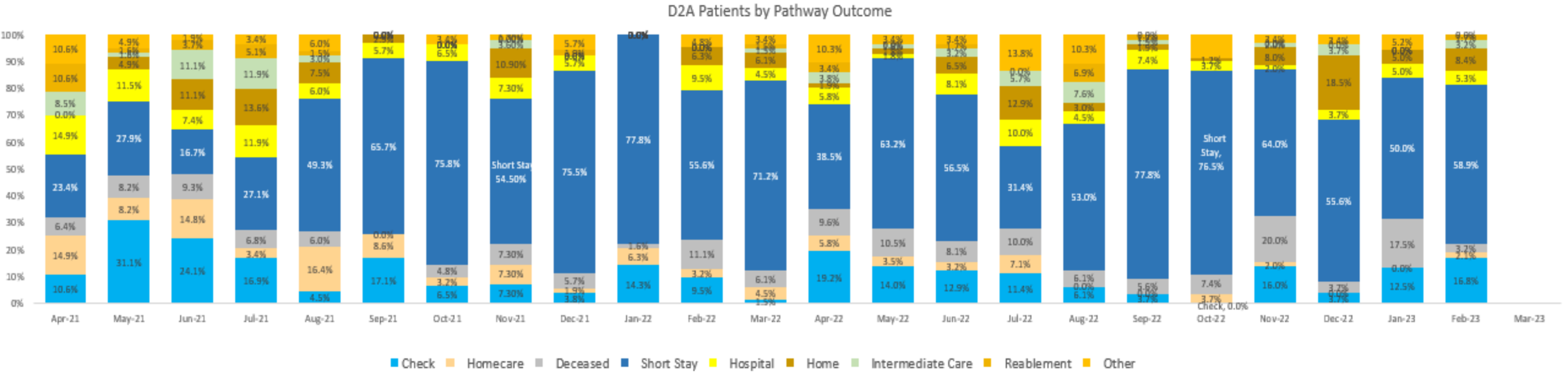
Key Findings – D2A Beds

Outcomes through D2A beds remain variable with data continuing to present a high proportion of 'short stay' outcomes

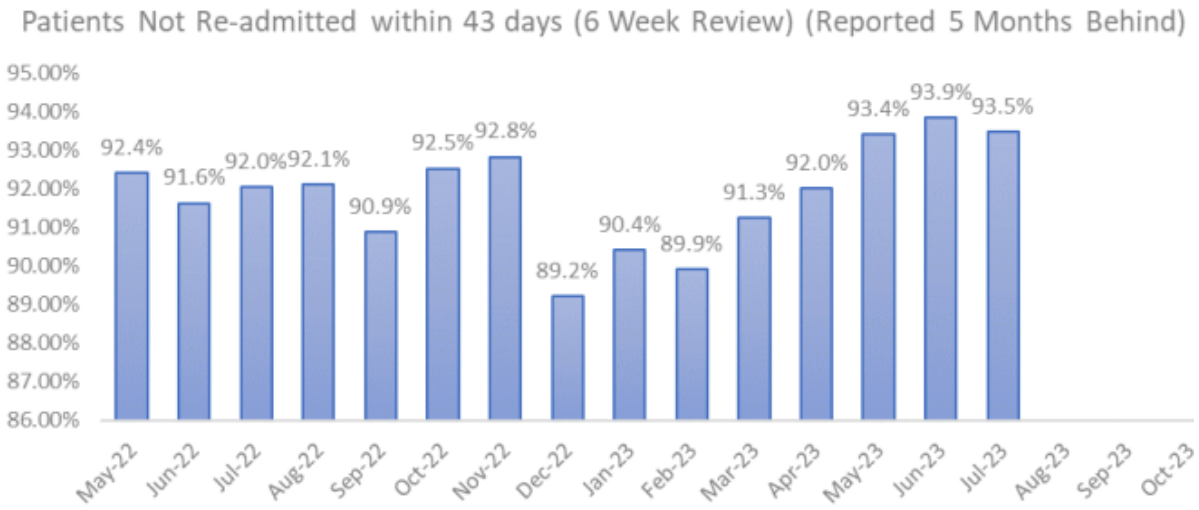
There is a need therefore to understand:

- Reasons for growth in these outcomes
- Understanding of outcomes following Short Stay (e.g. what proportion convert to a long term placement)
- total length of stay in a bed base since the LOS in a D2A bed metric may be masked by the change in status of the bed from D2A to Short Stay (whilst the patient/service user continues to reside in the bed) – note that average LOS for these patients in hospital equates to 29 days
- Impact of delayed stays in D2A beds across resource capacity, e.g. short stay outcomes from D2A beds impacting on therapy capacity, need to understand likely outcome at the end of D2A stay to help inform capacity planning



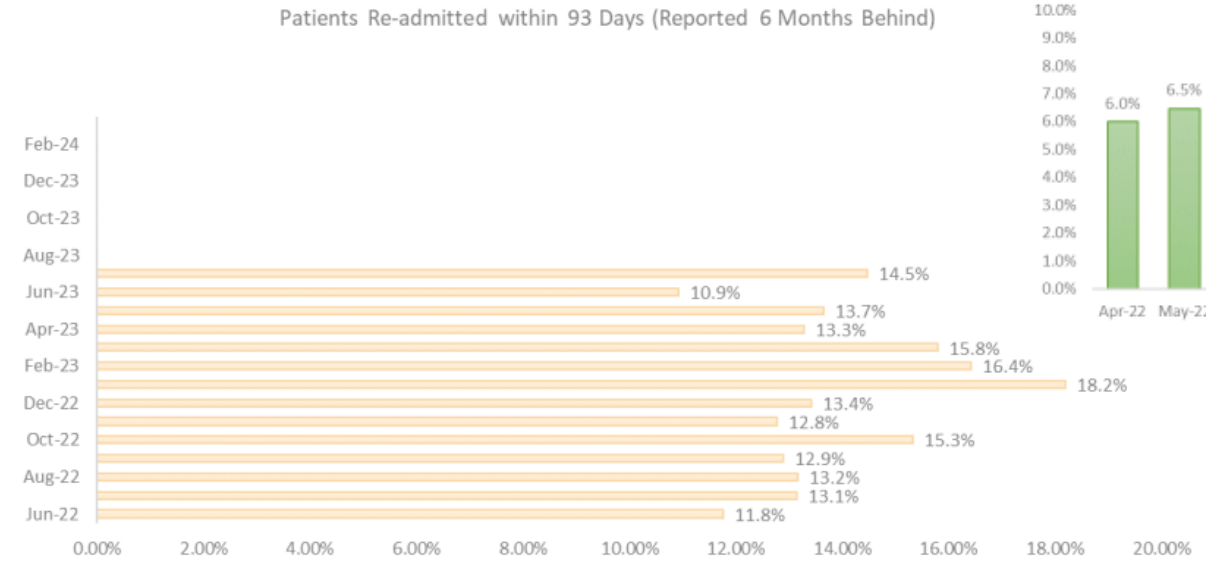


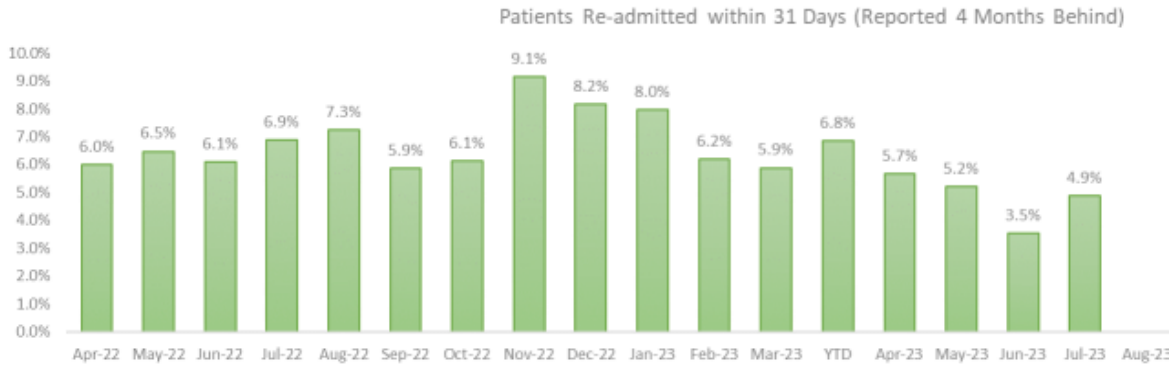
Re-admission Data



YTD Date Figures

- Patient re-admitted within 31 days – 4.8%
- Patient not re-admitted within 43 days – 93.2%
- Patient re-admitted within 93 days – 13.1%





Key Findings – TOC and Assessment Capacity (CHFT Data)

Referrals - referral rate onto TOC is 38% higher for Kirklees when comparing 2022 to 2019. These referrals account for patients on Discharge Pathways 1-3 only – **need to identify if the resources of services such as Discharge co-ordinators and Social Workers has been optimised to manage this additional demand**

Acuity - patients requiring hospital admission are often very acutely unwell. This can make recovery and potential deconditioning longer and more severe. If the right capacity is not there to assess in a timely manner, the system will continue to encounter delays at point of discharge from hospital.

Reablement – on average patients are staying for a slightly shorter LOS in hospital (19 days LOS). Although the LOS for discharge planning has reduced, this still does not meet NICE Guidelines of admitting into the service within 48hrs of referral (avg LOS on TOC = 4 days)

Intermediate Care (Beds) – on average patients supported through an IMC beds pathway are residing in hospital for an average of 20 days. The LOS for discharge planning on TOC is 5 days which does not meet NICE Guidelines of admitting into the service within 48hrs of referral

D2A Beds - Patients supported in to D2A/Short Stay beds are spending on average 29 days in hospital (LOS admission to discharge), 11 days of which are on TOC which highlights complexities in system flow in this pathway

Packages of Care - The number of patients being referred for packages of care at home has increased over time. Avg LOS for these patients in hospital (admission to discharge) equates to 25 days, with LOS on TOC being 8 days which highlights some difficulties in obtaining packages of care particularly in certain rural areas of Kirklees

Long Term Resi/Nursing - When comparing 2022 to 2019, there has been an overall decrease in the number of patients being referred from hospital to permanent care home settings. the length of time on the TOC list has increased again in 2022 – with over 10 days spent in hospital awaiting these assessments and placements to be sourced

Workforce

Kirklees Health & Care Partnership

Kirklees Integrated Workforce Development Strategy
Our Strategic Priorities

As part of our workforce strategy we have a focus on recruitment of staff and on staff health and wellbeing [which is a key factor in staff retentions]. Working with Calderdale, we have a number of initiatives in place to support these areas. These are designed to complement what is already being done in individual organisations and add value by:

Achieving things that can only be achieved, or can be better achieved, by working collaboratively

Supporting organisations and sectors that are less able to provide in house support to staff due to their smaller size meaning they have less in house capacity [which are often those based in communities and neighbourhoods]

Making them available to all parts of our health and care system, including those organisations that work more closely in communities and neighbourhoods such as GP practices, community pharmacies, and care homes

Where, we can supporting people in our communities to find good employment opportunities by working with people who may require support to help them do so. Over time this should help to address inequalities in our communities.

A summary of some of these initiatives is given on the following slides and more detail on these are in the separate detailed slide deck.

Kirklees Health & Care Partnership

Recruitment & Retention

Summary of Programmes

C & K Careers - Health & Social Care Project - Working in Partnership with the Princes Trust. A programme to support young people into sustainable employment. To date 176 young people registered , 49 offered permanent employment/apprenticeships, 40 have either started or have a confirmed start date, and 26 have sustained employment of 3+ months

As partnership we are proactively working with a range of partners from across the system to create employment and volunteering opportunities for Refugees. Working very closely with Refugee Nursing for NHS England North East and Yorkshire. Our local partners include our VCSE sector, Kirkwood Hospice, and Kirklees Care Association as well as our acute Trusts. This supports both the refugees themselves and helps our health and care system to support its workforce.

As a partnership we are working with West Yorkshire Joint Services to establish a Joint apprenticeship levy thereby utilising all underspend where possible. And working to support organisations who work in communities and neighbourhoods to access this funding to support their staff.

Additionally our retention group are focusing on innovative strategies to support recruitment and retention approaches, such as compassionate HR process, joint talent management while identifying common themes where this makes sense to work on together.

Working with C&K Careers and The Ahead Partnership on our Calderdale and Kirklees Health and Care Pathways Programme to encourage and support children in high schools to take up careers in health and care. To date over 10,000 children have engaged with this programme across 27 schools, supported by 80 health and care partners.

Kirklees Health & Care Partnership

Staff emotional Health and Wellbeing

Programmes of health and wellbeing support

Compassionate cultures – we run an annual conference open to all partners from across our H&C system to encourage and support compassion in the workplace. We also run a Compassionate Leadership Programme to specifically support managers to do this in their organisations.

Kirklees and Calderdale Festival of Wellbeing Events Menopause Sessions and Healthy Habits. A programme of offers to support staff from across our health and care system with advice on the menopause such as support groups, nutrition advice, HRT, and impact on relationships. Feedback on these if that they have been very helpful for our staff.

Our Social Care Innovation Programme is specifically designed with and for staff working in care homes and we take the offers to them as they often struggle to take time away from work to attend. We run workshops, offer advice, provide health checks and other wellness offers. These are proving very popular with staff with significant number reporting that they have helped to improve their physical and mental health.

Integrated Schwartz Rounds. Developed in a hospital setting, these are structured, supportive conversations for staff where they share their experiences of work, listen to others and provide a safe space to share work experiences. We have taken these into community services and they have been very well received by staff.

Kirklees Health & Care Partnership