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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds on
Wednesday, 29th February, 2012 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

R Charlwood	-	Moortown;
C Fox	-	Adel and Wharfedale;
S Armitage	-	Cross Gates and Whinmoor;
K Bruce	-	Rothwell;
J Chapman	-	Weetwood;
A Hussain	-	Gipton and Harehills;
W Hyde	-	Temple Newsam;
J Illingworth	-	Kirkstall;
G Kirkland	-	Otley and Yeadon;
L Mulherin (Chair)	-	Ardsley and Robin Hood;
S Varley	-	Morley South;
	-	

Co-optees

Joy Fisher	Alliance of Service Users
Sally Morgan	Equality Issues
Betty Smithson	Leeds LINk
Paul Truswell	Leeds LINk

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **No exempt items on this agenda.**	

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES** To approve the minutes of the Scrutiny Board Health and Wellbeing and Adult Social Care meeting held on 25th January 2012 (minutes attached)	1 - 12
7			**LEEDS HEALTH AND SOCIAL CARE TRANSFORMATION PROGRAMME - UPDATE** To consider a report of the Head of Scrutiny and Member Development on an update on the work of the Transformation Board (report attached)	13 - 26

			HEALTH AND SOCIAL CARE INTEGRATION Items 8 to 11 form the parts of an overall item on Health and Social Service Integration	
8			**HEALTH AND SOCIAL CARE SERVICES INTEGRATION : AN OVERVIEW** To consider a report of the Director of Adult Social Services providing an overview of the principal integration initiatives currently underway between Leeds City Council, Adult Social Services and colleagues form the NHS family of organisations in the City (report attached)	27 - 54
9			**HEALTH AND SOCIAL SERVICE CARE INTEGRATION: SUPPORTING WORKING AGE ADULTS WITH ENDURING MENTAL HEALTH ISSUES** To consider a report of the Director of Social Services providing an update on progress since the Scrutiny Inquiry undertaken in 2009/10 in developing a more integrated service for those people with severe and enduring mental health problems who require support from both health and social care (report attached)	55 - 66

10			**HEALTH AND SOCIAL SERVICE CARE INTEGRATION - PROPOSAL TO DEVELOP INTEGRATED HEALTH AND SOCIAL CARE TEAMS** To consider a report of the Director of Adult Social Services providing details on the work being undertaken in Leeds to improve the effectiveness of health and social care services, including the approach of using demonstrator sites to test out and develop aspects of the model of service (report attached)	67 - 74
11	Beeston and Holbeck;		**HEALTH AND SOCIAL CARE SERVICE INTEGRATION - HARRY BOOTH HOUSE** To consider a report of the Director of Adult Social Services providing an overview of the development of the City's first intermediate care unit to provide residential and nursing care beds jointly commissioned and delivered in partnership with Leeds Community Health Trust (report attached)	75 - 84
12			**DECOMMISSIONING THE LEEDS CRISIS CENTRE** To consider a report of the Director of Social Services providing detail of the steps taken by Adult Social Care working in partnership to decommission the Leeds Crisis Centre following the decision taken by Executive Board in February 2011 (report attached)	85 - 96
13			**DATE AND TIME OF THE NEXT MEETING** Wednesday 21st March 2012 at 10.00am (Pre meeting for all Board Members at 9.30am)	

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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

WEDNESDAY, 25TH JANUARY, 2012

PRESENT: Councillor L Mulherin in the Chair

Councillors C Fox, S Armitage, J Chapman, A Hussain, W Hyde, J Illingworth, S Varley, K Groves and A Khan

Co-opted Members – J Fisher, S Morgan, E Smithson and P Truswell

53 Opening remarks

The Chair opened the meeting and welcomed everyone in attendance, in particular those members of the Board attending as nominated substitutes.

54 Late Items

Although there were no formal late items, the Board was in receipt of the following supplementary information for consideration at the meeting:

- The draft Leeds Tobacco Action Plan (2012 – 2015) – the draft action plan (minute 58 refers);
- Major Trauma in Yorkshire and the Humber – local implications – submission from Leeds Teaching Hospitals NHS Trust (minute 60 refers);
- Review of Children's Neurosurgical Services – local implications – submission from Leeds Teaching Hospitals NHS Trust (minute 61 refers);
- Draft report of the working group considering the arrangements for meeting the needs of blind and visually impaired people in Leeds (minute 62 refers).

55 Declarations of Interest

The following declarations were made at the meeting:

- Cllr Mulherin declared a personal interest in the Review of Children's Neurosurgical Services (minute 61 refers) as a member of Epilepsy Action;
- Cllr Chapman declared a general personal interest due to:
  - a close family member being an NHS employee; and,
  - a close family member currently accessing mental health services;
- Cllr Khan declared a general personal interest due to a close family member currently accessing mental health services;

- Cllr Illingworth declared a general personal interest due to a close family member currently accessing mental health services.

56 Apologies for Absence and Notification of Substitutes

Apologies for absence and notification of substitutes we received as follows:

- Cllr. Charlwood – with Cllr. Asghar Khan attending as a substitute;
- Cllr. Bruce – with Cllr. Kim Groves attending as a substitute;
- Cllr. Graham Kirkland

57 Minutes

RESOLVED –

That the minutes of the Scrutiny Board (Health and Well-being and Adult Social Care) meeting held on 21st December 2011 be approved subject to the following amendments to minute 47, Yorkshire Ambulance Service (YAS) – Foundation Trust Proposals:

- References to the 'traditional 4 Ridings' to be amended to read 'the 4 sub-regions of Yorkshire'; and,
- References to 'the East, West, North and South Ridings of Yorkshire' to be amended to read 'East, West, North and South Yorkshire'.

Cllr. A Hussain joined the meeting during the discussion of this item at 10:05am.

58 Reducing Smoking - the draft Leeds Tobacco Action Plan 2012 - 2015

The Board considered a report of the Head of Scrutiny and Member Development providing background information on the development of the draft Leeds Tobacco Action Plan and were presented with a copy of the current draft plan for consideration.

The report outlined that the action plan aimed to implement the national tobacco action plan *(Healthy Lives, Healthy People: A Tobacco Control Plan for England)* at a local level in Leeds and therefore reflected the following key themes:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Effective communications for tobacco control

The report also outlined that a Leeds Tobacco Control Management group responsible for achieving the commitment and agreement of Leeds City Council (LCC) directorates and partner organisations for the

proposed action plan and summarised the associated timescales as follows:

- Production of 1st Draft of Strategic Action Plan: January 2012
- Consultation on 1st Draft of Strategic Action Plan: February/March 2012
- Production of final Strategic Action Plan: April 2012
- Strategy and Action Plan approved by Health and Wellbeing Board: April 2012
- Action Plan published and launched: May 2012

The Board welcomed the following representatives who attended for this item:

- Dr Ian Cameron (Joint Director of Public Health) – Leeds City Council / NHS Airedale, Bradford and Leeds
- Heather Thomson (Head of Health Improvement) – NHS Airedale, Bradford and Leeds
- David Lodge (Divisional Manager (Fair Trading)) – West Yorkshire Joint Services

Reference was made to the previous action plan that had seen smoking levels in Leeds reduced from 30% to 23%. However, it was also reported that difficulties in maintaining the level at 23% were being experienced. It was outlined that the draft action plan sought to target activities in the following areas:

- Establishing an infrastructure to achieve comprehensive tobacco control;
- Preventing the uptake of smoking;
- Tobacco cessation; and,
- Protecting the population from the environmental impacts of tobacco.

It was outlined that the current draft action plan aimed to reduce smoking levels to 22% by 2015. It was reported that the 1% reduction represented 6,000 smokers and was seen as a significant challenge. It was outlined that actions would be targeted at areas of the City with higher levels of smoking.

Arrangements for some of the enforcement work undertaken by West Yorkshire Joint Services (Trading Standards) around tobacco sales were discussed. It was reported that enforcement work had traditionally been targeted using local intelligence arising from public reports and complaints – however performance had plateaued.

Details of a project in the Armley and Middleton areas of the City were also reported. The project had identified under-age tobacco sales of around 40% compared to the city average of 18%. It was recognised that this represented a significant issue that had not been identified

through traditional means (i.e. public reporting). It was hoped that the project could be extended to other areas of the City.

A wide ranging discussion followed, with members of the Board examining a number of areas / issues, including the:

- Need for an anti-smoking Council champion / advocate;
- Cost and availability of nicotine patches;
- Importance of anti-smoking education and communication, and tailoring messages to suit different audiences and communities;
- Importance of gathering accurate and reliable data;
- Impact/prevalence of illicit tobacco sales and the role of West Yorkshire Joint Services (Trading Standards) in combating this area;
- Involvement and engagement of large organisations / institutions within the City, such as Leeds Teaching Hospitals NHS Trust and the City's universities;
- Possible correlation between smoking prevalence and the availability of health facilities across the City;
- Availability of additional funding and/or targeting of resources;
- Balance between national and local interventions;
- Relationship between age (when stopping smoking) and optimum health gains;
- Need to balance efforts on preventing smoking (particularly among children) and smoking cessation interventions;
- Relative success of smoking cessation interventions reported as being 70% at 4 weeks and 20% at 52 weeks, compared with the national averages of 55% and 13% respectively;
- Involvement of Trade Unions in the development of work based programme for smoking prevention/ cessation.

During the discussion of this item, Mr P Truswell declared a personal interest as an Honorary Vice President of the Trading standards institute.

RESOLVED –

(a) That the information presented be noted and the representatives in attendance be thanked for their contribution to the discussion;

(b) That a draft report/ commentary outlining the Board's main observations be presented to the meeting in March 2012.

Cllr. W Hyde left the meeting following conclusion of this item at 11:00am (approx.)

59 Urgent care services - Consultation

The Board considered a report of the Head of Scrutiny and Member Development introducing NHS Airedale Bradford and Leeds' public

consultation around the future provision of urgent care services in Leeds.

The purpose of the item was to provide an opportunity for the Scrutiny Board to submit an informed response to the consultation.

The Board welcomed the following NHS Airedale, Bradford & Leeds representatives to present and discuss the consultation options:

- Nigel Gray (Deputy Director of Commissioning)
- Martin Ford (Head of Commissioning – Urgent Care Lead)

The consultation document presented three broad options, as follows:

- Option A – retaining the current configuration of urgent care services;
- Option B – reconfiguration of provision, with potential use of current A&E sites;
- Option C – reconfiguration of provision, with potential use of a new urgent care centre in or near to the city centre and in the east of the City.

The consultation document also presented information around the national NHS 111 service, due to replace the West Yorkshire Urgent Care telephone service from April 2013.

In presenting the options, it was reported that the current arrangements for the provision of urgent care services across Leeds were, at times, confusing for patients. It was highlighted that the public consultation closing date was 4 March 2012, which represented a 14-week consultation period – 2 weeks beyond the statutory 12-week period required, recognising the potential impact of the Christmas period.

It was reported that a range of public consultation meetings and events were planned and there was an intention to present the analysis of the consultation and a business case to the NHS Airedale, Bradford and Leeds Board as soon as possible after the close of the consultation period, hopefully in March 2012.

A discussion on the options presented in the consultation document followed and a number of matters highlighted, including:

- Confirmation that urgent care relates to both physical and mental health;
- While much of the focus of the consultation document was around the geography or location of future urgent care services across the City, it was important to ensure sufficient consideration of the future quality of services in all urgent care settings across the City;
- The potential differences in interpretation of ‘urgent’ between professionals and patients/ the public;
- Potential to improve the current signage around Lexicon House;

- Some support for Option C with future provision in East Leeds and the City Centre to replace current provision at Lexicon House.

In summarising the discussion, on behalf of the Board the Chair welcomed the consultation and, in particular the extended consultation period. The Chair recognised that within the Scrutiny Board, there had been no clear consensus on a preferred option and therefore a formal consultation response could not be submitted. However, the Chair encouraged all members of the Scrutiny Board to submit individual consultation responses.

RESOLVED –

(a) That the information presented be noted and the representatives in attendance be thanked for their contribution to the discussion;

(b) That in the absence of a formal consultation response from the Scrutiny Board, all members of the Board be encouraged to submit individual consultation responses by 4 March 2012.

Cllr. C Fox left the meeting during the discussion of this item at 11:10am (approx.).
Cllr. A Hussain left the meeting during the discussion of this item at 11:30am (approx.)
J Fisher left the meeting following conclusion of this item at 11:45am (approx.)

60 Major Trauma in Yorkshire and the Humber - local implications

The Board considered a report of the Head of Scrutiny and Member Development providing background information around proposals to change existing local patient pathways for accessing Major Trauma services across Yorkshire and the Humber.

The Board also considered written submissions from NHS Yorkshire and the Humber and Leeds Teaching Hospitals NHS Trust.

It was proposed to establish 3 sub-regional Major Trauma networks across the region, including designated Major Trauma Centres (MTC), with Leeds Teaching Hospitals NHS Trust (LTHT) due to become a designated MTC for West Yorkshire from April 2012.

The Board welcomed the following representatives who attended for this item:

- Tim Barton (Strategy Lead) – NHS Yorkshire and the Humber
- Matt Neligan (Executive Director Commissioning Development) – NHS Airedale, Bradford & Leeds
- Helen Barker (Divisional General Manager, General Surgery) – Leeds Teaching Hospitals NHS Trust
- Karl Milner (Director of Communications and External Affairs) – Leeds Teaching Hospitals NHS Trust

- Dr Jeff Perring (Director for Paediatric Intensive Care Unit (PICU) and Medical Lead for Embrace) – Sheffield Children's Hospital
- Alison Hollett (General Manger, Critical Care Directorate (which includes Embrace)) – Sheffield Children's Hospital
- Dr David Macklin (Associate Medical Director) – Yorkshire Ambulance Service (YAS)

It was reported that major trauma was not a common occurrence and the total number of major trauma patients across the region was relatively small. Nonetheless, the proposed changes were aimed at improving outcomes and the quality of life for patients. It was also highlighted that the proposed network approach and designation of MTC reflected the available evidence in terms of outcomes for patients.

Representatives from Leeds Teaching Hospitals NHS Trust (LTHT) reported that there were some funding issues still to be resolved, which were a result of the patient number modelling/ assumptions used to date. It was outlined that this was not an isolated issue for the Trust and reflected the national position. However, it was stated that a phased implementation was proposed, which would allow more detailed analysis of patient numbers and subsequent implications for the Trust.

Representatives from Yorkshire Ambulance Service (YAS) outlined it would be implementing a triage programme, to help in the assessment and appropriate assignment of major trauma patients across the network. It was stated that there was some nervousness around the potential volume of patients, but it was believed that the proposed phased implementation would result in a smoother transition to the new arrangements.

It was reported that the full impact on provider organisations, including LTHT, YAS and Embrace was difficult to predict at this stage. Nonetheless, the proposed phased implementation would provide an opportunity to capture actual numbers and therefore help to better describe the proposals.

LTHT outlined that current plans were based on a maximum of 521 additional patients. However, it was reported that this would result in little change for trauma patients within the Leeds boundary.

The Board discussed the proposals in more detail, with the following issues highlighted:

- LTHT leading the sub-regional network, with monthly network meetings. Consideration was also being given to rotating medical staff, to help maintain skills within units and across the network.
- The role of YAS in a major incident and helping to direct patients to an appropriate site within the capacity limits of individual units;
- LTHT was set to operate a 26-bedded trauma ward with an improved rehabilitation service for patients;

- Work was progressing to resolve the potential funding gaps likely to arise as a result of the national tariff and shift in activity across individual units;
- Commissioners and providers were working together to ensure the stability of services.

In summarising the discussion, the Chair thanked all those in attendance and proposed that, following the first phase of implementing the proposals, a further report be presented to the Board in the new municipal year that would provide a more detailed analysis of the arrangements, patient numbers and associated implications.

RESOLVED –

(a) That the information presented be noted and the representatives in attendance be thanked for their contribution to the discussion;

(b) That a further report, providing more detailed analysis of the arrangements, patient numbers and associated implications, be presented to the Board in the new municipal year (Autumn 2012).

Cllr. W Hyde rejoined the meeting during discussion of this item at 11:45am (approx.)

61 Review of Children's Neurological Services - local implications

The Board considered a report of the Head of Scrutiny and Member Development providing background information around the national Review of Children's Neurosurgical Services.

The Board also considered written submissions from Safe and Sustainable review team (provided via Yorkshire and the Humber Specialised Commissioning Group) and Leeds Teaching Hospitals NHS Trust.

The Board welcomed the following representatives who attended for this item:

- Cathy Edwards (Director) – Yorkshire and the Humber Specialised Commissioning Group
- Stacey Hunter (Divisional General Manager, Children's Services) – Leeds Teaching Hospitals NHS Trust
- Dr Colin Ferrie (Consultant Paediatric Neurologist) – Leeds Teaching Hospitals NHS Trust
- Dr Jeff Perring (Director for Paediatric Intensive Care Unit (PICU) and Medical Lead for Embrace) – Sheffield Children's Hospital
- Alison Hollett (General Manger, Critical Care Directorate (which includes Embrace)) – Sheffield Children's Hospital
- Dr David Macklin (Associate Medical Director) – Yorkshire Ambulance Service (YAS)

The Director of Yorkshire and the Humber Specialised Commissioning Group (SCG) introduced the item, highlighting the following points:

- This was a national review being undertaken as part of the Safe and Sustainable programme;
- The review involved the following 3 key workstreams:
  (i) Setting up Children's Neurosciences networks
  (ii) Procurement of additional complex surgical treatments, particularly around epilepsy surgery
  (iii) Establishing a multi disciplinary team (MDT) approach for rare and complex brain tumours
- The review was a standards based approach – identifying agreed standards of care to ensure consistency across the country.
- A significant amount of work had been undertaken in preparing the draft standards, which would be made available shortly for comments. On publications, the period to provide comments would be 3 months. There would be further opportunity for workshops with parents and other key stakeholders, alongside a web-based questionnaire to help gather comments.
- Following comments on the standards, SCGs would be responsible for establishing the configuration of neurosciences networks – likely to be completed by June 2012.
- Implementation of the new arrangements was targeted for the beginning of 2013.

It was highlighted that some priority work areas included ensuring 24/7 medical cover, robust data collection, arrangements for image sharing and governance arrangements for networks. It was also reported that there were significant links with the major trauma arrangements discussed elsewhere on the agenda.

It was reported that additional capacity around epilepsy surgery was subject to a procurement process, the outcome of which should be known in February 2012. The aim of the procurement was to:

(i) Deliver additional surgical capacity;
(ii) Allow earlier access to surgery;
(iii) Organise service arrangements for 1-5 year old children.

It was emphasised that while work was progressing, it should be noted that no final decisions had been made around the arrangements and configuration of networks. As such, there would be an opportunity to influence decisions through commenting on the range of documentation soon to be published.

Commenting on the information presented to the Board, representatives from Leeds Teaching Hospitals NHS Trust highlighted the following points:

- In terms of the procurement for additional epilepsy surgery – a consortia approach effectively representing the North East of the

country (involving Leeds, Sheffield and Newcastle Hospitals Trusts) had failed to reach agreement and had not submitted a bid to Stage II of the process. However, it was re-emphasised that the procurement process aimed to secure additional epilepsy surgery capacity.

- The potential implications for the sustainability of services associated with a range of current designations around children's services and the collective impact of individual reviews.
- The review of Children's Neurosurgical Services would impact on Children's Neurosciences Services as a whole.
- The history of the review has been professionally driven following a perception that the number of surgical centres in England was excessive and the care provided in a number of centres (i.e. not 24/7 cover) was not appropriate for modern services. It was also suggested that the number of centres did not generate the number of cases necessary to maintain the level of surgical skills required.
- There was some evidence that outcomes were not as good as they could be and there was some tension between the provision of emergency and elective (planned) services. The proposed network approach, which was likely to see current surgical centres remain open (for at least 2/3 years), was seen as a compromise and was not whole-heartedly supported by all professional bodies involved.
- An interview process, aimed at recruiting a 4th neurosurgeon, was scheduled to take place in February 2012.

Representatives from Embrace and YAS provided the following comments:

- Data collection over a 9-month period showed there had been around 170 transfers of children across the Yorkshire and Humber region; with many of these being low dependency repatriation transfers following surgery.
- It was not anticipated that many children would need to travel long distances as a result of the review.
- A by-pass service for children suffering head injuries (utilising the air ambulance) was already in place.

The information outlined in the report and supporting documents presented to the Board were given full consideration, alongside the details highlighted at the meeting.

RESOLVED –

(a) That the information presented be noted and the representatives in attendance be thanked for their contribution to the discussion;

(b) That consideration be given to commenting on the range of documentation due to be published in the near future.

Cllr. S Armitage left the meeting during the discussion of this item at 12:15pm (approx.).
Cllr. K Groves and P Truswell left the meeting during the discussion of this item at 12:20pm (approx.).

62 Work Schedule - January 2012

The Head of Scrutiny and Member Development submitted a report together with a copy of the Board's current work programme. Minutes arising from the Executive Board meetings held on 14 December 2011 and 4 January 2012 were appended to the report, along with the Council's Forward Plan (1 January 2012 – 30 April 2012), which detailed items relating to the Board's portfolio and terms of reference. A summary of the main areas of inquiry was also detailed in the report.

The draft working group statement in relation to the provision of services for the blind and visually impaired across Leeds, presented to the Board as supplementary information, was specifically considered and discussed. The following matters were raised:

- The inclusion of 'peer support' within the recommendation detailed in paragraph 23 (g).
- Members raised some concerns regarding the regular respite afforded to carers, that resulted from previous social group meetings at Shire View. It was recognised that this matter had been one of the concerns raised by the deputation to the Scrutiny Board, at its meeting in October 2011 (minute 28 refers). However, it was also recognised that due to the emerging complexities presented, this had not been a specific consideration of the working group. The Board agreed to draw this matter to the attention of Executive Board.
- Members of the Scrutiny Board (not directly involved in the working group discussions) raised the possibility of a 'review and refresh' clause within future contractual arrangements when commissioning services. It was felt that the use of such clauses would allow the Council to consider any potential changes to the needs of service users, and specify any appropriate service changes, at regular and pre-determined intervals during the duration of a contractual agreement. While it was recognised this had not been a consideration of the working group, the Scrutiny Board agreed to draw this matter to the attention of Executive Board.

It was reported that the minutes from the Health Service Developments Working Group (referred to in the report) were not yet available and would be presented to the next meeting of the Board.

RESOLVED –

(a) To note the information provided and to agree the updated work schedule, as presented in Appendix 1.

(b) Subject to the amendments identified at the meeting, the working group statement in relation to the provision of services for the blind and visually impaired across Leeds, be submitted for consideration by the Executive Board at its meeting on 10 February 2012.

S Morgan left the meeting during the discussion of this item at 12:45pm (approx.).

63 Date and Time of the Next Meeting

Wednesday 29th February 2012 at 10.00am (pre-meeting for all Board Members at 9.30am)

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 29 February 2012

Subject: Leeds Health and Social Care Transformation Programme: Update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The transformation of Health and Social Care Services is identified in the Scrutiny Board's Terms of Reference. At its meeting on 22 July 2011, the Board agreed to include this matter and the work of the Transformation Board within its work schedule for the current year.

2. At its meeting in September 2011, the Scrutiny Board considered a position statement on behalf of the Transformation Board. This provided an overview of the Leeds Health and Social Care Transformation Programme and outlined the supporting managerial / governance arrangements. The report highlighted five portfolio areas and provided a summary of three priority areas, as detailed below:

Portfolio Area	**Summary provided**
Older people and long-term conditions;	Yes
Urgent and emergency care;	Yes
Clinical value in elective (planned) care;	Yes
Estates; and,	No
Technology	No

3. Following the discussion, the Scrutiny Board agreed that a further update be provided to the February Board meeting.

4. An update report is presented at Appendix 1 to this report and appropriate representatives supporting the work of the Transformation Board have been invited to attend the meeting to present and discuss the information provided.

5. In addition, to help provide some national context around health and social care transformation, an extract from the House of Commons Health Committee's report on public expenditure is attached at Appendix 2. This extract details the conclusions and recommendations outlined in the Health Select Committee's report published on 24 January 2012. The full report is available using the following link: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499.pdf

Recommendations

6. To consider the information presented and determine any specific matters that warrant further scrutiny and/or identify any specific matters for consideration at a future meeting.

Background documents

Scrutiny Board (Health and Well-Being and Adult Social Care) – Terms of Reference (May 2011)

Report to the Scrutiny Board (Health and Well-Being and Adult Social Care) – The transformation of Health and Social Care Services (21 September 2011)

Report of the House of Commons Health Committee report – Public Expenditure (Thirteenth report of session 2010-12) available at: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499.pdf

The Leeds Health and Social Care Transformation Programme Update

1. What is the Programme?

The Leeds Health and Social Care Transformation Programme is a city-wide agreement between health and social care partners to work together to deliver the challenges ahead, including increasing quality and innovation and productivity. It is designed to bring key organisations together on this important task; to ensure their full engagement in identifying and delivering the most appropriate solutions to sustain quality whilst substantially reducing the overall cost in the Leeds health and social care economy by the end of 2014.

In parallel, the city is moving to a new model of health and social care as a result of the national reforms for the NHS and local authority, where we need to focus even further on:

- Improving the health and well being of people in our communities;
- Reducing health inequalities and social exclusion;
- Improving health and social outcomes through our services;
- Achieving savings and cost reductions; and
- Implementing efficiencies to help meet increasing demand.

The programme will be delivered in a constrained financial environment and, at the same time, ensure that we respond successfully to increasing demands on services. It is the means by which, together, we will drive and deliver the transformation of health and social care services with the people of Leeds.
It is linked to, but does not encompass the programme of work required to deliver the transitional and systemic changes to the health and social care system set out by the government in *Equality and Excellence: Liberating the NHS*.

2. What will it deliver?

Programme success will mean the following benefits will be achieved for the people of Leeds:

- A continued strong focus on quality and safety;
- The local people who receive both health and social care services will benefit from more integrated services which are tailored to their needs;
- Local people will be supported to remain independent for longer and empowered to take greater personal responsibility for their health and wellbeing;
- More health and care services will be delivered in the community and closer to people's homes, when and where appropriate;
- Front line health and social care services will be better able to respond to increasing demand through a strong focus on increased productivity and the smarter use of technology in key areas; and
- Public money will be spent in more effective and targeted ways to better meet the needs of individuals and local communities.

3. How will we do this?

The Transformation Programme builds upon all the existing improvement work that is going on within the health and social care settings around the city. To deliver these improvements, all the partners have agreed to use this set of principles to guide collaborative working:

- Commission and develop services that are based around the needs of the people of Leeds and their communities rather than the needs of organisations;
- Reduce barriers for all people within communities in Leeds to accessing services and reduce the number of unnecessary or repeat contacts that people need to have by increasingly getting it right first time;
- Look at the totality of investment and resources available to public bodies concerned with health and social care and agree how these could be better utilised to meet community needs and increasing demands for services;
- Develop an agreed approach to managing the risks and sharing the rewards from designing better ways of delivering services in Leeds and not seek to move costs from one organisation to another; and
- As part of the approach to governance, assess the impact of proposals to achieve efficiencies within and across individual organisations on others.

Board members have agreed the initial priority portfolios of clinically focused work as:

- Clinical value in elective care;
- Urgent and emergency care; and
- Older people and long term conditions.

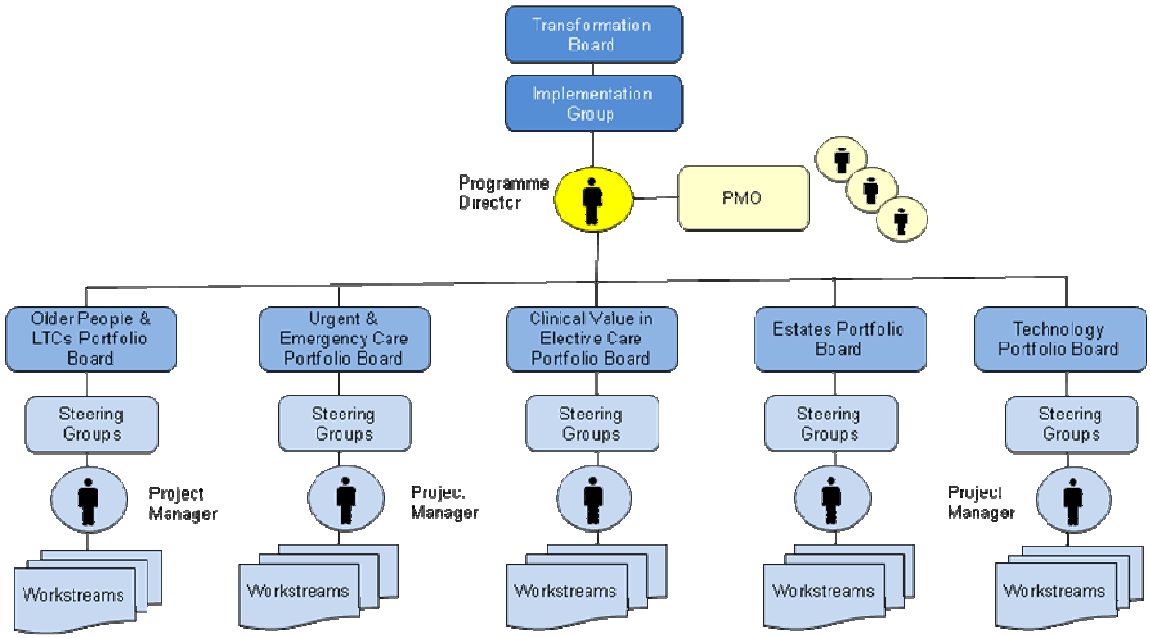
4. How will we ensure delivery?

The programme is being led by NHS Leeds, which has the legal responsibility for improving health across the city. The organisations listed below are key partners in the programme and therefore have a seat on the Board which guides this work:

- NHS Leeds
- Leeds City Council
- Local GP Commissioners
- Leeds Teaching Hospitals NHS Trust
- Leeds Partnerships NHS Foundation Trust
- Leeds Community Health Care NHS Trust

The Transformation Board is chaired by John Lawlor, Chief Executive of NHS Leeds. The role of the Programme Board is to steer and oversee the programme, ensuring delivery. It provides a mechanism for high level governance and ownership with strong links back to the boards of partner organisations. As a non-statutory partnership, the Programme Board does not have formal decision-making responsibilities. Its role is to clear the path ahead by agreeing shared approaches for consideration by individual boards.

The Programme Board meets monthly, although the precise timing and frequency of meetings is flexible to take account of key milestones in the programme plan.
It is supported in its role by a programme infrastructure which is summarised in the diagram below.



5. How will stakeholders be involved?

Involving the public and patients for whom health and social care services are provided in Leeds and working with them as we plan and make decisions about the future is fundamental to the way we want to work. This comes down to a core belief that if we work in this way, then the results achieved will be more appropriate, work better and fit more closely with what is needed.

This is coupled with a statutory duty on all NHS trusts to involve and consult patients and the public on planning services they are responsible for, developing and considering proposals for changes in the way those services are provided and decisions to be made that affect the operation of those services. We also have a duty to consult the local Scrutiny Board (Health and Wellbeing and Adult Social Care) on any proposal for "substantial development or variation of the health services." NHS Leeds retains organisational responsibility for ensuring that appropriate and adequate public consultation and engagement is undertaken on proposed health service changes until closure in 2013. Leeds City Council holds similar responsibilities for ensuring appropriate consultation around changes to social care services. The Programme Board has agreed that each partner organisation is responsible for supporting the delivery of this patient and public consultation and engagement work for individual projects.

6. What is the current position?

6.1 Clinical value in elective care

The September 2011 update to Scrutiny Board Members advised that this portfolio has prioritised three main projects identifying efficiencies within elective (planned) care which have a basis in clinical evidence, values and best practice. The following section provides Scrutiny Board Members with a progress update for each of the projects.

The **referral management** project has successfully worked across organisations to implement a number of redesigned pathways, including new guidance for the management of a male specific urology pathway and the adoption of NICE guidance in relation to direct access endoscopy services. The urology pathway project will deliver a consistent approach to management of the condition with telephone follow-ups (rather than face to face) and conservative management in primary care. The result of this action will streamline the pathway, reduce waiting times and improve patient experience as patients will be clear about the management of the condition and what they will receive from the service. The pathway will be implemented in contracts from the 1st April and the project is on course to deliver as expected. Implementing the NICE guidance for Dyspepsia will result in patients being managed in primary care rather than initially being referred to secondary care for a diagnostic test (endoscopy). The new pathway will deliver additional capacity into the system to enable more urgent patients to be seen quicker, reduce the overall numbers of patients having an endoscopy test and provided care closer to the patient's home through their own GP. The changes to the pathway will be implemented from the 1st April and the project is on course to deliver as expected.

The redesign of musculoskeletal clinical pathways is well underway and the redesigned hand/wrist and hip pathways are being implemented from July 2012. The planned date for the removal of triage for the remaining four pathways is 1 April 2013, following an evaluation of the first stage. In order to facilitate the changes additional IT resources have been purchased and training delivered to practices so that there is a high level of awareness and therefore implementation. Following the removal of triage for the first two pathways from July, GPs will be able to refer patients directly to secondary care rather than through the existing MSK service, the result of which will be streamline pathways, improved patient experience and additional capacity to allow the MSK service to focus on patients requiring treatment and care. An evaluation of the new pathways will take place and influence the implementation of the four remaining pathways.

The **outpatient follow up** project has delivered a reduction of around 12,000 face to face follow ups through the development of more appropriate and innovative follow-up care including telephone follow-ups and primary care intervention. From the 1st April the reduction in face to face follow ups will be reflected in the contract. The further development of evidence based pathways will ensure that patients continue to receive high quality care and follow up where appropriate, but patients will no longer be required to attend secondary care appointments when more innovative methods can be used. Across the system, benefits will include enabling secondary care activity to be refocused to contribute to the maintenance of elective waiting times, increased levels of patient satisfaction through more joined up locally delivered care and reduction in patient journeys.

Following the successful delivery of the first phase of the project future work will cover a focused review of neurology, urology and ophthalmology pathways. It is expected that the outcomes of this work (and subsequent reduction in follow ups) will be implemented during 12/13.

The **prescribing** project has four primary workstreams: improved shared management of medicines, including the use of drugs with limited clinical value and the prescribing care of patients who use multiple health and wellbeing services; the

development of a centralised supply chain to reduce unnecessary prescribing costs; and two workstreams looking to reduce medicines waste in the city through, for example, unnecessary repeat ordering and stockpiling. Since the last report to the Scrutiny Board, the citywide prescribing formulary has been updated and a new traffic light system implemented with the intention of providing clinicians with guidance to deliver a consistent approach to prescribing. Following the completion and roll-out of the central clinical verification service, the procurement project team is now assessing potential alternative supply routes. This will involve dietetic expertise to develop the oral nutrition element of the project. The aim of the project is to deliver a centrally based high quality service, providing patients with choice, a more responsive service and improved levels of satisfaction. The cross-sector and enhanced care projects continue to identify patients for review and assessment and are delivering system wide patient benefits focused on improving quality of care and patient experience. Overall projects are progressing well and delivering to expected levels.

Finally, an awareness campaign to reduce medicines waste is also being planned and will be implemented shortly. The aim of the campaign is to increase awareness, improve safety and effectiveness and reduce unnecessary prescribing costs. All work streams within this area have a strong focus on stakeholder and patient level consultation, and on working with staff involved in prescribing activity.

6.2 Urgent and emergency care

This portfolio of work is focused initially on redesigning ambulatory care (non-inpatient) pathways; and front end (primary care) assessment.

The redesign of **ambulatory care** is well underway and, following an assessment of the 49 pathways, a prioritised review plan has been developed and being implemented. The first phase (April 2011 to March 2012) is focusing on the management of venous thromboembolism (VTE), deliberate self harm, a surgical and urological group of pathways and finally a group of community pathways and once complete additional phases will be commenced. The primary aim of the workstream is to improve patient outcomes through avoidance of unnecessary admissions to hospital, reduce lengths of stay and replace emergency responses with more proactive elective services.

The front end (primary care) assessment project is now called **Consult and Treat** as it has been aligned to the re-procurement of the out of hours service and the NHS 111 Programme. The project will provide a single model of care throughout West Yorkshire, including increased patient choice and effective demand management. The project has developed robust governance arrangements with the 111 element being delivered on a West Yorkshire cluster basis and local elements managed by an NHS Leeds project team. The project is progressing well and delivering against expected milestones. The service will include a front end clinical assessment and GP telephone consultation prior to home visit. Patients will receive a safe streamlined service which has strong safeguards in place regarding provider management and responsibilities, other benefits include a visible shift in the provision of activity to a more appropriate place and increased levels of self care though improved patient empowerment. The period of patient and public engagement outlining the three options for the location of GP Out of Hours services commenced

in December 2011 and runs for 14 weeks until 4 March 2012. The feedback from the consultation will be used to take the final decision around the location of the facilities and the planning for the future costs of the service is underway.

6.3 Older people and long term conditions
This portfolio focuses on the key long-term conditions areas where there is the largest opportunity for improvement and potential to integrate services.

The first of these projects will look at **risk stratification**. Following a market test exercise, the John Hopkins University ACG® (Adjusted Clinical Groups) risk stratification tool has been selected as an approach to measure the morbidity of patients and populations. The tool relies on diagnostic code information and pharmaceutical data to stratify patients' morbidity status into 93 distinct groups – Adjusted Clinical Groups. Further work is also underway to develop the tool and 'front end access point' and once this is complete, the risk stratification of patients will commence. In the early stages of the roll-out, the project will focus on the integrated health and social care demonstrator sites to deliver patient benefit from a more proactive approach to diagnostic and management of disease. Stakeholder training and development has already commenced and, once the impact on patients becomes clearer, engagement work will be undertaken with people with long-term conditions to support them in understanding this new proactive approach to their care.

The second project in this group aims to further improve support for older people and people with long-term conditions outside of hospital by reducing duplications and gaps in care. The aim of this work is for **integrated health and social care teams** to provide more unified care by delivering community health and social care services for this cohort of patients through fully integrated services.

Significant progress has been made in the integrated health & social care teams project since the September 2011 update to Scrutiny Board Members, including the establishment of three demonstrator sites in Kippax/Garforth, Pudsey and Meanwood, with the full roll out of teams expected across the city by March 2013. The project team is also working to agree the model of working for the community based interface geriatrician roles.

The staff engagement programme is commencing shortly, with 'getting to know you sessions' already in development. Wider engagement with patients, voluntary and community sectors will commence shortly afterwards. As previously advised, funding has been secured from the National Endowment for Science Technology and the Arts (NESTA) to develop an innovative project that puts patients with long term conditions in control of their own health. The project development is underway and has involved NHS staff, GP commissioning consortia, Leeds LINk and Leeds City Council, working in partnership to make sure that all the services people need are included. Over the next 12 months, this will benefit from a financial grant and non financial support from leading experts. Further updates will be provided as this work progresses.

The final two updates provide Scrutiny Board Members with a position statement on the type 2 diabetes and home oxygen projects. The main objective of the **type 2 diabetes** project is to create an improved model of care to allow patients who have

diabetes to access care at appropriate levels and closer to home. Other benefits of this work include a reduction in secondary care costs and associated expenditure, increased productivity within the community diabetes team, and a reversal of the upward trend of the cost of prescribing diabetes drugs through robust protocols. The new GP Clinical Commissioning Groups (CCG) have led the roll out of referral pathways packs and the project has now been mainstreamed across all member practices with a number of positive service changes already implemented. The project has delivered strengthened relationships between commissioners and providers through the development of the city wide model, in addition to prescribing guidelines leading to a reduction in the use of self monitored blood glucose reagents. Further work will be required to maintain momentum and deliver the large scale changes expected, and this will form part of the continual review process.

The aim of the **home oxygen** services work is to improve patient care by enabling patients to more effectively manage their own health. It will reduce the number of hospital-based reviews needed, whilst increasing visits to homes where oxygen use can be monitored more effectively. And, it will mean that fewer patients are inappropriately given long-term oxygen therapy; freeing them from the routine of using home oxygen and saving the NHS money. Patients who currently use long-term home oxygen therapy will be engaged in developing the local assessment and review processes through ongoing involvement work. To date, all members of staff involved have received external training in capillary blood gas testing and are now carrying out the procedure and working directly on home oxygen service reviews. Following the success of the long term oxygen therapy reviews by the Leeds Community Healthcare Respiratory Service, the scope of the project has been extended to include patients with Chronic Obstructive Pulmonary Disorder (COPD) on the caseload of the community matron. In February 2012, the respiratory team is holding a city wide 'Oxygen Awareness Week' which forms part of the engagement agenda.

7. Next Steps

The members of the Programme Board continue to meet monthly to drive forward this work, with a work programme which both holds to account and supports projects to deliver.

The engagement and consultation elements of each project are included as appropriate under the transformation theme of the Health and Wellbeing and Adult Social Care Scrutiny Board's horizon scanning material and agendas for the Health Service Development Working Group. Each element of the Programme will therefore be shared with the Scrutiny Board in accordance with these usual working arrangements.

Given the pace of change, and arrangement that appropriate projects will continue to be considered by the Health Service Development Working Group, Scrutiny Board members are asked to advise when they would welcome a further update to the full Scrutiny Board.

Philomena Corrigan
Programme Director
February 2012

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Extract from the report of the House of Commons Health Committee report – Public Expenditure (Thirteenth report of session 2010-12)

Conclusions and recommendations

Meeting the Challenge: the need for service redesign and integration

1. The evidence submitted to the Committee is unambiguous. The Nicholson Challenge can only be achieved by making fundamental changes to the way care is delivered. (Paragraph 9)

2. While the separate governance and funding systems make full-scale integration a challenging prospect, health and social care must be seen as two aspects of the same service and planned together in every area for there to be any chance of a high quality and efficient service being provided which meets the needs of the local population within the funding available. We would like to see best practice in this rolled out across the Health Service and underperforming commissioners held to account for failure to engage in this necessary process of change. (Paragraph 13)

Setting and achieving targets

3. At a time when all NHS bodies are being required to make efficiencies and need to plan strategically to reshape services it is unhelpful for the Department of Health to require them to make bids for capital funding to short deadlines and without adequate preparation (Paragraph 39)

4. It remains too early fully to assess the types of savings being made in 2011–12, the first year of the QIPP programme. The Government remains confident that savings are on track. Nevertheless, we have heard strong concerns from the NHS Confederation, the Foundation Trust Network and the King's Fund, among others, about the ability of NHS organisations firstly to meet their saving plans and second, to do so in a manner that is sustainable and releases further savings in future years. We are concerned that there appears to be evidence that NHS organisations are according the highest priority to achieving short-term savings which allow them to meet their financial objectives in the current year, apparently at the expense of planning service changes which would allow them to meet their financial and quality objectives in later years. (Paragraph 40)

Progress on service reconfiguration

5. The Nicholson Challenge can only be achieved through a wide process of service redesign on both a small and large scale. These changes should not be deferred until later in the Spending Review period: they must happen early in the process if they are to release the recurring savings that will be vital in meeting the challenge. In the meantime, we are concerned that savings are being made through "salami-slicing" existing processes instead of rethinking and redesigning the way services are delivered. (Paragraph 57)

6. The reduction of the tariff is intended to encourage service redesign. This link needs to be made much more explicit if there is to be a proper understanding in the NHS and among the wider public of the scale of service change which is needed to meet the Nicholson Challenge. (Paragraph 58)

The impact of the White Paper restructuring

7. The reorganisation process continues to complicate the push for efficiency gains. Although it may have facilitated savings in some cases, we heard that it more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings. (Paragraph 63)

Pressure on social care services

8. The overall picture of social care is of a service that is continuing to function by restricting eligibility, by making greater savings on other local authority functions and by forcing down the price it pays to contractors for services. In each case, the scope for further efficiencies is severely limited. The Government's response to the Dilnot Commission's proposals due in the first half of this year will, we hope, set out how a sustainably funded system will continue into the future. The challenge for local authorities and the Government is to continue to provide a meaningful service until a new system is in place. (Paragraph 76)

Access to services

9. In spite of Government assurances, local authorities are having to raise eligibility criteria in order to maintain social care services to those in greatest need. Paragraph 84)

10. It is deeply concerning that £116m of the £648m intended to be spent through the NHS on improving the interface between health and social care is being spent on sustaining existing eligibility criteria. This suggests that this money (which was intended to support greater integration of services) is in fact being used to maintain the existing system. To the extent that this is true it is a lost opportunity to promote the necessary process of service integration. (Paragraph 85)

11. ADASS has found that 82% of councils are only providing care to those whose needs are assessed as significant or higher. The Permanent Secretary at the Department of Health told us that the settlement was intended to "hold the position steady" until a new funding system for social care was developed. The tightening of eligibility criteria demonstrates that the settlement is not sufficient to achieve this. (Paragraph 86)

Integration of health and social care

12. A January 2012 joint report by the King's Fund and the Nuffield Trust, on the integration of health and social care, called on the Department of Health and the NHS Commissioning Board to "develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations" and to set "a clear, ambitious and measurable goal linked to the individual's experiences of integrated care that must be delivered by a defined date". (Paragraph 94)

13. Although the Committee welcomes the continuing interest and support for the priority accorded by the NHS Future Forum to greater service integration, it found precious little evidence of the urgency which it believes this issue demands—on both quality and efficiency grounds. It is a question to which the Committee will

return in its Report on Social Care. In the meantime it calls on the Government and local authorities to set out how they intend to translate this aspiration for greater service integration into the reality of patient experience. (Paragraph 95)

Investment of NHS funds in social care

14. Early reports from the Health Service are that the transfer of money from the NHS to be spent on social care has been effective. That effectiveness may be because there was a very straightforward control mechanism: the money had to be spent by agreement. We do not underestimate the importance of this transfer, but the fact remains that it represents just 1% of annual funding for the NHS. Clearly there is scope to extend transfers of this kind (Paragraph 101)

15. The Committee believes that, as a matter of urgency, the Department of Health should investigate the practicalities of greater passporting of NHS funding to social care. (Paragraph 102)

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Leeds CITY COUNCIL

Report author: Dennis Holmes
Tel: 74959

Report of Director of Adult Social Services

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 29 February 2012

Subject: Health and Social Care Service Integration: An Overview

Are specific electoral Wards affected? **If relevant, name(s) of Ward(s):**	☐ Yes	☒ **No**
Are there implications for equality and diversity and cohesion and integration?	☒ **Yes**	☐ **No**
Is the decision eligible for Call-In?	☐ **Yes**	☒ **No**
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ **No**

Summary of main issues

This report provides an overview of the principal integration initiatives currently underway between Leeds City Council Adult Social Services and colleagues from the NHS family of organisations in the City, Leeds Community Health (LCH) and Leeds Partnership Foundation Trust (LPFT). The report highlights the further range of opportunities for closer commissioning relationships with the current Airedale, Bradford and Leeds Primary Care Trust (LPCT) and the the Leeds Clinical Commissioning Groups (CCGs) who are likely to succeed the LPCT in fulfilling NHS commissioning responsibilities subject to the passing of primary legislation during the course of this year.

The report points to the latest national policy initiatives and research[1] which provide the rationale for seeking to develop partnerships up to and including fully integrated service delivery models. The report highlights the need for robust governance systems and structures to be put into place so that the Local Authority and it's NHS partners can be assured that their statutory accountabilities can continue to be legally discharged with appropriate democratic accountability and oversight.

Finally, the report seeks to draw together themes from companion reports to be presented today which provide detailed information on each of the current initiatives underway in the City.

[1] Appendix 1 - Nuffield/Kings Fund submission to the national future forum

Recommendations

Members of Health, Well-being and adult Social Care Scrutiny Board are recommended to note the content of this report.

1.0 Purpose of this report

1.1 This report provides an overview of the principal integration initiatives currently underway between Leeds City Council Adult Social Services and colleagues from the NHS family of organisations in the City, Leeds Community Health (LCH) and Leeds Partnership Foundation Trust (LPFT). The report highlights the further range of opportunities for closer commissioning relationships with the current Airedale, Bradford and Leeds Primary Care Trust (LPCT) and the the Leeds Clinical Commissioning Groups (CCGs) who are likely to succeed the LPCT in fulfilling NHS commissioning responsibilities subject to the passing of primary legislation during the course of this year.

1.2 This report seeks to draw together themes from companion reports to be presented today which provide detailed information on each of the current initiatives underway in the City.

2.0 Background information

2.1 The case for the closer integration of Health and social care services has most recently been set out in the context of the Governments proposals for the redesign of health and social care services in England and Wales. In it's submission to the 'Future Forum' established by the Government to inform and influence the proposed changes, (and presented in full as Appendix 1) the Nuffield Institute and Kings Fund joint report suggested the following:

"The ageing population and increased prevalence of chronic diseases require a strong re- orientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.

This is a message recognised by most western developed nations, which are all seeking through different means to bring about a significant shift in the balance of where care is provided. In England, we know that standards of care for frail people with complex conditions are not always as they should be. Numerous reports have pointed to the need for significant improvements in care to frail older people that is better co-ordinated, of higher quality, and assures dignity and compassion (eg, Care Quality Commission 2011; Equality and Human Rights Commission 2011).

This lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. They add that: 'achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety' (National Voices 2011)."

2.3 The principle of integration is not new, the integration of many Health and Social Care functions has been a stated policy objective of successive governments. This has varied from the provision of financial stimuli designed, for example, to facilitate

more speedy hospital discharge for patients requiring health and social care interventions post discharge, and amendments to primary legislation to allow the pooling of budgets between Local Authorities and Health organisations (Health Act 2006).

2.4 Although there is no statutory definition of 'Integration', guidance offered by the Department of Health suggests that there are 5 principle types ranging from 'informal' to 'statutory'. The broad typologies are set out below:

- *Relative Autonomy - the co-ordination of activity exists but is informal*
- *Co-Ordination - some co-ordination in relation to a joint strategy*
- *Joint appointments - Key co-ordination posts are jointly appointed, teams collaborate but are not integrated/combined*
- *Enhanced Partnership - shared strategy and integration across most functions, senior and middle tier joint appointments but separate legal entities are preserved*
- *Structural Integration - a single integrated legal entity.*

2.5 Nationwide (England and Wales) there are only a very small number of Authorities which have achieved structural integration in the areas of service under consideration in Leeds. The most frequently exampled is Torbay and the most recent to announce a large scale integration initiative is Staffordshire with more than 600 Local Authority staff joining a new organisational unit alongside their health service colleagues.

2.6 In Leeds various models of integrated service delivery have existed over a number of years. In learning disability services for example, a pooled budget and integrated commissioning and care management teams have operated (using a pooled fund arrangement managed under S75 of the 2006 Health Act) for the past 14 years. The joint Leeds Equipment Service has operated under a similar arrangement for the previous 7 years. Parallel arrangements exist for the Local Authority to discharge elements of some NHS functions, for example the administration of monies provided for the support of carers (an arrangement managed under S256 of the 2006 Health Act).

2.7 It is also true to say that other partnership arrangements have also developed without the use of Health Act flexibilities or pooled fund arrangements. Two examples of this work would be the joint (Leeds City Council/ LPFT) Community Mental Health teams which have operated in the City for the past 13 years and the Joint Care Management Teams for older people (LCC/LCH) that have operated for the previous 10 years). In these examples Leeds City Council employees work alongside colleagues employed by NHS organisations within a single management structure but with separate budgetary accountability and professional leadership.

2.8 Over the last several months it has become apparent that the less formal partnership arrangements offer enormous potential to be developed into more formal partnerships and that other pathways of care offered similar opportunities for the creation of productive partnerships aimed at providing significantly better patient experience and removing unnecessary duplication, thereby creating efficiencies within the whole system of care.

2.9 Other reports to be considered on this agenda highlight these initiatives specifically in relation to adult mental health services and elements of intermediate care services for older people including the establishment of a joint intermediate nursing care facility to be staffed by both NHS and Local Authority employees for the purpose of diverting people from acute care.

3.0 Main issues

3.1 The theme of all the reports under consideration today is that the integration of Health and Social Care services reflects a desire on behalf of people who need to use such services for the care that they receive to be seamless, regardless of which organisation or professional background of the person who co-ordinates or provides that care. Responding to this desire, National policy initiatives such as the 2000 National Framework for Older People, introduced the concept of a 'Single Assessment Process' (SAP), this envisaged the ability of a wide group of Health and Social Care professionals having the potential to assess, arrange and co-ordinate care for older people.

3.2 National policy initiatives recognised that as well as providing a better experience for people needing to access such services, more seamless delivery held the potential to deliver organisational efficiencies in terms of stripping out needless duplication and, potentially, streamlining back office functions.

3.3 In Leeds there are specific issues which more integrated service models, pathways of care and organisational arrangements will help to address. As well as improving peoples experience and reducing duplication, the proposals set out in other reports to be considered today, also seek to reduce the use of acute hospital services (in relation to both physical and mental health). For adult social services, reducing the need for people to access such acute services will help to prolong their independence and also has important and beneficial financial consequences by reducing the volume of people, or the length of time spent by people requiring long term care following acute hospital care.

3.4 It is however important to recognise the scale on which the proposed integration models are being planned. Few if any, templates exist from other Metropolitan Authorities of integration initiatives undertaken across such broad areas of service delivery, the undertaking is therefore ambitious in it's scope. This also means that invention and innovation in the design of new services, pathways and governance models will be essential. The companion reports presented today set out the current proposals in relation to the three design features.

3.5 Clearly, the governance models deployed for integrated services, particularly those provided within integrated organisational structures, need to ensure clarity of accountability and responsibility for the service and take due account of the fundamental requirement for democratic oversight and scrutiny. It is in this regard that both the Health & Wellbeing Board and the Health, Wellbeing & Adult Social Care Scrutiny Board may wish to keep this particular feature of all the integration initiatives under review as part of it's work programme.

4.0 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Significant consultation has taken place and will continue to take place with Leeds people with regard to the ways in which their health and social care services are shaped and provided. Significant consultation has and will also take place with all key stakeholders with regard to the most appropriate legally constituted organisational structure best equipped to deliver those redesigned services.

4.1.2 It is equally important that all stakeholders, particularly people needing to avail themselves of the new models of care and the staff who will deliver them, are most closely engaged in their development and implementation. This engagement will be a significant feature of the integration planning and is reflected in the companion reports presented today.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Major service or organisational changes resulting from the desire to integrate across health and social care provision will be subject to Equality impact screening and, where required, impact assessment.

4.3 Council Policies and City Priorities

4.3.1 As previously described, the closer integration of health and social care services is central to the delivery of many of the health and wellbeing targets for the City, particularly those designed to reduce the use of acute and long term care venues for people with long term health conditions.

4.3.2 As explained in para 3.4, there are significant potential implications and opportunities in relation to the future role to be played by the Health and Wellbeing Board in relation to providing strategic democratic direction and performance assurance of integrated services and pathways.

4.3.3 Finally, the scale of the ambition of this undertaking in Leeds accompanied by the innovation and imagination required to secure it's delivery will place the City at the forefront of Authorities and contribute significantly to the ambition of the Council to be the best in England and Wales.

4.4 Resources and Value for Money

4.4.1 There are two significant resource implications contained in the reports under consideration today. Firstly, it is the case that the large scale reconfiguration of pathways of care and organisational structures requires significant programme and project management resource. The companion report presented today setting out the work of the Health and Social Care transformation programme, contextualises how that resource is currently deployed and how it will need to be augmented in the future to deliver the transformation priorities.

4.4.2 Adequately resourcing the programme and project management capacity across health and social care in the short term (using non-recurrent funding), provides the greatest chance of securing the long term benefits of more integrated delivery namely, significantly reduced duplication across health and social care services, smoother and more efficient business processes, more shared back office functions especially data and client record systems.

4.4.3 These resource efficiencies would be delivered alongside those (to which previous reference has been made) brought about by shifting the focus of the activity of the system away from acute care and into self management and primary prevention.

4.5 Legal Implications, Access to Information and Call In

4.5.1 Para 3.5 makes reference to the governance challenges which will need to be addressed to ensure integrated models of care, pathways and organisational structures fulfil the statutory responsibilities of those organisations who will be party to their implementation. These arrangements will continue to need to be formal and robust so that each party is confident that improved outcomes are being achieved alongside the anticipated efficiencies.

4.5.2 In many instances, the governance requirements will be relatively simple to implement (such as those currently enjoyed by the joint commissioning service for people with learning disabilities), however, others will require careful working through to ensure that the interests of all parties to such agreements are appropriately and adequately reflected.

4.6 Risk Management

4.6.1 Clearly there are risks involved in seeking to implement whole system change, the companion reports presented today provide an overview of both the risk appetite and mitigation strategies that have been put into place already to manage service transition.

5.0 Conclusions

5.1 This report sets out the basic tenets of integration, namely that it is desired by people who may need to use health and social care services by virtue of their circumstances or condition and who experience a confusing series of 'hand offs' between different organisations and professional groups. People in this predicament clearly see no good reason for this and would prefer less disjointed service responses.

5.2 From the perspective of health and social care organisations in responding to the citizen and patient voice, significant opportunities are created to generate more efficient and more effective ways of providing and delivering a range of health and social care interventions designed to reduce the use of acute and long term care.

6.0 Recommendations

6.1 Members of the Health, Wellbeing and Adult Social Care Scrutiny Board are recommended to note the content of this report and the other specific companion reports which appear on the agenda today and which deal with the current service

change proposals currently in development between Health and Social Care organisations.

7.0 Background documents

A report to the Department of Health and the NHS Future Forum – "Integrated care for patients and populations: Improving outcomes by working together" Kings Fund/ Nuffield Institute – January 2012. (presented as Appendix 1)

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A report to the Department of Health and the NHS Future Forum

Integrated care for patients and populations: Improving outcomes by working together

Authors: Nick Goodwin, Judith Smith, Alisha Davies, Claire Perry, Rebecca Rosen, Anna Dixon, Jennifer Dixon, Chris Ham

Key messages

This paper has been written as a contribution to the work of the NHS Future Forum and in support of the government's espoused aim of placing integrated care at the heart of the programme of NHS reform. Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives. It can be delivered without further legislative change or structural upheaval. The aims of integrated care are widely supported by NHS staff as well as patient groups, and taking forward the proposals set out in this paper would therefore be welcomed by key stakeholders.

In the view of The King's Fund and the Nuffield Trust, these are the main priorities for the future.

- **Setting a clear, ambitious and measurable goal to improve the experience of patients and service users**

  Developing integrated care for people with complex needs must assume the same priority over the next decade as reducing waiting times had during the last. Government policy should be founded on a clear, ambitious and measurable goal to improve the experience of patients and service users and to be delivered by a defined date. This goal would serve a similar purpose to the aim of delivering a maximum waiting time of 18 weeks for patients receiving hospital care. To be effective, it needs to set a specific objective around which the NHS and local government co-ordinate their activities to improve outcomes for populations. Improving integrated care should be seen as a 'must do' priority to ensure it receives the attention needed.

- **Offering guarantees to patients with complex needs**

  Setting an ambitious goal to improve patient experience should be reinforced by guarantees to patients with complex needs. These guarantees would include an entitlement to an agreed care plan, a named case manager responsible for co-ordinating care, and access to telehealth and telecare and a personal health budget where appropriate. Many of these measures are already an established part of health and social care policy but they have not been implemented consistently. Making them happen is therefore less to do with extra spending and more related to variations in local policy and practice that need to be tackled as a matter of urgency.

- **Implementing change at scale and pace**

  Integrated care must be delivered at scale and pace. This requires work across large populations at a city- and county-wide level. There should be flexibility to take forward different approaches in different areas and to evaluate the impact, with the main emphasis being on people with complex needs. Financial incentives are needed to support rather than inhibit organisations to work together around the needs of patients, and the NHS Commissioning Board and Monitor must ensure that policies on regulation and competition facilitate integrated care where it will bring benefits. A programme of organisational development should be put in place to support NHS organisations and local authorities to make change happen.

  This will require significant reform to develop capacity in primary and community care and to prioritise investment in social care to support rehabilitation and re-ablement. The independent sector and third sector organisations have an important contribution to make in developing new models of care. The result would be to make a reality of care closer to home and to reduce the inappropriate use of acute hospitals.

Introduction

In its June 2011 summary report, the NHS Future Forum stated: *'we need to move beyond arguing for integration to making it happen'* (Field 2011, p 20). The report called for the commissioning of integrated care for patients with long-term conditions, complex needs, and at the end of life, building on the ideas that The King's Fund and the Nuffield Trust presented as part of the listening exercise on the Health and Social Care Bill. The Department of Health then approached our two institutions for help in supporting the development of its national strategy on integrated care and to feed our ideas directly into the ongoing work of the NHS Future Forum.

This report seeks to provide a framework for the Department of Health to help meet the challenge set out by the NHS Future Forum and support the development of integrated care 'at scale and pace'. It examines:

- the case for integrated care
- what current barriers to integrated care need to be overcome and how
- what the Department of Health can do can do to provide a supporting framework to enable integrated care to flourish
- options for practical and technical support to those implementing integrated care, including approaches to evaluating its impact.

The case for integrated care

The ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated.

This is a message recognised by most western developed nations, which are all seeking through different means to bring about a significant shift in the balance of where care is provided. In England, we know that standards of care for frail people with complex conditions are not always as they should be. Numerous reports have pointed to the need for significant improvements in care to frail older people that is better co-ordinated, of higher quality, and assures dignity and compassion (eg, Care Quality Commission 2011; Equality and Human Rights Commission 2011).

This lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. They add that: *'achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety'* (National Voices 2011). **Our view is that care for people with complex health and social care needs must be made a real and pressing priority for commissioners and providers as this will be the key to assuring people of high-quality care and making the health and social care system more sustainable.**

The government will have to accept and prepare for the consequences of such a change. **Significant reform is needed to develop capacity in primary and community care; prioritise investment in social care to support rehabilitation and re-ablement; and take forward the subsequent downsizing of activity undertaken in acute hospitals.** In all of the successful integrated care projects we examined, additional and improved services outside hospital were required – shining a light on the lack of current capacity and capability in community services to deliver care co-ordination and more intensive care in the home environment.

If executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality, innovation, prevention and productivity (QIPP) challenge in the longer term – one of the core themes in *The Operating Framework for the NHS in England 2012/13* (Department of Health 2011). This requires tackling waste and inefficiency in services in all settings to release resources for investment in new forms of care.

Understanding integrated care
Integrated care means different things to different people. At its heart, it can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs. To achieve **integrated care, those involved with planning and providing services must impose the user's perspective as the organising principle of service delivery** (Lloyd and Wait 2005; Shaw *et al* 2011).

While many are enthused about the potential benefits of integrated care, others are uncertain about what it might entail or are threatened by its possible consequences. In part, such fears are related to the organisational changes that are often implied. However, **organisational integration appears to be neither necessary nor sufficient to deliver the benefits of integrated care.**

No single 'best practice' model of integrated care exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations (Curry and Ham 2010). Moreover, **integrated care is not needed for all service users or all forms of care but must be targeted at those who stand to benefit most.**

Making the case for integrated care
It is important to define the ambitions and the goals of integrated care and to translate these into specific and measurable objectives. **Making a compelling case for integrated care, both as a national policy and in terms of local care redesign and delivery, is essential** if people are to understand why it is being promoted as a priority.

In our view, integrated care is necessary for any individual for whom a lack of care co-ordination leads to an adverse impact on care experiences and outcomes. It is an approach best suited to frail older people, children and adults with disabilities, people

with addictions, and those with multiple chronic and mental health illnesses, for whom care quality is often poor and who consume the highest proportion of resources. It is also important for those requiring urgent care, such as for strokes and cancers, where a fast and well-co-ordinated care response can significantly improve care outcomes.

Keeping the needs and perspectives of the individual at the heart of any discussion about integrated care is critical. One approach to this was in Torbay (Thistlethwaite 2011), where they identified that many older people were at significant risk of falling into long-term care in a nursing home and/or a long hospital stay. By invoking the fictional character of Mrs Smith – a woman in her 80s with a range of long-term health and social care needs yet encountering daily difficulties and frustrations in navigating the health and social care system – managers and clinicians created a unifying narrative to explain the purpose of integrated care, underpin the design of a new integrated health and social care system, and act as a clear point of reference for judging success.

Without integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines, and the potential for cost-effectiveness diminishes (Kodner and Spreeuwenberg 2002). The challenge facing today's health and social care system in England is its ability to offer high-value care in the face of a difficult financial and organisational environment. The task is especially daunting in the context of a population in which the burden of disease is growing and medical advances offer increasing opportunities to treat disease, but at a cost. The result, if nothing changes, will be significant unmet need and threats to the quality of care.

The benefits of integrated care

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011). Many different approaches have been taken, and five different examples are provided below to illustrate some of the benefits that can accrue (see box overleaf).

Care for older people in Torbay
Care for older people in Torbay is delivered through integrated teams of health and social care staff, first established on a pilot basis in 2004 and since extended throughout the area. Each team serves a locality of between 25,000 and 40,000 people and is aligned with the general practices in the locality. Budgets are pooled and used flexibly by teams who are able to arrange and fund services to meet the specific needs of older people. A major priority has been to increase spending on intermediate care services that enable older people to be supported at home and help avoid inappropriate hospital admissions. The work of integrated teams has been taken forward through the work of the Torbay Care Trust, created in 2005. Results include a reduction in the daily average number of occupied beds from 750 in 1998/9 to 502 in 2009/10, emergency bed day use in the population aged 65 and over that is the lowest in the region, and negligible delayed transfers of care. Since 2007/8, Torbay Care Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes, with a corresponding increase in home care services targeted at prevention and low-level support (Thistlethwaite 2011).

Diabetes care in Bolton
The Bolton Diabetes Centre, set up in 1995, has a team of community-based specialists. The team works with the local hospital for inpatient care and with general practices to provide support and undertake shared consultations. The vision is of care that is delivered in the appropriate place at the appropriate time by the appropriately trained professional. Bolton aspires to develop a fully integrated diabetes service without gaps or duplication and with quick referral from primary care to specialist advice. Patients and staff have reported high levels of satisfaction with the service, and in 2005/6 Bolton reported the lowest number of hospital bed days per person with diabetes in the Greater Manchester area (Irani 2007).

Stroke care in London
In London, implementation of a pan-London stroke care pathway and the development of eight hyper-acute stroke units has improved access and reduced length of stay in hospitals: 85 per cent of high-risk patients who have had a stroke are treated within 24 hours, compared with a national average of 56 per cent, and 84 per cent of patients spend at least 90 per cent of their time in a dedicated stroke unit, compared to a national average of 68 per cent. Five of the top six performing hospitals in the National Sentinel Audit for Stroke are now London-based hyper-acute stroke units (Intercollegiate Stroke Working Party 2011).

Chronic care management in Wales
In Wales, three Chronic Care Management Demonstrators in Carmarthenshire, Cardiff and Gwynedd Local Health Boards pioneered strategies to co-ordinate care for people with multiple chronic illness. By employing a 'shared care' model of working between primary, secondary and social care – and investing in multidisciplinary teams – the three demonstrators report a reduction in the total number of bed days for emergency admissions for chronic illness by 27 per cent, 26 per cent and 16.5 per cent respectively between 2007 and2009. This represented an overall cost reduction of £2,224,201 (NHS Wales 2010).

Integrated service networks in the Veterans Health Administration system in USA
The experience of the Veterans Health Administration in the United States provides evidence of the benefits of transforming from a fragmented, hospital-centred system in the mid-1990s into a series of (now 21) regionally based integrated service networks responsible for the provision of all forms of health and long-term care within a fixed budget (Ham *et al* 2011). Family doctors work closely with medical specialists in managing patients with chronic diseases, and integrated working is supported by information technology, including an electronic medical record. Studies have shown that bed use fell by 55 per cent after the implementation of integrated service networks (Ashton *et al* 2003). Evidence also shows that the quality of care improved.

Approaches to integrated care are likely to be more successful when they cover large populations (covering a city or county, for example) and a range of groups: older people; people with particular diseases or conditions; and people requiring access to specialist services (Goodwin *et al* 2010; Curry and Ham 2010; Humphries and Curry 2011). For example, the evidence for case management and care co-ordination shows that it is less likely to succeed unless it is part of a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation, re-ablement and independent living (Ross *et al* 2011). The evidence shows that it is the cumulative impact of multiple strategies for care integration that are more likely to be successful in meeting the demands and improving the experiences of patients, service users and carers (Powell-Davies *et al* 2008).

A priority for action
During the work we undertook with colleagues in the NHS and social care to inform this report **we uncovered a sense of urgency in turning ideas about integrated care into action, and for this agenda to be developed at scale and pace**. Moreover, there was an overwhelming sense that the future challenges in the system could be overcome only by focusing on the health *and* wellbeing of populations, and with the freedom to innovate and embed new ways of working over a minimum of five years.

The delivery of integrated care must become a clear political and managerial priority for action, so that high-quality and well-co-ordinated care for frail or vulnerable people with complex needs can be assured. **Put simply, integrated care should become the main business for health and social care. This requires the Department of Health and the NHS Commissioning Board to set a clear, ambitious and measurable goal that is linked to patients', users' and carers' experience of integrated care and that must be delivered by a defined date. This goal should be included in the annual NHS Operating Framework, and NHS and partner organisations should be held to account for its delivery.**

As there are many different ways to achieve integrated care, but no one best model for doing so, it follows that **any support framework must be permissive and based on 'discovery and not design'. Hence, the focus should be on removing the barriers to integrated care, avoiding being prescriptive about how it should be done.** We now turn to the question of how the barriers to integrated care can be overcome.

Current barriers to integrated care

Significant international attention is currently being paid to the 'integrated care conundrum', typically expressed as a need to find much better ways of delivering well-co-ordinated care to people living with complex conditions and multiple health needs (eg, Canada – Baker and Denis 2011; New Zealand – Cumming 2011; England – Ham *et al* 2011a; USA – Kodner 2009; Australia – Powell Davies *et al* 2009). In all cases, there is a focus on imposing the individual's perspective as the organising principle of care delivery (Lloyd and Wait 2005), and on developing processes, methods and tools of integration that can facilitate such integrated care (Leutz 2005).

But why is it such a challenge to develop services in such a way that patients, service users and carers, particularly those struggling with complex and long-term needs, feel satisfied that care is well co-ordinated, and not reliant on regular prompts and actions by these users and carers? There is a set of systemic barriers to integrated care that need to be addressed, some organisational, and others related to health and social care policy.

Organisational barriers to integrated care

In the work we carried out with NHS and social care colleagues for this report, the following organisational barriers were most frequently cited as barriers to developing integrated care.

- **NHS management culture often talks about innovation yet demonstrates a fundamentally 'permission-based' and 'risk averse' approach** to approving local service developments. This culture manifests itself through the application of rules about payment approaches, policy on competition, setting targets that lead to undue management attention being focused on certain (typically elective) areas of care, and the apparent discomfort about investing in service developments that significantly challenge the configuration of local hospital care. This last point was often expressed as an 'underlying sense of fear' that such actions would not be acceptable to higher authorities.

- **The divide between primary and secondary care in the NHS**, **and also that between health and social care.** Differences in staff contracts, employment arrangements, funding approaches, and approaches to service provision build allegiances to the needs of specific organisations that make it difficult for multidisciplinary teamwork to happen. As social care is means-tested at the point of access, this adds a further degree of complexity that all too often results in overlapping or missing services.

- **The lack of time and sustained project management support accorded to demonstration sites** means that integrated care has often been restricted to short-term pilot projects. Without the time and resources to demonstrate change, research results often report that integrated care has failed to achieve its desired goals (Steventon *et al* 2011).

- **The absence of a robust shared electronic patient record** that is accessible to and used by all those involved in providing care to people with complex conditions is a major drawback to supporting a more appropriate and integrated response to people's needs (eg, Curry and Ham 2010; Rosen *et al* 2011).

- **The persisting weakness of commissioning** that means they have struggled to use their power as 'paymaster' to exert changes in chow providers deliver services that might avoids fragmentation and duplication (Ham *et al* 2011). Particular weaknesses are found in: the lack of active clinical involvement; an approach to procuring care services that focuses on individual organisations as opposed to partnerships; and payment based on episodic (hospital-based) care (Ham *et al* 2011).

Policy barriers to integrated care

The experience of those developing integrated health and social care services is that innovations often seem to stall at the point at which they start to have a significant impact on the provision and configuration of services. Indeed, the experience of developing integrated care in places such as Cumbria, North West London, Smethwick and Trafford suggests that more support is needed at a policy level if integrated care is to become more than just a minority interest for a few enthusiasts (Ham and Smith 2010; Ham *et al* 2011b). Key policy barriers included:

- **the Payment by Results approach to funding hospital activity** that has led to increased activity and decreased lengths of stay. Incentivising hospitals to increase admissions (as long as they can find a commissioner to pay), mitigates against different providers (eg, community health, hospital and general practice) coming together as a network to develop and deliver new forms of integrated

care. Stronger incentives are required if health providers are to collaborate to address the fragmentation and duplication in care.

- **choice and competition policy** that appears at times to run contrary to the desire in many sites for more integrated care (Ham and Smith 2010). The key issue here is the *unit* of competition and whether this is defined narrowly (eg, for an annual foot check) or broadly (eg, for a year of care to a diabetic). It also begs the question as to how competition should operate – should it be competition for the market (ie, tendering to providers) or within the market (ie, patient choice of location and caregiver).

- **NHS regulation that focuses too much on organisational performance and not enough on performance across organisations and systems**. It is a specific provider (hospital, community health service, practice) that is currently subject to regulation in respect of service quality, rather than services across a continuum, which is what patients, service users and carers experience. Furthermore, the economic regulation of foundation trusts appears to focus more on how they are governed, can grow as entities and create financial surpluses, rather than on how they might shape integrated services with partner organisations and deliver new models of care.

- Policy proposals for the future of the NHS in England currently set out three different outcomes frameworks against which performance will be assessed. Currently, these three outcomes frameworks have some shared indicators, but these are quite minimal. **Action needs be taken to develop a single outcomes framework to promote joint accountability for delivering services that are joined up for patients, service users and their carers** (Humphries and Curry 2011).

For those working on the ground, none of these policy barriers is so fundamental that they cannot be overcome if there is sufficient local commitment, system leadership and the will to succeed. However, to develop integrated care at scale and pace, more energetic support, and explicit encouragement, is required.

Overcoming the barriers to integrated care

The most fundamental prerequisite to the development of integrated care at scale is the **crafting of a powerful narrative at both a national and local level** about how services could and should be delivered for people with complex conditions - especially, but not exclusively, frail older people. At present, there is significant national and press attention on failings in the care of frail older people, but less focus on what needs to be done to re-orientate the health system towards addressing such concerns. The case for change will not be made on quality alone, but also on the basis of efficiency, for there is an increasing consensus in the NHS that to address the 'Nicholson challenge', a major shift will be required in how care is delivered (NHS Confederation 2011; Imison *et al* 2011).

As part of this narrative, there is a need for a **clear articulation of the benefits to patients, service users and carers**, backed up by regular and detailed assessment of their experience of NHS services. This assessment should not be undertaken on a purely provider basis, but across the continuum of care as experienced by the individual, enabling regular monitoring of how far integration efforts are succeeding. Such tracking of patients', service users' and carers' experience should be used pro-actively by commissioners and providers to improve quality of care and should be aggregated at a national level as part of wider regulation and performance management of the care system.

We agree, therefore, with the view of National Voices that **the Department of Health and the NHS Commissioning Board should give urgent priority to investing in approaches that measure the experiences of patients, service users and carers in relation to integrated care** – in particular, those that: measure how active and confident individuals feel about managing their own care; describe outcomes in terms of the impact on people's health and wellbeing; and describe their care experiences and whether services are being delivered that meet their needs (National Voices 2011).

A prerequisite to providing consistent, well-co-ordinated care for people will be significant investment in primary and community services. In particular, **there is a need for general practice to adapt rapidly so that it operates at a scale that can provide the platform for integrated care** (The King's Fund 2011). This requires general practice to act as the hub of a wider system of care that takes direct responsibility for co-ordinating and signposting individuals to services within the NHS as well as beyond health care on a 24/7 basis. In particular, a capability needs to be developed that enables specialist (eg, hospital consultant, community specialist, social worker) support and advice to be provided to primary care teams so that they can make sure that people receive well-co-ordinated and personalised care.

To encourage integrated care, payment incentives and new local currencies are needed. These might include giving a capitated budget to a local organisation (eg, a federation of GP practices, or a foundation trust and its local GP practices) and then holding the organisation to account for delivering care to specified standards of user experiences, health outcomes, and costs. In this way, the incentives to deliver proactive care to people identified as being at risk would be shared across the partners within the local organisation. Recent analysis by the Nuffield Trust (Dixon *et al* 2011) about the allocation of health resource at an individual level provides a robust basis on which to calculate accurate capitated budgets.

Another option is to use bundled payments for a range of services relating to a particular episode of care or care pathway, such as is being proposed in the Whittington Health integrated care organisation (Clover 2011). Exploring the idea of extending the 'year of care' approach to paying for care of people with long-term conditions that has been piloted in diabetes services (Year of Care Programme Board 2011) also holds some attraction. Such approaches, however, are likely to be more suitable for dealing with patients with specific diseases and will not adequately meet the needs of people with multiple needs.

There is an urgent need for experiments in changing the nature of tariffs for NHS care, to enable greater investment in primary and secondary prevention, alongside delivering community and acute health services where needed. Commissioners might also seek to increase the use of pooled budgets as a way of enabling closer health and social care collaboration. Using quality-based incentive payments across pathways of care might likewise incentivise best practice models and partnership working, while ensuring that providers are incentivised to make a contribution to the health and wellbeing of the whole population. Personal health budgets, too, might enable some patients and service users to commission their own care in ways that better meet their needs.

As well as the alignment of financial incentives, **governance needs to be aligned across the various health and social care providers to drive shared interests and accountability in care delivery for people** across hospitals, community services, general practice teams and social care. Given the complexity of designing and organising services across existing organisational and professional boundaries, careful attention will need to be paid to the governance (both financial and clinical) of new services, ensuring that accountability for an individual's care is clear to all parties.

Integrated care might also be adopted more quickly by **commissioners changing the way that they procure services**, moving away from contracts with individual organisations that specify items of delivery, to a focus on commissioning for outcomes achieved with specific populations or client groups. In particular, **commissioners need to have the ability to identify individuals in need of care and support, which requires a population-based approach with sophisticated tools** to identify those people in local communities with complex needs and to target the proactive support and management of their needs**.** The use of low-cost tools to stratify the risk of future ill health of individuals in the population will be crucial to help target care and support appropriately.

Innovative approaches are needed to sharing data together with a commitment to developing shared clinical records. This can be time-consuming and expensive, so the Department of Health should seek a streamlined approach to the governance of data sharing that can be applied across England to avoid this becoming a waste of taxpayers' money.

Finally, it is important to re-iterate here that **effective integrated care can be achieved without the need for formal ('real') integration of organisations.** What matters most is the clinical and service integration that improves care co-ordination around the needs of individual patients and service users. Demonstrating the extent of progress will require significant time and project management support, together with careful and robust evaluation. Organisational integration may be a consequence of clinical and service integration but in our view it should not be the starting point.

What the Department of Health, the NHS Commissioning Board and Monitor now need to do

Our knowledge of the evidence suggests that integrated care for people with complex needs can be achieved without further legislative changes to the current Health and Social Care Bill. Indeed, a message from those working on the ground is that 'where there's a will there's a way' and any barrier can be overcome if there is sufficient local commitment, system leadership and the will to succeed.

The most pressing problem in ensuring proactive and well-co-ordinated care for people with complex conditions appears to be linked to the 'permission-based' culture in NHS management and the fear that mitigates against local innovation. **If the vision for a more integrated health and social care system is to be realised at scale and pace, then it is clear that the Department of Health, together with the NHS Commissioning Board and Monitor, must adopt an enabling framework to guide integrated care over the next five to ten years.** This framework would seek to make the assurance of high-quality care of frail people with complex conditions a 'must-do' for both the NHS and local authorities, addressing the policy barriers to integrated care described above, enabling integrated care to flourish, and requiring the achievement of outcome indicators that reflect the degree of service integration experienced by patients, service users and carers.

We have identified the following ten key elements to this framework.

- ***Provide a compelling and supporting narrative for integrated care***

The Department of Health's current focus on integration has begun to inspire a range of initiatives across England. However, many people remain unsure about the vision for and purpose of integrated care and about the Department of Health's long-term commitment to supporting it. Defining the ambitions of integrated care and setting out what it would look like in practice is the highest priority. We would argue that this should be part of a national strategy to address the needs of people with long-term conditions, for whom integrated care is particularly important.

We would urge the Department of Health to take up a position that provides a strong case for integrated care based on its potential to improve significantly the lives of millions of individuals with complex needs and of their carers. In addition, to be taken seriously by commissioners and strategic decision-makers, integrated care must be seen as a strategy that is central to the achievement of QIPP and the shaping of a more sustainable model of care delivery than can help turn the tide of hospital admissions. As we have argued, this vision will need specific and measurable objectives in the NHS Operating Framework if integrated care is to avoid being just a talking-shop across many local organisations.

- ***Allow innovations in integrated care to embed***

Integrated care must be given sufficient time to embed locally, with strong leadership and sustained project management, before significant benefits to individual service users can be demonstrated. This will require sites delivering integrated care at scale to be granted – for up to five years – certain freedoms from national constraints. Providers from the independent sector and third sector should be encouraged to support innovations in integrated care.

To enable this to happen a longer planning cycle is needed in which budgets are assured and within which new tariffs and payment systems could be tested. Current financial accounting rules constrain commissioners, and to some extent providers, as they are required to balance their books annually. Moreover, whereas we may be able to predict what the financial settlement in health care will be, it is much more volatile (and currently less generous) for local authorities, meaning that it is problematic to enter into long-term arrangements to support jointly funded health and social care services. This funding uncertainty restricts any ability to 'invest to save' across different financial years, something that is a pre-requisite in developing integrated care.

- ***Align financial incentives by allowing commissioners flexibility in the use of tariffs and other contract currencies***

It is imperative that local commissioners are able to modify financial incentives and develop new currencies to support integrated care as described above. The priority should be to develop ways of paying for care that reward good outcomes (eg, evidence of well-co-ordinated care across the patient journey) and avoid perverse incentives that, for example, increase hospital activity. This is about modifying, not dismissing, the current NHS system of paying providers. Payment by Results will continue to be highly relevant for planned care where episodes and pathways are relatively easily specified and accounted for.

- ***Support commissioners in the development of new types of contracts with providers***

The NHS Commissioning Board has a duty to support commissioners in developing a new model of contracting, for example, based on pathways of care as experienced by patients, or using risk-sharing capitation-based contracts with integrated care partnerships of GPs, community health services, and specialists. The latter approach to contracting would need to ensure that the services provided were population-orientated and comprehensive in scope. While a desire to integrate care around people with certain diseases might legitimately be part of the provider's strategy, we would caution against commissioning purely for certain diseases (such as diabetes) as there is a risk of creating new silos of clinical conditions in place of existing organisational silos. The use of carefully crafted outcome measures that assess the person's experience of care across organisations will be critical in demonstrating progress in improving the integration of care, and flagging the introduction of any new fragmentation of services across disease pathways.

- ***Allow providers to take on financial risks and innovate***

Approaches to integrated care often work best when some of the responsibilities for commissioning services are given to those who deliver care (Christensen *et al* 2009). Giving providers freedom to take 'make or buy' decisions means that the redesign of care and services will be clinically or professionally led (Smith *et al* 2009). Importantly, it promotes collective accountability among providers for the quality, costs and outcomes of care, and there is evidence that innovations in integrated care can develop faster when providers have the incentive to improve service quality while taking on a degree of financial risk. For example, integrated medical groups in the USA that have combined responsibility for commissioning and provision have often been successful in delivering high-quality integrated care (Curry and Ham 2010; Thorlby *et al* 2011).

While such approaches would need to be carefully monitored to ensure that quality of care to patients, service users and carers is not compromised, we would support the development of integrated care partnerships where existing professional relationships are such that they are keen to take shared responsibility for delivering a range of services for a defined population (Smith *et al* 2009; Lewis *et al* 2010). These partnerships might be based on federations of general practices, but they might also be rooted in a foundation trust that seeks to be the care co-ordinator and hub for a local community or in a joint health and social care venture such as a care trust. The independent sector can also play a positive part in integrated care partnerships. Given evidence on the difficulty faced by commissioners in enabling integrated care (Ham *et al* 2011b) it is likely that many integrated care partnerships will be led by providers rather than commissioners in the first few years.

It is important to reiterate here that a prerequisite for integrated care will be the need for significant investment in developing skills and capacity in primary and community care. What is clear is that as a minimum, there will be a need for more federations of general practices (as providers) so that they are in a position to assume contracts to carry out much more extensive, 24/7 co-ordination of care, along with ensuring the provision of a range of intensive community-based services.

- ***Develop system governance and accountability arrangements that support integrated care, based on a single outcomes framework***

There is a need to align governance and accountability arrangements centrally, and in particular the ways in which local organisations will be measured in respect of health and social care outcomes. The Department of Health, NHS Commissioning Board, Monitor, the Care Quality Commission, and Public Health England should set a central expectation

for integrated care to be delivered, using robust and extensive baseline assessment of patients', service users' and carers' experience of services across organisations. They then need to act in a concerted and consistent way to support implementation.

We would strongly support the adoption of a single outcomes framework for the NHS, social care and public health. Health and social care organisations need to be mandated to work collectively to meet common outcomes related to the health and wellbeing of the populations they serve, and this will entail indicators that examine the degree of integration/fragmentation of care given to people with complex conditions. It will also be vital, if we are to avoid any risk of the issues uncovered at Mid Staffordshire NHS Foundation Trust, that regulatory and performance management responsibilities for the care of frail people with complex conditions are absolutely clear.

- ***Ensure clarity on the interpretation of competition and integration rules***

Competition and integration are means not ends. Monitor must adopt a proportionate approach that encourages both of these where this benefits patients and service users. It is important that integrated care is 'hard wired' into the health and social care systems of the future, so the primary duty of Monitor should be the protection and the promotion of interests of patients and the public. Changes to the Health and Social Care Bill have supported this dual role, yet it remains unclear in practice how the rules of competition and integration will be interpreted. Monitor should work closely with the NHS Commissioning Board to provide guidance and support on the commissioning and provision of integrated care and to hold commissioning bodies to account for delivering this against a transparent outcomes framework. We are pleased that The King's Fund and the Nuffield Trust have recently been commissioned by Monitor to support them in assessing how this key task can best be performed. We envisage the independent sector playing an increasing part in the development of integrated care.

- ***Set out a more nuanced interpretation of patient choice***

Patient choice should be intrinsic to the provision of integrated care as it should allow people greater opportunity to make informed decisions about their care and treatment options. However, those that we talked to saw the policy of patient choice as a barrier to integrated care as it is often used as a mechanism to promote provider competition rather than to provide the sorts of choices that patients and service users would better value. There is a paradox between requiring commissioners to enable people to access a range of providers and allowing them to devise new forms of integrated care that might benefit patients. While patients and service users should always have the option to access alternative services, we agree with Sir Stephen Bubb (Chair of the Choice and Competition Stream of the NHS Future Forum) that a more nuanced interpretation of the policy is necessary as '*choice is much more than the ability to choose a different provider of elective surgery. It is about the choice of care and treatment, the way care is provided and the ability to control budgets and self-manage conditions.*'

Much more needs to be done to empower patients and users to make informed choices about their care and treatment. This can be done by putting in place a single assessment process covering health and social care and by agreeing a care plan with patients, users and their families. Where appropriate, care plans should guarantee access to a named case manager who would be responsible for ensuring effective care co-ordination between care providers to meet the goals of the plan. As discussed, personal health budgets will have a part to play in empowering some patients and users in this, and the greater use of home-based technologies that support people to remain independent and in control of their health and wellbeing should also be a priority.

Putting in place a package of measures centred on individuals is, in our view, at least as important as removing the policy barriers to integrated care and facilitating the

development of integrated care for populations. Many of these measures are already an established part of health and social care policy but they have not been implemented consistently across England. Making them happen is therefore less to do with expenditure and more related to variations in local policy and practice that need to be tackled as a matter of urgency.

- ***Support programmes for leadership and organisational development***

Integrated care is unlikely to happen at scale and pace unless those implementing it are given support; those we spoke to stated that programme support was what they most needed to facilitate the development of integrated care locally. A wide range of needs were articulated, such as:

- building leadership, trust, engagement, legitimacy and a common vision among key partners
- investing in the development of information technology to achieve a shared patient record, inter-operability between data systems, and the ability to use tools that identify at-risk individuals in the community
- providing advice and support to commissioners on: finance and procurement processes; new types of contract currencies and incentive schemes; prime contractor models; and public health skills for prioritising investments
- encouraging networks to share learning and ideas
- deploying approaches that promote quality and consistency in care provision.

While much of this might be sought and delivered independently, there is a need for the Department of Health and the NHS Commissioning Board to: invest resources and support the development of skills and competencies for integrated care; promote learning and share ideas to support the adoption and successful application of integrated care; commission, analyse and report on progress on integrated care, including benchmarking this against international developments.

- ***Evaluate the impact of integrated care***

An essential component of any integrated care programme is the ability to demonstrate its impact. The Department of Health's strategy for integrated care should outline how integrated care will be evaluated at a national level and emphasise the importance of appropriate evaluation at a local level. The NHS Commissioning Board should be tasked with developing guidance for commissioners to ensure any evaluation is appropriately conducted and can be used to inform service development.

To understand whether integrated care has been successful, it is first necessary to define the goals of integrated care and to ensure that these are what patients, service users and their carers actually want. Robert and Cornwell (forthcoming) suggest a framework for how 'what matters to patients' could be determined and acknowledge that more work is needed on how this could work in practice in the reformed NHS. There are many different methods for assessing an individual's views of care (Vrijhoef *et al* 2009); for example, the Patient Activation Measure (PAM) is used to evaluate patients' ability to manage their own illnesses; and Patient Reported Outcome Measures (PROMs) help capture impact on people's health and wellbeing (for example, reduction in pain, or increase in mobility). The best-tested measures are those used in the Department of Health's national patient survey programme. Successful integrated care as experienced by the individual is not well defined (National Voices 2011), and the degree to which questionnaires capture patients' perceptions of actual care integration is not clear. An urgent priority for the Department of Health and the NHS Commissioning Board is to invest in approaches that can be used locally and nationally to measure the experiences of patients, service users and carers.

An assessment of the utilisation and costs of care services within new integrated care developments is rarely considered. The complexity of integrated care, along with the difficulty of assigning costs to processes and outcomes delivered at a local level, make economic evaluation difficult (Vondeling 2004). The NHS Commissioning Board should provide advice and support to local commissioners on how to access the skills necessary to evaluate the costs of integrated care.

To be able to demonstrate an *improvement* in care, a baseline assessment on all of these measures is needed to track progress over time and, where possible, to use 'matched populations' to investigate whether integrated care can achieve better results compared to where it has not been implemented. Several recent evaluations – for example, of the Whole System Demonstrator pilots and the Partnership for Older People Projects programme (Steventon *et al* 2011) – have highlighted the benefits of linking routinely collected data on individuals and of monitoring interventions in as close to real time as possible. This is relatively cheap, provides results quickly, exploits existing data sources, and is at the forefront of evaluative methodology internationally.

Integrated care is complex and an assessment of its success is likely to be limited by the resources available. However, the Department of Health's strategy should reiterate the importance of appropriate evaluation and make it a core component of the strategy that seeks to promote it.

Conclusion

Integrated care lies at the heart of the aims of the Health and Social Care Bill – to put patients first, improve health outcomes and empower health professionals. The amendments to the Bill that have sought to recognise the importance of integration as well as competition represent an important signal of the need to make integrated care a 'must-do' priority. If executed well, focused and sustained work that addresses the fragmented and inadequate nature of care for people with complex needs will help to create the foundations for sustainable delivery against the QIPP challenge.

The Department of Health and the NHS Commissioning Board must now develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations. This requires the setting of a clear, ambitious and measurable goal linked to the individual's experiences of integrated care that must be delivered by a defined date. This goal should be produced in partnership with patient and user representative organisations and should resonate with the experiences of every individual and their carer where good care co-ordination is essential to meeting their needs. This goal should be included in the annual NHS Operating Framework, and the NHS and partner organisations should be held to account for its delivery. Results should be made publicly available and reviewed on a regular basis.

Finally, if the vision for a more integrated health and social care system is to be realised at scale and pace, we conclude that the Department of Health, together with the NHS Commissioning Board, must adopt an enabling framework to guide integrated care over the next five to ten years**.** We have described in this report ten key elements of such a framework but would stress that the approach must be permissive and based on 'discovery and not design,' with performance management focused on the outcomes that are delivered to individuals and communities rather than on the means used.

The benefits of integrated care to the individual will not be realised until significant efforts are made to develop capacity in primary and community care, to prioritise investment in social care to support rehabilitation and re-ablement, and to take forward the subsequent downsizing of activity undertaken in acute hospitals. In improving care

for every person with complex health and social care needs, a population-based approach is therefore required that reaches out to local people and provides proactive care and support to meet their needs**. The prize to be won is a health and social care system centred on the needs of individuals and patients and delivering the best possible outcomes.**

About this work

The work we have undertaken to inform this report has involved collating the learning from previous research by the Nuffield Trust and The King's Fund research into a slide pack of evidence about integrated care (Goodwin and Smith 2011). In addition, in October 2011, we held a half-day expert seminar with managers and practitioners from the NHS and social care at the forefront of developing integrated care. This event helped us to test ideas about how integrated care might be adopted at scale and how to support this. These elements were then further tested through follow-up interviews with representatives from nine sites known to The King's Fund and Nuffield Trust as particularly active in delivering new forms of care for people with long-term conditions and complex needs. A second seminar to examine the messages from this work was held in November 2011 with senior policy-makers, including those from the Department of Health, Monitor, and the NHS Future Forum.

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Leeds CITY COUNCIL

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Report of the Director of Social Services

Report to Scrutiny Committee

Date: 29 February 2012

Subject: Health and Social Service Care Integration: Supporting working age adults with enduring mental health issues

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In 2009/2010 there was a scrutiny inquiry into the support available to working age adults with severe and enduring mental health problems. One of the areas the inquiry focused on was the partnership arrangements between Leeds Partnerships NHS Foundation Trust (LPFT) and Adult Social Care (ASC), with consideration given to how we could work more effectively together to improve experience and outcomes for service users.

2. Since the inquiry there has been a significant amount of work put into progressing this. A new model of partnership working was approved by Executive Board in December 2011 and the two organisations are working together to implement a new model of service delivery, built around the individual and their needs.

3. This approach is strongly linked to the national strategy whose emphasis is on wellbeing; recovery, prevention and early intervention; choice and self-determination. As such its general direction is consistent with Government's new policy direction: No Health without Mental Health - *Delivering better mental health outcomes for people of all ages* DH 2011.

4. The division of responsibility of health and social care services (health to NHS and social care to Local Authorities) can prove problematic for individuals with complex mental health problems who, typically, have simultaneous and linked needs to health and social care – requiring multiple assessments. Direction from national

government increasingly emphasises the importance of partnership working and of more integrated health and social care provision.

5. This proposal is the forerunner of a number of local initiatives, across council services and Departments. It supports a direction of travel - that service improvements and delivering better outcomes for citizens in a difficult financial climate can only be achieved in partnership and where appropriate integration with other key stakeholders in Leeds.

6. This proposal extends the current best practice of co-location and multi-disciplinary teams that is being developed across the city with other NHS organisations and is at the forefront of how the Council and the NHS in Leeds is developing a closer working relationship based upon partnership and integration where this will deliver improved service user experience and outcomes.

7. The proposal approved by Executive Board is to delegate the specialist mental health social work function to LPFT, to second local authority staff from ASC to LPFT and to integrate management structures to ensure clear lines of accountability.

8. To facilitate a whole system approach to be taken to the delivery of health and social care an integrated health and social care service would be developed and LPFT would assume responsibility for the adult placement budget.

9. A partnership agreement under Section 75 of the National health Services Act 2006 would be drafted to support the partnership, which would clearly define the roles and responsibilities of each partner.

Recommendations

(a) Note the decision taken by Executive Board in December 2011 to integrate specialist mental health social care services with specialist secondary mental health service with LPFT acting as host organisation for the partnership.
(b) Note the development of a partnership agreement under Section 75 of the National Health Services Act 2006 detailing the governance of the partnership between ASC and LPFT
(c) Note the secondment of social care staff to LPFT from 1 April 2012
(d) Note that further detailed work will be undertaken to ensure the ongoing balance of social care management in the partnership.
(e) Note the review of roles and functions of social work within the partnership.
(f) Note how potential risks around Governance ,Finance ,HR, and Performance will be managed in the phased approach to implementation described within this report .

1 Purpose of this report

1.1 The purpose of this report is to update on progress since the Scrutiny Inquiry of 2009/10 in developing a more integrated service for those people with severe and enduring mental health problems who require support from both health and social care.

1.2 In December 2011 Executive Board approved a proposal for a more integrated model of partnership working. This report describes the model of partnership, including details of the governance arrangements, implications for staff and benefits for service users. It goes on to describe the work that will be progressed to realise the benefits of an integrated service.

2 Background information

2.1 Discussions have been ongoing since May 2010 culminating in a proposal, approved by Executive Board in December 2011, that current partnership arrangements between Adult Social Care (ASC) and Leeds Partnerships NHS Foundation Trust (LPFT) be reviewed and a new model developed that would include a streamlined route into health and social care services for mental health service users.

2.2 The background to this proposal and the current partnership arrangements in place between the two organisations is described in the Dec 2011 Executive Board report. The move to a more integrated service fits with the overarching strategic direction for health and social care services in the City – *Health and social care services will work together better to help people stay active and independent for as long as possible and provide care when needed in local communities (City Priority Plan 2011 to 2015)*

2.3 In developing a new model of partnership between the two organisations particular consideration has been given to management and governance arrangements, HR implications and finance.

2.4 LPFT have been reviewing the way that they deliver services with an aim to move to a model of service delivery that is more closely built around individuals and their needs. The transformation of LPFT's service model (known within LPFT as the Transformation project) will impact on the way that mental health social workers work and Adult Social Care have been involved in this work. Developing a new model of partnership working in parallel with this transformation work gives ASC and LPFT an opportunity to work together to build an integrated service model which ensures the individual using the service can access the health and social care they need in a timely way.

3 Main issues

The Proposed Model of Service

3.1 The core elements of the service include a single point of access into secondary mental health where an initial assessment will be undertaken to determine the parts of the service the individual needs to access. Some support will be able to be delivered by the multi-disciplinary community teams, other support will be more specialist and will be delivered by staff in specialist teams.

3.2 Piloting began in the South of the City in November with rollout planned from April 2012. What has been highlighted within the pilot is that significant work is needed to integrate social care processes. Work will need to be done within the initial phase of integration to develop and test tools to screen for social care needs alongside health needs. This will ensure that people who are eligible for social care support are consistently identified regardless of where they enter the service or who does the initial assessment of need.

3.3 To reduce the need for people to retell their story we will also be looking at how health and social care assessment processes and documentation can be more effectively joined. At the same time consideration will be given as to how people are allocated to professionals for assessment – if it can be identified at initial point of contact that someone appears to have a mix of health and social care needs it would be more appropriate for this service user to have an assessment with a professional who understood self directed support and could assess for social care needs at the same time as health needs.

3.4 The model of assessment and care planning adopted by social care through the introduction of self directed support – involving the service user much more in the identification of support needs, goals and outcomes and in the planning of support - sits well with the principles in health services around self management and recovery. There is the opportunity to build a joint service which embraces a culture with the service user at the centre and to reflect this in both process and in the approach of practitioners.

Phasing of Implementation.

3.5 The proposal agreed by Executive Board recommended phased integration of the specialist mental health social work function with the specialist secondary mental health services delivered by LPFT. To ensure there are clear lines of responsibility which are as streamlined as possible, the model agreed was of a single management team with a ratio of two thirds health managers to one third social care managers in front line management posts.

3.6 Phased integration was proposed in recognition that the intention is not to bolt on an existing social care service to an existing health service but to create something new jointly for the benefit of the people who use our services. As outlined in 3.2 – 3.4 there is still a significant amount of work to do to develop a fully integrated service model.

3.7 The phases of integration are described in detail in the Executive Board report and are summarised in the table below. This report focuses on the work to be done in the first phase of integration.

Phase	Staff position	Governance arrangements	Financial position
1	Secondment of front line social workers, Team Managers and Service Delivery Manager. These ASC staff will work within the LPFT operational structure. Management structures will support care pathways and revised team arrangements developed through the transformation project. First line management to reflect 1/3 social care to 2/3 health ratio of social work trained staff (with current competence and experience)	ASC to provide part time Professional Lead for Social Care. This role will have a direct link to LPFT via Director of Care Services. ASC retains professional accountability for statutory services: Community Care Assessments Safeguarding and AMHPs[1]. LPFT is responsible for the day to day management of services	The budgetary responsibilities transfer to LPFT, however risk and accountability remains with LCC (shadow management) Principle of non betterment agreed between the two parties. Costs and benefits of efficiencies to be shared equally between the two parties. LCC contribution required regarding ASC related management posts. In year incidental costs will be borne by respective organisations. Commissioning arrangements remain with LCC.
2	Secondment of front line staff continues as for phase one.	ASC continue to provide part time Professional Lead for Social Care Further development and integration of social model within LPFT services, including the development of skills and expertise in delivery of social care throughout the organisation, supporting the delivery of statutory functions.	Risk and benefit sharing model to be determined. Relative risk levels for each organisation to be identified and the proportionality of same to be established. Review placement budgets in year, in preparation for LPFT to take on full responsibility.
3	Review staffing arrangements, including the option to consider TUPE. ASC staff and management structure fully embedded within LPFT structure	Full development and integration of a social care model within LPFT services LPFT would ensure knowledge and skills are available at a senior level to discharge the statutory duties delegated by the DASS within the LPFT management structure. Social care leadership and professional supervision will be provided by LPFT.	LPFT to take financial control and responsibility of placement budgets. Clear definition of commissioner and provider split.

[1] Approved mental health professionals (AMHPs) are trained to implement coercive elements of the Mental Health Act 1983, as amended by the Mental Health Act 2007, in conjunction with medical practitioners. AMHPs are responsible for organising and co-ordinating, as well as contributing to Mental Health Act assessments

3.8 Within phase one operational management of social care mental health services would transfer to LPFT. Social workers would be seconded to the Trust and an integrated management structure would be developed. Statutory Accountability will be retained by Leeds City Council (LCC) with delegated responsibility delivered through the Chief Operating Officer at LPFT. Financial Placement budgets would remain with Adult Social Care but a shadow management arrangement will be developed for this budget to allow staff seconded to LPFT to authorise spending on support packages and placements.

HR Considerations.

3.9 There are 56 social care staff that make up the specialist mental health social work service who would second to LPFT under this proposal. This includes a Service Delivery Manager, 5 Team Managers (4.5 WTE) and 50 Social Workers (42.6 WTE) Of the 50 staff LPFT fund 14 (12.4 WTE) posts.

3.10 Within phase 1:

- Health and social care staff will work as part of a multidisciplinary team.
- A single management structure will be developed with a mix of health and social care managers
- The day to day operational management of ASC staff will be differentiated from that of professional support and supervision.
- Responsibility for managing the workload of team members, leave requests, absence management and other day to day operational management responsibilities will be provided by the individuals' direct line-manager within an LPFT management structure
- Social care staff will continue to receive professional supervision from a social care professional and all staff will be able to take advice from the professional lead for social care.
- A Head of Service from ASC would work with the senior leadership team within LPFT to support them in fulfilling social care responsibilities. The Head of Service would also provide professional supervision (but not operational line management) to the Service Delivery Manager.

Financial Considerations.

3.11 The financial content of a partnership arrangement is critical to its success. Extensive discussion about the relative risk sharing elements of the partnership have resulted in recommending a phased transfer of financial accountability to LPFT with careful evaluation of impact and effective management.

3.12 In phase 1

- LPFT would 'shadow manage' the budget.
- The operational management of the budget on a day to day basis would sit with LPFT but with oversight from ASC.
- The responsibility for the budget would remain with ASC. This would allow LPFT the time to become familiar with the budget and satisfy itself that it is reflective of need and demographic trends and would allow the development and testing of new governance and reporting arrangements.

3.13 The management of both Health and Social Care budgets together will encourage a whole system approach to planning and increase the awareness of the impact of decisions in each part of the system.

Governance

3.14 With secondment of staff and, over time, the adult placement budget, ASC are proposing to delegate the full management of statutory social care responsibilities to LPFT. A partnership agreement will be developed which will underpin the relationship.

3.15 In Phase One:

- A Section 75 agreement will be developed that clearly lays out the responsibilities of each organisation, describes the partnership and the performance indicators.
- A service level agreement and reporting arrangement with ASC will also form part of this agreement and new governance and reporting structures will be put in place.
- Accountability of statutory social care responsibilities will always ultimately remain with the Local Authority with operational responsibility for carrying out these duties delegated to the LPFT Trust Board.
- Both partners would be answerable to the Health and Wellbeing Board and Scrutiny board for social care services provided within secondary mental health services.

3.16 LPFT would, through its management structures, assist and support the Local Authority (through their delegated officer) to carry out it's roles and responsibilities in relation to its mental health statutory responsibilities, in particular:

- Account directly to the Director of Adult Social Services
- Advise the Council and the management team in respect of mental health
- issues
- Provide professional leadership to social care staff seconded to LPFT.
- Take responsibility for the quality of social care services provided to local
- people, whether directly or through delegation, contracting or commissioning.
- Act as the principle point of contact, below Chief Executive for the conduct of business
- Provide information as requested by Scrutiny and the Care Quality
- Commission.

4. Corporate Considerations

4.1 Consultation and Engagement

4.1.1 There has been ongoing consultation and engagement throughout the process of developing the partnership model. This was documented in the Executive Board report in December 2011.

4.1.2 We are now planning a formal consultation process to discuss proposals around secondment arrangements with staff and trade unions with the aim of seconding staff to LPFT at the beginning of April 2012.

4.1.3 Whilst staff would transfer in their current roles they would be involved in the service transformation work and there may be a requirement to review job descriptions going forwards when building a new holistic service model. In addition, and as described earlier in the report ,the intention is to streamline management structures and implement a single integrated management team. Any changes would be subject to further consultation with staff and trades unions.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Work was undertaken to understand the way that services are delivered now - to capture the differences between teams working practices, to identify what works well and where there are potential areas of inefficiency or duplication. This work revealed that access to social care services varied dependent on:

- referral route into social care (whether someone was referred directly to Adult Social Care or was a referral to mental health services)
- age of the service user (over 65s operate a different service model to under 65s)
- social care knowledge of individual care co-ordinators (or other key personnel)

4.2.2 An Equality Impact Assessment has been conducted. Access to social care services was most inconsistent within the population of working age adults with severe and enduring mental health problems. Uptake of self directed support is also much lower in this group than in any other service user group across Adult Social Care. Service users in this group are more likely to be referred into an open access service than offered a community care assessment.

4.2.3 Self Directed Support has the potential to significantly improve outcomes for mental health service users when incorporated as part of a holistic care plan. Personal budgets can be an effective way of accessing support tailored to individual goals and recovery in a more responsive way than open access services are able to provide.

4.2.4 The development of an integrated service will embed social care within the core business of LPFT and ensure consistent consideration of social care support service users as part of the holistic assessment for people accessing secondary mental health support.

4.3 Council Policies and City Priorities

4.3.1 This change to the service model and partnership arrangement is about working more effectively in partnership with other organisations to improve outcomes for the citizens of Leeds.

4.4 Resources and Value for Money

4.4.1 The integrated care pathways model aims to develop efficient streamlined services. The new pathways will remove duplication in management and in service delivery and this will improve the experience for service users in accessing a single service that can meet a range of support needs whilst maximising use of resources.

4.4.2 SDS being applied within the recovery model offers an opportunity to empower service users to move through the system and need less or no support in the future. Whilst the uptake of personal budgets in working age adults with severe and enduring mental health problems has been low the impact for those individuals who have accessed support in this way has been positive. There is evidence emerging that individuals who have had complex support packages leave mental health service and take up employment and education opportunities following a year of intensive, recovery focused support through SDS. Integrating social care with secondary mental health services will support the process of identifying people who could benefit from SDS in a more systematic way.

4.4.3 The management of both Health and Social Care budgets together will encourage a whole system approach to planning and increase the awareness of the impact of decisions in each part of the system. Phased transfer of financial accountability to LPFT will allow time for skills and breadth of expertise to be developed within the Trust with continued oversight from LCC.

4.5 Legal Implications, Access to Information and Call In

4.5.1 The model includes a proposal to delegate operational responsibilities for Statutory Social care to LPFT. This will be underpinned by a Section 75 agreement that will clearly describe the roles and responsibilities of both ASC and LPFT.

4.5.2 NHS Foundation Trusts are set up as public benefit corporations with a legal duty to provide NHS services to NHS patients. They are membership organisations with local people, patients and staff able to join, having more say in how the organisation is run and how NHS services are provided. Councillor Yeadon is a Governor of LPFT.

4.5.4 Foundation Trusts are assessed, authorised and regulated by the independent regulator “Monitor”. Any resources that ASC transferred to LPFT would also be subject to this regulation

4.6 Risk Management

4.6.1 A full risk analysis has been carried out in formulating this proposal. Potential risks fall broadly into four categories – Governance, HR, Finance and Performance

4.7 Governance

4.7.1 The main risk around governance is in transferring the operational responsibility for delivering statutory social care responsibilities to an external organisation. Robust governance structures need to be put in place with clarity around roles and responsibilities and clear monitoring arrangements. The phased approach we are proposing to changes in governance allows time for LPFT to develop skills and

expertise in social care and fully embed social care responsibilities within its governance and quality assurance framework.

4.7.2 During the project a number of integrated partnerships nationally were visited to help inform the development of the model. All partners talked about the importance of having a robust partnership agreement in place which clearly sets out the roles and responsibilities of each partner ensuring clarity over financial, and performance activity reporting and staffing related issues and which is supplemented with detailed operational schedules. The Project Team have looked at a number of partnership agreements which provide a basis for drafting a section 75 partnership agreement for Leeds and have adopted a best practice model most suited to the Leeds context.

4.7.3 Any identified risks around safeguarding will be reduced and further mitigated with the adoption within the new model of clear lines of accountability and clear recording procedures.

4.8 Human Resources

4.8.1 Consultation and the work on culture identified that there are a number of concerns held by some staff members regarding the different cultures and priorities of health and social care. If left unaddressed this could lead to dissatisfaction in the workforce, active change resistance and potentially could impact on the quality of service that individuals receive. The timing of the proposed integration with the development of a new service model that is built around the individual provides an opportunity for health and social care staff to build something new together for the benefit of the people who use our services. The continued input of a senior manager from social care through phases 1 and 2 further facilitates the development of the partnership and helps to embed social care perspective and values across the organisation.

4.9 Finance

4.9.1 There is a risk if the social care budget is not effectively managed or is subject to in year variation in demand leading to overspend. This presents a financial risk to both organisations across the phases. Initially the individuals with operational management responsibility for this budget will be social care staff seconding from ASC who are familiar with the budget and with Fair Access to Care Services (FACS) eligibility.

4.9.2 The development needs of staff in the partnership including the levels of knowledge of social care that different staff groups require will be analysed and appropriate support will be arranged. Social care will become embedded within core trust business. Risk will be further mitigated by arrangements described in section 3 above where a phased approach is taken to transferring budgets from ASC to LPFT and of having a continued reporting mechanism to ASC through the Head of Service at the start of the partnership.

4.10 Performance

4.10.1 The main risk identified around performance was not about quality of performance but that operating two IT systems would result in Key Performance data (KPI) not being fully captured and therefore not fully evidencing performance detail. If this proposal is approved a robust Information Governance agreement will be developed which will detail roles, responsibilities, systems and processes to capture and record health and social care activity.

4.10.2 Regular monitoring meetings will be held to monitor and meet finance, quality and performance requirements.

5. Conclusions

5.1 Adult Social Care are planning a number of changes to current partnership arrangements with LPFT which both ASC and LPFT believe will result in better outcomes for the people using their services who will enjoy simpler pathways into health and social care service with fewer assessments and avoiding the duplication of professional support. This proposal includes:

- Seconding social care staff to LPFT
- Developing integrated care pathways together that are built around the health and social care needs of individuals.
- A phased transfer of the adult placement budget for mental health to LPFT
- Delegating statutory social care functions to LPFT which will enable the trust to take a whole system approach to service provision
- Development of a robust partnership agreement to underpin these new arrangements

6 Recommendations

6.1 The Scrutiny Board is asked to:

(g) Note the decision taken by Executive Board in December 2011 to integrate specialist mental health social care services with specialist secondary mental health service with LPFT acting as host organisation for the partnership.
(h) Note the development of a partnership agreement under Section 75 of the National Health Services Act 2006 detailing the governance of the partnership between ASC and LPFT
(i) Note the secondment of social care staff to LPFT from 1 April 2012
(j) Note that further detailed work will be undertaken to ensure the ongoing balance of social care management in the partnership.
(k) Note the review of roles and functions of social work within the partnership
(l) Note how potential risks around Governance ,Finance ,HR, and Performance will be managed in the phased approach to implementation described within this report

7 Background documents

National health Services Act 2006

Report to Executive Board, December 2011, Partnership arrangements between LPFT and ASC
Report to Cabinet, May 2010, Adult Social Care and Leeds Partnerships NHS Foundation Trust Mental Health Partnership Proposal
Equality Impact Assessment
Draft Section 75 Partnership Agreement
Report on Consultation with Staff and Service Users
No Health without Mental Health - Delivering better mental health outcomes for people of all ages DH 2011
City Priority Plan 2011 to 2015

Leeds CITY COUNCIL

Report author: John Lennon
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Report of Director of Adult Social Services

Report to Scrutiny Committee

Date: 29 February 2012

Subject: Health and Social Care Service Integration: Proposal to develop Integrated Health and Social Care teams

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. Many people who receive both health and social care support have to cope with two sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Most of these people are living with one or more long-term conditions – and many are elderly.

2. In some parts of the country, health and social care teams have begun to work closely together in a more integrated way. They have found that this more streamlined, joined-up approach often results in services which patients and carers say are better for them – and fewer people ending up in hospital or in long-term residential care.

3. In Leeds we are looking at how we can work together more effectively by developing integrated health and social care teams. This work is made up of three interconnected strands that are being implemented together:

   3.1. **Risk Profiling**. Understanding the needs of the population, identifying those who are at risk of needing hospital or long term care in the future and targeting more intensive support at an earlier stage for those who need it.

3.2. **Integrated Health and Adult Social Care teams**. GP practices, community health and social care staff working together in a more co-ordinated way to reduce the number of different professionals an individual needs to see, and create a more streamlined approach, both for people using services and those who provide them.

3.3. **Self-care – a joint approach to helping people help themselves:** Staff, people who use services, their families/carers and community organisations working in an equal partnership to make sure people have the right tools and information to better manage their condition and live as independently as possible.

4. GP practices, health workers, social care staff and patients will be working more closely together to improve outcomes and quality of care for older people and those with long-term conditions.

5. They will take a combined approach to identifying who's most at risk and providing earlier, targeted support to help people stay as healthy and independent as possible.

6. Shared information, systems and processes will help clinicians and social care teams to reduce waste and duplication and create a smoother experience for people using services.

7. The ambition is to have integrated health and social care teams in place across the whole City by March 2013 starting this process with three demonstrator sites in Kippax & Garforth, Pudsey and Meanwood.

Recommendations

8. Members are requested to note the information within this report and request that further updates on the progress of the demonstrator sites be provided to them over the coming year.

1 Purpose of this report

1.1 This report gives Scrutiny detail of work going on in Leeds to improve the effectiveness of health and social care services. It describes the approach of using demonstrator sites to test out and develop aspects of the model of service.

2 Background information

2.1 *"People want services that feel joined up, and it can be a source of great frustration when that does not happen. Integration means different things to different people but at its heart is building services around individuals, not institutions. The Government is clear that joint, integrated working is vital to developing a personalised health and care system that reflects people's health and care needs."* (Department of Health/Department of Communities and Local Government, 2010)

2.2 The White Paper *Healthy Lives, Healthy People* and the *Transforming Community Services* agenda call for the NHS and Local Authorities across the country to take a joint approach to developing more personalised, preventive services focused on delivering the best outcomes for our communities.

2.3 In Leeds Health and Social Care partners are working together to transform the way services are commissioned and delivered in order to meet the challenges ahead. The detail of the strategy and the Transformation Programme is provided in a separate report.

2.4 An important aspect of this work for Adult Social Care is to look at how organisations can work together more effectively by developing integrated health and social care teams. Integrating services will ensure that the people of Leeds get timely, appropriate health and social care services and reduce the need for people to retell their story to different professionals to get the help they need

2.5 The development of integrated teams will be progressed together with two other key aspects of work: risk stratification – understanding the needs of the population and identifying those most at risk of needing high levels of health and social care support; and improving self-care – empowering individuals to take control of their treatment, care and support through systematic self management.

The model being proposed is based on:

- Existing profile on use of services by people with long term conditions;
- Opportunities to improve health, increase life expectancy, reduce health inequalities within the city;
- Agreement to adopt a model based on national evidence base (Sir John Oldham's model) of risk stratification, integrated teams, systematic self care;
- A desire to develop co-production based on 'no decision about me without me', improving patient/service user experience, promoting choice and personalisation.

2.6 The implementation of adult health and social care teams aims to:

- maintain a strong focus on quality and safety,
- join up care and services offered,
- reduce duplication and waste and offer people greater choice.

2.7 It is envisaged through better integrated and co-ordinated working more people will be supported to remain independent for longer and be enabled to take greater personal responsibility for their health and well-being. This model of service delivery has clear benefits for service users but also benefits the health and social care economy.

3 Main issues

3.1 It is proposed that integrated teams will be rolled out across the City over the next 15 months. To start this process three Demonstrator sites have been identified that will lead the way. These sites will test out new ways of working and their experience of what works will be fed into the service model that will be used in Leeds.

3.2 Three areas have been identified as demonstrator sites by the Clinical Commissioning Groups (CCGs). Whilst there needs to be consistency of approach and equitable services across the City it is also recognised that different neighbourhoods also have their own needs and are in different places to one another in terms of health inequalities and the support available from community groups The demonstrators will be considering how a service model is developed which allows sufficient flex for local variations but provides consistent access to services and high quality care for all. The initial three demonstrators are very different to one another in terms of the geography and density of population and have been chosen for that reason. The chosen demonstrators are clusters of GP practices in Kippax/Garforth, Pudsey and Meanwood. The demonstrators will bring together a full range of health and social care staff and services at a practice/neighbourhood level.

Demonstrator site	CCG	Local Authority Area	Number of practices	Total population	Over 65 population
Kippax/Garforth	Leeds South and East (formerly Leodis)	SE	7	41,775	8,205
Pudsey	Leeds West (formerly H3+)	WNW	6	51,049	7,961
Meanwood	Leeds North (formerly Calibre0	ENE	15	101,342	14,071

3.3 Meanwood is the largest of the demonstrators and is based within the North Leeds CCG. Area (see map in appendix 1) There are 15 GP practices involved with a GP practice population of 101,000 with over 14,000 patients over the age of 65. Pudsey is the second largest demonstrator site with 6 GP practices in the Leeds West CCG area and a practice population of over 51000 nearly 8000 of whom are over 65. Kippax/Garforth in the Leeds South and East CCG area is on the surface the smallest demonstrator site with 7 GP practices with a population of 41775.

However, analysis of the practice populations within this demonstrator highlight a population with more over 65s than the average for Leeds – there are 8205 over 65s registered with these practices.

3.4 For the purpose of the demonstrator areas the teams will be working with all individuals within the practices that are identified as in need of support, this includes those who live outside of the geographical area. .

3.5 A project team has been put together to facilitate the development of the teams. Work is underway on identifying staff to work in the demonstrator sites and the staff in the first demonstrator will be co-located at Kippax Health Centre from 29th February. However, the project has steered away from having a blueprint for the teams to allow service users/patients and frontline health and social care staff engaged in the demonstrators to shape the process redesign and develop a new model of working.

3.6 Co -location will allow health and social care staff to achieve a better understanding of how multi-professional teams can support people holistically – for example, staff will be encouraged and empowered to identify gaps in services and potential solutions for doing things better in the interests of the people they support.

3.4 Staff will be aware of the needs and choices of the people they work with, and with local knowledge will be able to link them into appropriate services in their own local communities.

3.5 Working in a more integrated way will help us to minimise delays, reduce duplication or fragmentation of services, reduce the number of different professionals who need to be involved (so people don't have to keep repeating the same information to different staff), and ensure that information is shared between different professionals more effectively – to create a smoother, more streamlined experience for the individual.

3.7 To monitor the impact of this change programme a number of jointly agreed quality and outcome measures have been identified, namely:

- Patient experience measures
- Staff experience measures
- Activity and finance measures
- Health inequality measures

3.8 Work is underway to agree joint metrics for these measures and to collect baseline data for the demonstrators. In addition options are presently being developed for a formal evaluation of the impact of Integrated Teams linked to risk stratification and systematic self care management. This will be performed by an external agency.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 This service transformation proposal recognises the need to place patients and service users at the centre of the process and to that extent a detailed public patient involvement plan is being produced which will include, at all levels of project structure, patient and service user representation and involvement.

4.1.2 A series of meetings are being held across the city and across organisations, to ensure the full engagement of all staff upon which the success of this proposal depends. There is further detailed work going on in the demonstrators to engage with all stakeholders on a neighbourhood level – including the people who use services and neighbourhood and community groups.

4.1.3 To ensure clear, consistent messages are delivered a Citywide Communications and Engagement Strategy has been produced and a toolkit of communications materials is being put together that can be adapted for local use.

4.1.4 Trades unions have been informed of these proposals through the routine business meetings with the Chief Officer and through the formal JCC meetings and have been assured they will be kept fully informed of developments.

4.1.5 A report has been prepared for Area Committees and the Health and Well Being Partnerships and members of the Project Executive are attending meetings to present this work, to ensure Members and other stakeholders are made fully aware of these developments and can request regular updates to their Board on the projects progress through the year.

4.2 **Equality and Diversity / Cohesion and Integration**

4.2.1 These proposals will be subject to an equality impact assessment throughout the timeline of the project and the outcome of that assessment will be reported upon at its conclusion along with any recommendations as to how services may need to be modified

4.3 **Council Policies and City Priorities**

4.3.1 This proposal is about working more effectively in partnership with other organisations to improve outcomes for the citizens of Leeds and is line with the City Priority Plan 2011 – 2015.

4.4 **Resources and Value for Money**

4.4.1 The integrated care pathways model aims to develop efficient streamlined services. These new pathways will remove duplication in management and in service delivery. This will improve the experience for service users in accessing a single service that can meet a range of support needs whilst maximising use of resources.

4.5 **Legal Implications, Access to Information and Call In**

4.5.1 There are no specific legal implications arising from this report.

4.6 **Risk Management**

4.6.1 The main issues for the council are outlined in the main body of the report. A full risk analysis will be carried out within the context of developing this proposal. The potential risks will fall broadly into four categories – Governance, HR, Finance and Performance and a more detailed report on these areas with be provided at the conclusion of the project.

5 Conclusions

5.1 To meet the increasing demands made on health and social care services In a challenging financial climate both the Council and the NHS need to make radical changes to the way that we work for the people of Leeds .

5.2 In Leeds this proposal is to more closely align health and social care services based on national evidence of what works to help people stay active and independent for as long as possible and provide care when needed in local communities.

5.3 This work is made up of three interconnected strands which are being implemented together:

1. **Risk profiling:** Identifying people who are more likely to need hospital or long-term care in the future, so we can target them with more intensive support at an earlier stage, to reduce this risk.
2. **Health and social care teams working more closely together:** GP practices, community health and social care staff working together in a more co-ordinated way to reduce the number of different professionals who need to be involved in a person's care, and create a more streamlined approach both for people using services and those who provide them.
3. **Self-care – a joint approach to helping people help themselves:** Staff, people who use services, their families/ carers and community organisations working in an equal partnership to make sure people have the right tools and information to better manage their condition and live as independently as possible.

6 Recommendations

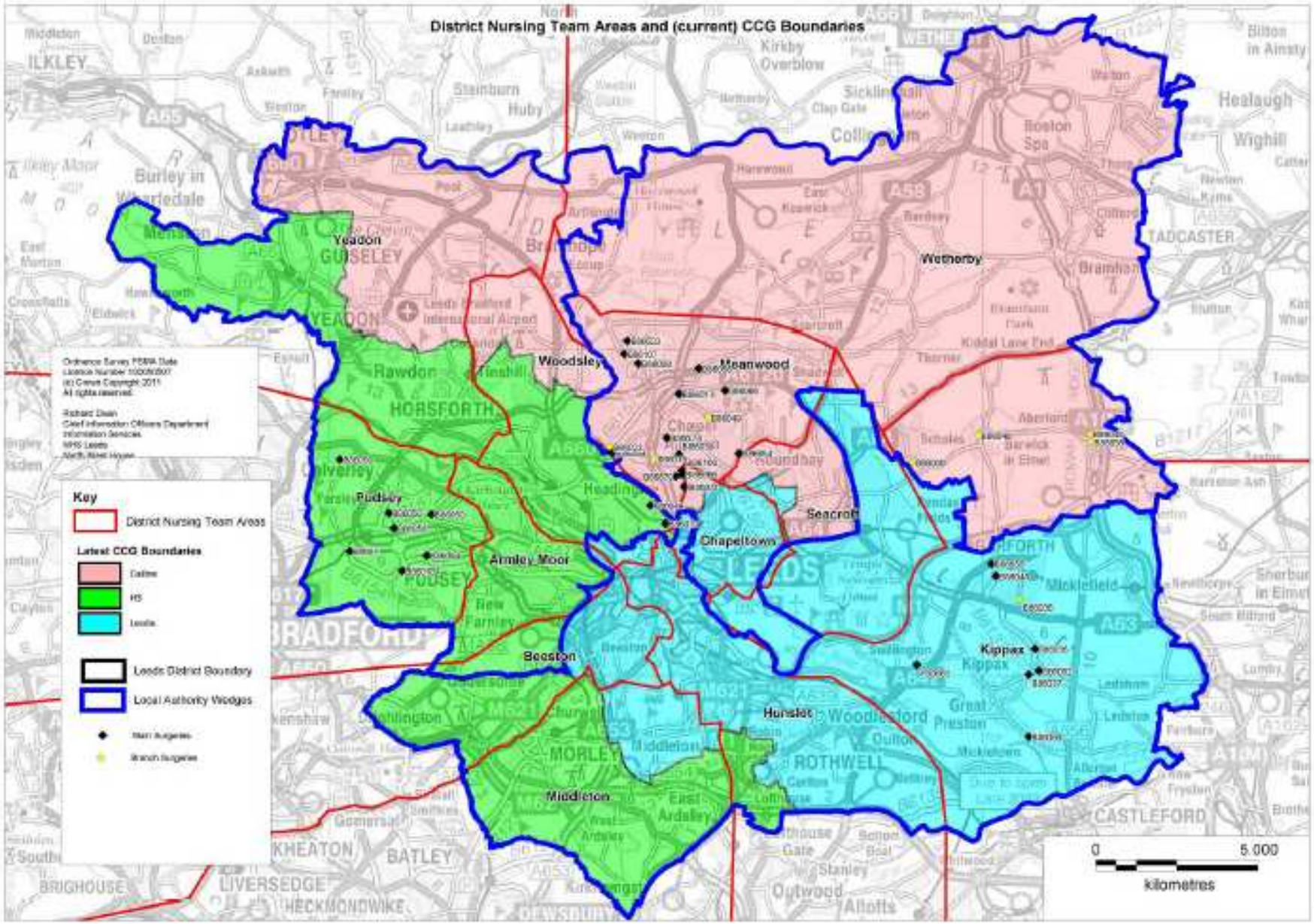
6.1 Members are asked to note the content of this report and to request regular updates on the progress of the demonstrator sites over the next 12 months

7 Background documents

White Paper *Healthy Lives, Healthy People-Dept of Health*

Transforming Community Services Report –Dept of Health

Draft map showing district nursing team areas, potential clinical commissioning group (CCG) and local authority boundaries



Leeds CITY COUNCIL

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Report of Director of Adult Social Services

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 29 February 2012

Subject: Health and Social Care Service Integration: Harry Booth House

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	x Yes Beeston & Holbeck	☐ No
Are there implications for equality and diversity and cohesion and integration?	x Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	x No

Summary of main issues

1. This report provides an overview of the development of the City's first Intermediate Care unit to provide residential and nursing intermediate care beds jointly commissioned by NHS Airedale, Bradford and Leeds [NHSLBA] and Adult Social Care delivered in partnership with the Leeds Community Health Trust [LCH].

2. The report sets out the progress made so far in the project and the plans for delivering the service by October 2012.

3. The Leeds Clinical Commissioning Groups [LCCG] are aware of the project.

Recommendations

4. The Scrutiny Board are invited to consider and comment on the issues addressed in the report.

1 Purpose of this report

1.1 The purpose of this report is to update members of Scrutiny Board on the programme of work developed by Adult Social Care (ASC) to progress and implement the recommendations of Executive Board to develop in partnership with NHSLBA and LCH, the city's first residential care home with nursing and intermediate care beds.

2 Background information

2.1 At its meeting in June 2010, the Adult Social Care Scrutiny Board agreed to undertake an inquiry into the future provision of older people's residential care services. The inquiry offered the first opportunity since the inspection of Adult Social Services conducted in 2008 to begin to articulate the ways in which care and support services for older people could be better shaped to offer a significantly wider range of high quality future options.

2.2 Further to this inquiry, a report to Executive Board in December 2010 considered the future requirements of the Council's residential services particularly in light of the changing demographic profile of older people in Leeds and people's wishes to remain living independently and safely at home for as long as possible. One of the overwhelming messages received from the course of extensive consultation undertaken last year on proposed future options for older people's care was that maintaining people's independence is a priority. People also indicated their support of partnership working with the NHS to ensure that priorities for older people's care and support are not set in isolation.

2.3 Following this consultation, at its meeting on 7 September 2011, Executive Board approved recommendations to recommission Harry Booth House as a specialist facility, in partnership with NHSLBA and LCH. The aim is to deliver directly provided residential care home with nursing to provide 30 nursing and 10 residential intermediate care beds.

3 Intermediate Care – the local context

3.1 Harry Booth House is a 40 bedded residential care home in Beeston. It is a large building with four wings of 10 bedrooms each and ample communal space over two floors.

3.2 Intermediate care is defined as:

3.3 "A short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays, or inappropriate admission to hospital or residential care. The care is person centred, focused on rehabilitation and delivered by a combination of professional groups"

3.4 Intermediate care can be described as a 'bridge' between hospital and home. It is a rehabilitation service that aims to help people regain the best possible level of independence following illness. It can also be an aid in the recuperative process following on from hospitalisation or to avoid hospital admissions.

3.5 The three principles underpinning an intermediate care service are:

- Services should be provided that prevent people being admitted to hospital;
- Services should be provided to assist a timely hospital discharge;
- Services should be provided that encourage promotion of good health, enabling people to make informed choices to remain as independent as possible, within their own homes.

3.6 Intermediate care is offered to those no longer needing hospital care; those who need extra support/therapy to prevent admission to hospital; those requiring rehabilitation after a stroke/fall; those living in the Leeds area that have been assessed as being able to benefit from a short period of focused rehabilitative work to enable a return home.

3.7 The benefits of intermediate care are that it provides intensive rehabilitation in a non-hospital setting with the aim of providing care closer to home. It also allows people to become as independent as possible before going home. In Leeds, Harry Booth House will be part of a continuum of care with acute services at one end, Intermediate Care in the middle and reablement and support service at home at the end of the spectrum.

3.8 Intermediate nursing care is currently provided at a number of independent sector homes across the city on a spot basis, this is not the most efficient way of delivering these services as the beds tend to be spread over a wide geographical area in non-specialist homes.

3.9 There is agreement that a dedicated unit for intermediate care will provide better results in terms of the increased range of services delivered from the facility. In addition it will provide opportunities for positive joint working and more efficient use of adult social care and health staff resources, allowing the service to operate in more integrated ways.

3.10 Current intermediate care services in Leeds delivered from Richmond House reflect the local commitment to joint working at both grass roots and strategic level. The model of Richmond House is one that provides residential intermediate care with nursing support and is not directly comparable with the model to be developed at Harry Booth House.

3.11 Considerable work has been undertaken by officers in the Council and the NHS during the last year to clarify the vision and direction for services for older people. To this end a partnership between NHS Trusts (Leeds Teaching Hospitals NHS Trust, NHS Leeds and Leeds Community Healthcare (LCH)) and Local Authorities has been developed. Other working relationships (statutory, private and voluntary agencies) contribute to maximising or optimising the opportunities to realise the objectives of Intermediate Care.

4 Main issues

4.1 Project Management.

4.2 A Project Team has been established comprising membership from all commissioning and provider partner organisations and chaired by the Chief Officer for Older People and Learning Disabilities and the Director of Integration for LCH. Governance and Terms of Reference have been drafted and circulated for consideration by Project Team members. The project lies within the Better Lives for Older People Programme and has dedicated project management support.

4.3 Progression towards the change of use of Harry Booth House is being made and a number of workstreams established which will;

- develop operational policies and procedures;
- undertake asset management and building works;
- elicit and deliver IT requirements; identify workforce requirements;
- carry out other changes necessary to become an Intermediate Care Unit.

4.4 The Project Team oversee a detailed action plan and set delivery targets against each workstream. It receives monthly Highlight Reports in line with the Council's project management systems. The following section outlines work underway to progress each workstream;

4.5 Service Users

4.6 The social work assessments of the permanent residents at Harry Booth House are now complete. There are four residents remaining in the home. Of these, two are awaiting confirmation that their new accommodation is ready and they are expected to leave within 4 weeks. The other two will remain within the home as, following their assessments, it has been agreed with their families that it would be in their interests to remain at Harry Booth House due to their individual circumstances. However this will be reviewed by a Consultant Geriatrician before work begins to ensure this is still the case as it may be a greater risk for them to remain. We are mindful that the building works required are carried out in a way that does not adversely affect the remaining residents if possible although this may be problematic.

4.7 Service Specification

4.8 There is a formal specification for the service and ASC will be the lead commissioner on behalf of ASC and NHSLBA. The completed specification will form a part of an agreement between NHSLBA and ASC as part of a Section 75 Agreement within the provisions of the National Health Service Act 2006. The service specification sets out the outcomes we wish to achieve for people who access the service and the contribution it will make to the health and social care system in Leeds.

4.9 The service will ensure that it complies with current guidance around best practice requirements issues by the Care Quality Commission. Compliance with these

standards will ensure that people who use our service are protected from harm, supported by suitably qualified and experienced staff.

4.10 The provision of this service will enable older people to receive care and support closer to home in an environment that reduces the risk of exposure to healthcare associated infections, reducing the time they need to be away from their own home.

4.11 The service will contribute to the achievement of the national performance indicators for health and social care by reducing the numbers of avoidable admissions to an acute hospital and providing an alternative to remaining in hospital when they no longer need that level of care and support.

4.12 The service will promote the recovery and continued independence of people who use it through the multi-disciplinary team who deliver the care and support that is required. The staff team will comprise of both health and social care staff including nurses, physiotherapists, occupational therapists, care and ancillary staff. This skill mix will ensure support is provided in a holistic way so that people who use the service will not have to face multiple assessments and it will enable the more efficient use of the staff resource.

4.13 By supporting people to maximise their independence through and ability to undertake the activities of daily living safely they will be less likely to require a long term intervention such as residential or nursing care. People will leave the service better equipped to live in the community with a reduced package of care or, in some cases, with no support needs.

4.14 The service provided at Harry Booth House will be an integral part of the wider network of intermediate tier and preventative services which will be developed across the City in partnership with NHSLBA and LCH. The team at Harry Booth will have close and established links with services and be better able to ensure the seamless transfer from a residential based service to a package of community support through close liaison with the Intermediate Care and Social Care Reablement Teams [SKills].

5 Benefits of intermediate care

5.1 Joint working between Health and social care brings benefits in terms of the whole economy, intermediate care aims to prevent premature admission into hospital by providing a service at home that can help people to receive a level of care that reduces the need for admission to hospital. By saving this cost in the acute sector, resources can be invested into lower level services which tend to be more cost effective. Risks involved in hospital admission are the loss of skills, which can occur with older people alongside the avoidance of hospital acquired infections such as MRSA.

5.2 Another outcome is to promote early discharge from hospital and ensure people get the therapy and rehabilitation support in a unit that often doesn't occur in a hospital setting. By reducing dependence on acute beds and improving outcomes for people, the unit would provide a timely alternative to inappropriate admissions and lengthy stays in a hospital environment.

5.3 This approach is supported by evidence from a number of authorities across the country and from the success of the Intermediate Care Project for Older People in Leeds [DoH Report – Commissioning Care Closer to Home (2009)]. This project promoted independence, reduced the need for beds based solutions, extended the range of home based services, realigned systems to support prevention and earlier intervention and partnership working. This partnership continues through the dementia CIC beds provided across the City

5.4 Kent County Council developed a partnership with the West Kent PCT to develop an intermediate care centre [The Limes] in Dartford. At the beginning of the project the average number of delayed discharges from the acute hospital was over 40 per week. After 18 months that had reduced to single figures. Outcomes for residents were improved. Between January and July 2002 53 residents were referred to The Limes. Of these 42 (79%) were discharged to their own home with a reduced package of care; 7 (13%) went into residential care 1 (2%) was admitted to a nursing home; 2 (4%) returned to hospital and 1 (2%) died. Six months after discharge 35 (83%) remained in their own home; 2 (12%) were admitted to residential care and 2 (5%) died. These figures do illustrate the potential benefits we would expect to see as a result of the development of Harry Booth House.

5.5 The aim is to track the outcomes for people upon discharge from the unit to monitor the extent of reduction in care packages upon leaving the unit, also to create a reduction in residential care placements and provide an analysis for the following twelve months to demonstrate the extent to which the unit has reduced dependence on services and enabled people to live more independently in the community.

6 Staffing issues

6.1 Consideration will be given to the arrangements for staff working within the service and options for the future management of staff in the new redesigned service. These management arrangements are the subject of discussion and confirmation of the staffing arrangements within the service are not yet concluded. The job descriptions, person specifications of both parties employees will be reviewed to ensure that they are fit for purpose to deliver the model of intermediate care required.

6.2 Any arrangements or proposals to change the job description or person specification will be subject to consultation with staff and the trade unions and LCC's job evaluation protocols. The consequent financial risk of any potential change in the grade posts because of additional duties has been logged with the project team as a risk.

7 Operational Policies and Procedures

7.1 NHSLBA commissioners are currently deciding on how they wish to commission the medical support for the unit and are considering a number of options. A workshop is arranged for 2nd March 2012 to consider the options and a recommendation will then be brought back to the Project Board. Officers from both LCH and ASC are working together to ensure that the day to day operational

procedures and reporting systems will ensure that the partners comply with all of regulations as determined by the Care Quality Commission and so enable the service to be registered with them from October 2012.

8 Asset Management

8.1 Harry Booth House is currently registered with the Care Quality Commission as a residential home that provides personal care for older people. Work is on going between corporate property management and estate managers from LCH to ensure that Harry Booth House can deliver nursing care in the future. The site has been measured against agreed guidance and necessary works have been identified. The capital monies for the works have been included in the capital plan and are funded by NHSLBA. In addition some capital investment is required for backlog maintenance works which are required to bring the building up to a suitable standard. Estimates are currently being worked up.

9 Finance

9.1 The cost of the new service has been agreed between NHSLBA; LCH and ASC and the funding will be managed by ASC through a pooled budget mechanism. The details of this will be included in the Section 75 agreement establishing the service.

9.2 The funding envelope for the service is in the progress of final calculation but the estimate is it would be around £2 million total running costs for the 40 beds. The 30 nursing beds will cost more than the 10 residential due to the more complex nature of the users and the need for more intensive support including nursing care. The project will be funded by contributions from both NHSLBA and ASC.

9.3 The capital costs are currently being developed with estimates being drawn up, at the time of writing no agreed costs were available.

10 Consultation and Engagement

10.1 The future of Harry Booth House was the subject of consultation undertaken between May and August 2011 on the future of residential and day services for older people and reported to Executive Board in September 2011. It was also subject to a Scrutiny Board review as part of the reporting process to the Executive Board in September 2011.

10.2 There will be formal consultation with staff and the trade unions on the proposed working arrangements and any proposals to change the job description or person specification for staff.

11 Equality and Diversity / Cohesion and Integration

11.1 The Equality Impact Assessment [EIA] on the proposal to change the service was completed in September 2011.

11.2 By nature of the need for intermediate care, most of the users of this service are some of the most vulnerable and excluded residents in the City. Improving this service will help to ensure that people are enabled to have more control over their care and reduce the risks to the loss of their independence. A further EIA will be undertaken once the final service specification has been agreed by the commissioners and project board.

12 Resources and value for money

12.1 The project is jointly commissioned and funded by NHSLBA and LCC. ASC contributions are from existing revenue budgets. In addition some capital investment is required for backlog maintenance works which are required to bring the building up to a suitable standard. NHSLBA are providing the remainder of revenue funding and are also providing significant capital funding and equipment costs for the new service.

12.2 Officers are currently working up an ideal, affordable scheme which will inform the extent of the refurbishment and capital works required.

12.3 Investment in the project will reduce demand for long term nursing and residential care placements funded by the authority. This will have a positive impact on the community care placements budget.

13 Legal Implications, Access to Information and Call In

13.1 A Partnership Agreement under Section 75 of the National Health Service Act 2006 will define the partnership arrangements for the joint commissioning of services. Individual services specified in the Schedule are to be provided from the Commencement Date under section 75 of the 2006 Act Lead Commissioning Arrangements. Under these, the Council will be responsible for commissioning the named services on behalf of the NHS. In addition, this Agreement includes the arrangements for the local agreed transfer of social care funds to go directly from the NHS to the Council as required by the Department of Health.

14 Risk Management

14.1 The completion of the various activities outlined in this report will determine the earliest completion of the project. Currently the suggested timescale for the operational start date is 1 October 2012. Commissioners in NHS Leeds will be appraised of any issues and risks that could impact on this date. The Project will be subject to a full risk assessment.

15 Recommendations

15.1 The Scrutiny Board are invited to consider and comment on the issues addressed in the report.

16 Background documents

Inquiry into the future of residential care provision for older people in Leeds, Adult Social Care Scrutiny Board October 2010; November 2010.

Future Options for Long Term Residential and Day Care for Older People; Executive Board December 2010.

Better Lives for Older People; Executive Board, September 2011.

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Leeds CITY COUNCIL

Report author: John Lennon
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Report of the Director of Social Services

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 29 February 2012

Subject: Decommissioning the Leeds Crisis Centre

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In February 2011 Executive Board approved a recommendation by Adult Social Care to decommission the Leeds Crisis Centre. This decision was called in to scrutiny. Scrutiny endorsed the decision of Executive Board and requested that a report be brought back to Scrutiny detailing the closure of the service and its impact.
2. Within the closure period all individuals using the service were able to complete their course of counselling.
3. Adult Social Care worked in partnership with health commissioners and providers to ensure that referrers were aware of the timetable for closure and were clear on the pathways into Crisis and counselling services.
4. People who called the service during the closure period were able to be safely signposted to alternative provision.
5. Staff were supported to find alternative roles. When the service closed all staff had been deployed into alternative roles. Some of these were with Leeds City Council, others opted for Early Leavers Initiative or secured posts with external organisations including primary mental health services.

6. The closure as not impacted significantly on the capacity or waiting lists of counselling and crisis services in the City.

Recommendations

Scrutiny are asked to note the measures taken to ensure that the Crisis Centre was closed safely.

1 Purpose of this report

1.1 This report provides detail of the steps taken by Adult Social Care, working in partnership with NHS commissioners and providers, to decommission the Leeds Crisis Centre following the decision taken by Executive Board in February 2011.

1.2 The report also looks at the use of alternative provision in the intervening period and since the closure of the service.

2 Background information

2.1 In February 2011 Executive Board approved a recommendation by Adult Social Care to decommission the Leeds Crisis Centre. This decision was called in to scrutiny. Scrutiny endorsed the decision of Executive Board and requested that a report be brought back to Scrutiny detailing the closure of the service and its impact.

2.2 Established in 1989 by Leeds City Council, the Leeds Crisis Centre provided short-term counselling and support for adults struggling to cope with daily routine because something stressful has happened in their lives. The service provided a rapid response, short-term counselling service 365 days per year. The service received a large number of inappropriate referrals and acted as a referral service for those whose mental illness was more appropriately addressed in the NHS psychiatric or crisis resolution service, or by another type of counselling service. The Crisis Centre itself was not a crisis intervention and resolution service, nor a suicide prevention service.

2.3 The decision to close the Crisis Centre was set in the context of the budgetary pressures faced by the Council. The service cost £696,000 per annum to provide. The provision of this type of service does not fall within the statutory responsibilities of the Council and there had been significant investment in primary care mental health services through IAPT (increasing access to psychological therapies) in recent years. The breadth of provision of both Crisis and counselling services within Leeds was considered appropriate to meet the needs of the population and very different in nature to the provision available when the Crisis Centre was founded.

2.4 At its February 2011 meeting Members of the then Scrutiny Board (Adult Social Care) received a request for Scrutiny from Leeds Local Involvement Network (LINk) concerning the proposal to decommission the Crisis Centre. At this meeting it was agreed that the Board would review 'the exit strategy' for the Centre and the decommissioning process.

2.5 Subsequently at its April 2011 meeting (the last meeting of the municipal year) Members' attention was drawn to the scope of the Inquiry which would focus on future provision and exit strategies. It was reported that implementation of the decision to decommission the Crisis Centre had commenced following the outcome of the call-in meeting on 4 April 2011. At this meeting Members considered and agreed draft terms of reference.

2.6 The agreed terms of reference were subsequently re-presented to the Scrutiny Board (Health and Wellbeing and Adult Social Care) at it meeting in October 2011 in order to re-affirm the Scrutiny Board's agreement to the terms of reference. However at

that meeting, and in lieu of a full scrutiny inquiry into the impact of the closure of the Crisis Centre, the Scrutiny Board agreed to request a monitoring report from the Director of Adult Social Services, setting out the re-provision of services and the impact of change on service users since the closure of the Crisis Centre.

3 Main issues

3.1 **Managing the Closure.** There were a number of elements involved in closing the service:

- **People** – existing service users, potential service users, referrers and the staff team.
- **Information** – communicating the closure and ensuring information is available on alternatives.
- **Asset Management**

A project manager was assigned to the closure to ensure that all of these elements were co-ordinated.

Working with Stakeholders to develop a closure plan

3.2 When the decision was taken by Executive Board to decommission the service there was a period of time when the service remained open to referrals. This was a difficult period for the staff team within the Centre. They were facing uncertainty in their future, had active caseloads and, without an agreed closure date to work back from were continuing to take new referrals for support. In consultation with staff it was decided that it would be preferable to close to new referrals as soon as possible but to continue to offer a telephone support and signposting service. For the service to be in a position to stop taking referrals it was important that referrers were not only advised of the closure timetable but that they were clear on the routes into Crisis and Counselling services within the City.

Service Users

3.2.1 The service offered a time limited counselling service. The number of sessions an individual attended for would vary according to need but averaged around 10 weekly sessions. It was agreed at the outset of the process that anyone accessing counselling would be able to complete their full course of sessions. A letter was prepared for those currently accessing the service to inform them of what was happening and reassure them that they would continue to receive a service. At the same time it as made clear that for some people this may necessitate a change of counsellor. The staff offering support shared this with service users, offering the opportunity to ask questions.

3.2.2 Whilst the service did not get a significant number of repeat users and did not have an ongoing client group there were a number of people who had indicated that they wished to remain in contact with the Centre and were on a database of previous

service users. These individuals were written to. The letter informed individuals, as people who had previously found the service helpful, that the service would be closing and also contained a list of counselling services in Leeds should they feel the need to use a similar service in the future.

3.2.3 All service users finished their individual course of counselling. Weekly lists were compiled of numbers of calls to the service, numbers of people in counselling and the expected number of sessions remaining for each individual. This helped to plan when individual staff could be released and also highlighted referrers that may not have received the message regarding the closure.

Staff.

3.2.4 The staff team were helpful and co-operative throughout the closure period. They worked with senior management to plan a phased closure which included: agreeing a date to stop taking referrals and move to a signposting service for callers; reducing opening hours to balance the needs of the service with a reduction in staff numbers; agreeing phased leaving dates for staff and agreeing a full closure date.

3.2.5 Several staff members opted to take Early Leavers Initiative but agreed to stagger their leaving dates to ensure sufficient cover within the service. The team delivered a professional service throughout – offering support to distressed service users whilst going through the process of managing workforce change, experiencing a rapid reduction in the team size as colleagues began moving on, and dealing with the practicalities of closing a service – archiving records, collating inventories etc.

3.2.6 The majority of staff had left the employment of the council prior to the closure of the Crisis Centre in July. Of the seventeen people that worked for the service, seven opted for the early leavers scheme, one member of staff secured permanent employment in the private sector and five secured position with IAPT. Four members of staff entered Managing Workforce Change and all had placements when the service closed. Three of these have now been permanently redeployed.

Of all the staff from the Crisis Centre, only one has yet to find a permanent position. The individual is currently on placement until end March 2012, although there are hopes this placement will be made permanent. This post has been budgeted for in the 2012/13 budget.

Referrers.

3.2.7 A significant proportion of the referrals received by the service were self referrals (although it is not possible to tell from the information collected whether these were largely signposted by other agencies or were people who had seen the service advertised). The service continued to answer telephone calls and signpost people up to the point of closure and telephone calls did drop to practically none – suggesting that most were signposted. The other referrers were largely health services.

3.2.8 Adult Social Care set up a series of meetings with NHS partners running through the closure period to ensure that clear communications and information was in place to direct people to appropriate services. Referrals continued to be monitored

throughout and within 6 weeks of the initial communication to referrers that the service would be closing the number of referrals from professionals had dropped from 3 – 4 per week to an occasional phone call (less than weekly).

3.2.9 In the paper that was taken to Executive Board recommending decommissioning of the service one of the key issues that was highlighted was that the majority of referrals for the Crisis Centre (70%) were inappropriate and were signposted on to other services with a split of approx 45% to other counselling services and 55% to Crisis services and other specialist secondary mental health services. After the service closed to new referrals this information continued to be tracked. All service users could be signposted to other services and the callers that the Crisis Centre may have taken were signposted to IAPT services.

Information – communicating the closure

3.3 As mentioned in 3.2.8 above there was significant work with health partners to ensure that referrers were not only informed of the closure but reminded of pathways into counselling and crisis services. The information on pathways into crisis services was reviewed and refreshed with GPs. Details of accessing IAPT was also included. The primary care link workers from NHS Leeds worked with the small number of GP surgeries that made most use of the Crisis Centre to ensure they were aware of alternative provision. A joint letter was sent to the Chief Executives of the health trusts regarding the closure and letters were sent to all referrers recorded as using the Crisis Centre in the past. Newsletter articles went into all of the health and social care newsletters and those of the voluntary sector.

3.4 The Leeds City Council website was updated when the service closed to new referrals but continued to signpost, when the opening hours were revised and when the service was closed. The website also housed details of what to do in a Crisis, a list of voluntary sector counselling services that offered free or low cost counselling services and links through to NHS services.

3.5 The communications team searched for references to the Crisis Centre on the internet and contacted other directories to request that details be removed. This was checked periodically to ensure that it had been actioned.

3.6 The Crisis Centre was also mentioned in a number of paper directories and leaflets that were already in circulation so it remained possible that people could still try to contact the service from out of date paper based information. When the service was closed the phone number was kept live with an answerphone message telling callers that the service was now closed and signposting people to their GP or to emergency service when in mental health crisis. This message was also used as an auto-reply on the service's email address although this would not be a usual route for referrals.

3.7 The need for clear information for service users on the wide variety of counselling services available was highlighted. There is no one single counselling service that will meet the needs of all and one of the services that the Crisis Centre was essentially fulfilling was a screen of need and signpost to the most appropriate services based on local knowledge of capacity and specialisms of the different counselling services on offer. As an interim measure the department pulled together an updated list of voluntary sector counselling services with descriptions of what was

on offer which was posted on the website. A more detailed review of the information requirements of the population around mental health services is being progressed as part of a wider piece of work on community support services (mental health day services review) and also forms part of the department's work on developing an information, advice and advocacy strategy.

Impact of Closure on Alternative Provision.

3.8 There are a number of difficulties in determining the impact of the closure of the Crisis Centre on other services:

- **The Size of the Service.** The Crisis Centre was a relatively small service. In the 12 months prior to the proposal to decommission it offered face to face support to approximately 500 people. In a City with a population of over 750,000 and with over 40,000 people accessing primary and secondary mental health services in the same period we would expect the impact to be small.

- **Identifying the population.** The group of people that may have accessed the service is unknown. Most of the people that accessed the service did so once. They were given or came across the Crisis Centre number at a time when they needed support. We have no way of collecting information on how many people that accessed other services might have accessed the Crisis Centre instead had it been available.

- **Changes to Mental Health Services.** IAPT services have been promoted within primary care and their capacity increased. Secondary mental health services have been reviewing their client group to ensure that they are only supporting those with complex mental health issues. This has included a review of people accessing LPFT outpatients. The survivor led crisis service now opens for an additional evening and there has been changes to other counselling services in the City with some obtaining grants to be able to increase the amount of hours support they can offer.

- **Changes to the External Environment.** The economic climate has continued to deteriorate with more people experiencing pressures at work or threats to employment which in turn can affect relationships and put people's mental health under increased strain. This could be expected to lead to increases in the number of people accessing support for mental health issues.

3.9 In the 16 weeks from April when the service stopped taking new referrals to July when the service closed the detail on calls to the service continued to be logged. The number of calls received by the service dropped dramatically as work with referrers was progressed. The service took 36 calls in the week commencing 9th May. In the week commencing 13th June the service took 7 calls. Everyone who called the service was able to be safely signposted to alternative services. The majority of people who the service would have offered an assessment to were referred safely on to IAPT.

3.10 We have spoken to voluntary sector providers and NHS commissioners and they are not reporting any discernable change in workload as a direct result of the closure of the Crisis Centre.

3.11 Information from the NHS reports that primary care mental health practitioners have observed changes in the last twelve months. Individual practitioners report seeing 1 – 2 people per month that have presented in crisis. A number of case management interventions have been put in to respond to this. These include:

- Ensuring crisis management plans are in place and more liaison with GP's to manage risk
- Liaison with other services, including Safeguarding teams, Health Visitors, Housing, Police, CRHT
- Fast tracking on to caseloads, where immediate intervention is required (because the risk or severity may increase if having to wait longer for an intervention).
- Regular telephone support and management of risk, whilst patients are on waiting lists for interventions from the service.

3.12 A direct link cannot be made between the closure of the Crisis Centre and the number of people presenting to IAPT in crisis. This service has 2000 people per quarter entering therapy, and for all of the reasons described in 3.8 above it is not appropriate to attribute small changes in a large service to just one of many variables. Primary care staff have highlighted a number of issues that arise from working with people in crisis – increased stress amongst staff working with more 'risky' clients, not having the time for liaison with other agencies and services and not being able to offer frequent enough appointments. NHS Commissioners and providers understand their responsibility in monitoring the responsiveness of the service and ensuring that the pathways through primary and secondary mental health services are clearly understood by referrers.

Asset Management.

3.13 Adult Social Care worked in partnership with Corporate Asset Management to ensure the building was closed appropriately and transferred to asset management once void. A plan was drawn up with the process detailed and clear areas of responsibility that sat with the service – paperwork, furniture and equipment inventory, utilities, IT, mail, and with asset management – DDP report, securing property, final meter readings, transfer of asset on date of closure – identified together with action owners.

3.14 All files and paperwork that needed to be retained were archived appropriately within Adult Social Care and all other paperwork was shredded.

3.15 An approach was made to Adult Social Care from a group who were interested in continuing the service provision. This approach came at a point when many of the staff had already left the service. A representative of the group met with ASC Commissioners to discuss their proposal. They agreed that it was not viable at this point to take on the existing building but wished to conduct a feasibility study on the continuous need for such a service and explore potential avenues of financial support. Adult Social Care recommended speaking to primary care in relation to the needs analysis and provided advice about enterprise development and signposting to charitable trusts. The group thanked us for the guidance and said they would get back in contact but to date we have heard nothing further about this proposal.

4 Corporate Considerations

4.1 Consultation and Engagement

Service Users

4.1.1 The Crisis Centre operated a time limited, one to one counselling service supporting people who were experiencing a particularly difficult period in their lives. People accessing the service were at different points in their series of sessions of counselling and it was not seen as appropriate to bring people together as a group or to embark on a formal consultation around the closure. What we wanted to ensure was that people were reassured that we would honour the commitment we had made to them in accepting them for counselling sessions and that they would be able to continue with their personal support. All communication regarding the closure, the impact on the people using the service and any discussion around proposed changes to opening hours were directed through the staff member with whom the individual had their counselling session.

Staff

4.1.2 A series of meetings were set up involving staff, HR, senior managers and trade union representatives to discuss the implications of the closure for staff and their options. Early Leavers Initiative and redeployment were discussed with staff, and an offer was made to support staff if they, as a group, wished to explore the feasibility of taking forward the service as a social enterprise. The staff group at the time did not opt for the latter option. Individual formal consultation meetings were also organised with all staff.

4.1.3 The service manager met regularly with the Principal Unit Manager and the Project Manager to discuss actions that needed to be completed and decisions that needed to be made. Staff views were brought to these meetings and the staff were involved in decisions around the timetable for closure including when to stop taking referrals and the need to revise opening hours as staff began to leave the service.

4.1.4 Senior managers met with staff on a monthly basis to discuss the current position of the service and any issues and concerns that staff wanted to raise. Staff were keen to ensure that the service continued to deliver the levels of support that were required for the service users who remained with the service and some staff opted to delay their leaving date to allow this to happen. The department ensured that these staff were not disadvantaged by this decision and that where people needed to leave to take up another position they were supported to do so.

4.1.5 Opportunities for meaningful work post closure were discussed with the staff that entered Managing Workforce Change but all staff had found roles elsewhere by the time the service closed.

Referrers.

4.1.6 Adult Social Care worked with NHS Leeds to agree the most appropriate methods for engaging with referrers. In some instances (for example writing to past service users or to voluntary sector providers) it was agreed to be most appropriate for Adult Social Care to take this communication forward. With health organisations a

joint letter was prepared from ASC and NHS Leeds. NHS Leeds then did some further engagement work with some GPs utilising primary care link workers.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 A full Equality Impact Assessment was carried out when considering the proposal to decommission the Crisis Centre. Full consideration was given as to any potential equalities impact and to determine if there may be any evidence of particular impacts of the proposal to close the Crisis Centre on any group in particular.

4.2.2 The proposals did not appear likely to affect any of the user groups disproportionately within their discrete equalities groups and it was felt that the general impact of the proposed closure was well mitigated by the availability of alternative provision to meet the needs of people who would have chosen to access the service offered by the Crisis Centre. As the service offered time limited support of up to 12 weeks counselling, and commitment was given to allow anyone already accessing services the opportunity to complete their full course of counselling, none of the client group accessing the service at the time would have been disproportionately affected by the closure.

4.2.3 As staff started to leave the service it became necessary to review the service opening hours to ensure sufficient staff cover. Consideration was given to patterns of access of clients in making this decision.

4.3 Council Policies and City Priorities

4.3.1 Council policies were followed in the closure of the service.

4.3.2 With regard to City Priorities the learning from this work feeds into the commitment for health and social care services to work together better for the benefit of the people of Leeds. The Crisis Centre, whilst providing a valuable service to those who accessed it, sat outside of the commissioning plans around either counselling or crisis support and to an extent duplicated provision elsewhere. Health and social care services are committed to working together both in commissioning and in the provision of services to ensure the offer to the people of Leeds is one of joined up services that meet the needs of the population.

4.4 Resources and Value for Money

4.4.1 The difficult decision to decommission the service was taken on the back of the financial challenges facing the council. The service was a discretionary rather than a statutory service. It offered counselling support to a relatively low number of people (around 500 a year) at a cost of £696,000 per annum with a range of alternative provision commissioned by the NHS.

4.4.2 Once the decision had been taken to close the service the speed with which the service was closed balanced the need to make in year savings with the commitment of the department to ensure that no-one currently accessing the service was disadvantaged and that work had been undertaken with referrers to raise awareness of routes into alternative provision

4.5 Legal Implications, Access to Information and Call In

4.5.1 There are no legal implications from this report.

4.6 Risk Management

4.6.1 A project management approach was adopted to ensure that all actions that needed to be taken through the closure period were clearly owned, tracked and risks and issues highlighted and addressed.

4.6.2 The Council worked in partnership with health colleagues to ensure that all actions had been taken to clearly signpost referrers to alternative provision for support before the Crisis Centre closed.

5 Conclusions

5.1 Adult Social Care worked with the service staff and health partners to ensure the safe closure of the Crisis centre

5.2 During the closure period callers were able to be safely signposted to other services.

5.3 The number of calls to the service fell rapidly following work with referrers to inform them of the closure and ensure they were aware of alternative provision.

5.4 There has been no significant impact on the capacity or waiting times for counselling or crisis services in the City as a result of the closure.

6 Recommendations

6.1 Scrutiny are asked to note the measures taken to ensure that the Crisis Centre was closed safely.

7 Background documents

7.1 Report to Executive Board 11 February 2011 Proposal to decommission a non statutory mental health counselling service known as the Leeds Crisis Centre

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