Leeds CITY COUNCIL

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Report of Director of Adult Social Services and Chief Executive Officer Leeds Community Healthcare NHS Trust

Report to Scrutiny Board (Adult Social Service, Public Health, NHS)

Date: 28 July 2015

Subject: 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. Considerable work has been undertaken over the last 3 years to develop the vision and model for integrating or joining up our services across Leeds to improve access and outcomes for people. This report summarises work to date.

2. Ongoing work has moved into the implementation phase, building on what has worked well to date, testing out further concepts and trying out further options on the ground.

3. There is further 'must do' work to support integrated working including having estates solutions in place for all teams and development of shared performance measures. There is also the opportunity to build on the foundation that integrated teams provides to embrace partnership working on a much broader level within local communities picking up on the wider determinants of health and wellbeing.

4. The significance of key enablers namely; ongoing organisational development, IMT(Information Management & Technology), workforce supply and skill, estates, contracting and finance cannot be underestimated in securing the desired outcomes from this work.

Recommendations

The Board is asked to note the update on progress and next steps as outlined.

1 Purpose of this report

1.1 This report updates Scrutiny Board on the progress to date in developing integrated health and social care teams. It provides background to the teams including detail of where and when they were established, what it was hoped the integrated teams would achieve and details of how they operate. It also details the outcome measures developed to capture what good would look like and describes outstanding work remaining.

2 Background information

2.1 The 2012 Health and Social Care Act set out obligations for health and social care to work together to improve service quality and service user experience. This is of particular importance for individuals with complex needs whose experience of the system is of multiple handoffs between services and unnecessary duplication.

2.2 Considerable work has been undertaken over the last 3 years to develop the vision and model for integrating or joining up our services across Leeds to improve access and outcomes for people. The City has developed a neighbourhood model with services organised at a local community level. Ongoing work has moved into the implementation phase, building on what has worked well to date, testing out further concepts and trying out further options on the ground.

2.3 A proposal was brought to scrutiny committee in February 2012 to establish integrated health and social care teams across the City by March 2013. The proposal was to bring social workers, district nurses and community matrons together in 12 teams which between them provided citywide coverage. The first three teams were established by March 2012 and by end of December 2012 each of the twelve neighbourhoods had a team in place.

2.4 *"I think common sense would tell you that when we all work more closely together, patients benefit: increased quality, less duplication and a much better, well-rounded service,"* Community Matron.

2.5 The teams were part of a three-pronged approach which included 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; and supported self-management - 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.

2.6 The role of the teams was to provide joined up care and support close to home to citizens of Leeds[1] with a mix of health and social care needs, preventing unnecessary admittance to hospital, facilitating timely and safe discharge for those that need to go into hospital and to deliver co-ordinated care.

2.7 *"It's so useful being able to take advantage of the nurses' knowledge about the person you're supporting. It means we don't need to ask the person as many questions – so they don't feel they're being asked the same things over and over by different staff."* Social worker.

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[1] Who are also registered with a Leeds GP.

2.8 From 2013 each team was given the freedom to try out new ways of working together and then share good practice across the City, rather than a prescriptive direction on new ways of working. This produced mixed results with staff groups unsure of the boundaries and limitations within which they were operating and with operational pressures and established systems and processes limiting creativity. However, there were a number of positive initiatives that were developed by teams and some areas of concern that were common to all. This resulted in an extensive piece of consultation work with all stakeholders to develop a common target model for community integration.

2.9 A series of outcomes were developed – working collaboratively with staff and people who used health and social care services – capturing what would be different for service users, for staff and for the system when we had developed the integrated service.

2.10 The Outcomes framework (below) was agreed by Health and Social Care Transformation Board in February 2013.

	Better	**Simpler**	**Better value**
Service user and carer	I have choice and control over the services I get. Services see and treat me as an individual. I feel there is time for staff to listen to me.	Teams share information (with my consent), so I don't have to tell my story to too many different people. I know who go to if I need to discuss my support. I am seen in hospital swiftly if that's the best place for me.	Formal services help me to make good use of everyday, community services and support. I can get the support I need to manage my own condition.
Staff	Service users receive a more holistic response because we're integrated. Integration enables us to use planning and meeting time more effectively. We are able to take a more preventative approach to support.	I can spend more time with users and carers because we're integrated. I am clear about my role and responsibilities and how they fit with other roles in the whole system.	There is less duplication because we're integrated. Processes (assessment, recording and review) are streamlined and transparent. We have clear ways of sharing learning and best practice between teams.
System	Integrated teams have led to improved health and well-being. Information flow between teams and to and from the wider system (Third sector) is better.	Integrated teams have led to shorter times from referral to response. There is a shared care plan across all relevant partners.	Integrated teams have helped people stay at home (and not go into hospital or care homes). There is flexibility in roles (for simple tasks) within neighbourhood teams and the wider system.

2.11 The emerging teams were starting to produce improved outcomes for the people of Leeds. Each team could give examples of how being located together, having more opportunity to talk to colleagues and work closely together meant that people were receiving services in a more timely manner and these were more joined up. There are examples across the City from each team of how being in an integrated team has helped to achieve each of the outcomes described in 2.10.

2.12 *"I have been working with the Pudsey team and have found that the team has evolved over the time I have been attending and is delivering results" Geriatrician.*

2.13 At the same time a number of issues had arisen that needed to be addressed. It was clear that to maximise the benefit of neighbourhood working a greater breadth of professionals needed to be part of the team. Operating to different boundaries and working with different populations was also limiting effective partnership development.

2.14 *"I think enhancing the teams with staff from ICT(Intermediate Care Teams) and JCM(Joint Care Management Teams) will make them more useful" "I feel the next step should be more engagement with GP colleagues"* Geriatricians.

2.15 The model was reviewed in 2014 and agreement reached that the teams would work with GP practice populations rather than to strict geographical boundaries, with a thirteenth neighbourhood created. This would mean that for the first time adult social care, GPs and community healthcare staff would be supporting the same people at a local level and would be better positioned to build strong working relationships across organisations. The decision on which GPs aligned with each neighbourhood took into account natural communities across Leeds as it was recognised as equally important that the teams fostered relationships with local voluntary and community groups.

2.16 Teams were strengthened with the inclusion of staff from intermediate care services, adult domiciliary physiotherapy and by a realignment of social work and reablement services into thirteen neighbourhoods with the support of three area based initial response teams. A number of posts which were developed to trial the approach, using short term funding to establish benefits to the system – interface geriatricians, carers support workers provided through Carers Leeds and mental health workers from Leeds and York Partnership NHS Foundation Trust – have also enhanced the work of the teams.

2.17 Post-election the Secretary of State has signalled his intention/commitment to the further development of community based care through:

- Shifting the focus away from hospital settings
- Improving access to primary care
- Further development of true integration

2.18 All of the above are seen as crucial to ongoing sustainability for the NHS and public sector.

3 Main issues

3.1 <u>Outcomes</u>

3.1.1 There have been a number of key achievements in establishing the integrated health and social care teams:

3.1.2 **Improved understanding of one another's roles, leading in turn to more appropriate and timely referrals between services.** This has been achieved through shadowing opportunities, co-working cases and bringing together different professional perspectives in multi-disciplinary case meetings. A positive new development is the opening of reablement pathways so that health colleagues within the team can refer people directly into the service to avoid hospital admission or support discharge rather than needing to refer via a colleague from social care.

3.1.3 **Improved relationships with community and voluntary sector groups and services and raised awareness of the Leeds Directory.** Map of Medicine, used by GPs to navigate a range of services for patients, now links to Leeds Directory giving GPs a wealth of information on community services. The Directory has been promoted heavily within the teams and neighbourhood searches have been added to the Directory to support use of the tool.

3.1.4 **Teams have established links with local neighbourhood networks and have carried out specific pieces of work with community and voluntary groups including social prescribing initiatives.** Teams invite attendance at multi-disciplinary meetings from voluntary sector organisations as appropriate. Specific schemes have linked voluntary sector workers with the teams. Carers Leeds employ Carers Support Workers and Alzheimers Society are in the process of recruiting Memory Support Workers.

3.1.5 **Examples of how more co-ordinated work between professionals as a result of improved relationships and co-location has resulted in improved outcomes for the people we are supporting.** Some of these are captured as case studies at www.leeds.gov.uk/transform.

3.1.6 ***"****My community matron has been working closely with adult social care to put a system in place that means I can have some independence and control back in my life."* Service User.

3.1.7 **Regular multi-disciplinary meetings happening weekly at a local level providing a co-ordinated means of considering individual needs holistically and benefitting from a range of professional perspectives.** Monthly Multi-disciplinary team meetings have been held since teams were first established in 2012. In May 2014 weekly case management meetings were added in. In the twelve months following over 2000 people benefitted from this approach. Some people received additional input from the team as a result of this approach. However, better use of neighbourhood networks and other local authority commissioned third sector services has meant many did not need additional statutory services. Having different perspectives on a case led to increased community input or practical support around equipment. Each neighbourhood produces a case study quarterly capturing good practice.

3.1.8 Multi-disciplinary Team Meetings have "*invariably improved standards of care and in a few cases have staved off unnecessary admissions."* Geriatrician.

3.1.9 **Shared leadership and statutory and mandatory training programmes developed.** Making effective use of training resources, ensuring consistency in standards and providing staff with further opportunity to develop a shared culture which benefits from a range of perspectives.

3.1.10 **Development of a shared 'front door' at Westgate to support integrated working at a local level.** Still under development but providing a single way in to community services for other professionals, improving speed of access to services rather than navigating a number of different routes in. One of the strengths of this model is having a single number when a rapid response is required to avoid hospital admission. Early indications are that this is having a positive impact on demand reduction and accuracy of response.

3.1.11 **Rollout of Leeds Care Record allowing staff within the team access to information from partners on the people they are supporting.** Staff within different health and social care provision use different recording systems and patient records. Leeds Care Record takes information from each system in real time and allows professionals involved in an individual's care to see who else is involved and what input has been provided. This saves time in knowing who you need to talk to and also reduces risk in deciding whether someone can be safely supported at home. There has been a project rolling the record out across the teams and all will have access by September. Initial feedback is extremely positive.

3.1.12 **Peer review project to capture the impact of integrated teams for people using services.** This is discussed in further detail in section 4.

3.2 Challenges and Key Risks

3.2.1 Whilst the foundation of integrated working has been established and benefits of this work are starting to be realised there is still work to be done to fully realise the benefits. This includes completing structural change, sharing and embedding consistent good practice but also building on this foundation with new ways of working.

3.3 Performance.

3.3.2 Implementing a joint performance management framework: There are no performance measures in place that teams work to as an integrated team. Both organisations continue to capture performance measures specific to their internal requirements. Work was undertaken by commissioners to identify activity measures that may indicate success as per the outcomes framework and this has been pulled into a dashboard but further work is needed to develop a coherent set of performance measures that integrated teams collectively own.

3.3.3 Whilst some practice is consistent across all integrated teams there are a number of initiatives that have been tried in one or two neighbourhoods that now need to be evaluated and rolled out across the City.

3.3.4 **Estates.** Structural changes have been necessary to establish the teams and further work is necessary in this area to maximise the benefits for the City. Identifying suitable estates to bring staff together has been, and continues to be an issue. It is essential for team building that members of the team can come together in their neighbourhood but there are insufficient buildings with capacity to house the team in some areas. There have also been difficulties in scoping the requirements for the teams, particularly through the initial stages, however, 50% of the teams nowhave a base that accommodates the whole team.

3.3.5 Estates has been a particular challenge as we have tried to bring together corporate asset management strategies across and within two organisations and identify a solution for one service area when asset management colleagues need to balance the needs of a multitude of service areas. Estates solutions and efficiencies are also dependent upon the teams adopting a similar model of 'New Ways of Working' (NWOW) as that currently adopted within the Council for City Centre staff. It is recognised that this represents a further significant change for the teams to absorb at this time. Notwithstanding these difficult issues the Programme continues to work with partners from asset management to address them.

3.3.6 Different IT systems and infrastructure meant investment was needed in bases to enable health and social care staff to work from the same place. Interdependent work within LCH (Leeds Community Healthcare) to move staff to mobile technology is in the process of being delivered and there is additional pressure on bases until staff have the tools to work in more flexible ways. Work is being progressed by both organisations to try to establish shared bases in all thirteen localities and to equip staff with technology to be able to work more flexibly.

3.3.7 **Climate of Change.** LCH has been balancing the developing partnership with Adult Social Care with a major internal restructure of services. This restructure is still in the process of being implemented and staff are trying to establish their identity within the teams and develop new skills. New processes have been developed as part of this work and will be implemented over the coming year. This will support more integrated working but won't be fully realised until 2016.

3.3.8 Change has taken place in a climate when other large scale change was also being progressed. In addition one off development money led to a large number of short term projects being run concurrently. Many of these impacted on the same frontline staff as the development of integrated teams and this slowed the pace of progress.

3.3.9 **Scale of Change.** Both organisations needed to realign staff teams impacting 1200 staff. This involved significant engagement work with staff which took time. It also required additional work from teams to prepare for realignment, movement of cases across teams and changes to care records. This needed to be balanced with the priority of delivering essential frontline services. As there was no additional resource to support this activity pace of change was slow.

3.4 Future Actions and Plans.

3.4.1 The programme board have identified a number of actions in their work plan this year to progress the model:

3.4.2 Refine the vision and required outcomes based on current evidence and thinking.

3.4.3 Define and implement a clear performance management framework against which teams can be measured (singly by organisation and as a joint service).

3.4.4 Implement a clear and consistent model across Leeds, learning from the best, that defines 'what good looks like' in a neighbourhood team, that is also flexible enough to be responsive to local needs.

3.4.5 Ensure positive and proactive leadership at every level to achieve shared objectives.

3.4.6 Continued engagement with customers to ensure their needs are at the heart of everything the neighbourhood teams do.

3.4.7 Consideration of how to better engage with other partners – including GPs, mental health services, neighbourhood networks and other voluntary and community groups.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Throughout 2012 and 2013 whilst the model was being shaped and developed a designated patient and public involvement lead was employed to ensure that people that use services were engaged in the development of the service model. This was achieved through attendance at workshops and events, through specific task and finish groups and through a reference group; together with use of existing forums across the City.

4.1.2 There has been media coverage of the developments, designated web pages showcasing examples of integration and several roadshows in shopping centres and within the foyer of St James Hospital aimed at raising public awareness of this work and gathering opinions.

4.1.3 During implementation we have been interviewing people that have used both health and social care services. A team of older people were recruited and trained as peer evaluators. They work with each neighbourhood in turn asking the team to identify people who have accessed both health and social care services in the last six months and would be happy to be interviewed. After all interviews for a neighbourhood have taken place the peer evaluators meet with the neighbourhood team and provide feedback which then feeds into the team's service improvement plan to positively impact on service development and delivery going forwards.

4.1.4 As mentioned above the development of the neighbourhood model impacts directly on approximately 1200 staff across Leeds City Council and Leeds Community Healthcare NHS trust. The approach of the programme has been led by operational services with support from project staff. A year long piece of work on future workforce planning involved hundreds of staff and service users and throughout the development there have been opportunities for staff and unions to engage in the work.

4.1.5 New concepts have been developed and tested by the groups of staff impacted by change before being rolled out across the City.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 When teams started working together it became evident that having some services working to practice populations and others working to geographical boundaries meant that there was an inequity in the service offered. For those people whose surgery fell within the right geographical boundary they could benefit from the full support of an integrated team but for those who sat in the

geographical boundary of another neighbourhood team there was no added benefit.

4.2.2 In making changes to boundaries and moving to practice populations thought was given to natural communities and, considering the wider determinants of good health, the need for integrated teams to work effectively with local communities. This resulted in some branch surgeries being supported by a different team to their main practice. For example North Leeds medical centre at Moortown corner has a branch surgery, Milan Street, in Chapeltown. Chapeltown has a much younger demographic and a different ethnic make-up to Moortown. It was agreed that this branch served a different community and they would benefit more by being supported from a neighbourhood that was actively working with the community. Chapeltown neighbourhood is part of the 'Better for Me' proactive care pilot targeting people in their 50s and 60s who have been newly diagnosed with long term conditions such as diabetes or heart disease and may need extra support to help them learn how best to manage their condition. It is appropriate that all members of this community are able to benefit from this initiative.

4.3 Council policies and the Best Council Plan

4.3.1 This development is about working more effectively in partnership with other organisations to improve outcomes for the citizens of Leeds.

4.3.2 Integration sits as one of the three strands of the Better Lives Programme – objective 4 on the 2015/16 objectives in the Best Council Plan.

4.4 Resources and value for money

4.4.1 There were no specific cashable savings targets assigned to this work. Leeds, in common with the rest of the country, is facing a rise in the number of older people combined with an increase in the number of people who live with multiple chronic health problems. This will increase the demand on services in the future. Development of the neighbourhood model, together with more proactive approaches to managing an individual's health are designed to slow the demand, reduce the use of acute (hospital) services and reduce use of unplanned care. The development of the ongoing performance management frameworks in support of the new model of services will enable the benefits of this work to the whole Health & Social Care system in Leeds to be both measured and monitored more effectively.

4.4.2 The significance of key enablers namely; ongoing organisational development, IMT, workforce supply and skill, estates, contracting and finance cannot be underestimated in securing the desired outcomes from this work.

4.5 Legal Implications, Access to Information and Call In

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

4.5.2 As an information report to Scrutiny Board, this report is not eligible for call in.

4.6 Risk Management

4.6.1 There is a requirement from the Department of Health that local authorities can demonstrate integrated working with the NHS by 2018. This sits as a risk within the corporate risk register and progress on the integrated teams work is reported within this quarterly.

5 Conclusions

5.1 Whilst teams were in place across the City at the end of 2012 integrated working has continued to develop over the subsequent two and a half years with a process of develop, test and embed applied in continuing to expand the scope of the teams.

5.2 There are clear benefits emerging from the establishment of integrated health and social care teams. Partnership projects with community and voluntary groups and with other statutory partners highlights the potential to develop this model further to meet the health and wellbeing needs of the population with a focus on local communities.

5.3 The programme has a number of objectives clearly identified for action in 15/16 to ensure that the neighbourhood model is consistently embedded and providing effective, responsive services.

6 Recommendations

6.1 The Board is asked to note the update on progress and next steps as outlined with particular reference to the achievements to date, the identified actions required around estates and performance and the future plans.

7 Background documents[2]

7.1 None

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.