Leeds CITY COUNCIL

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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