Leeds CITY COUNCIL

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Report of Director of Adult Social Services

Report to Area Committees

Date: 14 February 2012

Subject: 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. 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 **co-production and self-care** – empowering individuals to take control of their treatment, care and support.

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 Committee Members 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 At the same time, all NHS organisations and local authorities must deliver efficiency savings while maintaining or improving the quality of services, to meet QIPP (Quality, Innovation, Prevention and Productivity) and local authority Spending Review targets, respectively.

2.4 The Leeds Transformation Programme is a city-wide agreement between Health and Social Care partners to work together to deliver the challenges ahead. Programme Board membership includes the Director of Adult and Children's Social Services together with the Chief Executives of all of the NHS trusts within the City.

2.5 Demand for health and social care services is growing because of a continued increase in the proportion of people aged over 65 and, in particular over 85 years; new developments in health and care interventions; and trends in 'lifestyle' challenges such as obesity, levels of exercise, smoking, and drug and alcohol dependency.

2.6 To ensure we can rise to these challenges successfully, we need to fundamentally reshape the way in which health and social care services are delivered in partnership with the people of Leeds.

2.7 Through the Transformation Programme, public sector organisations in the city will work, together with third sector colleagues, to pool resources, support integration and deliver services tailored around the needs of individuals and local communities. The Programme is the means by which, together, the NHS and Adult Social Care will drive and deliver the transformation of health and social care services with the people of Leeds.

2.8 Some projects within the programme impact more directly on Adult Social Care than others. The Urgent Care and Older People and Long Term Conditions work areas are particularly important in ensuring 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

2.9 An important aspect of this work is to look at how organisations can work together more effectively by developing integrated health and social care teams. 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 co-production and improving self-care – empowering individuals to take control of their treatment, care and support.

The model being proposed t is based on:

- Existing profile on use of services by people with long term conditions;
- Opportunity 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.

2.10 **Shaping the Workforce.** The proposal is to work with the staff delivering health and social care services and with service users to consider the support people would access from health and social care teams and the skills the teams need to deliver this support. This information will then be will used to build the multi-disciplinary teams of the future with the right blend of professional skills and practices .A model of workforce development will be used to engage staff and service users in identifying the skills needed. This will then inform the numbers of staff and types of role that will make up the teams. The idea of generic workers will also be explored.

2.11 To help us develop a model of partnership working that will be right for Leeds the proposal is to start with three demonstrator sites – one in each of three areas of the City. Health and social care staff in the demonstrators will be co-located and will test out and consider the tools and processes that they need to be in place for effective joint working. The teams will be based around GP practice populations linked to neighbourhoods- working closely with GPs and with the voluntary sector and community groups.

2.12 **Focus of the Model.** The initial focus of the teams will be on those individuals identified as having the highest level of need – these will often be older people living with more than one long term condition. By targeting those who are most at risk of arriving at hospital as an unplanned or emergency admission efforts can be made to tailor appropriate health and social care services to the individual and their needs – helping them to remain safe and supported in the community.

2.13 If people do need a period of time in hospital ,integrated teams can also facilitate discharge from hospital when people are medically fit to leave. By having an integrated health and social care system with appropriate support co-ordinated from the community, planning for discharge can start earlier with people quickly directed to the most appropriate support setting for them.

2.14 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.

2.15 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 we develop a service model 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	Leodis	SE	7	41,775	8,205
Pudsey	H3+	WNW	6	51,049	7,961
Meanwood	Calibre	ENE	15	101,342	14,071

3.3 Meanwood is the largest of the demonstrators and is based within the Calibre 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 H3+ CCG area and a practice population of over 51000 nearly 8000 of whom are over 65. Kippax/Garforth in the Leodis CCG area is the smallest demonstrator site with 7 GP practices with a population of 41775 but with over 65s numbering 8205..

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 who will facilitate the development of the teams. Work is underway on identifying staff to work in the demonstrator sites and, working with the staff defining the work of the demonstrators. 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 Working more closely together 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 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:

- Baselines for demonstrator sites prior to go live
- 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. 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.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 This service transformation proposal recognises the need to place patients and service user 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, initially for staff teams within the demonstrator areas, but eventually across the city and across organisations, to ensure the full engagement of all staff upon which the success of this proposal depends.

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

4.1.4 Early in the new year it is planned that this report and a presentation will be provided for all Area Committees and Health and Well Being Partnership Boards 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.

4.5.2 This report is eligible for call in.

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 and delivers improved patient and service user experience and outcomes.

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

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

7.2 Transforming Community Services Report –Dept of Health

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